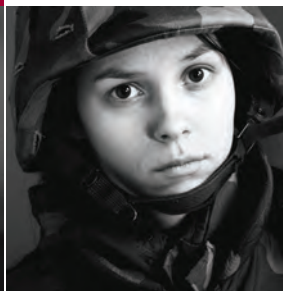


# SOCIAL WORK & CHRISTIANITY

JOURNAL OF THE NORTH AMERICAN ASSOCIATION  
OF CHRISTIANS IN SOCIAL WORK

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## **SPECIAL ISSUE: RELIGIOUS AND SPIRITUALLY-ORIENTED INTERVENTIONS WITH VETERAN AND MILITARY POPULATIONS**

### **INTRODUCTION TO SPECIAL ISSUE**

Introduction: Spiritual and Religious Interventions with Military  
Affiliated Clients

### **ARTICLES**

Moral Injury in Warriors and Veterans: The Challenge to Social Work

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of Post-Traumatic Stress Disorder in the Military

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in Social Work Practice with Service Members and Veterans

Trauma, Spirituality, and Mindfulness: Finding Hope

### **POINT OF VIEW**

Warrior Faith: A Marine's Lesson in Religion, Health, and Healing

# SOCIAL WORK & CHRISTIANITY

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*Social Work & Christianity (SWC)* is a refereed journal published quarterly in March, June, September, and December by the North American Association of Christians in Social Work (NACSW) to support and encourage the growth of social workers in the ethical integration of Christian faith and professional practice. *SWC* welcomes articles, shorter contributions, book reviews, and letters which deal with issues related to the integration of faith and professional social work practice and other professional concerns which have relevance to Christianity.

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RELIGIOUS AND SPIRITUALLY-ORIENTED  
INTERVENTIONS WITH VETERAN AND  
MILITARY POPULATIONS

**Introduction: Special Issue  
on Religious and Spiritually-  
Oriented Interventions  
with Veteran and  
Military Populations**

*Dexter Freeman & Laurel Shaler*

*This introduction provides a brief, yet comprehensive synopsis of this special edition of *Social Work & Christianity* that was designed to address the dearth of literature on how to effectively incorporate spiritual and religious beliefs and content in the assessment and treatment of service members and veterans. The authors provide a conceptualization of the context of the problems that service members present with, as well as a review of what the reader can expect to receive from each article within this uniquely designed special edition.*

**I**N *THE COST OF COURAGE* (2012), PRYCE, PRYCE, AND SHACKELFORD recount the heart-breaking story of an Army First Sergeant by the name of Jeff McKinney. They explained how war changed him and it all ended one hot July day when he fired off two shots from his weapon into his chin. There was no suicide note or indication to his soldiers that he was considering such a drastic escape from the pain he had been trapped in for so many years. Although Sergeant McKinney's story is tragic, not just for him, but also for those who are left behind, this is a story that is far too common

for service members and veterans. Paquette (2008) described the relentless and unyielding atrocities of war that soldiers of today and yesterday are continuously enslaved to when she said, "The soldiers also bear witness to their dehumanizing behavior of not only killing the enemy but also innocent civilians...The inability to forget what they experienced and what they did in the name of war is the private hell many veterans live with for the rest of their lives" (p. 143). Some refer to the battle-wounds that soldiers return with as wounds to the soul as well as wounds to the body. A plethora of studies have been performed over the past decade and have confirmed the effectiveness and significance of spirituality and religion in the healing process of soldiers and veterans who may be seeking to cope with wounds to their body and soul. This special issue invited practitioners, researchers, and educators to submit papers with an emphasis on demonstrating the effectiveness of integrating religious and spiritually-focused interventions with military populations.

This special issue of *Social Work & Christianity* was designed to equip social workers, counselors, psychologists, psychiatrists, and other behavioral health providers who may be grappling with how to address the deep spiritual needs of service members and veterans who may be hampered by the wounds of war. Studies have shown that there is a significant relationship between religion/spirituality and traumatic injuries related to war (Currier, Holland, & Drescher, 2015; Falsetti, Resick, & Davis, 2003; and 2012; and Fontana & Rosenheck, 2004). Nevertheless, there remains a dearth of information about how to actually incorporate and address spiritual and religious issues with military populations. This special issue seeks to address this void.

In the first article, Blinka and Harris discuss moral injury among warriors and veterans. They state that as more warriors survive severe physical injuries, there is increased awareness of the immense spiritual toll inflicted on warriors, veterans and their families by wounds to the spirit and soul. This paper defines moral injury, outlines its history, explores metrics already developed to measure it, discusses programs to address it, and reviews ongoing research.

In the second article, Freeman describes the diversity of spiritual and religious resources that support and compel military service members to pursue a career in the military. Moreover, this article exposes the reader to an assessment instrument, the family circle, that enables clients and social workers to identify spiritual, emotional, and social resources to help service members and their families cope with the consequences of defending America's freedom.

In the third article, Shaler examines the ethical integration of Christian faith in social work interventions with veterans. Shaler takes a cogent

look at the faith of the military member and how providers can ethically integrate their faith into the treatment milieu. This article is designed to increase the awareness and competency of clinicians who work with service members and veterans.

In the fourth article, Wade describes how clinicians can effectively incorporate spirituality with cognitive processing therapy when treating service members who present with symptoms of post-traumatic stress. Wade presents the relevance and effectiveness of incorporating spirituality with evidence-based treatment for service members who are struggling with combat-related PTSD.

In the fifth article, Foley, Albright & Fletcher describe a unique model for integrating spirituality into social work practice with military populations. Their model depicts how signs and symbols can be used to facilitate the integration of religion and spirituality into social work with service members and veterans.

In the sixth featured article, Kick and McNitt state, “duty to country and one’s battle buddies surmounts all else. The underside of ‘service before self’ is the shame and guilt a service member experiences when they are unable to manage fear and anxiety once they return to the civilian world.” The authors discuss how the use of Terror Management Theory can assist the person in conceptualizing the world as a “just place” that helps create a space for the person’s spiritual views and belief system.

There are two final components of this special edition. The first is a point of view article by Thomas. She describes her personal journey as a Marine officer, and the lessons she learned about religion, health, and healing. This is followed by a compilation of resources to assist providers who might desire additional information and training about this very important subject.

This special edition of *Social Work & Christianity* is far from complete in terms of providing an all-inclusive compendium of resources to enable practitioners to meet the spiritual needs of service members and veterans who may be seeking wholeness due to their hidden wounds from war. However, this journal will definitely help practitioners who desire to incorporate spirituality into their practice with military populations to feel more confident and knowledgeable to respond to the spiritual needs of their clients. ❖

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# Moral Injury in Warriors and Veterans: The Challenge to Social Work

*Dee Blinka & Helen Wilson Harris*

*Each generation grapples with the enduring trauma of war. As more warriors survive severe physical injuries, there is increased awareness of the immense spiritual toll inflicted on warriors, veterans and their families by wounds to the spirit and soul. In the face of high suicide rates in both warriors and veterans, the concept of moral injury has emerged as this generation's contribution to the challenge of healing these men and women. This paper will review the definition of moral injury, the metrics developed to measure it, the social work role and programs to address it, spiritual implications, and ongoing research. The particular spiritual and professional relevance of this concept to social work and the integration of faith and practice is discussed.*

*The soldier answered, 'Heal me if you will,  
Maybe there's comfort when a soul believes  
In mercy, and we need it in these hells.  
But be you for both sides? I'm paid to kill  
And if I shoot a man his mother grieves.  
Does that come into what your teaching tells?'*  
(Sassoon, 1916 as cited by Hart-Davis, 1983)

**W**AR HAS ALWAYS INFLICTED MORAL INJURY ON ITS PARTICIPANTS; mankind's innate horror and taboo against killing another human being is recorded throughout civilization. "The moral anguish of warriors defines much literature about war from ancient times to the present" (Brock & Lettini, 2012). Shay (1994, 2002) wrote that the literature

of the world is rich in stories depicting this suffering. As a British poet of the First World War, later killed in combat in 1918, Wilfred Owen distilled into his poems the utter desolation of his dreaming and awake world (Silkin, 1972). A loving Christian God is nowhere to be found in Owen's work (Owen, 1963). His poems speak to the loss of hope for humanity, made more profound by the sheer irrationality of what was happening.

### **Defining Moral Injury**

In 1994, drawing on over 20 years of experience of treating Vietnam vets, Shay published *Achilles in Vietnam: Combat Trauma and the Undoing of Character*, which was welcomed by veterans and warriors alike. Shay stated in the introduction that his aim was to "put before the public an understanding of catastrophic experiences that not only cause life-long disability but can ruin good character" (p. xiii). In 2002, *Odysseus in America: Combat Trauma and the Trials of Homecoming*, Shay called for the prevention of "psychological and moral injury in military service" (p. 6). More recently, Shay (2011) stated that while there are broader meanings that have become associated with the words "moral injury," the current, most precise and narrow definition has three parts. Moral injury "is present when 1) there has been a betrayal of what's right 2) by someone who holds legitimate authority 3) in a high stakes situation" (p. 183). Further, when all three are present, moral injury is present, "and the body codes it much in the same way it codes physical attack" (Shay, 2014, p.185).

Out of many years of service to the military as a psychiatrist and in a number of consultant/advisory roles, Shay became convinced that "ethical leadership is a combat strength multiplier" (2011, p. 183). The author believed that leaders who deviate from what is right and moral contribute to a significant reduction in motivation and loyalty that can lead to disobedience to military authority. Instead, the author stated that troops "do want to know that what they are doing has a constructive purpose" (2011, p. 183). It is arguable that this is more significant in the wars of recent centuries where troops, whether on the ground, sea or air, may experience more and more meaninglessness when there is no front, where victory remains elusive and unclear, where collateral damage occurs on a daily basis, and where perceived allies become attackers. These circumstances without constructive purpose can make the many deaths and injuries of both warriors and civilians all the more painful.

A broader and equally useful concept of moral injury has been defined and elaborated in a carefully researched landmark paper by Litz, Stein, Delaney, Lebowitz, Nash, Silva, & Maguen (2009). Their working definition of situations that may cause moral injury and thus define the response has been widely accepted:

....perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations (p. 700).

The authors clarified that transgressing one's own moral code can include active participation or passive witness of actions understood to be immoral. The very act of bearing witness to the unbearable can cause moral injury.

These clarifications of moral injury are often part of war, but not always. Shay's definition provided a starting place for understanding moral injury. Litz et al. provide the working definition for this article and much social work response.

### **Moral Injury and PTSD**

While moral injury is a fairly new term in the literature, Post Traumatic Stress Disorder (PTSD) is a psychiatric diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). While the DSM-5 enumerates criteria for diagnosis of PTSD, practitioners and scholars continue to define the latest thinking about PTSD, particularly in warriors and veterans (Guina, Weton, Broderick, Correll, & Peirson, 2016). Litz and associates (2009) wrote to clarify war injury as spiritual wounds that in some cases does not include the physiological arousal seen in PTSD (2009, p. 697). However, Shay (2014) stated, "From my observation, where leadership malpractice inflicts moral injury, the body codes it as a physical attack, mobilizes for danger and counterattack, and lastingly imprints the physiology every bit as much as if it had been a physical attack" (p. 185.) What then is the relationship of moral injury to PTSD, if any?

There is ongoing discussion as to where moral injury stands in relation to the diagnosis of Post-Traumatic Stress Disorder (PTSD). Most researchers in moral injury emphasize that moral injury is separate from PTSD (Shay, 2014; Maguen & Litz, 2014; Litz et al., 2009; Drescher, Nieuwsma, & Swales, 2013). Certainly if PTSD is understood simply as a severe anxiety disorder it makes no sense to classify moral injury under the same label (Litz et al., 2009).

As Maguen and Litz (2014) stated in an article entitled *Moral Injury in the Context of War*, there is a need for additional research on the commonalities and distinctions between the two. The authors stated "although the constructs of PTSD and moral injury overlap, each has unique components that make them separable consequences of war and other traumatic contexts" (p. 4). They go on to describe PTSD as a mental disorder, requiring a diagnosis, but define moral injury as a "dimensional problem," with no threshold:

At any point in time a Veteran may have none, or mild to extreme manifestations. Transgression is not necessary for PTSD to develop nor does the PTSD diagnosis sufficiently capture moral injury (shame, self-handicapping guilt, etc.) (p. 4).

It is therefore important when evaluating a warrior or veteran to assess mental health symptoms and moral injury “as separate manifestations of war trauma” (p. 4), in order to get a clear picture and recommend relevant treatment. Additionally, Maguen, and Litz (2012) reported both that moral injury is a significant risk factor for the development and worsening of PTSD and that PTSD has responded to treatment for moral injury.

One of the important aspects to this whole debate is that warriors and veterans consistently verbalize their discomfort with treatment and the word disorder (Shay, 2011; Barrus, D., personal communication, 2015). Consequently, a more constructive and useful term might be *war injury*, which can encompass both PTSD and moral injury. Shay’s use of the terminology “wound,” referring to the damage of war or trauma, offers a sense of partnership between the warrior and veteran and the clinician. Shay (2011) said, “the surgeon’s concepts of *primary* wounds in war and of wound *complications* and *contamination* serve as models for psychological and moral injury in war” (p. 179). Shay feels that these ways of phrasing war injuries (even when these are psychological, as in moral injury) are much less stigmatizing than PTSD. By using the term *war injury*, the helping professional working with a warrior or veteran can remain watchful for a variety of conditions and symptoms including physiological arousal and dissociation.

### **Moral Injury and Dissociation**

Dissociation has long been considered a symptom of psychological injuries sustained in war, and it is another important characteristic in considering war injury and PTSD. Van der Hart, van Dijke, van son, and Steele (2015) convincingly describe somatoform dissociation in traumatized World War I combat soldiers. Reading their descriptions of the conditions suffered in the trenches during those war years and of “the constant bombardment of shelling, one is vividly reminded of the many stories today from our warriors, of collecting body parts, often of their buddies, with the constant noise, smell, blast and incineration from exploding mines; but also of the massive power of their weapons to blow an insurgent to bits in front of their eyes, tales of horror which provoke ‘the two thousand yard stare’” (Lea, 2008, p. 195; Barrus, D., personal communication, 2015). Dissociation with moral injury suggests that PTSD is also present.

### **Moral Injury and Suicide**

In 2014, Bryan, Bryan, Morrow, Etienne, and Ray-Sannerud (2014), National Center for Veterans Studies-University of Utah, reported the results of their study that examined moral injury, suicidal ideation, and suicide attempts in a military sample. Their purpose was to see if certain aspects of moral injury serve as risk factors for the development of self-injurious thoughts and behaviors (SITB) among military personnel. Using the MIES (Nash et al., 2013) to assess moral injury, the findings from this sample of 151 active duty Air Force personnel seeking outpatient mental health care supported the hypothesis that certain aspects of moral injury serve as risk factors for SITB. They stated, “military personnel and veterans who express distress regarding the ‘rightness’ or ‘wrongness’ of their actions may be at increased risk for SITB and *may experience more intense suicidal crises*” (Bryan et al., 2014, p. 5). They also made the point that such inner, intense conflict can occur in warriors and veterans who may have never directly experienced life-threatening situations. Since killing is a major objective of war, the risk factor of what Litz et al. (2009) term “transgression other” needs to be evaluated when looking at combat through the lens of taking life rather than fear about losing one’s own.

Nasarov and associates (2015) connect moral injury to the likelihood of succumbing to debilitating PTSD. They reviewed nineteen articles and concluded “there is strong evidence linking exposure to and the perceived perpetration of moral transgressions with experiences of guilt and shame” (pp. 1, 11). The authors found that there was a relationship between the participants’ guilt and shame and their mental health outcomes, specifically negative mental health including PTSD, increasing their vulnerability to self-harm and suicide. Brock and Lettini (2012) found that “the consequences of violating one’s conscience...can be overwhelming...and the only relief may seem to be to leave this world behind” (pp. xv-xvi).

Maguen & Litz (2014, p. 6) found in their sample of Vietnam War veterans a statistically significant relationship between the experience of killing the enemy and incidence of suicidal ideation. Veterans who had killed were twice as likely to consider suicide, even when accounting for PTSD diagnoses, depression, and substance abuse.

### **Moral Injury as Insufficient Concept**

Drescher and associates (2011) assessed whether moral injury suffices as a concept in a study in which participants (chaplains, mental health providers, academic researchers and policy-makers) were asked to respond to a questionnaire about moral injury. Participants gave strong support for the concept but found the definition to be inadequate. Some named the response

to these challenges as “moral repair” (p. 8). While moral injury maintains its distinction in the literature, in certain theological centers moral injury is sometimes spoken of at the same time as “soul repair” (Brock & Lettini, 2012). These terms are focused more on responses to moral injury than to assessment or identification of the phenomenon.

### **Professional Responses to Moral Injury**

The identification of moral injury is only the beginning of treatment. Chaplains with therapy training and skills and social workers and other mental health professionals with spiritual sensitivity and religious cultural competence are well suited for this work. Social workers engaged in work with those with moral injury must have several areas of competence including (1) the quality of therapeutic presence and unconditional regard, (2) treatment modalities for trauma, (3) the ethical integration of faith and practice, and (4) moral injury specific assessment and intervention. Preparation for these competencies begins with social work education and requires professional development through continuing education as the field develops.

### **Therapeutic Presence**

The role of social worker as mental health practitioner is important when clients present with the possibility of moral injury. The holistic approach of social workers, including sensitivity to spirituality and the valuing of each person, provides significant space for persons with moral injury to seek help. As is true with all clients, there is a clear need for the warrior or veteran experiencing moral injury to perceive that he or she is listened to and respected (Harrington-LaMorie & McDevitt-Murphy, 2011; Shulman, 2012). Civilian social workers with the U.S. military will often comment that warriors will thank them for “just being with,” just sitting and listening; this is often the first time the soldier has been received in that way (personal communication, Barrus, D., 2015). Litz and associates (2009) spoke to the need for a therapist “who must portray unconditional acceptance and the ability to listen to difficult and morally conflicted material without revulsion” (p. 702). Social workers whose training and ethics, from the beginning, urge the need to “start where the client is” (Clark, 2015; Shulman, 2012) are ideally suited to this role of unconditional acceptance and regard. This is particularly true in the current climate in which fewer families and fewer social workers are exposed to the military. “. . .the social work community, with a few exceptions, has been slow to come to terms with the worldwide conflict in which we have been engaged for several long years with no definite end yet in site (Pryce, Pryce, & Shackelford, 2012). This calls for the social work skill of therapeutic presence, i.e. the ability

to “be with” the client in their circumstance without judgment. Drescher, Nieuwsma, and Swales (2013) discuss treatment for moral injury as “soul repair” and described how a helper can best support a veteran or warrior in this work, with the opinion that

[S]oul repair...best happens when helpers sit alongside the veteran in the midst of pain and anguish and bear hopeful witness to the long journey of transformation that may occur. When helpers too quickly jump in to fix or answer, the focus can be on the social worker’s journey or answers rather than that of the client (p. 53).

This is important to remember when discussing concepts like forgiveness. The offering of quick forgiveness or suggestion of self-forgiveness may be dismissive of the depth of pain of the client and is sometimes more about the worker’s need for resolution than sensitivity to the client’s pain. Attention to the integration of faith and practice in social work is essential to avoid this fundamental error.

### **Faith and Practice**

Social work practice addresses this in self-awareness, the use of consultation, and starting where the client is. This is particularly true in the ethical integration of religion and spirituality with social work practice. The three organizing principles of the ethical integration of faith and practice include the (1) the faith or religion of the client, (2) the faith or religion of the social worker, and (3) the organizational context (Harris, Yancey, & Myers, unpublished manuscript, 2016).

In work with clients experiencing moral injury, the principle of understanding and working with the client’s religious and spiritual worldview and values is fundamental to the helping process. Tick (2005) pointed out that there can be a disconnect in the understanding that war and religion are both “linked since the beginning of time” (p. 269) and simultaneously apparently contradictory to human relationships. It is the very violation of the warrior’s own moral code in the horror that is war that can result in moral injury.

Second, the social worker’s awareness of his or her own spiritual life and lens is also important to the process. What does the social worker believe about the concept of “just war” and the difference between “Thou shalt not kill” and “Thou shalt not murder”? (Tick, 2005). Social workers often serve in settings where they manage the tension of their own values and those of their clients with skill and dignity.

Third, in a military setting and with military clients, an understanding of how faith and spirituality are honored and how they are separated is also important to the therapeutic intervention. Social workers may seek train-

ing to understand military culture and may use the skills of ethnographic interviewing to experience the client as cultural guide and expert. The National Association of Social Workers' (NASW) Standards and Indicators of Cultural Competence in Social Work (2015) include the concept of cultural humility, which includes social workers taking a listening, non-judgmental stance and relating to the particular religion, faith, or worldview the warrior or veteran, espouses.

The issues that cause most pain in moral injury arise from feelings of deep shame, self-disgust, and guilt (Litz et al., 2009; Steenkamp, Nash, Lebowitz & Litz, 2013; Nazarov et al., 2015). Social workers, with their long-standing knowledge and skills in treating and advocating for victims of abuse and violence, have a deep grasp of how to treat long-term companions of moral injury: "poor self-care, alcohol and drug abuse, severe recklessness and parasuicidal, self-handicapping behaviors, such as retreating in the face of success or good feelings, and demoralization, which may entail confusion, bewilderment, futility, hopelessness, and self-loathing" (Litz et al., 2009 p. 701). Guina, et al. (2016) reported that the potential for successful identification and treatment of war-related problems in the military includes the need for reducing stigma and unintended negative consequences for disclosure. The context of the military focuses on the strength of warriors. Social workers may help normalize the moral strength of seeking treatment in service members.

These three principles of the ethical integration of religion and spirituality and social work practice are fundamental to effective helping (Harris, Yancey, & Myers, unpublished manuscript, 2016). They are also essential to interdisciplinary work, including military settings where chaplains are identified as providers of spiritual or religious care with their focus on the service person's religion or spirituality. Social workers are prepared to work closely with chaplains and other religious leaders so that the issues of moral injury repair can be most effectively treated. The value of social work in this inter-professional team is the social workers' role as therapist/clinician and family systems facilitator.

### **Therapeutic Role**

One particular contribution of social workers to the team addressing moral injury is professional focus on understanding the more recent conceptualizations of the neuro-biological underpinnings of PTSD (Yehuda & McFarlane, 1995). This includes the study of peri-traumatic and somatoform dissociation and complex PTSD (van der Hart, Nijenhuis, & Steele, 2005; Frewen & Lanius, 2015). Social workers trained to work with persons who have experienced trauma are prepared to listen for the themes of moral injury and to provide evidence-based response. Frequently, those who are less traumatized will find their way to their spiritual leaders, but the

majority, though troubled by moral injury, may need the informed skills of the trauma-informed social worker, who supports those with moral injury and establishes safety to facilitate seeking further healing.

The spiritually-sensitive and competent social worker is able to assess war injury differentially for dissociation, for PTSD, and for moral injury. This assessment includes the warriors' or veterans' belief systems and how they make meaning out of their war experiences. Social workers who integrate religion, spirituality, and worldview into their practice are able to help clients discuss and apply concepts from the client's own belief system like forgiveness, restoration, and peace. The spiritually-sensitive, culturally-competent social worker begins where the client is, learns his/her language for spiritual concepts, and helps the client to integrate the complexities of meaning-making. Further, their assessment includes competencies for assessing, understanding, and intervening with trauma.

### **Trauma-informed Social Work**

The social worker whose clients have experienced trauma must be prepared with clinical skills for psychotherapies that are evidence-based and evidence-informed. At minimum, this means understanding them well enough so as to be able to refer appropriately as needed. Familiarity with the three evidence-based psychotherapies approved for the treatment of PTSD in 2010 by the World Health Organization (WHO) (2013), the Veterans Administration (VA), and the Department of Defense (DOD) is essential. These treatments are Cognitive Processing Therapy (CPT), Prolonged Exposure (PE), and Eye Movement Desensitization and Reprocessing (EMDR).

A trauma-informed social work therapist will be able to recognize dissociation and be able to calm and handle dissociative symptoms. They will similarly be competent to help those clients experiencing physically tense or numbed psyche and body. Advanced therapeutic approaches which are valuable in helping social workers learn and practice these skills include Sensorimotor Psychotherapy (Ogden, Minton, & Pain, 2006), Somatic Experiencing (SE) (Payne, Levine, & Crane-Godreau, 2015); Emotional Freedom Techniques (Church, Pina, Reategui, & Brooks, 2011). These are therapies which already have significant evidence for effectiveness with trauma. Additional new therapies are emerging for trauma that also have potential for effectiveness with moral injury.

The trauma-informed social worker can develop knowledge and skills by study and training and at a minimum, visiting or volunteering at these programs in order to be able to assess their value for clients. Knowledge of such programs can be valuable to the social worker because warriors and veterans will depend on the social worker for intervention and for referral. Additionally, social workers who work with veterans and warriors need to begin their own research projects including single-subject design with measurement of effectiveness.

Additionally, social workers assisting veterans and warriors will need to be familiar with programs described later in this paper designed particularly to treat moral injury in military settings, including Adaptive Disclosure, Acceptance and Commitment Therapy, and Impact of Killing. A short term treatment program currently gaining recognition for trauma is Accelerated Resolution Therapy (ART). Initial research by Kip, et al. (2015) appears promising and needs additional research to determine how effective the combination of elements of CPT, PE, and EMDR are compared to the other evidence-based therapies.

Competent trauma-informed practice begins with a good understanding of the major threats to mental health in all populations with specific attention to risk in warriors for suicide, substance abuse, major depression and bi-polar disease, and Complex PTSD (C-PTSD). Nickerson and Goldstein (2015) provide one compelling narrative and overview of these risks, including their negative experiences and client outcomes with flawed systems. Their experience speaks to the importance of macro as well as clinical change necessary to effectively treat moral injury and PTSD.

### **Implications for Social Work Education and Training**

In a seminal paper, *Moral Injury: An Emerging Clinical Construct with Implications for Social Work education*, Kopacz, Simons, and Chitaphong (2015) suggested that core competencies be developed for work with clients suffering from moral injury. The authors observed that Advanced Social Work Practice in Military Social Work (Council on Social Work Education CSWE, 2010) does not address moral injury. They addressed this gap in competencies through a series of recommendations for social work education, including teaching practice behaviors related to military social work and to the treatment of moral injury. There are increasing numbers of programs with concentrations and specializations in military social work. The authors also addressed the important role that religion and spirituality play in social work practice as part of developing a social worker's holistic view of the person-in-environment. This, in turn, emphasizes the significance of social work education in preparing students with the knowledge and understanding of the many diverse religious beliefs practiced by warriors and veterans.

The social work approach to the client's religious or spiritual beliefs and experiences includes cultural competence. Leigh (1998) suggested that cultural competence is achieved through ethnographic interviewing in which clients are the experts on their own experience. The 2015 Educational Policy Statement and Standards include religion as culture as do The DSM-5 (2013) and the NASW Code of Ethics (NASW, 2008). Teaching the ethnographic approach of client as expert provides skills to take a spiritual

history as an integral part of the client's story, ideally in the intake process to open up further avenues for discussion. This may include issues of moral injury experienced by the warrior or veteran. There are many examples of this possibility. Perhaps if Alyssa Peterson, a young intelligence analyst who committed suicide in 2003 (Pryer, 2014), could have entrusted a social worker with her personal conviction that she could not take part in so called "torture-lite" interrogations and that her shame included that she was reprimanded in her chain of command, her death might have been prevented and perhaps more could have been done to begin a conversation about moral injury. Cases such as these are ideal for social work education and professional continuing education and skill development.

### **Assessment and Treatment Modalities**

Social workers understand that best practice with clients begins with an examination of the research literature. The commitment to evidence-informed practice is an important component of effective social work practice. The adaptation of treatments for related conditions is also an important hallmark of evidence-informed treatment. Appropriate treatment begins with assessment. There are several assessments being used and tested for moral injury which we discuss here. We then turn our attention to intervention modalities including Adaptive Disclosure (AD), Acceptance and Commitment Therapy (ACT), Impact of Killing in War (IOK) techniques, and Peer Group Support. Additional therapies being used by social workers and mental health practitioners treating moral injury are mentioned briefly as well.

### **Assessment Metrics for Moral Injury**

Defining a problem or response is the beginning of understanding. Measuring the construct allows improved assessment necessary to treatment and evaluation of treatment. The Moral Injury Events Scale (MIES) (2013) is a brief, 11 item, scale developed by the Association of Military Surgeons of the U.S. This tool is specifically designed to assess for suicidal ideation and gives insight to perceived transgressions and perceived betrayals. The scores give insight to exposure to events that might contradict deeply held moral beliefs.

A second tool, the Military version (MIQ-M) (Currier, Holland, Dreshler, & Foy, 2015), was developed and tested with veterans of Iraq and Afghanistan assessing for a number of events which may trigger a response of moral injury. Items address betrayal, violence, suffering and death, civilian population, and moral/ethical conflicts.

Both of these tools are being tested for reliability and validity against other older instruments for PTSD and war injury like the Combat Experi-

ences Scale. Social workers are encouraged to use these scales to assess for moral injury and to contribute their discovery around effectiveness and usefulness to the emerging literature.

### **Intervention Modalities**

Social workers whose client assessments include the possibility of moral injury have available to them several evidence-based treatment possibilities and have evidence that some of the approaches for PTSD may not be the best approaches for treating moral injury. Having defined what they see as the essence of moral injury, Litz and colleagues go on to delineate specific treatment strategies. They make the case that traditional, empirically validated, fear-based conceptual treatments for PTSD such as Cognitive Behavioral Therapy (CBT), Prolonged Exposure (PE), and Cognitive Processing Therapy (CPT) may not be sufficient to successfully treat moral injury with its strong component of guilt and overwhelming shame (Litz, et al., 2009, p. 702). At the heart of their concern is their conviction that the theories about the development of post-traumatic syndromes have been based on the concept of harm done to an individual by others. These theories and resultant responses have not included consideration of “potential harm produced by perpetration (and moral transgressions) in traumatic contexts” (Litz, et al. 2009, p. 699). In other words, the shame and self-blame that accompanies violation of one’s own moral code and is part of moral injury requires a different, if related, approach to therapeutic intervention.

The approaches of Adaptive Disclosure, Acceptance Commitment Therapy, the Impact of Killing in War (IOK), Eye Movement and Reprocessing Desensitization (EMDR), and Peer Support are introduced here as current therapies being explored with moral injury. Readers are provided a brief overview here with the recommendation that social workers who are interested in competence in a particular modality train with an experienced practitioner who has used the model successfully.

**Adaptive Disclosure.** Litz and associates (2009) developed “Adaptive Disclosure,” an eight-step pilot program for Marines redeployed from Iraq and Afghanistan.

- Step One is Connection, defined as “a strong and genuinely caring and respectful therapeutic relationship” in which, to encourage disclosure, “the therapist must portray unconditional acceptance and the ability to listen to difficult and morally conflicted material without revulsion” (p. 702).
- Step Two is Preparation and Education, which helps the warrior understand moral injury and normalize the path to wellness.

- Step Three is Modified Exposure, which includes a “focused reliving of the event.”
- Step Four is Examination and Integration, which is an exploration of the warrior’s moral code and understanding before the war events to provide a baseline.
- Step Five is Dialogue with a Benevolent Moral Authority, which includes a technique similar to the Gestalt empty chair with a trusted person to whom to tell their story.
- Step Six is Reparation and Forgiveness, which allows the warrior to make amends and reconnect with personal values.
- Step Seven is Fostering Reconnection, which includes connecting and reconnecting with others moving toward normalcy in relationships.
- Step Eight is Planning for the Long Haul, which includes preparing for times when the trauma may be retriggered in the future and skills for managing that.

The thoughtfulness with which this program is elaborated reminds the reader of how important Litz and colleagues feel the understanding of moral injury is in treating the despair felt by many warriors and veterans. The incorporation of spiritual concepts, including forgiveness and a higher power, serve to address important dimensions of moral injury. It also appears to us that social work education has the potential to prepare social workers to take on the role of treating moral injury with Adaptive Disclosure and including forgiveness and reconciliation, particularly when social workers are prepared to ethically integrate spirituality and social work practice.

**Acceptance and Commitment Therapy.** A second approach is Acceptance and Commitment Therapy (ACT). This therapy was developed during the past decade as the result of the new research regarding moral injury. Grounded in Cognitive Behavioral Therapy (CBT), ACT stems from a growing body of research (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Lappalainen, Lehtonen, Sharp, Taubert, Ojanen, & Hayes, 2007; Powers, Zum Vorde Sive Vording, & Emmelkamp, 2009; and Ruiz, 2010) that supports shifting the focus away from simply treating cognitions to an emphasis on expanding skills and flexibility to deal with life’s challenges. “Patients are supported in mindful awareness of their experience and acceptance techniques” (Nieuwsma, Drescher, & Nash, 2015, p.196). Work centers on present awareness and managing the ambiguity of cognitions where the trauma of the past is juxtaposed against the “normality” of the present.

ACT, with its accent on avoiding rigidity, may have additional contributions by protecting “the construct of moral injury from developing into an overly medicalized phenomenon” (Nieuwsma et al., 2015, p. 204). The

focus on mindfulness and skill building and the emphasis on working in community and with chaplains and other spiritual leaders may also be helpful to social workers in their efforts to help warriors and veterans struggling with the guilt and shame of moral injury. This therapeutic model connects mindful awareness of what life brings us with tolerance or acceptance of unpleasant feelings without a need to do anything in response to them. This combination of the CBT connection of thoughts, feelings, and behaviors is enhanced by mindful awareness in the present with acceptance of ambiguity.

**The Impact of Killing in War (IOK).** A third approach is a relatively new program entitled the Impact of Killing in War (IOK) (Maguen & Litz, 2012; Maguen & Litz, 2014). This experimental, six-session course consists of a series of lessons to be used in conjunction with ongoing clinical treatment for PTSD for veterans suffering from moral injury. The first session takes an educational approach concerning the biological, psychological, and social aspects of killing in war and how these aspects can relate the development of moral injury. The later sessions build on this base, looking at meaning, the self-blaming cognitions that develop, and the opportunities to experience self-forgiveness and the development of an action plan to make amends, where possible. Social workers working outside military settings may also see clients who attend these sessions.

**Eye Movement Desensitization Reprocessing (EMDR).** EMDR, discovered more than 20 years ago by Dr. Francine Shapiro, has been empirically validated in more than 24 random controlled studies for the treatment of trauma. The therapy uses an eight step process that includes history taking, preparation, assessment, desensitization, installation, body scan, closure and reassessment. The therapy is centered in bilateral stimulation to activate neural pathways, adaptive information processing of mal-adaptively stored memories, and dual attention (present focus with memory processing) (Shapiro, F., 2016; Shapiro, F., 2014; Shapiro, R., 2005). Licensed therapists may complete approved training provided by certified trainers and consultants.

**Peer Groups.** Shay (2011) advocates strongly for peer support for warriors and veterans. It makes sense, in view of the military emphasis on cohesion and the “buddy” system, that, on redeploying, warriors and veterans will relate most easily to their “reference group.” A survey conducted by the Wounded Warrior Project (WWP, 2014) found that 59% of warriors and veterans who had served during OEF/OIF (Operation Enduring Freedom and Operation Iraqi Freedom), identified talking with other OEF/OIF veterans “as a top resource for coping with stress” (WWP, 2015, p. 15). They state that “veterans remain reluctant to seek care, with half of those in need not utilizing mental health services” (Hoge, 2011, p. 549). This is significant because of the poor retention of veterans in treatment for PTSD.

Among veterans who begin PTSD treatment with psychotherapy or medication, a high percentage drop out....With only 50% of veterans seeking care and a 40% recovery rate, current strategies will effectively reach no more than 20% of all veterans needing PTSD treatment (WWP, 2015, p.15).

Is it possible that issues with moral injury are part of the reason for this failure in treatment and retention, particularly as moral injury is related to PTSD but not necessarily responsive to the same interventions as PTSD? In that case, it will be helpful for social workers, in addition to understanding moral injury, to be knowledgeable about local and national peer support groups. Examples are “Real Warriors,” “Bootcamp In. Bootcamp Out,” “teamRedWhiteandBlue,” “stopsoldierssuicide.org,” and “vets4warriors.”

**Emerging Treatments.** There are additional trauma-related treatment modalities which are being explored by clinicians working with moral injury. Some are showing positive results and are the focus of current research.

**Progressive Counting.** One of the trauma treatments developed as an adaptation of EMDR is Progressive Counting. This therapy includes the EMDR concepts of dual attention, memory consolidation, scaling of symptoms, and negative cognitions. It also integrates motivational work, cognitive-behavioral integration, and other treatment skills in “three steps: (a) client preparation...; (b) exposure...; (c) review” (Greenwald 2013, p. 49).

**Soul Repair.** Already mentioned in this article is Drescher, Nieuwsma, and Swales’ (2013) work on moral injury and the treatment called soul repair. The authors describe this method as being one primarily used by clergy, chaplains, spiritual care providers, and mental health providers. The response focuses on “connecting within a supportive community, building friendships, emotional expression through the arts, recovering meaning and purpose through service, and ‘deep listening’ on the part of the helpers (p. 53). The central concepts are those of bearing witness and therapeutic presence.

**Equine Assisted Therapy.** Ferruolo (2015) and others observed that veterans with psychological impairments may resist traditional talk therapies and seek alternative treatments. The author reports that one of those alternative treatments, equine assisted therapy, is showing good outcomes. Ferruolo reported on a pilot study with significant improvement in depression, anxiety, and PTSD in veterans. Most certified equine therapists in the United States are social workers with additional training and certification (p. 50).

### **Research in Moral Injury**

Further research is ongoing, but more is needed before clear recommendations can be made to address increasing suicide rates in warriors and

veterans (Hurley, 2015; Shinsheki, 2010, p. 1). An insightful paper prepared by eight authors (Steenkamp, Litz, Gray, Lebowitz, Nash, Conoscenti, Amidon, & Lang, 2010) described the development of a pilot program to provide evidence-informed treatment specifically designed for Marines deploying to the Middle East war zone. The concern was that veterans/warriors were not benefitting from the traditional progressive exposure approaches. Prior to the introduction of the pilot program, the researchers reported that issues presented by the warriors/veterans were more centered on guilt and shame, consistent with moral injury and grief rather than PTSD. So the interventions needed to be tailored to the presenting problems. Steenkamp et al. (2010) emphasized that for many of the veterans in their study, their most troubling symptoms did not involve PTSD issues of “threat of death, injury, or loss of physical integrity” (DSM-IV-TR, APA, 2000, p. 467). Their issues were not traditional fear-based events but were those involving perceived moral transgressions. The resulting therapeutic approaches already discussed in this paper, Adaptive Disclosure, ACT, and IOK call for further research. Random controlled trials of AD, funded by the Department of Defense (DOD) began in 2013. Social workers with a commitment to the evaluation of practice effectiveness are uniquely positioned to continue this research. Further, the integration of concepts around forgiveness, reconciliation, and moral and soul repair fit the social work model for the integration of faith and practice.

### **Conclusion: A Spiritual Endeavor of the Highest Order**

As we have seen, so many questions are unanswered. By viewing the issues to work on in terms of moral injury, the social worker is able to bring to the table a better understanding of the issues, a professional approach to evaluation of practice that will inform evidence for future treatment, and the hope that these approaches begin to address despair and resulting suicide rates. Although we believe passionately that a trauma-informed approach to the suffering that veterans and warriors experience with PTSD and moral injury is necessary and that using the terminology of moral injury will bring better results, the reality is that for insurance and compensation reasons, diagnoses for the immediate future may need to be made in terms of disorders. Development of evidence for the phenomenon of moral injury and appropriate and effective treatment may lead to changes in diagnostic labels in the future.

In the meantime, attitudes and decisions toward treatment do not have to be confined by diagnostic labels. The movement to promote understanding of moral injury has helped social workers and therapists see a wider area of pain and suffering than was previously recognized or addressed. Van der Hart, Nijenhuis, and Steele (2005), for example, made a convincing case for their belief that dissociative symptoms and dissociative

disorders are essential features of PTSD, evident in the somatoform nature of the warrior or veteran's clinical presentation. They found that it is the presence of these symptoms that contributes to the failure in treatment to integrate traumatic experience. The same concepts may well be true in the exploration of and response to moral injury.

One concern and promise is that, while the concept of moral injury offers a valuable place to start in understanding warrior and veteran suffering post deployment and on redeployment, social workers, whether employed as civilians in military settings or in the community at large, may often be the first clinicians to sit down with the warriors or veterans and actually hear their stories. It is vital to listen for themes of moral injury; it is also vital that other important issues and symptoms such as dissociation and physiological response to trauma are noticed and addressed with appropriate therapeutic interventions including trauma-focused CBT, EMDR, and in some cases, PE.

The issue of moral pain and injury in time of war is not new. The terror of battle and the sickening fear of death resulted in shell shock and PTSD. Those who survived war and their physical wounds may have lived long with the wounds to their understanding of humanity and with their own moral compass badly damaged. Dickson (1950) wrote a biography of Richard Hillary, an English fighter pilot who took part in the Battle of Britain at age 22 and whose plane failed to gain height on the second mission of the night. Dickson, a personal friend of Hillary's, writes about a metaphor of the war response quoting Arthur Koestler that we live our lives alternating between a trivial plane and a tragic plane. "When we live on the tragic plane, the joys and sorrows of the other are shallow, frivolous, trifling" (Dickson, p. 183). Living for a long time, as in war, on the tragic plane has consequences; "as few people can bear it for long, they elaborate conventions and formulae" (p. 183). One thinks here of slang and acronyms widely used by the military. Recent suicide rates and mental health struggles have made it impossible to ignore the impact of moral injury and PTSD. The labeling and compartmentalizing has not worked. In the end, this attempt to try to integrate the tragic with the trivial plane fails. Dickson quotes Koestler's final dictum: "It is one of the mechanisms of the evolution of civilization; to petrify the violent and tragic into conventional formulae" (p. 183).

We referred earlier to Owen's poetry that included his own moral injury that intruded in his waking hours and disturbed his dreaming world. Owen's struggle with the moral depravity of war and the violation of his own values gives no indication of hope, of redemptive love, of forgiveness, or of healing. That need not continue to be so for those of our age who suffer moral injury. We have the opportunity before us to understand the great pain and suffering of those who have borne the burden of war and to develop and refine therapeutic, spiritually sensitive practices to support them and address and heal the pain. This generation's task in facing the disaster and suffering

that war inflicts on our warriors and veterans is represented in the powerful concept of moral injury. Social workers of all faiths and worldviews will find working with this concept a spiritual endeavor of the highest order. ❖

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# Family Circles: Assessing Family and Spiritual Connections with Military Clients

*Dexter R. Freeman*

*This article describes the diversity of spiritual and religious resources that can support and often compel military service members to pursue a career in the military. Moreover, this paper exposes the reader to a little known assessment instrument called the family circle. This instrument enables clients and social workers to identify some of the spiritual and dynamic motivations for military service members who choose to defend America's freedom. This article also discusses the various components of the military culture that may contribute to spiritual wholeness for service members. Finally, a case vignette is provided as a step-by-step description of how social workers can conduct a family circle interview to assess community, family, spiritual, and religious resources with military clients.*

**W**HAT MIGHT COMPEL A MAN OR WOMAN TO LEAVE THE HOME, environment, and way of life that he or she knows to join a culture and defend a cause that he or she may not fully understand? Some suggest it may be financial stability, educational opportunities, the need to get away from a difficult home situation, or maybe the need to decide what one wants to do with their life (Hall, 2011b; Woodruff, Kelty & Segal, 2006). Research shows that men and women enlist in the military due to economic factors, a desire to serve their country, an opportunity to travel and see new places, the ability to partake of educational benefits, a desire to learn new job skills, and a need to escape a litany of social problems (Eighmey, 2006). While these reasons indicate why a person might pursue the military, it doesn't explain why they choose to stay. The literature on career military involvement (Eighmey, 2006; Mariscal, 2007; Woodruff, Kelty, & Segal, 2006) suggests that it is the achievement of a sense of purpose, a connection with others who understand their

unique perspectives, existential experiences, and the ability to fulfill one's responsibility to serve self and others that convinces service members to stay beyond their initial enlistment.

Sergeant Ryan Kranc is a good example of the transformation that occurs in the lives of service members. He was deployed in northwestern Iraq, and was considering leaving the military when he had an epiphany that in many ways was a spiritual experience. Shortly after hearing that one of his comrades had been killed following an attack by insurgents, he said that there is no way he would leave the military now. He said, "We serve for those who are willing to lay down their lives for those fundamental and inalienable rights that distinguish our country from all others" (Who influenced you to stay in the Army, September, 2011, p. 82). Christina Grof (1993) put it this way: "Many of us yearn for something that we may not be able to name. Yet we believe that it will help us feel all right, at home, and as though we belong. We believe that if we could find it, we would no longer be lonely. We would know what it is like to be loved and accepted, and we would be able to love in return" (p. 4). Sergeant Kranc appears to have experienced a spiritual connectedness that exceeds human reasoning. Grof (1993) refers to this state of connectedness as spiritual wholeness or completeness; recognized as a state of being in which one experiences a sense of oneness with all things to include a divine source of meaning (Jung, 1933).

A premise of this article is that humanity is divinely created to connect and that this spiritual compulsion to connection often takes place within the military. I will demonstrate through a case vignette how this spiritual impulse can be expressed through a Christian lens. It is the quest for wholeness that compels many to join the military, as well as make it a career. I will discuss the components of spiritual wholeness so that the reader may better understand this powerful, but numinous force that many Christians rely upon to reconcile the challenges of serving in the military. Finally, I will introduce the family circle instrument as a means by which military social workers can help military service members and their families identify the resources they rely upon to provide a sense of completeness or spiritual wholeness. I will also use the case vignette to describe key characteristics of the military culture as well as demonstrate how the family circle instrument can be used to identify and articulate the components of spiritual wholeness that exists within the military culture.

### **Social Work in the Military: Conserving the Fighting Force**

Social workers have been serving the military community since World War I, when Red Cross workers provided counseling and case management related service to military service members in military hospitals (Garber, 1992; Harris, 1999). Social workers were effective in helping service members cope with the horrific images and consequences of war,

as well as provided transition and reintegration assistance to those who were deemed unsuitable for the military.

Social workers became commissioned officers in 1943 and over the years have assumed a plethora of duties and responsibilities in an effort to promote growth and healing with the military community (Harris, 1999). For instance, uniformed social workers now assume a primary role in conserving the fighting force through providing community-based support services to promote family stabilization, marriage and family counseling in outpatient counseling clinics, and supervision and direct mental health clinical services to active duty service members in behavioral health clinics (Brand & Weiss, 2015). Social workers also assist service members and families who may have developed substance dependency and abuse problems as a means to cope with the stress and trauma related to the military lifestyle and mission (Blaisure, Saathoff-Wells, Pereira, Wadsworth, & Dombro, 2012). Furthermore, they serve in community hospitals and teaching medical centers as psychiatric and medical social workers, provide individual, group, and organizational counseling support services in theaters of operations as brigade behavioral health officers, and fulfill a litany of administrative, educational, and policy oriented duties (Rubin & Barnes, 2013).

Even though the military may be experiencing a reduction of forces across the various services, the need for social workers and behavioral health providers is even more essential than ever (Brand & Weiss, 2015). Advances in military medicine and changes in the modern battlefield mean that service members who deploy are more likely to survive traumatic incidents such as suicide bombers, improvised explosive devices (IED), serious physical injuries, traumatic brain injuries, and are more likely to witness the deaths of comrades and civilian casualties of war than in past wars (Melcer, Walker, Galarneau, Belnap, & Konoske, 2010).

As a result, a record number of service members are directly affected by the atrocities of war and their families are carrying secondary wounds as a result of living with a family member who has made major sacrifices for his or her country and the mission. The wounds of war (many of which are invisible) often cause an absence of wholeness and service members and their families often question the sacrifices they made. Chronic feelings of isolation, emptiness, and detachment are too much for many service members to bear. Post deployment studies with service members have shown that they experience increases in alcohol use and abuse, the misuse of pain medication, and suicide attempts and completions (Larson, Wooten, Adams, & Merrick, 2012).

### **Spiritual Wholeness: Its Relevance and Definition**

When Sergeant Kranc experienced the loss of his fellow soldier, something beyond himself compelled him to remain in the military so that he might

challenge social injustice and make meaning out of his loss. The death of Sergeant Kranc's comrade, along with the other atrocities of war, enabled him to feel insecurity, loyalty, compassion, isolation, uncertainty about his purpose, and a range of perspectives that can serve to help him feel more complete. Something within Sergeant Kranc, as it is within each of us, compels him to seek a sense of completeness or spiritual wholeness. He experiences wholeness when he can embrace the duality that exists within himself; i.e., recognizing that he is strong and weak, confident and insecure, as well as a caregiver and selfish.

Military social workers must be knowledgeable and capable of helping soldiers and military family members to embark upon spiritual journeys to wholeness. Wholeness is essential for service members and their families to experience a sense of meaning and purpose during times of despair and uncertainty. However, social workers and clients who pursue spiritual wholeness must understand and acknowledge that it is a dynamic and transcendent process that is ongoing and never totally complete. Nevertheless, throughout this journey clients and social workers will recognize that God can use everything, including the apparent senselessness of war or death of a comrade, to work for the good of those who love the Lord and are called according to his purpose (Romans 8:28, New International Version).

Edwards, Pang, Shiu, and Chan (2010) defined spirituality as a dynamic process recognized as a personal search for meaning and purpose in life. Burkhardt (1998) described spirituality as the core of all that we are and all that we do. Vaughan (1991) said that spirituality is the origin of compassion, thankfulness, and faith in a divine and higher dimension of existence. It is the genesis of the desire to pursue one's true meaning and purpose in life. In summary, spirituality represents a universal dimension that encourages humans to explore their true purpose and meaning through connecting individuals with entities and forces within, around, and beyond them. Jung (1933) referred to this state of connectivity as individuation or wholeness. Jung (1933) said the quest for spiritual wholeness is a continuous process that involves "tearing oneself loose from an all-embracing, pristine unconsciousness that claims the bulk of mankind almost entirely" (p. 197). Moreover, spiritual wholeness is best defined as a dynamic state of being that is recognized by a connection with a conglomeration of masculine and feminine energies, strengths and weaknesses, and internal and external forces that serve a divine purpose to help individuals to live the lives they were created to experience (Freeman, 2001). This is the primary definition for spiritual wholeness that I will rely upon throughout this article.

Jung (1959/1990) called dynamic forces that promote wholeness archetypal energies, and he theorized that they evolved from the collective unconscious of humanity. My research (Freeman, 2007, 2015) has shown that there is a statistically significant relationship between an individual's identification with archetypal energies and the experience of spiritual well-being.

### **From Civilian to Service Member: Embracing the Warrior Culture**

Recruits often raise their right hand and agree to protect and defend America's freedom for practical rather than patriotic reasons. Mariscal (2007) and Blaisure et al. (2012) assert that young people enter the military for a variety of pragmatic reasons: money towards college, economic or vocational self-improvement, health care benefits, and family expectations; as well as reasons rooted in deeper meaning such as freedom, connection with others, and a desire to be part of something bigger than themselves. Even though practical reasons (financial, education, and health care benefits) may have consciously compelled recruits to join the military, a deeper level of commitment is required to transform a civilian recruit into a marine, soldier, airman, or sailor who is willing to embrace a warrior or military culture and die for a cause that he or she may not understand.

Hall (2011b) described the military community as having a zero-tolerance for personal or social defects. Military personnel and their families live in a psychological fortress that projects self-reliance and a mentality that prevents others from seeing their weaknesses (Hall, 2011a; Wretch, 1991). This psychological fortress allows service members and families to maintain a warrior society that emphasizes three traits: secrecy, stoicism, and the denial of feelings or fears. Thus, to project the warrior ethos, service members quickly learn the importance of maintaining secrecy (keeping unit issues and concerns private from those outside the unit), never showing their fears or concerns to others, and seeking to maintain a controlled and stoic demeanor at all times (Hall, 2011a; Hall, 2011b). It is important that behavioral health providers who serve military service members recognize these values and understand how these values might hinder a sailor or soldier, an airman or marine from pursuing or benefiting from mental health services.

Behavioral health providers also need to understand that military families are affected by the same values that uphold a warrior society. Military families that adapt to the military culture uphold these values so that they might survive and thrive within a military community. For instance, a civilian spouse who is a victim of domestic violence may be conditioned to maintain secrecy about what goes on within their home so that she does not adversely affect her spouse's military career. Also, a teenager who has grown accustomed to deferring his needs for the sake of allowing his service member parent to focus on his or her job, might suffer in silence about his inability to cope with the feelings of abandonment that he may be experiencing as a result of the parent's recent deployment. This teenager's actions exemplify the military culture's belief that the mission comes first. Therefore, anyone who serves military families must acknowledge the significant role that warrior societal values play in the day-to-day lives of military service members and their families.

The previously mentioned description of values that exists within the military culture is not to suggest that all service members are the same. For instance, the means by which a soldier from a combat arms unit (infantry, armor, field artillery, aviation, or special forces) displays these values may be significantly different from soldiers working as quartermaster (supply) specialists, medical technicians, dental technicians, and other combat support arms fields (Devries, Hughes, Watson, & Moore, 2012). Soldiers in combat arms units have a unique lexicon and set of acronyms. These units also typically maintain a high level of preparedness, are male dominated, and also tend to have a higher level of cohesion between the members (Rosen et al., 1996; Rosen, Knudson, & Fancher, 2003). However, soldiers working in combat support areas may not always adhere to certain relational boundaries due to the technical nature of the unit's mission. Therefore, a counselor who provides mental health support to a service member must also take into consideration the type of job a service member has when it comes to understanding the military culture that may influence a service member's worldview.

The case vignette below reflects many of the typical dynamics of military families. This fictional case will highlight some of the motivations for military service as well as demonstrate how social workers can use the family circle instrument to identify spiritual and religious resources available to promote wholeness.

### **The Case of Specialist Amy Stevens**

*Specialist (SPC) Amy Stevens grew up in a modest Midwestern town, the youngest of three siblings. Amy joined the Army when her husband was no longer physically or emotionally able to financially support her and their two children. He had sustained a severe physical injury that left his body permanently disfigured, and his mind hampered with guilt, anger, shame, difficulties sleeping, and other symptoms indicative of posttraumatic stress. One of John's greatest adjustments, since being medically discharged from the military, has been trying to accept his role as a military family member, and supporting his wife, Amy, as the primary provider for the family. John and Amy admit that this change in the family constellation has negatively affected their marital relationship; however, they are trying to slowly rebuild their relationship.*

*Amy sought counseling from a social worker at the Department of Behavioral Health to help her cope with family related-problems she and John had been experiencing, and to seek guidance about how to handle their three-year-old daughter who was having temper-tantrums in daycare. She also has been having problems sleeping alone at night over the past year. Amy thought that her daughter was having problems adjusting to being in daycare because she was accustomed to being at home with her for the first year of her life. However,*

she and John became concerned when this behavior continued beyond the first six months in daycare.

Amy's nuclear family consists of her husband John, six-year-old daughter Lori, and three-year-old daughter, Lisa Ann. Amy describes Lori as a six-year-old who appears to be far too mature for her age at times. She never demonstrated any acts of rebellion and is extremely agreeable. She helped Amy around the house when John was deployed and frequently tells Lisa Ann to "stop being such a baby." Amy admits feeling guilty at times because she thinks she puts too much responsibility on Lori to be a good girl and most of her attention now goes toward Lisa Ann and John. Amy said that Lori reminds her of her oldest sibling, Sally, who has always been a quiet person that never seems to have any conflicts with others. The middle child in Amy's family of origin is her brother, Jake. He is like Amy's father, quiet and mechanically skillful, but he hated school so he couldn't wait to begin working with their father after he graduated from high school.

Amy's parents, Jake, Sally, and their families all attend the same Baptist church and they all are committed to the faith. Jake and Sally are actively involved in various ministries at the church. Amy, however, admitted that she frequently questioned some of the religious beliefs of the Baptist faith and she always viewed herself as somewhat rebellious when it came to accepting the family's religious beliefs. She infrequently attended church after she and John got married, and she had not seriously prayed to God until she saw John laid up in a hospital bed fighting for his life. She stated that she was confused and angry that God would allow this to happen to John, especially after they had tried to do the right thing by getting married and choosing to take care of their children.

Amy married her husband John at the age of 17 for two reasons. First, she was pregnant and her family was a conservative Baptist family who did not consider abortion as an option. Likewise, Amy and John believed that the only option they had was to get married. John was a star on the football team and he grew up in a hardworking Christian family that encouraged John to take care of his responsibilities in a way that would be pleasing to God. John had hopes to play football in college, but after he discovered that Amy was pregnant, it was an easy decision for him—college was no longer an option because he now had a family.

The entire church was shocked to learn that Amy was pregnant, and Amy's entire family was extremely upset and ashamed about this situation. Amy's mother was especially upset because she too had become pregnant before she and Amy's father got married. She had plans of finishing high school and possibly going to college. However, she gave up her college dream to marry Amy's father and raise their children in a Christian home. She wanted Amy to go to college and hopefully become a physician someday. Amy also had dreams of studying medicine and becoming a pediatrician, but those dreams would have to wait because she was pregnant.

The second reason Amy married John was that in addition to loving John, she saw her parents as controlling, rigid, overly religious, and smothering. She saw the military and her marriage as the perfect opportunity to get out of what she called “a stifling hick town.”

After four years of marriage, things were progressing well; John was enjoying his military job as a cavalry scout at Fort Smith, Texas, and Amy had just given birth to their second child. She was satisfied with where things were in their family relationship. John was on his second deployment and, as one could expect, Amy was very anxious about him being away. She had learned from the first deployment to do what she could to try to stay busy, and avoid watching too much news.

Amy always felt close to her maternal grandmother, and during John's first deployment she moved back home for a couple of months to be near her. Amy was feeling very lonely and under a great deal of pressure during John's first deployment. She and John often argued about the sense of abandonment that Amy was feeling. John suggested that Amy go home and spend some time with her family while he was deployed. After a month of going to the same places and answering the same questions about what it was like being a military wife and mother, she became frustrated with the attitudes and comments she was hearing from members of her family and others in the community. She often found herself defending the military against some of the “simple-minded” comments made by her extended family. Amy recognized during John's first deployment that she left home as a kid, but now she was a grown woman and a proud military family member. Therefore, she opted to stay in the Fort Smith community during John's second deployment.

About a month prior to John's projected return from his second deployment, Amy received news that John was seriously injured and was being medically evacuated to a military medical center near Houston, Texas. He had been badly burned and his right leg amputated below the knee as a result of an IED bombing. Amy was devastated to receive the news about John's injuries. She recalled praying for John's healing so he could continue to do the military job he loved. She had always been taught that God hears the prayers of His children. Therefore, Amy was committed to do all she could to nurse John back to health, hoping that God would help John and keep their family structure intact. Although John appeared to be in shock and was reluctant to ask questions, Amy not only asked the providers questions, she also frequently researched the information they were given and kept a journal of all her communications with the providers. Amy's maternal grandmother and her mother frequently traded off watching the children while Amy stayed at the hospital with John. Amy and John received countless cards, gifts, and visits from members of John's unit and their hometown Baptist church.

Amy was overwhelmed with the level of support she was receiving from the other military family members in John's unit. She was particularly surprised

*about by the outpouring of love she received from other Christians in the church back home as well as a local Baptist church. The support she received was influential in convincing her to begin attending church after she and John realized that he would never be able to return to the military.*

*Although it was taxing for Amy to take care of John, it was also stimulating because for the first time, since her high school years, she had the opportunity to revisit her love for medical science. She had a sense of fulfillment and medical curiosity that she had not experienced in many years. John's physical recovery took over a year and he was still struggling with emotional scars from the war when Amy sought counseling from a social worker. During the first year of rehabilitation, Amy and John talked about the various options available for their family. Even though John was medically retired and considered 100% disabled by the Veterans Administration, neither he nor Amy considered moving back to their hometown.*

*Amy, with John's support, decided to enlist in the Army to ensure the family's stability. She also saw this as an opportunity to follow her dream of getting into the medical field. She met with an Army health care recruiter and enlisted as a health care specialist. In the civilian sector, a health care specialist could be an emergency medical technician, a licensed vocational nurse, or an operating room technician.*

### **The Family Circle: Theory and Background**

How does one describe or depict the family structure, connections, boundaries, and spiritual forces that might exist within, around, and outside an individual or family? How can you help a client identify changes to a family's dynamics after the birth of child? When a parent or child is deployed by the military? When there is marital conflict, or when a couple divorces? Even the most astute social worker may need to meet with a client several sessions before gaining this type of insight. This is where the family circle instrument demonstrates its strength.

The family circle interview is a quick and easy graphic method of gathering, assessing, and working with family dynamics and structure based upon the perceptions of the family members (Asen, Tomson, Young, & Tomson, 2004). Although the family circle instrument is simple to execute, it yields a wealth of information about intra-familial and extra-familial connections. The circle that one produces is influenced by the current perceptions of the person doing the drawing.

Family circles are not projective tests to be interpreted by the social worker in an effort to uncover deep-seated thoughts and emotions of the drawer (Asen et al., 2004). These drawings are designed to be a non-threatening means for individuals and families to express and discuss family dynamics in a controlled environment. Thus, the process will often by-pass

many of the defenses and discomforts that military families experience when it comes to discussing family issues that typically remain secret.

The family circle instrument is based upon family systems theory and enables clients and social workers to view family structure, boundaries, and subsystems from the client's perspective. According to family systems theory, every family has boundaries or invisible borders that moderate the flow energy (connection) between the members within the family, the family as a whole, and with systems outside the family (Coleman, Collins, & Collins, 2005; Walsh, 2008). The family circle is an assessment method that social workers can use to allow clients to describe and discuss how their family appeared in the past, present, and how the client would desire their family to look in the future (Thrower, Bruce, & Walton, 1982).

### Conducting a Family Circle Interview

The family circle session includes a facilitator (social worker), client drawer, and other family members who may also draw their family circles. The first step in conducting the family circle interview is for the social worker to describe what a family circle is and explain the purpose of the interview. The facilitator explains to clients that a family circle is a schematic diagram that enables them to depict their connections with other individuals, friends, animals, organizations, beliefs, events, or passions. As a result, these entities may be perceived as part of their family. For example, in the case of Amy, the emotional and physical trauma that John experienced during his second deployment has become a major part of their family over the past couple of years. Therefore, she might include posttraumatic stress or his physical injury in her family circle. Figure 1 shows what Amy's initial family circle might look like.

**Figure 1: SPC Stevens' Beginning Family Circle**

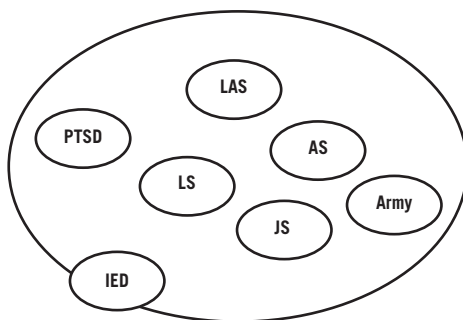


Figure 1: This is the beginning of Amy Stevens' (AS) family circle. The significant objects that she connects with as part of her family circle at this phase of the family circle interview include her husband John (JS), daughter Lori (LS), daughter Lisa Ann (LAS), the Army, I.E.D, and PTSD.

The second step of the family circle interview is to describe the process and rules for completing family circle drawings (described in greater detail below). The final step of the family circle interview is to have each drawer describe the components or objects he or she connects to as part of their family. Figure 2 shows Amy's family circle drawn according to the instructions outlined below.

### **Constructing Family Circle Drawings**

After the facilitator is certain that the drawer(s) understand the procedure and purpose, each drawer begins constructing his or her family circle by drawing a large circle on a blank sheet of paper. Next, the facilitator asks each individual to draw smaller circles that represent them and other family members. Each drawer should have 5 to 8 minutes to complete his or her family circle drawing. Once client drawers have completed their initial family circles, the facilitator asks each drawer to add circles to represent those individuals, activities, beliefs, or organization that meet the following criteria:

1. What or who enables you to recognize or experience your vulnerabilities or weaknesses (*orphan energy*)?
2. What or who encourages you to never give up or to have confidence and trust in others (*innocent energy*)?
3. What or who helps you feel nurtured and cared for (*caregiver energy*)?
4. What or who reminds or reminded you to challenge injustice or advocate for yourself or others' needs (*warrior energy*)?
5. What or who helps you make sense or to transform your pain, sorrow, and difficulties to something meaningful (*magician energy*)?
6. What or who causes you to question your path and direction in life (*seeker energy*)?
7. What or who enables you to recognize that it is time for you to change or let go of things you used to see as important (*destroyer energy*)?
8. What or who enables you to recognize that you have the power to respond to situations from multiple perspectives (*ruler energy*)?
9. What or who allows you to recognize the life you should be living (*creator energy*)?
10. What or who allows or encourages you to express or experience passion (*lover energy*)?

11. What or who allows you to experience freedom through expressing those actions or perspectives that are wise and prudent (*sage energy*)?
12. What or who encouraged or enabled you to live in the moment without being overly concerned about the consequences (*jester energy*)?

These questions are based upon Pearson and Marr's (2003) indicators of dynamic (archetypal) energies, which they theorize as being available to everyone to promote spiritual wholeness. Pearson and Marr (2003) identified twelve archetypal motifs that combine to create wholeness: innocent, orphan, warrior, caregiver, lover, seeker, destroyer, creator, ruler, magician, sage, and jester energy. Each motif carries a unique perspective that contributes to experiencing wholeness. For instance, innocent and orphan energy provides perspectives that promote security; warrior and caregiver energy provides unique perspectives by which individuals fulfill their responsibilities; destroyer and creator energy enables people to experience a sense of authenticity; seeker and lover energy enables individuals to identify what is most important or their sense of purpose; magician and ruler energy provides a perspective that promotes a sense of power over circumstances; and sage and jester energy allows individuals to experience freedom through altering their perspective (Pearson, 1991; Pearson & Marr, 2003). Studies (Freeman, 2007 & 2015) have shown that Pearson and Marr's dynamic energies are significantly correlated with spiritual well-being.

### **Rules for drawing and discussing family circles**

Once all drawers have completed their family circles, each member is invited to describe his or her circle to the others. Following each drawer's circle presentation, the facilitator and other family members are encouraged to ask clarifying questions to give the drawer an opportunity to expound upon and clarify anything in the drawing. The facilitator's questions should encourage the drawer to consider the effects of time and specific phenomena on their family circle. Asen et al. (2004) and Thrower et al. (1982) provide examples of these types of questions.

### **Amy Steven's Family Circle: An Example**

The case of SPC Amy Stevens and the family circle below demonstrates how this instrument can effectively visually display social, emotional, and spiritual attachments that exists within a client's perceived family. Figure 2 depicts how Amy's complete family circle might appear.

**Figure 2: SPC Amy Stevens' Family Circle**

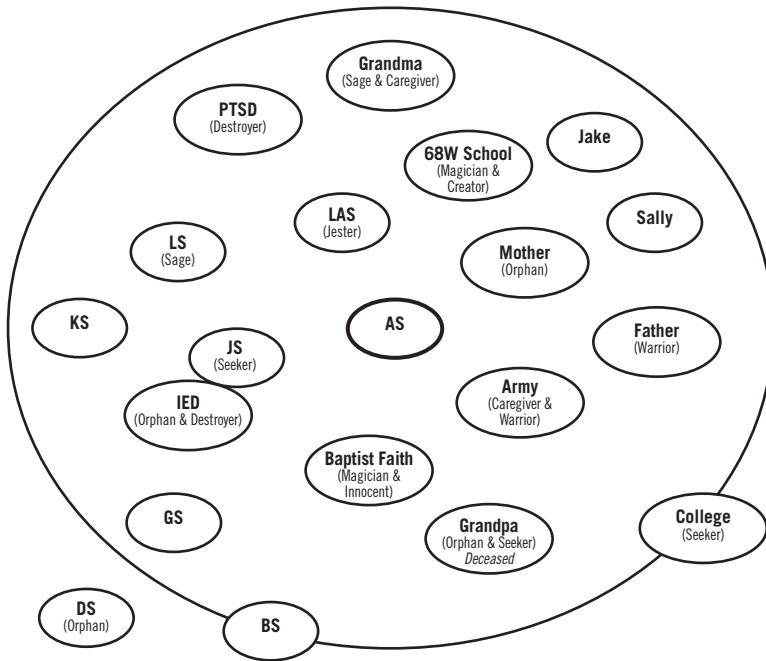


Figure 2: This family circle was drawn by SPC Amy Stevens (AS) after she enlisted in the Army. The significant objects that she connects with as part of her family circle are her Health Care Specialist training school, her desire and fear of attending college, her Baptist faith, her mother and father, her grandmother, her deceased grandfather, her youngest daughter (LAS), her first born child (LS), her husband (JS), her mother-in-law (KS), her estranged father-in-law (DS), her brothers-in-law (GS) and (BS), the IED incident, and the Army.

Amy's family circle would include key members of her nuclear and extended family. She would also include key figures that represent spiritual and religious sources in her life (see Figure 2). Amy's extended family includes her grandmother, who continues to promote caregiver and sage energy by reminding Amy to unconditionally care for others and do those things that are wise and appropriate. She also received unconditional nurturance from members of John's military unit and her home church congregation. This energy proved significant in her decision to begin worshipping at the local Baptist church.

Her maternal grandfather, although deceased; encouraged her to go to college to be productive. She described him as a man of deep faith that believed if a person trusted in the Lord there is no problem that God won't help a person to overcome. Amy admits that she reflects back on messages from her grandfather more now that she is expected to do more to take care

of her family. The spiritual energy that emits from Amy's maternal grandfather's image is comparable to Pearson and Marr's (2003) description of innocent and magician energy that encourage people to trust and have faith in divine goodness, power, and purpose. Magician energy enables people to use their pain and challenges as an opportunity for growth (Pearson, 1991). Amy relied upon this dynamic energy when she enlisted in the Army.

Amy's circle might also include family members that are connected in significant ways to John, even though she does not know them well. For example, she would include John's mother, Karen (KS); his estranged father, Doug (DS), who walked out on the family when John was in the 6th grade; his older brother, Gene; and his younger brother, Bobby. It was the sense of abandonment (orphan energy) that John experienced from his father (DS) that compelled him to marry Amy and put his relationship with his children before his dream to play college sports.

Amy's family circle also includes her mother and father. For many years Amy had conflicts with her mother because she thought her mother wanted to hold her back. Now she realizes that her mother gave up her desire to become a teacher because she chose to stay home and take care of Amy and her siblings.

Amy's mother was afraid of Amy's rebellious attitude during her adolescent years and was worried Amy would make some of the same mistakes she made. Amy now realizes that her mother is a very intelligent person; she did not pursue education because she thought Amy's father would not be able to handle having an educated wife. The dynamic energy that Amy's mother reflects is indicative of Pearson and Marr's (2003) orphan energy, which enables people to experience the reality of pain and disappointment.

Amy's father was not educated (he received his high school equivalency certificate at age 18), but was well respected in the community. He is a vehicle mechanic that runs a successful business and provides financial support to his family. Amy's father reminds her of the importance of confronting challenges and adversity head-on. Pearson and Marr (2003) referred to the dynamic energy that is represented by her father as warrior energy.

Other members of Amy's family of origin in her family circle include her big brother, Jake, and her sister, Sally. She is not as close to either of them as she used to be, and she wishes they were closer.

Amy's nuclear family consists of her husband John, older daughter, Lori, and her younger daughter, Lisa Ann. Although Lisa Ann is only three years old, she already displays a free spirit that gets all she can out of every moment. Lori is the typical big sister who seems to display wisdom and responsibility much greater than her six years of life should allow. These children appear to project Pearson and Marr's (2003) jester and sage dynamic energy, respectively.

Lori Ann enables Amy to appreciate the importance of living life in the moment and Lisa encourages Amy to carefully evaluate opportunities for

growth prior to pursuing them. Both of these dynamic forces are essential to experiencing wholeness. The dynamic energy that John represents in Amy's family circle has changed since their relationship began. Originally, John was Amy's passionate protector who helped her feel safe and protected, while living life to its fullest at the moment. This dynamic energy is indicative of Pearson and Marr's (2003) warrior and lover energy that helps people fulfill their sense of responsibility through aggressively confronting challenges (warrior energy) and identifying what is most important by wholeheartedly committing to it and following that commitment (lover energy). Today Amy looks at John as someone who is full of questions: What should I do with my life? Why did this happen to me? What does it mean to be the head of my family? All of these questions reflect the presence of seeker energy. Pearson and Marr (2003) state that seeker energy is activated when people experience dissatisfaction and a sense of emptiness.

Amy added the IED incident to her family circle when she was asked to add what or who has caused her to question the path or direction of her life (destroyer energy). She added posttraumatic stress disorder (PTSD) when she was asked to consider adding what or who has enabled her to recognize that it is time to let go of things she used to see as important (destroyer energy). She included her Baptist faith and Health Care Specialist (68W) School and training when asked to include what or who has helped her use and/or make sense of the pain, sorrow, and difficulties she has experienced (magician energy). Amy frequently thinks about going to college and pursuing her degree in medicine (seeker energy); especially now that she has made it through her Health Care Specialist (68W) training.

Therefore, her 68W training is not only a source of transformation; it is also a means for her to fulfill her deferred dream of working in the field of medical science (creator energy). She expressed that her confidence in her ability grew as her supervisors and teachers during her 68W training demonstrated trust and faith in her ability to handle greater levels of responsibility. Organizations that are motivated by innocent energy tend to thrive on simplicity, predictability, trusting its workers to do the right thing, and it clearly explains to workers what they should emphasize for the organization to be successful (Mark & Pearson, 2001). Amy stated that her 68W training made it easy to be a successful Health Care Specialist. They taught her exactly what she needed to be a good Health Care Specialist; she did it and the organization appreciated her even more for her ability to follow orders.

Now that Amy and the social worker have examined some of the key connections and spiritual forces in her life via the family circle, Amy needs an opportunity to reflect upon what this experience has meant to her. It is important that the social worker remind Amy that the energy she identified in her family circle is a part of her as well as the people, events, or organizations she has identified. At the conclusion of the family circle

assessment, the goal is for Amy to recognize she is more than a nurturing (caregiver energy) mother who has faith (innocent energy) in God and her husband to take care of her and their family. She now recognizes that God will provide for her (a lesson learned from the affirming spiritual messengers in her life), but His love will not remove all pain and destruction. However, the spiritual messengers in her life will remind her that it is only through the pain, destruction, uncertainty, hope, and faith that she can experience the wholeness that her soul desires. Furthermore, Amy has learned to let go of previous self-limiting perspectives when she embraces destroyer energy that entered her family via the IED and PTSD. Once she was able to embrace destroyer energy, she was then able to gain the strength to create the life her soul desired. Amy was exposed to the potential for her to create a new life through her involvement in the Health Care Specialist School.

### **Conclusion**

The Bible espouses that humanity lives, moves, and has its total existence through God and His spirit (Acts 17:28). Likewise, Pearson (1991) theorizes that in order for people to experience spiritual wholeness, they must embrace universal dynamic energy that will enable them to experience a greater sense of completeness.

This article described how the family circle instrument and interview can help military service members recognize the transformative role that spiritual resources assume in their life as they seek to experience wholeness. In the case of Amy Stevens, the IED incident served as a spiritual force that allowed Amy to embrace the need for change and to begin questioning the direction of her life. Prior to the IED, she was ostensibly content being a military wife that relied upon her husband to serve as a protector. When she and her husband began seeing the emotional scars from the IED incident, Amy started accepting how vulnerable and helpless she was (orphan energy) and realized that she can't rely on others to always be there to care for her. Posttraumatic stress, which followed the IED incident, helped her see that she would have to let go of old perceptions about how her life was supposed to be (destroyer energy). The dynamic energy that PTSD and the IED represented ultimately led to Amy recreating a new life for herself and her family.

This article has demonstrated how the family circle instrument can be used to identify the various spiritual connections that military service members form, and how these connections contribute to an individual's sense of spiritual wholeness. Seemingly, people enter the military to fulfill social, educational, financial, and emotional needs; however, at the core of these motives is the quest for wholeness.

The Psalmist says, "Where can I go from your Spirit? Where can I flee from your presence? If I go up to the heavens, you are there; if I make my bed in the depths, you are there (Psalm 139:7-8)."

The family circle instrument and spiritual assessment process presented in this article acknowledges the spiritual origins of humanity. This instrument also provides social workers with a process to help clients get in touch with the spirit of God that exists within and around them. ❖

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# Ethical Integration of Christian Faith Into Clinical Work With Service Members and Veterans

*Laurel Shaler*

*This article addresses the unique needs of service members and veterans, such as posttraumatic stress disorder and substance abuse, along with current treatments, particularly those that are evidence-based and being utilized within the U.S. Department of Veterans Affairs facilities. Additionally, the faith of the military member and the ethical integration of their faith into mental health treatment is explored to help increase awareness and competency of clinicians working with service members and veterans. Particular attention is paid to the Christian faith..*

**W**HILE THE EXACT NUMBERS OF CHRISTIANS IN THE MILITARY are unknown, there is no debate that many service members count faith as an important factor in their lives. Several years ago, a report was published on the shortage of chaplains across all branches of the U.S. Armed Forces (Stone, 2008). Yet, the spiritual needs of the service members have not decreased. Sometimes, those needs, such as struggling with faith and God after experiencing a traumatic event, intersect with a need for psychotherapy services. This article will address the unique experiences and needs of military members and veterans, and how to ethically integrate the faith of the soldier into evidence based mental health treatment.

## **Unique Experiences**

Numerous experiences and mental health conditions among service members and veterans exist that, while not confined to this population, are certainly prevalent among this population. These experiences and conditions include posttraumatic stress disorder (PTSD), military sexual trauma

(MST), and substance use. These will be addressed within a military and veteran context, with a focus on prevalence among and the uniqueness of each as it pertains to service members, followed by a discussion on faith integration and examples of how the Christian faith has been or can be utilized in the treatment of clients experiencing the effects of PTSD, MST, and substance abuse.

### **Posttraumatic Stress Disorder (PTSD)**

Posttraumatic stress disorder (PTSD) is currently classified in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-V) under the “Trauma- and Stressor-Related Disorders” category. According to the publisher of the manual, the American Psychological Association (APA, 2013), this diagnosis can be made if an individual meets all criterion, including: “exposure to actual or threatened death, serious injury, or sexual violence” (p. 271), one or more intrusion symptom (such as distressing memories or dreams), avoidance (of reminders, for example), “negative alterations in cognitions and mood associated with the traumatic event(s)” (p. 271) of two or more symptoms, and at least two hyper-arousal symptoms (such as irritability, hypervigilance, or sleep disturbance). Additionally, there is a one month duration criteria, and the symptoms have to cause “significant distress or impairment in social, occupational, or other important areas of functioning” (APA, 2013, p. 272).

According to the National Center for PTSD, 7-8% of the U.S. population will have PTSD at some point in their lives (U.S. Department of Veterans Affairs, 2015). That is actually fairly low given the fact that 50-60% of people will go through a trauma at some point in their lives. Despite common misconceptions, the fact is that PTSD is not a “given” after exposure to trauma. There are pre-event, event, and post-event factors that contribute to the development of this disorder. Some examples include repeated traumas, being seriously hurt, already experiencing mental health concerns, alcohol or drug use, and low family support (Williams & Poijula, 2013). Young women are also more likely to develop PTSD, as are minorities. A meta-analysis of 32 studies that included 21 studies with American veterans found that females, minorities, enlisted (rather than officer), and being in the army (rather than other branches) were risk factors for the development of PTSD (Xue, et al., 2015). Of note, there is a growing number of minority women joining the armed forces, and as of 2011, nearly one-third of females who serve active duty were black (Patten & Parker, n.d.).

Specifically related to the military, 11-20% of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans will develop PTSD in any given year. Research indicates that 12% of Gulf War (also known as Desert Storm) veterans and 15%-30% of Vietnam veterans develop PTSD at some point in their lives since being in combat (U.S. Department of Veterans

Affairs, 2015). Not only is it important to understand factors that contribute to the development of PTSD in order to address prevention, but also to help develop effective treatments. Several evidence-based treatments for PTSD are endorsed and utilized by the U.S. Department of Veterans Affairs. One such treatment, Cognitive Processing Therapy (CPT), will be explored in the Treatments section of this article.

### **Military Sexual Trauma (MST)**

MST stands for *military sexual trauma* and is an experience rather than a diagnosis. According to the National Center for PTSD (U.S. Department of Veterans Affairs, 2014a), 1 in 4 women and 1 in 100 men report they have experienced sexual harassment or assault in the military when asked by a provider from the Department of Veterans Affairs (VA). It can be difficult for those who have experienced MST to come forward for a variety of reasons including fear of negative consequences to themselves as a result. The VA offers free counseling to anyone who has experienced MST, including outpatient, inpatient, and residential treatment options. While the most common mental health diagnostic result of MST is PTSD, and is the trauma most associated with PTSD among women (Moller, Backstrom, Sondergaard & Helstrom, 2014), there are a number of other mental health concerns expressed by those who have experienced MST, including depression and substance use disorders (U.S. Department of Veterans Affairs, 2014a). A study with almost 75,000 veterans found that 31% of women with PTSD screened positive for MST, and that they had more comorbid mental health diagnoses including depression, anxiety, and eating disorders (Maguen et al., 2012). This same study found that men with PTSD and a history of MST were more likely to have a substance use disorder diagnoses. This issue will be discussed next.

### **Substance Use**

Alcohol use is very prevalent among service members and veterans for a variety of reasons, including use as a negative coping strategy or self-medication. Shaler (2011) found that 100% of the 100+ participants in a research study involving OED/OIF veterans reported problematic drinking behavior following deployment. Across the military, almost half report binge drinking (Koebler, 2012). Illicit drug use is low among the military due to the zero-tolerance policy, according to the National Institute on Drug Abuse (2013); however, there is an increase in prescription drug abuse along with a binge drinking increase (Koebler, 2012).

There is a known relationship between substance abuse and PTSD. The National Comorbidity Survey found that half of those veterans who seek treatment for substance abuse also meet criteria for PTSD (Berenz &

Coffey, 2012). Substance abuse treatment programs have typically required individuals to go through substance abuse recovery before going into treatment for other issues such as PTSD, but now it is recognized that there is a need to offer dual diagnosis treatment. More about this will be explored in the Treatments section of this article.

### Treatments

Now that some of the unique concerns among service members and veterans have been explored, the current treatments utilized by the Departments of Defense and Veterans Affairs will be discussed. Cognitive Behavioral Therapy (CBT) will be explored first, followed by a specific form of CBT used for the treatment of PTSD, and ending with substance abuse treatment options.

#### **Cognitive Behavioral Therapy (CBT)**

Cognitive Behavioral Therapy (CBT) blends cognitive therapy and behavioral therapy, and focuses on thoughts/beliefs and the influence they have on feelings and actions with a goal of changing unhealthy thinking and behaviors (National Institute of Mental Health, n.d.). CBT has been demonstrated through research to be effective for the treatment of many mental health concerns including depression, anxiety, bipolar disorder, and eating disorders (National Institute of Mental Health, n.d.). Additionally, CBT has been determined to be evidence-based for the treatment of panic disorders, phobias, generalized anxiety disorder, obsessive compulsive disorder, and posttraumatic stress disorder (PTSD) (SAMHSA's National Registry of Evidence-Based Programs and Practices, 2014). Multiple advantages to using CBT include that it is time-limited, cross-cultural, structured, researched, and adaptive (Pucci, 2010).

CBT-D (cognitive behavioral therapy for depression), has been disseminated by the Department of Veterans Affairs. This is a 12-16 week protocol that uses specific CBT skills such as scheduling activities to improve mood, setting up graded task assignments, teaching problem solving skills, identifying stressful situations, identifying negative mood states and automatic thoughts, and identifying adaptive responses to these negative thoughts (Karlin et al., 2012). The training program for this protocol had positive results with "large decreases in depression and improvements in quality of life" (Karlin et al., 2012, p. 707). The Departments of Defense and Veterans Affairs identify CBT forms of therapy as a first line of evidence-based treatment for PTSD (U.S. Department of Veterans Affairs, 2009). CPT, a specific form of CBT, will be described in more detail in the following section.

### **Cognitive Processing Therapy (CPT)**

Cognitive Processing Therapy (CPT) for the military and veteran populations was designed by Drs. Patricia Resick, Candice Monson, and Kathleen Chard, and is a short term treatment for PTSD that helps clients explore the impact of the trauma on their lives, learn about the relationship between thoughts, feelings, and behaviors, experience the emotions associated with the trauma, and challenge and modify negative thoughts (known as “stuck points”) about trauma (Medical University of South Carolina, n.d.). It was first studied as a treatment for rape victims (Resick & Schnicke, 1992), and was used by the VA starting in 2006 after research was conducted using a veteran sample (Karlin et al., 2010). CPT specifically focuses on issues related to esteem, intimacy, power/control, safety, and trust.

CPT helps clients identify their patterns of problematic thinking and replacement thoughts for their struck points. It can be facilitated with or without a written traumatic account, which involves the client writing in detail about his or her most traumatic event and reading this account daily. Research shows no difference related to the reduction of PTSD symptoms between the two treatment protocols (Walter, Dickstein, Barnes & Chard, 2014). Essentially, it is up to the client to determine if he or she wants to write out and repeatedly read the traumatic account or not. CPT can also be facilitated within a group context; however, trauma accounts are not read aloud in a group setting. CPT has been found to be effective for the treatment of PTSD. One study of mostly Vietnam veterans found that 40% of those who completed treatment no longer met diagnostic criteria for PTSD, and that guilt significantly decreased for those that completed the treatment as opposed to those who did not receive treatment in this randomized control study (Monson et al., 2006).

### **Substance Abuse Treatment Program (SATP)**

The U.S. Department of Veterans Affairs provides a wide variety of treatments for substance abuse problems including medication interventions and individual and group care (U.S. Department of Veterans Affairs, 2013). Some of the options include outpatient therapy, intensive outpatient therapy, and residential care or inpatient treatment. The latter is used specifically when someone needs detoxification, which has been related both to the high cost of in-patient treatment as well as possibly being related to good clinical practice (Stecker, Curran, Han, & Booth, 2007). As a part of the outpatient treatment, motivational interviewing and couples counseling are utilized in addition to other effective treatments (2013).

Additionally, as noted previously, it is recognized that there is a relationship between substance use problems and PTSD. Over 20% of veterans with PTSD have a co-occurring substance use disorder, about 1 out of every 10 OEF/OIF veterans has a problem with drugs or alcohol, and 1 in 3 veterans seeking treatment for a substance use issue also has PTSD (U.S. Department of Veterans Affairs, 2014d). Fortunately, co-morbid treatment is being successfully utilized. One survey of VA professionals found that *Seeking Safety* (a CBT model) and *Relapse Prevention* were the most helpful treatments for those dually diagnosed individuals (Najavits, Kivlahan, & Kosten, 2011). *Seeking Safety* has 25 coping skill topics in four categories: cognitive, behavioral, interpersonal, and case management (Bernhardt, 2009). *Relapse Prevention* is “based on social-cognitive psychology and incorporates both a conceptual model of relapse and a set of cognitive and behavioral strategies to prevent or limit relapse episodes” (Larimer, Palmer, & Marlatt, 1999, p. 151). Sadly, “persons dually diagnosed with PTSD and substance abuse more often avoid treatment than seek it” (Bernhardt, 2009, para. 9).

### **Ethical Integration of Faith**

Now that some of the more frequently expressed concerns among service members and veterans, along with treatment for said concerns, have been addressed, the integration of faith within these treatments will be explored. There is no question that people come to the military with various kinds of faith, and this faith may be challenged, stretched, or grown through the service experience. It is imperative that issues of faith are not ignored, but rather intentionally explored and addressed through the therapeutic process. Vasegh (2011) explains that many individuals who seek psychiatric care indicate they have religious or spiritual needs, and that religiously accommodated therapeutic interventions should be utilized with these clients. Particular focus will be given to the integration of the Christian faith with Christian clients.

Results from a meta-analysis of 46 studies, most of which addressed the Christian faith, conducted by Worthington, Hook, Davis, and McDaniel (2011) “present clear findings about the effectiveness of religious and spiritual accommodation” (p. 212). Essentially, therapy that is oriented towards religion or spirituality is an effective and valid option for those clients who desire religious or spiritual accommodation, with the primary benefit being improvement in spiritual outcomes. The spiritual outcome varies based on the religious or spiritual goal that is being measured. These authors used the Hill et al. (2000) definitions of religion and spirituality with the former meaning “defined as adherence to a belief system and practices associated with a tradition in which there is agreement about what is believed and practiced” (as cited in Worthington et al., 2011, p. 205) and

the latter meaning “a more general feeling of closeness and connectedness to the sacred” (in Worthington et al., 2011, p. 205).

What exactly is religious or spiritual accommodation? According to the Worthington et al. (2011) meta-analysis some potential accommodations include:

- Praying for the client(s) outside of treatment
- Praying for the client(s) in treatment
- Allowing the client(s) to pray in session
- Providing treatment that is consistent with Christian values
- Utilizing Scripture in session
- Reading the Bible in session
- Discussing theological questions
- Helping the client find a church
- Helping clients understand God

The fact is that there is no consistent definition of religious or spiritual accommodation. What seems to make the most difference is how and how much the client wants to integrate faith into treatment (Worthington, et al., 2011).

It is important for all clinicians to assess the client's spirituality as a part of a holistic assessment. Historically, healthcare and faith have been well integrated. This began to change in the 1960s as healthcare providers became concerned about the ethics of this practice (Cohen, Wheeler, Scott, Edwards, & Lusk, 2000). However, these authors indicate a shift back to clinicians asking about the faith of the client to explore how it may be a potential resource or a challenge. In fact, they state, “Clinicians have no professional obligation to hide or to deny the religious dimension of their own lives” (p. 46). However, while value neutral therapy is now recognized as a myth (Petet, 2014), clinicians do have an obligation to be guided by the client and to avoid exploiting the relationship, which includes not imposing their own beliefs on clients. That being said, Christian therapists may, because of their personal faith beliefs related to the sacrifice of Jesus Christ for mankind, recognize the importance and significance of each human, which can help contribute to a positive therapeutic relationship despite the pain that brings clients to therapy (Bretherton, 2006). Determining if religious or spiritual accommodation is appropriate for a client, deciding what type of integration is appropriate, and demonstrating that it was effective are all important components of ethical faith integration. Some examples are in the next section.

### **Examples**

While anecdotal evidence is not sufficient to determine evidence of efficacy, it can be helpful for clinicians to learn from examples. I would

like to provide some case examples from my work with clients with various mental health diagnoses treated at the Department of Veterans Affairs between 2006-2012. These clients expressly desired the integration of the Christian faith into their treatment.

### **Example A**

A former service member and retired police officer presented for therapy after his adult son was murdered. The client, an African American, was diagnosed with Major Depressive Disorder due to the severity of his symptoms and the length of time he had been experiencing the symptoms. During the initial session, the client indicated he was a Christian, and desired to integrate his faith into his sessions. One way this was accomplished was by adding prayer in an early session. During prayer, the client began to cry, which was unusual for him, as he did not typically allow himself to express his sorrow in this manner due to his belief that “real men shouldn’t cry.” The prayer allowed the client to open up in his grief process. This moment was the catalyst for this client making progress in his therapy sessions, and he continued to experience an increase in relief from his deeply held grief and depression as he increasingly opened up and more fully participated in psychotherapy. Additionally, the use of prayer demonstrated cultural competence since spirituality is an important aspect for many African Americans (Abernathy, Houston, Mimms, & Boyd-Franklin, 2006), which proved to be true in this case.

### **Example B**

Two groups of veterans had been coming together for weekly support sessions for many years. One group consisted of combat veterans with PTSD and the other group consisted of veterans diagnosed with a substance use disorder. Both groups chose to end each session by praying together. On their own, they joined together in a circle and a group member would pray aloud. It was their long held tradition that group members who were not interested in praying left prior to this time of prayer, but it was rare that someone would leave prior to the prayer. Various group members took turns praying week to week, and all offered a Christian prayer using terms such as “Heavenly Father,” “Lord and Savior,” and “In the name of Jesus.” It was apparent that this was a meaningful part of the group process for these veteran groups. They were unified physically through the hand-holding and spiritually through the prayer. These traditions began long before I was involved in facilitating groups at this facility, and there did not appear to be any reason to disrupt the tradition as it appeared to be unifying and no member expressed a concern about the practice. Additionally, prayer as part of therapy has been viewed as a “healing force”

that encourages clients to concentrate and turn their hearts and minds to something sacred (Torre, 2004). As a result, Christian clients may find prayer to be a particularly helpful and meaningful intervention, whether in or outside of the therapy room..

### **Example C**

A female veteran presented to the clinic requesting Christian counseling. While this was not explicitly offered or provided to the client, she was referred to me since it was known that I was a Christian and open to the integration of the Christian faith into sessions if the client so requested. (It is important to note that while all clinicians should be open to the client's faith, there is a difference between this and the clinician specifically integrating faith from personal knowledge and understanding of a faith that is shared with the client. An expansive discussion on this is outside the scope of this paper.)

This particular client had experienced military sexual trauma and developed PTSD and a depressive disorder as a result. She was very active in her church, prayed regularly, and routinely read her Bible. The Christian faith of this client was clearly a strength in her life and held great meaning for her. As a result, she wanted to ensure that her treatment was not in conflict with these deeply held and practiced beliefs. For her, having a therapist with a like faith was important since it provided her some reassurance that her faith would not only be respected, but understood.

### **Example D**

This final example will illustrate how to specifically integrate the Christian faith into PTSD treatment with a combat veteran client. Research demonstrates that religious beliefs can decrease as a result of a traumatic event (Falsetti, Resick, & Davis, 2005). Because CPT deals with beliefs, specifically repetitive thoughts known as "stuck points" that lead to negative feelings, integrating faith into CPT is a good fit for those that have upsetting thoughts and feelings related to faith. For example, one client stated his activating event was "My best friend was killed in front of me." From there, the client's long-held belief became "God doesn't care about me or anyone in my world." As a result, the client felt sad and angry, based on this repetitive thought about God not caring about him or those he loves. The client was able to explore these upsetting beliefs using the same method as he would to explore and challenge other stuck points in the CPT protocol, and came to his own conclusion about this being an unrealistic belief. As a part of this exploration, other upsetting thoughts and feelings regarding the client's faith were able to be explored.

## Conclusion

There is clearly a great need to address the unique concerns of veterans, including mental health concerns related to PTSD, MST, and substance disorders. The use of evidence-based therapies continues to expand, and more research is being done to enhance these programs and develop new ones. At the same time, there is a need to consider the spirituality and faith of veterans and to incorporate the faith of the veteran into treatment in an ethical manner based on the client's request. This article has described the various concerns, indicated common evidence-based treatments, and provided examples of the integration of the Christian faith into mental health treatment with the hope of raising awareness on all of these issues for the military community and beyond. ❖

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# Integrating Cognitive Processing Therapy and Spirituality for the Treatment of Post-Traumatic Stress Disorder in the Military

Natalia R. Wade

*Combat-Related Post-Traumatic Stress Disorder (PTSD) is a common behavioral health problem treated by many military health providers. Cognitive Processing Therapy (CPT) has proven to be effective in treating PTSD by assisting to restructure the cognitions of the client, which in turn reduces PTSD symptoms. Research has shown that individuals with PTSD who value spirituality tend to have a different world perspective than those individuals who do not highly value spirituality in their lives. Therefore, it would be important to incorporate spirituality into the treatment settings of those individuals who possess religious schemas. This paper proposes the use of spiritually informed cognitive processing therapy (SICPT) as a potentially effective approach for treating religious and/or spiritually focused service members who present with symptoms of PTSD.*

**M**ILITARY POWER WINS BATTLES, BUT SPIRITUAL POWER WINS WARS” (General George Patton, as cited in American Veteran’s Memorial, 2015). According to Mohr (2006), the four essential components of an individual are the physical, emotional, social, and spiritual dimensions. For many service members, spirituality is an important aspect of their identity, professionally and personally (Wester, 2009), and they use spiritual wellness to establish peace and harmony in their everyday lives (University of California, 2014). The Pew Forum on Religion and Public Life (2008) states that more than 92% of Americans believe in the existence of God or a universal spirit, 72 % believe in life after death, and 41 % of

individuals who are not affiliated with a particular spiritual or religious tradition state that spirituality or religion is somewhat important in their lives. Research has shown that beliefs associated with spirituality assist service members to cope with the stressors related to traumatic experiences during combat deployments (O'Reilly, 2004). These beliefs include hope, meaning, harmony, and transcending. When clinicians ignore these beliefs in service members who value spirituality as an important aspect in their life or use spirituality as a coping mechanism in crises, it may have a negative outcome on treatment (Drescher, Smith, & Foy, 2007).

For many service members who have experienced combat deployments and related traumatic experiences, spiritual practices have been shown to have a significant influence on their mental health, particularly for PTSD symptoms (Aflaksier & Coleman, 2009). Additionally, according to Drescher, Smith, and Foy (2007), religiosity or spirituality may serve as an effective coping resource among those exposed to war-related trauma, where religious or spiritual participation such as prayer or meditation has been associated with exposure to combat-related traumatic experiences (Ai, Tice, Huang, & Ishisaka, 2005) and a belief in God or a higher power is negatively correlated with symptoms of PTSD and related depression (Naelys, Diane, & Eloise, 2009). A number of studies on different modalities which address spiritual or religious beliefs in psychotherapy have reported results which demonstrate an increase in positive outcomes when compared to typical treatments or usual care (Worthington, Hook, David, & McDaniel, 2011; Pandzic, McLay, & Morrison, 2015).

In contrast, a religious crisis such as questioning faith or weakened faith has been associated with the increased use of behavioral health services (Fontana & Rosenheck, 2004), and spiritual crisis and moral injury are associated with prolonged recovery and persistent need for mental health services (Currier, Holland, & Drescher, 2015).

The purpose of this paper is to present the relevance and effectiveness of incorporating spirituality with service members who are struggling with combat-related PTSD..

### **Combat-Related Post-Traumatic Stress Disorder**

Studies indicate that approximately one in eight service members who were wounded in Iraq and Afghanistan War screened positive for Post-Traumatic Stress Disorder (PTSD) in the months following their return from combat (Grieger, Cozza, Ursano, Hoge, Martinez, Engel, et al. 2006). The National Institute of Health (2009) estimates that PTSD afflicts almost 31% of Vietnam veterans, as many as 10% of Gulf War (Desert Storm) veterans, 11% of veterans of the war in Afghanistan, and 20% of Iraqi war veterans. Approximately 6.8% of the general population will experience PTSD sometime during their life. By comparison, the lifetime prevalence

of PTSD among veterans is 27.3% (Slone, 2006). According to the National Center for PTSD (2015), combat-related PTSD symptoms consist of re-experiencing, avoidance, alterations in arousal, and negative cognitions and mood in response to combat-related traumatic events. Longitudinal research shows that combat-related PTSD can become a chronic psychiatric disorder which may persist for decades or even a lifetime, often marked by several remissions and relapses (Friedman, 2016).

According to the American Psychiatric Association (APA, 2013), the first criterion specifies that the service member has been directly exposed to a catastrophic event involving actual or threatened death or injury, or a threat to the physical integrity of him/her or others. Re-experiencing symptoms of PTSD include reactions or responses to the original traumatic event such as panic, terror, dread, grief, or despair, which manifest during intrusive daytime images of the event, traumatic nightmares, and vivid reenactments known as flashbacks. Additionally, trauma-related stimuli can trigger recollections of the original event which can engender mental images, emotional responses, and physiological reactions associated with the original trauma.

The avoidance criterion of PTSD consists of behavioral strategies which service members diagnosed with PTSD use in an attempt to reduce the likelihood that they will expose themselves to trauma-related stimuli. For example, many service members report avoiding the 4th of July fireworks, military funerals/memorials, or crowded events such as movie theatres or concerts. According to the National Center for PTSD (2015), many veterans who experienced traumatic events on combat deployments may avoid situations that remind them of the original incident and often find anniversaries of the incident to be very difficult.

Alterations in arousal such as hypervigilance and extreme startle are key characteristic symptoms of service members diagnosed with combat-related PTSD and very often the hypervigilance become so intense it presents as paranoia (Friedman, 2016). Other symptoms of this category can include irritability or outbursts of anger, which may present as aggressive behavior; reckless and/or self-destructive behavior such as impulsive acts, unsafe sex, reckless driving and suicidal behavior; insomnia or sleep disturbances such as nightmares, night terrors and night sweats, and cognitive impairment.

Symptoms reflected in the negative cognitions and mood criterion are persistent alterations in beliefs or mood a service member can develop after exposure to a combat-related traumatic event. Many service members diagnosed with combat-related PTSD have erroneous cognitions about the causes or consequences of the traumatic event which leads them to blame themselves or others, and will express the common beliefs of inadequacy and weakness. Their expectations about the future may have been permanently altered because of the event (Resick & Monson, 2006). Examples of such erroneous appraisals are “Nothing good can happen to me,” or “The

world is entirely dangerous.” Additionally, service members diagnosed with combat-related PTSD display a wide variety of negative emotional states such as anger, guilt, or shame.

Other symptoms include diminished interest in significant activities or previously enjoyed activities; feeling detached or estranged from others and socially isolate from family and/or friends; the inability to experience positive feelings such as love, pleasure or enjoyment, which can significantly impact marriages or otherwise meaningful interpersonal relationships; and dissociative psychogenic amnesia, which involves cutting off the conscious experience of trauma-based memories and feelings (Friedman, 2016).

Over the past thirty years, research results have shown that psychotherapy, specifically exposure-based therapies such as Prolonged Exposure (PE), Eye-movement desensitization and reprocessing (EMDR), and Cognitive Processing Therapy (CPT) have been the most effective interventions used to treat PTSD (Cukor, Olden, Lee & Difede, 2010). According to Foa, Keane, Friedman, & Cohen (2008) and the Veterans Administration (VA) in conjunction with Department of Defense (DoD, 2004), Cognitive Processing Therapy (CPT) has been endorsed as one of the best practice models and has proven to be one of the most effective treatments for service members diagnosed with combat-related PTSD.

### **Cognitive Processing Therapy**

Cognitive Processing Therapy (CPT) is used as a treatment modality for PTSD by teaching service members new ways to handle distressing thoughts and to gain an understanding of traumatic events. According to Cukor and associates (2010), the CPT exposure-based protocol focuses on increasing the cognitive components while decreasing the amount of exposure necessary for treatment, which is believed to be more palatable to service members diagnosed with combat-related PTSD. CPT is comprised of two integrated elements; cognitive restructuring and exposure. The cognitive component focuses on deconstructing assimilated distorted beliefs such as guilt, and global beliefs about the world and self (Resick, Monson, & Chard, 2014). The exposure component entails having the service member recreate the traumatic event by writing an Impact Statement, which addresses what the service member's thoughts about the cause of the traumatic event and the effects the event has had on their beliefs about self, others, and the world in the following areas: safety, trust, power/control, esteem, and intimacy (Resick, Monson, & Chard, 2014).

Based on a review of the literature there are several studies that indicate the efficacy of CPT as a treatment modality for combat-related PTSD in service members. For example, the results of a randomized trial of CPT versus waitlist control, 40% of service members receiving CPT no longer met criteria for PTSD at the study's end and 50% demonstrated a clinically

significant reduction in PTSD symptoms at post treatment assessment one month later (Monson, Schnurr, Resick, Friedman, Young-Xu, & Stevens, 2006). However, despite the positive research results and the VA mandate that veterans diagnosed with PTSD receive CPT or Prolonged Exposure (VA, 2010), less than 10% have completed a course in either modality (Mott, Hundt, Sangsiry, Mignogna, & Cully, 2014). Additionally, while CPT does indirectly address spiritual issues, it does not typically focus on spiritual struggles, moral injury, loss of faith, or actively utilize spiritual resources as part of the treatment (Maguen & Brett, 2015). According to Resick and associates (2014), clinicians may address spiritual crisis in CPT sessions where the discrepancy between trauma-related beliefs and prior spiritual beliefs can be reduced through assimilation (altering the trauma's meaning), accommodation (altering beliefs), and over accommodation (extreme alterations to or overgeneralizations of beliefs).

### **Spirituality**

Spirituality has several definitions. According to O'Reilly (2004), human potential is fulfilled through an expression of transcendent ways. Becker (2001) describes spirituality as a combination of the mind or the soul and different aspects of human nature that are intangible. Mohr (2006) contends that spirituality is an individual's search for meaning and belief in a higher power. Bormann, Lui, Thorp and Lang (2011) define spirituality as having meaning, purpose in life, transcendence or connectedness to a higher being, force, or energy. In this article spirituality will be defined as a connection to God, a higher purpose, or to the universe, and an inner belief to what the meaning and purpose of life is.

### **Spiritual Crisis**

According to McBride (1998), a spiritual crisis or spiritual emergency is a "form of identity crisis where an individual experiences drastic changes to their meaning system (i.e., their unique purposes, goals, values, attitude and beliefs, identity, and focus) typically because of a spontaneous spiritual experience" (p. 91).

Similar to negative post-traumatic cognitions about the self, others, and the world, the construct of spiritual crisis represents negative spiritual/religious cognitions about self, God or a higher power, and the world, and may thereby contribute to or exacerbate PTSD symptoms (Brewin & Holmes, 2003). When a soldier begins to question core values and beliefs and also experiences an unacceptable amount of cognitive dissonance between the things he or she has participated in and their core beliefs (regardless of whether or not it was to fulfill a military mission), this typically results in psychological trauma

## Spiritual Crisis and PTSD

According to Sherman, Harris, and Erbes (2015), psychological trauma during deployment may result when service members are confronted with experiences that may stand outside their normal systems of meaning and which overwhelm their existing coping strategies, and disrupt their psychosocial functioning. Survivors of combat-related trauma can also face difficult spiritual (personal belief system) and/or religious (organized system of beliefs and rituals in a faith community) challenges.

Since many service members typically enter the military as young adults, many of the service members who deploy may not be developmentally prepared for the complexities of war (Sherman, Harris, & Erbes, 2015) and as a result can experience a spiritual crisis. One of the unique spiritual crises combat veterans face is induced by incidences where they may be required to kill or wound others, which in most other contexts would be considered “wrong” or a violation of a service member’s moral or ethical code (Resick, Monson & Chard, 2014), causing them to ask questions such as “Does God exist?” or “Is God fair and just?” Another example, according to Resick, Monson, and Chard (2014), are spiritual struggles or disruptions in spiritual beliefs which include thoughts such as, “How could God let this happen?” or “Is God punishing me?” Spiritual discontentment is another example of a spiritual crisis according to Pargament, Koenig and Perez (2000), where the service member experiences anger focused at God or their higher power, where they question God’s love or wonder if they have been abandoned or let down by God or a higher power.

Research indicates that service members who are diagnosed with combat-related PTSD and in addition experience a loss of faith or spiritual crisis have worse mental health outcomes and require more mental health services than those who keep their faith intact (Ben-Ezra, Palgi, Sternberg, Berkley, Eldar, Hildai, & Shrira, 2010; Fontana & Rosenheck, 2004). Spiritual crisis or discontentment has been related to combat-related PTSD symptoms, higher levels of associated depression and suicidality in service members (Harris et al., 2008).

Spiritual crisis, unlike PTSD, is not a psychological disorder (Nakashima-Brock & Lettini, 2012). According to Litz and associates (2009), the fundamental distinction between PTSD and spiritual crisis is in the core emotion; spiritual crisis is rooted in guilt and shame, whereas PTSD is fear-based. Litz and associates further distinguish spiritual crisis from PTSD, indicating that guilt and shame are signs of an intact moral compass and the existence of a spiritual crisis in service members who are diagnosed with combat-related PTSD indicates discernible expectations about “goodness, humanity and justice” (2012, p. 701).

However, many behavioral health providers who provide care to service members are reluctant to address the spiritual and religious beliefs

and practices of their clients because they are unsure how to do so within the boundaries of ethical standards (Drescher, Nieuwsma & Swales, 2013). Another reason for this hesitancy appears that many behavioral health providers lack general training in this domain and, according to Drescher and associates (2013), very few APA-accredited clinical programs and internships address religion and spirituality systematically and some do not address this subject at all. The Council on Social Work Education accreditation standards require that professional social work programs prepare graduates to address spiritual and religious diversity but provide little specific direction (CSWE, 2015). Drescher and associates (2013) suggest that in order to build a bridge between spirituality and clinical treatment for service members diagnosed with combat-related PTSD, behavioral health providers should learn how to competently address spiritual or religious issues with the service members they are treating, which should begin as an integral part of their initial training and be developed through continued education.

### **Spiritually Informed Cognitive Processing Therapy**

Research has shown that when clinicians practice the inclusion of spiritual or religious practices, such as prayer or meditation, increased positive outcomes of psychotherapy have been noted in both the physical and mental health domains (Hall, Dixon, & Mauzey, 2004). According to Hood, Hill and Spilka (2009, pp.179), healthy spirituality is often associated with lower levels of symptoms and clinical problems in service members diagnosed with combat-related PTSD. For example, anger or rage demonstrated by service members after a traumatic event during deployment may be tempered by forgiveness, spiritual beliefs, or spiritual practices.

However, it should be noted that even though spiritual beliefs may have been originally used as strength or a resource, clinicians working with service members diagnosed with combat-related PTSD who are experiencing a spiritual crisis, should recognize that it can also be a weakness. For example, “God has abandoned me” or “God is persecuting me” can be signs of a weakening of faith or signs of negative religious/spiritual coping, which can be associated with more severe combat-related PTSD in some service members (Drescher, Smith, & Foy, 2007, pp. 441).

The goal of the approach of Spiritually Informed Cognitive Processing Therapy (SICPT) is to encourage and increase personal and spiritual growth and well-being (Sperry, 2005) and to develop a spiritual identity consistent with core beliefs and values (Martin & Booth, 1999), while decreasing the symptoms of PTSD.

SICPT makes use of the scriptures, spiritual/religious imagery, and references to spiritual/religious theology to help dispute irrational thoughts (Richards & Bergin, 2005), using spiritual precepts derived from client’s

spiritual world-view (Hodge, 2006). In doing so, the service member becomes able to recognize ways that he or she can use spirituality for support and guidance throughout the treatment process, as well addressing disruptions in preexisting beliefs. Thus, spirituality is strengthened as the service member grows in overall emotional well-being (Hodge, 2006), while decreasing PTSD symptoms. SICPT focuses on how problems in distorted thinking may occur after exposure to a combat-related traumatic event. According to Foa, Ehlers, Clark, Tolin, & Orsillo, (1999), when a service member experiences a combat-related trauma, those events violate or distort several commonly held assumptions and schemas, such as “the world is safe” or “my God/higher power will always protect me from extremely negative events.” When distorted thinking patterns are identified, the clinician will utilize biblical truth to conduct cognitive restructuring and behavioral change interventions (Tan & Johnson, 2005).

SIBT techniques range from integrated contemplative worship with religious imagery to prayer between client and clinician (Hawkins, Tan, & Turk, 1999). Other techniques include scripture memory, which is memorization of different spiritual/religious verses, the participation in many different forms of spiritual or Christian support groups, meditation/mindfulness, and prayer (Richards & Bergin, 2005).

For example, confession is one of the many classic but effective spiritual techniques which clinicians can employ to address service members diagnosed with combat-related PTSD who are experiencing a spiritual crisis (Antal & Winings, 2015). According to Antal and Winings (2015), confession can be incorporated into the treatment intervention as a catalyst towards forgiveness and reconciliation not only of self, but extended into the service member's community if necessary. Antal (2012) documented the story of a service member, Angelito, who turned his in-therapy confession into a song, which he publically performed before a religious community during deployment. According to Antal (2012, pp 390), Angelito used the technique of confession to address his spiritual crisis which started with an intense emotion of shame, moving to a feeling of appropriate guilt for actions, and finally to gratitude.

### **Clinical Issues**

According to Worthington and Sandage (2001), there are five clinical scenarios where spirituality or religion may be addressed in therapy. The first scenario occurs when the service member requests religious or spiritual therapy and/or questions the personal beliefs of the clinician. According to Miller and Thoresen (1999), it is essential for clinicians to be adequately prepared for these questions in order to effectively address the needs of the client and respond in an open, nonjudgmental, accepting, and empathetic manner. For example, Pargament (2013) suggests that if

clinicians are unfamiliar with the service members' spiritual practice or religion, the clinician should start by asking the service member questions about his or her spirituality or religion. This communicates to the service member that the clinician is genuinely interested in what is important to the service member and can open the door to effective rapport. Additionally, clinicians should consult with experts who represent different religious and spiritual traditions and different professional traditions to gain a more in-depth understanding in order to deliver more culturally competent service (Pargament, 2013).

According to a review of the literature, there are mixed opinions about self-disclosure if a service member directly questions the personal spiritual/religious beliefs of the clinician. According to Howe (2011), self-disclosure about spiritual/religious beliefs by a clinician, particularly if those beliefs are congruent with the service members', may instill hope, reduce shame, and reduce feelings of isolation in the service member, where real-life examples divulged in self-disclosures of a clinician can be especially compelling.

Conversely, self-disclosure about spiritual/religious beliefs by a clinician, particularly if those beliefs are incongruent with the service members' can cause the service member to feel as if the clinician is impaired or incompetent (Howe, 2011). Many clinicians respond to questions about themselves almost routinely from the perspective that the service member's asking must reflect some underlying need that should be explored (Howe, 2011; Knox and Hill, 2003). Examples of such responses include, "I wonder why you are asking?" or "I will answer you, but only after we discuss why you are asking."

Before making the decision to disclose personal information to the service member, the clinician most importantly should assess whether this self-disclosure will benefit the service member (and not the clinician) and the clinician should assess his/her comfort level with disclosing personal information to the service member (Howe, 2011; Knox and Hill, 2003).

The second clinical issue often evidenced in therapy involves those service members who are personally opposed to spiritual or religious beliefs in treatment. According to Worthington and Sandage (2001), these service members may overtly express these feelings or expect the clinician to filter out any information in regards to spirituality, particularly if the service member assesses that the clinician has a spiritual or religious affiliation. For example, the clinician may publically display spiritual material or have spiritual/religious office décor. It is imperative for the clinician to address these attitudes during assessment in order to gain an understanding of the client and his or her feelings regarding spiritual components in treatment in order to proceed in a competent, ethical manner (Worthington & Sandage, 2001). Clinicians should neither ignore spiritual and religious issues nor impose their own beliefs or practices (Resick, Monson & Chard, 2014).

The third clinical issue that can arise in treatment is when the clinician's approach to spirituality is implicit, rather than direct (Worthington & Sandage, 2001). This may lead to friction between the service member and the therapist, as the service member may desire a clinician who interacts with patients in a more direct manner with regard to spirituality, while the clinician may be unwilling or unable to do so. However, according to Hebert, Jenckes, Ford, O'Connor, and Cooper (2001), clinicians do not need to have personal spiritual or religious beliefs to recognize the importance of spirituality. Instead the focus can be shifted to clinician behaviors such as active listening, availability, and understanding, where good spiritual care can be provided without shared beliefs (Herbert, Jenckes, Ford, O'Connor & Cooper, 2001; Pargament, 2013).

A fourth clinical issue may surface in the context of treatment when religion and spirituality act as fundamental aspects of an individual's culture and cause interference with the acculturation process (Worthington & Sandage, 2001). This is an issue when beliefs regarding religion or spirituality function to define one's existence. For example, spirituality/religion is highly valued in Latino culture, and is usually practiced through Roman Catholicism. Such clients will often express their spirituality through their own personal ideologies and folk religions, such as seeking advice or healing powers of a "Curandera" (Canive & Castillo, 1997).

The fifth issue raised by Worthington and Sandage (2001) occurs when the service members are part of a relational system, such as a married couple, for example, where obvious differences about spirituality or religion could lead to additional stress and turmoil. An example of this could be a situation in which a service member diagnosed with combat-related PTSD who is experiencing a spiritual crisis engages in marital therapy and the service members' spiritual beliefs differ from those of the spouse or significant other. This example demonstrates the marital or relational tension which can occur on top of the service member's symptoms of combat-related PTSD and spiritual crisis. The same problem can also exist in group therapy or family therapy.

### **Conclusion**

The prevalence of combat-related PTSD is estimated to be as high as 27.3% in returning veterans (Slone, 2006) and CPT is an evidenced-based treatment protocol that has been found effective for the treatment of PTSD and other corollary symptoms following traumatic events (Center for Deployment Psychology, 2013).

However, conventional CPT does not always specifically and intentionally address spiritual crises or struggles and for many service members, spirituality is an important aspect of their identity, professionally and personally. Incorporating spirituality with CPT in individuals with a religious and/or

spiritual worldview can better mitigate PTSD symptoms, while addressing a spiritual crisis. ❖

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**Keywords:** cognitive processing therapy, combat-related PTSD, religion, spirituality, spiritual crisis

# Navigating the Minefield: A Model for Integrating Religion and Spirituality in Social Work Practice with Service Members and Veterans

*Patrick S. Foley, David L. Albright, & Kari L. Fletcher*

*Integrating religion and spirituality in social work practice with service members and veterans is akin to metaphorically “navigating the minefield.” To begin with, service members and veterans may be reluctant to address religion and spirituality due to military culture and/or the effects of combat/other trauma. Additionally, attempting to utilize religion and spirituality in therapy risks a conflation of the secular and religious or spiritual (sacred) domains and a subjugation of one to the other. To ease integrating religion and spirituality and avoid conflation/subjugation of secular and sacred, the concepts of sign and symbol can be utilized as a way to successfully “navigate the minefield.” This article proposes a parallel process model that uses sign and symbol as a means of accommodating religion and spirituality (with special reference to Christianity), easing into a consideration of how these values bear on behavioral health, and maintaining the distinction and dialectical tension between secular and sacred.*

**S**IGN AND SYMBOL ARE INSTRUMENTAL IN EVERY FORM OF RELIGION and spirituality. While there are many and varied types of signs and symbols that are used to communicate religious and spiritual values, this paper is concerned with considering the instrumental role that sign and symbol as concepts serve in communicating value. Prior to elaborating on sign and symbol as concepts and their relevance for religion and spirituality, it is important to define the two terms (a definition of religion and spirituality from the perspective of social work will be offered later). Sign is defined as, “any signal, gesture, mark, emblem, or token with an identifiable

meaning” (Colman, in Dictionary of Psychology, 2015) whereas symbol, “generally designates the combination of a **sign** (a word, graphic, gesture, image, etc.) with its **meaning** (tree, honesty, patriotism, etc.)” (Calhoun, in Dictionary of the Social Sciences, 2002). Both sign and symbol work in tandem to communicate religious and spiritual values.

With respect to Judaism and Christianity, signs such as the rainbow and those associated with the deliverance of the Israelites from Egypt point to the grandeur of God and create an anticipation of liberation, known as a covenant, in the collective faith of these communities. For Christians, the symbols of bread, wine, the Cross, the Body of Christ, and Christ Himself all express or represent the fulfillment of the ancient covenant promises.

Sign and symbol are relevant not only for religion and spirituality but also figure prominently in military culture and the behavioral sciences (as will be demonstrated further on in the paper). The relevance of sign and symbol for religion and spirituality (with special reference to Christianity), military culture, and the behavioral sciences provides the basis for the following question: “What role might sign and symbol play in facilitating the integration of religion and spirituality in social work practice with service members and veterans?”

The paper will proceed by laying the foundation of a consideration of sign and symbol from the perspective of semiotics. As a field of academia, semiotics is concerned with, “the study of patterned human communication in all its modes, including touch, facial expression, gestures, and the spoken and written signs and symbols of human languages” (Colman, in Dictionary of Psychology, 2015). With this foundation in place, the relevance of sign and symbol in the following areas will be explored: religion and spirituality, the Christian tradition, military culture, and the behavioral sciences. The importance of integrating religion and spirituality in social work practice with service members and veterans will also be considered. Finally, a model for utilizing sign and symbol as a means of integrating religion and spirituality in social work assessments and interventions will be proposed, along with the inter-religious implications of the model.

### **A Semiotic Approach to Sign and Symbol**

K. Oslem Alp, a researcher who has studied semiotics and published on the role of sign and symbol in culture and art, notes that sign and symbol are often used interchangeably and without much consideration as to their distinctive place in semiotics (Alp, 2010). However, sign and symbol have a unique role both in semiotics and with respect to the manner in which each facilitates meaning making and religion and spirituality.

## **Sign**

Sign provides a sense of definiteness, symptom, indication, notice, mark, and showing by gestures (Turkce translated in Alp, 2010, p. 2). Sign “denotes” (MacIver, 1953,) and points to something in the literal sense. With regard to sign as “denoting” something else, it is important to note that the prefix “de-” in denote means to be subtracted or reduced; therefore, through the function of pointing to something else, a sign is subtracted, reduced, or removed from the meaning making process. Sign points and implies, transports information or a state (Alp, 2010) and “signifies only one thing to which it points” (Alp, 2010, p. 4). In other words, sign points to something in a very direct and concrete way and then fades in relevance. For example, a highway sign warning drivers of the potential of falling rock on the road ahead points literally to this threat and is soon forgotten in the mind of the driver as he or she prepares to react. In contradistinction to sign, symbol does not fade in its role in communicating meaning but can become even more relevant.

## **Symbol**

Symbol is described as, “a concrete matter... image, figure, or icon representing something that cannot be expressed by senses” (Turkce translated in Alp, 2010, p. 2). Symbol does not disclose as does sign but “hides” in the sense that it entices and invites an active engagement with its meaning (Alp, 2010). Symbol “draws attention by its one-to-one unexplainable character” (Alp, 2010, p. 4). Symbol “connotes” not only pointing to something in a literal sense but also suggesting figurative possibilities. In comparison to the denoting function of sign, it is important to note that the prefix “con-” in connote means “together or with”. The function and dynamism of symbol is well represented by the American flag. The flag represents a history and values that transcend what can be fully expressed and invites those who look upon it into active contemplation of its manifold historical and cultural meaning. While the flag points to a literal meaning (e.g., the existence of fifty states), it also admits to figurative interpretations (e.g., liberty, democracy, and sacrifice) that are both comprehensible and inexhaustible in meaning. The denotative properties of sign and the connotative properties of symbol as explicated by the discipline of semiotics make them especially well-suited to express religious and spiritual meaning.

### **Sign, Symbol, Religion, and Spirituality**

Before briefly exploring the relationship between sign, symbol, religion, and spirituality, it is important to define the latter terms. According to social work researchers Canda and Furman (2010), religion is:

...an institutionalized...pattern of values, beliefs, symbols, behaviors, and experiences that involves spirituality, a community of adherents, transmission of tradition over time and community support functions (e.g., organizational structure, material assistance, emotional support, or political advocacy) that are directly or indirectly related to spirituality (Canda & Furman, 2010, p. 76).

Canda and Furman define spirituality as a process that focuses on:

...the search for a sense of meaning, purpose, morality, and well being; [the] relationship with oneself, other people, other beings, the universe, and ultimate reality however understood; orienting around centrally significant priorities and engaging a sense of transcendence (experienced as deeply profound, sacred, or transpersonal) (2010, p. 75).

The following analysis of the relationship between sign, symbol, religion, and spirituality will proceed generally along existential lines. In other words, how does this relationship serve the purpose of, “focus[ing] on the immediacy of human experience and how people deal with the human condition of impermanence, suffering, death, and the inhumanity of human beings” (Canda & Furman, 2010, p. 187).

One way to appreciate the relationship between sign and religion and spirituality is that sign serves the existential function of pointing to something more and, therefore, creating anticipatory space in a person’s imagination. By “pointing to” (Alp, 2010) and “denoting” (MacIver, 1953) something else, sign orients and creates an anticipatory sense regarding what the content or experience of the something else might be. In terms of the aforementioned definitions of religion and spirituality, sign points to “values, beliefs, symbols, behaviors, and experiences” (Canda & Furman, p. 76) and directs one to “meaning, purpose, morality, and well being” that is transcendent (Canda & Furman, p. 75). The very act of orientating to something else, or, something beyond, implies that between sign and that which is signified, a space opens in the imagination that is characterized by anticipation. As in the previous example of the function of a sign, the driver who encounters a highway sign that indicates the potential of falling rock ahead likely anticipates what such falling rock might look like and how to react to the event.

In contrast to sign, the function of symbol as it applies to religion and spirituality is not orientation but relation. In other words, symbols connote meaning only by being inextricably linked to something else in a mode of mutual interpenetration. To reference the American flag again, it has become

inextricably linked to patriotic sacrifice in part by virtue of the many service members who have raised it before or after battle (e.g., the dramatic flag raising at Iwo Jima). Such is the symbolic “interpenetrative bond” between the flag and patriotic self-sacrifice that the raising of the flag at public events immediately conjures awareness of those who have sacrificed all for their country. It is through this interpenetrative bond that symbol and that which is symbolized can be appreciated and comprehended—though never exhaustively (which is what Alp likely means in saying that symbol and symbolized have, “one-to-one unexplainable character,” 2010, p. 4). The capacity for symbol to have inexhaustible meaning points to precisely why symbol is acutely adept at facilitating religion and spirituality: symbol gives depth of expression to the “values, beliefs... behaviors, experiences and traditions” (Canda & Furman, 2010, p. 76) of religion and also embodies the relational and transcendent aspects of spirituality. We will now consider more precisely how sign and symbol facilitate religion and spirituality by briefly treating the role of each in the Judeo and Christian tradition.

### **Sign, Symbol, and the Judeo and Christian Traditions**

The role that sign and symbol play in the Judeo and Christian traditions will be considered in terms of the communal effect of sign and symbol and their psycho-spiritual (meaning, psychological processes that are also connected to spiritual development) impact on the collective and individual faith imagination. While the role of sign and symbol in the Judeo and Christian traditions could be considered from many different vantage points (e.g., worship, ethics, morality), the communal and psycho-spiritual categories were chosen because of their relevance to the discipline of social work (i.e., person-in-environment and the value of the person).

When one considers the manner that God communicated to the ancient Israelites in the Hebrew Scriptures, one cannot help but come to the conclusion that sign played an essential role. So numerous are signs in the Hebrew Scriptures that one might refer to these texts collectively as “a book of signs.” Among the most notable signs are the rainbow in the Book of Genesis (9:12) and the signs that God manifested when God delivered the Israelites from bondage in Egypt in the Book of Exodus (6:20, 8:6, 8:17, 8:24, 9:6, 9:10, 9:23, 10:12, 10:22, 12:29). The communal function of signs for the ancient Israelites was the following: they shaped the identity of the Israelites as the chosen of God and “commemorated divine actions in the past and contain[ed] a lesson for successive generations” (Lipinski, 2007, p. 569). Lastly, signs were “guarantees of a covenant” (Lipinski, 2007, p. 569). As “guarantees of a covenant” (or, the sacred pact between God and the Israelites outlined through promises and responsibilities), signs impacted the imagination of the Hebrew people by facilitating a dynamic remembering of covenant “events” (e.g., the Exodus).

This dynamic mode of remembering is referred to in theology by the Greek term, *anamnesis*, which means “making present a person or object from the past” (Senn quoted in Cody, 2006, p.48). Anamnesis is as much an act of faith and commitment (i.e., spirituality) as it is a cognitive act of recollection. Yet, because of the fact that the ancient covenant with Israel is largely promise-based, recalling the covenantal promises not only involves a dynamic moment of anamnesis but also implies an act of faith regarding the fulfillment of these promises in the future. Therefore, the signs of the covenant not only make the promises present through anamnesis but also create anticipatory space regarding their future fulfillment.

This anticipatory space between the promises that are simultaneously “already” established and “not yet” fulfilled can be encapsulated by another theological and Greek term, *kenosis*. For Christians, *kenosis* as a scriptural and theological concept was used from early on in the tradition to describe an ancient scriptural hymn in the Letter to the Philippians (2:2-8) devoted to the self-emptying love of Jesus Christ (Clifford, 2004, p. 23). Originally having the connotation of self-emptying, the meaning of the term has been expanded in modern theology. According to the contemporary theologian Hans Urs von Balthasar, the term *kenosis* also refers to “the movements of self-giving toward the other in order to receive the other that are constitutive of divine and human personhood” (Papanikolaou, 2003, p.42).

In applying this contemporary definition of *kenosis* to the “anticipatory space” that opens up in the faith imagination of those who adhere to either the Judeo or Christian covenants, the kenotic movement consists in allowing the signs of the covenant to create openness within the adherent toward an anticipation of an ever-greater fulfillment of these promises. In other words, allowing for anticipatory space implies a continuous oscillation between giving of self to God and receiving the grace of God. For the Christian, this oscillation between giving and receiving reaches fullness in the perfect melding of human and divine in the person and symbol of Jesus Christ.

If the Hebrew Scriptures could be referred to as “a book of signs”, then the Christian Scriptures (i.e., “New Testament”) might be described as “a book of symbols.” Referring back to the function of sign, the signs of the Hebrew Scriptures provided a sense of “definiteness...indication, notice, mark, and showing by gestures” (Turkce translated in Alp, 2010, p. 2) that God was with the ancient Israelites as their deliverer. In the Christian Scriptures, symbols such as the Cross connote the historical and ongoing mystery of the sacrifice of Jesus embodied in the Church and each believer. In addition to the Cross, some of the more prominent symbols that connote Jesus’ message and person are bread, wine, the Body of Christ, and, even Jesus Himself (Alp, 2010, p. 5; Haight, 2005). As was done in the case of sign, we will approach symbol in an existential manner by briefly

considering the communal and religious and spiritual import of symbol for the Christian community. The communal function that the above symbols serve is to establish commonly held and aspired to values that bond the Christian community (MacIver, 1953, p. 102). Furthermore, the symbols of bread, wine, and the Cross “vivify and reinforce” (MacIver, 1953, p. 102) the essence of Christ and Christian discipleship by dynamically re-presenting them in a manner that makes them present and relevant to a given person’s situation and historical context. Again, the religious and spiritual mechanism at work in facilitating this dynamic act of remembrance and re-presenting of the Christian mysteries is anamnesis.

In comparison to the role that anamnesis plays in recollecting the events of the Hebrew Scriptures, the type of dynamic remembrance and re-presentation noted above could be described as an “enhanced” anamnesis, or, a remembrance characterized by embodying, participating, and relating not only to a promise but to a person (Christ). According to the theologian, Karl Rahner, S.J., (as paraphrased by Daniel Pekarske, 2002): “accepting Christ as our basic act of religion also implies anamnesis, recalling and rendering present his history in the Eucharist and in the tradition of the Church” (p. 234). This Christian act of anamnesis is both a mode of remembering God’s promises and relating to Christ. Such an enhanced anamnesis, therefore, involves the psycho-spiritual movement of *kenosis* through sign (making room for God’s promises) and *perichoresis* through symbol (relating to Christ).

Perichoresis is a Greek Stoic term that means, “interpenetration” (Stramara, 1998). The term was also introduced from very early on in the Christian tradition (7th Century) and connotes the intimate manner that God relates to God’s self as Father, Son, and Spirit and the extension of this relational intimacy to humanity in the Son and through the Spirit (Egan, 1994; Stramara, 1998). It is important to note that the term does not imply a relational interpenetration that vitiates—or, reduces—the value or quality of each person in the partnership (Stramara, 1998) but is one that simultaneously enhances the value and quality of the person and the relationship in like proportion.

The dynamism of the psycho-spiritual movements of *kenosis* and *perichoresis* implies a third dynamism of *theosis*, or, the humanization and divinization of the subject who is receptively disposed to receive the gift of God’s self in Christ and who allows this gift to become ever-deepened through the Spirit. Just as *kenosis* and *perichoresis* have ancient roots and contemporary relevance to the Christian tradition, so also, “doctrines of *theosis* have a well-rehearsed history” in both ancient and contemporary Christian theology (Habets, 2009, p. 489).

To connect the relevance of these insights regarding sign and symbol and how they facilitate the psycho-spiritual movements of *kenosis*, peri-

choresis, and theosis to military culture and those who have served in it, we will further delve into the relevance of sign, symbol, spirituality, and religion for those who serve or have served in the military.

### **Relevance of Sign, Symbol, Religion, and Spirituality for Military Culture**

#### **Relevance of Sign and Symbol**

As a distinct culture, the military employs a vernacular (comprised of sign and symbol) that is quite unique and distinct from its civilian counterpart. The military makes liberal uses of acronyms (essentially functioning as signs) that promote communication and “unspoken dynamics” (Reger, Etherage, Reger, Gahm, 2008, p.24). The military additionally makes liberal implicit use of symbol to enhance the distinctiveness of its culture (Brim, 2013) and subscribes to an explicit, standardized set of symbols used to depict battlefield dispositions on a map (*Military Symbols for Land Operations*, 1999). The purpose of focusing on how sign and symbol are used in military culture is to highlight the distinctiveness of each in creating meaning for service members and veterans so that social workers can ultimately identify and make use of sign and symbol as a bridge in addressing religious and spiritual matters (should this be indicated in assessment and intervention).

To illustrate how sign and symbol figure concretely in military culture, we will consider the following example of the relevance of sign and symbol in the case of an Army Infantry unit. Small, six-person U.S. Army Long Range Surveillance (LRS) teams must learn to expertly read the signs of their environment if they are to successfully survive and complete their mission. Upon insertion into their area of operations (usually by helicopter), LRS teams immediately conduct a tactical procedure known as “SLLS” (pronounced, “sills”), an acronym that stands for “stop, look, listen, and smell.” What the team is looking for is any sign of the enemy in the area: this could be something as significant as an enemy patrol investigating the helicopter landing to something as subtle as a foot trail on the ground. The members of the patrol also listen for the natural sounds that are indigenous to the environment to slowly come back to life after insertion. Finally, the patrol members smell for any scent that betrays a human presence. Foot trails, a lack of indigenous sounds returning after insertion, and certain smells are all signs of the presence of an enemy force that could spell mission compromise. To successfully complete a LRS mission, LRS patrol members must not only be able to read signs but also embody symbolic values.

LRS soldiers—and all service members—must not only hone their senses to read signs but also allow the imagination and will to be formed by symbols in order to embody military values. From the very beginning

of military indoctrination, all service members are immersed in an environment rife with symbols: unit patches, unit designations, unit history, unit phrases, unit coins, and unit values all inculcate a particular warrior ethos, esprit de corps, and mission resolve. For the LRS soldier, the motto, *In Orbe Terrum, Non Visi*, Latin for, “in all the world, unseen”, symbolizes the LRS mission resolve to exhibit the highest degree of stealth and to remain uncompromised. Using this example as an illustration of how sign and symbol figure concretely in military culture as a whole, we will now delve more deeply into the psychological function that sign and symbol serve for current and former service members.

With respect to the psychological role of sign and symbol in the military, one might describe the role of sign as fostering “reactive” consciousness whereas symbol promotes “reflective” consciousness. In the illustration above, when a LRS soldier conducts a listening halt, the soldier strains the senses to identify the presence of signs that might indicate an enemy’s presence. If the LRS team does not react quickly and cohesively to signs of the enemy, this threatens the successful completion of the mission and the very survival of the team.

Signs in this context immediately constellate an individual and collective reaction on the part of the LRS soldier and LRS team. This individual and collective response is formed through countless exercises and battle drills that condition team members to react rather than to think when faced by a threat. Such repetitive training—in addition to other stress-immersion training techniques (e.g., survival training, sleep and food deprivation)—is believed to promote resilience and inoculation to stress. Repetition and stress-immersion is a common element to all military training, not merely for infantry or LRS. However, research suggests that resilience building and stress-inoculation training focused solely on developing the capacity to react while stressed may actually degrade a service member’s ability to deal with stress and discern a real threat (Stanley & Jha, 2009). Recent research pertaining to stress-inoculation training alludes to the importance for service members to learn not only how to react to signs but to also learn how to reflectively embody the value of various military symbols.

In an article published in *Joint Forces Quarterly*, Stanley & Jha (2009) describe a relatively new initiative to build mental resilience, known as Mindfulness-Based Mental Fitness Training, or MMFT (referred to as “M-Fit”). Compared to stress-inoculation training that is based largely on being able to “read the signs” and react to them while stressed, MMFT conditioning is based on mindfulness principles and involves daily exercises that promote attentiveness and reflection. According to the authors, mindfulness is “paying attention in a particular way, on purpose, in the present moment, and non-judgmentally” and has been used in the treatment of PTSD among service members and veterans (Stanley & Jha, 2009). In contradistinction to the manner that mindfulness is used to treat the

effects of trauma reactively, MMFT training is believed to be a proactive buffer to the ill-effects of trauma by promoting mental fitness and resilience (Stanley & Jha, 2009).

MMFT is a 24-hour course that is taught over a period of eight weeks. The main conditioning mechanism is specially designed mind fitness exercises conducted for thirty minutes daily (Stanley, Schaldach, Kiyonaga & Jha, 2011). In a pilot study of Marine Reservists (n=31) who received MMFT training prior to deployment, those Marines who practiced MMFT techniques enjoyed higher levels of cognitive performance and lower levels of deployment stress compared to those who made less use of MMFT (Stanley & Jha, 2009). This study offers supportive data that, in addition to the importance of reading and reacting to signs through stress-inoculation training, mental fitness and resilience is also enhanced through processes of systematic attention and reflection. Such cognitive processes are naturally promoted by symbol due to the previously discussed capacity of symbol to foster an ability to hold the tension between opposites and between stimuli that compete for one's attention. The importance of the complementary role that symbol (a more value-based semiotic device) can play in a military culture that disproportionately emphasizes the role of sign (a more rule-based semiotic device) is illustrated through the following study.

In an assessment of the current state-of-affairs of military indoctrination into moral and character education, Williams (2010) highlights the fact that the ability to reflectively discern and hold the tensions inherent in modern combat has perhaps never been more important: "the current operations in Afghanistan and Iraq have accentuated the reality of the three-block war... in which soldiers conduct humanitarian support, peace-keeping, and combat actions" (p. 42). William's assessment of a soldier's moral and character development was based on pre- and post U.S. Army Military Police Initial Entry Training (IET) interviews of soldiers (n=40) to determine positive and negative change in these categories. What Williams (2010) found is that while there was significant change in soldiers' attitudes, there was little moral and character development. It is important to note that IET does focus on content related to morals and values such as the Army Values and Soldier's Creed. The Army Values are loyalty, duty, respect, selfless service, honor, integrity, and personal courage and the Soldier's Creed inculcates living the Army Values, being a warrior and a team member, serving American interests, priority of mission, never accepting defeat, never quitting, never leaving a fallen comrade, discipline, professionalism, and proficiency.

Despite initial indoctrination into these values, Williams (2010) attributes the lack of development to, "emphasis on rules, inconsistent leader actions, lack of moral challenge, ineffective training methods, and moral climate" (p. 50). More disturbingly, Williams (2010) notes that, "IET reinforced a rules-based approach to moral decision making...soldiers learned

new rules but did not necessarily understand or apply the principles that support the rules. Soldiers also indicated that IET eliminated the need for personal decision making” (p. 50). Williams believes that the complex conflicts of today and tomorrow require morally and ethically astute soldiers. According to Williams (2010), soldiers become moral and ethical agents not through “repetition and reinforcement” (i.e., learning to read and react to signs) but through the demonstration of Army Values (i.e., “symbolic embodiment”) on the part of Army leaders and the policies and procedures of Army units (p. 51).

With respect to the implications of this study for the relevance of symbol for military culture, another way to express this conviction is that Army leaders and Army units must become the symbolic embodiment of the Army Values and Soldier’s Creed if such values are to be re-enacted in future generations of soldiers. The consequences of not symbolically embodying the above value system in the face of increasingly complex conflicts is that soldiers may be susceptible to incurring the invisible wounds of war in terms of PTSD and moral injury – with the latter defined as, “an act of transgression that creates dissonance and conflict because it violates assumptions and beliefs about right and wrong and personal goodness” (Litz et al, 2009, p. 698). Another means of enhancing the moral character of service members and mitigating moral injury and PTSD is through the influence of religion and spirituality.

### **Relevance of Religion and Spirituality**

To ascertain the relevance of religion and spirituality for military culture in terms of its capacity to cultivate character (the need for which is highlighted in the Williams article above), we will refer back to the definitions of religion and spirituality discussed earlier. It is not difficult to derive the characterological benefits of religion and spirituality for service members when, for example, one compares the core facets of the definitions of religion and spirituality with the structure of the military in general and the Army Values and Soldier’s Creed in particular. Both the military and religion are similar in the sense that they are, “an institutionalized...pattern of values, beliefs, symbols, behaviors, and experiences that involve...a community of adherents, transmission of tradition over time and community support functions” (Canda & Furman, 2010, p. 76). They differ, however, in their particular aim: religion is at the service of spirituality (Canda & Furman, 2010) and the military is at the service of a particular nation’s interests (which are likely not explicitly spiritual). The importance of religion (and spirituality) for a service member, therefore, is that it can give him or her a sense of distinctive and transcendent value. If one were to adhere to religion in such a manner, the capacity to act as a moral and ethical agent would likely be enhanced due to fact that service

members would be equipped with a value system separate from military values that could effectively serve “as a final court of appeals” should the two come into conflict.

Spirituality is akin to the Army Values and the Soldier’s Creed in that both spirituality and the latter place high value on “meaning, purpose, morality...the relationship with oneself and others” (Canda & Furman, 2010, p. 75) and an orientation to transcendence (i.e., something greater than one’s self/self-interest). Again, it is likely not difficult to derive the value of spirituality for developing character, the capacity for moral and ethical decision making, and being able to symbolically embody both spiritual and military values. Additionally, the value of religion and spirituality for service members—and especially veterans—is the buffering and mitigating effect they can have on the effects of trauma, PTSD, and moral injury.

Numerous studies on the effects of religion and spirituality on the general population and service members’/veterans’ experience of trauma and PTSD have been conducted in recent years. While these studies can be quite nuanced, the following represents a sampling of some of the more broad-based findings. To begin with, a meta-analysis of 49 studies dealing with religious coping and adjustment to stressful events across multiple populations conducted by Ano and Vasconcellas (2005) revealed that, “religious coping strategies are significantly associated with psychological adjustment to stress” (p. 473). More specifically, “a moderate positive relationship exists between positive religious coping strategies and positive outcomes to stressful events” (p. 473). Another study focused on persons from the general population with PTSD showed that religiosity promotes positive coping in the face of multiple traumatic events (Falsetti, Resick & Davis, 2003, p. 396). With regard to spirituality, “repeating a sacred phrase or mantram has been shown to reduce the severity of post-traumatic stress disorder symptoms (PTSD) in veterans with military trauma” (Bormann, Liu, Thorp & Lang, 2012, p.496).

A study by Harris, et al. (2011) involving a spiritually oriented intervention in the treatment of military related PTSD provided rigorous empirical evidence “that addressing spiritual concerns can reduce symptoms of PTSD in trauma survivors” (p. 434). Again, the intervention mentioned above—in addition to targeting PTSD symptoms—involves strategies to address moral injury through spirituality (Harris, et al., 2011). Given the relatively straightforward relationship between moral injury and religion and spirituality, it should not be hard to see the relevance of the latter in the treatment of the former. What is more challenging, however, is forging a bridge between the conventional behavioral science approach to sign and symbol and using sign and symbol to facilitate an integration of religion and spirituality in social work interventions with service members and veterans.

### **The Role of Sign and Symbol in the Behavioral Sciences**

In seeking to establish the above-mentioned bridge, it is important to briefly consider the role of sign and symbol in behavioral science assessments and interventions. In behavioral science assessments and interventions, signs can be indicators of adaptive mental health - i.e., signs that point to protective factors and strengths - and indicators of risk factors and maladaptive mental health. As identified earlier in outlining the definition of sign, sign is most often synonymous with symptom and therefore is more likely associated in behavioral health (and social work) circles with maladaptive health criteria or symptoms to be healed, cured, or remedied. In being associated with symptoms, signs might therefore be more relevant to the process of diagnosis and directive treatments through evidence-based practice interventions. As in semiotics, sign in behavioral health points to something else—a symptom, diagnosis, and intervention—and then fades into irrelevance. Again, as in the discipline of semiotics, a symbol is treated quite differently in the behavioral sciences as something that must be reckoned with, in and of itself.

Unlike sign—such as risk and protective factors—which points to adaptive or maladaptive aspects of the self and then fades in importance, symbol in the behavioral sciences (to include social work) is often used in assessments and interventions to represent the self and can become more salient as therapy progresses. Also, whereas sign is most frequently identified with symptom and therefore associated with diagnostic assessments and evidence-based practice interventions, symbol is more often utilized in narrative, existential, analytical, and interpersonal therapies because of its associations with the self, with others, and with existence.

Two brief examples from psychotherapy of the utility of symbol in embodying self-process and facilitating intra- and interpersonal development are Jung's approach to symbol and Winnicott's Transitional Object. Jung's corpus of writings includes three books devoted to analyzing symbols: *Collected Works, Volume 5, Symbols of Transformation*, *Collected Works, Volume 18, The Symbolic Life*, and *Man and His Symbols*. The overall purpose of symbol in Jungian theory is to facilitate intrapersonal development, or, individuation. Winnicott's Transitional Object—an object of play or comfort for a child such as a blanket or teddy bear—is symbolic in the sense that it embodies the maturational dynamism of a child holding the tension between clinging to and separating from the mother (Helsel, 2010, pp.1822-1823). The manner in which symbol is used in Jung and Winnicott's systems are intended to give but very brief examples of the role and dynamism of symbol in psychotherapeutic assessment and intervention.

For the purposes of this paper, it is perhaps more important to emphasize the notion that, with regard to assessment and intervention

of service members and veterans, sign and symbol serve distinctive and complementary roles. When taken together, both sign and symbol align with the social work values of treating the whole person and considering the person-in-environment (rather than reducing a person to mere thought, behavior, symptom, or syndrome and as an entity abstracted from a specific context). While it is important to consider sign and symbol together, it can also be important to develop clinical sensitivity on how to distinguish one from the other.

In working with service members and veterans, it can be quite beneficial to develop a clinical sensitivity to whether an individual is communicating more in terms of “sign” language or “symbolic” language and to understand what this may imply for assessment and intervention. Service members or veterans who present for therapy and express their fundamental difficulty in terms of sign or symptom (e.g., hypervigilance, isolation, anger, irritability, flashbacks) would likely benefit from an evidence-based therapy - such as Prolonged Exposure. However, if service members or veterans are using symbolic terms to emphasize more existential issues – such as loss of meaning, guilt, shame, a faith crisis, etc. – this manifestation may call for a very different therapeutic approach. To not correctly distinguish between signs/symptoms that point primarily to the psycho-physiological ill effects of trauma versus the symbolic language that reveals moral and ethical injury could result in intervening in a manner that might actually do harm (Litz et al., 2009, p. 702).

This became clear to one of the authors in recently working with a veteran with a complex trauma history consisting of both childhood and combat trauma. While the veteran had been diagnosed with PTSD, he most often spoke about suffering from survivor’s guilt due to serving as a combat medic and not being able to save those he believes he should have. The veteran began a course of Prolonged Exposure therapy but dropped out due to the therapy causing an increase in severity of symptoms and an exacerbation of his survivor’s guilt. The veteran was subsequently recommended to engage in therapy that targeted his extremely negative and indicting self-narrative prior to targeting an alleviation of his PTSD symptoms (which were essentially “signs” of more complex issues). Had the symbolic language that the veteran frequently used (e.g., being a medic, which, for him, was symbolic of a type of savior) been given credence over his symptoms, a different therapy may have been prescribed from the outset and thusly resulted in less suffering.

In general and in the example above, assessment and intervention would ideally involve the flexibility to address both the signs and symbols of maladaptive health through a process that Litz et al., (2009) refer to as “modified exposure” (Litz et al., 2009, p. 703). In essence, what Litz and associates (2009) are proposing is a parallel process of assessing and

intervening both at the psycho-physiological level and also at the moral, ethical, and existential levels.

Another way to represent this process is sequentially in terms of symptom → self → synthesis. In this sequential movement, “symptom” refers to treating the psycho-physiological signs, “self” refers to treating the moral and ethical injury, and “synthesis” would be the successful integration of the two. To integrate religion and spirituality into social work practice with service members and veterans, we would propose adding a semiotic and religious and spiritual component to the above.

### **Integrating Religion and Spirituality in Social Work with Service Members and Veterans Through the Use of Sign and Symbol**

Up to this point we have examined the relevance of sign and symbol for military culture, religion and spirituality (with special reference to Christianity), and the behavioral sciences. We also considered the relevance of religion and spirituality for service members and veterans in order to demonstrate the value of each and to encourage social workers to be more deliberate in seeking to integrate them into assessment and intervention. With regard to the relevance of sign and symbol for religion, spirituality, and Christianity, the potential spiritual dynamism of sign and symbol were explicated using the Greek concepts of *kenosis* (sign), *perichoresis* (symbol), and *theosis* (synthesis of sign and symbol) to illustrate how they can be at the service of promoting an existentially focused religion and spirituality. The purpose in outlining the above is to lay the foundation for a model that utilizes sign and symbol (something familiar to all three domains) to promote the integration of religion and spirituality in conducting social work assessments and interventions with service members and veterans.

At the end of the previous section, we proposed a model for depicting a therapeutic and integrative way of addressing both symptom and self in working with veterans and service members in terms of symptom → self → synthesis. We would now like to propose two parallel layers to this model that we believe can promote the integration of religion and spirituality in working with service members and veterans. The two additional layers of the model are illustrated in the following figure.

**Figure 1: A Parallel Process Model for Integrating Religion and Spirituality in Social Work Practice with Service Members and Veterans**

Symptom → Self → Synthesis (level 1: psychotherapy)  
 Sign → Symbol → Synthesis (level 2: semiotics)  
 Kenosis → Perichoresis → Theosis (level 3: religion and spirituality)

This is a parallel process model due to the similar dynamism in the movement from one point to another along each level and also due to each point corresponding to the one directly below or above it (the nature of the correspondence has been articulated throughout this paper). The way that the model “works” in terms of integrating religion and spirituality would be through the progressive movement from one level to another in the therapeutic process.

With regard to the ordering of the levels, the psychotherapy level is referred to as “level 1” due to it likely being the level that service members and veterans present at in the beginning of therapy (symptoms and issues bearing on the self). When symptoms and issues of the self are received by a social worker/therapist with an appreciation of the dynamism of sign and symbol, he or she can encourage a service member or veteran to move to a consideration of what sign and symbol are pointing to or embodying in terms of behavioral health. Finally, if the client expresses the desire or need to integrate religion and/or spirituality into the therapy process, the social worker/therapist and client (in this example, a Christian client) can move to the third and final level of a consideration of symptom/sign and self/symbol along the lines of the religiosity and spirituality embodied in the concepts of kenosis, perichoresis, and, theosis.

The overall reason for proposing a parallel process model with three levels is because one naturally leads to the other and service members and veterans are often unlikely to delve into religion and spirituality without progressive and subtle invitation. To further illustrate what a movement to level three might look like in practice, we will briefly consider the therapeutic value of the above concepts for (Christian) service members and veterans who have endured trauma.

### **Kenosis**

The concept of kenosis can enhance the behavioral science approach to symptom and sign by suggesting a consideration of the religious and/or spiritual value of space and anticipatory space. For example, when service members or veterans present with signs and symptoms of PTSD and/or moral injury, in terms of kenosis these signs and symptoms point both retroactively to a traumatic event and the need to create space between the self and the event and prospectively in terms of the opportunity to clarify values/meaning or to embrace new values/meaning. When signs and symptoms of PTSD and moral injury point retroactively to an unprocessed traumatic event, a kenotic assessment of this is that there is a fundamental lack of existential space between the event and the present moment such that the two become truncated or conflated. The effect of this truncation or conflation is that the traumatic event is re-experienced as something occurring in the present and therefore triggers a number of

psycho-physiological symptoms that essentially result in a dissociation of one's self from the here-and-now. The intervention called for in such a situation is often times an exposure-based approach (Prolonged Exposure or Cognitive Processing Therapy) that facilitates a repeated and controlled exposure to the event that mitigates the psycho-physiological symptoms.

The kenotic adjunct to the above intervention might be to highlight the religious or spiritual process inherent in creating space between one's self and a given event in order to view it not as a current existential threat but as a time-limited event that involves both injury and opportunity. As one veteran involved in an existentially based adjunctive PTSD therapy program at the Connecticut VA put it, through this program he became more resilient not despite his PTSD *but because of it* (Southwick, Gilmartin, McDonogh & Morrissey, 2006, p. 174).

The spiritual or religious dynamism inherent in space making is that space allows for self-regulation, habitability, hospitality, mutual exchange, expression, and affirmation and expansion of the self. In terms of a kenotic assessment and intervention with respect to the prospective aspect of symptoms and signs, they would be regarded as not only orienting one to process and integrate a traumatic event that occurred in the past but also as creating anticipatory space to a future clarifying or embracing of values. A kenotic approach to the signs and symptoms of trauma in retroactive terms could complement prolonged exposure and in prospective terms could complement moral injury interventions.

One theological article stated the following with regard to the implications of the concept of kenosis for trauma therapy: "In the kenotic movement toward the other, the survivor of trauma is moving from self-enclosure created through fear toward the other, in order to receive the care, trust, friendship, love of the other, the sources of empowerment" (Papanikolaou, 2003, p. 56). By "kenotic movement" the author is referring to a survivor of trauma having etched out the requisite space to engage in the mutual exchange that facilitates a reparative relational experience. The relational aspects of care, trust, friendship, love and empowerment identified by this author that are a "product" of a kenotic movement provides an entrée into considering how perichoresis as a religious and spiritual value is an outgrowth of kenosis and can complement social work assessments and interventions.

### **Perichoresis**

To reiterate, perichoresis is a term from Greek Stoic philosophy that was used from early on in the Christian tradition to describe the mutual indwelling and co-inherence of the persons of the Trinity and its use has become "increasingly fashionable" in contemporary Western theology (Crump, 2006, p. 396). As a religious and spiritual adjunct to social work assessments and interventions with service members and veterans, the

concept could be used to emphasize the importance of moving from self-enclosure and isolation (a characteristic symptom of PTSD) into relationships marked by, “care, trust, friendship, love of the other, the sources of empowerment” (Papanikolaou, 2003, p. 56).

As Papanikolaou (2003) makes clear, the purpose of kenosis in therapy is an act of space-making not with the intent that a trauma survivor can then be an island unto one’s self but so that a space of hospitality can be created for mutual affirming, giving, and receiving (Papanikolaou, 2003, p. 56). For the Christian service member or veteran who desires to integrate religion or spirituality into therapy, perichoresis could also be used to repair the systematic desensitization to violence and dehumanization that is often an inherent part of military indoctrination and that is an obstacle to forming relationships of trust and mutuality.

Perichoresis as a religious/and or spiritual adjunct can complement traditional therapies by addressing the invisible wounds of war and military service that go far deeper than the psycho-physiological symptoms that may merely be symptoms of a tortured soul. As we discussed above, when kenosis and perichoresis are incorporated as religious and/or spiritual adjuncts into traditional therapy, the overall effect is likely to be an intra-personal healing and spaciousness that is a prerequisite to being able to accept and receive the other in a mutually affirming and empowering way. Such space making and mutual relating cannot but help to empower a service member or veteran to access a fuller experience of being human. Experiencing fullness of human life in Christian terms also corresponds to an experience of what it means to be divine (since Christ melded the human and divine perfectly). This is what the Christian tradition refers to as theosis or, bearing more and more of a divine presence in and through assuming a fuller humanity.

### **Adaptations of the Model**

Up to this point we have largely focused on integrating Christian religious and/or spiritual concepts in social work assessments and interventions with veterans. However, the proposed model can also be used to integrate other faith perspectives. The flexibility of the model consists in the fact that sign and symbol are instrumental to every form of religion and spirituality. Therefore, level three of the model could conceivably incorporate religious or spiritual principles from a variety of religious and/or spiritual convictions.

The model could, for example, be adapted to Buddhist religious principles in the following manner:

Symptom → Self → Synthesis (level 1: psychotherapy)

Sign → Symbol → Synthesis (level 2: semiotics)

Noble Truths 1/2 → Noble Truth 3 → Noble Truth 4

(level 3: religion and spirituality)

Noble Truths One and Two are amenable to the spiritual function of sign due to the emphasis on accepting suffering as an integral part of human experience and that inappropriate desire and possessiveness accentuate this suffering (Canda & Furman, 2010, p. 145). In other words, accepting the above is akin to making space for the totality of life experiences. The third Noble Truth focuses on eliminating inappropriate desire, expunging “the illusion of a separate self,” and forfeiting egotistical attachment in exchange for embracing the interdependent nature of life (Canda & Furman, 2010, p. 145). This principle is akin to the spiritual function of symbol in the manner that symbol embodies mutual exchange and interdependence to forge a fuller complex of meaning and experience of being human. Finally, the fourth Noble Truth is essentially a synthesis of the previous Noble Truths by emphasizing the practice of the above through a “disciplined way of life” (Canda & Furman, 2010, p. 145).

This example demonstrates the flexibility of this integrative model and encourages social work practitioners to make critical connections between sign, symbol, and various other religious and spiritual systems in an effort to integrate religion and spirituality in parallel fashion as they work with service members and veterans.

It should be noted that, if social workers agreed in principle to the spiritual values espoused by kenosis, perichoresis, and theosis but wanted to translate them into more humanistic terms, each could be translated into terminology that may be more easily received and readily understood by clients espousing humanistic values. In essence, kenosis refers to “space making,” perichoresis might be referred to as “mutual relating,” and theosis could translate into “self transcending” (or something to this effect).

### **Case Example**

A more humanistic approach was recently used by one of the authors in a supportive therapy session with a veteran client. The veteran presented with a complex mental health profile that included a diagnosis of anxiety disorder, substance use disorder, and delusional disorder. Prior to meeting with the author, the veteran had succeeded in creating contentious relationships with most of his medical and mental health providers. At issue between the veteran and his providers was his desire for an alternative, holistic approach to his care.

In the initial part of the session, the veteran was quite reserved and the author was very deliberate in creating space for acknowledging the veteran's concerns and to affirm his convictions. After the author made space for the veteran to feel a sense of trust, the veteran disclosed the following signs and symbols regarding his current behavioral health "state of affairs." The "signs" manifested by the veteran had to do with anxiety and delusional symptoms (e.g., distortions in the veteran's experience of being persecuted by his providers) that were creating barriers in his relationship with his providers. The "symbols" that the veteran expressed had to do with a deistic faith orientation and his convictions regarding the healing powers of nature. The author made therapeutic use of the signs and symbols that the veteran disclosed regarding his mental health symptoms and personal convictions to lead the veteran into a consideration of the implications of his belief system for his relationships with his providers.

A question was posed to the veteran along the lines of "if health and wholeness is constituted by interconnectedness (a faith conviction professed by the veteran), then how might you partner with your providers to get what you need from the system?" In formulating the question in this manner, the author intended to mitigate the delusional symptom (sign) of the veteran feeling persecuted by appealing to the symbols associated with the veteran's faith convictions (nature, interconnectedness of nature, healing powers of nature). Furthermore, the question was formulated inductively by reading and receiving the signs and symbols that the veteran presented to the author which allowed for a transition to the third level of the above parallel process model (religion and spirituality). Using the metaphor of partnership and dance, the author led the veteran to consider an alternative way to approach his providers along the lines of perichoresis or "mutual relating." This movement from space making (kenosis) at the beginning of the session to mutual relating (perichoresis) toward the end of the session gave the veteran pause and led him to a place of vulnerability in order to explore the loneliness he was feeling as a result of alienating himself from those who were trying to provide care for him.

Finally, the author suggested spiritual practices in keeping with a deistic orientation (i.e., the idea that the divine creates and "steps back" to let creation unfold according to its own intrinsic laws) to help the veteran experience the interconnectedness and beauty of existence (and thus alleviate his feelings of being persecuted, angst, mistrust, and loneliness). Should the veteran follow through with these practices, this could lead to a degree of healing and an experience of wholeness (theosis). This vignette offers a brief example of how the proposed model can be applied in general to a veteran client and more specifically to a client embracing religiously "neutral" values.

### **Conclusion: A Parallel Process Model for Integrating Religion and Spirituality**

This article addressed the question of how sign and symbol could be used to facilitate the integration of religion and spirituality in social work with service members and veterans. Sign and symbol were specifically chosen as a means for integration due to being familiar to military culture, religion and spirituality (with special reference to Christianity), and the behavioral sciences. We have attempted to be careful in proposing a model in keeping with social work practices (i.e., considering the whole person and person-in-environment) and that would promote integration and not conflation. Hence, the proposed model was designed as a parallel process model to demonstrate how sign and symbol can be used to meet a client where he or she is in terms of religion and spirituality and mediate between the realms of social work and religion and spirituality without admixture.

If one were to omit the mediating role of sign and symbol and simply make more direct connections between the secular and religious levels, one would risk a conflation of the two and potential subjugation of one to the other. Additionally, the proposed parallel model would also facilitate a process of integration due to progressively moving in the direction of integrating religion and spirituality if this were desired on the part of the client. This is important because service members and veterans may have difficulty disclosing matters of a religious and/or spiritual nature due to military culture or the effects of trauma (Harris, Park, Currier, Usset, & Voeks, 2015).

With respect to a progressive movement and transition from sign and symbol to religion and spirituality, the Greek terms *kenosis*, *perichoresis*, and *theosis* were selected from the Christian tradition due to their correspondence with the spiritual function of sign and symbol. A spiritual approach to sign corresponds to *kenosis* through the capacity of sign to create both reflective space and anticipatory space. The connection between symbol and *perichoresis* consists of both referring to a semiotic and relational process of mutual interpenetration and mutual enhancement. The synthesis achieved by the movements of *kenosis* and *perichoresis* is an experience of a fuller human life, which, according to the Christian tradition, also implies bearing more of the divine likeness (*theosis*). Finally, to demonstrate the flexibility of the proposed parallel process model and the social work ethic of accommodating a diverse range of religious and spiritual sensibilities, the model was adapted to incorporate Buddhist religious convictions and could accommodate many other religious and spiritual sentiments due to the universal role that semiotics plays in communicating religion and spirituality. ❖

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# Trauma, Spirituality, and Mindfulness: Finding Hope

Kimberly A. Kick & Myrna McNitt

*The prevalence of Post-Traumatic Stress Disorder (PTSD) and the role faith and spirituality play in mitigating some of the more devastating effects of PTSD are explored. Terror Management Theory is used as a theoretical framework to understand the military service experience of those individuals who have been deployed to the theater of war. Service members do not serve in a vacuum; when they return home their wartime experiences impact the family and community. Hence, an understanding of the effects of PTSD on service members and their loved ones is essential. Spirituality, the way in which people connect with their belief and faith, the belief that there is something “bigger than us,” will be explored as a protective factor for service members and their families. The article also explores how combat can cause individuals to question their faith and spirituality and the effect this questioning can have on overall mental health.*

*Every gun that is made, every warship launched, every rocket fired signifies in the final sense, a theft from those who hunger and are not fed, those who are cold and are not clothed. This world in arms is not spending money alone. It is spending the sweat of its laborers, the genius of its scientists, the hopes of its children. This is not a way of life at all in any true sense. Under the clouds of war, it is humanity hanging on a cross of iron. (President Dwight D. Eisenhower)*

**A**FTER SEPTEMBER 11, 2001, THE UNITED STATES BECAME EMBROILED in conflicts in Afghanistan and Iraq. More than 1.9 million men and women deployed in support of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Over 1 million of these individuals are now classified as veterans, no longer serving actively in the armed forces (Worthen, Moos, & Ahern, 2012):

There are numerous stressors associated with deployment including: separation from family and friends, boredom, communication issues with loved ones at home, threat to life and limb, harsh living conditions, and the uncertainty of day-to-day life (Wood, Britt, Wright, Thomas, & Bliese, 2012). OEF and OIF service members face the day-to-day realities associated with the risk of serving in high conflict theatres. Both visible (physical issues related to severe injury such as loss of limb) and invisible (mental health-related issues) wounds are side effects of deployment. Some of the more common invisible wounds experienced by service members include depression, traumatic brain injury (TBI), and post-traumatic stress disorder (PTSD).

Symptoms related to these mental health issues can result in risk taking behaviors, substance misuse and abuse, interpersonal problems, and financial concerns (Walter, Barnes, & Chard, 2012). Families are faced with the harsh reality of having a loved one return with the consequent issues related to ongoing mental health challenges. In 2007, the Department of Defense (DoD) task force reported that 38% of soldiers reported returning from deployment with issues related to mental health (Bell, Hunt, Harford, & Kay, 2011).

An array of support and services are needed for veterans and their families to respond to the physical, behavioral, and mental health needs of the military. Spirituality and faith, as well as formal organized religion, may be seen as support and part of the service system used by veterans and their families. Many veterans and their families may turn to their faith community for support from fellow congregates, or look to their pastor, priest, rabbi, or Iman for guidance when trying to make spiritual sense of the experience of war.

Good practice notes the importance of the mental health professional assessing the client's spiritual view and belief system as part of a holistic assessment of the individual. "Spiritual assessments are now mandated in numerous settings, including hospitals, home care organizations, long-term care facilities, and behavioral health care organizations providing addiction services. This requirement is consistent with the views of most social work practitioners" (Hodge & Limb, 2010, p.297). To respond in a culturally competent manner, a framework for understanding how individuals attempt to integrate these experiences is necessary.

### **Post-traumatic Stress Disorder**

Over 50% of soldiers and Marines deployed during OIF reported being shot at, witnessing death or serious injury to another person, or having killed an enemy, according to the Government Accountability Office study (GAO, 2004). This same study determined that multiple deployments are associated with higher rates of mental health problems. The three signature wounds of OEF/OIF are TBI, Major Depressive Disorder (MDD), and PTSD (Tanielian, Jaycox, Schell, Marshall, Burnam, & Ebner, 2008).

PTSD has been defined as, "...a bundling of psychological, medical, and social symptoms stemming from the trauma and crisis of witnessing atrocities, fearing death, and experiencing multiple periods of loss of control over one's well-being" (Dupont-Morales, 2010, p. 33). Many individuals are now advocating for the renaming of PTSD since they do not believe it should be viewed as a disorder, but an injury. Adherents of this movement believe that in our culture, having an injury is more acceptable, hence the stigma associated with seeking help for a PTSD will be removed (Shay, 2009). Most individuals would agree that PTSD is a normal (most of the population would respond in a similar fashion) response to very abnormal (not a situation or event that occurs in everyday life) situations for the service member. Given the sheer amount of stress and violence witnessed in the theatre of war, responding in a way that is consistent with symptoms listed in the DSM 5 is not surprising.

Given that symptoms associated with PTSD are common among those who have suffered trauma, but not experienced by all who experience traumatic situations, the question arises as to what makes one individual more susceptible to developing symptoms associated with PTSD than another? Some of the factors that have been found to correlate to the development of PTSD are past psychological trauma experienced as a child, TBI, including the number and severity of concussions, and the "inner speech" one has regarding her ability to make it through the situation (Dupont-Morales, 2010).

Factors that have been found to serve as a buffer against developing PTSD are: the use of humor, developing an acceptance of one's situation, avoiding self-criticism, and being able to see the positives in a situation. For some service members, prayer and meditation are resources to abate the negative impact of PTSD during and after deployment. In fact, Sergeant Kendel of the 48th Infantry Brigade of the Georgia National Guard wrote a book about his experiences in Iraq during his deployment in 2005, and how meditation and the Shambhala community helped him mediate stressors associated with deployment in a war zone (Kendel, 2011). Additionally, service members who have shorter deployments and do not have multiple deployments are at decreased risk for developing PTSD. Service members who are able to find meaning in stressful situations are able to handle the stress associated with deployment in a combat area more readily (Dupont-Morales, 2010).

Research by Wood, Britt, Wright, Thomas, & Bliese, (2012) defined benefit finding as the ability to find the positive in stressful situations. Their research indicated that service members who engaged in benefit finding had a lower chance of developing PTSD early in the deployment cycle. Benefit finding did not seem to have an effect in the latter stages of the deployment cycle. The researchers speculate this may be due to a threshold point at which point the benefits begin to decrease. Thus, for mental health practitioners or clergy, it is important to explore how the individual has managed stress in the past, whether they were able to maintain a more positive attitude, and at what point they felt overwhelmed by the stimuli they were being exposed to.

### **Case Example**

Mary returned from her deployment to Iraq in 2006. This was her first deployment to a combat zone. Mary reported having a “normal” childhood. She was raised in a small town in the rural Midwest, her parents both worked as teachers, and she resided near extended family members. Mary reported being raised Episcopalian and attending church every Sunday during her youth. Mary joined the Army to get the GI bill so she could attend college.

When Mary returned from her deployment she found it hard to “get back into the swing of things.” Mary reported waking up frequently during the night and feeling disoriented. She also said she had a hard time relating to family and friends, especially when they were complaining about what she considered to be trivial matters-like a long line at the grocery store. Mary found herself making excuses when friends asked her out, isolating more at her parents’ home, and getting into arguments she said never would have happened in the past.

Part of therapy with Mary involved completing a thorough psychosocial history. This included questions about her childhood, past trauma or abuse (physical, sexual, or emotional), identification with religion, faith, and spirituality, ways she relieved stress prior to and post-deployment, and relationship history. Questions were also included asking if she had been the recipient of unwanted attention during her time in theatre. These questions were aimed at determining if Mary had experienced Military Sexual Trauma. The clinician also directly asked Mary how her feeling changed (if at all) during the deployment cycle. It was determined that Mary was experiencing symptoms consistent with a diagnosis of PTSD according to the DSM 5. Prognosis was good as Mary had no past history of trauma, maintained her connection to her faith, considered herself to have a strong spiritual connection, and was able to identify positive experiences that “made me a better person” in spite of the horrors she witnessed during her deployment. Through all of her difficulties, Mary considered herself a stronger, more independent person post-deployment.

### **Terror Management Theory**

Numerous researchers have studied terror management theory and its application to work with trauma disorders. Terror Management Theory makes use of an individual’s cultural worldview, the development of self-esteem, and the fear and anxiety found in facing death (Greenberg, Pyszczynski, & Solomon, 1986; Solomon, Greenberg, & Pyszczynski, 2004; Tomer & Eliason, 2007 as cited in Rodgers, 2011). Terror Management Theory assumes that individuals threatened with death will develop a set of responses to manage anxiety and exhibit efforts to preserve life. This can include the individual’s belief in an afterlife and feeling connected to

an enduring mission. In general, core aspects of terror management center on preserving the individual's sense of self-esteem by giving meaning to their actions and values (Gailliot, Schmeichel, & Baumeister, 2006; Simon, Arndt, Greenberg, Pyszczynski, & Solomon, 1998).

Individuals who join the military are indoctrinated into a role and given a new identity. Every branch has its own creed and each service member will integrate that creed as part of his/her identity. This new identity serves to increase sense of self and give meaning and purpose to one's life through service to country. Every service member understands the consequent risks associated with their respective role in the military and understands, at least cognitively, that death is one such risk. When service members experience the death of a colleague, witness the atrocities of war, or are faced with taking fatal action directed toward the enemy, trauma may result. Faced with a different culture, being in an unknown, hostile environment, and facing the maiming and death of comrades forces service members to search for meaning. This may be accomplished through solidarity with battle buddies and a belief that what they are doing is making a difference.

The fear of death and anxiety about the future may be abated when cultural beliefs promote a shared worldview by the group. The culture of the military creates this shared worldview: a single vision with an identified mission and specific role each individual plays in supporting that mission. A person's self-esteem is affected by how well they are living up to the standards set by the cultural worldview of their group. Service members are trained to put mission first. This is accomplished at one's induction into the service and initial training in boot camp. One's civilian identity is stripped and replaced with the identity of military tough, specific to the branch the person serves in. The service member may be filled with fear about their own mortality, but they face the future by striving to live up to the cultural standards of their training: the belief that one perseveres no matter how stressful the situation. Duty to country and one's battle buddies surmounts all else. The underside of "service before self" is the shame and guilt a service member experiences when they are unable to manage fear and anxiety once they return to the civilian world. Admitting one is having a difficult time adjusting post-deployment is viewed as being weak, and service members do not receive training in being able to ask for help or admit weakness.

Terror Management Theory assists the person in conceptualizing the world as a "just place" and helps create a space for the person's spiritual views and belief system. The person's identification with formal religion can help defend their held cultural beliefs and serve as a buffer against possible threats to self (Harmon, 1997). Belief that their mission is purposeful and integrates well with held personal beliefs helps military personnel carry out their duties and serves as a protective factor. Greenberg (1992) and others see Terror Management Theory as a means to understand the military

experience. Spirituality, one's belief system in the larger cultural identity of the group, and religion becomes a protective cloak for the service member justifying duty as a function of nationalism and religion.

Service members are focused on the mission; however, some may struggle with a belief in the morality of their actions in carrying out the mission. As explained by Terror Management Theory, the service member is coping with living up to standards and the culture ingrained from childhood and duties of military life. At times the disparity between long held religious beliefs and the actions one must take in service to country can cause internal stress and shake the sense of identity long held by the individual. The stated military culture of toughing it out may be counter-intuitive and contraindicated in helping the service member recover from trauma. An understanding of Terror Management Theory can help mental health practitioners and clergy help service members understand the disconnect between their fears, anxiety, and the trauma experience vis-a-vis their military identity and sense of self-esteem.

### **Case Example**

Joe joined the military at 18. He was looking to get out of his hometown, which held little hope for the future in terms of finding a job that could support him. Joe decided that he had what it took to become a Marine and enlisted upon graduating high school. Joe grew up in a poor home where hard work was held as the standard of a person. Joe's family had plenty of Baptist ministers amongst them and Joe grew up in a fairly strict Baptist home. The basic tenets of the 10 Commandments were strictly ingrained in Joe from a young age. Hard work, belief and service to God, and treating others as you would want to be treated made up his value and belief system. Joe believed that prayer and a strong faith in God would take you through the hard times.

When Joe joined the Marines he had a hard time at Boot Camp. He was around people who were different from him and didn't share his belief system. He was quickly taught that he wasn't there to think or share his opinions. Joe was a hard worker and made it through Boot Camp. He felt more "grown up" once he completed Boot Camp and noticed that he thought about things a bit differently.

Joe was a Marine four years prior to gearing up for his first deployment to Afghanistan. Joe was excited to finally put all of his hard work into action. Once in Afghanistan, Joe was in shock. He had never known such cruelty and senseless destruction. He was required to go out on missions in villages and make sure the areas were clear. Joe didn't see the purpose in many of his duties and was dismayed with how some of the guys who were on their second or third tours seemed to tune it out and treat the locals with disrespect. When Joe first said something about this, he was immediately

shut down. The veterans let him know he didn't "know how it was" and hadn't lost any buddies yet or seen what happened to them over there.

While in Afghanistan, Joe had what he termed a "spiritual crisis." The senselessness of the death and destruction around him made him question his long held beliefs in a God and hard work conquering all. Joe eventually ended up at his local VA to talk to a mental health professional. He attended weekly individual sessions and group therapy with other vets who had deployed. Fortunately for Joe, his therapist was familiar with Terror Management Theory and helped Joe integrate the world he saw during his deployment with his long held belief system.

### **Spirituality and Therapeutic Interventions**

According to Hodge (2001) "*spirituality* can be understood as individual's existential relationship with God (or perceived transcendence), and *religion* can be seen as flowing from spirituality, the actual expression of the spiritual relationship in particular beliefs, forms, and practices that have been developed in community with other individuals who share similar experiences of transcendence" (p. 315). Eliciting a service member's view of spirituality and religion helps create a narrative of the trauma story.

A popular saying notes "there are no atheists in foxholes." The phrase is credited to Father William Cummings, who, in a sermon stated that life and death experiences promote reality checks (Reyes, 2013). War can push the service member either toward faith or to abandon it. Trauma places individuals beyond their normal systems of meaning, strains current methods of coping, and disrupts psychosocial functioning. Many individuals who experience trauma struggle with their spirituality and their faith communities. Combat veterans may have a hard time integrating the violence, suffering, and death witnessed during deployment (Sherman, Harris, & Erbes, 2015). In cross-sectional studies, symptoms of PTSD are exacerbated for individuals who have a hard time forgiving self, experience guilt and fear related to their religious beliefs, and do not feel connected to their Higher Power. This finding held when controlling for factors such as the severity of the trauma and social support systems (Berg, 2011).

Combat related experiences can contribute to veterans questioning long held religious beliefs. Many veterans may experience what has been termed "moral injury." This is when the veteran questions his religious beliefs (Currier, Holland, Drescher, & Foy, 2015). Veterans who experience moral injury are more likely to have issues related to social functioning, experience an inability to trust others, feel a loss of sense of spirituality, and have been found to be at a higher risk for depression and PTSD (Nash, et al., 2013). Struggles faced by individuals relating to a sense of spirituality can lead to feelings of disappointment and anger with their Higher Power or faith-based community. Individuals struggling with their spirituality

report higher levels of depression, anger, suicidal ideation, and anxiety (Exline, 2002).

Other studies note the use of religion when experiencing extreme stress (Wozniak, 2015). Research has indicated that for survivors of trauma, those who maintain their faith have better mental health outcomes than those who lose faith (Ben-Ezra et al., 2010). Ironically, individuals who have been diagnosed with PTSD are less likely to attend faith-based services (Berg, 2011). However, mental health treatment is sought more frequently by individuals who identify as having lost their faith (Fontana & Rosenheck, 2004). For faith-based practitioners, understanding the view of the service members regarding their spirituality and religion offers opportunity to help the service member and their family integrate the military experience.

Pargament, Mahoney, Exline, Jones, & Shafranske (2013) have found that spirituality is connected to having a sense of purpose, feeling satisfied, happy, and being more resilient. Park (2005) contends that spiritual beliefs can assist clients in finding meaning while assigning well-disposed characteristics to the traumatic event. Post-traumatic growth is experienced by some individuals after experiencing a trauma. These individuals are able to identify positive ways in which they grew after the trauma. Some of the factors related to post-traumatic growth include: feeling comforted by one's faith, feeling a sense of satisfaction with one's relationship with her Higher Power and faith-based community, and finding a sense of purpose through faith (Ogden, et al., 2011).

There is a need to incorporate spirituality into treatment interventions. This has happened with mindfulness-based therapies that focus on one's awareness of an experience and the consequent effects of the experience. Mindfulness-based therapies, including Dialectical Behavioral Therapy (DBT) and Acceptance and Commitment Therapy (ACT), have proven effective in treating mental health issues, including PTSD. In recent years, Mindfulness-Based Cognitive Therapy (MBCT) has been used in group settings aimed at stress reduction. Preliminary indications are that MBCT reduces the severity of symptoms and the amount of emotional distress experienced in veterans. In MBCT, individuals, "...strive to entrain sustained mindful attention to and acknowledgment of even unpleasant emotions or memories in a nonjudgmental manner" (King, et al., 2013, p. 639). In groups run at various VA facilities, MBCT has also been used in preparation for veterans about to participate in Prolonged Exposure Therapy (PE). Many veterans, even though PE is effective in reducing PTSD symptoms, are reluctant to participate. This may be due to the process of having to relate traumatic experiences (King et al., 2013).

A thorough assessment should include as assessment of the individual's spiritual beliefs, religious affiliations, and relationship to their Higher Power. The need to include mindfulness and awareness into practice can benefit individuals who are feeling disconnected. Social workers need to ensure

they are not coercing their own spiritual beliefs or religious affiliations onto their clients. Respect for differing spiritual beliefs and practices, religious orientations and values, or the lack thereof by the client must be respected.

### **Hope for the Future**

Serving in the military is a high-risk career where exposure to trauma can be expected. Chambers (2009) brings focus to the complexity of working with high risk individuals and the need for appropriate resources to help the service member and family normalize their experiences. It is also important to help the practitioner learn to manage their anxiety and tensions associated with the secondary trauma when working with the difficult experiences of veterans and service members. It is important to recognize the key place of resiliency in helping the veteran reintegrate to family and community life.

Service members use lessons learned in the military that include an ability to use resiliency skills as a response to trauma. Luthar (2006) states that:

Resilience is defined as a phenomenon or process reflecting relatively positive adaptation despite experiences of significant adversity or trauma. Resilience is a superordinate construct subsuming two distinct dimensions—significant adversity and positive adaptation—and thus is never directly measured, but is indirectly inferred based on evidence of the two subsumed constructs. (p. 742)

The military and their families are taught to be ready to serve, to follow orders, and to respond to command. Stress and trauma take its toll on service members and their families. It is important to recognize stress and trauma, but also the important role of resilience. There is a clear role for spirituality and faith in recovery from trauma and helping build resiliency. The Real Warrior website (<http://www.realwarriors.net>) notes the important role of spirituality in helping the military to cope. Spirituality can be expressed through prayer, meditation or mindfulness, a sense there is a higher being, and a way to overcome moral injury (Real Warrior (n.d.)). Spirituality in all its forms of expression gives the service members and their families the foundational support to realize their strengths and resiliency. It is transformational.

Richard Rohr, a contemplative priest, describes spiritual transformation as a process flowing from great love and great suffering. The experience of great suffering is embodied in all that a service member experienced in war. Much that happens in war is against the will of the service member. The fear and anxiety discussed a part of Terror Management Theory is expressed in what Rohr describes as an unjust world. By going to the core of the suffering, spirituality and faith can transform the military experience to

enriched compassion helping the service member to develop context and leave the bitterness behind (Rohr, 2009). What Rohr suggests is a process for the service member to develop new ways of coping with their suffering (PTSD) and take the small steps likened to the 12 Steps of Recovery from Addiction, by recognizing the role of a Higher Power. An informed faith community that understands the dimensions of suffering of the veteran can become a partner in the transformation. The faith community can help the service member find ways to explore positive expressions of love and concern toward their family, community, and fellow veterans. This transforms the service member from a passive victim to a resilient community member.

Recovery from the trauma associated with military service needs a multidimensional response—one type of therapy and one intervention is not the answer. Increasingly there is evidence regarding the importance of nurturing supportive peer relationships—the spirit de corps of military life as well as the benefits of mindfulness in helping the service person manage the trauma of service. Understanding the role of culture as defined by Terror Management Theory is helpful when working with the military. Helping professionals from all disciplines assist the military member to face their past by focusing on strengths, encouraging the service member to be proud of their role of serving the nation, and acknowledging there may be a crisis of faith. The journey facing the trauma of service may be long for members of the military; but when trained professionals come together there is hope that multiple pathways of support will help the service member's recovery, build on their resilience, and find and renew the strengths that drew them to military service. ❖

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# Warrior Faith: A Marine's Lesson in Religion, Health, and Healing

*Kate Hendricks Thomas*

*As mental health issues in the military-connected community continue to command attention within the social work and public health communities, the question of faith's role in reintegration and readiness is highly relevant. The practical issue is whether resilient traits can be cultivated through spiritual fitness practices. This review discusses the biopsychosocial benefits of religiosity for military personnel in transition by employing both personal narrative and research. The mental health protective effects offered by spirituality and religiosity are very powerful; both statistically and practically they are even more powerful than many of the behavioral health practices in which the military currently invests. People who identify as possessing high levels of subjective religiosity enjoy a number of benefits at the psychological and neurological levels. These health benefits are amplified and extended when faith is practiced in ritualized fashion within social community groups. Researchers have found strong correlations between the practice of prayer and physiological changes, including lowered blood cortisol levels and increased cognitive capabilities. Because the brain influences bodily functions like heart rate, blood pressure, and the immune system, shifting that neurological activity through spiritual practice can have significant physical impacts. This review underscores the importance of honestly discussing faith in any conversation about military mental fitness and resilience.*

\* \* \*

*Be still and know that I am God. (Psalm 46:10)*

**I**DON'T REGRET MY TIME IN IRAQ. I VOLUNTEERED TO GO, I LOVED THE people with whom I served, and I was fortunate beyond measure to come home safely. Most days during my deployment, I was young and convinced of my own invincibility. I was always armed, rarely alone, and at 25

that was good enough for me. Whether we were inside or outside the wire, I felt pretty confident that I had control over whether I was alive or dead.

*That all changed on a Friday night.*

Friday night didn't mean anything different on deployment than other nights of the week, but it was a psychological thing – it still felt like Friday to us. I had a small crew of fellow company grade officers that I could always count on to be excited about the non-event, too. We would occasionally buy a non-alcoholic beer and pretend it was a completely normal week's end. We'd tell a few dumb stories, laugh a bit, and then go back to work.

It was a way to connect with one another and a way to relax like we might at home. That night, we were doing exactly that, sitting on the roof of a concrete building inside the base. The air was balmy, but a breeze was blowing if you climbed high enough. We were probably talking about our significant others back home, and we were feeling pretty darn pleased with ourselves.

One moment we were laughing at the sensitive guy we loved tormenting with our teasing, and the next instant the quiet was shattered. There was a whine overhead, a whistle that sounded different than the incoming mortar rounds with which I had grown surprisingly comfortable. It was sharper somehow, and I flinched noticeably as a fireball zipped past my field of vision.

The rocket crashed below us into a section of cans that we used as sleeping quarters, sparking like a firework and making a shrill screeching sound as metal tore into aluminum.

We ducked and zipped down the building's wall to take cover, wondering who was in the can that just got hit – hoping it was no one we knew too well.

*Glad I was on this roof instead of in there...*

It was one random rocket – far from spectacular. It made an impressive show of tearing apart the sleeping quarters that it hit, but it hadn't hurt any of us. Turned out, the can housed an acquaintance, another young Lieutenant who would be grateful the rest of his life that he'd been on a mission that night.

It really wasn't that big of a deal, which is why I couldn't explain why it sent me into such a funk.

I walked around the next few days feeling down, unable to put my finger on what was bothering me. It wasn't fear, really. It felt colder than that.

*I knew to brace myself when we left the Forward Operating Base, but I thought we were pretty safe inside the wire.*

*That could have gotten any of us.*

*If it did, what if I had been walking along with no clue? In the shower? Out jogging?*

*Would that even count as a combat death?*

*If it happens, is it going to happen in some pointless way?*

I finally realized that I'd lost my pretty illusion of control. If I died in Iraq it might be in a completely random way. An incoming rocket might simply choose my building. An IED might just glance my vehicle. There likely wouldn't be the chance for a firefight, to make a difference against a

known threat, or to protect the people I cared about. If it came, death would be out of my control, random, and wouldn't fit into some heroic fantasy. It depressed the hell out of me.

*If I'm not in control, who is?*

### **The Role of Religiosity in Resilient Trait Cultivation**

I often hear that it is hard to find atheists in foxholes, and I believe it. When confronted with a crisis, it is normal to think about our notions of the larger world and our connection to something larger (Hendricks Thomas, 2016). Facing our own mortality at least caused most of us to pause and consider the question.

To spend a bit of time talking about the role of faith in cultivating resilience, though, requires really understanding what I am speaking of. This article isn't about dogma; I am talking very specifically about faith as it is practiced, not merely conceptualized. There are so many ambiguous terms out there that people use to discuss the intensely personal topic, and I want to be explicit that I am speaking of *organized religiosity* when I talk about it.

Researchers talk about religious practices as being organized or not, with motivations for practice coming from internal or external sources (Koenig, McCullough, & Larson, 2001). Organizational religiosity simply means that in addition to holding a personal belief system, a person also attends religious services, meets with small groups, or is involved in other community-related activities such as outreach or volunteer efforts (Levin, 2002). Non-organized religious practices are individual and are often conflated with the term spirituality. Spiritual practices are often derived from the self-disciplining techniques of religious adherents, though today we often hear them spoken about in a secular sense. Meditation, chanting, and breath work practiced by Christian mystics are discussed in broader, more inclusive contexts today, particularly in spiritual traditions that are focused on internal exploration and self-fulfillment. Sometimes they are talked about in even more secular senses with a focus on performance enhancement (Koenig, 2008).

We often hear, "I'm spiritual but not religious."

There is tremendous personal utility and some health benefit to personal, non-organized spiritual practices (Koenig, McCullough, & Larson, 2001). However, the majority of religion and health science shows maximum benefit for people involved in organized religious communities, which is why in any discussion about how to build resilience, semantics matter (Dein, Cook, Powell, & Egger, 2010).

For me personally, faith means really spending time on the disciplines that bring me closer to God, not for purposes of getting healthier, but for meaning and joy and hope. This means being part of a life-giving church

community and spending time in prayer, reading scripture, and talking through it all with people who are similarly engaged and searching.

As mentioned already, it is interesting that when we look at the research, religious affiliation is the sort of variable that yields both practical and statistical significance, meaning it matters in people's lives as well as in statistical models (Larimore, Parker & Crowther, 2002). Scientists have found two religion variables that yield the most significance, even when other related or modifying variables are present. If someone is involved in organized religious practices (church attendance, small groups, volunteering) and holds those beliefs dearly (subjective religiosity), they are less likely to suffer from a host of health issues (Koenig, 2008).

The bottom line is this – we are wired to connect with God and with each other. Studies overwhelmingly affirm this (Koltko-Rivera, 2006). Much like exercise, religion offers true protective effects against heart disease, depression, and even cognitive decline (Dein, Cook, Powell, & Eagger, 2010). Religiosity is correlated positively with improved mental and physical well-being, and is important for people coping with trauma. Increased involvement in a faith community strengthens the positive impact it can have (Moll, 2014).

Faith impacts human health psychologically, socially, and physically, because most religious traditions encourage healthier choices and philanthropic acts (Koenig, McCullough, & Larson, 2001; Levin, 2002). People who identify as religious have lower rates of mental health problems, particularly depression or depressive symptoms (Newberg & d'Aquili, 2008).

### **Behavioral Benefits of Religious Involvement – Healthy Living and Social Support**

Behaviorally, belonging to a religious community promotes healthier lifestyles and offers social support (Haas, 2012; Moll, 2014). In a secular social contract, support is both given and offered. People of faith believe that it becomes their duty to offer social support when people are in times of great need, even as illness or personal problems prevent them from giving much back (Hodges, 2012). This may explain why studies show that social support from religious communities yields greater health benefits than other types.

After the birth of my first baby, the women in my small group from the Church of the Highlands showed up each night with meals. I was new at the motherhood game, fumbling, and desperately trying to keep my wailing son happy by never putting him down. We all might have starved to death had it not been for those women. Shortly after that, we moved away for a new job and left the church community. Everything they did for us was done with no expectation of reciprocity, as they all knew about our pending relocation. These are acts of kindness I will never forget.

I grew up around religion in a bit of a stiff form. I well remember picture books with Bible stories enchanting us kids, but church wasn't a place I saw people light up and come together. It felt like a ritual that we had to do, not something that we enjoyed and felt part of. As kids, we kept it fun for ourselves in totally inappropriate ways. I definitely remember secretively torturing my siblings in the pew next to me when we said prayers that involved holding hands. We would try to prompt one another to make a noise (and get in trouble) by squeezing too hard. I would roll my eyes at my younger sisters wiggling with impatience during long church services, even as I wiggled impatiently next to them.

I grew up to be a bit of a lapsed Christian, but that was because I was really just a lazy believer. I made time for all sorts of things but very rarely the study or practice of faith. As it does when we take our eyes off Him and focus on other things, my closeness to God dwindled to minimal levels during this time; I worked many a Sunday rather than go to church.

When I became a Marine Corps Officer, my faith life took even more of a backseat to everything else I was doing. I believed that I had time for my Marines and our mission, for training my body in intense and sometimes damaging ways, but nothing else.

After that rocket shocked me into thinking about it again, I realized how long it had been since I had even said a prayer.

*I think I have forgotten how to talk to God.*

My first instinct was to get right on that, attack the problem and make a plan to figure it out. Maybe I could write the plan in a journal and color-code it somehow? Probably need to snag a few more highlighters...

*Maybe a few prayers will keep us safe in the middle of this craziness.*

I tried in my clumsy way, but planning to pray and trying to figure out how to do it seemed somehow unsatisfying.

*I really don't think this is how it is supposed to go.*

Something felt off about simply asking God to get involved in keeping me in one piece, especially after not having spoken in years. My focus was still just on everything in front of me.

The purpose of prayer is not to inform God what needs to be done on earth; the purpose of prayer is to align ourselves with his realities in heaven. Prayer is not about him coming down – he's already here with us through his Spirit. Prayer is about us being lifted up; it's choosing to look up and beyond, choosing to yield to his ways and not begging like a spoiled child for our own desires to be fulfilled...be assured, when something is happening to you, God wants to do something in you (Hodges, 2012, p. 89).

Despite my own shortcomings trying to return to faith, I stayed lucky and started to regain my attitude of youthful invincibility – it was a job requirement, really. My experiences in Iraq on convoys and with incoming indirect fire were characterized by excellent timing and good fortune; I came home totally unscathed by either contact or injury. The most I ever saw on the road was a controlled IED detonation. That is a pretty rare thing to be able to say and for many people I loved, this wasn't the case.

My younger brother and I have always been close. He was a Marine Corps Infantry Officer, and when I was near the end of my stint overseas, his was just beginning. Stars aligned when his unit flew in and I had just convoyed down to the Forward Operating Base where they were to arrive. We overnighted there, and I made sure to check the incoming flight list.

I was able to get to the hanger around the time his unit was landing and be there waiting for him. I probably had some big-sister notion about welcoming him and telling him everything he might need to know to stay safe. I still remember watching him getting off the C-130 with all his gear. He looked ten years old to me, buried in a rucksack with big, blue eyes peering out from under his Kevlar helmet. I wondered for a moment how his unit had let a kid on the flight.

My heart sunk when I saw him, and for the first time since arriving in Iraq I allowed myself to feel reality. I knew where his guys were headed and it terrified me. Ramadi was a bad place in 2005; we all knew that.

A month later, I was landing safely in North Carolina as an Improvised Explosive Device was changing the world of several Marines and a young Navy corpsman forever. My brother was in that vehicle. I was a few miles away, useless and in the dark.

Thank God, he lived through the experience, though it crushed him that not everyone did. Ignorant and unaware, I was packing gear while my little brother beat me home on a medevac plane.

*I guess God wants to do something in me, because a hell of a lot is happening to me and mine...*

Pretty words have never been what most compel me, and I got to see my family's faith in action during the time we came together during his recovery. We were there for him and for each other in the ways that really mattered while my brother fought off infections and tried to piece his body back together.

*God is everywhere in this hospital.*

I watched my father hold an unknown young Marine's hand through narcotic-induced nightmares.

I watched my brother's fiancé work all day and spend every night in a chair by his hospital bed.

I saw the corpsman who had saved my brother's life focus on the people coming to see him rather than his own missing limbs. I won't forget the

youth of his young wife next to him, or watching him comfort his mother from his own recovery bed.

I watched the courage with which they all fought for mobility, independence, and a restored sense of self.

I watched as the sweetest nurse, the young one who always answered questions while looking in your eye, teased my brother and made everyone on the ward smile. There was steel in her spine; I could see it.

There was so much to believe in when I looked at these people, and some were only nineteen.

*When He has tested me, I shall come forth as gold. (Job 23:10)*

It was in a hospital room one night that I felt God talk to me again the way I remembered from younger years. I was tired, but trying to stay awake to occasionally press my brother's morphine drip so that he could stay asleep. I hadn't asked anyone if that was a good idea, but I thought I was helping since he hadn't gotten a lot of rest lately.

*I hate seeing him in pain.*

I was raging inside in a way I could barely understand. I felt guilty that I was walking around without the tiniest scratch and that I'd been cracking jokes and packing bags to leave when he could have used me by his side at Baghdad Surgical. It felt wrong that so many people were suffering like this, that I didn't know how else to help besides sit there. I felt angry and vengeful and hostile towards someone, everyone – anyone really. I wanted to trade places with my little brother.

*At least I can help him sleep through some of this pain if I keep clicking this little button.*

He woke up with a sharp inhale and looked at me in alarm. He was gasping for breath with a funny sucking sound and terror shot through me.

*Kate – something's wrong! My heart is racing!*

I ran and got the night nurse, who flew in behind me and pressed some buttons on the ten different machines surrounding him. She explained to me in the kindest way a medical professional ever could that pressing that morphine drip while he slept was not helpful. It didn't keep my brother pain-free and sleepy, it risked sending him into respiratory arrest.

She should have slapped me upside the head and told me I could've killed him, but she was gentle about it.

*I can be a real idiot sometimes – super confident as I move forward with no idea what I am doing.*

After he fell back asleep, I resumed my spot in the chair, utterly deflated. I felt vulnerable and imperfect and scared – all emotions I never usually let myself feel anymore. In the quiet of his dark room I felt my hard façade let down, and I wept quietly as I asked God for help, for peace, and for healing for all the beautiful and shattered people around me. It was time for a personal return to faith.

*I can't do everything by myself. I'm not as together or competent as I pretend.*

It was a much-needed humbling.

I asked a close friend to pray with me later, and to ask Jesus to assume control and presence in my life and heart again. I wanted to reconnect but had no idea how to do it. I was still so, so angry, and I had no idea how to follow-up on it, or what was ahead of me in the self-destructive times to follow. Though I would fall off my well-intentioned path dramatically in coming years, it was a beginning.

We were crushed and overwhelmed beyond our ability to endure, and we thought we would never live through it. In fact, we expected to die. But as a result, we stopped relying on ourselves and learned to rely only on God, who raises the dead. And he did rescue us from mortal danger, and he will rescue us again. We have placed our confidence in him and he will continue to rescue us. (2 Corinthians I: 8-10, NLT)

Military personnel are more likely to speak about stressful issues with chaplains than clinicians (Nieuwsma, et al., 2013). As a result, religious leaders have a prominent role to play in helping veterans access help and get plugged back in to their communities. Studies back-up the simple truth that encouraging faith practices also encourages health and happiness (Levin, 2002; Koenig, 2008). Communities of faith can be profound sources of social support, healing, and hope for veterans returning home and experiencing the stress and possible trauma of transition (Kopacz & Pollitt, 2015).

I laughed when a friend told me that for a long time he had trouble personally believing in God, but he and his family continued to go to church. He got the value of the weekly ritual even as he struggled with his own questions about the religion of his youth. He knew that if something happened to him on his next deployment, their church family would reach out to support and love his wife and children.

*Take care of widows and orphans, right?*

I smiled because I got it – it is easy to know that faith is important and probably a good idea, but often hard to carve space in our noisy lives for our own organized religious practice. I knew all about God for years without making time or space for Him to connect in a real way in my own life.

My friend came home from what should be his final deployment about a year ago. There were things he didn't want to talk about, even with those of us who knew him well. What struck me most was his eagerness to get back to church with his family. There was a difference to his Sunday choices and the way he spent time with his kids. He was joyfully alight from the inside, legitimately happy and calmer. My friend had come to God in his own time, in his own private way.

It was a new beginning.

I had lots of new beginnings like that, mostly because although I was often well intentioned, I wasn't always up for the hard part of practicing faith. For many people who grew up in religious communities, which for me was a Catholic church, it can be hard to always feel at home among those who seem to be blissfully certain. My questioning and searching didn't feel truly welcome, I was dismayed at visible hypocrisy or abuse cover-ups, and my politics and priorities didn't always align with the cultural questions being debated. I didn't think I had the time to really connect, get involved, or engage in grand, culturally-nuanced theological exploration.

I felt a bit too good for it all, and walked away from religion with the excuse that I was staying above the fray. It was easier to work from a purely secular standpoint, even though that wasn't an authentic place of wholeness for me. For too many of us, it is easier to disengage when faith gets human and complicated. I just avoided all the divisive theological questions and took the intellectually and spiritually lazy route. I thought I could hang on to my belief in God without actually being a part of a flawed, human institution. I tried to be a Christian on my own, and that never worked out as I hoped.

When I read the work of Sarah Bessey I felt a click of recognition absorbing her words on becoming a parent. Questions of belief that one fumbles around with carelessly (or even brushes aside in frustration) as an independent individualist matter differently when crafting a home for a baby. My path had several false starts, but for me the difference became motherhood. Bessey (2013) writes in *Jesus Feminist*, "My mother was drawn to God through my birth...her great love for her daughters put her feet on the path toward the empty tomb and the risen Christ and his invitation to recover her true life...now I understood."

My son made a practicing believer out of me the second I knew he was on his way. My annoyed, superior, turning away wasn't an option anymore. In parenting, I knew I had hit a wall I wouldn't be able to jump with a simple training program and I think I for the first time knew I faced a challenge I couldn't meet on my own strength, (that favorite lie I always told myself).

I couldn't begin to pretend that I knew everything or held the world up and together on my own brilliance and strength when faced with my baby's presence. I won't be a limiting feature in his life by continuing to believe my own self-delusions of competence and total independence. I'll find other ways to disappoint and embarrass him, I am sure, but not here. It is my job to bring my best forward each day for him, to help him hone his gifts and make a difference in the lives of those around him. Let's be real – I cannot do that sleep-deprived and on my own strength.

*I'm just not that good.*

I looked at his roundly serious face right after he was born and was overwhelmed by the light he already has within him. New moms all rave a bit about their babies, but I know it is more than the oxytocin talking. A

caterwauling baby brought quarreling family into the same room, replaced frowns with smiles, motivated people to set aside judgments and just love one another. He is our unexpected miracle. We named him Matthew after his uncle – my brother and my lifelong friend.

In truth, he is also named for a New Testament verse.

*In the same way, let your light shine before others, that they may see your good deeds and glorify your Father in heaven.  
(Matthew 5:16, NIV)*

It isn't just attendance at religious services that offers healing to people. Belief and connection with God does something unique to us when reinforced through personal practice and supported by a community (Haas, 2012; Yancey & Brand, 2010). Peter Haas (2012) is one of my favorite authors and talks about two powerful tools that infuse faith practices with true, healing meaning: *constant meditation* and *inconveniently Godly friends*.

Those *inconveniently Godly* friends show up when it matters, willing to both support in hard times and push through a veteran's desire to ruminate or look backwards. Mostly, they show up faithfully ready to listen. Not all veterans lose their social support systems upon returning home, though many of us do. It can be tough to stay close to people when we aren't sure that we speak the same language any longer. Here, the role of communities of faith and uplifting friends cannot be understated – they can literally save lives.

Unlike me, some veterans are blessed with the ability to keep communication lines open, even in hard times and with faithful loved ones able to weather the storm alongside. These are the cases that highlight even more powerfully the importance of connection, and I will always be grateful that this was my brother's experience.

I was already deployed to Iraq when my brother e-mailed me to share that he was probably going to propose to his girlfriend before he headed over. They'd found a church in which to get married and life seemed all sunshine. She was a civilian schoolteacher from Philadelphia that I had yet to meet, and I just rolled my eyes when he shared his romantic plans with me. I was surrounded by guys losing their girlfriends to the grind of deployment, and I expected that his schoolteacher would be mailing him the same "dear John" letter after a few months. I told him I didn't have a problem with the proposal, but admonished him to buy her a ring made out of cubic zirconia. No sense in buying a diamond he might never get back.

As younger brothers often do, he ignored my advice and bought her a beautiful ring.

*Well that is some cash he will never see again! Should have listened to me!*

When a wounded service member is medically evacuated, he or she often has a long period in a hospital ward and in lots of different outpatient

treatment facilities ahead. I watched the prospect of a long, uncertain recovery level some people, and bring out the diamond-hard character of others.

When my brother arrived at Bethesda, we didn't know what he might be facing. There was so much damage. On his third surgery, the physicians in the operating room took a vote about whether or not to amputate his leg at the hip; he had infection setting in and they were worried it could get worse. Two voted to amputate, and three voted to give him a couple of days.

Ward 5 was a dark place some days. We were surrounded by morphine drips, pain, injury and struggling families who weren't sure what to make of it all.

Into this world walked my brother's civilian schoolteacher.

*She won't be able to handle this.*

Throughout this period I watched his young fiancé with a cynical eye. I stereotyped her on sight—she was a pretty girl who often wore make-up and always had on matching accessories. I assumed she lacked gravitas and would fall apart any minute.

*She never did.*

When her leave ran out at work she went back to teaching all day long in nearby Virginia, but made the drive every night to sleep in a chair at my brother's bedside. I would find her sitting by his side laughing about some silly thing or another, always keeping him smiling. She never complained and never gave up, never confessed fears about marrying a man with so many new health issues.

While I fumbled gracelessly in his hospital room, once even dropping a portable DVD player on his gaping wounds, she was all kindness and poise. She kept him looking towards their future on a daily basis. Even when he left the hospital and had to spend long days in a reclining chair, even when he needed help with any and all of the most basic tasks.

The make-up had fooled me; she was more than serious. Only in her twenties, she helped him make it to the bathroom, shower, move, and get through hard physical therapy appointments without complaint. I don't think I ever saw her with messy hair, either.

There were guys on the ward whose wives filed for divorce when they saw what they were going to have to struggle through together. I don't think the thought ever crossed her mind.

She helped him through medical retirement, a search for a new career and a civilian identity, and they became parents with that joyous excitement reserved for newbies who don't yet know how much sleep they will soon go without.

She married a Marine with three sisters, all of whom would gladly hide a body for her today – no questions asked.

She has a good memory, though. Every now and again, I hear about that cubic zirconia comment.

### **Psychological Benefits of Religious Involvement—Hope and Positivity**

*Belief is mentally healthy and it is what we are neurologically wired for.*

I am a health scientist with no training or skills in theology. Though there are a million reasons to cultivate a relationship with God, I invite you to read the work of savvy pastors to talk about those. In my work on religion and resilience, I focus particularly on those reasons for belief that show up in our bodies. In Psalm 139 David sings about being *fearfully and wonderfully made*, and truer words are hard to find.

Whether speaking from a secular or religious position, the question of divine connection always comes up when one discusses human mental health and happiness. My favorite researcher in the field of social work spent years immersed in interviews with people about happiness, vulnerability, and shame (Brown, 2013). Dr. Brown's work found that faith mattered a great deal to really happy people. Without exception, spirituality – the belief in connection, a power greater than self, and interconnections grounded in love and compassion emerged as a component of resilience.

Social psychologists discuss human needs as happening in hierarchy, with the need for transcendence being the highest. In this secular sense, transcendence is discussed as the need to help others seek deep meaning and to discover it for oneself (Koltko-Rivera, 2006). Humans are biopsychosocially wired to seek God and connect with one another (Moll, 2014).

Seeking God alone or in groups often requires focused and attentive prayer. Neuroscientists at the University of Pennsylvania have mapped what happens in the brain during quiet, attentive prayer (Newberg & d'Aquili, 2008). The posterior parietal lobe that normally orients us in space and time and offers feelings of “self vs. other” deactivates a bit, while the section of the brain that creates feelings of compassion and empathy activates (Masters & Spielmans, 2007; Moll, 2014).

These changes to the prefrontal cortex become permanent over time, as the brain acts like a muscle that can be trained. Neurons and synapses get used to connecting during prayer and cause our compassion and sense of loving connection to one another to grow (Koenig, 2008; McCullough, 1995).

The book of Romans talks about prayer and faith renewing the mind, and brain scans have demonstrated that such renewal is real (Masters, 2005). “Be transformed by the renewing of your mind” (Romans 12:2, NIV).

This renewal leads to action in this world that optimizes health for the faithful and improves the communities in which they live (Putnam, 2001). Psychologists know that rumination and intense self-focus are unhealthy for mental wellness (Thomas & Plummer Taylor, 2015). Christian scripture encourages philanthropic focus on others' needs, and prayer's impact on the compassion centers of the brain prompt concern and focus beyond

one's own walls. Interestingly, studies have shown that religious Americans are more likely to do anything from donate blood to help a sick neighbor dealing with depression. Among older adults, 70 percent of volunteer work happens in a religious setting. Americans who self-report going to church give four times the amount of money to charity that their secular neighbors do, and they are more likely to do volunteer work with the poor, infirm, and elderly twice-over (Sherman, 2011).

I don't share the health and community-building benefits of faith to set Christians apart in any self-aggrandizing way, but rather to demonstrate the importance of spiritual health for any person, and to veterans struggling with reintegration in particular. Medical professionals and clinicians have begun focusing on the importance of spirituality to their patients simply because it is important to so many. Medical schools offer classes on spirituality and healing, and researchers convene at major institutes focusing on the religion and health realms.

Our personal spirituality is interwoven with our physical body and our mental and emotional processes (Koenig, 2008). If we want to optimize our wellness, we cannot think of them as separate, or simply ignore one area like I did for so long.

*The question for me became whether I was just saying that I understood health from a mind, body, spirit perspective, or actually believed in the concept enough to invest my time.*

*If I believed that time spent on my spirituality was important to my overall wellness, could I avoid asking myself what spirituality looked like for me? Could I simply continue to overlook my faith?*

### **Conclusion**

Today my brother is a husband and father, and my son is named after him. He even goes jogging now and again and dances with his beautifully wild children.

I praise God for his recovery and for the life he gets to have.

It almost didn't happen that way.

Things are different for me since making space for a belief in Jesus that also includes a set of active practices and communion with people, rather than those parts of faith being something I passively skip over. I still have to wrestle with thorny questions and agree to disagree with many whose views on politics, culture, or theology don't match my own.

*That's ok.*

What is no longer an option is to throw my faith out with the debate, no matter how many times I get frustrated or see something that looks like the opposite of what Jesus would have us do. I have to engage, care, come together in community with other seekers, and explore the importance of my spirituality to my notion of who I am as a person. I'm no longer inter-

ested in living a life carved into parts, and I won't offer that old version of me to my family.

*She was kind of a jerk.*

I'm unabashedly singing and clapping and praising these days. My professional efforts aren't about getting the next pay raise or promotion and I love, love, love my inconveniently Godly friends. I don't chafe with angry thoughts and bitterness all the time, and my focus is outward on helping veterans and Wounded Warriors in my community.

*It has made all the difference.*

God reminds me every day about the beauty present in humanity, and my relationship with Him is no longer rote or incidental. I'm not a naturally generous or thoughtful person, and I need to pay attention to God to keep myself moving in a direction worth heading. Naturally, I am a controlling egomaniac, if I am to be honest with you. I have to practice my faith in a conscious way and actively seek out positive social support.

That requires practice, prayer, and most of all people. My faith community today is vitally important for my family.

I worry less about denomination or dogma than about positive examples, truth in deed, joy, and support in a Christian community.

Faith has made me more resilient. It makes me a much better wife and a more patient mother.

*If only I had known Him earlier. ❖*

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# Resources for Social Work Practice with Military Affiliated Clients

## Articles

- Brelsford, G.M., & Friedberg, R.D. (2011). Religious and spiritual issues: Family therapy approaches with military families coping with deployment. (4), 255-262. doi: 10.1007/s10879-011-9174-4.
- Brelsford & Friedberg review the literature on military families and religious and spiritual coping, followed by a description of the strategies for understanding the religious and spiritual lives of military families who have experienced deployment.
- Brenda, B. B., DiBlasio, F.A, Pope, S.K. (2006). Spiritual well-being, relationships, and homeless veterans with alcohol/other drug problems. *Alcoholism Treatment Quarterly*, 24(1/2), 109-124. doi: 10.1300/J0202v24n01\_07.
- Brenda, DiBlasio, and Pope examined 600 homeless males to identify predictors for readmission to inpatient substance abuse treatment. Spiritual well-being was found to be positively related to the length of time homeless veterans remained in the community without readmission.
- Currier, J.M., Holland, J.M., & Drescher, K.D. (2015). Spirituality factors in the prediction of outcomes of PTSD treatment for U.S. military veterans. *Journal of Traumatic Stress*, 28, 57-64. doi:10.1002/jts.21978.
- Currier, Holland, and Drescher examined the longitudinal association between spirituality and PTSD symptom severity among U.S. Veterans in residential treatment for combat-related PTSD. The student revealed a positive relationship between adaptive dimensions of spirituality and treatment effectiveness.
- Denney, R. M., Aten, J. D. & Leavell, K. (2011). Posttraumatic spiritual growth: A phenomenological study of cancer survivors. *Mental Health, Religion & Culture*, 14(4), 371-391. doi: 10.1080/13671003758667.
- Denney, Aten, and Leavell present the results of a qualitative study that examined how cancer affected spiritual growth in cancer survivors. The researchers used phenomenological data to analyze the spiritual growth of 13 cancer survivors. The participants reported experiencing spiritual growth in the following domains of spiritual development: (a) general spirituality, (b) spiritual development, (c) spiritual social participation, (d) spiritual private practices, (e) spiritual support, (f) spiritual coping, (g) spirituality as a motivating force, (h) spiritual experiences, and (i) spiritual commitment.
- DePalo, R. (2009). The role of hope and spirituality on the road to recovery. *Exceptional Parent Magazine* (February, pp. 74-77). Retrieved from [www.eparent.com](http://www.eparent.com).
- DePalo explores the effects of combat on service members who have returned home and are attempting to cope with traumatic experiences while reintegrat-

ing into the daily life of family, community, and work. This series focuses on traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), and related health issues. In this article, the author explores the role that hope and spirituality can play in a service member's life by reviewing the literature which chronicles the findings of noted professionals working in the areas of hope and spirituality and the connection that these have to recovery.

Malmin, M. (2013). Warrior culture, spirituality, and prayer. *Journal of Religious Health, 52*, 740-758. doi: 10.1007/s10943-013-9690-5.

Malmin examines the idiosyncratic nature and influence of warrior culture and subculture and offers recommendations to promote culture change. He examines how faith-based spirituality and prayer can serve as adjunct modalities for stress management and emotional healing.

Orsan, H.C., Smee, D.E., Screenivasan, S., Weinberger, L.E. (2010). Living outside the wire: Toward a transpersonal resilience approach for OIF/OEF veterans transitioning to civilian life. *Journal of Transpersonal Psychology, 42*(2), 209-235. Returning to civilian life, with no "platoon" to serve as a psychological safety net, veterans may once again experience in a different sense—living "outside the wire." Moreover, experiencing or seeking help for psychological distress is often perceived as weakness. How do we help these warriors maintain emotional, spiritual, in addition to physical, well-being "outside the wire"? Combat experiences, if placed within a meaningful context, carry the potential to promote spiritual and emotional growth.

Shaw, A., Joseph, S., & Linley, P.A. (2005) Religion, spirituality, and posttraumatic growth: A systematic review. *Mental Health, Religion & Culture, 8*(1), 1-11. doi: 10.1080/1367467032000157981.

Shaw, Joseph, & Linley conducted a systematic review of empirical studies that reported a link between religion, spirituality, and posttraumatic growth. This review showed that religion and spirituality are consistent protective factors for coping with the aftermath of trauma.

## Books

Blaisure, K. R., Saathoff-Wells, T., Pereira, A., Wadsworth, S. M., & Dombro, A. L. (2012). *Serving military families in the 21st Century*. New York, NY: Routledge. This text introduces readers to military families, their resilience, and the challenges of military life. Personal stories from active duty, National Guard, reservists, veterans, and their families, from all branches and ranks of the military, and those who work with military personnel.

Brock, R.N., & Lettini, G. (2012). *Soul repair: Recovering from moral injury after war*. Boston, MA: Beacon Press, Inc.

The authors tell the stories of four veterans of wars who reveal their experiences with moral injury and how they learned to live with it. This book will help the reader to understand the impact of war on the conscience of veterans.

Exum, H.A., & Coll, J.E. (2008). *A civilian counselor's primer for counseling veterans*. Deer Park, NY: Linus Publications, Inc.

This book is an essential resource for any behavioral health provider that desires to provide culturally competent support to military service members and their families. The provide insight to providers who want to understand the military organization, culture and mission of the military, counseling resources available to veterans, issues that bring military into counseling, and much more.

- Dees, R. F. (2011). *Resilient Warriors*. San Diego, CA: Creative Teams Publishing.
- Dees, R.F. (2013). *Resilient Leaders*. San Diego, CA: Creative Teams Publishing.
- Dees, R. F. (2014). *Resilient Nations*. San Diego, CA: Creative Teams Publishing.  
 Note: This series (*Resilient Soldiers*, *Resilient Leaders*, and *Resilient Nations*) are written by Maj. Gen. Bob Dees (ret.) and are faith-based guides to “bouncing back,” recovering from past wounds, and thriving in the face of adversity. <http://resiliencetrilogy.com>.
- Everson, R.B, & Figley, C.R. (2011). *Families under fire: Systemic therapy with military families*. New York, NY: Routledge.  
 This book fills in the gaps for providers by offering real-world examples, clear, concise prose, and nuts-and-bolts approaches for working with military families, utilizing an effective systems-based practice.
- Jones, P., & Beckman, C. (2009). *God's hiddenness in combat: Toward Christian reflection on battle*. Lanham, MD: University Press of America, Inc.  
 The heart of this book is one primary question: Where is God for the person in combat? The authors present the narrative perspectives of other combatants who have experienced the trauma of war and, at times, the questioning of their faith. The authors also present the perspectives of Christian combatants whose faith has become solidified as a result of their experiences.
- Mansfield, S. (2006). *The faith of the American soldier*. New York, NY: The Penguin Group.  
 This book examines issues of faith and spirituality as it pertains to service members and wars.
- Moore, B. A. (Ed). (2012). *Handbook of counseling military couples*. New York, NY: Routledge.  
 This book provides a clear, thorough introduction to military culture and couple relationships within military communities. Providers who read this book will better understand the state of marriage in the military, how to effectively use a variety of treatment models with military couples, and an array of other pertinent issues.
- Moore, B. A. & Penk, W. E. (2011). *Treating PTSD in military personnel: A clinical handbook*. New York, NY: The Guilford Press.  
 This book provides treatment approaches, including numerous evidence-based therapies, for treating PTSD and co-occurring disorders (such as substance use, sleep disorders, and traumatic brain injury) in a military population.
- Moore, B. M. & Jongsma, A. E. (2015). *The veterans and active duty military psychotherapy: Treatment planner*. Hoboken, NJ: John Wiley & Sons, Inc.  
 This treatment planner provides pre-written treatment plans including goals, objectives, and interventions for over three dozen presenting problems that are most common among veterans and active duty personnel.
- Pryce, J. G., Pryce, D. H., & Shackelford, K. K. (2012). *The cost of courage: Combat stress, warriors, and family survival*. Chicago, IL: Lyceum.  
 The authors present best practices and eclectic approaches that encourage social workers and other mental health professionals to consider the needs of military service members and their families. This book introduces practitioners to the “warrior culture” and cultural competency to successfully interact with members of this diverse population.
- Williams, M. & Pojula, S. (2016). *The PTSD workbook: Simple, effective techniques for overcoming traumatic stress symptoms*. Oakland, CA: New Harbinger Publications, Inc.

This self-help workbook provides techniques and interventions in order to provide trauma survivors tools and techniques for addressing their PTSD symptoms. [http://www.amazon.com/PTSD-Workbook-Effective-Techniques-Overcoming/dp/1626253706/ref=dp\\_ob\\_title\\_bk](http://www.amazon.com/PTSD-Workbook-Effective-Techniques-Overcoming/dp/1626253706/ref=dp_ob_title_bk).

## Websites

Army One Source (<http://ww.armyonesource.com/>)

Contains resources, news and information for those who are caring for wounded soldiers and their families. Describes Military Suicide Prevention Program resources and services provided by the Military One Source Crisis Intervention Hotline. This website also provides resources for parents of soldiers.

Courage to Care (<http://www.usuhs.mil/psy/courage.html>)

This website was created for military families and helping professionals. It contains information on health care and fact sheets relating to the military.

DeploymentLINK: Deployment Health Support ([http://deploymentlink.osd.mil/deploy/family/family\\_support.shtml](http://deploymentlink.osd.mil/deploy/family/family_support.shtml)).

Provides information that enhances the quality life of deploying soldiers and their families. Information includes locator services, legal resources, entitlements, education and websites on family support, transition services, recreational services, mental, physical and emotional well-being.

Military OneSource (<http://www.militaryonesource.com/>)

This website covers information on family advocacy programs, child care, personal and family readiness, relocation resources, survivor outreach services, Army Wounded Warrior services, Army Reserve Program, addiction and recovery resources, emotional well being, health, disabilities, parenting, education, retirement, and employment.

National Center for Posttraumatic Stress Disorder (<http://www.ptsd.va.gov/>)

This government website provides a great deal of information regarding PTSD. You can sign up to receive regular updates sent via email.

Operation HomeFront (<http://www.operationhomefront.net/>)

Website provides information for troops and their families. A variety of areas pertaining to the military family are addressed. Some areas are: glossary of military terms, military career spouse center, children and adolescents, emergencies and disasters, and parenting.

## Online Training

Medical University of South Carolina - Cognitive Processing Therapy (<http://www.cpt.musc.edu/>)

This site provides a FREE training on Cognitive Processing Therapy.

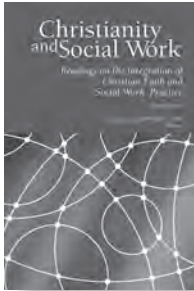
DoD Deployment Health Clinical Center (<http://www.pdhealth.mil/education-and-training>).

These professional development opportunities and resources provide clinical training and psychological health information for military and community health care providers.

## PUBLICATIONS AVAILABLE FROM NACSW

### **CHRISTIANITY AND SOCIAL WORK: READINGS ON THE INTEGRATION OF CHRISTIAN FAITH & SOCIAL WORK PRACTICE (FIFTH EDITION)**

T. Laine Scales and Michael S. Kelly (Editors). (2016). Botsford, CT: NACSW \$55.00 U.S., \$42.99 for NACSW members or orders of 10 or more copies. For price in Canadian dollars, use current exchange rate.

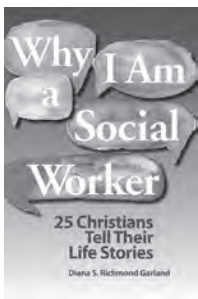


At over 400 pages and with 19 chapters, this extensively-revised fifth edition of *Christianity and Social Work* includes six new chapters and six significantly revised chapters in response to requests by readers of previous editions including chapters on evidence based practice (EBP), congregational Social Work, military social work, working with clients from the LGBT community, human trafficking – and much more! The fifth edition of *Christianity and Social Work* is written for social workers whose motivations to enter the profession are informed by their Christian faith, and who desire to develop faithfully Christian approaches to helping. It addresses a breadth of curriculum areas such as social welfare history, human behavior and the social environment, social policy, and practice at micro, mezzo, and macro levels. *Christianity and Social Work* is organized so that it can be used as a textbook or supplemental text in a social work class, or as a training or reference materials for practitioners and has an online companion volume of teaching tools entitled *Instructor's Resources*.

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### **WHY I AM A SOCIAL WORKER: 25 CHRISTIANS TELL THEIR LIFE STORIES**

Diana R. Garland. (2015). Botsford, CT: NACSW. \$29.95 U.S., \$23.95 for NACSW members or orders of 10 or more copies. For price in Canadian dollars, use current exchange rate.



*Why I Am a Social Worker* describes the rich diversity and nature of the profession of social work through the 25 stories of daily lives and professional journeys chosen to represent the different people, groups and human situations where social workers serve.

Many social workers of faith express that they feel “called” to help people – sometimes a specific population of people such as abused children or people who live in poverty. Often they describe this calling as a way of living out their faith. *Why I Am a Social*

*Worker* serves as a resource for Christians in social work as they reflect on their sense of calling, and provides direction to guide them in this process.

*Why I Am a Social Worker* addresses a range of critical questions such as:

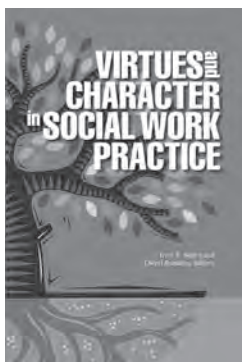
- How do social workers describe the relationship of their faith and their work?
- What is their daily work-life like, with its challenges, frustrations, joys and triumphs?
- What was their path into social work, and more particularly, the kind of social work they chose?
- What roles do their religious beliefs and spiritual practices have in sustaining them for the work, and how has their work, in turn, shaped their religious and spiritual life?

Dr. David Sherwood, Editor-in-Chief of *Social Work & Christianity*, says about *Why I Am a Social Worker* that:

I think this book will make a very important contribution. . . . The diversity of settings, populations, and roles illustrated by the personal stories of the social workers interviewed will bring the possibilities of social work to life in ways that standard introductory books can never do. The stories also have strong themes of integration of faith and practice that will both challenge and encourage students and seasoned practitioners alike.

### **VIRTUE AND CHARACTER IN SOCIAL WORK PRACTICE**

*Edited by Terry A. Wolfer and Cheryl Brandsen. (2015). Botsford, CT: NACSW. \$23.75 U.S., \$19.00 for NACSW members or orders of 10 or more copies). For price in Canadian dollars, use current exchange rate.*

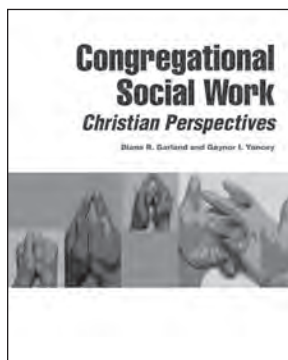


*Virtues and Character in Social Work Practice* offers a fresh contribution to the Christian social work literature with its emphasis on the key role of character traits and virtues in equipping Christians in social work to engage with and serve their clients and communities well.

This book is for social work practitioners who, as social change agents, spend much of their time examining social structures and advocating for policies and programs to advance justice and increase opportunity.

**CONGREGATIONAL SOCIAL WORK: CHRISTIAN PERSPECTIVES**

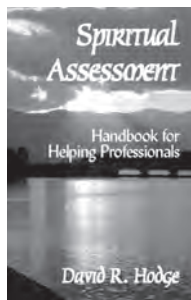
Diana Garland and Gaynor Yancey. (2014). Botsford, CT: NACSW. \$39.95 U.S., \$31.95 for NACSW members or orders of 10 or more copies). For price in Canadian dollars, use current exchange rate.



*Congregational Social Work* offers a compelling account of the many ways social workers serve the church as leaders of congregational life, of ministry to neighborhoods locally and globally, and of advocacy for social justice. Based on the most comprehensive study to date on social work with congregations, *Congregational Social Work* shares illuminating stories and experiences from social workers engaged in powerful and effective work within and in support of congregations throughout the US.

**SPIRITUAL ASSESSMENT: HELPING HANDBOOK FOR HELPING PROFESSIONALS**

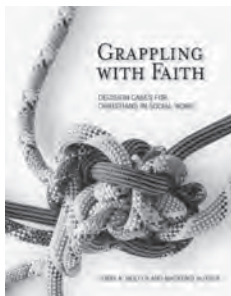
David Hodge. (2003). Botsford CT: NACSW \$20.00 U.S. (\$16.00 for NACSW members or orders of 10 or more). For price in Canadian dollars, use current exchange rate.



A growing consensus exists among helping professionals, accrediting organizations and clients regarding the importance of spiritual assessment. David Hodge's *Spiritual Assessment: Helping Handbook for Helping Professionals*, describes five complementary spiritual assessment instruments, along with an analysis of their strengths and limitations. The aim of this book is to familiarize readers with a repertoire of spiritual assessment tools to enable practitioners to select the most appropriate assessment instrument in given client/practitioner settings. By developing an assessment "toolbox" containing a variety of spiritual assessment tools, practitioners will become better equipped to provide services that address the individual needs of each of their clients.

**GRAPPLING WITH FAITH: DECISION CASES FOR CHRISTIANS IN SOCIAL WORK**

Terry A. Wolfer and Mackenzi Huyser (2010) \$23.75 (\$18.99 for NACSW members or for orders of 10 or more). For price in Canadian dollars, use current exchange rate.

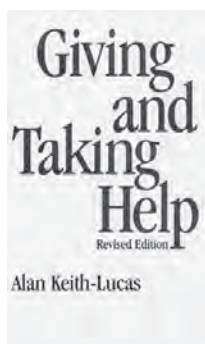


*Grappling with Faith: Decision Cases for Christians in Social Work* presents fifteen cases specifically designed to challenge and stretch Christian social work students and practitioners. Using the case method of teaching and learning, *Grappling with Faith* highlights the ambiguities and dilemmas found in a wide variety of areas of social work practice, provoking active decision making and helping develop readers' critical thinking skills. Each case provides a clear focal point for initiating

stimulating, in-depth discussions for use in social work classroom or training settings. These discussions require that students use their knowledge of social work theory and research, their skills of analysis and problem solving, and their common sense and collective wisdom to identify and analyze problems, evaluate possible solutions, and decide what to do in these complex and difficult situations.

**GIVING AND TAKING HELP (REVISED EDITION)**

Alan Keith-Lucas. (1994). Botsford CT: North American Association of Christians in Social Work. \$20.75 U.S. (\$16.50 for NACSW members or orders of 10 or more). For price in Canadian dollars, use current exchange rate.

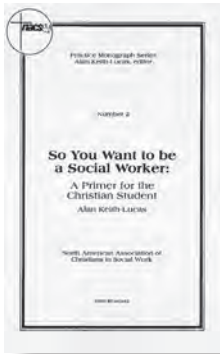


Alan Keith-Lucas' *Giving and Taking Help*, first published in 1972, has become a classic in the social work literature on the helping relationship. *Giving and taking help* is a uniquely clear, straightforward, sensible, and wise examination of what is involved in the helping process—the giving and taking of help. It reflects on perennial issues and themes yet is grounded in highly practice-based and pragmatic realities. It respects both the potential and limitations of social science in understanding the nature of persons and the helping process. It does not shy away from confronting issues of values,

ethics, and world views. It is at the same time profoundly personal yet reaching the theoretical and generalizable. It has a point of view.

**SO YOU WANT TO BE A SOCIAL WORKER: A PRIMER FOR THE CHRISTIAN STUDENT**

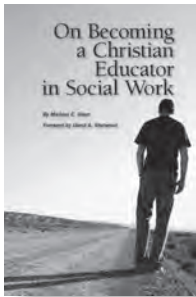
Alan Keith-Lucas. (1985). Botsford, CT: NACSW. *Social Work Practice Monograph Series*. \$11.50 U.S. (\$9.00 for NACSW members or orders of 10 or more). For price in Canadian dollars, use current exchange rate.



*So You Want to Be a Social Worker* has proven itself to be an invaluable resource for both students and practitioners who are concerned about the responsible integration of their Christian faith and competent, ethical professional practice. It is a thoughtful, clear, and brief distillation of practice wisdom and responsible guidelines regarding perennial questions that arise, such as the nature of our roles, our ethical and spiritual responsibilities, the fallacy of “imposition of values,” the problem of sin, and the need for both courage and humility.

**ON BECOMING A CHRISTIAN EDUCATOR IN SOCIAL WORK**

Michael Sherr (2010) \$21.75 (\$17.50 for NACSW members or for orders of 10 or more). For price in Canadian dollars, use current exchange rate.



*On Becoming a Christian Educator* is a compelling invitation for social workers of faith in higher education to explore what it means to be a Christian in social work education. By highlighting seven core commitments of Christian social work educators, it offers strategies for social work educators to connect their personal faith journeys to effective teaching practices with their students. Frank B. Raymond, Dean Emeritus at the College of Social Work at the University of South Carolina suggests that “Professor Sherr’s book should be on the bookshelf of every social work educator who wants to integrate the Christian faith with classroom teaching. Christian social work educators can learn much from Professor Sherr’s spiritual and vocational journey as they continue their own journeys and seek to integrate faith, learning and practice in their classrooms.”

**HEARTS STRANGELY WARMED: REFLECTIONS ON BIBLICAL PASSAGES RELEVANT TO SOCIAL WORK**

Lawrence E. Ressler (Editor). (1994). Botsford, CT: North American Association of Christians in Social Work. \$9.25 U.S. (\$7.50 for NACSW members or orders of 10 or more). For price in Canadian dollars, use current exchange rate.

*Hearts Strangely Warmed: Reflections on Biblical Passages Relevant to Social Work* is a collection of devotional readings or reflective essays on 42 scriptures pertinent to social work. The passages demonstrate the ways the Bible can be a source of hope, inspiration, and conviction to social workers.

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**THE POOR YOU HAVE WITH YOU ALWAYS: CONCEPTS OF AID TO THE POOR IN THE WESTERN WORLD FROM BIBLICAL TIMES TO THE PRESENT**

Alan Keith-Lucas. (1989). Botsford, CT: North American Association of Christians in Social Work. \$20.75 U.S. (\$16.50 for NACSW members). For price in Canadian dollars, use current exchange rate.

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**ENCOUNTERS WITH CHILDREN: STORIES THAT HELP US UNDERSTAND AND HELP THEM**

Alan Keith-Lucas. (1991). Botsford, CT: North American Association of Christians in Social Work. \$11.50 U.S. (\$9.00 for NACSW members). For price in Canadian dollars, use current exchange rate.

**To Order Publications:**

To order a copy of any of the above publications, please send a check for the price plus 10% shipping and handling. (A 20% discount for members or for purchases of at least 10 copies is available.) Checks should be made payable to NACSW; P.O. Box 121, Botsford, CT 06404-0121. Email: [info@nacsw.org](mailto:info@nacsw.org) 203.270.8780.



*North American Association  
of Christians in Social Work*

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888.426.4712, or email NACSW at [info@nacsw.org](mailto:info@nacsw.org)

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## NORTH AMERICAN ASSOCIATION OF CHRISTIANS IN SOCIAL WORK

NACSW's mission is to equip its members to integrate Christian faith and professional social work practice.

Its goals include:

- Supporting and encouraging members in the integration of Christian faith and professional practice through fellowship, education, and service opportunities.
- Articulating an informed Christian voice on social welfare practice and policies to the social work profession.
- Providing professional understanding and help for the social ministry of the church.
- Promoting social welfare services and policies in society which bring about greater justice and meet basic human needs.

