

# SPIRITUAL CARE HANDBOOK ON PTSD/TBI

**The Handbook on Best Practices  
for the Provision of Spiritual Care to  
Persons with Post Traumatic Stress  
Disorder and Traumatic  
Brain Injury**

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# TABLE OF CONTENTS

Introduction-----	4
Figure I- Stress Continuum Model	
 Section I: Definitions & Symptoms	
 Chapter I - What is Post-Traumatic Stress Disorder? -----	6
 Chapter II - PTSD Diagnostic Criteria -----	8
• Stressor	
• Intrusive Recollection	
• Avoidant / Numbing	
• Hyper-Arousal	
• Duration	
• Functional Significance	
 Chapter III - What is Traumatic Brain Injury? -----	10
• TBI Symptoms	
• Mild TBI	
• Moderate to Severe TBI	
• Coping and Social Support	
• Some Tips for Working with People with TBI	
 Section II: Overarching Principles	
 Chapter I - Definitions -----	16
• Compassion Fatigue	
• Coping	
• Countertransference	
• Cure vs. Heal	
• Desired Clinical Outcome	
• Intentional Ministry of Presence	
• Mission	
• Moral Distress	
• Moral Injury	
• Spirituality	
• Spiritual Care Intervention	
• Spiritual Concerns, Spiritual Distress, Spiritual Despair	
• Spiritual Community	
• Transference	
• Trauma	
• Victim Triangle	
 Chapter II - Integrate and Collaborate with the Mental Health Team-----	20

Chapter III - Herman’s Stages of Recovery -----	22
• Safety	
• Remembrance & Mourning	
• Reconnection	
Chapter IV - Be a Nonanxious Presence -----	30
Chapter V - Be a Nonjudgmental Presence -----	31
Chapter VI - Sensitivity to Differences in Religion, Culture and Gender -----	32
• Woman	
• African American	
• Hispanic/Latino/Latina	
• Asian American/Pacific Islander	
• Native American	
• Generational	
Chapter VII - Need for Self-Care -----	36
 <b>Section III: Interventions</b>	
Chapter I - Group Work Spiritual Care Interventions-----	39
• Rationale for the Use of Groups	
• Types of Groups	
• Tips on Groups	
• The Twelve-Step Approach to PTSD	
Chapter II - Spiritual Care Interventions- TBI-----	46
1. Intentional Ministry of Presence	
2. Spiritual Reframing	
3. Focus on Spiritual Gratitude & Blessing	
Chapter III - Spiritual Care Interventions- PTSD-----	49
 Basic Interventions	
1. Intentional Ministry of Presence -----	49
2. Meaning Making -----	50
3. Grief Work -----	55
 Specific Chaplain Interventions	
1. Clinical Use of Prayer -----	58
2. Healing Rituals -----	62
3. Confession – Guilt – Forgiveness Work (Ventilative Confession) -----	64
4. Percentage of Guilt Discussion-----	69
5. Life Review – Spiritual Autobiography Work -----	71

6. Scripture Paralleling / Education-----	73
7. Reframing God Assumptions, Examining Harmful Spiritual Attributions -----	76
8. Encouraging Connection with a Spiritual Community-----	78

Specialty Interventions

1. Spiritual Mantram Repetition -----	80
2. Creative Writing-----	84

Interventions Requiring Special Training

1. Sweat Lodge – Apache Warrior Ritual -----	85
2. Psychic Judo - Going With the Negative Emotions -----	87
3. Interpersonal Psychotherapy (IPT) -----	88
4. Trauma Incident Reduction (TIR) -----	91

Section IV: Appendices

Appendix I - Evidence Grading -----	94
Appendix II - Bibliography-----	95
Appendix III - Telephone Interviews -----	107

# INTRODUCTION

As of the beginning of April, 2009, there have been approximately 5,000 U.S. casualties in the Overseas Contingency Operation (accessed 4/5/09 at: <http://icasualties.org/Iraq/index.aspx>). This does not include those whom have been wounded in action and have returned or not returned to duty. Over 1.4 million service members have been involved in the Overseas Contingency Operations, and most return home changed in some way. The life threat, loss, fatigue, and inner conflict that many service members experience are expected human responses to extremely abnormal events. These challenges elicit reactions and responses from each person, most of which are normal reactions and responses to such abnormal events. For many, the difficulty comes in seeking to reset – to somehow turn off the military skills and coping strategies that may have served them well in combat, yet no longer are healthy or with purpose once the service member returns home (Oliver, 2008)

The research surrounding traumatic stress is still quite young. The research connecting traumatic stress and spirituality is consequently quite sparse. As such, many of the Spiritual Care Interventions recommended are based on the opinion and experience of expert clinicians who have been professionally addressing the spiritual and emotional needs of those with PTSD and TBI; rather, than in-depth social research.

To simplify the presentation, several terms are used generically. “God” should be understood to refer to whatever the person’s concept of a higher power is, including: God, Yahweh, Allah, etc. Service member, Sailor, Marine, Soldier, Airman, and veteran are used synonymously to refer to anyone who has been in combat as a member of a uniformed military service.

Leaders at all levels are responsible for preserving the psychological health of their service members, just as they are responsible for preserving their physical health. This responsibility applies to every link in every chain of command, from team leaders and work center supervisors to combatant commanders and commanding officers. Medical, religious ministry, and other support personnel can help with this task, but only line leaders can balance operational requirements, which expose service members to risks, against the imperative to preserve their health and readiness. The Maritime COSC Doctrine (MCRP 6-11c/NTTP 1-15: Draft) is line led with program elements supported by Navy Medicine and the Chaplain Corps. The foundation of COSC/OSC is the Stress Continuum Model (Figure 1.) which provides service members, leaders, and family members a visual tool for assessing stress responses ranging from ready to ill and practical steps to take to mitigate stress injuries. As an element of force health protection, COSC/OSC has three main goals: prevention, identification, and treatment of stress problems arising from military training and operations. This handbook focuses on spiritual care for those with stress illnesses and traumatic brain injury.

FIGURE 1

READY (Green)	REACTING (Yellow)	INJURED (Orange)	ILL (Red)
<p><u>Definition</u></p> <ul style="list-style-type: none"> <li>• Optimal functioning</li> <li>• Adaptive growth</li> <li>• Wellness</li> </ul> <p><u>Features</u></p> <ul style="list-style-type: none"> <li>• At one’s best</li> <li>• Well trained and prepared</li> <li>• In control</li> <li>• Physically, mentally, and spiritually fit</li> <li>• Mission focused</li> <li>• Motivated</li> <li>• Calm and steady</li> <li>• Having fun</li> <li>• Behaving ethically</li> </ul>	<p><u>Definition</u></p> <ul style="list-style-type: none"> <li>• Mild and transient distress or impairment</li> <li>• Always goes away</li> <li>• Low risk</li> </ul> <p><u>Causes</u></p> <ul style="list-style-type: none"> <li>• Any stressor</li> </ul> <p><u>Features</u></p> <ul style="list-style-type: none"> <li>• Feeling irritable, anxious, or down</li> <li>• Loss of motivation</li> <li>• Loss of focus</li> <li>• Difficulty sleeping</li> <li>• Muscle tension or other physical changes</li> <li>• Not having fun</li> </ul>	<p><u>Definition</u></p> <ul style="list-style-type: none"> <li>• More severe and persistent distress or impairment</li> <li>• Leaves a “scar”</li> <li>• Higher risk</li> </ul> <p><u>Causes</u></p> <ul style="list-style-type: none"> <li>• Life threat</li> <li>• Loss</li> <li>• Moral injury</li> <li>• Wear and tear</li> </ul> <p><u>Features</u></p> <ul style="list-style-type: none"> <li>• Loss of control</li> <li>• Panic, rage, or depression</li> <li>• No longer feeling like normal self</li> <li>• Excessive guilt, shame, or blame</li> </ul>	<p><u>Definition</u></p> <ul style="list-style-type: none"> <li>• Clinical mental disorder</li> <li>• Unhealed stress injury causing life impairment</li> </ul> <p><u>Types</u></p> <ul style="list-style-type: none"> <li>• PTSD</li> <li>• Depression</li> <li>• Anxiety</li> <li>• Substance abuse</li> </ul> <p><u>Features</u></p> <ul style="list-style-type: none"> <li>• Symptoms persist and worsen over time</li> <li>• Severe distress or social or occupational impairment</li> </ul>
Leader Responsibility	Individual, Shipmate, Family Responsibility		Caregiver Responsibility

# SECTION I: DEFINITIONS & SYMPTOMS

# CHAPTER I

## WHAT IS POST-TRAUMATIC STRESS DISORDER?

Post-Traumatic Stress Disorder (PTSD), “results from exposure to an overwhelmingly stressful event or series of events, such as war, rape or abuse” (Schiraldi, 2009, p. 3). Traumatic event(s) resulting in PTSD are so extraordinary that anyone who experiences them would be distressed. In the experience of the trauma, the person usually fears for his or her life or the lives of others. This triggering traumatic event overwhelms the person’s ability to respond or cope adequately.

The trauma is a wound which can create distress in many “systems”: physiological, neurological (as well as neuro-chemical), cognitive, behavioral, emotional, social, psychological and spiritual. PTSD is a clinical, medical diagnosis. Only a physician or clinical psychiatrist may diagnose a person as having PTSD, and only if the person exhibits a specific set of symptoms as specified in the most recent *Diagnostic and Statistical Manual IV- Text Revision* (American Psychiatric Association, 2000).

The current definition and explication of PTSD in the DSM-IV-TR does not distinguish those who are a victim of or witness to a trauma - such as assault or rape - from those who, like many service members with combat-related PTSD, may have been a perpetrator of trauma on another person or persons, such as participating in killing in the midst of combat. This distinction is important and will be discussed in more depth in the section, “Spiritual Care Interventions,” within the discussion about guilt and forgiveness.

PTSD is an anxiety disorder first officially described in the DSM-III in 1980. PTSD is the only condition in the present DSM that includes a stressor as part of the diagnosis. Patients with PTSD perceive the world as dangerous, and view themselves to be essentially incompetent (Foa, 2000). The inability to live with apparent contradiction is central to the anxiety of many, and most service members with PTSD struggle with contradictions about how they feel they should have acted versus how they did act, how they feel the mili-

tary should have gone about things versus what actually happened, etc. (Fleischman, J., personal communication, January 21, 2009). Trauma upends a person’s emotional, psychological, spiritual and personality processes through shattering assumptions about safety, power and control, the self and the world (Harris et al., 2008). Trauma impacts all areas of a person’s life, yet when the spiritual is acknowledged and addressed, it can often resonate with the service member and help him or her feel better understood (McBride, 2002).

Those with PTSD have had many basic, fundamental assumptions about the world shattered as a result of their experience with a traumatic event. These assumptions, about themselves, humanity in general, the military, God, religion, the United States and others, are often implicit, unarticulated and un-reflected upon. They are central to one being able to make meaning. The traumatic experience that triggered the PTSD for most service members fundamentally comes down to how they can make meaning now, integrating what they now know and what they have seen and experienced.

Service members exposed to combat have more severe symptoms of PTSD on two of five measures, and are less likely to seek mental health assistance (Brinker et al., 2007). One chaplain observed that many service members within his branch of the military were afraid to go to the chaplain following the dramatic or traumatic experience common in war. He states they fear that it may appear as if they could not handle the pressure (Drescher et al., 2007). This tension with the warrior ego and many service members’ assumptions about what a “good” service member needs or does not need is a constant and ongoing conversation within all branches of the military. The more the need for getting help is stigmatized and viewed as weakness or vulnerability unbecoming a service member, the less likely it will be for those who do need assistance to seek help. This situation may be complicated by the service member who is fed up or distrusting of



“the system,” therefore resisting any efforts from that “system” to help him or her readjust. As a result, many soldiers feel they are better off figuring it all out on their own (Navy Medicine, 2008).

PTSD involves many parts of a service member beginning to function below optimal levels. These parts include but are not limited to: damage/dysfunction in several structures in the brain, dysregulation of the central/peripheral nervous system, complex cognitive and emotional dysfunction, social/interpersonal maladaptation and spiritual disequilibrium (Fortunato, J., PowerPoint, Used by permission of the author).

Other studies have demonstrated that one of the major predictors of the severity of the symptoms of PTSD is the severity of the traumatic event experienced (Gold et al., 2000). Another study stated that the amount of exposure to combat conditions was one of the best predictors of subsequent PTSD symptoms (Schnurr et al., 2001). The most disruptive combat-related experiences of trauma include but are not limited to: being wounded, witnessing a comrade-in-arms being maimed or killed, feeling responsible for the deaths or maiming of comrades-in-arms, and feeling responsible for the deaths or maiming of “innocents.” Often these experiences lead a person to begin to question all he or she had thought that he or she understood about life, death, war, humanity, God and him- or herself.

It can be important for the chaplain working with the person with PTSD to remember that for that per-

son, there is a “new normal.” The service member, as well as that service member’s family, friends and work environment back home, have all changed and are no longer the same as they were pre-deployment. The disorientation the service member feels upon returning home often leads him or her to withdraw from the very relationships in his or her social support circles that would help provide the stability of structure, order and predictability he or she craves. Regardless of whether a service member has PTSD or not, nearly every returning service member has acute stress reactions and other re-integration issues. Working through these traumatic experiences with service members is similar in many ways to working with grief. As in grief work, things evolve in their own time, and time does and can indeed help heal (Navy Medicine, 2008).

It may also be important for the chaplain working with the person with PTSD to know that, for such persons, everything is paradoxically the same and different. Readjustment to domestic life takes more time than adjusting to deployment. Seeking to reintegrate leaves many feeling disconnected from their familiar environment. One believes he or she should feel comfortable, safe and content at home, but inexplicably does not. Things at home and at work have changed or evolved during the service member’s absence. For many coming home, this may be the first time they have had the opportunity to reflect upon what they have seen, done and experienced in the combat theater.

# CHAPTER II

## PTSD DIAGNOSTIC CRITERIA

The diagnosis of PTSD uses a set of criteria based on disruption of thought and function around key symptoms. It is important to recognize that people can have significant disruption of quality of life before they meet the minimum criteria for a confirmed diagnosis. The spiritual care strategies in this handbook can be used for trauma related suffering even before a confirmed diagnosis.

### CRITERION A: STRESSOR

The person has been exposed to a traumatic event in which both of the following have been present:

- The person has experienced, witnessed or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of the person or others.
- The person's response involved intense fear, helplessness, or horror. Note: In children, it may be expressed instead by disorganized or agitated behavior.

### CRITERION B: INTRUSIVE RECOLLECTION

The traumatic event is persistently re-experienced in at least one of the following ways:

- Recurrent and intrusive distressing recollections of the event, including: images, thoughts or perceptions. (Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.)
- Recurrent distressing dreams of the event. (Note: In children, there may be frightening dreams without recognizable content.)
- Acting or feeling as if the traumatic event were recurring, which includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, including those that occur upon awakening or while intoxicated. (Note: In children, trauma-specific reenactment may occur.)
- Intense psychological distress at exposure to internal or external cues that symbolize or resemble

an aspect of the traumatic event.

- Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

PTSD can be viewed as fear of the unpleasant memories of the traumatic event that repeatedly intrude into one's awareness. (American Psychiatric Association, 2000, p. 7).

- Can be thoughts, images or perceptions that may be unwelcome, uninvited, or painful
- Often bring out feelings of fear, vulnerability, helplessness, rage at the cause, disgust, guilt, shame, sadness and hollowness
- Often triggered by something directly or indirectly associated with the traumatic event (a firecracker being perceived as gunfire, etc.)
- Nightmares are common – either directly about the trauma or related disturbing symbolism
- Flashbacks when awake, feels like the person is experiencing the event in the present tense

### CRITERION C: AVOIDANT/NUMBING

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

- Efforts to avoid thoughts, feelings or conversations associated with the trauma
- Efforts to avoid activities, places or people that arouse recollections of the trauma
- Inability to recall an important aspect of the trauma
- Markedly diminished interest or participation in significant activities
- Feeling of detachment or estrangement from others
- Restricted affective range (e.g., unable to have loving feelings)
- Sense of foreshortened future (e.g., does not expect to have a career, marriage, children or a normal lifespan).

The person often will seek to withdraw and avoid

all potential traumatic reminders due to flashbacks or nightmares entailed in intrusive recollection. Many self-medicate through abuse of alcohol, narcotics or other illicit drugs; food, sex or work.

The majority of things that brought pleasure prior to the trauma (e.g. vacations, hobbies, etc.) are often abandoned in an attempt to suppress all feelings. Self-isolation begins to occur because no one may understand what the patient has experienced. The patient feels dirty, tainted, unforgivable, changed and views those with whom they have been in relationship (significant other/spouse, family, friends, social circles, church, God, military, the nation, humanity) as changed as well. This situation may crudely be described as a “psychic numbing” or “emotional anesthesia.”

Focusing intensely on the past trauma and present torture may lead one to feel disconnected from his or her future. This is referred to as “a sense of foreshortened future.”

#### CRITERION D: HYPER-AROUSAL

Persistent symptoms of increasing arousal not present before the trauma, indicated by at least two of the following:

- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating
- Hyper-vigilance
- Exaggerated startle response

Other symptoms include:

- Trouble with sleep (difficulty falling asleep or staying asleep)
- Irritability or angry outbursts leading to smashing objects, heated arguments, screaming, intense criticizing and impatience, which may in reaction, lead to shame, guilt and self-loathing
- Difficulty concentrating or remembering things
- Hyper-vigilance – being on guard at all times, always sitting with one’s back to a wall, extremely cautious, checking parked cars for bombs, etc. “Like revving at a much higher rate” (Oliver, J, personal communication, February 3, 2009).
- Feeling immensely vulnerable, fearful of many “ordinary” things, unable to feel calm in safe places
- Fear of repetition of the traumatic event
- Dreading disaster
- Rapid scanning, looking over one’s shoulder

- Keeping weapons
- Being overprotective / smothering loved ones
- Paranoia
- Exaggerated startle response

#### CRITERION E: DURATION

Duration of the disturbance (symptoms of B, C and D) is more than one month.

#### CRITERION F: FUNCTIONAL SIGNIFICANCE

The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

- Acute: If duration of symptoms is less than three months
- Chronic: If duration of symptoms is three months or more

With or without delay onset: Onset of symptoms at least six months after the stressor.

(American Psychiatric Association. 2000, p.4)

# CHAPTER III

## WHAT IS TRAUMATIC BRAIN INJURY?

**T**raumatic Brain Injury (TBI) is the result of an abrupt, violent blow to an individual's head, causing the brain to collide with the internal walls of the skull. This collision may bruise the brain, tear nerve fibers and cause bleeding. It can also lead to swelling of the brain, creating an increase in Intracranial Pressure (ICP – pressure in the fluid surrounding the brain) due to the brain swelling within the confined space of the skull. This condition may create long-term impairment. TBI may also be caused by external objects (a bullet, broken piece of skull bone, etc.) piercing the skull and entering the brain tissue itself. TBI's severity can vary greatly, depending upon which part of the brain has been affected, the nature of the actual injury (i.e., a closed-head trauma versus a foreign object entering the brain matter) and the extent of the damage. A mild traumatic brain injury may cause temporary confusion and headache, but a serious injury may be fatal.

### TBI SYMPTOMS:

Most people know very little about the scope of TBI and how traumatic it may be to the injured person and his or her family and friends. Unlike physical injuries that are visually obvious (a broken leg, a tear in skin, etc.), TBI may be difficult to “see,” and may be initially un- or misdiagnosed as the medical team focuses on saving the individual's life. Prior to medical advances in knowledge and technology enabling medical professionals to control breathing with respirators and decrease intracranial pressure, the death rate from traumatic brain injuries was considerably higher than it is today. However, even with progress in knowledge, technology and treatment, the effects of TBI on a person's life remain significant.

The effects of TBI may be profound and far-reaching. Individuals with severe injuries may be left in an unresponsive state for an indefinite amount of time. For many people with severe TBI, long-term inpatient

rehabilitation is often necessary to maximize function and independence. With mild TBI, the consequences to a person's existence may be life changing. Even a small change in brain function can dramatically impact one's family, job and social / community relations.

Immediate physical effects include bruising and swelling of the brain. Swelling, injured brain tissue creates a secondary delayed problem -a rise in Intracranial Pressure. As the injured tissue expands, it pushes against the internal skull with increasing force, creating the potential for additional damage.

TBI is classified into two categories: mild and severe. A brain injury is classified as mild if loss of consciousness and/or confusion and disorientation is less than thirty minutes. MRI and CAT scans may often appear normal; however, the person continues to have cognitive problems, such as headaches, difficulty thinking, memory problems, difficulty focusing and/or attention deficits, emotional lability and frustration. These injuries are commonly overlooked. Although this type of TBI is called "mild," its effect on the family and injured person may be devastating.

Severe TBI occurs when loss of consciousness is more than thirty minutes, and memory loss post-injury lasts more than 24-hours. The deficiencies range from impairment of higher-level cognitive functions to comatose states. Survivors may have limited functionality of their arms or legs, abnormal speech or language patterns, loss of thinking ability and/or affective problems. Range of injuries and degree of recovery are extremely variable.

### MILD TBI (mTBI):

A mild traumatic brain injury is a type of concussion, often resulting from a blow to the head (Yosick, Unclassified PowerPoint Presentation, 2007). This injury can be caused by a blast or explosion, motor-vehicle accident, fall, direct blow or any type of closed

head trauma. This wound does not create a visually obvious physical injury because the damage is within the person's head. One does not need to lose consciousness to have sustained a mild traumatic brain injury. If consciousness is lost, it diagnostically must be for less than thirty minutes. The person may initially appear dazed, confused and describe it as "having your bell rung."

Signs and symptoms of a mild traumatic brain injury (concussion) may include:

- A brief period of unconsciousness
- Amnesia for events immediately before and after the injury
- Headache
- Confusion
- Dizziness or loss of balance
- Sensory problems, such as blurred vision, ringing in ears or a bad taste in the mouth
- Mood changes
- Memory or concentration problems
- Nausea / vomiting
- Irritability

## MODERATE TO SEVERE TBI

If the injury is moderate to severe, the list of signs and symptoms includes the aforementioned under Mild Traumatic Brain Injury, and adds the following signs and symptoms:

- Persistent headache
- Repeated vomiting or nausea
- Convulsions or seizures
- Sleep paralysis
- Dilation of one or both pupils of the eyes
- Slurred speech
- Weakness or numbness in the extremities
- Loss of coordination
- Profound confusion
- Agitation, combativeness

## COPING & SOCIAL SUPPORT

Clinical depression may become a major obstacle for persons with TBI. One study reports that 36% of people who "only" had mTBI developed clinical depression within three months (Petchprapai & Winkelman, 2007). A study (Kalpakjian, et al. 2007) compared the spirituality of persons with TBI with

those with Spinal Cord Injuries, and determined that, "although both groups reported a greater self-awareness, sense of purpose, and thinking of themselves as mortal and finite, those with TBI were more likely to associate religious or mystical experience with their injuries." This positive association and relationship between one's injury and his or her spirituality may well be an appropriate Desired Contributing Outcome for chaplains working with those with TBI.

This same study (Kalpakjian, et al. 2007) discovered that what improved the Quality of Life (QOL) for those with TBI the most was integration into the community, the person's level of social support and having a positive attitude or affect. Notably, having a positive attitude or affect was highly associated with spirituality. A helpful Desired Contributing Outcome for a chaplain working with a person with TBI would consequently be to help positively foster the person's coping and attitude through helping them connect their spirituality with their injury and/or rehabilitation.

One final study analyzed the impact of social support on the recovery of the person with TBI and concluded that the more the person participated in his or her community, the less emotionally and psychologically impaired that person would ultimately be (Winstanley, et al. 2006). The degree of emotional distress a person with TBI experienced was associated far more with the degree of community reintegration the person with TBI had achieved; rather, than with the extent of their physical injury and impairment. Additionally, lower psychological distress results when the person with TBI re-acclimates into his or her pre-injury community. Re-acclimation is an appropriate Desired Contributing Outcome for a chaplain assisting the person with TBI. While assessing these categories with the person with TBI, it is important to know that special attention should be given to post-traumatic factors (e.g. social support and functional incapacity), that may be modified, addressed or assisted by the intervention of mental health professionals, and/or the chaplain. It is helpful to note that a history of exposure to childhood or adulthood violence increases the risk for chronic PTSD.

Social integration appears to be one of the most desired outcomes for persons with TBI. A 2006 study discovered that society and the public at large have a less favorable opinion of those with TBI, than for those without TBI (Linden & Crothers, 2006). As such, overcoming and/or coping with any form of

social stigma, isolation or self-isolation may well be a productive Desired Contributing Outcome for a chaplain working with the person with TBI.

Another study examined individual coping strategies for stress and how they changed following a Traumatic Brain Injury (Dawson, et al. 2006). For many, their coping strategies become maladaptive and worked against community reintegration, an important Desired Contributing Outcome for persons with TBI. A person with TBI may become extremely preoccupied emotionally with a task, person, issue, etc. This marked increase in emotional preoccupation often means the person with TBI struggles to achieve the same productivity he or she had pre-injury. TBI patients who become more emotionally preoccupied often cope with stress through distractive behaviors (avoid thinking about the injury or subsequent pain, become emotionally preoccupied with something else, etc.), and consequently fail to focus as needed on how to live with the pain or the revision of their self-understanding post-injury. The shift in focus from self-distraction to the beginnings of constructive coping is a useful Desired Contributing Outcome for a chaplain assisting the person with TBI.

Another relevant study (McColl, et al. 2000) discovered that those with TBI placed a significant emphasis on the importance of their families. As a result, the person with TBI is seemingly more aware of the need to trust because of his or her own cognitive or memory issues. Fostering the sense of trust and shift in self-expectation and understanding in the previously independent person, now in need of trust and co-dependence for assistance, is another helpful Desired Contributing Outcome for a chaplain working with the person with TBI.

The VA/DoD Guidelines (Dept. of VA/DoD, 2004) described various ways in which the facilitation of social and spiritual supports is imperative for the person with TBI. These include:

- Preserving an interpersonal safety zone protecting basic personal space
- Providing:
  - nonintrusive ordinary social contact
  - opportunities for grieving a loss
  - access to religious/spiritual resources when sought
  - direct spiritual care when sought

In developing a psychosocial assessment, the chap-

lain may assist mental health professionals through addressing the following:

- Past psychiatric illness, treatment or admission
- Past/ongoing problems with anxiety, impulsivity, mood changes, intense/unstable interpersonal relationships, suicidality, and hallucinations
- Recreational use of drugs, alcohol, tobacco or caffeine
- Social support: family, friends, homelessness/housing issues, community and financial status
- History of losses: bereavement, friend/family member injuries/death, occupation and moral injury/betrayal
- Occupational, educational or military history
- Legal issues
- Religious and/or spiritual history and/or autobiography

Specifically, the role of the chaplain may be crucial in helping the person with TBI make meaning following a trauma. Spiritual Care Interventions may include:

- Providing education and consultation to both the person with TBI and their immediate caregivers or social support
- Assisting mental health and rehabilitation professionals in the preparing action plans and forwarding recovery processes
- Encouraging and empowering facilitation of adaptation and mastery in the face of social change
- Assisting in identifying and developing networks of community support and assistance
- Supporting the development of a positive recovery organization
- Serving as a source of communication and processing for the person with TBI and their immediate social support, as they strive to make meaning following the injury.

Another study (McGrath. 2004) examined the constructiveness of helping the person with TBI (and the team caring for the person) shift his or her focus from restoration – seeking to regain the same level of independence, community involvement and/or “go back to how things were before the injury” – to a focus on the potential for transformation. Upon reaching the limits of the restorative programs, the person with TBI may need to begin developing a personal identity which takes into account the realities of his or her lost

function(s). This process is in contrast to seeking to re-establish life as it was pre-injury. Such forward-looking, hope-inspiring focus can move away from focusing purely on deficits and “abnormalities” and begin to construct a meaningful post-injury identity. The chaplain’s involvement as the person with TBI seeks to make meaning may be integral.

A potential risk factor for the person with TBI is to also develop Post-Traumatic Stress Disorder (PTSD) if he or she remembers the causative event of the traumatic brain injury (Gil, et al. 2005). Lacking memory of the event decreases the likelihood of PTSD developing. Therefore such acute amnesia may serve to protect the injured person. Assessing if a person remembers the traumatic event that spurred their TBI is possible as early as 24-hours after the trauma occurs. Additional factors determining whether a person with TBI may develop PTSD include a history of previous trauma, psychiatric co-morbidities and physical injury.

#### SOME TIPS FOR WORKING WITH PEOPLE WITH TBI:

It may be necessary for the chaplain to alter their usual interactive style when working with the person with TBI; including variations in interpersonal communication such as: slower articulation, writing important points, simpler words and more explicit nonverbal communication (Block, 1987). This interaction will not be the chaplain’s usual pastoral care visit. It will differ in that any movement or resolution by the person with TBI may transpire more slowly than what a chaplain may be familiar with. For the chaplain it requires intentionality and a large measure of patience to work deeply with the person with TBI.

It is important to note that the chaplain should focus on the use of concrete language, entailing the spare use of metaphors, abstractions or hypotheticals. Using words already used by the person with TBI may serve as a helpful, initial language boundary.

The person with TBI often focuses on certain thoughts and ideas nearly to obsession. He or she may continually repeat and/or reanalyze the object of their present focus, which in turn may result in a slower than usual interactive response with the chaplain. The person’s thoughts may take longer than usual. Indeed, for caregivers, it is tempting to complete the person’s thought(s) or word(s) under the well-intentioned as-

sumption that doing so will assist the person in communicating. In fact, such action may deny the opportunity for the person with TBI to complete his or her own thought(s) and word(s), and distance him or her from the chaplain in establishing a trusting relationship. It is best to be patient, calm the inner impulse to finish sentences, and allow the person with TBI to find their own thought(s) or word(s).

The person with TBI may be less aware of the social impact of their actions. They may seem abrupt or on edge. The chaplain must not personally internalize the attitude or behavior(s) of the person with TBI, nor should the chaplain assume such attitude and behavior(s) is in need of addressing and correcting. It may be helpful for the chaplain to inform those around the person with TBI that such attitude or behavior(s) are a result of the injury and not intentional. Remember to resist the urge to confront the person with TBI if they become antagonistic. Permit the person with TBI to find his or her own solution(s) to the tension experienced when he or she responds in ways, which in other relationships may be socially and/or interpersonally challenging. Such responses as, “you seem upset by that,” or “you disagree with me” may in the long-run be far more productive than responding in kind, or “meeting their challenge.”

When families of those with TBI are present in the recovery process, they are often very supportive and involved. The family may consistently encourage and cheerlead, which may unintentionally create pressure for the person with TBI. The family will say things such as “it is going to be OK,” or “you are going to be just fine.” Such well-intentioned affirmations may starkly contrast with the sentiments of the person with TBI in regards to his or her injury and potential for recovery. The progress through trial, error and daily struggles that the person with TBI confronts may well be stymied by family members who are too physically present and well-intentioned. It is natural and understandable for many family members to be consistently upbeat, optimistic, and proactive; and yearn to help the person with TBI in some tangibly visible way. The chaplain may help mitigate this potentially regressive dynamic through informally educating and facilitating conversation with not only the person with TBI, but also his or her family and friends.

In comparison to the healing of broken bones or various common surgeries, a brain injury can be excruciatingly slow to heal. To ascertain the ultimate

functioning level is difficult. In such circumstances, families and the person with TBI, alike, need consistent, compassionate truth about their current situation and prognosis. The chaplain may be helpful by serving as a liaison between the person with TBI and his or her family, and the medical and mental health professional team. The chaplain is uniquely positioned to understand much of what is occurring clinically, as well as having a working knowledge of the thoughts and feelings of the person with TBI and his or her family regarding recovery, injury and process.

The Aphasia Institute in Toronto put together a valuable resource, entitled, "Talking to Your Counselor or Chaplain", available at: <http://www.aphasia.ca/training/index.html#res>. As part of an interactive series of publications, this booklet is a pictographic resource designed to facilitate conversation between counselors or chaplains, and persons with aphasia. It is based on

the techniques of Supported Conversation for Adults with Aphasia (SCAT), developed by the Aphasia Institute. Chapters include:

- Getting Started
- I Want to Talk About
- Problems: What's Wrong, Feelings
- Spirituality
- Health and Illness
- Relationships and Issues
- People
- Settings
- Time

Additionally, a recent article by a recovered person previously aphasic describes her experience and the kind of care she found helpful (Leighty & Heinzekehr, 2008).



# SECTION II: OVERARCHING PRINCIPLES

# CHAPTER I

## DEFINITIONS

For the purpose of this project, the following definitions are being offered:

Compassion Fatigue:

*“A state experienced by those helping people in distress; it is an extreme state of tension and preoccupation with the suffering of those being helped to the degree that it is traumatizing for the helper. The helper, in contrast to the person(s) being helped, is traumatized or suffers through the helper's own efforts to empathize and be compassionate. Often, this leads to poor self-care and extreme self-sacrifice in the process of helping. A summation is compassion fatigue and symptoms similar to post-traumatic stress disorder (PTSD).”* (<http://dying.about.com>, Retrieved April 12, 2009)

Further complicating the situation is if past traumas and/or struggles of the chaplain begin to interfere with his or her Ministry of Presence. Such solipsism on the part of the chaplain may impede the person with PTSD from sharing his or her pain and narrative of traumatic experience. How to help prevent and/or prophylactically manage this is explicated in the section on the need for self-care

COPING:

*“Encompassing cognitive, behavioral, psychological, emotional, and spiritual or religious strategies to resolve or alter the stressful situation (problem-focused coping), and to manage distressing emotions aroused by the stressor (emotion-focused coping) or spiritual impact of the stressor or trauma (spirituality-focused coping)”* (Hyer., et al. 1996).

Most coping strategies do one of two things; they either seek to approach or engage the trauma, or avoid or disengage from the trauma. One important distinction is that coping can be context-specific. It can be beneficial as a form of psycho-education to talk with the person with PTSD about the difference between coping skills in a war zone / combat theater, versus coping skills in civilian life (Various Authors, 2007).

COUNTERTRANSFERENCE:

*“A psychotherapist's own repressed feelings in reaction to the emotions, experiences, or problems of a person undergoing treatment.”*

It is not unusual for the chaplain to experience feelings of wanting to rescue or be the hero in the eventual narrative of the person with PTSD's recovery. Stories from the person with PTSD may trigger various emotions for the chaplain. Sometimes compassion for the individual fosters the chaplain's need to be needed. It is imperative for the chaplain to secure a safe environment where he or she may process his or her own experience of working with those with PTSD. This will help mitigate and protect both the person with PTSD and the chaplain from such dangers as countertransference and Compassion Fatigue (The Free Dictionary, Retrieved April 12, 2009).

CURE VERSUS HEAL:

CURE:

*“To remedy, correct, fix, remove, restore to health.”*

Heal:

*To become whole”* (From the same Greek word (hagios or hagnos) as “holy”).

*“In curing, we are trying to get somewhere, we are looking for answers. In curing, our efforts are specifically designed to make something happen. In healing, we live questions instead of answers. We hang out in the unknown. We trust the emergence of whatever will be. We trust the insight will come. The challenge in medicine is not the choice between one and the other. We need both. The lesson I learned is never to be afraid to take people into the heart of their pain, because at the heart of their pain is the healing, and at the heart of the healing is the pain and the joy”* (Epstein, 2007).

## DESIRED CLINICAL OUTCOME

*"The hoped for and anticipated result of a spiritual care intervention, this is about the effect of the spiritual care intervention – what impact did it have on the person?"*

The Desired Clinical Outcome should be sensory-based, communicable, and shared. Sensory-based means that it can be "expressed to others and recognized when it happens in terms of what we see, hear and feel." The Desired Clinical Outcome is also communicable, meaning that it can be briefly and clearly described to other members of the mental health team in terms "that have meaning for their perception of how this outcome fits within the over-all interdisciplinary care plan and objectives." And the Desired Clinical Outcome is shared, meaning the goal or objective of one's pastoral caregiving is communicated directly to the person who is receiving the care, and that this person "buys in." This is not necessarily a formal pastoral counseling contract, but rather it allows the person receiving care to take a sense of ownership in the potential positive outcome of the Spiritual Care Interventions. (VandeCreek & Lucas, 2001)

## INTENTIONAL MINISTRY OF PRESENCE

*"A form of servanthood characterized by suffering, alongside of and with the hurt and oppressed. Ministry of presence in the pastoral office means vulnerability to and participation in the life-world of those served." (Hunter, R. 1990)*

## MISSION:

*"A specific task with which a person is charged, a pre-established and often self-imposed objective or purpose"*

The word "mission" can be re-appropriated from the military setting to the spiritual, theological or even psychological setting. The mission can be one of healing and reintegration into civilian life with family, friends and work following the traumatic experience (Various Authors, 2007).

## MORAL DISTRESS:

*"The painful psychological disequilibrium that results from recognizing the ethically appropriate action, yet not taking it, because of such obstacles as lack of time, supervisory reluctance, an inhibiting power structure, institution policy, or chain of command considerations"(Corley, et al., 2001)*

As discussed in detail below in the section of Spiritual Care Interventions on Guilt & Forgiveness, many service members have intensely conflicting emotions about actions they have committed in the military. Such emotions may have direct spiritual connections for them.

## MORAL INJURY:

The behavioral, cognitive, and emotional aftermath of unreconciled severe moral conflict, withdrawal, and self-condemnation closely mirrors the reexperiencing, avoidance, and emotional numbing symptoms of PTSD. Unlike life-threat trauma, moral injury may also include: self-harming behaviors, such as poor self-care, alcohol and drug abuse, severe recklessness, and parasuicidal behavior, 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, Stein, Delaney, et al. 2009).

## SPIRITUALITY:

*"A person's pursuit to connect to something or someone beyond him- or herself as a means of making meaning or significance" (Kimball, 2008), (McColl, et al. 2007), (Drescher, et al. 2007).*

This meaning or significance can be found in relationship with self, others, ideas, nature, higher power, art or music. These relationships are prioritized by the person seeking meaning (Navy Medicine). Spirituality in general has been demonstrated to have a direct positive effect on post-traumatic growth (Cadell, et al., 2003).

## SPIRITUAL CARE INTERVENTION

This encourages and values personal exploration

of spiritual issues, symbolic language, socialization issues, suffering issues, healing issues, death/dying, grief/loss, God/church, guilt/forgiveness, life values, and prayer support. (accessed from the website: <http://www.cancercenter.com/oral-cancer/spiritual-support.cfm> on 12/9/09.)

## SPIRITUAL CONCERNS, SPIRITUAL DISTRESS AND SPIRITUAL DESPAIR

The following three definitions are essentially the same process, differing only in degree. They can be viewed as a continuum of intensity or severity of spiritual disequilibrium.

### SPIRITUAL CONCERNS:

*“The potential disruption of one’s beliefs, assumptions, or values that occurs when one’s valued relationship with one’s self, others, ideas, nature, higher power, art, or music is threatened or challenged.”*

Spiritual concerns are the least threatening type of spiritual disequilibrium. They may occur from a challenge or dissonance about one’s beliefs, but do not shake a person’s beliefs to their core.

### SPIRITUAL DISTRESS:

*“The disruption of one’s beliefs, assumptions, or values that occurs when one’s valued relationship with one’s self, others, ideas, nature, higher power, art, or music is threatened or broken.”*

The more meaningful the relationship a person has with how he or she was making meaning, the higher the level of spiritual distress. Critical mass is reached when the spiritual distress becomes almost intolerable, leading to Spiritual Despair.

### SPIRITUAL DESPAIR:

*“The dissolution and/or disintegration of one’s source of meaning and hope, leading to one’s feeling little to no hope of resolution.”*

This is a crisis of faith and must be addressed. This is essentially a more intense, longer-lasting and more debilitating form of Spiritual Distress. This often shat-

ters one’s relationship with God and/or other spiritual resources and connections, and any accompanying source of making meaning is rendered helpless and/or useless (Webb, 2004).

The following are helpful in seeking to determine if a person is in spiritual distress, or closer to spiritual despair.

Questions that may indicate either Spiritual Distress or Spiritual Despair, depending on the context:

- How could God let this awful thing happen?
- I’m so angry with God!
- Why does God not hear my prayers?
- O my God, where are you?
- Why do you stand so far off, O Lord?
- Why, Lord, do you hide yourself from me in times of trouble?

Some kinds of spiritual stress symptoms that may characterize a person in a crisis of faith (spiritual despair):

- Sense of being abandoned by God (a sense of disruption in relationship)
- Difficulty in praying (a sense of breakdown in communication and connectedness)
- No yearning for righteousness (a sense of confusion with respect to one’s purpose in life)
- No spirit of thankfulness (a sense of loss of joy and purpose for living)
- No sense of hope (a sense of isolation and despairing helplessness).
- A sense of being lost and uncertain due to feeling as if God has abandoned them
- A lack of desire to seek intimacy with God through prayer
- A sense of apathy regarding pursuing a righteous life
- A loss of sense of thankfulness and hope
- A lack of comfort and support from reading and meditation on Scripture
- A sense of apathy to continue relationships with fellow faith members

## SPIRITUAL COMMUNITY

For the purpose of this document, Spiritual Community will be defined as any group of people with whom the service member participates who are able to assist the service member in finding meaning. This often includes a faith community (church, synagogue, mosque, etc.) but can also include, but is not limited

to, such organizations as Alcoholics' Anonymous and other 12-step programs, fellow service members who meet regularly in an attempt to discuss and/or find meaning in their common war-related experience, or close friends or family who actively seek to assist the service member in making meaning of his or her experience.

#### TRANSFERENCE:

*“In psychoanalysis, the process by which emotions and desires originally associated with one person, such as a parent or sibling, are unconsciously shifted to another person, especially to the analyst.”*

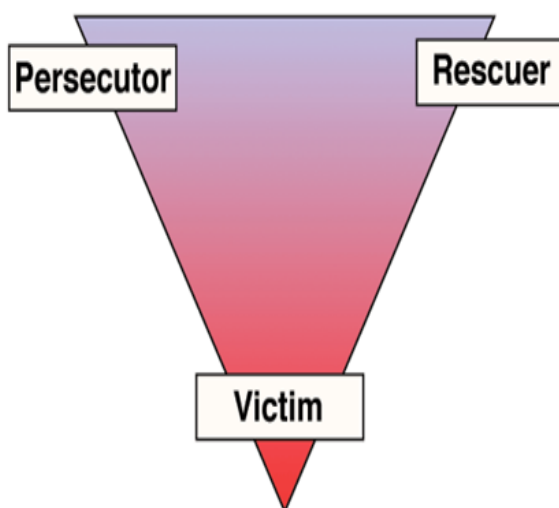
The chaplain must be cognizant of the potential entanglements of transference. As a result of the trauma, the person with PTSD will have a warped relationship with authority. Inevitably, the fallout of this deformed relationship will be “aimed” at the chaplain. In the mind of the person with PTSD, the chaplain may emotionally assume as proxy, the role of God, the military, the government, parent(s), etc. The person with PTSD may idealize the chaplain, casting the chaplain as a potential rescuer or magical hero. This is a fantasy the chaplain may be tempted, consciously or unconsciously, to reinforce (Herman, 1992).

Ultimately all chaplains will fail to fulfill the unrealistic expectations of the person with PTSD. When this “failure” occurs, the person with PTSD may react with anger and feel betrayal. He or she may even castigate the chaplain to the same level as the perpetrator(s) of the trauma. Indeed, “many traumatized people feel

similar rage at the caregivers who try to help them and harbor similar fantasies of revenge. In these fantasies, they wish to reduce the disappointing, envied therapist to the same unbearable condition of terror, helplessness, and shame that they themselves have suffered.” (Herman, 1992, p. 138).

The two primary ways the self-perceived victim relates to others are either as a Rescuer or Persecutor. If the chaplain fails to “rescue” the self-perceived victim, the victim will often react angrily and consider the chaplain a Persecutor. This inversion paradoxically leads the self-perceived victim to act as a Persecutor through the subsequent victimization of the chaplain. Ultimately the issue is power and the use of it. The chaplain must be aware of the potential negative entanglements of tumbling into the dynamic of the Victim Triangle with a person with PTSD (Forrest, L., Retrieved April 12, 2009).

Specific to service members, it can be a common and expected experience for theodicy to be superimposed on this Victim Triangle. Theodicy is defined as “defense of God's goodness and omnipotence in view of the existence of evil.” (<http://www.merriam-webster.com/dictionary-> accessed December 10, 2009) In this context, a person who has experienced the intensity of war may well view God as the Persecutor, and him- or herself as the Victim. As such, the Spiritual Care provider can be cast in the role of Rescuer by the service member, somehow trying to defend God against accusation of unfairness or injustice. This dynamic can become a trap for many Spiritual Care Providers. It is not advisable to seek to defend God against the perceived attacks by the service member. Instead, assisting this individual in articulating his or her struggle of “how could God allow this to happen?” can begin the therapeutic process. At stake are a fundamental worldview about God's character, how God works in the world, and often the basic assumption that God rewards people who are good and holy and punishes those who are bad and evil. Any attempt by the Spiritual Care Provider to defend God against accusations of unfairness, or defend the service person from the self-understanding that he or she somehow deserves the intense experience that is challenging them, can unintentionally reinforce some unhealthy spiritual and religious beliefs. Instead, through an Intentional Ministry of Presence, a Spiritual Care Provider can assist the person in articulating their genuine feelings, and begin to explore those directly.



# CHAPTER II

## INTEGRATE AND COLLABORATE WITH THE MENTAL HEALTH TEAM

The medical diagnosis of PTSD involves neurochemical and physiological changes in a person. It is a war wound (Navy Medicine). As such, diagnosis may only be made by a mental health professional (psychiatrist, psychologist, nurse, etc.), but never by a chaplain. Many spiritual issues may be intertwined with the person's condition; however, his or her diagnosis of PTSD is never exclusively a "spiritual issue." While PTSD has some deeply spiritual components, it still remains a neurological and physiological wound, and cannot be perceived, nor handled, as exclusively spiritual. Ideally the chaplain's role is complementary to the various roles in the mental health team. Just as the chaplain would not diagnose and treat a person with internal bleeding from battle, so too, the chaplain must not seek to diagnose or treat the person with PTSD.

A chaplain interviewed for this project adamantly urged chaplains to never "label" a person as having PTSD, even if PTSD is the known clinical diagnosis. To do so may lead to a fracturing of the fledgling trust between the person with PTSD and the chaplain, complicating the already complicated considerably. Additionally, the term "disorder" may imply a defect. PTSD is more an injury than a disorder. It is also recommended for chaplains to use the lexicon of PTSD, only if the person with PTSD does, and even then, do so sparingly (Oliver, J, personal communication, February 3, 2009),

The chaplain must learn when and how to "stay in their lane" while working with the mental health professionals. Knowing the chaplain's role is important and so knows what other professionals' roles are, so one can stay on task while letting others make their particular contributions (Hokana, S, personal communication, January 23, 2009).

Potential problems for the chaplain counseling the

person with PTSD includes differentiating clinical signs / symptoms, as follows:

- Major Depression vs. Grief Reaction
- Brief Psychotic Reaction vs. Intrusive Ideation
- Brief Psychotic Reaction vs. Dissociation
- Dissociation vs. Intrusive Ideation
- State Dependent Learning Sequela vs. Personality Disorder(s)
- Acute Transitory Cognitive Impairment vs. Severe Incapacitation

Other major issues can include:

- Failure to detect suicidal or homicidal cues.
- Lack of familiarity with the guidelines for psychological triage and referral. Failure to refer to mental health services when indicated.

The chaplain working with the person with PTSD ought to do everything in his or her power to be integrated into the mental health team. The more integrated a chaplain is with the team, the more effective the entire team becomes. Chaplains do provide a unique and potentially integral role in the healing of the person with PTSD. To maximize this positive impact, the chaplain should be involved in multiple levels of care – including initial spiritual assessments, interdisciplinary team meetings regarding patient / family situations, facilitation or co-facilitation of support groups or 12-step recovery groups, etc. The chaplain may be especially supportive by intentionally seeking involvement in outpatient PTSD treatments.

The more aware the chaplain is of how PTSD is treated by the mental health team, the better the chaplain and mental health team can work together towards the common goal of healing the person with PTSD (Peterson, H, personal communication, January 28, 2009). If the chaplain is aware the person with PTSD

is receiving Cognitive Behavioral Therapy (CBT) through a psychologist, and understands a number of the potential logistical and emotional implications of such a therapeutic modality, the chaplain will have a greater ability to walk along side the patient, providing support as the patient processes the impact CBT therapy will have on his or her life. Chaplains must understand what conventional PTSD treatment entails, such as the kind of skills utilized by mental health professionals. The chaplain may then decide which complementary Spiritual Care Interventions to have in his or her own arsenal, so the care is fully integrated. For example, mental health professionals use relaxation techniques when working with individuals with symptoms relating to hyper-arousal. Most spiritual traditions support various ways of encouraging relaxation – from meditation to breathe prayer or centeredness (Drescher, K, personal communication, February 11, 2009). The chaplain may complement what is being done by mental health professionals without being an alternative to their interventions.

In 2002 a study concluded that as many as 80% of those with PTSD meet the criteria for at least one other psychiatric diagnosis (Rogers & Koenig, 2002). What a chaplain brings to the table for those with PTSD is unique and necessary. The mental health team examines PTSD purely through the lens of the DSM-IV-TR, and like any lens, it focuses only on select facets (Fortunato, J, personal communication, January 14, 2009). Take for example, a 19 year-old service member whom has attended church his entire life and recently returned from war. His existential questions are enormous. Who am I now that I have killed 26 people? How do I define myself now? I used to think of myself as a gentle father and husband. How do I now incorporate this into who I am? What meaning does life have? It can be cheap. The service member may say, I used to think I had the answer to what happens when I die, but after what I saw. . . . I don't believe in the God that I was taught to believe. Most psychiatrists would interact with this service member and diagnose him or her as having a form of depression, and subsequently prescribe an antidepressant, such as the commonly prescribed Selective Serotonin Reuptake Inhibitors. In contrast to such a psychopharmacological intervention, the chaplain may help the young man work on the burdensome, existential questions. By doing so, the chaplain assists the young service member in balancing the shifting

tectonic plates that make him who he is. The chaplain has a unique and integral role in this situation. The chaplain offers the service member a place where he can bring up these ultimate questions.

One tip for collaborating well with the mental health team is to respect confidentiality and ask permission from the person with PTSD before sharing something with the mental health team. This may ensure that trust is not jeopardized. Everything shared with a chaplain may be viewed as strictly confidential, and a chaplain must use extreme discretion in determining whether to, when and how, to break that confidentiality (Hokana, S, personal communication, January 23, 2009).

It is also extremely important that the chaplain is well-versed in suicide prevention. Approximately 22,000 veterans called the Veteran Associations PTSD suicide prevention hotline within the first 12 months of operation, preventing 1,221 suicides. The number is 1-800-271-TALK (8225), and a veteran should press "1" after being connected. The marketing slogan for the hotline is that "it takes the courage and strength of a warrior to ask for help." In January, 2009, for the first time, Army suicides outnumbered those killed in combat during that same month (Alvarez, L. New York Times, February 6, 2009). This is the fourth straight year suicides have increased. A chaplain must discuss with mental health professionals ways in which to help those who may be actively suicidal. It is imperative to recognize the symptoms, and to have a plan in place to know what to do including whether to and how to refer.

In working with the person with PTSD, it is essential that a chaplain know where the person is in regards to his or her recovery. The chaplain may have the perfect Spiritual Care Intervention for the person, but its efficacy will depend in large part on timing. It is possible to have the right Spiritual Care Intervention and use it at the wrong time. For example, a person who has yet to develop trust with the chaplain will be unable to share his or her experience of trauma in-depth.

# CHAPTER III

## HERMAN'S STAGES OF RECOVERY

Judith Herman's groundbreaking 1992 book, *Trauma and Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror*, is helpful in explicating the three distinct stages that the majority of people who have experienced trauma undergo. What helps heal and is productive in one stage may not do the same in another. Like many descriptions of psychological stages, the stages should be seen as descriptive and not prescriptive. The person with PTSD may go back and forth from one stage to another in seeking to make sense of his or her traumatic experience. Therefore, Herman's stages should not be taken literally or prescriptively.

But most people who have experienced trauma pass through these three distinct stages at some point. The first stage is primarily about safety – the need to develop trust at one's own pace. The second is remembrance and mourning – the need to rediscover one's own narrative of the traumatic experience and begin to grieve the impact it has had on the person's life. The third and final stage is reconnection – this is focused primarily on bridging the person back into his or her most meaningful relationships, such as a significant other, a group of friends and/or a faith community. Overall, "it should be possible to recognize a gradual shift from unpredictable danger to reliable safety, from dissociated trauma to acknowledge memory, and from stigmatized isolation to restored social connections" (Herman, 1992, p. 155)

### STAGE ONE – SAFETY:

The vast majority of people with PTSD struggle with feeling safe. In response, a chaplain must continuously focus on being consistent, fully present, open and patient with the person with PTSD. The more the chaplain embodies these attributes, the more likely the person will begin to develop a sense of safety in the chaplain's presence. This safety is quite simply a prerequisite if a person is to begin to open up and let a chaplain into his or her pain and suffering (Jackson, V., personal communication, February 17, 2009).

The central task of the first stage is safety, and a

long-term Desired Contributing Outcome should be to increase the person's feelings of safety. The traumatic experience fundamentally takes away a person's feelings of power and control. Healthy recovery leads to the restoration of power and control in the life of the person with PTSD. This is not merely about ensuring the person that no bullets or IEDs will physically threaten the person again. It is about the person feeling unsafe in his or her own body. His or her emotions and thoughts are out of control, often leading to feelings of no control and safety around other people. The chaplain must be able to intentionally work toward the central theme of safety in all of areas of the person's life (Herman, 1992).

There are various categories within which the person feels threatened or unsafe. Neuro-chemical components are often addressed physically, such as with medications to reduce hyper-arousal and reactivity, as well as behavioral interventions, such as relaxation exercises and intense exercise aimed at reducing stress. The mental aspects of PTSD are addressed through cognitive and behavioral interventions. This includes psycho-education (recognizing and naming symptoms), daily logs recounting both symptoms and responses, different behavioral homework assigned by mental health professionals and articulating and agreeing to a specific safety plan (Herman, 1992). The social impact of PTSD is addressed through social interventions. These intervention may focus on mobilizing and encouraging (and even educating) the person's natural support system – family, friends, significant others, etc. These interventions may include the use of self-help organizations or groups such as 12-step groups, as well as mental health professionals and social welfare (Herman, 1992).

The chaplain's interactions should seek to assist the establishment and maintenance of safety, beginning with the person's sense of control over his or her own body. These include, but are not limited to: a focus on one's basic health needs, regulating one's body functions like sleep, exercise, eating and drinking; the management and coping with the three PTSD symptom clusters of intrusive recollection, hypervigilance



and avoidance/detachment; and ultimately control over one's self-destructive and/or unhealthy behaviors. Establishing and maintaining control should move outward to one's environment. This includes, but is not limited to: finding and maintaining a safe living situation, ability to function socially and in public, and a safe plan for living one's daily life.

This stage is where the Spiritual Care Intervention of the Intentional Ministry of Presence is so essential for a chaplain (Tyrrell, G., personal communication, January 7, 2009). This presence takes time and an intentional investment by the chaplain, to build a bridge of relationship to the person with PTSD (Navy Medicine). A chaplain must be able to go slowly, resist the urge to move toward a deeper level or more personal interaction, and allow the person with PTSD to begin to develop some trust and a sense of safety. The chaplain, in doing this, should focus on the present, and on being present with the person in the present. This stance can ground a person enough to allow for safety and trust to develop. One tip from Chaplains Taylor and Wilson was to not bring any paper into group meetings or one-on-one visits, as this can be viewed as something untrustworthy. (Taylor, J. & Wilson, B, personal communication, February 9, 2009) Without safety and trust, and the rapport that is rooted within it, a chaplain will not be able to help a person work on healing.

For most with PTSD, their sense of what it means to be human has been shattered by their experience of trauma, along with many other assumptions about life, the world, God and humanity (Organ, J., personal communication, January 12, 2009). The person with PTSD often begins to question what it means to be human, for humans cannot be trusted in light of the traumatic experience. Humans are not noble or upright. Many with PTSD no longer feel that the world is safe or that they are safe – these feelings of safety and security feel shattered forever by their traumatic experience (Paquette, M., personal communication, January 22, 2009). The person with PTSD may believe that he or she was unable to be as noble or upright as he or she would have desired in the given situation. As a result, the person with PTSD feels guilt and shame. Faith in a God who did not respond is questioned deeply.

The person with PTSD must believe the chaplain respects his or her faith beliefs and idiosyncratic spirituality in order to feel safe and trusting (Drescher, et

al., 2007). This issue is discussed in more depth below in the section on being a nonjudgmental presence.

#### PACING:

*“To counter the compelling fantasy of a fast, cathartic cure, the therapist may compare the recovery process to running a marathon. Survivors immediately grasp the complexities of this image. They recognize that recovery, like a marathon, is a test of endurance, requiring long preparation and repetitive practice. The metaphor of a marathon captures the strong behavioral focus on conditioning the body, as well as the psychological dimensions of determination and courage. While the image may lack a strong social dimension, it captures the survivor's initial feeling of isolation. It also offers an image of the therapist's role as a trainer and coach. While the therapist's technical expertise, judgment, and moral support are vital to the enterprise, in the end it is the survivor who determines her recovery through her own actions”* (Herman, 1992, p. 174).

Thus safety and trust are also developed by the chaplain intentionally by not being the one to make moves to go deeper. These moves must originate with the person with PTSD, and be invited, both explicitly and implicitly, by the chaplain. The choice of when to go deep, how deep to go, and most of the major “moves” that occur in spending time with the person with PTSD must come from that person, not the chaplain (Navy Medicine). The chaplain plays the role of a witness, sometimes a guide, an ally and supportive presence, but the work to be done must originate and be driven by the person with PTSD (Ridley, P, personal communication, February 10, 2009). This process can be as much about pacing and timing as it is about trust and safety.

The chaplain's role is supportive, holding the hand of the person with PTSD on his or her journey. To push the cathartic moment too quickly is problematic and can result in a greater emotional distance between the person with PTSD and the chaplain. It is common and may be expected that the person with PTSD will adopt what seems to be either a flippant or irreverent attitude about the trauma he or she has experienced. Sometimes this manifests as a detached overly rational description of what happened. An inexperienced chaplain may view this as a lack of concern or the person

being callous or even monstrous, but it is important to allow the person the freedom to use the defenses he or she has developed when he or she feels the need to (Miller, 2004).

Patience is fundamental in all of these experiences. It is important not to get too excited by a good “session” with a person, or too down about a difficult one. Pushing too soon for a more in-depth discussion without an appropriate level of trust and rapport having been developed can trigger an explosion of intrusive symptoms of PTSD. The intervention may be the “right” technique or Spiritual Care Intervention, but if done at the wrong time in the person’s journey, it may result in damage, rather than healing.

Preparation for what may come, and knowing what to do when it does, is yet another way the chaplain may help foster safety and trust within his or her relationship with the person with PTSD. These coming events may include, but are not be limited to, flashbacks; stories of appalling or distressing actions, thoughts, or feelings (both described in the context of combat and since then); outbursts of anger or rage; intense emotional displays; lack of appropriate affect (such as laughing or talking about killing someone, or crying over something that appears insignificant, or showing no emotion at all in describing a very emotionally-taxing experience); and, direct challenges by the person with PTSD.

#### DO NOT SEEK TO FIX:

It may be a struggle for the chaplain to stay with a person in the midst of his or her darkness. Most people feel the impulse to bring in some hope or light. For the chaplain working with the person with PTSD, it may be important to simply stay with the person in his or her hopelessness and darkness – being a container for it than a judge or rescuer (Organ, J., personal communication, January 12, 2009). It may be challenging for many chaplains to resist the urge to “fix” someone, let alone be the bearer of hope. The key is to focus on the present and on the Spiritual Care Intervention of an Intentional Ministry of Presence – truly listening closely without thoughts of how you are going to fix the person with PTSD or what you will say to help them. It is pivotal to “just” listen compassionately, without trying to judge or solve anything (Peterson, H., personal communication, January 28, 2009). The chaplain in doing this permits the person to reach within his or her

own inner spiritual resources to find healing.

Ultimately, walking alongside someone in the midst of his or her suffering is a powerful and healing Spiritual Care Intervention in and of itself (Oliver, J., personal communication, February 3, 2009).. Those with PTSD do not need fixing. Instead, they need unfiltered presence, affirmation and encouragement to begin the long journey of healing from loss. Here the chaplain may be instrumental in helping the person with PTSD focus not only on his or her traumatic experience; but, as aforementioned, the person’s strengths and insight (Various Authors, 2007). This Intentional Ministry of Presence can be the time when fewer words may be spoken, and the time that is holy and potentially healing. (Rogers & Koenig, 2002)

An Intentional Ministry of Presence goes beyond being physically present. It calls for the chaplain to actively listen. The chaplain working with persons with PTSD should listen much more than he or she talks (Ridley, personal communication, February 10, 2009). This kind of listening requires an extra measure of patience. It is important not to interrupt the person sharing his or her story, waiting even during pauses while he or she is speaking. The chaplain cannot understand the person until the person has been heard, and the person cannot feel understood until he or she feels heard (Navy Medicine). Many traditional post-traumatic emotional and psychological interventions have focused almost exclusively on verbal expressions of grief and mourning, perhaps to a fault. Consequently the chaplain should be attuned to finding supplemental non-verbal channels/avenues of communication (Chan, et al., 2006).

The person with PTSD may be encouraged through invitations to continue his or her narrative, such as “this means a lot to you . . . tell me more about that.” If the chaplain has an important question regarding the narrative, even if it has reached the conclusion, it may still be wise to ask permission – “Do you mind if I ask you a question?” This allows the person with PTSD to remain in “the driver’s seat,” setting both the pace and the intensity of the interaction to what level of trust, safety and comfort he or she needs (Hokana, S., personal communication, January 23, 2009).

The chaplain should focus on inviting the person with PTSD into a healthy, balanced and potentially healing relationship. The trauma the person with PTSD experienced has led to a loss of feelings of empowerment and social-connection. Therefore, healing

should focus on empowering the person with PTSD, and creating healthy connections while encouraging reconnection to healthy pre-existing relationships (Herman, 1992).

#### CONFIDENTIALITY:

The chaplain is the only professional in the entire field of “helping professionals” without a mandate to report through a chain of command. Though not legally required to report potential suicidal ideation or homicidal intent, the chaplain should refer a patient to mental health services and assume that they will receive appropriate follow-up for either circumstance. The chaplain must be aware of the aforesaid VA suicide hotline and other additional resources in the chaplain’s respective institution.

#### STAGE TWO - REMEMBRANCE AND MOURNING:

##### REMEMBRANCE:

Once the first stage of safety has been accomplished, the task changes to working on remembrance and mourning. This task involves the person telling the entire narrative of his or her traumatic experience, in-depth and in detail. Working through the telling and reconstructing of the traumatic experience transforms the memory itself, and ultimately integrates it into the narrative and life of the person sharing.

Mental health professionals are likely the initial facilitators of the retelling. The chaplain’s role and involvement may be central and/or complementary. The chaplain may focus more on the impact of the process on the person with PTSD, than on the process itself. The process of repetitive telling of the narrative is a form of Cognitive Behavioral Therapy (CBT) called Exposure Therapy. It should not be facilitated independently by the chaplain without training and/or coordination with mental health professionals. The chaplain must maintain consistent conversation with the appropriate mental health professionals throughout the treatment of the person with PTSD. This is to ensure all professionals are on the same page, remain in their respective roles, and work openly in concert for the best interest of the person with PTSD. To assume the chaplain is solely responsible for helping the per-

son with PTSD reconstruct his or her narrative would be a mistake, just as it would be a mistake to assume that the chaplain is not involved because involvement is somehow the exclusive domain of mental health professionals.

The first telling of the story will likely seem very detached and emotionless – a kind of “just the facts” recounting. The story does not evolve in time and likely includes little if any of the person’s emotions, reactions or thoughts concerning the traumatic event. Metaphorically, the story is a succession of snapshots beaded aside one another on a string. To “go deeper” and begin to confront these powerful memories of a traumatic event rests with the person with PTSD sharing his or her narrative. The chaplain’s role is witness, presence and ally; a safe container where the person may speak the unspeakable.

Throughout the retelling stage, the chaplain, and the person with PTSD, must strive to balance between the impulse to avoid and the impulse to recklessly rush in head first. Healing can plateau and stagnate if the person with PTSD avoids the power of the narrative too much. Recklessly rushing into the retelling may be counterproductive and lead to reliving the trauma in much the same way as a flashback or intrusive recollection. The more the chaplain assists the person to make well-paced decisions, consistently asks questions and brings attention to this part of the process, the better the potential outcome.

The first section of retelling a traumatic event includes the narrative of life well before the traumatic event, and the proximate events prior to the traumatic event. Here the chaplain may learn of prior trauma, loss or struggles the person with PTSD may have endured, which may reveal past means of coping and if such means were positive and healthy or not. The person with PTSD should be encouraged to include important relationships, dreams, aspirations, ideals, a spiritual journey (consistent with the Spiritual Autobiography Spiritual Care Intervention delineated below), struggles and conflicts. The chaplain should be tuned in and listening for repeated phrases; self-talk; the assumptions imbedded in the story about God, the person him- or herself, the world or the military; and all of the “should” and “would” haves. These issues may be at the root of some of the cognitive errors, spiritual distress and/or despair and the existential crisis of meaning that the person is now facing as a result of the trauma shattering prior assumptions.

The next step is to begin to tell the narrative of the traumatic event. This often can, and should, begin as a newspaper story – with just the facts. Slowly, from the broken imagery and memories, the chaplain and/or mental health professional and the person with PTSD construct a thorough, in-depth, temporally and contextually appropriate account of the event. The narrative should eventually present the event as fact, the person's responses to the event and the impact it has had on his or her life.

Description of the traumatic event then moves to the person's emotional responses and reactions. Emotional components of the narrative should be as detailed and descriptive as the retelling of the facts themselves. This process may be overwhelming for the person. The primary impetus for the development of PTSD is the person's memory becoming overwhelmed. As the person describes what he or she felt during and immediately following the traumatic event, he or she will likely be reliving the event as if it were occurring in the present. Consequently, the person may be journeying emotionally between the traumatic event's occurrence and the present telling of it. The person may simultaneously experience all the intensity of the traumatic event while remembering and reminding him- or herself that he or she is safe – although the event has shattered his or her feelings of safety. In the telling of the trauma narrative and his or her responses and reactions to it, "the traumatic event challenges an ordinary person to become a theologian, a philosopher, and a jurist. The survivor is called upon to articulate the values and beliefs that she once held and that the trauma destroyed. She stands mute before the emptiness of evil, feeling the insufficiency of any known system of explanation." (Herman, 1992, p. 178).

During this time, the chaplain must assist in normalizing the person's described responses and reactions, helping him or her assign and articulate the appropriate words for his or her feelings, and ultimately carrying some of the emotional and spiritual burden of the trauma. Doing so can be overwhelming not only for the person with PTSD, but for the chaplain. It is imperative that the chaplain working closely with the person with PTSD have a pre-determined self-care plan to mitigate the possibility of vicarious traumatization and compassion fatigue. This issue is discussed more in-depth in the section on self care. Walking with the person with PTSD during the repetition of the narrative permits the chaplain to assist him or her in

making meaning from the traumatic event and entailed personal responses and reactions to it, focusing on resilience, hope, strengths potentially underestimated, while affirming the person's dignity and value throughout.

While the chaplain listens attentively to the person with PTSD, it is important to remember the mistake of making assumptions about the presented facts or the meaning the trauma has for the person with PTSD. The chaplain must be naturally curious and inquisitive, asking detailed questions to prevent superimposing his or her assumptions, feelings and interpretations onto the person's narrative. What the chaplain may intuitively feel is a small or insignificant detail or response may be central and have tremendous importance for the person with PTSD. The person may vacillate in telling his or her narrative. Denial of the reality and its impact on his or her life will lead the person to feel crazy. Such denial may also lead to too much cognitive and emotional dissonance to comfortably function. Nonetheless, accepting the enormity of the trauma in all its stark reality may feel beyond what any person could ever bear or endure.

As the person retells his or her complete trauma narrative, it becomes in a very real way, his or her testimony. Testimony is obviously loaded with importance for some religious traditions. Yet, it is important to remember that testimony has public and private components. Public testimony is political and judicial – the testimony of a person before Congress or a trial witness, whereas a private testimony is confessional and spiritual. All meanings may apply to the person with PTSD while working with the chaplain. Through the sharing of the person's testimony, the narrative may progress beyond focusing on shame, guilt or humiliation and instead move towards focusing on dignity, survival, strength in the midst of adversity, God's presence and/or protection, and virtue.

#### MOURNING:

Inevitably profound grief results when the person is ready to process the traumatic event in-depth. His or her losses may not be explicit and go unrecognized. "Typical" responses to mourning can feel insufficient at best, and provide little if any meaningful consolation. Most have lost a friend in war, often gruesomely. The person with PTSD has expended great energy to keep the ramifications of the trauma at bay. In resisting

grief, the person may have experienced nightmares, flashbacks, ruminations, etc. This kind of prolonged exposure therapy has been called, “grief work on meth” (Fortunato, J., personal communication, January 14, 2009). The chaplain is instrumental in helping slow the process down, taking the time to allow the person to grieve in a safe environment and even invite the presence of God into this person’s wounds, grief, anger, guilt and shame. The chaplain may also subtly shift the focus to reframe the person’s mourning and grief as an act of courage and strength instead of weakness, vulnerability or humiliation.

Aversion or avoidance of mourning is perhaps the most common reason a person with PTSD may get stuck in this stage. Such avoidance or resistance to the work of mourning and grieving often comes in the form of one of three fantasies – that the loss will somehow be magically resolved through revenge, cheap forgiveness, or compensation. The revenge fantasy is one of the most common forms of “wish catharsis.” In this fantasy, the person with PTSD imagines that getting even with the object of his or her anger will force someone else to experience the same level and intensity of terror, shame, guilt, suffering or pain that he or she has experienced. The assumption behind this desire for revenge is most often that this is the only way for the person to restore his or her power or sense of control. These fantasies often are quite elaborate, imagining the process of getting even; the smells, feelings, looks on people’s faces, etc., and often become as graphic as the memory of the traumatic event itself. To safely continue to heal from the trauma, the person with PTSD must eventually come to terms with the fact that this type of revenge is not possible, nor would it provide him or her the assumed relief, control or power.

There are those with no fantasies of revenge; rather, a deep spiritual or religious ideal of forgiveness. This fantasy is the polar opposite of revenge. As such, at its root is the assumption that this forgiveness will restore one’s sense of power or control. The person assumes he or she can transcend the intensity of fear, helplessness and rage, and forever expunge the impact of the trauma from his or her life, but only if he or she is able to defiantly love enough. This is a form of magical thinking, as one cannot eradicate or exorcise the impact of trauma from one’s being through love and forgiveness any more than through hatred and revenge. In most religious traditions, even divine forgiveness

is rarely if ever unconditional. Forgiveness such as the person is seeking to grant is only strictly possible when the perpetrator of the trauma seeks it and strives to earn it through confession, forgiveness and penance of some kind. A chaplain interviewed for this project, recognized the difference between cheap magical forgiveness as an escapist or avoidant fantasy, and true spiritual forgiveness and love. He recommends naming the former option as “pardon” rather than “forgiveness” (Oliver, J., personal communication, February 3, 2009). To pardon someone as a spiritual and loving act may be empowering with no requisite action from the pardoned. A more in-depth discussion about forgiveness, guilt and shame is included below in the Spiritual Care Interventions section.

Thirdly, some attempt to avoid having to deal with the power of his or her narrative by seeking some form of compensation. This person assumes someone owes him or her something for all that he or she has endured. This “someone” may be the government, the military, one’s family, Americans indifferent or apathetic to the war(s); sometimes the person him- or herself. The chaplain must be aware that the three magical solution fantasies – revenge, cheap forgiveness and compensation, may delay and/or complicate a person’s healing and recovery. The chaplain must be cognizant of the possibility of the person with PTSD developing an irrational fixation with such hollow solutions. As always, coordination with the mental health team is essential.

The person with PTSD must find a way to grieve the loss of his or her ideals and assumptions about the world, God, humanity, etc., and to find his or her own way to atone or make sense for what cannot be undone. Once a person has experienced the intensity of a trauma, there is no going back and living the life prior to the traumatic event. The event cannot be undone. This, in and of itself, is a loss that must be mourned. When a person with PTSD begins to share their traumatic stories, the chaplain should note clues to the person’s remaining capacity for love, strength, resilience and healing. “Almost invariably it is possible to find some image of attachment that has been salvaged from the wreckage. One positive memory of a caring, comforting person may be a lifeline during the descent into mourning.” (Herman, 1992, p.194).

The primary work of remembrance and mourning in the second stage of healing and recovery is accomplished when the person may once again claim his

or her own history, and begin to feel a cautious and tentative hope and energy for reconnecting with that history. Time may unfold continuously again, with the present being the present and the traumatic event in the past. This change is important, for by having the trauma remain in the past, the person may choose to think about it or not.

### STAGE THREE: RECONNECTION:

An entire section below describes in detail the *Spiritual Care Intervention of Encouraging Connection with a Spiritual Community*. Some discussion in this third and final section about the stages of recovery will reinforce and reiterate what is discussed in that section.

For the person with PTSD, the impact of a traumatic event fundamentally results in feelings of helplessness and isolation. Therefore, at its core, the recovery and healing process seeks to empower and reconnect. The goal is not to eradicate the fear but find ways to cope healthily with it – or even find ways of using that fear to lead to positive energy and wisdom (Herman, 1992).

### RECONCILING WITH ONESELF:

The resilient and self-affirming statement, “I know I have myself,” invariably sums up the essence of the final stage of recovery and healing. The person with PTSD feels in control and possession of him- or herself, rather than the PTSD or the traumatic event owning him or her. The person must begin to create an ideal self in which to again spend energy. This is accomplished with the newly liberated abilities to imagine a better situation as a realistic possibility, and how one might achieve that end. The chaplain becomes a sort of professor overseeing a laboratory. Here the person with PTSD uses trial and error, experimenting with behaviors, thoughts or even emotions. In doing this, he or she begins to learn how to live with mistakes or missteps, and begin to appreciate the oft-unexpected successes. In many ways the person is more liberated and adventurous in the world. Simultaneously his or her life begins to return to routine and normalcy. As the person begins to reconnect with the self he or she once knew, he or she will begin to settle down, breathe deeply and be able to face day-to-day

life calmly and with increasing confidence. This final stage of recovery often finds a person’s sense of self-worth and pride re-emerging (Herman, 1992).

### RESOLVING THE TRAUMA:

*“Resolution of the trauma is never final; recovery is never complete. The impact of a traumatic event continues to reverberate throughout the survivor’s lifecycle.”* (Herman, 1992, p. 211).

As such, the chaplain may serve to help empower and educate the person with PTSD, and help the person find ways of intentionally examining his or her life for potential obstacles or setbacks. Patients should be told to expect some of the PTSD symptoms to resurface in times of unusual stress. Knowing to expect this may go a long way in helping a person find productive and healthy ways to cope when this occurs. For example, it is important to be aware of anniversaries of the event, birthdays or other days of significance. Having a child who reaches the age that the person was when his or her trauma occurred can bring about intense emotional responses. The chaplain helping with some preparation and some basic psycho-education can be extremely productive.

Herman quotes the psychologist Mary Harvey describing seven different criteria for the resolution of trauma. They include:

1. “Physiological symptoms of post-traumatic stress disorder have been brought within manageable limits.”
2. “The person is able to bear the feelings associated with traumatic memories.”
3. “The person has authority over her memories: she can elect both to remember the trauma and to put the memory aside.”
4. “The memory of the traumatic event is a coherent narrative, linked with feeling.”
5. “The person’s damaged self-esteem has been restored.”
6. “The person’s important relationships have been re-established.”
7. “The person has reconstructed a coherent system of meaning and belief that encompasses the story of the trauma.” (Herman, 1992, p. 212-213).

The chaplain can and will likely be integrally involved in the final three, and quite possibly, numbers

two through four.

Reconnecting the person with PTSD to a group; be it a group for recovery, like a twelve-step group, faith community or social group; provides camaraderie and solidarity. These connections are likely the strongest, most powerful tools the person with PTSD may have in dealing with the intensity of his or her life after the traumatic event. Remember to remind the person with PTSD that the primary source of ongoing support and protection against despair and loneliness is one's pre-existing family, friends and spiritual community. Social support transcends isolation; whereas trauma isolates an individual. The person must seek a sense of belonging and unity. Trauma contributes to a person's shame and stigma, while social support may affirm and bear witness to one's strength and resilience (Herman, 1992).

Social support in general has been proven to provide direct positive impact for those with PTSD. The more social support the person has, the more the person experiences post-traumatic growth (Cadell, et al., 2003). Consequently, anything the chaplain does to help the person with PTSD nourish his or her social support is helpful. Opportunities to focus and strive for compassion for one's self and others with whom one relates are discerned while the chaplain processes with the person with PTSD his or her social ups and downs, be they with a significant other, friends or comrades-in-arms (Chan, et al., 2006). This two-pronged focus is well-suited to help the person work on interpersonal issues and recognize the connection between his or her self-talk and its impact on relationships with others. Additionally, it focuses on parallels between how the person treats him- or herself and how he or she is treating other people.

Additional studies demonstrate that "just" the social support received from one's faith community (as opposed to social supports of consanguinity or affinity) through participation in religious activities is beneficial to his or her healing following the traumatic event (Fontana & Rosenheck, 2004). Furthermore, a 2005 study indicated that networks for social support account for an 8-22% variance in one's psychological well-being following trauma (Halcomb, et al., 2005). In 2008, a study demonstrated that traumatic severity and social support were two of the most consistent predictors of the severity of a person's PTSD symptoms (Landau, et al., 2008). Any social group has the potential to assist the person with

PTSD make meaning of the traumatic event, as well as remind the person of the significance of that meaning. To illustrate the importance of a social group, the low prevalence of PTSD among Finnish World War II veterans, following that cruel war, was largely due to the community surrounding these veterans allowing them to continue to bring significance to their suffering through rituals, opportunities to share and celebrations honoring their sacrifice. This process allowed for a collective meaning to inform, supplement, reinforce or even reinterpret their personal meaning (Hautamäki & Coleman, 2001).

The chaplain should elicit from the person with PTSD those individuals in his or her social circle. These include, but are not limited to: immediate and extended families, friends, neighbors, comrades-in-arms, schools, employers and colleagues, clergy and other members of one's faith community, healthcare providers, and even legal aid and social support providers (Landau, et al., 2008). These support systems have the capacity to provide healing resources for the person with PTSD. The chaplain may also play an assisting role in the community surrounding a person with PTSD (Various Authors, 2007) (Dept. of VA/DoD, 2004). This role can be accomplished through providing talks, education and support, to the family and friends of the veteran, as well as at VFWs, support groups, congregations and other communities of faith. The chaplain who works with the person with PTSD should seek to link him or her with their extended social support networks or systems, and work within those support networks in equipping them to be supportive, patient and understanding of the person with PTSD. The assumption is that through encouraging human connections and a sense of community, the person will find threads of continuity between the past pre-trauma and the current post-trauma self. This connection may lead to more optimism and hope for the future. As one reconnects with families, friends and faith communities, one also reconnects with those communities' wealth of stories and narratives which remind the person how others have weathered difficulties. Thus, the person is encouraged to recognize the hidden strength and support he or she possess (Walsh, 2007). Additionally, reconnecting a person with communities of support diminishes the counterproductive fundamentalism of "we/they" assumptions.

# CHAPTER IV

## BE A NON-ANXIOUS PRESENCE

Most chaplains inherently understand the need to be a non-anxious presence. This presence is needed far more when working with the person with PTSD. It is important for the chaplain to not take things personally, as most with PTSD will test the chaplain in numerous direct/indirect ways (Oliver, J., personal communication, February 3, 2009). Persons with PTSD, like victims of violence or trauma, often have highly attuned intuitions regarding others' perceptions, gestures, feelings, etc. They are often strikingly adept at looking for subtle clues of how a person is receiving or reacting to them and their narrative. This situation can lead to a rift in trust between the chaplain and the person with PTSD, as he or she perceives some level of anxiety, discomfort, disgust, pity, or antipathy on the part of the chaplain. He or she may react with much energy, sometimes violently (Drescher, K., personal communication, February 11, 2009).

One of the most important active ingredients for the efficacy of the chaplain in working with a person with PTSD is how to be physically present. The person with PTSD will express anger, even rage, sometimes directed at the chaplain. The chaplain needs to recognize threatening behavior and learn how to not escalate the person's feelings. The capacity to tolerate the person's wide swings of emotive states, as well as the capacity to help reduce anger and/or buoy depression can be essential (Organ, J., personal communication, January 12, 2009). Part of the way in which the chaplain may do this is being non-anxious in the midst of often overwhelming emotion on the part of the person with PTSD.

The chaplain can reduce anger by tracking, moving with the conversation and the person, and moving toward what is "life giving." It is important to learn the distinction between tracking a person's anger and escalating it. Statements such as, "that makes you quite angry" is a way to track a person's anger, and subtly honoring it while not dismissing it. Once the person begins to see that the chaplain "gets it" and is honoring him or her as a person unconditionally, he or she will often begin to shift subtly toward an interper-

sonal and spiritual connection. It can be helpful for the chaplain to remind him- or herself that anger is almost invariably a response to a different deeper emotion – such as pain, betrayal, fear, or helplessness (Organ, J.- personal communication, January 12, 2009) (Goodman, P.-personal communication, January 23, 2009).

The person with PTSD may have identity issues mitigated by the chaplain being sympathetic, empathetic, non-anxious and nonjudgmental. As the person begins to develop trust with the chaplain, he or she will begin to share some very intense, personal, and terrible things – experiences or things they witnessed, thoughts or actions they have had themselves. The chaplain must remain empathetic when he or she is challenged by the intensity of the person's experience (Powers, R., personal communication, January 14, 2009), (Jackson, V., personal communication, February 17, 2009). In the midst of the person's crisis the chaplain must be neutral and non-energetic. If the chaplain allows the person to react strongly with him or her, similar to the "psychic judo" Spiritual Care Intervention section detailed below, the chaplain's lack of resistance allows the person's energy to decrease (Downey, 1973).

The chaplain assumes various roles by being non-anxious. The first role is a Safe Haven. This is accomplished through offering a calm, safe, nonjudgmental and non-anxious presence; providing clear, reliable boundaries of respect; being present with the person with PTSD and his or her family during the storms of reintegration; and through providing a compassionate space large enough to contain that person's horrors of war and traumatic experience (Navy Medicine).

The second role is the listener. This role involves avoiding offering platitudes, or seeking to solve or fix the person's problems. It also involves listening without interruption or comment. The role of the chaplain as listener is demonstrated when the chaplain can hear the content and the emotion with respect, conveying warmth and acceptance of the person, and his or her journey and struggles. The chaplain should avoid asking questions, and notice what is caring and authentic (Navy Medicine).



The chaplain may also ground the person with PTSD. This role involves providing a roadmap of opportunities for appropriate outlets for frustration, pain, fear, guilt and trauma. It can also involve providing avenues of dialogue for spiritual and religious growth and engagement. The chaplain should also seek to provide honest and realistic reflection of the recovery process, and provide spiritual, religious, and community resources to the person with PTSD and his or her family (Navy Medicine).

The chaplain's role is also one who accept the person "as is," without condition. The chaplain seeks to understand the both/and nature of good and evil, and of then and now. The chaplain should avoid trying to fix the unfixable, and be able to offer deep reflection on the nature of goodness. The chaplain should be a good guide for the person with PTSD in being able to find goodness in him- or herself as well as in others. All the while, the chaplain needs to be able to understand and accept the "dark side" of humanity – what we are each capable of and be able to find humanity's brokenness there rather than its flaws (Navy Medicine).

The chaplain should also be able to provide basic emotional and spiritual support. This means being able to relate to the person with PTSD as a whole person who has the capacity and potential to enrich society through his or her experience. The chaplain must recognize that returning service members do not need to be fixed, but rather need affirmation and encouragement to heal. The chaplain should help champion the celebration of his or her strengths and insights throughout the healing process, and assist the person in discovering thankfulness and grace within the entire military experience. It can be helpful for the chaplain to begin some of the conversations by focusing on the strengths the person with PTSD has shown during the hardships of deployment and his or her experience of trauma. The chaplain should be the advocate of the whole person in helping others recognize and remember that the most difficult wounds to heal may not be the physical ones but the emotional and spiritual ones (Navy Medicine).

## CHAPTER V

# BE A NON-JUDGMENTAL PRESENCE

**T**he chaplain should be well-equipped to walk with the person with PTSD through his or her experience of trauma without judgment. As a person begins to share his or her experience with the chaplain, his or her weaknesses, mistakes, and struggles can only be safely shared in an environment that protects against shaming and harsh judgment – regardless of the person's offenses. Judgment would potentially not only distance the chaplain from the person, but add to his or her struggles (Herman, 1992).

The chaplain is often in a position to listen to a patient's re-creation of his or her stressor, and their horrific experience(s) in graphic and minute detail. Especially as a representative of God or spirituality in general, the chaplain must be aware that his or her reactions and responses will be gauged by the patient and potentially used to confirm or deny some of his

or her doubts or concerns about God's response to his or her behavior. Often a person is concerned that what they did in the combat theater puts them outside the scope of God's love, forgiveness, and good grace. If the chaplain, God's representative in the flesh physically hearing the retelling of this narrative, winces or cringes or even subtly feels repulsed or evaluates the veteran's behavior, the veteran can quickly confirm their fears that God indeed does condemn their actions, thoughts, and feelings. This reaction can lead to considerably more intense feelings of being ostracized by God and ultimately judged by God. Consequently, it is essential that the chaplain attending to the retelling of a veteran's experience be prepared to listen with detachment as much as possible, as if everything that person is sharing is as benign as hearing them tell of a high school football game or experience at the mall.

Also a part of being a nonjudgmental presence is having absolute regard for the primacy and acceptability of the person's own spiritual and religious tradition. The chaplain should want to know where the person is spiritual, and how that person's spirituality works for

them (Hokana, S., personal communication, January 23, 2009). One chaplain interviewed for this project

# CHAPTER VI

## SENSITIVITY TO DIFFERENCES IN RELIGION, CULTURE, AND GENDER

The chaplain should be an advocate for sensitivity to diversity in all forms – including but not limited to religion, culture, gender, and sexual orientation. Grief, loss, mourning, and their subsequent expressions are highly culturally-specific. Any Spiritual Care Interventions should seek to be complementary to the pre-existing religious, cultural, and traditional rituals that are in place within the community of the person who has PTSD (Bryant, 2003). A young white woman from a small farming community in Kansas will likely have different constructs for processing and moving through the experience of trauma and its aftermath than a black young man from the inner city of Chicago or a middle-aged Latino from Phoenix.

Many of these differences in culture, ethnicity, religion and the like lead to different responses to traumatic experiences which will come to the surface most explicitly in a group setting. For example, many ethnic groups from outside the Western hemisphere may well have much more somatized responses to grief rather than psychological or existential responses (Powell, 2007). Different groups will not only have different ways of reacting and responding to a traumatic experience, they will also have different sources of strength and resilience that can be positive sources of coping and healing. The chaplain should seek to patiently explore with individuals what they feel they have as sources of strength and resilience, inviting them to share, model, and nuance the chaplain's understanding

or assumptions. If English is a second language to the person the chaplain is dealing with, it would be best to work with an interpreter who may become a valuable resource not only linguistically but culturally. Most institutions such as hospitals have contracts with interpreters and/or an interpreting service (such as a Cyra-phone) that should be accessible for the chaplain's use.

The chaplain may well find that some cultures actually better equip people for the experience of trauma than others. For example, in many cultures, story telling and group discussion is a highly valued norm and is a common form of corporate coping and healing. This norm may well make discussing difficult experiences even more acceptable or offer less resistance than some from within the "dominant" Western culture (Regel & Dyregrov, 2007). Especially when assisting a person in making meaning, the chaplain should proactively work with the person from a different culture to consider culturally-specific contextualization of such things as expressions of disequilibrium or chaos, distress, formats, language, and concepts. If the chaplain is unfamiliar with a specific culture, at the very least being sensitive to the levels of difference between the chaplain and that culture is a necessity. The chaplain should also listen carefully for nuances of meaning, purpose, and values and seek to incorporate these potential spiritual strengths into a pastoral care plan (Rogers & Koenig, 2002). The chaplain can ask the person to share how his or her parents or grandparents would have dealt with this experience, and/or to

ask questions such as, “I am not as familiar with your specific culture and ways of doing things. How would you normally respond to this?”

The following sections will examine different cultural issues and some of the content of the literature regarding each. It is not a comprehensive list, and the specific cultures discussed come not from an intentional search for culturally-specific Spiritual Care with people with PTSD, but rather were incidental in a broader search for anything to do with Spiritual Care and PTSD. Each discussion of a specific demographic or category of diversity should not be assumed to be true for each individual member of a specific group, but rather informative generalizations and observations rooted in the literature. There is a need to find and establish a balance between being pro-active with cultural sensitivity and the best clinical practice (Scurfield, 1995). Other helpful material in this area can be found on the web site of the Association of Professional Chaplains ([www.professionalchaplains.org](http://www.professionalchaplains.org)).

## WOMEN:

Women’s ways of knowing, being, and experiencing the world are different from men’s, and consequently are often questioned, dismissed, or silenced – often inadvertently or indirectly. This reality increases the likelihood of post-traumatic stress symptoms and can directly intensify a woman’s anger and rage below the surface (Rogers & Koenig, 2002). On the flip side, sometimes it is the chaplain who is the woman and the service members who are men. One female chaplain interviewed for this project described her concern about being female and working with service members who have PTSD as follows: “Here I am, standing in a room in front of trained killers who are angry, confused, and who have come here because they need help, and I am a woman” (Jackson, V., personal communication, February 17, 2009). It is important for any chaplain to recognize issues of gender that arise from working with those with PTSD. These can include the concerns of a female chaplain working primarily with men who have PTSD – with all of the inherent potential issues of power, fear, victimization, sexuality, transference and countertransference. Or, it can be the male chaplain working with a female service member with PTSD – recognizing the same potential issues. This does not mean that only men should work with men and only women with women. However, each

chaplain should be pro-active in recognizing, taking into account, and strategizing about issues of gender and sexuality in the work with people who are potentially both vulnerable and volatile.

It is important for the chaplain to know that PTSD for a woman is not the same as PTSD for a man. Statistics say that nearly twice as many women as men experience PTSD following exposure to a trauma over the course of his or her lifetime (Fallot & Heckman, 2005). If a woman has PTSD, her potential levels of religious coping, both positive constructive coping and negative destructive or complicating coping, are higher than for women in the general population. Researchers believe this the case because of how trauma shatters one’s fundamental assumptions about the world, safety, power, self, and meaning. Because trauma raises these ultimate questions, those who have experienced it understandably reach for religion and spirituality, with the goal of making meaning. Specific to women, the levels of positive religious coping were considerably higher than negative religious coping, but both forms of coping were higher than for someone who had not experienced trauma (Fallot & Heckman, 2005).

Another study described the differences in how women and men responded to trauma, and determined that women were more likely to become depressed following a trauma. They also found that a woman is six times more likely than a man to develop post-traumatic stress symptoms (Solomon, 2005). While this study was not focused on the military, (it was looking at the general population’s emotional response to the September 11 attacks in 2001), it claims that women are simply more susceptible to post-traumatic stress disorder than men. It described the six most unique (as opposed to men) common coping strategies for women as talking to others about the trauma, checking on the status of loved ones, actively searching for social support, self-distraction through some form of activity, avoiding television, radio, and the news, and faith in God (Solomon, 2005). While the conclusions of this study may not perfectly reflect the specific context of military combat-related PTSD and the implications of gender difference in that situation, it does underscore and remind the chaplain that responses to trauma are indeed impacted by one’s gender and sexuality. Trauma “is not gender-blind and . . . men and women differ in their exposure to terror and in the way they perceive the threat and cope with it.” Although women are

less exposed to terror events than men, these events, nonetheless, arouse in them a stronger sense of danger, both for themselves and for the people who are close to them” (Solomon, 2005).

Another important statistic to know about and take into consideration when working with military women who have PTSD is the high incidence of sexual trauma and harassment experienced either while in the military or prior to enlisting (Rogers & Koenig, 2002). One study claims that more than 70% of military women have been a victim of sexual trauma while enlisted (Schnurr, et al., 2007). There is also a high prevalence of sexual trauma among women enlisted in the armed forces that occurred prior to enlisting. So-called pre-existing sexual trauma is one of the major risk factors for subsequent development of PTSD following a military experience of trauma.

#### AFRICAN AMERICAN:

There was minimal research found on the distinctive characteristics of African Americans with PTSD. One study looking at African Americans throughout the United States and not specific to the military claims that the “risk of developing PTSD endured throughout the life course for blacks whereas whites rarely developed PTSD after young adulthood” (Himle, et al., 2009).

#### HISPANIC / LATINO/LATINA:

The only study found describing any unique attributions of the Latino / Latina population found that they seek mental health services assistance less than whites, regardless of diagnosis (Brinker, 2007).

#### ASIAN AMERICAN / PACIFIC ISLANDER:

In many Asian countries, the group – whether it is a family, a community, a village – is a central value. As such, group therapy can be a very natural approach. Also as a result, if the chaplain is working one-on-one with an Asian American, it can be helpful to emphasize or take into account his or her family, community structure, culture, and religion to assist in coping and understanding his or her values (Bryant, 2003). It is also often the case that Asian Americans value controlled emotional expression, which would mean that

they may well choose not to engage in talking openly about their deepest emotions (Chan, et al., 2006).

It can be important to know that, for most Buddhists, there is an assumption and basic understanding that life is a series of crises and traumatic experiences. Suffering is a necessary path to awakening. The eight types of suffering according to most Buddhists include: birth, old age, sickness, death, being separated from loved ones, meeting people one hates, not getting what one wants, and suffering caused by the senses of the body and the mind. If a person sees suffering as inevitable to the human experience, it can actually, ironically, be normalizing and calming to discuss the trauma in that context. In order to move away from suffering, a person must give up unrealistic expectations or assumptions about life, God, self, the nation, the military, etc., as well as attachments to how things should be versus how things actually are. In some ways, a Buddhist is more easily moved to challenge the assumptions that created the existential crisis for many with PTSD – as this is a fundamental underpinning of the Buddhist tradition (Chan, et al., 2006).

The focus when working with a Daoist (also known as Taoist) in relationship to trauma is about unpredictability. Daoism teaches that real life and nature is constantly changing, and that the ying of one experience is often counter-balanced by the yang of another. The chaplain can assist the Daoist in seeking to appreciate how unpredictable life can be, as this is the beginning of accepting whatever does come in life, and attaining a state of being that is free of care or suffering (Chan, et al., 2006). Many Asian people believe in a form of Karma, which is a basic token economy. This belief can be a challenge at times in working with those who have experienced a great trauma, as they may choose to look at their experience through the lens of individualistic karma – meaning what have I done that I would deserve this traumatic experience? However, the chaplain can assist them in shifting the focus to a more collective sense of karma – that everyone has a share in the bad karma that is shared by all of humanity. Also, if the person believing in Karma recognizes that the positive decisions he or she makes has a positive impact on the well-being of his or her loved ones, that person is often more willing to take charge of his or her own life and commit to a virtuous lifestyle. In this way, he or she is creating good karma that may begin to counter-balance the bad (Chan, et al., 2006).

Finally, working with those who espouse Confu-

cianism, the chaplain can emphasize perseverance. Confucians believe that each personal ordeal or struggle is a blessing in disguise. The chaplain can ask a person what the blessing or lesson might be from the experience of the trauma that led to the PTSD.

#### NATIVE AMERICAN:

As with Latino / Latina Americans, Native Americans seek mental health services less than whites (Brinker, 2007). Native Americans are unique in that they are one of the only ethnic groups in the United States who could be said to have come from a society of warriors. This is not the case with every tribe, but with many. One article discussed the use of the Sweat Lodge (see complete section below in Spiritual Care Interventions) with Native American service members. This purification ritual was built by a team of veterans as a team building exercise, and proved to be the most effective and frequently used traditional supportive activity (Scurfield, 1995). This same study also took Native American service members to pow-wows where the warrior role is celebrated and prominent (much in the same way, perhaps, as the community as meaning-enhancer that was seen with the Finnish service members who were veterans of World War II and described below). The final Native American-focused intervention brought in a recognized local leader and cultural consultant, and involved this person in many of the group treatments (both mental health and spiritual care) (Scurfield, 1995). One additional note, an apparent potential tension for some within the Native American community is the interpersonal tension between those who are more traditional and those who are more assimilated into Western culture.

It is also important for the chaplain to be aware that Native Americans can be culturally from a specific tribe and participate and use many traditional components of that culture (such as a Shaman or Medicine Man), while still being deeply involved in a standard Western (often-Christian) denomination. As a result, the Native American may request to pray with or participate in Christian rituals such as confession, communion, or seek spiritual guidance with the chaplain and also seek to consult with the Medicine Man or Shaman and participate in sweat lodges, vision quests, prayer circles or other traditional tribal functions (Rogers & Koenig, 2002).

#### GENERATIONAL (OLDER VETERANS VS. YOUNGER VETERANS):

There are many potential generational differences. The veterans from the Overseas Contingency Operations are likely to be distinctly different in experience, reactions, and efficacy of treatments than Vietnam, Korean, or the First Gulf War veterans. These differences include but are not limited to:

- Personal characteristics
- Context in which they served
- Repeated deployments of uncertain duration
- All volunteer
- Supportive services for reintegration of reserve troops is lacking
- Due to nature of current warfare, those who were not considered combatants (truck drivers) are now subject to high risk of traumatic exposure and injury (Drescher, et al., 2007).

All of these differences should be taken into account by the chaplain in working with those who have PTSD.

# CHAPTER VII

## NEED FOR SELF-CARE

*“The one who is wise, therefore, will see [his or her] life as more like a reservoir than a canal. The canal simultaneously pours out what it receives; the reservoir retains the water till it is filled, then discharges the overflow without loss to itself. . . . Today there are many [caregivers] who act like canals, the reservoirs are far too rare.”*

~ St. Bernard of Clairvaux (12th century)

Working with people who have PTSD is difficult, and can become increasingly heavy or burdensome emotionally and spiritually over time. People with PTSD will likely have a deep depression and profound grief stemming from unspeakable experiences of trauma, terror, and loss. Chaplains are heavily empathic people, and as such, can begin to slowly take on some of the dark affect of the people with PTSD. This progression is common, in some ways expected, and is something that the chaplain must address pro-actively before it becomes problematic (Organ, J., personal communication, January 12, 2009). The fact that every single person interviewed for this project mentioned self-care as a high priority emphasizes the importance of the chaplain being able to find ways of coping positively with the intense experiences of working closely with those who have PTSD.

For the chaplain working with people with PTSD, self-care must be central. It should be as high an intentional priority as serving patients. The chaplain must go gently, pace him- or herself, and know what signs will appear when he or she has become overly burdened with the weight of the people with PTSD. Perhaps counterintuitively, the longer the chaplain works with people with PTSD, the more likely it is that the intensity will become too much for him or her and the cumulative impact of vicarious traumatization, or compassion fatigue will become a problem (Fleischman, J., personal communication, January 21, 2009), (Goodman, P., personal communication, January 23, 2009). The chaplain is not meant to be Atlas, with the weight of others' worlds on his or her emotional and spiritual shoulders (Tyrrell, G., personal communication, January 7, 2009). The bottom line is that the chaplain must provide the same level of care

for him- or herself as he or she does for those in his or her care (Powers, R., personal communication, January 14, 2009).

Every chaplain working with those with PTSD should find a peer group, and have both formal and informal debriefing mechanisms in place (Oliver, J., personal communication, February 3, 2009). Many chaplains may be tempted to think that, “yes, I can see where the chaplain would need that. But, I don't because . . .” This is a mistaken assumption – a kind of exceptionalism. Working with people with PTSD does not get easier over time, though it may become more familiar. Talking regularly with other chaplains, faith leaders, colleagues, friends, or family members is essential not only to survive the intensity of the vicarious experiences, but to be able to balance that intensity with the receiving of support.

Chaplains are often hard-wired to be helping professionals, with a high need to feel needed. Working with those who have experienced such trauma will change the chaplain's emotional and spiritual balance. The more personal experience the chaplain has had with personal tragedy, loss, or trauma the more likely the chaplain is to experience compassion fatigue. The chaplain should establish, maintain, and model (both for those in his or her care and for those colleagues working alongside of the chaplain) appropriate time and energy boundaries. In one recent response to a disaster, when one person declined to take time off for rest and recuperation, it snowballed. Others felt compelled to keep up the pace and worked beyond their emotional and physical limits as well (Tarpley, 2002). Another study in a similar scenario of disaster response and mental health care providers stated that one of the major issues in their disaster plan was a lack of resilience training and emphasis for care providers

(Fortunato, Powerpoint). The more attention paid to resilience and the more focus given to the chaplain's own pace, self-care, and balance, the better the chaplain will be able to balance the often-competing needs of care for self and care for others (Hernández, 2007).

Those who work with traumatized people and persons with PTSD require an ongoing and intentional support system to be able to cope with and deal with these intense experiences. No survivor can recover alone, and in the same way, no one working with survivors can walk through their trauma alone (Herman, 1992). It is a real danger for the chaplain to feel overwhelmed by the trauma of the patient, and to subtly, or even abruptly, shut down emotionally and no longer be actively listening or providing a ministry of presence. This dynamic can greatly compound the issues of isolation, alienation, and trust with which the person with PTSD may well be already struggling.

The chaplain must pro-actively find ways of dealing with the intensity of the vicarious trauma he or she will experience through working closely with those with PTSD. The more intentional the chaplain is in choosing how to cope with the intensity of his or her

job, the healthier and more complete this coping can become. The choices can include some kind of physical release through exercising, weight lifting, playing a sport, etc. Or it can be working with a counselor or therapist. It is important to note what the chaplain does to cope. It is not uncommon for even the chaplain to begin to rely on excessive consumption of alcohol, food, sexuality, unhealthy relationships, or drugs in order to try to deal with the intensity of the cumulative impact of the trauma of those with PTSD.

Also recommended is that the chaplain find a way to continually restore and reconnect to his or her own spiritual resources. This connection is vital in being able to walk with others through their valleys of the shadow of death. This connection should be both personal and communal. A person's rejuvenation may come through study of sacred Scripture, music, art, nature, prayer, meditation, and other "contemplative" practices. A more communal restoration may come through informal debriefings with friends, colleagues, or family, through corporate worship, through formal debriefings and support groups, counseling, or therapy.

# SECTION III: INTERVENTIONS



# CHAPTER I

## GROUP WORK SPIRITUAL CARE INTERVENTIONS

### RATIONALE FOR THE USE OF GROUPS:

Group exercises can encourage self-disclosure and relationship building. They are wonderful environments within which to explore existential topics that many with PTSD are struggling with. Finding and articulating one's values for living, a person with PTSD can explore explicitly what his or her values are and how those values shape, or do not shape, daily living. A person can begin to find his or her meaning or purpose. This meaning can come from within one's own internal view of self, or can come from outside oneself, such as from relationships or support system. This sense of meaning can also be found and nurtured through "being meaningful," or creating a life where one matters to other people through relationship and service. The group can be a wonderful "laboratory" where a person can "try things on," seeing what might help him or her make more sense of the world than previous assumptions had allowed (Drescher, et al., 2007). The chaplain can encourage this process, and facilitate the group so that it is safe, mutual, and not dominated by a single vocal individual.

Some research suggests that many veterans who did not do well with individual interventions did well in a group intervention, whereas some who did not do well in a group, did well one-on-one (Herman, 1992). This finding was echoed by many of the chaplains interviewed for this project. Another benefit of the group is that a person is able to not only share his or her own experience of trauma and receive feedback from others who have experienced something similar, but gain a vicarious exposure to the narratives of others in the group. Groups promote healing through normalization of symptoms, increased therapeutic opportunities, increased exposure to different coping strategies and skill sets for how others have sought to make meaning, and improved self-esteem by allowing each participant to be both a helper and one being helped. Groups provide an opportunity to learn from the experience of

others, and help the person with PTSD recognize that he or she is not the only one with this kind of problem (Schnurr, 2001). There is a wider range of feedback than one-on-one interactions, and this feedback is often better received. It also builds connections and friendships with people for whom trust is an issue (Drescher, et al., 2007).

One advantage of the use of groups with persons who have PTSD is that a person begins to rebuild and restore social bonds through a dawning recognition that he or she is not alone. A group allows for this realization to occur powerfully and convincingly. As groups develop and pass through the stages of group development, cohesion and intimacy lead a person to be able to open him- or herself up to others and invite them into his or her pain and vulnerability, while at the same time offering to support and care for others as they do the same. This mutual benefit is called the "adaptive spiral - "in which group acceptance increases each member's self-esteem, and each member in turn becomes more accepting toward others" (Herman, 1992, p. 215).

One advantage of the use of groups in contradistinction to one-on-one interventions is that groups can develop into a peer cohort, a group of people who have shared a common experience. The participants in a group can be fiercely loyal, developing bonds much closer than that of chaplain-patient. When a person with PTSD shares his or her narrative or experience of trauma and its after-effects in a group, distorted perceptions are often corrected by the group (Powers, R., personal communication, January 14, 2009). The challenge to a person's misapplied logic or myopic self-blame has a different flavor or tenor when it comes from a group of other veterans with PTSD than it does coming from the chaplain.

Groups are not so much spiritual instruction as a platform for those with PTSD to re-examine the role that spirituality might play in their recovery. Many service members have a difficult time reconciling

their faith with what they experienced in the war zone (Drescher, K., personal communication, February 11, 2009). A question behind many of the spirituality groups, especially for those who, in their existential struggle to make meaning with what happened in their experience of trauma have abandoned their faith, is whether there is a chance they have thrown the baby out with the bathwater. The group can be the place where the person re-assesses his or her assumptions about God and the world rather than dismissing or abandoning God and the world entirely.

#### TYPES OF GROUPS:

Phillip Goodman, the chaplain at the VA in Philadelphia, leads two 12-step groups – one for veterans with combat-related PTSD and one for veterans with non-combat-related PTSD (Goodman, P., personal communication, January 23, 2009). He describes these as very focused groups. They seek to cover one step each week, and are patterned after other 12-step recovery groups. Peterson also uses the 12-step program as a basic spirituality course for veterans with PTSD. This group runs for 12-14 weeks, and deals with many of the same principles and steps as AA and other recovery groups. The group method, originally described by Dr. Joel Brende is included below. The overall focus is on God, one's understanding of God, powerlessness, helplessness, guilt, shame, trust, one's search for peace or Shalom, finding wholeness, and finding a connection with a spiritual community as an avenue or expression of service to others.

Peterson also developed a group he calls the "Art of Forgiveness" group. Based on Everett Worthington's books on forgiveness (*Dimensions of Forgiveness: Psychological Research & Theological Perspectives*, *Handbook of Forgiveness*, and others), this is a processing group that runs for close to a year. The first six months are about different aspects of forgiveness, developing trust, cohesiveness, and intense group bonding. The second half of the year is about people telling their stories. In this part, the participants share their early years, then their military time including combat, then their life since being in the military or combat. The group gives feedback to one another along the way, pointing out blind spots, growing edges, and other things they encourage the narrator to think about (Peterson, H., personal communication, January 28, 2009).

Taylor and Wilson focus their group on strength and resilience. They have service members share what they have been doing well, and encourage each to comment on how they see one another using his or her strengths and resilience to be able to get through day-to-day life (Taylor, J., & Wilson, B., personal communication, February 9, 2009). This kind of focus on resilience and strength can be in sharp contrast to many of the interventions the person with PTSD experiences from mental health professionals – where the focus can often be on dysfunction, disorder, and wounds. A change of pace and focus on what is going well, what strengths one possesses, and positive elements of life following the experience of a trauma can be a welcome change. Resilience is discussed in more depth in the Spiritual Intervention- Meaning Making below.

Drescher's spirituality group within the VA has eight sessions, taking a shotgun approach regarding one's relationship with spirituality. One session looks at "what's happened in your own spirituality," then another on "spiritual practices. Another centers on "spiritual practices - focusing on those that rebuild connection." There is always a conversation in one session about theodicy – where is God in the midst of suffering? The focus for this session is not so much about answering the question with a system of logic or belief, but allowing each person with PTSD to find a safe arena within which to ask those inevitable questions. There is another group on forgiveness of others, then another on self-forgiveness. There is a session on values – "what do I care about?", and then one on what do I want my life to be about following this experience of trauma? The final session is on meaning making.

There are several one-and-done groups led by the chaplain that can be constructive. Among these types of spirituality groups is a Joyful Spirit group focused on what brings the person joy. Another is the Finding My Purpose group, focused on what is the person's intention to be doing right now. Still another is the Loving Life group, focused on what is it that the person loves most about him- or herself. The Moving On group then asks the question, "what do I need to accept?" This single session format for groups, often 45-90 minutes each, does not allow for the more in depth exploration or trust development that can come from longer 10 – 15 week groups, but can nevertheless be a great balance and supplement to one-on-one chaplain interactions (Navy Medicine).

Judith Herman’s work, in *Trauma and Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror*, describes different kinds of groups and how they can be best for a person depending on what stage of recovery he or she is in (see section about Herman’s Stages of Recovery). The chart below demonstrates how each group and each stage is distinct from the others.

For groups working with people in Stage One, the therapeutic task is safety. These groups, like AA and other 12-step programs, tend to be very structured. They seek to offer a basic understanding of symptoms that are the after-effects of the trauma. The focus is not on the participants’ retelling of their narrative of experience of trauma, but on understanding the impact the trauma has on the lives of the participants. These

### THREE TYPES OF GROUPS:

GROUP	STAGE OF RECOVERY		
	ONE	TWO	THREE
Therapeutic task	Safety	Remembrance & Mourning	Reconnection
Time Orientation	Present	Past	Present, future
Focus	Self-care	Trauma	Interpersonal Relationships
Membership	Homogeneous	Homogeneous	Heterogeneous
Boundaries	Flexible, inclusive	Closed	Stable, slow turnover
Cohesion	Moderate	Very High	High
Conflict Tolerance	Low	Low	High
Time Limit	Open-ended/ Repeating	Fixed limit	Open-ended
Structure	Didactic	Goal-directed	Unstructured
Example	12-step program	Survivor group	Interpersonal Psychotherapy Group

groups also offer a structured set of rules or instructions that seek to empower each person and to restore his or her connection with others. The 12-step process works well for people in the first stage of recovery.

For groups more focused on the second stage of recovery, the therapeutic task is remembrance and mourning. These groups are also well-organized, and seek to encourage participants to both reconstruct the story of their experience of trauma as well as provide for each a powerful place of emotional support as he or she mourns and grieves. As more and more begin to share their stories, the participants begin to recognize that, though their personal experiences were unique, there is a profound sense of universality to their experience. It is important for the chaplain working with this kind of group to maintain a high level of structure and explicitly focus on each person uncovering his or her experience of trauma. The chaplain as facilitator or co-facilitator is responsible in this group for defining and describing the task of the group, as well as ensuring safety and the feeling for each person that he or she is protected. The structure of this group should also include a time limit. At the end of this group, a powerful ritual can be bound up with the termination of the group and its tasks.

Groups for the final stage of recovery have as their focus a reconnection to life, to social support, to one's self, values, beliefs, and attitudes. This kind of group tends to be more open-ended, as opposed to the highly structured groups for the first and second stages of recovery. The reconnection group focuses instead on addressing specific individual issues, symptoms, or concerns, and is more focused on interpersonal relationships – whether they are intimate such as marriage or significant other, or more social such as connecting with a place of worship or service group.

#### TIPS ON GROUPS:

It can be helpful to set up a group based on common roles, branch of the military, or some other similarities such as a veteran of a specific war, or role within that war. There can be a group of Iraqi war veterans and another of Afghanistan veterans. Chaplain Peterson also does a “Combat medics and corpsmen group” and a “spiritual alumni” group. The Spiritual Alumni group is for anyone who has completed one of the spirituality groups, and would like to meet with other alumni for continued support, fellowship, and work.

It is more like a maintenance group where people can relieve stress and get suggestions about how to cope with day-to-day living (Peterson, H., personal communication, January 28, 2009).

One good way to begin a spirituality group with those who have PTSD was suggested by John Oliver. This technique helps people understand how a trauma shatters one's assumptions and sources or methods of making meaning. He begins with everyone in a circle facing each another in chairs, and one person has a ball of yarn. That person states “What helps me a lot spiritually is \_\_\_\_\_.” Then that person holds onto the end of the string and tosses the ball to someone else in the group, who does the same thing. Eventually a web of meaning has been created by the group. One person may have three or four turns, each time coming up with a new source of meaning. At some point, once a fairly complex web has been created, the chaplain can take out some scissors and cut through many of the pieces – though not all. This cutting represents the traumatic event that each of the members of the group has experienced. A few strings are still holding, but a lot of them are no longer functioning because of the trauma. This analogy can be discussed among the group relative to how each person's trauma shatters some of the assumptions about life, God, humanity, the nation, oneself, one's family, etc., and how important it is to seek to reconstruct a healthy and strong web of meaning for oneself that incorporates all that was lost in the trauma (Oliver, J., personal communication, February 3, 2009). It can be meaningful to leave one chair empty in honor of those who have died. This parallels the empty chair for Elijah at the Jewish Passover table. Many groups, like the 12-step recovery groups, use the Serenity Prayer as a closing and an area of focus. Anything that can be done that is experiential, such as Oliver's yarn example demonstrating how trauma shatters one's assumptions, is better than relying exclusively on words.

***The Twelve-Step Approach to PTSD:***  
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STEP ONE (POWER):

*Our first step is to accept the fact that we have become*

*powerless to live meaningful lives.*

Even though we had the power to survive against the worst combat conditions, we must admit we have become powerless to win the battle against a new enemy—our memories, flashbacks, and combat instincts. Some of us have become powerless over the continuing wish to gain revenge over those sudden impulses to hurt those who cross us or unsuspectingly annoy us. We even hurt those who try to love us, making it impossible to love and care for our friends and family. So we isolate ourselves and cause others to avoid, dislike, or even hate us. Our attempts to live meaningful lives and fight this psychological and emotional hell which imprisons us seems to be in vain. We now find ourselves powerless to change it.

#### STEP TWO (SEEKING MEANING):

*Our next step is to seek meaning in having survived.*

If we are to survive this new battle, we seek meaning in having survived. We want to believe we have survived for a purpose. We would like to be free from nagging thoughts telling us we should never have left the battlefield alive—the place where our comrades gave their lives in war. We want to believe our lives will serve a better purpose if we are alive rather than dead. Thus, even though we often doubt that living is better than dying, we seek to find meaning in life rather than death, and hope to find life a privilege rather than a burden.

#### STEP THREE (TRUST):

*Our third step is to begin to find relief by seeking help from God as we understand Him, and from persons we can learn to trust.*

If we are to find relief, we seek a source of help from persons whom we can learn to trust. Many of us also would like to trust God, as individually understood, and ask Him to show us the way out of our mental prisons, renewing our sensitivities to human emotions and spiritual qualities we fear we have lost.

#### STEP FOUR (SELF-INVENTORY):

*We will make a searching, positive inventory of our-*

*selves.*

After taking the step of seeking and accepting help, we find ourselves aware of many negative qualities. In fact, although we might be willing to trust, we may fear that revealing ourselves to others will only be a negative experience. Thus, we ask a person we trust, and a higher power, to help us see our positive qualities. In that way, we can honestly evaluate the presence of both desirable and undesirable qualities.

#### STEP FIVE (RAGE):

*We will admit to ourselves, to God, and to a person whom we trust, all our angry feelings and homicidal rage.*

With an awareness that we are not alone, with improved self-esteem, and with a newfound desire to trust, we hope to understand the reason for our continuing rage. We will take the risk of revealing our angry feelings to a person we trust and God as individually understood. In so doing, we will discover that our anger is likely to be our only defense against helplessness and experiencing other emotions. Thus, this important step will help us open the door to other painful memories and emotions.

#### STEP SIX (FEAR):

*We will open the doors to the past and reveal to God and another person whom we trust, our frightening, traumatic memories.*

After beginning to realize that anger is often a defense against fear, we will now begin to understand the link between the two. In this way, we can begin to accept the fact that fear is normal and relief from fear may be found by facing it with the help of someone we trust and of God, as individually understood.

#### STEP SEVEN (GUILT):

*We will ask forgiveness from God as we understand Him, and recognize we are thus free from condemnation.*

We ask for and accept forgiveness from God, and a person whom we trust, for committing, participating in, or knowing about acts committed which were

unacceptable in our eyes, causing suffering and grief for other persons and now causing us to feel tormented with guilt and self-blame. After having accepted forgiveness from God and from another person(s), we can now forgive ourselves. But we recognize that old habits of self-condemnation are difficult to break. Thus, self-forgiveness must be a daily matter.

#### STEP EIGHT (GRIEF):

*We seek strength and support from God and another person to finally grieve for those whom we left behind.*

We seek strength to complete the grieving process for those who have died. We would like to finally be free, shedding tears without being lost in unending grief. This means also being able to understand the link between grief and all the feelings we have harbored for many years: anger at those who left us alone, guilt about surviving while others were killed, remorse for failing to save people who died, and yearnings to join those whose bodies have already been buried.

#### STEP NINE (FORGIVENESS VS. SELF-CONDEMNATION):

*We reveal to ourselves, God, and those we trust, all remaining suicidal or self-destructive wishes, and make a commitment to living.*

We wish to expose and purge those negative forces within us which still may prevent us from making a complete commitment to life. Thus, after further self-evaluation, we reveal to ourselves, to God, and those whom we trust, all remaining suicidal wishes, and ask to be purged of the remaining, destructive, death forces which have ourselves and others. Then, we seek and accept God's daily strength to make a daily commitment to living.

#### STEP TEN (FORGIVENESS VS. REVENGE):

*We reveal to ourselves, God, and another person, all remaining wishes for revenge, and ask for God's strength to give these up.*

We seek and accept God's strength to give up our wishes for revenge toward those who hurt us and injured or killed our friends and loved ones so we can

learn the full meaning of love of God, of others, and of ourselves.

#### STEP ELEVEN (FINDING PURPOSE):

*We seek knowledge and direction from God for a renewed purpose for our lives.*

Having been freed from those burdens which have kept us from having meaningful and purposeful lives, we are ready to find a renewed purpose for our lives. Recognizing that God's power also can be a source of strength to live, we will daily seek freedom from old burdens or new problems through prayer, meditation, and a daily surrender to God. In this way, we can continue to find daily freedom from the past prison of rage, guilty memories, and impacted grief, and gain knowledge of His purpose for our lives and the endurance to carry it out.

#### STEP TWELVE (LOVING AND HELPING OTHERS):

*Having experienced spiritual rebirth, we seek God's strength to love others and to help those who suffer as we have.*

Having had a spiritual awakening as a result of these steps, we seek to carry this message and to help all those who suffered as we have suffered.

#### SAMPLE 12-STEP PROCESS FOR FACILITATING A GROUP:

##### 1. Opening statement of meeting:

Welcome to the PTSD Twelve Step Group. The PTSD Twelve Step Group is a fellowship of veterans who share their experience, strength, and hope in order to solve their common problem. We believe that PTSD is, in part, a spiritual disease and that changed attitudes can and do aid in recovery.

The PTSD twelve step program is not allied with any sect, denomination, political entity, organization, or institution; does not engage in controversy, neither endorses or opposes any cause. The PTSD twelve step group is self-supporting through its own voluntary contributions.

The PTSD twelve step group has but one purpose:

to help the veteran with PTSD. We do this by practicing the twelve steps, by welcoming and sharing our message with other veterans and their families and friends, and by giving all who need the wisdom of this program, understanding and encouragement.

2. Ask if there are any newcomers to the group.
3. Ask those that are present to introduce themselves.
4. Read the twelve steps of PTSD going around the room.
5. The meeting lasts for one hour. Please stay the full hour so as to maintain order and decorum of the meeting.
6. Please remind attendees about no cross-talking, that is no commenting during someone else's sharing.
7. After those who have share who want to share, if time remains, call on the others if they wish to share again.
8. The closing of the meeting:

In the twelve step PTSD program, we believe life is for balanced living, both mental and spiritual. This

begins for most of us, when we accept the fact that PTSD is not a weakness but the result of a disease. We begin to change when we look within ourselves and find blockages there – blockages in the way we refuse to meet our problems, in the way we attribute all faults to PTSD, and in prolonged self-pity.

The twelve steps for us have been steps to a higher plane. From them we have learned we are less than balanced ourselves and are likely to remain so unless we learn to do something about it. In following the steps, we can gain courage and serenity. Gradually, we leave weakness behind and learn that change, though painful, is worth the suffering.

Would all who care to join us in the Serenity Prayer please stand:

God, grant me the serenity to accept the things I cannot change, courage to change the things I can, and the wisdom to know the difference.

# CHAPTER II

## SPIRITUAL CARE

### INTERVENTIONS-TBI

#### 1. INTENTIONAL MINISTRY OF PRESENCE:

##### *Objective:*

Facilitate spiritual healing through an intentional ministry of presence.

##### *Background:*

Many people with TBI have difficulty expressing themselves verbally, though this does not necessarily mean that they do not understand what is being said to them. As a result, many of the Spiritual Care Interventions that the chaplain would normally utilize with a person may not be as effective without the give and take of a two-way conversation. For many chaplains, this may appear to be unproductive time, or be discouraging due to not receiving the immediate feedback that other patients give. However, an intentional ministry of presence, where the chaplain spends time “just being there” can indeed make a positive impact on the patient with TBI. At minimum, it gives the patient practice with social interaction in a non-threatening environment which has been demonstrated to be very important to recovery.

##### *Recommendations:*

1. The chaplain should spend time with patients with TBI by being intentionally present, without an agenda to accomplish, especially if the patients are unable to express themselves vocally.
2. The chaplain should not assume that this time is wasted, but instead see the time as pregnant with possibility for spiritual healing.
3. The chaplain should not seek to fill the silence between the chaplain and the patient with TBI with words, prayers, spiritual teachings or monologues, but instead focus on truly being present with the patient in the midst of their silence.

##### *Discussion:*

Spending time with a patient with TBI without an agenda can be challenging, even for an experienced chaplain. It is important to remember that the Desired Contributing Outcome for a ministry of presence will be far less concrete than many other Spiritual Care Interventions. It may be to establish a relationship or rapport with the patient. It may be to be present with the patient in the midst of their suffering. But it will likely be less “visible” than many other Spiritual Care Interventions with other patients.

It is also important to remember not to superimpose one’s own spirituality on the patient. It can be tempting to pray for or over a patient, even if they are unable to articulate a request directly. However, this has the potential to put distance between the chaplain and the patient if the patient would not welcome it. Instead, praying silently and/or focusing on the patient directly can yield a strong nonverbal interpersonal connection.

This Spiritual Care Intervention has the Desired Contributing Outcome of establishing a safe and trusting rapport and relationship with the patient, which can often be healing in and of itself.

There is no specialized training needed to utilize the Spiritual Care Intervention.

##### *Evidence:*

Recomendations	Sources	QE	OQ	R
1. Provide an intentional ministry of presence for persons with TBI	(Interview-Ridley)	III	Poor	I

QE= Quality of Evidence OQ=Overall Quality  
R= Recommendation



## 2. SPIRITUAL REFRAMING

### *Objective:*

Assist the patient with spiritual reframing of their current situation and injury.

### *Background:*

One study (Block, 1987) demonstrated that, for many with TBI, there may well be a feeling that they deserved their injury. They may feel that they are a bad person and are being punished by God for something they did or did not do. This belief has some obvious spiritual repercussions. A person with TBI may well attribute their injury and subsequent life changes to God's punitive action.

### *Recommendations:*

1. The chaplain working with someone with TBI who attributes their injury to God's punishment may assist in seeking to reframe their injury as something that God did not do to them because they deserved it; but rather, that God enters into and can potentially help transform their suffering.
2. The chaplain must deal with this assumption of divine retribution actively, consistently and gently. One way the chaplain can help communicate this most effectively is through embodying God's acceptance and love for the person amidst their struggles.

### *Discussion:*

A person with TBI may not have the same cognitive ability to "reason out" their assumptions that they possessed prior to their injury. As a result, the chaplain may need to "think outside the box" about how to best gently and consistently communicate with the person with TBI that they are indeed loved by God and that God is not punishing them. Using art, music, appropriate physical touch, prayer, silence, nonverbal communication and Scripture may be helpful in this regard. The reframing will likely take much reiteration and reinforcement, slowly helping the person with TBI loosen their spiritual grip on a maladaptive assumption that God is punishing them.

One of the frustrations for many TBI patients is the feeling that he or she will never be able to fully recover from their brain injury, and that his or her identity has substantively changed following the injury. The fear the patient has is that he or she will not be the way

he or she was prior to the injury. This may likely be true. In this case, a kind of spiritual reframing can be a healthy Spiritual Care Intervention for the chaplain working with the person with TBI. "It's not so much about recovery as much as discovery," can be a helpful phrase to use gently and repeatedly with a patient expressing this concern. This intervention has the potential to move them out of the past (who I was is so different from who I am now) and into the present and even potentially the future (who can I be?). It recognizes that the patient may well never be the way he or she was pre-injury, but recovery and healing can occur in discovering who they are now, following the injury. This process may take some more in depth work in helping the patient articulate and identify new ways of interacting, perceiving him- or herself, and finding healing without actually being "cured."

This Spiritual Care Intervention has the Desired Contributing Outcome of assisting the patient in reframing their injury as something that is not a result of God's punishment, as well as slowly redirecting the patient's focus from what is not, to the good of what is and can be.

There is no specialized training needed to use this Spiritual Care Intervention.

### *Evidence:*

Recommendations	Sources	QE	OQ	R
1. Assist patient in reframing their injury as something that is not a result of God's punishment.	(Block, 1987)	III	Poor	I
2. Redirect patient's focus from what is not (who they were) to the good in what is and can be (who they can become)	(Interview-Huth)	III	Poor	I

QE= Quality of Evidence OQ=Overall Quality  
R= Recommendation

## 3. FOCUS ON SPIRITUAL GRATITUDE & BLESSINGS

### *Objective:*

Assist the patient through focusing on spiritual gratitude and "blessings."

*Background:*

For many persons with TBI, their recovery will be a long and circuitous journey full of positive milestones and occasional setbacks. As such, the chaplain can help the person with TBI by highlighting his or her strengths, the milestones achieved, how far he or she has come, etc. This kind of spiritual gratitude, or counting one’s blessings, helps the person find some hope and focus less on what they lack or no longer are able to do.

There can also be some “downward comparison” possibilities in the same vein. This occurs when a person recognizes that as bad as things may well be for him or her, he or she is better off than some other people are (quite possibly people he or she knows from rehabilitation). He or she may also be able to articulate how things are better now than they were previously. Just the explicit thankfulness of being alive and surviving their injury can be enough for some patients with TBI to allow them some measure of hope and positive thinking regarding their future.

*Recommendations:*

1. The chaplain working with someone with TBI who is having a difficult time finding hope in the midst of their struggles can assist that person in shifting focus from what he or she does not have or cannot do to what blessings and positive elements are within their current situation or narrative.
2. The chaplain should also consider using downward comparison, which allows a person to see how where they are is not as bad as if could be or as it once was.

*Discussion:*

When the chaplain recognizes that the person with TBI is focusing almost exclusively on what has been lost since their injury, it can prove helpful for the chaplain to inquire about some positive experiences or gifts that the person can begin to discuss. Discussing these positive experiences or resilience can allow for a marked shift of focus for the patient. The more the patient is focusing on losses, the more he or she will potentially feel discouraged and pessimistic about the future. The more the person can look into the rear-view mirror and see how far they have come in their recovery, or see times in their lives when they struggled and emerged from that struggle as a stron-

ger person, the more likely they will begin to hope that positive change is possible, that God may well be amidst even this struggle.

The chaplain can help the patient by beginning to ask what they have to be thankful for. This request must be made with sensitivity, recognizing that there is a risk that the chaplain may be moving away from the pain that the person is feeling and consequently miss an opportunity for comfort, spiritual presence and compassion. Yet, once trust has been established and the chaplain has been able to establish a positive relationship with the patient, it may be appropriate to help the patient begin to shift the focus from the negative to the positive. The concept of spiritual gratitude can be helpful here. The chaplain may ask what the person has to be thankful for, or where they have seen God at work or present with them since their injury (or even when they were injured).

This Spiritual Care Intervention has the Desired Contributing Outcome of identifying some aspects of the patient’s life for which the patient is grateful and assisting in restoring some hope.

There is no specialized training needed in order to use this Spiritual Care Intervention.

*Evidence:*

Recommendations	Sources	QE	OQ	R
1. Redirect patient’s focus from the negative of what has been lost and the difficulties of the struggle to the positive of what the patient has to be thankful for and ways in which they may have some hope for the future based on seeing God’s presence in their struggle.	(Interview-Huth)	III	Poor	I

QE= Quality of Evidence OQ=Overall Quality  
R= Recommendation

# CHAPTER III

## SPIRITUAL CARE

### INTERVENTIONS-PTSD

#### BASIC INTERVENTIONS:

##### 1. INTENTIONAL MINISTRY OF PRESENCE:

###### *Objective:*

Facilitate spiritual healing through an intentional ministry of presence.

###### *Background:*

Most people with PTSD have “trust issues” or issues with abandonment. As such, it is imperative that chaplains be consistent in their interactions. If the chaplain has committed to meet the patient at 2:00 pm on Tuesday, it is important in establishing this trust to be on time and not cancel the appointment if at all possible. Making oneself available as a chaplain and consistently, even pro-actively, being present allows the person with PTSD to be able to “count on” the chaplain.

It can also be helpful to persons with PTSD, who often struggle with issues of self-esteem and worthiness, to know that another person is concerned about them personally. It is subsequently important to remember their name, and anything else that communicates a caring, compassionate focus on them as a person worthy of the chaplain’s (and, by association, God’s) time, energy and effort. It can even be helpful to ask them if you can call them to check on them on occasion, and to do so.

A person with PTSD may well struggle to keep his or her appointment with the chaplain for various reasons. If this does occur, it can be helpful for the chaplain to call the person or swing by their room and check in on them, letting them know they were missed and seeking to reschedule the appointment. It is important to not use guilt as a motivator, but rather to stress that he or she was missed and that the chaplain cares about him or her personally and is invested in their personal relationship.

This consistent, pro-active spiritual presence can be therapeutic for the patient with PTSD. Anything that allows for routine and demonstrates responsibility reinforces that you are trustworthy. Much more can be read about the background of the need for this intervention in the section on establishing trust.

The patient is the one who should ultimately be seeking to make meaning from his or her own experience. The move toward this process should not begin with the chaplain (Miller, L., 2008). Most often, when a chaplain initiates this meaning-making discussion, it is motivated primarily by the chaplain’s need to play the rescuer bestowing a magical gift of a new and better or more meaningful life. This situation can be not only unhealthy for the patient, but can work against the very trust and safety that is the foundation of the chaplain-patient relationship.

###### *Recommendations:*

4. A chaplain should focus on providing a spiritual presence with a person with PTSD without an agenda.
5. The chaplain should seek to gently, appropriately be pro-active in his or her provision of spiritual care presence with persons with PTSD.

###### *Discussion:*

The person with PTSD will likely have anxiety about relationships, including issues with trust and abandonment. The chaplain can exacerbate these by not being consistent or pro-active in interacting with patients with PTSD, such as not doing something that was promised. People with PTSD often have highly attuned intuitions regarding interpersonal relationships, and the chaplain must do his or her best to maintain a positive, pro-active spiritual presence in the life and ongoing journey to recovery for those people.

The primarily Desired Contributing Outcome for this Spiritual Care Intervention of Providing an In-

tentional Ministry of Presence is the establishment of trust, safety, consistency, and a rapport and relationship with the person for whom relationships and trust are a struggle. This relationship can often be healing in and of itself. It is only once this trust is established that any more in depth spiritual care can be provided.

There is no specialized training needed to utilize the Spiritual Care Intervention.

*Evidence:*

Recommendations	Sources	QE	OQ	R
1. A chaplain should focus on providing a spiritual presence with a person with PTSD without an agenda.	Interviews with numerous chaplains	III	Poor	I
2. The chaplain should seek to gently be pro-active in his or her provision of spiritual care presence with persons with PTSD.	Interviews with numerous chaplains	III	Poor	I

QE= Quality of Evidence OQ=Overall Quality

R= Recommendation

2. MEANING MAKING:

*Objective:*

Assist the person with PTSD in making meaning following trauma.

*Background:*

The place and importance of meaning-making for a person with PTSD and the role of the chaplain in that process constitute a very broad area of concern. Many symptoms – not only those from the three clinical symptom clusters but also other symptoms of a person in spiritual distress such as anger, feelings of betrayal, polarized thinking (black or white, right or wrong, etc.), and struggling with assumptions about God – have numerous Spiritual Care Interventions which seek to address one over-arching component –how to make sense of the world, God, and one’s self after having experienced a trauma.

Researchers have sought to understand how it is that trauma impacts existing beliefs and assumptions about both oneself and the world (Ogden, et al., 2000). They

have concluded that the three most commonly impacted assumptions are invulnerability and personal safety, that the world is not inherently just and orderly, and that it can be extremely difficult to find a meaningful answer to the question of why it is they have experienced this trauma. As a chaplain seeks to work with a person with PTSD, it can be helpful to know which, if any, of these assumptions the person is struggling to reframe and/or redefine.

Significant research by Alan Fontana describes how the majority of people who have difficulty coping with the experience of a trauma are struggling with a loss of meaning in their lives. In his research, he found that veterans who have suffered a greater loss of meaning are more likely to seek help from clergy and VA mental health professionals (Fontana & Rosenheck, 2005). Those who seek help from clergy are primarily seeking a restoration of meaning that is specific to their loss. Fontana compares this loss of meaning to a weakening of religious faith. He states that “those who had suffered a greater loss of meaning from their war experiences were more likely to seek help from clergy than those who suffered a lesser loss of meaning.” (Fontana & Rosenheck, 2005). As a result, he concludes that a greater consideration should be given to addressing existential questions in the treatment of PTSD, and that these existential questions differ qualitatively from questions of interpersonal and social dysfunction in that resolution of existential questions requires an examination of the bases for moral judgments.

In a related study (Fontana & Rosenheck, 2004), Fontana also found that the primary motivation of most veterans for continuing pursuit of mental health treatment at VA hospitals is the search for meaning and purpose following their traumatic experiences. This is not the assumption that most mental health professionals have made and from which they operate. From their perspective, most veterans seeking assistance from the VA mental health professionals are seeking help with the three clinical symptom clusters – intrusive recollection, avoidance / numbing, and hyper-vigilance. As a result, Fontana concludes that the existential search that most veterans are pursuing is central to the spiritual care that chaplains can and should be providing for them. He sees one of the most far-reaching struggles for a person with PTSD as the loss of meaning or purpose in life that is often experienced as a weakening of religious faith or

spiritual distress or despair. He points to research that demonstrates a significant inverse relationship between strength of religious faith and severity of PTSD symptoms. (Fontana & Rosenheck, 2005). Fontana's example of a nineteen-year-old service member is described in the section above on integrating with the mental health team.

For many people with PTSD anger is also an issue relating to their struggle with meaning making. A kind of cognitive shattering that can occur after experiencing such a traumatic event can raise anxiety with a strong undercurrent of rage. Nothing feels safe any more, and everything appears vulnerable or up for grabs. This condition all originates from cognitive disruption that occurs in the person seeking to make sense after a trauma. One can have a sense of their country prior to trauma, but then, after being in combat, that assumptive understanding is shattered. His or her country now can appear far less benign, less caring, more callous, and more calculated. As a result, many can have anger or rage toward their own country – even as they remain deeply patriotic and proud of the service they have provided it.

A person with PTSD can also be angry due to how much he or she has changed and how much he or she and others have sacrificed in contradistinction to how little the civilian population, and even the government in charge, has suffered or sacrificed. His or her sense of what it means to be human is also shattered, especially if he or she feels a sense of injustice. As a result of his or her suffering, humans can no longer be trusted, and are no longer considered innately noble and upright. The person with PTSD may well feel that he or she was not able to be noble in that traumatic situation as meaningfully as he or she would have liked. Consequently, he or she will feel guilt, shame, and anger that God did not respond or protect or prevent the suffering from occurring.

Once a person's assumptions about him- or herself, the world, and God have been shattered, it is necessary to help this person to reconstruct meaning (Cadell, et al., 2003). Southwick, et al. (2005) have pointed out that there are specific psychological factors that are associated with depression on one end and stress or traumatic resilience on the other. These include: positive emotions, cognitive flexibility, religion/spirituality, social support, role models, coping style, exercise, capacity to recover from negative events, and stress inoculation.

Resilience can be defined as the process of adapting in a healthy way amidst trauma, tragedy, threats and/ or significant sources of stress such as relationship problems, health problems, or workplace and financial stressors. It means being able to “bounce back” from difficult and traumatic experiences. Being resilient does not mean that a person does not suffer or experience distress. Emotional struggles are normal and to be expected for people who have experienced significant trauma. Any journey leading to resilience will likely involve emotional struggle and difficulty in healing. However, people can and do experience positive transformations in their lives after a trauma, and for many people this takes on a spiritual component or understanding. This kind of growth is called post-traumatic growth and happens concurrently with the struggles and difficulties that may occur as someone responds to and processes a trauma. Post-traumatic growth goes beyond resilience and involves not only the ability to bounce back, but to also grow.

There is a resilience-focused way to look at trauma and its impact on a person. Recent research has begun to explore resilience that refocuses the discussion away from pathology and dysfunction and instead explores resilience and strength (Shaw, et al., 2005). For many who are doing their best to cope with traumatic events in their lives, they may experience significant changes in life priorities, a greater appreciation of life and its pleasures, and a stronger focus on their spiritual and/or religious life and issues. The majority of the world's religions, including the Jewish, Christian, Hindu and Muslim faiths, view suffering as a way a person can grow and develop wisdom, as well as a potential bridge to a deeper relationship with the divine. As a result, the chaplain can help the person with PTSD connect with his or her own spirituality and/or religious faith and teachings following a trauma. These beliefs may have assumptions or areas of emphasis that need to be reframed or reprioritized, and a chaplain is in a unique position to help the patient do this.

Tedeschi has developed a Post Traumatic Growth Inventory (PTGI) for measuring a person's growth following trauma (<http://locator.apa.org/ptgi/>). The main categories the scale assesses are: relating to others, new possibilities, personal strength, spiritual change, and appreciation of life. The positive benefits within each of these categories can be seen as Desired Contributing Outcomes of one's coping with his or her

traumatic experience. (Tedeschi, 1995)

With positive emotions, including optimism and humor, there should be a broaden-and-build approach to describe their impact on a person's resilience. As opposed to negative emotions, which narrow one's attention in order to enhance specific action or escape (fight or flight), positive emotions such as joy, interest, contentment, pride, and love broaden attention with such results as creativity, exploration and spontaneity. Of note is that humor has been demonstrated to be one of the more mature defense mechanisms and may generally be viewed as a healthy coping strategy which can decrease the likelihood of depression.

With cognitive flexibility, which includes a positive explanatory style, the ability to positively reappraise a situation, and acceptance, a chaplain can help the person with PTSD redefine or reframe his or her trauma as a challenge and search for meaning in response to it. The kind of resilient or positive changes a person can make following a trauma are a direct result of in-depth work as a person questions or challenges, shatters, and then rebuilds his or her basic assumptions about the world. A resulting lesson or conclusion may well include a greater appreciation for one's gifts or strengths (such as bravery), the development of new gifts or strengths (such as wisdom), a reaffirmation of the preciousness of life, and a reprioritization of one's focus of energy.

Other possible positive outcomes from this journey of rediscovery include a greater sense of solidarity with humanity, an increase in one's sense of community, an enhanced ability to have compassion and acceptance for others and their weaknesses, stronger ties to family and friends, a renewed spiritual or religious passion and commitment, a renewed appreciation of nature or pets, development of more effective and healthy coping skills for future stressful situations, a renewed commitment to health and wellness, an overall greater appreciation of life, and a newly-discovered meaning and purpose – often with a change or shift in emphasis in one's values, priorities, perspectives, and/or philosophy. A chaplain can work with a person with PTSD on these potential outcomes and know that these are focusing on post-traumatic resilience or growth.

Research with spirituality and religion has shown that they can help protect and enhance a person's physical and emotional well-being and contribute to resilience, as well as serve as a vital resource in cop-

ing with a trauma or suffering (Cornah, 2006). The more a person uses positive religious activities, personal spiritual practices, and involvement in a spiritual community to cope with a trauma, the less likely that person is to develop depressive symptoms. Within the framework of spirituality and religion, a focus on altruism and helping others can serve as a way to move the focus off of one's own struggles and begin to build self-esteem, feelings of worth and positive influence, and connection with others.

One helpful piece of information in seeking to communicate the idea that even a difficult or traumatic situation can be an opportunity for growth and maturity is seen in the Chinese symbol for the word "crisis", which combines the characters for danger and opportunity. For some people with PTSD, the realization that something positive is possible in the aftermath of a traumatic experience can be comforting (Chan, et al., 2006). In order to be able to adapt to the stress and life after such a traumatic experience, a person can seek to seize the opportunity for transformational coping, which is coping that benefits and changes a person positively. Just because a person has struggled or is struggling does not mean that they cannot thrive, or transform. It can be helpful to point out that the Chinese word for "trauma" (chuangshang) is the combination of two characters: "creation" (chuang) and "hurt" (shang). As a person seeks to make meaning following a trauma, he or she may well achieve enhanced personal maturation and wisdom. This result can be seen in the potential Desired Contributing Outcomes of a greater appreciation of relationships with others, increased personal strength, the evaluation of new possibilities in life, and an enhanced spiritual connection. A chaplain is in a wonderful position to assist the person with PTSD in recognizing that the trauma may well represent an opportunity to transform and sculpt their life into something they would like it to be.

For a chaplain working with patients with PTSD, this realization can be very helpful. As a person seeks to make meaning of the experience that they have had, a chaplain can help them focus on potential positive outcomes. This can be a renewed perspective on life, a reframing of former assumptions about God or one's self, an increased awareness of well-being and appreciation for the "little things." It can also lead a person to have a greater appreciation for, and motivation to seek and cultivate meaningful relationships with friends, with the divine, with a spiritual commu-

nity, and with family. Finally, focusing on resilience can allow a person to re-evaluate his- or herself as someone who can “take one on the chin,” and still be standing, who has an inner fortitude or is blessed by God enough to be able to not merely survive but be positively transformed through such a horrific experience. Specifically, searching for, finding, and redefining what a person finds as meaningful as a result of a trauma is not just a way of coping or distraction therapy, it is a pathway to transforming into something greater, better, and/or stronger than what was before.

Indeed, many people turn to their religious or spiritual beliefs or faith system for growth, meaning, and thriving after having experienced a trauma. Janoff-Bulman, in his book *Shattered Assumptions: Towards a New Psychology of Trauma*, writes that when a person experiences a trauma, that trauma shatters his or her assumptions about the world. In order to recover or heal psychologically from a trauma, a person should pro-actively construct new, revised or matured assumptions about the world that somehow incorporates the trauma into that worldview and new assumptions about it, God, and one’s self. The most basic assumption one who has experienced trauma is often seeking to redefine and rebuild is related to one’s purpose in life, relationship to significant others and self, and the divine. For many people, spirituality and/or religion can assist in providing an enhanced sense of meaning, and traumatic events can often lead to an enhanced spiritual or religious life (Shaw, et al., 2005).

It can be important to reinforce with a person with PTSD that when one finds meaning in a trauma, it does not mean that he or she will no longer suffer the consequences of that trauma. The goal of redefining and post-traumatic growth is to be able to incorporate that person’s after-effects of the trauma into the newly-revised worldview and spiritual understanding of oneself. Research has also demonstrated that when one bolsters or focuses on one resilience factor, that focus and energy has a positive impact and effect on other resilience factors (Southwick, et al., 2005). A chaplain can help a person focus his or her attention not on the struggles so much as on the victories, the positive emotions and by-products of experience, and the possibilities for hope and optimism. In doing this, it is important not to minimize, trivialize or pass over the very real negative impact of the trauma, in which case one runs the risk of invalidating the person’s experience. However, through respectful asking of questions,

guidance and subtle direction, a chaplain can indeed help the patient focus more on the hope and optimism than on the suffering and pathologies.

Fontana suggests that some healing for veterans seeking to make meaning following a trauma comes through an exploration of the redemptive role suffering has in many religious traditions. He also points out that there can be a focus on the potential for spiritual growth resulting from the trauma shattering the prior assumptions about meaning and purpose in life. Those pre-trauma assumptions may be replaced by something more mature, more realistic, more personally fulfilling and spiritually healing. He concludes that veterans “motivation for continued pursuit of mental health services does not appear to be primarily greater symptom relief or more social contact” but rather “their search for meaning and purpose to their traumatic experiences.” (Fontana & Rosenheck, 2004)

The difficulty in this dynamic is that veterans seeking to make meaning are looking to their therapists and mental health professionals to provide answers that are no longer being supplied by their religious faith. Fontana advocates that “among psychiatric disorders, however, the particular expertise of pastoral counselors would seem to be essentially relevant to the needs of people with PTSD because challenges to peoples’ beliefs concerning the meaning and purpose of life are common sequelae of exposure to trauma, and these beliefs are rooted inherently in existential issues that are at the center of religion and spirituality.” (Fontana & Rosenheck, 2004)

The chaplain can assist the person in making meaning of their trauma by seeking to help the person identify moments of transformation and/or resurrection not only in the midst of the traumatic experience, but in his or her life both before and after the trauma (Vanista-Kosuta & Kosuta, 1998). The chaplain’s role in this is to help the person with PTSD identify what it is that gave his or her life meaning prior to the trauma (Rogers, & Koenig, 2002). Then the chaplain can help guide the person in recreating a spirituality – a way to make meaning – with his or her new, revised perspectives and lessons and understandings of the world as seen through the eyes of someone who has experienced trauma. This spiritual woundedness may well be more devastating to the person than any of the psychological symptom clusters most commonly associated with PTSD.

Chaplains are in a unique position within the in-

terdisciplinary team to work with people who have experienced trauma around issues of meaning-making (Fontana- personal communication, January 23, 2009). One tool that a chaplain has is the storehouse of stories, parables and myths that deal with existential questions of life; where did we come from? Why are we here? What is the interplay between good and evil? What happens when I die? Each religious tradition addresses these existential questions with their stories.

One of the unique attributes of chaplaincy care is its ability to offer stories which express these eternal issues and propose meaningful answers. Through these stories, a veteran with PTSD is able to see that his or her own story is not as unique, not as idiosyncratic as he or she might have thought. They are not that unique in their suffering. They are not different from the rest of us. This realization has the potential to enable them to accept some sort of leniency in their moral judgments about themselves.

A chaplain may also need to help the person with PTSD integrate the trauma and its after-effects into his or her self-concept (Paquette, M - personal communication, January 22, 2009). The affirmation of the idea that he or she is indeed different now, not bad or worse, but fundamentally changed by the trauma can be healing for the person with PTSD. One chaplain describes the change as being like a cup of black coffee and a cup of coffee with cream and sugar. The coffee is still coffee, but it is also fundamentally different now. A person with PTSD can be encouraged to come to grips with the fact that he or she is no longer that cup of black coffee.

It is helpful for the chaplain to be able to assist the person with PTSD in identifying who his or her functional, realistic God is. What is his or her source of hope? Once that is identified, the chaplain can begin to build on that as a foundation for healing (Wilson, J & Taylor, B, personal communication, February 2, 2009).

#### *Recommendations:*

1. The chaplain should assist the patient with PTSD in making meaning through helping the patient integrate the narrative of the trauma into the greater narrative of his or her life.
2. The chaplain should assist the patient with PTSD in making meaning through helping the patient to better live with ambiguity.
3. The chaplain should assist the patient with PTSD

in making meaning through a focus on potential resilience and strength rather than dysfunction and pathology.

#### *Discussion:*

There are many formal and informal ways in which a chaplain can seek to assist a person with PTSD in meaning making. William P. Mahedy, in his book *Out of the Night: The Spiritual Journey of Vietnam Vets* demonstrates that many service members have particular issues that they are in anguish about. A chaplain can then match those issues with some story from the Bible. This is called Scriptural Paralleling, and is discussed as an independent Spiritual Care Intervention below. One of the potential Desired Contributing Outcomes for this would be that the patient with PTSD sees that what he or she has experienced is one journey in the human condition that can be placed in the context of a Greater Story. This is part of being human in these circumstances, and it can be possible to accept things he or she has been beating him- or herself up about and/or feeling guilty about. Once this realization has taken place, a person can turn toward what to do for the rest of his or her life.

Also as a result of the trauma the person with PTSD has experienced, that person's God image has been impacted or even shattered along with many other existential assumptions (Organ, personal communication, January 12, 2009). The God they thought they knew along with how that God interacts with humanity and the world are changed now that they have experienced this trauma and its after-effects. A chaplain as spiritual care provider can help rediscover, restore and reframe an image of God/sacred that would make sense in the context of what that person has witnessed or experienced. More can be read about this specific Spiritual Care Intervention in the section called "Reframing God Assumptions, Examining Harmful Spiritual Attributions."

The Desired Contributing Outcome for working with a person who is struggling with issues of anger and betrayal by country or civilians would be to seek to facilitate a less polarized way of thinking. The person in this circumstance is having a lot of black or white, good or bad, right or wrong thinking – with little if any nuanced or realistic understanding of human nature or critical reflection on the assumptions behind the tensions. That his or her ideals are not lived up to does not mean that the ideals are not valuable. To be



able to reappraise his or her experience and assumptions and think critically about them can be extremely beneficial.

Another study (Hautamäki & Coleman, 2001) attributed one group of Finnish veterans' ability to find resilience following their traumatic experience in World War II to their being able to give meaning to the suffering they experienced. This meaning proved more powerful in the context of community and the relationships therein. The Finnish culture continually reiterated their gratitude for the sacrifices and service of the service members, and found pro-active ways in which to memorialize this. The authors stress social support as a key mechanism that allows the person with PTSD to make meaning and ultimately supports the long-term effectiveness of the person's resilience in preventing PTSD. More can be read about the potential Spiritual Care Intervention of connecting a person with PTSD with a spiritual community in the section below devoted to that topic. These resilient veterans were able to assimilate their war traumas into the narrative of their lives, resulting in the authors' declaration that suffering can be endured in the long run if it can be made meaningful. The Desired Contributing Outcome for a chaplain working with a person and his or her significant others would be to assist them in endowing the trauma and its after-effects with a collective and personalized meaning.

There is no specialized training needed for a chaplain to work with meaning making with persons with PTSD. This intervention is in many ways one of the central and beneficial goals a chaplain can have.

*Evidence:*

Recommendations	Sources	QE	OQ	R
1. The chaplain should assist the patient with PTSD in making meaning through assisting the patient to integrate the narrative of the trauma into the greater narrative of his or her life.	(Mahedy, 1986)	III	Poor	I
2. The chaplain should assist the patient with PTSD in making meaning through assisting the patient in being able to better live with ambiguity.	Interview with Major Organ	III	Poor	I

Recommendations	Sources	QE	OQ	R
3. The chaplain should assist the patient with PTSD in making meaning through a focus on resilience and strength rather than dysfunction and pathology.	(Hautamäki & Coleman, 2001)	II	Fair	I

QE= Quality of Evidence OQ=Overall Quality  
R= Recommendation

3. GRIEF WORK:

*Objective:*

Assist the person with PTSD work through unresolved grief.

*Background:*

In many ways, PTSD is an overloaded grief response. A person can become so severely overloaded that the normal grief process gets interrupted and stuck. It can be a delay of normal "emotional digestion". A chaplain can be an integral partner with mental health professionals in working with a person with PTSD who is struggling with grief. Most chaplains deal with loss and grief on a nearly daily basis. As a result, this section will look at spiritual care for those with PTSD who are grieving instead of talking about global loss and grief issues.

For a person going through a normal grief process, his or her initial outcry and anger will evolve into a cycling between denial, disbelief and numbing, and intrusion of painful loss-related memories. In a healthy or normal grief response, all of these ultimately result in a new adjustment that integrates the loss into the person's life and worldview. While it is nevertheless painful, neither the denial nor the intrusion would be overwhelming or incapacitating for too long. By contrast, PTSD involves a re-experiencing of the trauma-related memories that get stuck – consistently being overwhelming and paralyzing. The person with PTSD is ill-equipped and ultimately unable to cope with the intrusive recollection – the traumatic memories – and finds ways to avoid them – drugs that may dull them temporarily, avoiding intimacy that feels too vulnerable, etc. The person is unable to work through the grief because working through it would require the ability to tolerate and deal with what has been lost. PTSD occurs precisely because tolerating and dealing with the loss is not currently possible.

The experience of the trauma is beyond compre-

hension – not only for those who develop PTSD but for others who do not. For those who develop PTSD, they often get into a loop of perpetual avoidance. They understandably fear the intrusive memories and do not wish to experience them ever again, so they run and avoid at all costs. Because of this loop of avoidance and intrusive memories, people with PTSD subsequently have an extremely difficult time living their lives following the trauma. Anger and other emotions feel out of control, and they feel frazzled all of the time. Some look to alcohol or drugs, others to sex or suicide – but most have a difficult time maintaining and developing close relationships.

People with PTSD may well be experiencing a traditional loss pattern related to either the traumatic event or other life experiences before or since that trauma. For many with PTSD, there may be an additional loss of innocence, faith (in God, in the nation or military, in society, in him- or herself as a good person, etc.), assumptions about the world, the future, or even a limb or adjustment to a new life with a combat-related injury.

As the person with PTSD is seeking to reframe his or her assumptions that were held prior to the trauma to accommodate the experience of that trauma, so grief is about redefining one's understanding of the world, oneself, and others.

#### *Recommendations:*

1. The chaplain should assist the person with PTSD in identifying what specific losses the person is grieving.
2. The chaplain can provide a safe place for the person with PTSD to actively express his or her grief, anger, resentment, and other “negative” emotions.
3. The chaplain can provide some basic grief education to help normalize the emotional cycles and responses a person is having.
4. The chaplain can assist the person with PTSD in identifying positive and effective coping strategies, including but not limited to religious and spiritual exercises.

#### *Discussion:*

The Cognitive Behavioral Therapy (CBT) and other psychotherapeutic modalities done by mental health professionals will assist the person with PTSD through providing a safe place in which to explore, unpack,

reappraise, and eventually work through his or her traumatic memory. The chaplain can work alongside the mental health professionals through understanding the processes they are using, where the person currently is within those processes, and proactively communicating with the mental health professionals about each person with PTSD with whom the chaplain is working. It is also important to “stay in one's lane” – that is, to provide spiritual care and not psychotherapy if one's role is chaplain.

The chaplain can walk with this person on his or her journey toward healing through an intentional ministry of presence. This grief work is in no way formulaic, but does tend to follow some basic trajectories. The first step would be the chaplain assisting the person with PTSD in identifying what specific loss or losses he or she is grieving. Once the loss has been identified, a chaplain may help the person put a voice or action to his or her pain through an empowering a safe outcry of grief. The person will then likely cycle back and forth between some kinds of denial and some intrusions of unwanted thoughts, feelings, and memories of the loss. The chaplain can assist in normalizing these responses and providing some basic psycho-education concerning grief responses. The person will then arrive at a place of being able to actively work through his or her grief.

For the chaplain to help the person identify what specifically has been lost can take some time. Relationship and rapport, trust and safety are all prerequisites for this work to begin. This process often needs time, consistency and compassion. As the person begins to feel safe, he or she will likely begin to divulge what loss it is he or she is grieving. The chaplain can assist in asking clarification questions, and gently probe to find not only the loss associated with a person's death or injury, but also the “existential” losses of faith, belief in one's basic goodness, etc. It is important for the chaplain to allow the person with PTSD to set the pace and make any major “move” toward trust, as a premature question or ill-timed suggestion may backfire and put distance between the person and the chaplain. Further discussion of this process can be found in the section on Need to be a Nonjudgmental Presence.

The chaplain can then assist the person who has articulated the loss with finding voice to express how much that loss hurts. Again, safety is paramount. This expression can be through screaming, finding a safe

and socially-acceptable physical outlet (such as vigorous exercise, martial arts, etc.), writing, music, or any other means that allows a person to get in touch with the raw pain that he or she has experienced. It is essential that the chaplain remain emotionally present with the person in this process, avoid being “shocked” at his or her narrative of trauma or response to it, and find ways of encouraging authenticity. This process can be terribly painful. The chaplain can encourage the person to find voice for his or her lament through use of sacred Scripture – the book of Psalms, Job, Ecclesiastes, or connecting the David narrative to the corresponding Psalms as a way of educating and modeling for the person that it is OK to bring one’s pain before God. God is “big enough” to handle his or her anger, pain, suffering and wounds.

Once there has been an opportunity for the person to voice his or her grief, the chaplain can help him or her by providing some basic psycho-education about what to expect next. The cycle between avoidance and intrusive memories of loss, some denial followed by some frightening or overwhelming episodes of nightmares or flashbacks – all of these are normal and can be expected. The more this situation is seen as normal, the easier it is for the person to deal with. The more the person with PTSD knows to expect these as possibilities – the less overwhelming and terrifying they can be when they do occur. The chaplain can also work with the person in processing how these are impacting his or her life – socially, personally, spiritually and emotionally.

Once this cycle begins to dissipate, the more in-depth grief work begins. This is the part of the process that is much more familiar to the chaplain who has worked with others on grief and loss. Grief support groups can be extremely helpful here as well as in earlier stages, supplemented by some one-on-one time with the chaplain. In this phase, the chaplain can assist the person in finding constructive outlets for his or her loss and energy, finding positive coping strategies (including but not limited to religious and/or spiritual ones), and encourage social support and connection.

The chaplain does not need any additional specialized training to work with persons through their PTSD-related grief.

*Evidence:*

Recommendations	Sources	QE	OQ	R
1. The chaplain should assist the person with PTSD in identifying what specific losses the person is grieving	(Dombeck, M- Accessed 4/16/09)/Interview with numerous chaplains)	III	Poor	I
2. The chaplain can provide a safe place for the person with PTSD to actively express his or her grief, anger, resentment, and other “negative” emotions	Interviews with numerous chaplains	III	Poor	I
3. The chaplain can provide some basic grief education to help normalize the emotional cycles and responses a person is having	Interviews with numerous chaplains	III	Poor	I
4. The chaplain can assist the person with PTSD in identifying positive and effective coping strategies, including but not limited to religious and spiritual exercises.	Interviews with numerous chaplains	III	Poor	I

QE= Quality of Evidence OQ=Overall Quality  
R= Recommendation

# SPECIFIC CHAPLAIN INTERVENTIONS:

## 1. CLINICAL USE OF PRAYER:

### *Objective:*

To assist the person with PTSD with the use of prayer as a coping strategy in order to strengthen his or her spiritual connection to the divine and to cathartically ventilate negative emotions.

### *Background:*

Prayer is one of the most important spiritual tools available to the chaplain and the person with PTSD. For many with PTSD, prayer may initially be a struggle due to a myriad of reasons – feeling too guilty or dirty as a result of actions in the combat theater, feeling too intimate or out of control in trying to speak with or to God, feelings of anger, betrayal, and abandonment in a relationship with God, etc. These obstacles to prayer should be addressed directly and patiently by the chaplain, not as something that is wrong and in need of correction; but rather, as a normal and understandable reaction to the struggles the person is undergoing.

There is a wide variety of “types” or areas of focus for prayer. Richard Foster’s book, *Prayer: Finding the Heart’s True Home* is a useful reference in working with persons in the Jewish or Christian traditions. The types of prayer that may be helpful to veterans include but are not limited to: supplicatory or petitionary prayer, prayers of thanksgiving, prayers of praise, conversational prayers, silent or contemplative prayers, the Serenity Prayer, the Lord’s Prayer, the Hail Mary, intercessory prayer, centering or breath prayer, soothing prayer, and prayers for healing or reconciliation. Each type of prayer and its potential Desired Contributing Outcomes will be discussed briefly in the Discussion section below.

### *Recommendations:*

1. Prayer can be used to help the patient with PTSD connect more closely with the divine.
2. Prayer can be used help the patient with PTSD articulate what it is he or she needs in order to heal.
3. Prayer can be used to help the patient with PTSD verbalize how he or she has been blessed.
4. Prayer can be used to help the patient with PTSD

connect more closely with his or her religious upbringing and resources.

5. Prayer can be used to help the patient with PTSD find ways of letting go of what he or she cannot control and focus on what he or she can control.
6. Prayer can be used to help the patient with PTSD connect with others through praying for them and/or for the relationship with them.
7. Prayer can be used to help the patient with PTSD soothe or calm his- or herself.
8. Prayer can be used to help the patient with PTSD feel empowered to heal and/or to be reconciled with the divine, the faith community, or significant relationships in his or her life.

### *Discussion:*

Supplicatory or petitionary prayer is often one of the most familiar kinds of prayer for people (Hokana, *Types of Prayer Handout*). In this type of prayer, the person praying asks God for something he or she feels they need or want. This prayer can be helpful for the person with PTSD in identifying what it is he or she needs or wants. In doing this, the person is allowing him- or herself to not have complete control and not know all of the answers. It is seeking help from outside him- or herself. A helpful Christian Scripture for this type of prayer is Philippians 4:6, which states, “Do not worry about anything, but in everything, by prayer and supplication with thanksgiving let your requests be made known to God.” The person asking for God’s help or assistance acknowledges on some level that help is indeed needed. A person using this type of prayer will often pray for healing in a broad, generic way. A chaplain can ask them to expand on that more in depth – what specifically needs healing and how might one know that God is answering this specific prayer? One Desired Contributing Outcome with this type of prayer is for the patient to be able to verbalize what specifically he or she feels is needed to move closer toward healing.

Another potentially constructive type of prayer for the chaplain to use with the person with PTSD is a prayer of thanksgiving. For many people with PTSD, their global view can be so distorted that there is a blanket assumption that nothing good happens to them any more. A chaplain can help reframe this myopic assumption through asking the person with PTSD what good has happened to them this week, or since the last time they met. This strategy allows the person

with PTSD to take his or her eyes off the negative and what is missing or broken, and instead search for and rediscover areas of his or her life which are going well, that are contributing toward healing, and which may be seen as hopeful. A Desired Contributing Outcome for this type of prayer would be for the person with PTSD to begin to be able to articulate what he or she is thankful for (either in his or her life prior to the trauma, during the trauma itself, or since the trauma has occurred), and to refocus attention on what is going well rather than what is not.

A prayer of praise is slightly different from a prayer of thanksgiving. The prayer of thanksgiving is thanking God for what God has done (saved me from the IED blast, brought me home from the war, etc.), whereas the prayer of praise is more about whom God is. There are numerous examples throughout the Hebrew book of the Psalms of praise or Hallelujah prayers. A Desired Contributing Outcome for this type of prayer may be to assist the person with PTSD in shifting the focus away from a self-centeredness and onto a focus beyond one's self.

A conversational prayer is less formal or structured than most other types of prayer. It is a more free and open communication, an attempt to exchange ideas between the person and the divine. This kind of prayer is often creative and can take a wide variety of forms. A person may wish to write in a journal, to pen a poem or letter to God, or create something artistically or musically. It may take place in different contexts – a conversation while driving down the road, while taking a shower or while exercising. One Desired Contributing Outcome for this type of prayer would be for a person with PTSD to feel more personally connected with God – to feel as if God “gets it” about what he or she is struggling with on a daily basis. Another Outcome would be for the person to understand that he or she can talk to God at any time without worrying about the language of formal prayer. A chaplain can serve as a brain-storming facilitator for a person in bringing up this type of prayer.

A silent or contemplative prayer requires more discipline and open-mindedness than many other forms of prayer. It is often indistinguishable from meditation. Instead of the person doing the praying seeking to articulate something to God, this prayer is a time of silent reflection and contemplation. The person is seeking to be open to God speaking or breaking into his or her world in some way. The person is inviting God to

be present in his or her immediate situation, and then sitting there expectantly searching for how God may be experienced. For this, a person should sit comfortably, turn off or put away any potential distractions (television, books, computer, phone, etc.), and reflect on God and how God may have been involved in his or her life prior to the trauma, during the trauma, and in the time since the trauma occurred. This openness to being in God's presence can be powerful. There should be no goal other than to sit and allow God's presence to wash over the person. The chaplain can be a guide in this process in the moment, or can help explain how to do it, and encourage the person with PTSD to report back how it went for them between chaplain visits. A Desired Contributing Outcome for this type of prayer is for the person to feel a stronger sense of God's presence with him or her in everyday life as well as an increased feeling of peace and contentment.

There are several scripted prayers that may be helpful in working with persons with PTSD. The most commonly used would be the Lord's Prayer. This Christian prayer is used most commonly by Roman Catholics and “mainstream” Protestant Christians (Lutheran, Episcopal, Methodist, Presbyterian, etc.). The more liturgical the tradition (the “high” churches), the more likely it is that the tradition uses the Lord's Prayer. The less liturgical the traditional (the “low” churches), the less likely the person is to be familiar and comfortable using the Lord's Prayer. There are several slight variations, noted below as appropriate. The basic Lord's Prayer states,

*Our Father, who art in heaven  
Hallowed be thy name.  
Thy kingdom come,  
Thy will be done,  
On earth, as it is in heaven.  
Give us this day, our daily bread.  
And forgive us our trespasses (Presbyterians & Reformed Traditions use debts)  
As we forgive those who trespass against us (Presbyterians & Reformed Traditions use as we forgive our debtors)  
And lead us not into temptation  
But deliver us from evil  
(For thine is the kingdom,  
And the power, and the glory forever and ever.) – this phrase is not used by some traditions  
Amen.*

This prayer can be discussed line by line, as well as be a resource that reaches back into the religious upbringing for many Christians. Because of its familiarity (like the 23rd Psalm), it can elicit a deep emotional and spiritual connection from many. For many with combat-related PTSD, the section about forgiveness may well be extremely powerful if used in discussion (see section on Guilt / Forgiveness as a Spiritual Care Intervention below). The Desired Contributing Outcomes for the use of this prayer include an increase in connection with the religious teaching from one's upbringing, an exploration of the potential impact of forgiveness on a person in relationship with God, and a way to articulate a prayer when spontaneous prayer may well be difficult.

The Hail Mary, a prayer familiar to most Catholic Christians, is a traditional prayer asking for the intercession of Mary, the mother of Jesus. This prayer forms the basis for the Rosary, in which the prayer is said each time a person places one of the rosary beads between his or her fingers, before moving on to the next one and repeating the same prayer. Praying the rosary like this can be meditative and deeply contemplative. If unfamiliar with this prayer and practice, more can be read about it at: [http://en.wikipedia.org/wiki/Hail\\_Mary](http://en.wikipedia.org/wiki/Hail_Mary). The Hail Mary states,

*Hail Mary,  
Full of Grace,  
The Lord is with thee.  
Blessed art thou among women,  
and blessed is the fruit  
of thy womb, Jesus.  
Holy Mary,  
Mother of God,  
pray for us sinners now,  
and at the hour of our death.  
Amen.*

For the patients who are familiar with this prayer, many will have been saying it by rote without much reflection or self-awareness of the words and the potential meaning those words might have for them. As a result, having the patient recite it with you, slowing it down, and asking how each phrase may be relevant to his or her current situation may be a helpful exercise. Among the Desired Contributing Outcomes from this prayer, a person may feel as if he or she has someone interceding on his or her behalf – especially if he or

she feels unworthy of directly addressing God. They may also feel an increase in comfort and peace, and a decrease in anxiety. If this prayer is meaningful to the person the chaplain is working with, the chaplain may seek to use the rosary and/or Spiritual Mantram Repetition (see Spiritual Care Intervention section on this) with the person.

The Serenity Prayer, penned by Reinhold Niebuhr, can be a helpful prayer for a person with PTSD (Brown, 1987). It states,

*God, give us grace to accept with serenity  
the things that cannot be changed,  
Courage to change the things  
which should be changed,  
and the Wisdom to distinguish  
the one from the other.*

*Living one day at a time,  
Enjoying one moment at a time,  
Accepting hardship as a pathway to peace,  
Taking, as Jesus did,  
This sinful world as it is,  
Not as I would have it,  
Trusting that You will make all things right,  
If I surrender to Your will,  
So that I may be reasonably happy in this life,  
And supremely happy with You forever in the next.  
Amen.*

A chaplain using this prayer with a person with PTSD may well point out that the first half of this prayer is often associated with Alcoholic's Anonymous and other 12-Step programs, and that many people, regardless of their level of religiosity, have found it helpful and peace-giving. It can be helpful to walk through the prayer one line at a time with the patient, asking them what this specific line might mean to him or her in his or her current circumstance. One Desired Contributing Outcome for the use of the Serenity Prayer is to increase the person's perceived feelings of peace, acceptance of what he or she can control and what is outside of his or her control, and the beginning of a strategy for positive change for those things that are within his or her control.

Intercessory prayer is prayer in which someone else is being prayed for. This prayer can come in two forms when a chaplain works with a person with PTSD. As mentioned earlier, many with PTSD feel too dirty or

ashamed to be able to articulate their own prayers before God – feeling that what they have done in the combat theater or since arriving home in conjunction with the after-effects of the experience of trauma makes them displeasing to God or worthy of God’s wrath and judgment. As such, one indirect way in which a chaplain can seek to reconnect a person with God is to ask that person what he or she would like the chaplain to pray for on his or her behalf. This process can also be a great way in which a chaplain can learn what it is the person desires most from God. A Desired Contributing Outcome would be indirectly allowing the person to articulate what he or she needs from God in order to be restored to some kind of relationship with God.

Another way in which intercessory prayer may be helpful is to ask the person with PTSD who it is he or she would like to be praying for and why. This discussion allows the person to shift the focus off of him- or herself, and to begin to think about the needs of others. One Desired Contributing Outcome in this context would be to refocus the attention of the person with PTSD away from his or her own struggles and allow him or her to altruistically express his or her concern for a significant other.

Yet another contemplative form of prayer is called Centering Prayer, or Breath Prayer. In this type of prayer, a person can focus on his or her breathing, and recite a specific prayer while inhaling and a specific prayer while exhaling. This, like the silent prayer, can take some meditation-like focus which initially may be a challenge for a person with an anxiety disorder such as PTSD. However with some guidance from the chaplain, a person can learn to breathe in stating what would nourish him or her now, and to breathe out what he or she needs to release right now. This type of repetitive, breath-focused prayer can have a Desired Contributing Outcome of an increased sense of peace and contentment, a sense of self-soothing, and an ability to articulate what he or she needs to feel more nourished and what he or she needs to let go of in order to be more peaceful.

*Evidence:*

Recommendations	Sources	QE	OQ	R
1. Prayer can be used by the chaplain to help the patient connect more closely with the divine.	Interviews with numerous Staff Chaplains	III	Poor	I
2. Prayer can be used by the chaplain to help the patient with PTSD articulate what it is he or she needs in order to heal.	Interviews with numerous Staff Chaplains	III	Poor	I
3. Prayer can be used by the chaplain to help the patient with PTSD verbalize how he or she has been blessed.	Interviews with numerous Staff Chaplains	III	Poor	I
4. Prayer can be used by the chaplain to help the patient with PTSD connect more closely with his or her religious upbringing and resources.	Interviews with numerous Staff Chaplains	III	Poor	I
5. Prayer can be used by the chaplain to help the patient with PTSD find ways of letting go of what he or she cannot control and focusing on what he or she can control.	Interviews with numerous Staff Chaplains	III	Poor	I
6. Prayer can be used by the chaplain to help the patient with PTSD connect with others through praying for them and/or for the relationship with them.	Interviews with numerous Staff Chaplains	III	Poor	I
7. Prayer can be used by the chaplain to help the patient with PTSD soothe or calm his- or herself.	Interviews with numerous Staff Chaplains	III	Poor	I

Recommendations	Sources	QE	OQ	R
8. Prayer can be used by the chaplain to help the patient with PTSD feel empowered to heal and/or to be reconciled with the divine, the faith community, or significant relationships in his or her life.	Interviews with numerous Staff Chaplains	III	Poor	I

QE= Quality of Evidence OQ= Overall Quality  
R= Recommendation

## 2. HEALING RITUALS:

### *Objective:*

Assist the person with PTSD through the facilitation of healing rituals.

### *Background:*

Most religions and spiritual belief systems have rituals that are meant to provide meaning through action of some kind. In working with a person with PTSD, it can be very helpful to know his or her specific religious, spiritual and cultural background. If the chaplain is familiar with this background, he or she may search for rituals from that framework that would aid the person in making meaning following a traumatic event. If the chaplain is unfamiliar with the person's traditions and background, one can ask the person directly if he or she knows of any specific rituals of healing that exist within his or her religious, spiritual, or cultural framework.

Rituals help people through drawing pain into the process of reconstructing memory (Cole, 2004). The potential for most pain or suffering to be transformed into something productive or constructive can be tied to its ritual transformation. Rituals work as they scaffold a person's memories and pain in the context of a strategically constructed narrative. Through the use of ritual, pain and suffering can become something which transforms, instead of something that has been endured.

Rituals can be elaborate and complex, and can appear strange to those outside of the narrative. They can also be small, meaningful actions throughout a day or period of time that bring a person away from his or her pain and into the realm of making meaning in the pres-

ence of that pain. Based on the verbalized need of the person with PTSD, the chaplain can either utilize some of that person's own religious, spiritual, or cultural rituals to help facilitate meaning making, and/or create rituals that would strive to assist that person in making meaning (Navy Medicine). The more a chaplain knows of a person's narrative and "meta-narrative" (such as his or her spiritual tradition, cultural heritage, stories and dates of important life events, etc.), the better the chaplain can be in constructing rituals that are meaningful, effective, and helpful in healing.

Many of religion's rituals can be adapted and/or utilized by the chaplain in seeking to help the person with PTSD. These can include but are not limited to: sacraments, holidays, songs, liturgy, specific prayers, etc (Everly, 2003). The chaplain can also create rituals that allow a person to experience his or her pain or specific narrative differently. These rituals can include but are not limited to: rituals of grief, candles, memorials, anniversaries of significant events, writing, prayers, etc.

### *Recommendations:*

1. The chaplain can assist the person with PTSD find meaning in his or her struggle through facilitating rituals that are consistent with that person's spiritual, religious and cultural background.
2. The chaplain can create or co-create rituals with the person with PTSD in order to facilitate meaning-making.

### *Discussion:*

There are many different types of rituals that a chaplain can utilize in helping a person with PTSD heal and make meaning of his or her situation. The following list is not intended to be exhaustive; but rather, provide examples of different goals and structures that can be used. The rituals themselves are limited only by a chaplain's creativity and imagination. These include but are not limited to: rituals of remembrance, rituals of grief, rituals of release, rituals of penitence, and rituals of appreciation. In each of these listed below, the Spiritual Care Intervention is the development and implementation of the ritual, whereas the Desired Contributing Outcomes differ based on the intervention.

Perhaps the most common types of rituals used with people who have PTSD are rituals of remembrance and rituals of grief. These two are closely related



and may well be the same ritual with the aim of both remembering and facilitating grief. In this type of ritual, the chaplain assists the person in finding ways to memorialize or remember someone or something that has been lost. This is commonly a friend fallen in combat, but can also be a loss of innocence or assumptions about the world, God, the nation, or oneself. The ritual involve having a candle burning throughout a session with the chaplain in honor of a fallen comrade, or lighting a candle on a day of specific significance – such as the birthday or anniversary of the death of a comrade (Fortunato, A, personal communication, January 14, 2009). A chaplain can work with the person with PTSD to develop an appropriate and healthy ritual that honors a lost loved one, and provides a safe opportunity for the person to explore his or her feelings of grief and loss. This ritual can include writing a letter to the loved one, or a role play with the chaplain playing the role of the person who has been lost. One Desired Contributing Outcome would be for the chaplain to equip the person with PTSD with healthy ways of memorializing or grieving without turning to drugs, alcohol and other “vices”. The possibility of dealing with an anniversary of a traumatic event without getting drunk or high or intentionally reckless can provide a sense of healing and positive momentum for the person struggling with PTSD. In working in a group setting, it can be helpful for the chaplain to initially create a master calendar with all significant dates of anniversaries of deaths of service members, traumatic events, etc. When one of those days arrives, the person impacted can share the story of the person or event with the group. Facilitated by the chaplain, this process can also model for each participant how to deal with an anniversary without getting drunk or high.

Another kind of ritual would be a formal process of release or letting go. This ritual can be similar to the previous descriptions of rituals for grief or remembrance, but focused more on letting go of connections or attachments. These rituals can include writing down and subsequently burning the struggles that have resulted from the trauma in the person’s life, or similar to the breath prayer described above – a person can learn to breathe in stating what would nourish him or her now, and to breathe out what he or she is needing to release right now. This practice can be therapeutic by allowing a person to name what stressors he or she can release emotionally, letting go in order to recognize that he or she does not need to hold tight to his or

her pain in order to honor it. A chaplain can help the person with PTSD identify potential triggers for his or her stress or distress, and coach him or her in how to use a self-soothing ritual to let go or release some of the tension resulting from the stress or unwanted thoughts and feelings. In learning to intentionally let go through the use of some daily rituals, a person can feel more in control of his or her emotions and more able to get through stressful days, events, or situations. Desired Contributing Outcomes for this kind of ritual would be an increase in feelings of peace and contentment, a decrease in feelings of emotional distress, and a letting go of one’s emotional attachments.

A ritual of penitence is focused on finding a way to express a person’s remorse or contrition. Much like the guilt discussion below, this may be for actions or inactions, and for “genuine” or “imagined” guilt. Many Catholics are familiar with these kinds of rituals, such as saying a certain number of Hail Marys. Other rituals with this goal would be writing a prayer of confession or a letter (whether or not it is mailed) to the family of those killed. Desired Contributing Outcomes include a decrease in feelings of guilt, and a decrease in feelings of being burdened by the traumatic experience.

A ritual of appreciation may be used to assist the person with PTSD in focusing on what he or she is grateful for rather than what he or she is struggling with. This may be as simple as encouraging the person to write down what he or she appreciates, or Thank You notes for people who have been positively significant in his or her journey during or since the trauma. One can also find creative ways of encouraging acts of service or kindness as a way to ritually embrace appreciation or gratitude. Examples include planting a tree in honor of a comrade, or contributing to or creating a scholarship in his or her memory. Among the Desired Contributing Outcomes for this kind of ritual are an increase in positive emotions, a decrease in focus on dysfunction or symptomatology, an increased awareness of blessings, and an increased sense of social connection to those to whom the person expresses his or her appreciation.

There is no specific training needed for a chaplain to utilize or develop and implement rituals of healing for persons with PTSD.

*Evidence:*

Recommendations	Sources	QE	OQ	R
1. The chaplain can assist the person with PTSD find meaning in his or her struggle through facilitating rituals that are consistent with that person's spiritual, religious and cultural background.	Interviews with numerous chaplains	III	Poor	I
2. The chaplain can create or co-create rituals with the person with PTSD in order to facilitate meaning-making.	Interviews with numerous chaplains	III	Poor	I

QE= Quality of Evidence OQ=Overall Quality  
R= Recommendation

### 3. CONFESSION – GUILT & FORGIVENESS WORK (VENTILATIVE CONFESSION)

*Objective:*

To help the person with combat-related PTSD confess his or her feelings of guilt, and focus on healing by giving or seeking forgiveness and giving pardon to others and to him- or herself.

*Background:*

Guilt is a cognitive and an emotional experience that occurs when a person realizes or believes - whether justified or not - that he or she has violated a moral standard, and is responsible for that violation. Guilt is an affective state in which one experiences conflict for having done something that one believes one should not have done (or conversely, having not done something one believes one should have done). It gives rise to a feeling which does not go away easily, driven by conscience. Many with PTSD will have feelings of guilt in connection with the trauma he or she experienced.

It can be helpful for the chaplain to differentiate what type of guilt a person is feeling. Different types of guilt will have different Spiritual Care Interventions and Desired Contributing Outcomes. One type of guilt is for actions taken or not taken that resulted in harm.

Another type of guilt is imagined guilt, which includes survivor guilt. Both types of guilt can be complicated by cognitive error – meaning a person's

unreflected-upon, often inaccurate or myopic, mental reasoning in relationship to the event about which he or she feels guilty.

One type of guilt is for actions taken or not taken that resulted in a perceived harm. A person feels guilty for an act of commission, for something he or she directly did or said. This action can be for killing a person in battle, or shooting or wounding a person in the combat theater. It can be guilt for having to make difficult decisions in the midst of extremely stressful times – such as a medic who must decide which of the wounded service members he or she can take with him on a rescue operation versus which ones he or she has to leave behind. These feelings can be significantly magnified if a person was involved in a friendly-fire occurrence. It can be important to recognize that guilt can arise for actions that resulted from the after-effects of the trauma, and not just the trauma itself – such as how a person is treating his or her family upon return from combat, including words or actions that wound others close to the person with PTSD.

One specific type of guilt for actions taken is a kind of moral guilt. This is the result of a service member following orders appropriately – whether to kill, attack, shoot, or flee, etc – and later feeling guilty for having done so or for the result of those actions. He or she was following the chain of command and acting in an appropriate way for which he or she may even receive medals of commendation, and later has begun to judge him- or herself guilty of having violated a moral or ethical code. This condition occurs when a person was told to do something which he or she did not agree with, but had to do anyway. This situation may directly challenge a person's faith system and structure, and provoke a deep questioning about the nature of God, one's faith system, and one's own self. The disconnect and emotional tension between actions a person is rewarded for in the combat theater on the one hand and would be punished for once back home on the other can be intense and deeply troubling.

For many service members, the more adept they are at killing in the midst of combat, the more awards and potential recognition they receive (Paquette, 2008). All branches of the military have become expert in creating service members out of civilians, and equipping them to be the best, most well-trained service members in the world. This training includes enabling the service member to kill when called upon to do so. However, comparatively little attention or focus has

gone to reversing this process and taking the service member trained to kill and helping him or her become a civilian once again after deployment. More energy has been given to this in recent years, but much can still be done. The inability to forget what they experienced and what they did in the name of war can become a private hell for some service members. Externally they are heroes for their actions in combat, while internally they judge themselves as monsters for what they have done.

A person may also feel guilty about feelings he or she has experienced – whether in combat or after returning from the theater. He or she may have felt exhilarated or thrilled to have killed, and later feel guilty for such an emotional reaction. He or she may have had violent thoughts or feelings toward loved ones upon returning, also leading to feelings of guilt layered on top of these feelings.

David Grossman's books, *On Killing: The Psychological Cost of Learning to Kill in War and Society*, and *On Combat: The Psychology and Physiology of Deadly Conflict in War and Peace*, are excellent resources for better understanding this dynamic of a wide and confusing range of feelings a person experiences in relationship to having killed another person. He describes the initial concern about killing each soldier has, and the kind of ritualized desensitization that occurs in basic training over the question, "Will I be able to kill in combat?" In the midst of the killing circumstance itself, Grossman says this becomes an instinctive reaction requiring almost no conscious thought. Yet those who are unable to kill when called upon may be traumatized and feel guilty by that "failure" to perform the act. One of the most common feelings a person has when killing in combat is an adrenaline-induced exhilaration or even euphoria. It can be an addictive feeling, and one's preoccupation with this feeling can lead to deep-seated reactions of guilt and shame. Following this exhilaration is remorse and nausea from a kill. Nausea and vomiting are common, and there is often deep remorse and ruminations about who was killed and the impact that killing will have on others. The final resolution may come from a rationalization and acceptance process, realizing that the event will never go away. For each person, this rationalization is different, with some accepting that there was no other choice, and others never accepting what occurred. Many of those who are unable to rationalize and accept the event are likely to become victims of

combat-related PTSD.

A person can also feel guilty for something he or she did not do and feels, in hindsight, that he or she should have done. This omission can be something like not taking a shot at the enemy when called upon, "freezing" in combat, or not responding as heroically as he or she feels he or she should have. These feelings can be closely linked to the more imagined guilt – as a person does not truly know what would have occurred differently if he or she had chosen to act as opposed to not acting.

There are also many who have a sense of imagined guilt. This guilt is for something that one is convinced would have led to a different, more positive outcome. Even when there is the absence of actual behaviors that endangered others or when there were not genuine choices available that would have altered the outcomes of events, some people experience guilt feelings. This includes what is commonly referred to as survivor guilt which is the mental condition that occurs when a person perceives him- or herself to have done wrong by surviving a traumatic event. People with combat-related PTSD often describe painful guilt feelings about surviving when others did not or about things they had to do in order to survive. Most often in combat, this happens when a person is nearby when a friend or compatriot is killed or injured, or could have been in that person's exact position had events unfolded differently. A person with PTSD may obsess over how "it should have been me," or how the family of the wounded or killed is suffering due to that person's injury or death. With survivor guilt, there may be a predominant sense that there have been sins of omission rather than commission. Research concluded that this may require additional treatment or interventions that would encompass the spiritual and religious dimension (Khouzam & Kissmeyer, 1997).

There is also a distinction between feelings of guilt and feelings of shame. Guilt is something a person feels about actions or inactions he or she has done. Shame is a feeling of not being worthy or about who one is in his or her core. A person feels guilt for what he or she does, and feels shame for what or who he or she is. These deeper rooted feelings of shame can be more complex, as it is an internalization of a person's feelings of guilt onto the essence of who he or she is.

For many veterans, beyond the basic three PTSD-related symptom clusters lie deep-rooted feelings of guilt. For the clinical definition of PTSD, one must

experience directly or witness an event which he or she feels endangers his or her life. This does not account for the possibility, as is the case with many with combat-related PTSD, of being the person who inflicts or creates this trauma for someone else – of being the perpetrator of violence on another. PTSD as an anxiety disorder is more focused on the victim of such violence – such as an attack on one’s own life or a rape. Many service members participate in killing another human – whether one of the “enemy” or even one of their own. Feelings of guilt for having inflicted trauma upon another, leads to emotions and issues beyond a strict PTSD diagnosis and treatment. It might lead to a loss of faith, depression, or changes in one’s ethical behavior.

There is scant literature discussing this dynamic. Kent Drescher is involved in some research exploring how this kind of “moral injury” creates shifts in how a person with PTSD sees him- or herself, the world, people in power and God. Rachel MacNair’s book *Perpetration-Induced Traumatic Stress* begins to explore this dynamic as a research topic. Chaplains are in a unique position to help the veteran who is experiencing guilt in this way with the broad and deep religious narratives exploring the connections between guilt, forgiveness, atonement and reconciliation. In assisting a person with PTSD and feelings of guilt for trauma he or she created in someone else’s life, chaplains are also unique among mental health professionals in discussing more in depth the “moral failings” and tension this person is experiencing.

One recent study (Fontana & Rosenheck, 2004) concluded that, for many veterans, the pursuit and use of mental health services appear to be motivated by their feelings of guilt and the impact this guilt has on weakening their religious faith than by the severity of their PTSD symptoms or issues with social functioning. This is consistent with the discussion above about the unique nature of PTSD for combat-related trauma. As such, a chaplain’s role can be integral for this population of people with PTSD, as both guilt and religious faith are central to his or her Spiritual Care Interventions and Desired Contributing Outcomes.

Specific to spirituality, many with combat-related PTSD who are experiencing feelings of guilt believe that God would not forgive them for what they did and express fears of God’s wrath or judgment for actions during combat as well as in response to combat (Rogers & Koenig, 2002). This guilt haunts and has the

potential to sabotage the person’s spiritual life. There is a fundamental assumption that God’s mercy and love, let alone forgiveness, does not apply to them. This assumption results not only in feeling guilty and irreparably tainted, but can also create alienation and isolation from God.

#### *Recommendations:*

1. A chaplain should seek to assist the person with PTSD in articulating what type(s) of guilt he or she is experiencing.
2. A chaplain can assist confession of a perceived guilt, and work toward absolution in a ritual paralleling the Roman Catholic sacrament of confession.
3. A chaplain can use sacred Scripture to normalize feelings of guilt and reframe assumptions about God’s grace and mercy.
4. A chaplain can be a representative of the divine in assisting a person as he or she seeks God’s forgiveness or absolution.

#### *Discussion:*

For most religious traditions, the experience of pain, loss, trauma, suffering, guilt and forgiveness are inter-related with theology, the spiritual or religious narrative, and everyday life (Boehnlein, 2006). For Jewish persons, the possibility of being restored into a right relationship with God through atonement is central. For Christians, repentance of sins, turning to God, and asking for Christ to walk with them through suffering, can bring forgiveness and new life. It is noteworthy that research shows that, for Christians, one of the greatest losses experienced in response to a trauma is the loss of God or one’s assumptions about God (Boehnlein, 2006). For Buddhists, there is a focus on acceptance of life as it comes, which would include traumatic events. And for Muslims, the death of a person is a divinely ordained event, and as such the survivor does not bear the guilt of the loss. An understanding of the nuances of each of these can inform a chaplain’s interventions with a person experiencing guilt and seeking some resolution to this.

Regarding a person who is feeling guilty for something he or she did either in combat or following combat, one possible Spiritual Care Intervention would be to explore these feelings of guilt in more depth in order to ultimately move toward self-forgiveness (Powers, R, personal communication, January 14,

2009). A person has to admit that he or she feels guilty before he or she can move toward addressing it, and in order to admit guilt, he or she must feel safe and trust the chaplain working with him or her. This goal of self-forgiveness, or intrapersonal forgiveness, has been correlated with decreasing feelings of depression, anxiety, and PTSD symptom severity (Witvliet, et al., 2004). In working with a person with PTSD who is feeling guilty, a chaplain should encourage the person to tell the story of what it is he or she is feeling guilty for (Fontana, A, personal communication, January 23, 2009). A potentially helpful Christian Scripture in dealing with this issue would be the story of the prodigal son from the Gospel of Luke. This story can provide hope to a person who feels that he or she is outside of God's favor or ability to forgive.

In listening to the story of why a particular person feels guilty, many people feel compelled to immediately respond with why the person should not be feeling guilty, that it will be OK, that any person would have done the same, etc. In doing so, the feelings the person is seeking to explore can be invalidated, putting distance between the person with PTSD and the chaplain. One possible Spiritual Care Intervention in this context would be to begin with a focus on the idea of confession for the person who is feeling guilty. In Mary Paquette's work, she has seen how instead of trying to convince a person who feels guilty that he or she should not feel this way, it can be possible for that guilt to be held up as a hypothetical truth and work from the spiritually-charged ideas of confession, penance, and absolution or forgiveness.

The concepts of confession and absolution have been used by religious traditions for centuries, and the modern clinical or therapeutic version of this process often imitates the ritual, with a few minor adjustments (Paquette, 2008). Confession can serve a strong ventilative role for a person – allowing him or her to express deep feelings of pain and struggle. This ritual can be patterned after the Catholic sacrament of confession. In that sacrament, a person confesses, and the priest hears the confession, prescribes penance if needed, and assures the person of the possibility for forgiveness and absolution. A clinical Spiritual Care Intervention version of this ritual can be used by a chaplain working with someone with PTSD who has a strong feeling of guilt for actions committed. For example, if a person is feeling guilty that he is now a murderer because he killed in combat, instead of

seeking to convince this person that this feeling is inaccurate or insufficient, a chaplain might say, "I do not personally believe you are a murderer, but, for the sake of this conversation, let's assume you are as a starting point. You say to me, "I am a murderer," and I will respond with something like "I forgive you, and God forgives you." This exchange can be done looking eye-to-eye, and repeated as many times as needed to begin to allow the person to move past his or her feelings of guilt and into the possibility of forgiveness and absolution. This can also be done in the context of a group of others with PTSD, where each person responds with the same forgiveness being offered as the chaplain's statement above. This ritual of confession and forgiveness can be powerful and healing, not only for the person seeking God's forgiveness, but also for those participating who are responding with the words, "I forgive you and God forgives you."

Therefore, when the problem is guilt, the solution is not about negating that guilt but providing a safe environment where a person can confess his or her guilt and need for forgiveness. If the guilt is made hypothetical, there can be a cognitive reframing of the event that is generating so much guilt. It can be helpful to discuss with that person what an "appropriate penance" might look like for him or her. Perhaps it would be making a contribution of time or money to a charity or cause related to the war or veterans, or associated somehow with his or her community of faith. Among the potential Desired Contributing Outcomes of this work can be an increase in feelings of self-forgiveness, a renewed relationship with the divine, a decrease in feelings of guilt, and an ability to articulate one's feelings of guilt and need for forgiveness.

When a person is experiencing a sense of moral guilt for having acted based on a chain of command or appropriate military action and the action ultimately conflicts with a sense of spiritual, religious or moral self, a chaplain becomes essential. One Spiritual Care Intervention that may be productive in this context would be to assist the person in articulating what the specific tension is between how he or she acted and what he or she feels would have been just or right. This acknowledgement of feelings of guilt, sorrow and regret for killing people in combat is not necessarily PTSD. It could be one of the healthiest and sanest things the service member does on his or her path to recovery – a reclaiming of his or her humanity. A chaplain can help reframe this process for the person,

with the Spiritual Care Intervention using applicable stories from sacred texts. For example, the story of David can be very helpful. Known as a “man after God’s own heart,” David nevertheless engaged in warfare and was guilty of killing many people. This kind of narrative can help a person normalize his or her feelings of guilt and facilitate the Desired Contributing Outcome of a normalization of feelings, an increase in the awareness of God’s mercy being applicable to the person with PTSD, and a decrease in isolating feelings of guilt.

Grossman’s description of the emotional responses to killing can assist the chaplain in some psycho-education of the person with PTSD. For example, when a person recognizes that research shows the feelings of exhilaration are normal due to a sudden increase in adrenaline, a person may be able to accept his or her reaction and ultimately feel less guilty. A Spiritual Care Intervention would be some psycho-education about the psychology and physiology of killing, with the Desired Contributing Outcome being a decrease in one’s feelings of guilt due to having normalized his or her emotional reactions to participation in a killing.

The majority of people who experience an imagined guilt, including survivor guilt, have arrived at these feelings through a cognitive error, or misapplied or myopic logic. A chaplain can assist the person whose self-talk includes “it should have been me,” and “it is my fault he is dead” through an invited retelling of the experience of trauma. Instead of allowing the person to reinforce these feelings of guilt, the Spiritual Care Intervention would be to intervene at the recrimination statements. A more in-depth version of this intervention is discussed in the stand-alone section on “Percentage of Guilt Discussion.” The Desired Contributing Outcome is more accurate assessment of what a person is responsible for, and a reduction in the feelings of guilt for having survived.

In seeking to have a person forgive him- or herself, it can be important to help the person see that forgiveness of self is about choosing to abandon one’s inclination to resentment and negative judgment, while nurturing a sense of compassion, generosity, and love toward oneself (Drescher, et al., 2007). Forgiveness cannot begin around distorted thinking, but the chaplain can assist the person in recounting a memory carefully, searching for distortions of belief, inappropriate assumptions or expectations, and illogical attributions. Helping uncover these often-subtle disconnects be-

tween the reality of a situation and a person’s recollection of it can greatly benefit the person’s self-assessment and sense of self-forgiveness. Ultimately that forgiveness is a choice.

Finally, a chaplain is often viewed as a de facto representative of God. Many with combat-related PTSD and guilt associated with actions while in combat assume that they are beyond the reach of God’s grace, acceptance, love, and forgiveness. A chaplain can provide a Spiritual Care Intervention that helps the person reframe those assumptions through looking at sacred Scriptures. Stories in Scripture abound of people who in no way “deserve” special status of divine acceptance, who nevertheless receive God’s approval. The patriarchs – Abraham, Isaac, Jacob, and Joseph were often less than savory in their actions, yet ultimately retained God’s favor. David is an ideal example of this, as mentioned above. Peter in the Christian gospels consistently is undeserving of Christ’s love and yet receives it anyway. These stories can assist the chaplain in working with the person with PTSD who has strong feelings of guilt for actions he or she feels put a distance between him- or herself and God. The Desired Contributing Outcome is finding a Scriptural parallel for one’s feelings of guilt and the assurance of God’s forgiveness.

There is no special training needed to work with persons on guilt and forgiveness as a chaplain.

*Evidence:*

Recommendations	Sources	QE	OQ	R
1. A chaplain should seek to assist the person with PTSD in articulating what type(s) of guilt he or she is experiencing.	Interviews with numerous chaplains: Oliver, Paquette, Hokana, Powers	III	Poor	I
2. A chaplain can assist confession of a perceived guilt, and work toward absolution in a ritual paralleling the Catholic sacrament of confession.	Interview with Paquette	III	Poor	I

Recommendations	Sources	QE	OQ	R
3. A chaplain can use sacred Scripture to normalize feelings of guilt and reframe one's assumptions about God's grace and mercy.	Interviews with numerous chaplains: Oliver, Paquette, Hokana, Powers	III	Poor	I
4. A chaplain can be a representative of the divine in assisting a person as he or she seeks God's forgiveness or absolution	Interviews with numerous chaplains: Oliver, Paquette, Hokana, Powers	III	Poor	I

QE= Quality of Evidence OQ=Overall Quality

R= Recommendation

#### 4. PERCENTAGE OF GUILT DISCUSSION:

##### *Objective:*

To assist the person with PTSD through helping him or her slowly appraise the feelings of guilt by determining exactly what percentage of guilt he or she actually deserves in the context of the trauma that involved many others' actions.

##### *Background:*

Raymond Scurfield, a clinical psychologist and veteran of the war in Iraq, in his book *War Trauma: Lessons Unlearned from Vietnam to Iraq*, describes a specific way of intervening with a person who is feeling disproportionately guilty for actions in combat. This process involves a long and in-depth discussion of the traumatic event and a therapist or chaplain-guided intervention that assists the person in making a more accurate assessment of how much of the blame or guilt each person involved in the trauma should have. The person retells the story of the trauma numerous times, and the chaplain guides them with questions about others' potential responsibility for the traumatic event. Each time a new responsible party is discovered, a percentage of blame is apportioned to them and so the person ultimately blames him- or herself for less of the total responsibility for the event.

##### *Recommendations:*

1. The chaplain can help alleviate some of the self-blame a person assigns to him- or herself through

assisting them in reframing the story to include all parties who bear some responsibility for the trauma beyond the person with PTSD.

2. The chaplain can also help the person with PTSD quantify how much more "punishment" is needed before absolution or self-forgiveness can occur, and assist the person in strategizing how to complete this punishment constructively.

##### *Discussion:*

The percentage of guilt discussion is a Spiritual Care Intervention that seeks to determine approximate percentages of responsibility for the trauma that resulted in the person's PTSD. As a person retells the narrative of the trauma repeatedly, the chaplain should look for opportunities to challenge the assumption that this person bears the full blame and responsibility (and ultimately the guilt) for the trauma. For example, the army buddy who was killed may have some responsibility for having made the choice to be where he was when he was killed. The person who killed the army buddy also may have some responsibility. The commanding military officers and their orders under which the operation was occurring may have some responsibility, as may the Commander in Chief, political opinion, etc. This is functionally a cognitive reframing technique. This process should all take place in one single sitting – lasting anywhere from 90 minutes to three hours.

In Step 1, the person with PTSD retells the complete and unedited narrative of the traumatic event to the chaplain. It is important to get a "baseline" clear description of the event and the person's perceptions and rationale for the degree of self-responsibility assumed. The chaplain should encourage the person to tell the story as he or she recalls it, including feelings, reactions and thoughts.

In Step 2, the chaplain gently challenges the person's exclusion or minimization of the role of others who were at the immediate scene of the trauma. The person is not God, does not control others' every movement, and must rationally understand that someone else may have had a small degree of responsibility for the trauma in addition to him- or herself. For example, the trauma may involve the death of a military buddy who was riding in the vehicle the person was

supposed to have been in and they changed places spontaneously prior to the beginning of a mission.

The vehicle with the buddy is attacked by a Rocket Propelled Grenade (RPG), and the person dies. The patient working with the chaplain should begin to admit that others at the scene have some responsibility for the result of the event. The buddy did choose to be in that vehicle, and consequently may have some responsibility for having been there. The driver of the vehicle may also have some responsibility. The person who launched the RPG also deserves some of the responsibility. As each new participant is discussed, the chaplain encourages the person to assign a numerical percentage of responsibility for each. The buddy may be 15% responsible, the driver 5%, and the enemy shooting the RPG 25%. As each person is added, the chaplain should encourage the person to reassess the previous numerical attributions to insure he or she still feels they are accurate.

Step 3 is similar. The chaplain challenges the person's exclusion or minimization of others who were not at the immediate scene of the trauma – such as the military commanders, the family of the person who died who insisted that he enlist in the army, or the enemy's military commanders.

In Step 4, the chaplain re-challenges the person's sense of his or her own percentage of responsibility for the actions and choices of others. This can be a challenge, as a person's self-punishment is serving a psychological purpose for him or her, and may not be easy to unseat or disrupt. It is serving a purpose or it would not be presented. As a person begins to see that he or she is not responsible for the entire event in its totality, a sense of relief and/or release may well occur.

Step 5 has the chaplain challenge the veteran to consider if he or she has been punished enough for his or her personal share of the recalculated responsibility for the trauma. This sense of penance or punishment is likely something the person has not sought to quantify before this discussion. The question of what would be a proper restitution or punishment for this recalculated degree of responsibility can be a new question. A chaplain may ask what specifically has been the cost or the punishment, what form it has taken in the life of the person seeking healing.

Step 6, then, is a constructive dialogue between the person and the chaplain in which the person seeks to describe a non-self-destructive plan to provide additional compensation for his or her responsibility in the trauma. This can be a place for creativity. Possibilities can include writing letters to families of people lost

in the war, service to a charity or religious organization, or any way of using that self-blame as an active ingredient for something good. The person may well decide that he or she has been punished enough, or at least sees a light at the end of the tunnel for when that day may arrive.

Step 7 is the articulation of this restitution as a homework assignment to be completed in a certain amount of time. The chaplain may wish to break the total "punishment" up into achievable tasks that the person can accomplish between each visit with the chaplain.

Step 8 has the chaplain end the session in a way that recognizes and confirms the positive work the person has accomplished in the session. The chaplain may wish to review what has changed explicitly, to assist the person in understanding the potential impact for the session on his or her feelings from this time forward.

This is a very specific and targeted intervention, and can be done by a chaplain after some study. The best resource for this would be Raymond Scurfield's book *War Trauma: Lessons Unlearned from Vietnam to Iraq*.

*Evidence:*

Recommendations	Sources	QE	OQ	R
1. The chaplain can help alleviate some of the self-blame a person assigns to him- or herself through assisting them in reframing the story to include all parties who bear some responsibility for the trauma beyond the person with PTSD.	(Scurfield, 2006)	III	Poor	I
2. The chaplain can also help the person with PTSD quantify how much more "punishment" is needed before absolution or self-forgiveness can occur, and assist the person in strategizing how to complete this punishment constructively.	(Scurfield, 2006)	III	Poor	I

QE= Quality of Evidence OQ=Overall Quality  
R= Recommendation



## 5. LIFE REVIEW – SPIRITUAL AUTOBIOGRAPHY WORK:

### *Objective:*

To encourage the person with PTSD to narrate his or her spiritual autobiography and (re)discover insights, strengths, themes, patterns, and possible resonances with their current situation following a traumatic experience.

### *Background:*

A spiritual autobiography or narrative can help a person with PTSD identify major themes, struggles, patterns, and gifts he or she has that are consistent in his or her life. It can be oral or written. The goal is to assist the person with PTSD in identifying themes that are important to him or her, as well as assumptions he or she may have held prior to the trauma that, in the light of examination following a trauma, may no longer be helpful but instead create tensions and struggles.

As a person describes his or her personal narrative in depth, themes and meta-narratives will emerge. They may not be obvious to the person telling the story, and the chaplain should be careful not to assign meaning to someone else's story. However, a chaplain can ask gently probing questions to assist a person in articulating the "why" behind actions or decisions, or the meaning given. As the chaplain listens to this story, it can be helpful to listen for repeated phrases or assumptions, and to note them. Often in telling about a person's experiences, patterns may also emerge. These patterns and assumptions and other attempts to make meaning of one's personal narrative can be helpful in healing. For example, if a person recognizes that he or she survived the death of a sibling and was able to cope with and deal with this prior to the trauma that triggered the PTSD, the chaplain can assist the person in bridging the healthy coping strategies from the past and find in them hope for the current situation.

Being familiar with James Fowler's ideas of faith development from his books *Stages of Faith* or *Weaving the New Creation* can be helpful for the chaplain throughout this Spiritual Care Intervention. With a working understanding of these and the basic reasons and ways people transition from one stage to another, a chaplain can assist a person who is telling his or her spiritual narrative by understanding how his or her idiosyncratic journey fits with a common struggle and

journey. The basic names and descriptions of each phase as described in *Weaving the New Creation* are:

### PRIMAL FAITH:

*"Earliest faith is what enables us to undergo these separations [from parents] without undue anxiety or fear of loss of self. Primal faith forms before there is language. It forms the basic rituals of care and interchange and mutuality. And, although it does not determine the course of our later faith, it lays the foundation on which later faith will build or that will have to be rebuilt in later faith" (p. 103).*

### INTUITIVE-PROJECTIVE FAITH:

*"The next stage of faith emerges in early childhood with the acquisition of language. Here imagination, stimulated by stories, gestures, and symbols and not yet controlled by logical thinking, combines with perception and feelings to create long-lasting faith images . . . Representations of God take conscious form in this period and draw, for good or ill, on children's experiences of their parents or other adults to whom they are emotional attached in the first years of life . . . when conversion experiences occur at later stages in ones' life, the images formed in this stage have to be reworked in some important ways." (p. 103)*

### MYTHIC-LITERAL FAITH (COINCIDES WITH PIAGET'S "CONCRETE OPERATIONAL THINKING"):

*"Here concrete operational thinking--the developing ability to think logically--emerges to help us order the world with categories of causality, space, time and number. We can now sort out the real from the make-believe, the actual from fantasy. We can enter into the perspectives of others, and we become capable of capturing life and meanings in narrative and stories." (p. 105)*

### SYNTHETIC-CONVENTIONAL FAITH (COINCIDES WITH PIAGET'S "FORMAL OPERATIONAL THINKING"):

*"The next stage characteristically begins to take form in early adolescence. The emergence of formal operational thinking [the ability to think abstractly]*

*opens the way for reliance upon abstract ideas and concepts for making sense of one's world. The person can now reflect upon past experience and search them for meaning and pattern. At the same time, concerns about one's personal future--one's identity, one's work, career, or vocation--and one's personal relationships become important" (p. 107).*

#### INDIVIDUATIVE-REFLECTIVE FAITH:

*"In this next stage two important movements have to occur. One the one hand, to move into the Individuative-Reflective stage, we have to question, examine, and reclaim the values and beliefs that we have formed to that point in our lives. They must become explicit commitments rather than tacit commitments. 'Tacit' here means unconsidered, unexamined, uncritically approved. 'Explicit' means consciously chosen and critically supported commitments . . . In the other move that this stage requires one has to claim what I call an 'executive ego.' In the previous stage . . . one could say that a person's identity is largely shaped by her or his roles and relationships . . . In moving to the Individuative-Reflective stage, one has to face and answer such questions as, Who am I when I'm not defined by being my parents' son or daughter? Who am I when I'm not defined by being so-and-so's spouse? Who am I when I'm not defined by the work I do? Who is the 'I' that has those roles and relations but is not fully expressed by any one of them?" (pp. 109)*

#### CONJUNCTIVE FAITH:

*"At midlife we frequently see the emergence of the stage we call Conjunctive Faith. This stage involves the embrace and integration of opposites and polarities in one's life. It means realizing in one's late thirties, forties, or beyond that one is both young and old, and that youth and age are held together in the same life . . . It means coming to terms with the fact that we are both constructive people and, inadvertently destructive people. Paul captured this in Romans 7 when he said, "For I do not the good I want, but the evil I do not want is what I do . . . Who will rescue me from this body of death?" (19, 24 NRSV); (p. 111)*

#### UNIVERSALIZING FAITH:

*"Beyond paradox and polarities, persons in the Uni-*

*versalizing Faith stage are grounded in a oneness with the power of being or God. Their visions and commitments seem to free them for a passionate yet detached spending of the self in love. Such persons are devoted to overcoming division, oppression, and violence, and live in effective anticipatory response to an inbreaking commonwealth of love and justice, the reality of an inbreaking kingdom of God." (p. 113).*

For many experiencing a crisis of faith due to a traumatic experience and subsequent PTSD, they can be stuck in the Synthetic of Individuative stage, and at a deep level understand that this is no longer functioning well for them. A chaplain can assist the transition to a more mature and deepened faith.

#### *Recommendations:*

1. The chaplain can help guide a person with PTSD through his or her life story – looking for insights, themes, patterns, and sources of coping and strength that will help the person in the current situation.
2. The chaplain can also assist the person telling the story in discovering functional spiritual assumptions behind some of the current spiritual distress, and assist the person in reframing those if applicable.

#### *Discussion:*

Each person starts by reflecting on his or her life beginning with the family of origin and context of growing up. This reflection should include all significant relationships, events, and experiences a person has had. It does not need to be tied to a religion or even spirituality, though for many that may be the case. This part of the story can include a person's parents' religious background and general spiritual approaches and practices. The chaplain should definitely seek to have the person articulate messages that he or she heard communicated (such as "God loves you" or "Be good or God will be mad and send you to hell"). Early spiritual struggles and their potential resolutions or resulting impacts are also relevant.

A chaplain can then ask about a person's early experiences with organized religion and any specific events that may have impacted his or her subsequent spirituality. This can include but is not limited to: spiritual role models or influential relationships, relationships with clergy or other religious leaders, major religious

teachings and functional understandings, and how one was taught to think about God, humans, sin, salvation, right/wrong. Most people’s spiritual autobiographies are about relationships with communities or specific people, not so much about dogma or theology proper. One Desired Contributing Outcome from this exercise would be to bring to the person’s awareness that he or she has experienced struggles before the trauma, and discover what healthy coping strategies worked for the person then and may, as a result, work for the person now. Another Desired Contributing Outcome would be for the person who is sharing the autobiography to reinforce and remind him- or herself of God’s presence throughout his or her life, to see patterns of God’s blessings or assistance, and to explore ways in which God may be providing help in the current situation.

For many, in the adolescent years, questions and doubts about spirituality and religion become more prevalent. These doubts may not have been resolved or assimilated by the time a person experienced a trauma, and as a result can create much spiritual angst and distress. In helping a person to articulate this journey, a chaplain provides third-party neutrality and a safe environment to enhance a person’s ability to critically reflect on the journey and themes. He or she may choose to accept some of what he or she was taught as a child, and reject other teachings or assumptions. This in-depth work of sifting through the assumptions and spiritual understandings of the past can assist a person in coming to terms with the limits of an unexamined faith structure, as well as beginning to construct new positive assumptions or understandings that incorporate the new reality of ambiguity, suffering and trauma. One Desired Contributing Outcome for this process would be to help the person with PTSD construct new positive assumptions or understandings of God that take into account the experienced trauma.

As the chaplain listens to the story being told, it is important to listen for, and even ask about, explicit assumptions about God and humanity and the self. These may take some digging, but everyone has a kind of functional theology that accompanies them in making meaning. As the chaplain discovers these assumptions from the past, it can be important to ask the person with PTSD if this is something he or she still believes in light of the trauma that has been experienced. It is often these assumptions that create the spiritual or existential crisis. Another Desired Contributing Outcome from this work can be to identify major func-

tional spiritual assumptions about God, humans, and spirituality or religion, and then to reflect critically on them to determine if they are healthy and helpful or unhealthy and creating spiritual distress.

There is no special training needed for the chaplain to work with a person with PTSD on his or her spiritual autobiography. A familiarity with James Fowler’s work can prove helpful.

*Evidence:*

Recommendations	Sources	QE	OQ	R
1. The chaplain can help guide a person with PTSD through the story of his or her life – looking for insights, themes, patterns, and sources of coping and strength that will help the person in the current situation.	Interviews with numerous chaplains	III	Poor	I
2. The chaplain can also assist the person telling the story in discovering functional spiritual assumptions behind some of the current spiritual distress, and assist the person in reframing those if applicable.	Interviews with numerous chaplains	III	Poor	I

QE= Quality of Evidence OQ=Overall Quality  
R= Recommendation

6. SCRIPTURE PARALLELING / EDUCATION

*Objective:*

To find stories within sacred Scriptures that resonate with the narrative of the person with PTSD, and help that person find meaning, hope or healing from that narrative.

*Background:*

Each major world religion has sacred writings or Scripture. For a person struggling with PTSD, the Scriptures from his or her religious tradition can be of great importance and relevance to that person’s current situation. Two major ways in which a chaplain

can utilize these spiritual resources of sacred Scripture would be to: 1) find a parallel narrative in the Scripture that connects with the narrative of the person with PTSD; and 2) assist the person with PTSD in finding a relevant teaching or verse that provides some hope and/or assurance of God's love.

In working to find Scriptural parallels for a person, it is obviously helpful to know his or her religious affiliation. A chaplain must consistently honor a person's own spiritual traditions, and not seek to use Scriptures from a tradition different from the person with PTSD to make a point or find meaning. This divergence can create distance and dissolve trust. If the chaplain is unfamiliar with the sacred text of the religious tradition of the person with whom he or she is working, the chaplain can ask the person to share some of the stories that he or she finds most relevant or applicable.

If the chaplain is familiar with the Scriptures of the person's own faith tradition, then the chaplain can encourage the person with PTSD to share the story of his or her journey before the trauma, the narrative of the trauma itself, and then the story of life since the trauma occurred. Each section should be distinct and can include facts, feelings at the time, thoughts about the events since, and reactions or responses of important relationships along the way. In listening to this in depth narrative, a chaplain can mentally note Scriptural narratives that may parallel the story being told. This parallel may be explicit or implicit, and should lean toward ultimately having some positive results or moral to the story if at all possible. Specific examples from different religious traditions are included below. A chaplain can then share this story with the person with PTSD and assist them in discovering how the two stories may connect or inform one another.

#### *Recommendations:*

1. The chaplain can assist the person with PTSD in finding a parallel narrative from that person's religious tradition's sacred Scripture that connects with the person's own story.
2. The chaplain can assist the person with PTSD in finding a relevant Scripture or verse that provides some hope and/or assurance of God's love.

#### *Discussion:*

In helping a person to make meaning following a trauma, a chaplain's use of Scripture can be especially helpful (Lindau, et al., 2008) (Fontana, personal communication, January 23, 2009) It can be meaningful

to be able to draw on the stories of hope and resilience from past generations. This process can help the person explain the current situation and reconnect to his or her faith tradition. It can also assist the person in making informed decisions about what to do next and how to do it.

The following Scriptures from different faith traditions are listed in an attempt to assist the chaplain in finding texts that may well be relevant for persons with PTSD. (Navy Medicine)

#### JEWISH SCRIPTURES (CHRISTIAN OLD TESTAMENT):

- Isaiah 44:22- "I have swept away your offenses like a cloud . . ."
- Isaiah 43:25- "I, even I am he who blots out your transgressions, for my own sake"
- Ezekiel 37:1-14 - Valley of dry bones
- Micah 7:19 - "he will again have compassion upon us"
- Psalms 22, 23, 30, 77, 121

#### CHRISTIAN NEW TESTAMENT:

- Romans 8:38-39 - "I am convinced that neither death nor life."
- Matthew 7:7-11 - "ask and it will be given unto you"
- Luke 15:11-3 parable of the prodigal son

#### MUSLIM:

- From the Holy Qur'an: Surah 1 (chapter 1) Al Fâti-hah, or the Opening

*In the name of Allah (God), Most Gracious, Most Merciful. Praise be to Allah, the Cherisher and Sustainer of the Worlds; Most Gracious, Most Merciful; Master of the Day of Judgment. Thee do we worship, and Thine aid we seek. The way of those on whom Thou hast bestowed Thy Grace, those whose (portion) is not wrath, and who go not astray.*

- Surah 2 (Chapter 2) Al-Baqarah, or the Heifer (The Cow)

*In the name of Allah, Most Gracious, Most Merciful Alif-Lam-Meem. This is the Book; in it is guidance*

*sure, without doubt, to those who fear Allah; Who believe in the Unseen, are steadfast in prayer, and spend out of what We have provided for them; And who believe in the Revelation sent to thee, and sent before thy time, and in their hearts have the assurance of the hereafter. They are on true guidance, from their Lord, and it is these who will prosper.*

- From the Book of Patients: Chaplain 1 #1949, narrated by Abu Sa'id Al-Khudri and Abu Huraira

*The Prophet Muhammad said, "no fatigue, no disease, nor sorrow, nor sadness, nor hurt, nor distress befalls a Muslim, even if it were the prick he receives from a thorn, but that Allah expiates some of his sins for that."*

#### BUDDHIST:

- *You can search throughout the entire universe for someone who is more deserving of your love and affection than you are yourself, and that person is not to be found anywhere. You yourself, as much as anybody in the entire universe deserve your love and affection.* – The Buddha
- *Hatred is not ceased by hatred. Hatred is ceased by love. This is an eternal truth.*  
– The Buddha, the Dhammapada
- *Even as a mother protects with her life, her child, her only child, should one cherish all living beings, radiating kindness over the entire world . . . outwards and unbounded, freed from hatred and ill will.*  
– The Buddha, Metta Sutra (Buddha's *Discourse Loving Kindness*)

The potential Desired Contributing Outcomes for this use of Scripture would include the facilitation of hope through the use of Scripture, to reconnect a person to his or her faith resources, and to find parallel stories in Scripture that enlighten, encourage and provide hope and assurance of God's love.

The following is a sample Scripture education or study compiled by Chaplain Brian Kimball of the U.S. Marines. It is designed especially for those with PTSD, and is an example of how one can use Scriptural education as a Spiritual Care Intervention (Kimball, 2008).

#### BRIAN KIMBALL'S SCRIPTURE STUDY:

Read Psalm 55:

Combat stress in Psalm 55:

- combat stressors:
  - (physical) Restless – v.2
  - (mental) pressure – v.3
  - (mental) terror – v.4
  - (mental) fear – v.5
  - (spiritual) betrayal – v.13
  - (spiritual) anger toward injustice – v.15
- combat stress reactions:
  - (physical) restless – v.2
  - (physical) trembling – v.5
  - (mental) distracted – v.2
  - (emotional) anxiety – v.4
  - (emotional) overwhelmed – v.5
  - (emotional) desire to escape – v.6-8
  - v.1-2a: invocation of God
  - v.2b-8: the psalmist's distress
  - v.9-11: plea for judgment of the enemy
  - v.12-14: the faithless friend
  - v.15: renewed call for judgment
  - v.16-19: statement of confidence
  - v.20-21: faithless friend reprise
  - v.22-23: confident trust in God

Discussion questions:

- Does it surprise you that David experienced combat stress?
- What are some of the obstacles a veteran must overcome in order to depend upon God as David did?
- In light of today's war, how does Psalm 55 apply to those returning from combat?
- How did God sustain you during your combat tour?

The potential Desired Contributing Outcomes from this kind of Scripture study and education would include: to increase the person's awareness of God's actions in similar situations in history, to provide assurance that God can provide for him or her just as God did for the person in Scripture, and to provide an example from Scripture that connects with the person's own experience.

A chaplain does not need any specialized training to use this Spiritual Care Intervention of Scripture Paralleling and Education.

*Evidence:*

Recomendations	Sources	QE	OQ	R
1. The chaplain can assist the person with PTSD in finding a parallel narrative from that person's religious tradition's sacred Scripture that connects with the person's own story	(Fontana, A, Interview)	III	Poor	I
2. The chaplain can assist the person with PTSD in finding a relevant Scripture of verse that provides some hope and/or assurance of God's love	(Kimball, 2008), (Landau, et al., 2008), (Navy Medicine)	III	Poor	I

QE= Quality of Evidence OQ=Overall Quality  
R= Recommendation

7. REFRAMING GOD ASSUMPTIONS-  
EXAMINING HARMFUL SPIRITUAL  
ATTRIBUTIONS

*Objective:*

To assist the person with PTSD by helping him or her examine his or her assumptions about God and God's character, as well as harmful spiritual attributions all of which may be contributing to spiritual distress.

*Background:*

A person who has PTSD will often be experiencing spiritual distress as well (Organ, J, personal communication, January 12, 2009 ). This distress involves reframing one's assumptions about God, and one's image of God. It can be similar to the archetypal struggle of Job in the Hebrew Scriptures – what is it like when one's assumed image of God, which one believes to be fixed, objective and accurate, no longer “fits” with the reality that one has experienced? This image of God is challenged directly by the trauma one has experienced, or even the trauma one has perpetrated in the name of

war. How does one reconcile the God who one thought was a specific way with a God who somehow encompasses all that has happened? Is God less powerful, more vulnerable? Is God somehow more mysterious and less personal? Is this even the kind of God I want to believe in any longer? The chaplain can work with the person in this kind of spiritual distress by assisting the person in discovering a new way of viewing God that accommodates those storm clouds. This new, revised God must be found in the midst of the chaos, disruption, disorder, and ambiguities that have been experienced during and since the traumatic event.

Pargament, Koenig, and others, have identified seventeen religious coping strategies that people use when facing stress (Pargament, et al, 1998). These can be categorized as either positive religious coping – which can lead to more healthy outcomes and potential for post-traumatic growth (Shaw, et al., 2005), and negative religious coping – which can lead to an increase in depression, anxiety, and PTSD symptom severity, and poorer adjustment to future stressors, higher levels of stress, poorer physical health, reduced quality of life, and poorer cognitive functioning (Witvliet, et al., 2004) (Harris, et al., 2008). The positive religious coping strategies include: searching for spiritual purification, looking for a new religious direction, providing spiritual support for others, seeking spiritual support from others, using God as a partner in problem solving, using religion as a distraction from stressors, actively giving God control of the situation, redefining the stressor as God's benevolence, seeking a stronger connection with God, and deliberately maintaining religious behavioral standards. The negative stressors are: feeling dissatisfied with one's relationship with God, attributing the stressor to the devil, passively waiting for God to change the situation, feeling dissatisfied with relationships with clergy and others in one's faith group, redefining God as other than omnipotent, identifying the stressor as punishment from God, and asking God for a miracle or direct intercession.

A chaplain can encourage the positive religious coping strategies listed above. He or she can also work with people through some of the negative religious coping strategies. It can be important to examine potential harmful spiritual attributions, such as “God abandoned me,” or “God is judging or punishing me.” One process for doing this is listed below, but it is hardly the only way for a chaplain to journey with

someone through such a crisis (Kimball, 2008). It is important to remember the importance of respecting another person's spiritual belief system, and not seeking to correct or fix their theology, assumptions, or beliefs. A chaplain should not challenge them so much as explore them with the person, to see if, in light of the traumatic experience and its after-effects, those are still what the person chooses to believe and assume. If the person is open to exploring other possibilities or is open to examining these beliefs and assumptions, then the chaplain can engage this process. If the person is not, then the chaplain should seek to find ways to remain in good relationship with this person and continue respecting that person's spiritual belief system as it is.

#### *Recommendations:*

1. The chaplain can assist a person with PTSD through encouraging positive religious coping strategies.
2. The chaplain can assist a person with PTSD through exploring negative religious coping strategies and helping the person examine each.
3. The chaplain can assist a person with PTSD through articulating the emotions he or she is currently experiencing in relationship to God.
4. The chaplain can assist a person with PTSD through helping the person shift focus from those emotions to the assumptions about God behind them.
5. The chaplain can then assist the person with PTSD in evaluating whether or not those assumptions about God are helpful, sufficient, accurate, or healthy in light of the trauma he or she experienced.

#### *Discussion:*

Overall, it can be constructive for a chaplain working with someone with PTSD to seek to encourage positive religious coping, and decrease those negative coping strategies that may be exacerbating or energizing some of the spiritual distress. To increase the positive religious coping strategies and decrease the negative religious coping strategies provides an excellent set of Desired Contributing Outcomes for this section.

It is possible for the person to push through this "dark night of the soul" and Job-like experience including feelings of guilt and shame, and come to a new appraisal of important images, concepts, and

relationship with a God that can transform. Just as Jesus felt abandoned by God in the Garden of Gethsemane in the Christian Scripture, the person with PTSD may likely feel or have felt this abandonment by God as a result of the trauma he or she has experienced. A chaplain can patiently, subtly, and persistently journey with this person in shifting focus from the perceived abandonment by God to the assumptions he or she previously held about God that may need to be challenged. This process requires delicate balance and timing. Relationship and sensitivity are paramount on the part of the chaplain.

Before this shift can occur, a chaplain must help the person with PTSD articulate what he or she is feeling in relationship to God. This is the first step in the journey. The chaplain can and should encourage the person to reflect on what he or she is feeling about God in relationship to the trauma and its after-effects on his or her life. This cry of distress, anger, abandonment, or whatever emotion is at the core of the relationship should be made explicit. This process can be excruciating and terrifying for many people, as it can be a struggle to find an example of how to be this authentic and this raw in conversation with God. A chaplain should use whatever resources best speak to the person in order to model and empower this for them. These can include but are not limited to: Scriptures such as Job, Psalms, Ecclesiastes, Lamentations, and some Gospel narratives; stories of people who have worked through their distress to find hope and a renewed relationship with God; and talking to the person with PTSD about people he or she is aware of who have lost faith only to have it replaced with a more mature, powerful belief system.

Once a person has been able to articulate the feelings he or she has about God in relationship to the trauma he or she has experienced, a chaplain can assist him or her to look at the assumptions behind the disappointments or negative emotions. Perhaps the person feels abandoned by God because he or she believed that God would protect him or her from ever being in a position where he or she might have to pull the trigger. It is important to elicit explicit articulation of the assumptions that created the spiritual distress.

Once the person's assumptions about God have been articulated and even listed, the chaplain can discuss with him or her whether he or she still believes these assumptions are helpful, accurate, or productive. This critical reflection upon one's spiritual assump-

tions can be challenging, as most people reactively believe that nothing as good or positive can possibly replace those assumptions. If the previous assumptions were wrong, or even just insufficient, then what else is “up for grabs?” The chaplain can be the best guide through this potentially frightening spiritual terrain. The more the chaplain can help the person normalize the feelings and journey itself, the better the person can likely feel about walking through it.

The ultimate goal is to have the person come to a more mature, experienced and “fire-tested” faith. This may mean that some of the previous assumptions are sacrificed and replaced with newer, more nuanced ones. The newer assumptions about God and God’s nature may be at odds with some assumptions of the person’s faith community, or family of origin’s faith community. This too can be a place where grief, fear and anxiety can be addressed directly by the chaplain.

In this process, it is extremely important for the chaplain to avoid any appearance of imposing his or her own values and beliefs. The chaplain should always remember that this process is about helping the person with PTSD find beliefs and assumptions that are right for them.

*Evidence:*

Recommendations	Sources	QE	OQ	R
1. The chaplain can assist a person with PTSD through encouraging positive religious coping strategies.	(Shaw, et al., 2005), (Witvliet, et al., 2004), (Harris, et al., 2008), (Kimball, 2008)	II	Fair	I
2. The chaplain can assist a person with PTSD through exploring negative religious coping strategies and helping the person examine each.	(Shaw, et al., 2005), (Witvliet, et al., 2004), (Harris, et al., 2008), (Kimball, 2008)	II	Fair	I
3. The chaplain can assist a person with PTSD through articulating the emotions he or she is currently experiencing in relationship to God.	Inter-views with numerous chaplains	III	Poor	I

Recommendations	Sources	QE	OQ	R
4. The chaplain can assist a person with PTSD through helping the person shift focus from the emotions related to God to the assumptions about God that underlie them.	Inter-views with numerous chaplains	III	Poor	I
5. The chaplain can assist the person with PTSD in evaluating whether or not those assumptions about God are helpful, sufficient, accurate, or healthy in light of the trauma he or she experienced.	Inter-views with numerous chaplains	III	Poor	I

QE= Quality of Evidence OQ=Overall Quality  
R= Recommendation

8. ENCOURAGING CONNECTION WITH A SPIRITUAL COMMUNITY

*Objective:*

Assist the person with PTSD through encouraging and empowering a connection to a healthy supportive community.

*Background:*

One of the byproducts of PTSD is social isolation and withdrawal that can allow a person to distance him- or herself and develop an environment where there is no one to provide a counterweight to the self-focused negative thought loops associated with PTSD and depression. One of the best ways to counteract this is to encourage a person with PTSD to be connected to a supportive, healthy community (Oliver, 2008). Ideally, this connection should come from within the person’s own natural environment as much as possible, including family and friends, faith community, and community organizations (Southwick, et al., 2005). The connections may include not only churches but AA, nonprofit helping organizations, service clubs, meditation groups, and sports teams (Drescher, et al., 2007).



Many of these supportive and healthy communities provide for the person with PTSD far more than merely surface social support. Within many organizations, a person with PTSD can develop a focus on others outside of him- or herself. The organization can assist the person with PTSD in making meaning of his or her traumatic experience. The study of the Finnish service members presented previously is again an example (Hautamäki & Coleman, 2001). In another study, the resilient communities expressed themes found to be effective in assisting those within the community to cope spiritually with trauma: requiems (where grieving was a communal affair), rituals (often led by spiritual leaders), and religious beliefs (where religious ceremonies incorporated the trauma experienced by those within the community) (Rajkumar, et al., 2008).

In yet another study, it was demonstrated that a supportive community can have a very large positive impact on those with PTSD through having an environment in which memorial rituals, vigils, anniversary remembrances, different rites of passage, and celebrations of milestones of recovery and healing all occur (Walsh, 2007). A chaplain can often assist not only the person with PTSD in finding a healthy community to join, but also assist that community in finding a mutually beneficial and healthy way in which they can be in relationship. This relationship can include honoring of birthdays or other significant anniversaries, which often can fade into the background and go unnoticed in the midst of the struggle to heal and work through the after-effects of a trauma.

A healthy community for a person with PTSD would also provide a place for testimony, community grief and mourning, and significance (Tankink, 2007). Many who may well remain silent in their day-to-day life about their trauma may find a church or spiritual community a safe and healing environment within which to express their suffering and journey. With the right community, this can lead to a restoration of feelings of trust of others, solidarity with people who may not have experienced the same trauma, and a renewed appreciation for the possibility that people can indeed be good. For many people who struggle to make meaning on their own, finding a community within which to search for meaning can be a God-send.

#### *Recommendations:*

1. The chaplain should assist the person with PTSD

in determining what social support he or she has available, including but not limited to: family, friends, co-workers, faith community, AA, and service groups.

2. The chaplain should strategize with the person with PTSD to find ways in which he or she can connect and/or build social bridges to these potentially supportive communities.
3. The chaplain can train and equip the communities of the person with PTSD in ways the community can be helpful and supportive to the person with PTSD.

#### *Discussion:*

It is important that the chaplain recognize that he or she is most likely the part-time visitor in the life of the person with PTSD, and that the person may have a wide and longstanding network of family, friends, co-workers, people at his or her faith community, former comrades-in-arms, and others that were in relationship with the person prior to the chaplain and will remain in relationship with the person long after the chaplain's role in his or her life is complete. Knowing this reality, the chaplain can and should be in a position to encourage the person with PTSD to reconnect socially with his or her own natural support systems. A Desired Contributing Outcome for this Spiritual Care Intervention is an increase in connection to a healthy, supportive community and a decrease in social isolation.

Another possible byproduct of getting involved in a faith community or service club is the outward focus these organizations can bring to a person with PTSD. The altruism, helping others, and service components of such communities can be immensely therapeutic for a person who is questioning his or her self-worth and relevance due to the traumatic experience. The more a person can pour him- or herself into service to others, the more his or her self-esteem is empowered. A Desired Contributing Outcome for this Spiritual Care Intervention would be an increase in altruistic endeavors and self-esteem and/or feelings of worth, and a decrease in focus only on self.

There is no specialized training needed for a chaplain to work with the Spiritual Care Intervention of seeking to connect a person to a healthy, supportive community.

*Evidence:*

Recommendations	Sources	QE	OQ	R
1. The chaplain should assist the person with PTSD in determining what social support he or she has available, including but not limited to: family, friends, co-workers, faith community, AA, service groups	(Oliver, 2008), (Southwick, et al., 2005), (Drescher, 2007), (Hautamäki & Coleman, 2001), (Rajkumar, et al., 2008), (Walsh, 2007), (Tankink, 2004)	III	Poor	I

QE= Quality of Evidence OQ=Overall Quality  
R= Recommendation

## SPECIALTY INTERVENTIONS

### 1. SPIRITUAL MANTRAM REPETITION:

*Objective:*

Empower persons with PTSD to address the three PTSD symptom clusters through the use of Spiritual Mantram Repetition.

*Background:*

Spiritual Mantram Repetition is a form of “self-regulation” and “attention training” (Bormann, Used by permission). The assumption behind Spiritual Mantram Repetition is that all humans have an inner reservoir of spiritual resources – peace, love, compassion, kindness, goodness, wholeness, healing, generosity, altruism, vitality and patience (St. John, 2007). Spiritual mantram repetition is based partly on work by Dr. Herbert Benson, who studied the relaxation response that results from most spiritual traditions’ use of some sort of repetition of words or phrases intended to bring comfort. Dr. Benson described the relaxation response, and demonstrated that mantram repetition elicits a measurable calming effect. He states it acts to balance the fight/flight response to stress which is a central dysfunction in those with PTSD. He also showed that it lowers heart rate, blood pressure, breathing rate, and oxygen consumption – all of which are signs of being calmer (Benson & Klipper, 2000)

Spiritual Mantram Repetition is also one of the eight points of Sri Eknath Easwaran’s spiritual program at the Blue Mountain Center for Meditation, the

others being meditation on a passage, slowing down, one-pointed attention, training the senses, putting others first, spiritual fellowship, and spiritual reading. While most people with PTSD will not sit still for meditation, many have been openly receptive to spiritual mantram repetition as a way to focus or train one’s attention and self-response to the troubling symptoms of PTSD. An excellent resource for this technique is Easwaran’s book, *The Mantram Handbook*.

The use of spiritual mantram repetition for persons with PTSD has been pioneered by nurse researcher Jill Bormann, who has been studying the impact this intervention has on veterans with PTSD at the VA in San Diego since 2001. Spiritual Mantram Repetition has been demonstrated to help veterans with PTSD address all three symptom clusters of PTSD – intrusive recollection, avoidant / numbing, and hyper-vigilance. One self-report demonstrated significant reduction in symptoms after using this technique for six weeks. What appears to be most promising is the intervention’s sustainability and ease of use.

In yet another study (Bormann, et al., Used by permission), spiritual mantram repetition was demonstrated to be good for health care workers as well, through decreasing stress, anxiety and anger, as well as increasing quality of life and spiritual well-being.

According to Daniel Lowenstein, a leading epilepsy researcher and neurologist, when a person uses Spiritual Mantram Repetition, his or her mind slows down and is brought into the present (Blue Mountain, 2008). This allows for more focused attention.

One study (Bormann, et al., 2005) looked at 176 veterans at the San Diego VA Hospital who took a five-week mantram repetition course. They used wrist-worn counters (golf scorers put to a different purpose) to track how frequently they repeated the spiritual mantram they had chosen. Despite the relatively small sample size, there was a statistically-significant improvement in all outcomes – using Cohen’s Perceived Stress Scale, PTSD-Checklist, Endicott’s Quality of Life Enjoyment and Satisfaction Short Form, and Ellison’s Spiritual Well-Being Scale. The two largest impacts were on trait anxiety and spiritual well-being.

Another small pilot study (Bormann, et al., 2006) saw thirty veterans participate as well as thirty-six additional people who were employees of the hospital. In this sample, Spiritual Mantram Repetition helped

manage stress, insomnia, and unwanted thoughts.

In Bormann's study of the use of Spiritual Mantram Repetition as a Spiritually-Based group intervention with veterans with PTSD (Bormann, et al., 2008), most veterans surveyed stated they would use complementary approaches to health care if they were available. One advantage of the Spiritual Mantram Repetition is that it does not require any specific posture, quiet surroundings, eyes closed, or religious/spiritual beliefs.

#### *Recommendations:*

1. Read about and begin practicing Spiritual Mantram Repetition yourself, as the best way to share its implications in one's life is to experience it oneself.
2. Introduce Spiritual Care Mantram Repetition to veterans with PTSD as a way to focus their attention and bring clarity of mind.
3. Assist the veteran with PTSD in choosing their Spiritual Mantram from the list below, or from their favorite applicable Scripture or prayer.
4. Offer practical ways to move the veteran with PTSD through the stages of adoption of the Spiritual Mantram Repetition, encouraging them to stick with it, self-report how frequency they use it, and explore the technique's impact on their lives through questions such as, "Have you noticed a decrease in the number of times you felt overwhelmed?"
5. Specifically encourage the person with PTSD to use Spiritual Mantram Repetition to address the three symptom clusters of PTSD – intrusive recollection, avoidance / numbing, and hyper-vigilance.
6. Reinforce their use of Spiritual Mantram Repetition through continued supportive conversation, response to questions, and exploration of its benefits in the patient's life.

#### *Discussion:*

Spiritual Mantram Repetition is such that the more concentration one gives the mantram; the more impactful it can become (Bormann, et al., Used by permission). For each person beginning to use Spiritual Mantram Repetition, there are predictable stages. The first is the Mechanical stage, when the repetition seems silly or strange. People often become resistant in this stage, feeling that it is corny or too easy to have

any kind of impact. In working with someone learning this technique, encouraging them to stick with it can be fruitful during this mechanical stage. The second stage is more experiential. It takes some time to begin to notice the impact. In reflection, a person who has been using this for a while will begin to notice that they are likely getting less frustrated and recovering from anger or irritability more quickly. The changes are often subtle but noticeable. It may well be that a chaplain's inquiries allow the person who has been using Spiritual Mantram Repetition to begin to become aware of its subtle impact on their moods and day-to-day life. The final stage is habitual, when the spiritual mantram becomes a habit that reminds the person with PTSD of his or her highest ideals. It can tap into his or her capacity to be kind, calm, and loving.

Specifically for persons with PTSD, Spiritual Mantram Repetition seeks to address all three PTSD symptoms clusters. For persons that are re-experiencing their trauma with intrusive recollection, it seeks to bring a person back into the present moment. For the person that is experiencing avoidance or numbing, it can help him or her think critically about their thinking, reactions, and seek to choose to respond with intentionality instead of reactivity. For the person with hyperarousal, Spiritual Mantram Repetition can soothe and relax them.

The chaplain can assist in helping the veteran with PTSD choose his or her mantram. While there may well be others that would function well for a specific person, the following Spiritual Mantrams are suggested based on the fact that they have been used for centuries in each of the applicable religious traditions:

LIST OF POSSIBLE MANTRAMS:

<p><i>Buddhist:</i> Om-Mani-Padme-Hum</p> <p>Name Butsaya</p>	<p>An invocation to the jewel (Self) in the lotus of the Heart</p> <p>I bow to the Buddha</p>
<p><i>Christian:</i> My God and my all Maranatha</p> <p>Kyrie Eleison</p> <p>Christe Eleison</p> <p>Jesus, or Lord Jesus Christ Jesus, Son of God Hail Mary or Ave Maria Mother of Jesus</p>	<p>St. Francis' mantram Lord of my heart (Aramaic)</p> <p>Lord have mercy, or Lord is risen</p> <p>Christ have mercy, or Christ is risen</p>
<p><i>Hindu / Indian:</i> Rama Eternal</p> <p>Ram Ram Sri Ram Om Namah Shivaya</p> <p>Om Prema Om Shanti</p> <p>So Hum</p>	<p>Joy within (Gandhi's mantram) (variation on Rama) An invocation to beauty &amp; fearlessness A call for universal love An invocation to eternal peace I am that Self within</p>
<p><i>Jewish:</i> Barukh Atiah Adonoi Ribono Shel Olam Shalom Sheheena</p>	<p>Blessed are Thou, O Lord Lord of the Universe Peace Feminine aspect of God</p>
<p><i>Muslim:</i> Allah Basmallah Ir-raham Ir-rahim</p>	<p>One True God In the name of Allah, the merciful, the Compassionate</p>
<p><i>Native American:</i> O Wakan Tanka</p>	<p>Oh, Great Spirit</p>

To go from choosing one's spiritual mantram to having integrated the Spiritual Mantram Repetition into one's day-to-day living, some tips include:

- Practice mantram when not stressed, so it will calm you when you are
- Silently repeat it as often as possible, throughout the day
- Repeat it every night before sleep to further support the mind-body connection

For several studies, self-monitoring of the Spiritual Mantram Repetition was done using wrist-counters (Falconwood golf-score keepers manufactured by ProActive Sports, Inc., Canby, OR) (Bormann, et al., 2007). The use of these counters not only assisted in counting the frequency of use of mantram, but they also served as a consistent reminder to practice the spiritual mantram.

It can also be helpful to incorporate the mantram by using it while waiting or when dealing with "annoying things"

- People who are late
- Standing in lines
- On hold on the telephone
- Getting cut off in traffic
- During arguments or disagreements with others
- Waiting for an elevator
- Prior to a job interview or public speaking
- Before answering the phone
- Before entering into a patient's room
- When sick and dealing with pain, illness, or surgery
- Before meals – reminding yourself to eat slowly
- In dealing with little compulsions or addictions
- Before going to sleep / dealing with insomnia
- When dealing with like & dislikes to overcome rigidity
- In the presence of a dying or suffering person when you want to "do" something and don't know what to do

Use the mantram when doing something that doesn't require full attention:

- Washing dishes, sweeping, vacuuming, dusting
- Lawn mowing, raking, gardening, watering plants
- Brushing teeth, combing hair, bathing / showering
- Exercising

Use mantram to manage unwanted emotions like impatience, ruminating or intrusive thoughts, fear,

frustration, anger, guilt, greed, resentment, worry, embarrassment, anxiety, envy or jealousy

Use mantram to focus oneself and bring attention into the present moment.

When describing the Spiritual Mantram Repetition to veterans with PTSD, it is best to describe it as a way to focus or train one’s attention, as a rapid focus tool, or pause button. This allows the veteran to be free from any potential stigma or assumptions that might be associated with a spiritual or religious intervention. What often appeals to the veterans about mantram is that it is a tool for focus in combat or to focus their attention in their day-to-day life. One potential Desired Contributing Outcome for the Spiritual Mantram Repetition is to assist the person with PTSD in finding one-pointed attention. As such, it can help raise one’s awareness of one’s thinking, increasing one’s mindfulness in the same way a magnifying glass focuses sunlight.

Spiritual Mantram Repetition can also be used for slowing down. It helps the person using it discriminate and triage his or her to-do list. It can also help one “let go” of things which can be a drain on energy – stressors which serve to distract and weigh down a person rather than lead toward healing or wholeness. It can help a person choose or make decisions more wisely, as it slows his or her thinking down and allows for a more thorough examination of options. The end result for many with PTSD who have begun to use Spiritual Mantram Repetition is living more fully, consciously, and intentionally. As such, a chaplain can utilize Spiritual Mantram Repetition in seeking to provide the Desired Contributing Outcome of assisting a person with PTSD in slowing down their thought processes and allowing for more control over their own thoughts.

There is no specialized training needed to be able to use this Spiritual Care Intervention. However, Dr. Bormann teaches a three-day “train the trainer” class that would allow the chaplain to learn how to teach Spiritual Mantram Repetition in an eight-week class with veterans who have PTSD. She can currently be reached at the VA in San Diego.

*Evidence:*

Recommendations	Sources	QE	OQ	R
1. Introduce Spiritual Care Mantram Repetition to veterans with PTSD as a way to focus their attention and bring clarity of mind.	Interview, Bormann	III	Poor	I
2. Assist the veteran with PTSD in choosing their Spiritual Mantram.	(Bormann, et al., 2005)	II	Fair	I
3. Offer practical ways to move the veteran with PTSD through the stages of adoption of the Spiritual Mantram Repetition, encouraging them to stick with it, self-report how frequently they use it, and explore the technique’s impact on their lives	(Interview, Bormann)	III	Poor	I
4. Specifically encourage the person with PTSD to use Spiritual Mantram Repetition to address the three symptom clusters of PTSD – intrusive recollection, avoidance / numbing, and hyper-vigilance.	(Interview, Bormann)	III	Poor	I
5. Reinforce their use of Spiritual Mantram Repetition through continued supportive conversation, response to questions, and exploration of its benefits in the patient’s life.	(Bormann, et al., 2005), (Bormann, et al., Used by permission), (Bormann, -FAQ’s , Used by permission), (Bormann, et al., Used by permission), (Bormann, et al., 2006), (Bormann, et al. 2006 Sep-Oct), (Bormann, et al., 2007), (Bormann, et al., 2008 June)	III	Poor	I

QE= Quality of Evidence OQ=Overall Quality  
R= Recommendation

## 2. CREATIVE WRITING:

### *Objective:*

To use writing creatively to assist a person with PTSD discover insights, process grief and loss, and get in touch with difficult emotions.

### *Background:*

The majority of Spiritual Care Interventions most chaplains utilize are face-to-face and verbal. If the person is not able to speak for some reason, the chaplain may still rely almost exclusively on verbal communication and intentional presence. One creative way to work with persons with PTSD that may yield some insights that otherwise are difficult to access is through the use of writing. This is a type of Spiritual Care Intervention that can be done either one-on-one or in a group setting.

Writing as a Spiritual Care Intervention comes under the category of Expressive Therapies, which would also include Art, Dance, Drama and Music. Each of those can be helpful in addition to therapeutic writing. If the chaplain wishes to find out more about any of these expressive therapies, a good reference is Cathy A. Malchiodi's 2005 work, *Expressive Therapies*.

Writing as a Spiritual Care Intervention can also be helpful for a person who is not yet ready to communicate the pain and suffering of his or her experience face-to-face. The chaplain can be creative, and adapt the form or process of the writing exercise to include what he or she feels would be best for the person with PTSD. A chaplain would give a writing "assignment" or "homework" – encouraging the person with PTSD to follow instructions in writing a particular assignment in order to elicit a subsequent conversation about the trauma, its after-effects, or impact on the person's life or spirituality.

### *Recommendations:*

1. The chaplain can assist the person with PTSD through choosing a type of writing assignment that allows the person to creatively express his or her feelings about the trauma and its impact on his or her life.
2. The chaplain can then use the piece the person has written to explore his or her feelings, spiritual distress and other relevant issues.

### *Discussion:*

The possibilities for variations in form, content, or process of the writing are limited only by the creativity of the chaplain and willingness of the person with PTSD to participate. These can include but are not limited to: journaling, poetry, writing or rewriting lyrics to a song, letters to loved ones, lost friends or comrades-in-arms, or to a person who has experienced the exact same trauma as the person him- or herself (Knaevelsrud & Maercker, 2007); spontaneous non-edited stream-of-consciousness about the trauma, life before or since, or some aspect of it, a play or role play, writing with one's non-dominant hand, reflections on feelings of guilt, shame, or other "negative" emotions, a letter to God, a prayer or a Psalm, a letter to a lost body part or innocence, a letter to the family of the person(s) the counselee has killed or injured, a creative short-story relating to the trauma or its after-effects, a letter to the bullet or bomb or IED that killed a comrade; and, writing out what one considers might be the potential positive consequences of the event in the person's life. The letters can be helpful to write whether or not they are actually sent.

As the chaplain then reviews the writing with the person who wrote it, it is good to encourage the person to reflect on his or her feelings about it, to challenge dysfunctional automatic thinking and behavioral problems, and to correct unrealistic assumptions. When these have been written down instead of merely discussed face-to-face, the chaplain can allow for that externalization to be able to more directly address some of the content. The chaplain can also seek to parallel some of the writings of the person with whom he or she is working with that person's sacred Scriptures. For example, if the person is Jewish and has chosen to write a Psalm, the chaplain in making the assignment can read several lament Psalms with the person, assign the Psalm-writing exercise, and then discuss the choices the person made once he or she returns the next time with an original Psalm. This process can be a healthy and safe segue into more in-depth discussions of spiritual distress, anger, abandonment and other difficult-to-discuss emotions.

Among the Desired Contributing Outcomes from this Spiritual Care Intervention would be an increase in a person's ability to articulate difficult-to-discuss feelings or impact of the traumatic experience, an increase in the creative expression of a person's pain, suffering, or concerns, and a decrease in negative or

unrealistic assumptions.

There is no specialized training needed to use writing as a Spiritual Care Intervention. However, the resource, Expressive Therapies, can be helpful, and a chaplain can look for specific workshops on the therapeutic use of writing if interested in developing this skill more intentionally.

*Evidence:*

Recommendations	Sources	QE	OQ	R
1. The chaplain can assist the person with PTSD through choosing a type of writing assignment that allows the person to creatively express his or her feelings about the trauma and its impact on his or her life.	(Malchiodi, 2005) (Knaev-elsrud, Maercker, 2007)	III	Poor	I
2. The chaplain can then use the piece the person has written to explore his or her feelings, spiritual distress, and other relevant issues.	(Malchiodi, 2005) (Knaev-elsrud, Maercker, 2007)	III	Poor	I

QE= Quality of Evidence OQ=Overall Quality  
R= Recommendation

## INTERVENTIONS REQUIRING SPECIAL TRAINING

### 1. SWEAT LODGE- APACHE WARRIOR RITUAL:

*Objective:*

To build and use a sweat lodge as both a team building and spiritual discernment exercise with people with PTSD.

*Background:*

The sweat lodge is a kind of ceremonial sauna traditionally used by several different Native American tribes for spiritual renewal and cleansing. This can be a structure built by the people in the PTSD group, or one already constructed on the grounds of the hospital. The structure can be a domed or oblong hut covered with planks or tree trunks. Stones are heated in a fire

immediately outside the door of the sweat lodge, and are then placed in a central pit in the ground within the hut. The stones are often granite and potentially glow red inside the dark sweat lodge.

If at all possible, it can be very helpful to invite a local Native American medicine man or spiritual leader to help introduce the sweat lodge to the group and to facilitate its construction and use. This would require some logistical planning – such as coordination with the hospital, permission for the patients to participate (including waivers for patients to sign), securing a site for the sweat lodge, and involvement and/or blessing of a local Native American spiritual leader or medicine man.

Different tribes and regions of the country have a variety of rituals associated with the sweat lodge. They may include complete silence, prayers, songs, drumming, or offerings to the spirit world. Some common practices and basic elements associated with sweat lodges include but are not limited to:

*Orientation of the lodge* – The door should face the fire. This forms a duality between the lodge and the fire which, according to many traditions, is symbolic of the male-female or heaven/spirit world-earth dualities. Placement and orientation of the lodge should be meaningful.

*Construction of the lodge* – The lodge can be built by the group of PTSD patients as a team building exercise. It should be done with careful precision and with respect for the environment, the materials being used, and the people constructing it. The building of the lodge itself is often done in silence, or with traditional drum music or while fasting.

*Clothing* – Participants should wear loose-fitting cotton clothing without any metal jewelry that could get very hot in the lodge.

*Offerings* – Different types of tobacco, dried cedar, or sweet grass are often placed on the rocks to create fragrance.

*Support* – With many different traditions, one or more people (called “dog soldiers”) remain outside the sweat lodge as the ceremony is occurring in order to protect it and help those participating. They may tend to the fire and place the hot stones.

If it has been possible to find a Native American medicine man or spiritual leader, he can assist the chaplain in not only the construction of the lodge but also in the ceremony itself. Most sweat lodge ceremonies have their own etiquette, which should be com-

municated to the group beforehand.

Some ceremonies involve complete silence, with others having singing, chanting, drumming, or other sounds. It is extremely important for each person to understand what is expected and allowed prior to entering the lodge for the ceremony. Most traditions put a high value on respect for the lodge itself. The basic tenet for most is – enter the lodge as you entered the world – empty, without expectation, open to experiencing what happens next. One of the most important practices of etiquette is that of gratitude. It is key to be thankful to the people joining you in the lodge, and those helping to support it.

It is also important to understand the risks of participating in a sweat lodge ceremony. It can become extremely hot. As such, one should not wear metal objects such as dog tags or eye glasses. One should also avoid wearing contact lenses and synthetic clothing. Cotton clothes are recommended. Unlike a traditional sauna, the sweat lodge ceremony can last for several hours. As such, it can be important for each person to know his or her limits, to begin the experience well-hydrated, and to know when it would be best to exit the lodge even if the ceremony is still underway. Ideally, each participant should have a physician’s permission to participate to prevent any complications with health and wellness.

Also, if rocks are used, do not use river rocks or any kind of rocks with air pockets within them. Igneous basalt can be the best type of rock to use, and they must be completely dry prior to heating them. It can also be important to be careful what is placed on the rocks once they are in the sweat lodge as certain plants may have been treated with pesticides or other chemicals and have the potential to create unhealthy fumes.

As a Spiritual Care Intervention, the Sweat Lodge can be extremely meaningful. Dr. John Fortunato’s Recovery and Resilience Center has their PTSD group build and use a sweat lodge roughly every six weeks. He states that this has been one of the most meaningful spiritual care interventions used at the center, with the building of it being a team-building exercise as well.

*Recommendations:*

1. If at all possible, find a regional Native American medicine man or spiritual leader to assist in the planning, building, and utilization of a sweat lodge
2. The chaplain can facilitate the building of a sweat

lodge when working with persons with PTSD for a team-building exercise

3. The chaplain can partner with the Native American medicine man or spiritual leader in preparing, participating, and debriefing the PTSD group in the use of the sweat lodge for spiritual searching, purification, and community-building.

*Discussion:*

The Desired Contributing Outcomes for this Spiritual Care Intervention of utilizing a sweat lodge include but are not limited to: a purification of the body, mind, and spirit to allow a new sense of Self to be present, connecting each participant with one another in a common bond and task, and opening oneself to a spiritual experience outside the norm in an attempt to discover new things about oneself.

While there is no specialized certification needed for a chaplain to use a sweat lodge, the chaplain is encouraged to partner with a regional Native American medicine man or spiritual leader to assist him or her in the planning, logistics, implementation and instruction of the sweat lodge.

*Evidence:*

Recommendations	Sources	QE	OQ	R
1. If at all possible, find a regional Native American medicine man or spiritual leader to assist in the planning, building, and utilization of a sweat lodge	(Wilson & So-kum Tang, 2007) (Wilson, 1989), (Mails, 1991), (Scurfield, 1995), (Rogers & Koenig, 2002) (Interview with Fortunato)	III	Poor	I
2. The chaplain can facilitate the building of a sweat lodge when working with persons with PTSD for a team-building exercise		III	Poor	I



Recommendations	Sources	QE	OQ	R
3. The chaplain can partner with the Native American medicine man or spiritual leader in preparing, participating, and debriefing the PTSD group in the use of the sweat lodge for spiritual searching, purification, and community-building.		III	Poor	I

QE= Quality of Evidence OQ=Overall Quality  
R= Recommendation

## 2. PSYCHIC JUDO – GOING WITH THE NEGATIVE EMOTION:

### *Objective:*

Assist the person with PTSD through teaching and equipping him or her to find a safe, time-limited environment within which to invite the negative emotions into the present.

### *Background:*

Note – this is a Spiritual Care Intervention that can be helpful, and a tool to give to persons with PTSD who have struggled with managing their anxiety and feelings of being overwhelmed. However, it would be best to discuss one’s intended use of this intervention with the mental health professionals working with that person. There may be some complicating psychological co-morbidities or underlying depression, suicidal or homicidal ideations of which the chaplain is unaware, in which case this (and other) Spiritual Care Intervention could do harm rather than help. This intervention may be best used after an established relationship has developed with the person, and once the person’s acute symptom clusters are controlled and he or she has learned how to manage the chronic after-effects of the trauma.

Psychic Judo is not a recognized name of a Spiritual Care Intervention, but a clever way to describe a Buddhist technique of anxiety management. The basic philosophy behind the technique is that a person often spends much energy seeking to avoid, distract, or ruminate on his or her negative feelings. In running from one’s negative emotions, a person gives those emotions power, often creating anxiety that is in addition to the raw negative feeling itself. Instead of “just”

feeling angry and vulnerable and guilty, a person feels anxious about feeling angry and vulnerable and guilty. Psychic Judo is based on the same philosophy as Judo, which allows a person to go with the energy that is attacking him or her rather than move against it. If a punch is coming toward a person, instead of moving into the punch and increasing the force of that punch, or instead of tensing up one’s muscles in anticipation of being hit, a person should move with the force of the punch itself, with muscles as relaxed as possible. Much of the energy of the punch is absorbed, allowing a person to recover quickly from it. Emotionally the exercise can be quite similar.

The end result can be a person who begins to recognize that the negative feelings that he or she has sought to avoid for so long are not as powerful as he or she originally feared. Even if the emotions are as intense and scary as the person had feared, the person may well have learned that he or she can survive a head-on collision with them. For most people who utilize this intervention, following the pre-determined time allotted to experience those emotions, the result can also be a decrease in the actual power of those emotions over that person. Not only is the person decreasing his or her anxiety and dread about those negative emotions themselves, but those negative emotions now have less potency for the person.

### *Recommendations:*

1. The chaplain can assist the person with PTSD in learning how to experience the negative feelings associated with his or her traumatic event safely and allow those negative feelings to lose much of their power over the person.

### *Discussion:*

A chaplain can either choose to demonstrate this for the person with whom he or she is working, or teach the theory and method and assign it as homework between visits. The person first must find a place where he or she feels safe and knows that nothing bad will happen if he or she “gives in to” the overwhelming negative feelings. This step is essential. Many people with PTSD may have underlying and complicating clinical depression. It is key to make sure that the person will not seek to harm him or herself or another during this process. This can be done with another trusted person in the room, or on the other side of the room, or in an adjacent room with the door open to

be able to step in and help if the person begins to feel too overwhelmed. The chaplain can play this role of “chaperone” with the person, and it may prove helpful to do several shorter segments of this initially to get the idea and demonstrate the potential effectiveness.

Then the person should identify, with the chaplain, how long he or she believes would be enough time to be able to fully experience this negative emotion, yet not be completely overpowered by it. The length may be minutes, or even a matter of seconds. It may be an hour, or two or four. The instructions encourage the person with PTSD to invite the negative feelings that usually require so much energy to avoid, to instead, wash over him or her as directly and powerful as the emotions can often do. There can be a pre-determined code word to alert the colleague or “chaperone” that it has become too powerful and it is time to stop regardless of the original timeframe that had been set.

Then, the person sits comfortably, or lies down, and experiences the negative emotions in as direct and explicit a way as possible. He or she may wish to scream, or cry, to be silent or to discuss with his or her companion what is being experienced. For the allotted time, the person allows these feelings that have created so much angst in his or her world to be primary in the person’s attention. The chaperone is the time-keeper, and communicates as needed how much time remains.

Among the Desired Contributing Outcomes for this Spiritual Care Intervention of Psychic Judo are an increase in feelings of control and optimism regarding his or her ability to cope with the negative emotions associated with the experienced trauma, and a decrease in one’s anxiety and dreadful feelings about those feelings.

There are no specialized trainings needed to facilitate this Spiritual Care Intervention. However, as mentioned above, it should be done in explicit conversation with a person’s mental health team.

*Evidence:*

Recommendations	Sources	QE	OQ	R
1. The chaplain can assist the person with PTSD in learning how to experience the negative feelings associated with his or her traumatic event in a safe manner, and allow those negative feelings to lose much of their power over the person.	Interviews with numerous chaplains	III	Poor	I

QE= Quality of Evidence OQ=Overall Quality  
R= Recommendation

3. INTERPERSONAL PSYCHOTHERAPY (IPT):

*Objective:*

To provide care for the person with PTSD through focusing not on the traumatic event associated with his or her PTSD but on helping and healing the interpersonal relationships that are impacted by a person’s PTSD.

*Background:*

Interpersonal Psychotherapy (IPT) is a time-limited psychotherapy that focuses on the patient’s interpersonal relationships and on enhancing his or her interpersonal skills in an attempt to mitigate unhealthy or tension-producing patterns of thought and behavior. IPT is based on the assumption that many interpersonal factors may well contribute significantly to psychological problems. It is commonly distinguished from other forms of psychotherapy in its emphasis on the interpersonal aspects of a person rather than the intrapsychic. This emphasis on the interpersonal does not exclude the intra-psychic but is a matter of emphasis.

Most people with PTSD have significant interpersonal tensions and struggles, as well as depressive symptoms and erratic mood swings (clinically labeled “affect dysregulation”). IPT has been demonstrated to alleviate each of these byproducts of PTSD. Among the interpersonal difficulties associated with PTSD are: distrusting others, low self-esteem, problems establishing appropriate boundaries, and fears of both intimacy as well as vulnerability in social interactions.

Interpersonal Psychotherapists encourage patients to focus on current life events and the relationship these events have on the patient's mood and behavior. They also seek to help patients make changes in the way they relate with others that have the potential to provide a renewed sense of control over their present situations while also reducing PTSD symptoms. The fact that PTSD is a diagnosed disease with a predictable cluster of symptoms may help patients relinquish feelings of guilt or self-blame.

*Recommendations:*

1. IPT is a highly-nuanced psychotherapeutic method of treatment. As such, it should not be attempted without specific and in-depth training and certification in this treatment. There are several levels of training, accredited through the International Society for Interpersonal Psychotherapy ([www.interpersonalpsychotherapy.org](http://www.interpersonalpsychotherapy.org)). The main reason this intervention is included in this research is for the chaplain to be aware of what some psychotherapists may well be providing for patients with PTSD, as well as what would be needed for the chaplain to provide these therapies for their patients.
2. Some of the major areas of focus with IPT (coaching on enhancing interpersonal relationships, a focus on self-esteem, a focus on interpersonal and social situations as opposed to the specific trauma a person has experienced), as well as a number of the techniques traditionally used by Interpersonal Psychotherapists (such as clarification, supportive listening, social role playing, communication analysis [the use of a Verbatim-like structure could be used here], and encouragement of expressing one's moods) can be utilized by chaplains supplementing the psychotherapies the patient is receiving from mental health professionals.

*Discussion:*

IPT has primarily been used for and researched in Clinical Depression, Bulimia Nervosa, Adolescent Depression, Dysthymic Disorder, Bipolar Disorder and Post Natal Depression. It has been demonstrated, though in small pilot studies only, that solving current interpersonal problems in interpersonal psychotherapy can yield overall improvement in the symptoms associated with PTSD, even for patients who have not been through exposure therapies, which remain the

current standard in the psychological treatment of PTSD. Preliminary studies looking at the application of IPT to people with PTSD are underway and appear to have some positive momentum.

The vast majority of participants in one small pilot study, one of the first in which IPT is used for people with anxiety disorders, reported declines in PTSD symptoms across all three symptom clusters. Depressive symptoms, anger reactions and interpersonal functioning also improved. Treating the interpersonal impact of PTSD on a person's life appears to improve other symptom clusters. IPT may be helpful for people with PTSD who are struggling with being exposed to the trauma they have experienced. A chaplain may assist the mental health team through a helpful, pragmatic approach dealing with the interpersonal impact of the PTSD on the person's life.

IPT is time-limited, usually 12-16 one hour sessions done in stages. In the first stages, which usually take up the first two hours of therapy, the goals of treatment include a diagnosis, completing the appropriate inventories of a patient's history and current situation, identifying the current areas of need or focus, and establishing a therapeutic contract with the patient which explains the nature of Interpersonal Psychotherapy. This phase of treatment ends with the creation of an "interpersonal inventory" which is a list of all the key relationships in the individual's life. Within the interpersonal inventory, relationships are categorized according to the four areas mentioned below.

In the middle stages of IPT, which usually take up the 3rd - 14th hours of therapy, the patient and the Interpersonal Psychotherapist begin work on the major problems identified in the first stage, remaining focused on the present. This stage of treatment is devoted to addressing the problematic relationship areas. As such, there is little focus upon the specific symptom clusters of PTSD. There are typically four main problem areas:

1. Grief, which is usually delayed or has distorted or atypical reactions.
2. Role Dispute, which means a patient possesses unrealistic or unreciprocated expectations about a relationship with someone else.
3. Role Transition, which means a patient is relinquishing an old role and struggling with taking on a new one.
4. Interpersonal Deficits.

In the final stages of IPT, which usually take up the 15th and 16th hours of therapy, the Interpersonal Psychotherapist reviews the patient's gains, priorities what still needs some focus or work, educates the patient about the possibilities of relapse or old patterns re-emerging, and allows for the expression of emotions about the termination of therapy.

#### CLINICAL TECHNIQUES USED IN IPT:

IPT uses a variety of therapeutic techniques, many of which are borrowed from other therapies such as Cognitive Behavioral Therapy or Brief Crisis Intervention.

Different questioning styles are used, most of which should be familiar to chaplains, and are often helpful in and of themselves. One such question is the question of clarification, which aims to mitigate the patient's biases in describing interpersonal issues. Another technique would be Supportive Listening – allowing the patient to describe for him or herself the relationship and its impact on current moods and situations.

Other interventions are more behavioral in focus. Social Role Playing allows the therapist to hear and experience first hand more of the interpersonal struggles of the patient. A Communication Analysis, similar in many ways to the verbatims used in Clinical Pastoral Education for chaplaincy training, can help the patient see in writing, and discuss more objectively, his or her communication tendencies and motivations, especially in the Role Dispute and Interpersonal Deficits arenas. A therapist will also Encourage Affect, meaning that they seek to allow a patient to safely experience unwanted or uncomfortable emotions. These difficult emotions often are the impetus for a person using less functional or healthy defense mechanisms. This encouragement allows the patient to begin to identify how his or her feelings are impacting his or her behavior and choices in communication.

One review of the effectiveness of PTSD treatments states that “IPT has potential as a substantive intervention for addressing the psychosocial consequences of traumatic stress. Limited pilot data suggest that it may help improve a global impression of social functioning, although this may take the form of non-specific anti-depressant benefit, rather than a specific impact on PTSD symptoms.” (Robertson, et al, 2004)

The Desired Contributing Outcomes for the use of

IPT are determined primarily by what problem area is being discussed.

For grief, a therapist aims to facilitate healthy grieving, encouraging the patient to accept difficult emotions, and the replacement or healing of lost or broken relationships.

For Role Dispute, a therapist aims to understand the assumptions and realities of the dispute, establish the communication patterns and movements the patient is using in this relationship, and help the patient maintain his or her core values while modifying some communication and possible assumptions about a relationship.

For Role Transition, a therapist will facilitate grief of the old role and the patient's giving that role up, encourage expressing the emotions about that loss, and begin to focus on the skills and support needed for the new role.

For Interpersonal Deficits, a therapist would use analysis of the patient's communication patterns, facilitate social role playing to “try on” different communication patterns or options, and seek to help the patient decrease their own social isolation, if applicable.

Specialized Training: As mentioned above, a chaplain would need to be specifically trained to formally use Interpersonal Psychotherapy. More can be found about the training necessary and availability of such training at [www.interpersonalpsychotherapy.org](http://www.interpersonalpsychotherapy.org). However, a chaplain can and should use many of the techniques involved in IPT as natural and appropriate Spiritual Care Interventions in a less formal manner. Many of the fundamentals of IPT are standard practices for chaplains and as such can be used with persons with PTSD without the formal structure of IPT.

*Evidence:*

Recommendations	Sources	QE	OQ	R
1. Some of the major areas of focus of IPT (coaching on enhancing interpersonal relationships, a focus on self-esteem, a focus on interpersonal and social situations as opposed to the specific trauma a person has experienced), as well as a number of the techniques traditionally used by Interpersonal Psychotherapists (such as clarification, supportive listening, social role playing, communication analysis [the use of a Verbatim-like structure could be used here], and encouragement of expressing one's moods) can be utilized by chaplains supplementing the psychotherapies the patient is receiving from mental health professionals.	(Robertson, et. al., 2004)	II	Fair	I

QE= Quality of Evidence OQ=Overall Quality  
R= Recommendation

4. TRAUMA INCIDENT REDUCTION (TIR):

*Objective:*

To lessen the symptoms of PTSD through the repeated “viewing” of the traumatic incident by the patient in a safe, structured and controlled environment guided by the therapist.

*Background:*

Trauma Incident Reduction (TIR) is another psychotherapeutic intervention for one-on-one interactions. Within a context of maximized safety and minimized distraction, a person with PTSD repeatedly “views” his or her traumatic memory. It is entirely patient-driven. The therapist does not evaluate or interpret but instead focuses on giving appropriate instructions aimed at having the patient view the trauma thoroughly from its beginning until the end. As a

result, the patient in TIR is referred to as the “viewer”, and the therapist as the “facilitator”. The facilitator assists the viewer through maintaining the structure of the session and giving the viewer something concrete to be doing throughout each session. The facilitator primarily gives instructions to the viewer, not offering feedback, advice, interpretation, or even reassurance.

*Recommendations:*

1. TIR is a highly-nuanced psychotherapeutic method of treatment. As such, it should not be attempted without specific and in-depth training and certification in its application. The 3-4 day workshops equipping a person to provide TIR can be found at <http://tirtraining.org/>. The main reason this intervention is included here is for the chaplain to be aware of what some psychotherapists may well be providing for patients with PTSD, as well as what would be needed for the chaplain to provide these therapies for their patients.
2. TIR can be used by the therapist or trained chaplain (the facilitator) to assist the patient with PTSD (the viewer) in recounting the traumatic event over and over as if watching a video of it, gradually working through it until the emotions are no longer negative and pathologic.

*Discussion:*

The first step in Trauma Incident Reduction (TIR) therapy is for the viewer to determine a specific and concrete time-defined trauma that he or she feels is the primary stressor resulting in his or her PTSD. Then the viewer takes a mental step back and treats the memory as if it were on a DVD or video tape. The tape is rewound, and then, played starting from the beginning of the event and through to the end – all without talking about it but merely viewing it. Once the viewer has completed this first viewing, the facilitator will ask what happened, and the viewer can either describe the event or his or her reaction to viewing it.

Once the viewer has finished one viewing followed by his or her description of the experience, the facilitator asks the viewer to rewind the tape to the beginning and view it again in the exact same way. The facilitator does not call for a specific amount of detail or even

content for each viewing. The viewer will watch with as much detail and emotional reaction as he or she is comfortable. Following several viewings, most viewers begin to become braver, venturing more into their emotional reactions to the viewings, and many of the uncomfortable details that they were not originally able to share begin to surface. The majority of viewers will gradually reach a kind of emotional high point once they have done several viewings, after which the emotional energy will begin to lessen. Ultimately the goal would be for this energy to diminish to the point of having no negative emotion about the event at all. Rather than reacting emotionally to the event, the viewer instead becomes reflective and often discovers new awareness about the traumatic event, life or meaning, or him- or herself, much of which may well be major. The viewer will then typically begin to have more positive emotions, such as humor, contentment, or calmness. It is at this point that the viewer has reached the end of the intervention, and the facilitator concludes it.

A session of TIR does not end until the viewer has reached this place of positive emotion and is feeling well. This process can take from a few minutes to several hours. The average session for a person new to this kind of treatment is an hour-and-a-half. The average number of sessions needed to best mitigate PTSD symptoms is ten, amounting to roughly fifteen hours.

The Desired Contributing Outcomes for a patient using Trauma Incident Reduction include but are not limited to: a decrease in negative coping tendencies; a decrease in all three symptom clusters of PTSD; potential insights into one's self, God's presence or involvement in their traumatic event and/or life before, during, or after the event; an increased Spiritual Well-Being; an increase in sense of control; and, Positive Reinterpretation of the traumatic event.

As mentioned above, TIR is a psychotherapeutic intervention that requires specialized training. In order to find training, see: <http://tirtraining.org/>. A chaplain should not attempt TIR without appropriate training and explicit understanding of the patient that TIR is going to be used.

*Evidence:*

Recommendations	Sources	QE	OQ	R
1. TIR can be used by the therapist or trained chaplain to assist the patient with PTSD in recounting the traumatic event repeatedly as if watching a video of it, gradually working through it until the emotions are no longer negative and pathologic.	(Moore, 2008)	II	Fair	I

QE= Quality of Evidence OQ=Overall Quality  
R= Recommendation

# SECTION IV

# APPENDICES

# APPENDIX I

## EVIDENCE GRADING SYSTEM

### QUALITY OF EVIDENCE (QE) :

**I-** At least one properly done RCT

**II-1** Well designed controlled trial without randomization

**II-2** Well designed cohort or case-control analytic study

**II-3** Multiple time series, dramatic results of uncontrolled experiment

**III** Opinion of respected authorities, case reports, and expert committees

### OVERALL QUALITY (OQ):

**Good** High grade evidence (I or II-1) directly linked to health outcome

**Fair** High grade evidence (I or II-1) linked to intermediate outcome; or Moderate grade evidence (II-2 or II-3) directly linked to health outcome

**Poor** Level III evidence or no linkage of evidence to health outcome

### FINAL GRADE OF RECOMMENDATION -THE NET BENEFIT OF THE INTERVENTION

**A** -A strong recommendation that the intervention is always indicated and acceptable

**B** -A recommendation that the intervention may be useful/effective

**C** -A recommendation that the intervention may be considered

**D** -A recommendation that a procedure may be considered not useful/effective, or may be harmful.

**I** Insufficient evidence to recommend for or against – the clinician will use clinical judgment.



# APPENDIX II

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# APPENDIX III

## TELEPHONE INTERVIEWS

JILL BORMANN, PHD., R.N.

January 12, 2009. 1:00PM.

Research Nurse Scientist

VA San Diego Healthcare System

Adjunct Research Associate Professor

School of Nursing

San Diego State University

Co-Chair of Complementary, Alternative, and Integrative Medicine Workgroup at the VA

DR. KENT D. DRESCHER

February 11, 2009. 12:00PM.

Researcher

Education Division

National Center for PTSD

Health Science Specialist

Palo Alto VA Health Care System

Menlo Park, CA

THE REV. JUDITH FLEISHMAN, BCC

January 21, 2009. 1:00PM.

Chaplain

Housing Works

New York, NY

DR. ALAN FONTANA

January 23, 2009. 10AM.

Research Associate

VA New England

MIRECC and NEPEC

Evaluations Division Staff

National Center for PTSD

DR. JOHN FORTUNATO

January 14, 2009. 1:00PM.

Benedictine Monk

Vietnam Veteran

Clinical Psychologist

Chief of Fort Bliss Center for Restoration & Resilience, El Paso, TX.

CHAPLAIN PHILIP R. GOODMAN

January 23, 2009. 2:00PM.

Rabbi

VA Medical Center

Coatesville / Philadelphia, PA

C LTC CHAPLAIN STEVE HOKANA, DMIN  
January 23, 2009. 11:00AM, January 27, 2009. 8:00PM  
Director of Pastoral Care  
U.S. Disciplinary Barracks  
Fort Leavenworth, KS

JIM HUTH  
February 27, 2009. 9:30AM  
Corporate Professional Leader  
Spiritual Care Services  
Toronto Rehabilitation Institute  
Toronto, Ontario, Canada

VIRGINIA JACKSON, MDIV, BCC  
February 17, 2009. 2:00PM  
Staff Chaplain  
Palo Alto VA Health Care System  
Palo Alto, CA

JOHN P. OLIVER, D.MIN, BCC  
February 3, 2009. 10:00AM.  
Chief, Chaplain Service  
ACPE Supervisor  
Durham VA Medical Center  
Durham, NC

MAJOR JOHN ORGAN  
January 12, 2009. 12:00PM  
Deputy Area Chaplain, Atlantic Area  
Canadian Armed Forces

DR. ANGELEA PANOS  
February 6, 2009. 11:00AM.  
Director – Crisis Response Program  
Intermountain Health Care  
Sandy, UT  
Ph.D. in Clinical Psychology  
Licensed Marriage & Family Therapist & Licensed Clinical Social Worker  
Specializing in traumatic stress treatment, dealing with war refugees, domestic violence, victims of rape, & child abuse.  
Board member of Gift From Within & International Center for Child & Family Resiliency

MARY PAQUETTE, PH.D, APRN-BC  
January 22, 2009. 5:00PM.  
Author of several articles in Perspectives in Psychiatric Care

CHAPLAIN HENRY PETERSON  
January 28, 2009. 5:00PM.  
Chaplain  
VA San Diego Health Care System  
San Diego, CA

CH MAJ ROBIN PIZANTI

January 23, 2009. 1:00PM.

Recently retired (12/08), former:

Chaplain Resource Manager

Department of the Army

Installation Chaplain Office

Schofield Barracks, HI

CH LTC ROBERT POWERS

January 14, 2009. 7:00PM.

Senior Clinician

Tripler Army Medical Center

Honolulu, HI

CHAPLAIN JAMES R. TAYLOR

February 9, 2009. 2:00PM.

Chief Chaplain

& CHAPLAIN BARBY E. WILSON

Chaplain

James A. Haley Veterans' Hospital

Tampa, FL

CHAPLAIN PHILLIP RIDLEY

February 10, 2009. 1:00PM

Chaplain with Wounded Warrior Floor

National Naval Medical Center

Bethesda, MD

CHAPLAIN GEOFF TYRRELL

January 7, 2009. 1:00pm.

CPE Fellow

D.Min. in Creation Spirituality – Interfaith approach to unifying themes between faiths

Palliative Care Chaplain Fellow

Veterans Affairs Palo Alto Health Care System

Palo Alto, CA

# ABOUT THE AUTHORS

REV. BRIAN P. HUGHES, BCC, has worked as a hospital chaplain in Phoenix, Dallas, and Philadelphia. He has a Master of Divinity degree from Princeton Theological Seminary, and a Master of Religious Communication from Abilene Christian University in Abilene, TX. Chaplain Hughes is involved in ongoing research projects in a number of chaplaincy-related areas, and is chair of the Association of Professional Chaplains' Education Committee. He is married to Dr. Jenevieve Hughes, a breast cancer surgeon in Richardson, TX, and they are raising a daughter, Adelyn.

REV. GEORGE HANDZO, BCC, is Vice President for Pastoral Care Leadership and Practice at HealthCare Chaplaincy. Rev. Handzo directs the only consulting service devoted to the strategic assessment, planning and management of chaplaincy services. Healthcare Chaplaincy employs best practices in strategic planning and clinical practice to maximize the effectiveness of an organization's pastoral care and to align it with the institution's overall objectives. George also leads the management of chaplaincy services in fifteen healthcare institutions in the metropolitan New York City area.

Rev. Handzo has authored or co-authored over fifty book chapters and articles on the practice of pastoral care. He lectures widely at medical institutions and is frequently sought after as a speaker at industry-wide congresses such as the American College of Healthcare Executives.

Prior to his current position, George was for over twenty years the Director of Chaplaincy Services at Memorial Sloan-Kettering Cancer Center and is a past president of the Association of Professional Chaplains. He serves on the Distress Guidelines Panel of the National Comprehensive Cancer Network. The Rev. Handzo is a graduate of Princeton University and Yale University Divinity School. He is also certified as a Lean Six Sigma Black Belt.