2021

From Military Service to Diakonia: A Training Program for Clergy Ministering to Veterans

Danielle Xanthos
University of Denver

FROM MILITARY SERVICE TO DIAKONIA:
A TRAINING PROGRAM FOR CLERGY MINISTERING TO VETERANS

A DOCTORAL PAPER
PRESENTED TO THE FACULTY OF THE
GRADUATE SCHOOL OF PROFESSIONAL PSYCHOLOGY
OFFICE OF GRADUATE STUDIES
UNIVERSITY OF DENVER

IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE
DOCTOR OF PSYCHOLOGY

DANIELLE XANTHOS
JUNE 29, 2021

APPROVED: _____
Nicole Taylor, PhD, Chair

_____
Terri Davis, PhD

_____
Philip Mamalakis, PhD

Abstract

Many veterans opt to seek the support of clergy before mental health professionals. Most clergy, however, are unfamiliar with the nuances of the veteran culture and experience. Mental health professionals who specialize in working with the veteran population can collaborate with clergy to bridge this gap of care to mutually develop a better understanding of veteran culture and symptoms of mental health conditions common among the veteran population, and by equipping clergy with basic tools that promote psychological and spiritual wellbeing. Special consideration is given to the concept of moral injury and the application of Acceptance and Commitment Therapy, illustrating ways in which they align with the cultural and theological implications of Orthodox Christianity. This paper is intended to serve first, as an informative resource for those interested in integrating mental health and spiritual care and second, as the foundation upon which to build an implementable training program for Orthodox Christian clergy ministering to the veteran and military population in their parishes.

Introduction

I was drawn to psychology because I longed to make sense of the human experience. My generation's coming-of-age was marked by the events of 9/11 and the events that followed. For my family, that meant hanging a blue star on our front door – a symbol used when a family member is deployed during a time of war. Though I grew up in a county of New York that has one of the highest populations of veterans in the country, I was the only student in my high school with a sibling deployed to Iraq at the height of conflict. It was an isolating experience and I was often met with the well-intended mark-missing words, "I don't know what to say." I fondly and gratefully remember the faces of my teachers and guidance counselor whose doors were always open to me and who welcomed my presence with great compassion. Hidden somewhere deep in the back of my mind, I can also recall those who politicized the experience – the community service club advisor who told me selling yellow ribbons to raise money and donate calling cards to deployed servicemembers was "too political" for the club to support, the unsolicited friend who reminded me "I support the troops, not what they are doing" during a particularly difficult day, and the callous classmate in social studies class who declared, "Anyone who signed up to fight deserves to die." While it is a tendency for people to recall painful experiences, I value them because they have, in part, encouraged me to develop this program. What I learned during this time was that shared experiences are *not* necessary in order to receive others and respond to their suffering with compassion and comfort. What is necessary, however, is a willingness to witness another, to be present with them, and to share in and listen to both the words and the silence.

This project was ignited by my personal experience, informed by my education in Orthodox Christian theology and psychology, and inspired by the many members of the armed forces and their families, both past and present, who have experienced both the honor and struggle

that often accompanies their service. Given my background in Orthodox Christian theology, this initiative was developed with the ethos, ontological understanding, and culture of the Orthodox Christian community in mind, which becomes most apparent in Module III. However, the audience need not be limited to the Orthodox Christian community as most, if not all, of the information regarding military culture and psychology presented is relevant and useful to anyone intending to support service members and veterans, regardless of their field or faith background.

This project is a response to the need of parish communities to tend to their veteran and military population and a recognition that this task is best endeavored with preparation, understanding, and awareness. The hope is to provide useful information to clergy and lay-ministers with varying degrees of exposure to the field of psychology and military culture, from seminarians and graduate students to chaplains and licensed therapists. The term *diakonia*, a Greek word most simply translated as "service," takes a prominent place in the name of the program. A more thorough understanding of the word embodies a proper spirit with which to tend to our veteran and military population. *Diakonia* is service that is done not out of obligation, but with compassion and *philanthropos* – or love for humanity. Often, veterans have shared their perceptions of providers with me, placing them into two groups: those who "do it for the paycheck" and those who "do it because they care." Maintaining a spirit of *diakonia*, the hope and intention is for those who engage with this program to remain among the latter group.

The program is composed of the following three modules:

- Module I provides a general overview of military culture, including branches and conflict eras, implications of discharge status, common challenges of reentry to civilian life, considerations when serving the female veteran population, the unique role of military chaplains and clergy, and factors that might encourage or discourage veterans to seek

psychological and spiritual support. For those with little to no exposure to the military, this module will ideally provide a foundation upon which to build understanding, and for those familiar with the military, this module will ideally serve as a reminder of special considerations and their unique role in this ministry.

- Module II provides an overview of mental health diagnoses, including the purpose of identification and diagnosis as well as symptoms that may be experienced by veterans – both those experienced internally and those noticeable by others. This module is *not* intended for the purposes of diagnosis, but to aid in identifying those who may need pastoral or clinical support. It introduces common mental health diagnoses among the veteran population, including posttraumatic stress disorder (PTSD), depression, anxiety, and substance use. Moral injury, though not considered a mental health diagnosis but a type of invisible wound, is also introduced. This module will be useful to illustrate to clergy and lay-ministers the broad spectrum of internal experiences and outward behaviors an individual may experience.
- Module III integrates both psychological and spiritual health, homing in on the psychological intervention of Acceptance and Commitment Therapy (ACT) and illustrating its congruence to elements of Orthodox Christian theology. This module will offer techniques by which to guide pastoral conversations with intention and awareness to the unique experience of each veteran, derived from the principles of ACT.

The hopeful purpose of this endeavor is threefold. First and foremost, to bolster support for our veteran population in the faith community. Second, to engage and orient clergy to the veteran

culture. Third, to encourage and aid mental health professionals in supporting clergy as they minister to our veterans and service members in our communities.

Before embarking on clinical or pastoral curriculum, the stage for this somewhat rare amiable collaboration between psychology and faith is set. From one we glean utility and the other, wisdom. Though not all mental health professionals are resistant to theology and not all clergy are resistant to psychology, there exists an unfortunate – and perhaps unnecessary – chasm between the two. A deeper exploration of either will reveal an intricate relationship between mental and spiritual health and wellbeing. The objective of this project, however, is not to convince the reader of this relationship. It is simply this: to better, *and more completely,* serve our veteran population.

There are an estimated 40,000 soldiers, sailors, and marines in the United States military who identify themselves as Orthodox Christian and there is a greater likelihood for servicemembers and veterans to approach clergy for support rather than mental health professionals due to differing limits of confidentiality, availability, and accessibility (Nieuwsma et al, 2013). Given these two trends, a great deal of responsibility rests on the shoulders of clergy and the faith community in regard to veteran support. Similar to mental health clinicians, it is impossible for clergy to become completely competent in tending to the vast array of challenges people experience. Mental health clinicians are required to train and often specialize in working with particular populations or presenting problems. For example, if a parent approaches a therapist for support with their young son or daughter, but the therapist does not have experience in working with children, it is the ethical responsibility of the therapist to either receive such training or, if the case is outside of the therapist's area of competence, refer the child and parent to another therapist. As stated in the American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct, "Psychologists provide services, teach, and conduct research with

populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience." There are no such limitations for clergy. On one hand, this allows clergy to minister to a broad population. On the other hand, clergy may find themselves tending to people with specific needs with which they may be unfamiliar.

Though there are exceptions, specializations are uncommon – and perhaps unfeasible – for the typical parish priest. A more robust professional network of cooperative and collaborative relationships in which consultation and referrals are common among clergy and clinicians can compensate for any gaps in training and experience. Veterans' willingness to meaningfully engage with those in the helping professions often depends on the receptiveness and understanding of those with whom they meet. Like most people, veterans are more willing to meaningfully engage when met with compassion from someone who has at least a general understanding of their life experiences. However, serving our veteran population can be a unique practice due to a complex culture otherwise unfamiliar to the civilian world – an unfamiliarity that can become an obstacle to effectively connect, engage, and serve.

My hope is that the following pages provide an introduction toward establishing an ongoing and collaborative relationship between mental health professionals and clergy as, together, we serve our veterans.

Module I: Context & Conditions

Military Culture

A better understanding of the unique culture, experiences, and challenges of our veteran population will enable both clergy and mental health professionals to better serve those who

served. When effort is put forth toward a better understanding of veteran culture and experiences, those serving them become better prepared and, subsequently, veterans become more willing to engage in the support they need or desire. Though each veteran is unique and true understanding of an individual veteran requires a personal relationship, general considerations that apply to all servicemembers and veterans will be explored.

The United States Military, which functions under the Department of Defense, has six main branches including the Army, Marine Corps, Navy, Air Force, Coast Guard, and Space Force. The National Guard functions as reserve components of the Army and Air Force under the authority of state government. Two ways of entering the military include enlisting and commissioning. Enlisting requires a high school diploma or GED, while commissioning requires at least a four-year degree and places the recruit in a specialized leadership position of an officer. There are both Active Duty and Reserve components of each branch, excluding the Space Force. Both Active Duty and Reserve servicemembers attend boot camp for a period of seven to 13 weeks, depending on their branch. After boot camp, Active Duty servicemembers serve full-time, are stationed on a domestic or overseas base for periods of two to six years and live on base or in military housing. Reservists, on the other hand, serve the military in a part-time capacity, maintain civilian jobs or education, and attend drills one weekend a month and an additional two-week period on base. Reservists may be called to Active Duty, particularly during wartime or national emergencies.

Today's military consists of an all-volunteer force. In the history of the United States, conscription – or a draft – has occurred during six conflicts, including the Revolutionary War, Civil War, World War I, World War II, Korean War, and Vietnam War. The last draft began in 1940 and ended in 1973. While this bit of US history may be interesting to some, it can seem irrelevant to clinical work or ministry. However, voluntary or compulsory entry into the military

can affect how subsequent events are experienced and understood by older veterans of the Korean and Vietnam Wars. For example, a veteran who was drafted and returned home physically unharmed after Vietnam may experience a more complex sense of guilt when remembering his childhood friend who voluntarily joined and was killed in action.

Because today's military consists of an all-volunteer force, fewer servicemembers are on hand, and many of those who served in Iraq and Afghanistan (OEF/OIF) experienced multiple deployments, more so than veterans of previous generations. Veterans who serve multiple deployments tend to suffer greater financial and relational stressors, placing them at a higher risk for maladaptive behaviors and coping responses (Smee et al., 2013). In a 2010 study, OEF/OIF veterans who experienced multiple deployments were three times more likely to screen positive for PTSD and depression, and two times more likely to report chronic pain (Kline et al., 2010). Since the initial invasion of Iraq in 2003, suicide rates and the prevalence of PTSD and other trauma-related psychopathologies increased.

Within the military there exist various subcultures, which include the culture of each service branch as well as the varied service generation, or era, and unique military experiences including deployments and/or combat. Veterans from the Koran War (1950-1955), Vietnam War (1964-1975), Persian Gulf War (1990-1991, Operation Desert Shield, Operation Desert Storm, and Operation Desert Sabre), and Iraq (2003-2011, Operation Iraqi Freedom [OIF] and Operation New Dawn [OND]) and Afghanistan Wars (2001-2014, Operation Enduring Freedom [OEF]) each have distinct characteristics (Fontana & Rosenheck, 2008). Each era resulted in unique toxic exposures and warfare that have contributed to unique culture and after-effects, including long-term era-specific health conditions for veterans. For example, many Vietnam veterans were exposed to Agent Orange, an herbicide used to control vegetation in Vietnam to better detect enemy

combatants that has been correlated to many health complications and life-threatening illnesses later in life, many Gulf War veterans were exposed to toxins of chemical warfare that led to a "non-specific illness" identified as Gulf War Syndrome, and many Post-9/11 veterans of OEF/OIF suffer complications from inhaling toxic particles in the are due to burn pits, which were used to dispose of trash including chemicals, metals, petroleum, plastics, and medical and human waste. According to the VA, however, the most prevalent service-connected disabilities among combat veterans are hearing problems. These health conditions illustrate some of the burden our veterans face as a result of their service and persisting long after their combat experience.

Discharge Status

Though knowing a veteran's discharge status may not be critical information in a brief pastoral or therapeutic encounter, having a general understanding of different discharge statuses can provide insight as to the reasons a veteran was discharged and whether their military service may be seen as a positive or negative experience in their life. The manner in which a soldier, sailor, or marine separates from the military is indicated by their discharge status on a document called a DD214 and among the most common are Honorable Discharge, General Discharge Under Honorable Conditions, Medical Discharge, Other Than Honorable Discharge, and Dishonorable Discharge. When a discharge other than an Honorable Discharge is indicated, it can be due to an array of administrative or disciplinary reasons, from illness and injury to serious crimes tried by court-martial. Whether an administrative or disciplinary non-honorable discharge, there can be negative implications for future employment, reenlistment, or eligibility of benefits, including education, housing, financial loans, and health insurance. Eligibility for VA services and benefits requires an Honorable Discharge, General Discharge, or Medical Discharge. Other Than

Honorable Discharges are determined on a case-by case basis, and Dishonorable Discharge disqualifies and individual from receiving VA benefits. Because VA services and benefits are only available to veterans with Honorable, General, and Medical Discharges, research and statistics regarding the health and wellbeing of veterans with non-honorable discharges are largely unknown. However, limited research has indicated a significantly higher prevalence of PTSD, depression, alcohol misuse, suicide risk, physical disability, and somatic symptoms among non-honorably discharged veterans (Barr et al., 2019). While discharge status may not be necessary to discuss with a veteran in the context of ministry, it becomes significant when connecting veterans to community resources. A growing number of non-profit organizations provide services to veterans regardless of discharge status. It can be helpful to be aware of such organizations when a veteran could benefit from connecting with community resources.

Transition to Civilian Life

For many veterans, it is not the experience of war itself that poses the greatest challenge, but the return home. In the context of the military, whether stationed on a military base in the United States or on an overseas deployment to a combat zone, there exists camaraderie, understanding, and shared experience. When separated from the military and reintegrating into civilian life, that camaraderie, understanding, and shared experience is no longer immediately accessible. These are elements of great value and can be pivotal toward healing for many veterans.

The experience of a veteran is highly individualized, as is the ability to transition back to civilian life after their service. The transition from the military to civilian life poses significant challenges, even for the well-adjusted veteran. For some veterans, this transition occurs within a supportive community, alleviating many of these challenges and enabling them to use their

strengths, skills, and talents to the benefit of themselves and others (Ridgway & Press, 2004). For others, the challenges of transition propel them into a spiral of instability and uncertainty. Considering the unique needs of a veteran's transition to civilian life, issues to address include housing, employment, healthcare, and community support. While some veterans are at a higher risk of suffering from mental health issues including PTSD, depression, substance use disorders, and unhealthy relationships, veterans who are seemingly well-adjusted after their service are also at risk but often go overlooked due to an outward appearance of resilience.

The transition home for Vietnam veterans was particularly unique because the celebratory images that come to mind of soldiers, sailors, and marines returning home from war was not the case for this generation. They were not welcomed home with fanfare, but rather met with the common story of being spit upon, screamed at, and called "baby killer." Most Vietnam veterans are now in their seventies. In the parish context, they are likely recent retirees of the Baby Boomer generation. In the best-case scenario, they have had successful careers, married, raised children, and are now involved in their grandchildren's lives. While these veterans are often considered "resilient," many quietly continue to bear the invisible wounds of war – as well as the additional untold wounds of returning home.

Female Servicemembers & Veterans

Female veterans experience unique stressors in the military that, when kept in mind, can help to guide a pastoral or therapeutic encounter. Additionally, when helping a female veteran connect with other services, such as healthcare or organizations, there is the option to seek support from specialized services and VA Medical Centers that house healthcare clinics dedicated to women's health. Unfortunately, literature focused on the female veteran population regarding

prevalence of mental health conditions and treatment is sparse. Though a minority among the military population, the percentage of women in the military continues to grow and roles continue to change. In 1988, the Risk Rule "excluded women from noncombat units or missions if the risks of exposure to direct combat, hostile fire or capture were equal to or greater than the risk in the units they supported" (United States Government Accountability Office, 1988). This rule was rescinded in 1994, though women were still excluded from units and missions whose role was to serve in direct combat. In 2015, combat restrictions for women in the military were lifted. This continues to be a debated topic as the gender dynamic within the military continues to evolve.

As a result of policy changes, a dramatic increase in the number of women exposed to combat is emerging, necessitating research to include women in the military. Among the general population, women are more likely than men to be diagnosed with depression and PTSD. Among the female veteran population who served in Iraq and Afghanistan, about 20% of women were diagnosed with PTSD and among women who served in or around Vietnam between 1964 and 1975, 27% suffered from PTSD at some point after the war (United States Government Accountability Office, 2009). Whether this trend regarding the prevalence of other service-related outcomes, such as moral injury, is upheld among women requires further research to gather the prevalence of mental health conditions among the female veteran population.

Military Chaplains, Clergy & Confidentiality

Chaplains and clergy play a significant and unique role in serving the military and veteran population. While the reader is likely familiar with the role of the chaplaincy in institutional settings, such as hospitals and universities, military chaplains and VA chaplains can provide a wealth of knowledge and insight to ministering to service members and veterans. The Assembly

of Canonical Orthodox Bishops of the United States of America endorses military chaplains as well as Veterans Administration chaplains. As one might expect, due to the small number of Orthodox Christians when compared to other larger denominations, Orthodox Christian chaplains are a relative rarity among military and staff at a VA.

Chaplains were first authorized to serve by the national government during the Second Continental Congress in 1775. Current standards place chaplains in the rank of captain, require a Master of Divinity, as well as an ecclesiastical endorsement. Regardless of rank, chaplains hold a non-combatant status which precludes them from carrying or firing weapons.

Admiral Chester Nimitz, whose rank has only been surpassed by George Washington, served as Admiral of the United States Pacific Fleet during World War II. In an address aired over the National Broadcasting Company on June 18, 1944, he referred to chaplains as the "spiritual armament to the fighting forces" and outlined "ministering to the spiritual needs" of troops as a "greatly appreciated contribution to our coming victory." Admiral Nimitz stated,

> By patient, sympathetic labors with the crew, day in, day out, and through many a night, every chaplain I know contributed immeasurably to the moral courage of our fighting men; none of this appears in statistics. Most of it necessarily secret between pastor and confidant. It is for that toil, in the cause both of God and country, that I honor the chaplain most.

What Admiral Nimitz refers to as "necessarily secret" is the unique privilege of full confidentiality – or "privileged communication," which is granted to clergy, whether during service in the military, speaking with a chaplain at the VA, or confiding in their parish clergy. Rule 503 of the Manual for Courts-Martial states, "A person has a privilege to refuse to disclose and to

prevent another from disclosing a confidential communication by the person to a clergyman or to a clergyman's assistant, if such communication is made either as a formal act of religion or as a matter of conscience." In a 2010 report by the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, the most significant benefit to this confidentiality was the non-stigmatizing nature of support. This confidentiality is unique to the chaplaincy and is set apart from state regulations for mental health professionals, contributing to a tendency for service members and veterans to have greater trust in clergy.

While mental health professionals are bound by the Health Insurance Portability and Accountability Act (HIPAA) to protect the confidentiality of those with whom they work, they are legally required to disclose information in certain circumstances, such as when the individual is a threat to themselves or others, when instances of child or elder abuse are disclosed, or when subpoenaed. Laws pertaining to the limits of confidentiality for mental health professionals vary by state. Within the context of the military, the Military Command Exception requires military personnel, including mental health professionals, to disclose information that may impede the servicemember's fitness for duty, an assignment, or mission. This dynamic between servicemembers and providers within the military can deter servicemembers from receiving necessary healthcare. However, because chaplains and clergy are held to a different rule of confidentiality and hold privileged communication that will not be disclosed to their command, service members tend to trust chaplains and clergy.

Facilitators & Barriers to Care

By recognizing both the facilitators and barriers to seeking and receiving support, both clergy and clinicians can better attune to the needs of a servicemember or veteran. Both mental

health professionals and clergy are considered among the helping professions, offering unique aspects of care to those they serve. While engaging in psychotherapy with a mental health professional mitigates psychological symptoms, experiences such as guilt and shame can be associated with poor treatment outcomes (Pyne, Rabalais, & Sullivan, 2019). Guilt and shame are unlike other mental health symptoms as they are shaped by a person's sense of morality and are connected to a deeper, spiritual aspect of a person. Many returning veterans identify the need to address spiritual conflicts as integral to their healing (Berg, 2011). This begs the question of who is responsible for the conversation that tends to both one's psychological and spiritual wellbeing – the clergy or the clinician? However, the better question might be *how* can both clergy and clinicians start the conversation that tends to both one's psychological and spiritual wellbeing? Developing a more collaborative and interprofessional network could ensure veterans' reception to more complete and holistic level of care they may need.

In 2019, Pyne, Rabalais, & Sullivan, a psychiatrist, psychologist, and chaplain all working within the Veterans Health Administration, published a study exploring the collaborative potential between mental health clinicians and community clergy in meeting the needs of veterans. In the study, they asked veterans, clergy, and mental health professionals to identify perceived or actual barriers and facilitators contributing to veterans' decisions to seek or not seek support from clergy and mental health professionals. Reasons veterans indicated for seeking care from clergy included the potential of finding their faith again, preference to talk with community clergy, seeking forgiveness, and decreasing veteran suicide rates by addressing guilt and shame issues. While mental health clinicians can facilitate these conversations, most mental health professionals stated they either were not trained or not comfortable with such a degree of religious and spiritual exploration. In the same 2019 study, veterans identified reasons that deterred them from seeking

support from clergy, which included clergy's potential lack of acceptance and unwillingness to work with veterans who did not believe in God, previous negative experiences with clergy resulting in a lack of trust, not knowing how to access clergy, feeling unworthy or undeserving of forgiveness, and clergy's lack of preparation in addressing veteran-specific problems – including combat experiences, mental health symptoms, suicidal ideation, self-harm, and a history of sexual assault or military sexual trauma. The main reason for veterans not engaging in mental health treatment included the likelihood of clinicians not discussing or integrating religion or spirituality into their practice. While clergy and mental health clinicians involved in the study recognized the benefit of both clergy and mental health clinicians to veteran care, neither indicated being well connected to the other professional community, which prevented them from consulting or referring veterans to necessary resources that would address both spiritual and psychological health.

This gap between experience, training, and providing care to veterans exists across various disciplines. For example, a 2017 study indicated the level of comfort and confidence civilian home care nurses had in working with the veteran population. While they worked with veterans routinely, the nurses had little to no experience and training specific to the population they were serving. Areas in which they felt least confident included knowledge of veteran resources available in the community, war-specific exposures, and veteran-specific health issues (Elliot, 2018). In order to close this gap in care, both mental health clinicians and clergy could benefit from not only recognizing the unique expertise and function of the other in meeting the very real needs of veterans, but by taking action, connecting and consulting with other professionals, and developing positive professional relationships in which referrals are not only utilized, but trusted.

Module II: Mental Health Conditions & Symptomology

Classification & Diagnoses

In exploring appropriate mental health and pastoral responses to military and combat experience, it is helpful to have a basic understanding of the development and use of mental health diagnoses as they pertain to the veteran population. The purpose of incorporating this section is not to equip chaplains and clergy with a lens to diagnose, but rather to notice those who may be silently struggling in the community. For healthcare professionals, classifying and diagnosing health conditions provides a systematic framework by which symptoms and causes of conditions can be understood. Rather than serving as a mere label to ascribe and by which to identify a person, it is more helpful to understand a diagnosis as a lens through which to better understand one's experience and consider appropriate courses of treatment. For the chaplain or clergy, the following information will help to identify those who may benefit from more intentional and personal pastoral care.

In the field of mental health, two standardized systems are commonly used, including The Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD). The DSM focuses on mental health conditions, whereas the ICD is comprised of all health conditions, both physical and mental. The DSM is a production of the American Psychiatric Association, a professional organization limited to the United States, and the ICD is a production of the World Health Organization, a global organization under the United Nations of which 194 countries are members. New iterations of both the DSM and the ICD reflect the statistical trends of conditions. As of the time of writing, the latest edition of the DSM is DSM-5, which was published in 2013, and the latest ICD is ICD-11 and was published in 2019.

The challenge of returning home from war has existed long before "posttraumatic stress disorder" was added to the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980. It predates "war neurosis" of WWII, "shell shock" of WWI, and the "soldier's heart" of the Civil War. It is a prominent theme in Homer's *The Odyssey*, which is believed to have been written between the 8th and 7th centuries BC. Scholars have even explored the of the effects of war in the Old Testament.

While the diagnosis commonly associated with the veteran population is PTSD and many veterans have been or can be diagnosed with PTSD, not all veterans meet criteria for PTSD. veterans also experience anxiety, depression, insomnia, substance use disorders, chronic pain, dementia, etc., as the rest of the population does, sometimes – but not always – at different rates. The effects of military and combat experience can manifest as a broad range of symptoms – many of which align with diagnostic criteria of DSM and ICD, and some that do not. When clergy are acquainted with the signposts of certain mental health conditions, they can better identify community members who might benefit from a phone call, sitting down for a cup of coffee, or checking-in with family members. Unless there is a major disruption at home or the community, the following conditions will likely not be noticeable in the absence of an authentic personal relationship.

Posttraumatic Stress

According to the DSM-5, a person may develop PTSD symptoms after being exposed to an event that involved actual or threatened death, serious injury, or sexual violation. The event could have been directly experienced or witnessed, or experienced by close family or friend, or involved repeated exposure to details of a distressing event. PTSD is characterized by *intrusive*

symptoms – including distressing memories, dreams, and flashbacks, *avoidant* symptoms – including efforts to avoid memories, thoughts, feelings, people, places, conversations, or other reminders of the event, *negative changes in thoughts and mood* – including difficulty remembering aspects of the stressful event, negative beliefs about oneself, others, and the world, feelings of fear, horror, anger, guilt, or shame, and feelings of detachment from others, and *changes in arousal* – including irritable and angry outbursts, reckless behavior, hypervigilance, difficulty concentrating, and difficult falling or staying asleep. In order to meet criteria for a diagnosis of PTSD, an individual must experience symptoms for at least one month.

PTSD affects both the veteran and non-veteran population; however, the prevalence among the veteran population is staggering in relation. An estimated 8% of civilians experience PTSD, while male veterans of all eras have a lifetime prevalence of PTSD of 36% (Johnson et al., 2013). When broken down by conflict era, the Department of Veterans Affairs estimates 11% of veterans who served in Afghanistan, 20% who served in Iraq, 10% who served in Desert Storm, and over 30% who served in Vietnam suffer from PTSD at some point during their lives. Unfortunately, many of these veterans do not actively seek support due to stigmatization. This stigma is illustrated in the American Psychiatric Association's 2013 publication regarding PTSD:

> Certain military leaders, both active and retired, believe the word "disorder" makes many soldiers who are experiencing PTSD symptoms reluctant to ask for help. They have urged a change to rename the disorder posttraumatic stress *injury*, a description that they say is more in line with the language of the troops and would reduce stigma. But others believe it is the military environment that needs to change, not the name of the disorder, so that mental health

care is more accessible, and soldiers are encouraged to seek it in a timely fashion.

The stigmatization of a PTSD diagnosis can leave a veteran feeling helpless, shamed, and defeated, in addition to the symptoms listed above. The DSM-5 offers a structured system for diagnosis; however, a diagnosis alone does not alleviate suffering. Merely naming an affliction is not enough for healing.

It is important to note not everyone who experiences an event that involves actual or threatened death, serious injury, or sexual violation will develop PTSD. In fact, most people eventually experience posttraumatic *growth,* including those who previously experienced PTSD, which leads to a greater appreciation of life, improved relationships with others, a better sense of personal strengths, recognition of new possibilities, and spiritual development (Tedeschi & Calhoun, 1996). For this reason, it is worth considering the language used when speaking about a "traumatic event." Use of the term "traumatic event" implies the event was, in fact, traumatic to the individual. However, two people may experience the same event (e.g. war) but have different reactions. One may develop symptoms aligned with PTSD while the other may continue to function as well, or in the case of posttraumatic growth – better, than they did prior to the event. For the former individual, this was indeed a traumatic event, while for the latter, it was not. To curtail the assumption of traumatic impact, the term *potentially traumatic event* is suggested (Bonanno, Westphal, & Mancini, 2011). In fact, the most common response to a potentially traumatic event is a resilient response and research has indicated 35-65% of individuals will respond to a potentially traumatic event with minimal impairment. PTSD generally effects 5-10% of individuals exposed to a potentially traumatic event, but the prevalence is significantly higher for those who experienced the event for a longer duration or with more intensity. For example,

PTSD among New Yorkers following 9/11 was estimated to be 6%, while those who sustained a physical injury on 9/11 experienced PTSD at an estimated 26% (Bonanno et al., 2006). Similar trends of PTSD prevalence have been indicated among Vietnam veterans in general (estimated 9%) compared to Vietnam veterans who experienced the highest rate of combat exposure (estimated 28%) (Dohrenwend et al, 2006).

Moral Injury

Unlike the other conditions discussed in this section, moral injury is *not* a mental health diagnosis and is not found in the DSM. Moral injury recognizes a complexity of an individual by distinguishing not only the physical and psychological impact of certain experiences, but the spiritual impact as well. Moral injury is what can happen when one's sense of their own humanity is destroyed. The concept of moral injury was initially introduced by Jonathan Shay, who served as a psychiatrist at the Boston VA for over twenty years. Over the course of his career, Shay focused on the Vietnam veteran population, drawing from the *Iliad* and *Odyssey* to understand the unique impact of deploying to combat and transitioning home that could not be captured by any clinical diagnosis, and certainly did not fit the medical model of illness that PTSD assumed.

Shay defined the first form of moral injury as a) a betrayal of what's right, b) by someone who holds legitimate authority, c) in a high stakes situation. All three of these aspects, *together*, contribute to moral injury (Shay, 1995). According to Homeric scholar, Johannes Haubold, "The early Greek epic sings about the incurably vulnerable nature of the *laoi* (people)," and when the leader, or "shepherd of the people," failed, he destroyed the people (Haubold, 2000). The leader, who the people looked to as a guide, teacher, and protector failed at upholding his honorable obligation and duty. This definition of moral injury focuses on the action of the other – the authority.

As moral injury surfaced in the field of veteran mental health, a second definition of moral injury was introduced to include one's own action – an act of commission, or inaction – an act of omission. This second nuance of moral injury is defined as the "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and experiences" (Litz et al., 2009). The wounds of moral injury, like PTSD, are invisible. Moral injury is unique from PTSD. The development and symptomology of PTSD is fear-based, characterized by physiological responses to a very real physical threat – one becomes hypervigilant to future threats, avoids situations that resemble the threat, and goes into "fight mode" quickly – all in order to survive the threat. The conceptualization of moral injury, on the other hand, recognizes a presence of "inappropriate guilt, shame, anger, self-handicapping behaviors, relational and spiritual/existential problems, and social alienation" (Currier, Holland, Malott, 2015). It is these shame-based feelings of moral injury that some suggest are the true root of certain PTSD symptoms, such as avoidance. These factors can serve as barriers to care and may exacerbate other mental health problems. Feelings of guilt and shame can turn into a deep sense of unworthiness – a person with a moral injury often no longer feels a sense of belonging, can no longer trust or be trusted, no longer feel connected to others, and no longer feel lovable. A person who has sustained a moral injury feels disconnected from the person they once were.

Just as in the case with *potentially* traumatic events, exposure to a *potentially* morally injurious event does not necessarily mean the person exposed will develop a moral injury. Exposure to such events are *necessary* but not sufficient in themselves for development of moral injury or PTSD (Nash et al, 2017). A person's response to stress and trauma is uniquely theirs. The only way to begin to understand the needs of a veteran is to build a trusting and supportive relationship with the veteran. Bringing moral injury to the forefront of the conversation brings a

greater depth of understanding and allows for a more holistic and complete provision of resources and care. Considering moral injury as a contributing factor to the psychological and spiritual wellbeing of a veteran helps to better, and more thoroughly, assess and support their needs.

Depression

Two major indicators of depression include a sad, hopeless, or empty mood and loss of interest or pleasure in activities once enjoyed. Someone who meets criteria for Major Depressive Disorder will experience one of these two indicators in addition to at least four of the following symptoms: significant weight loss or gain or change in appetite, difficulty falling or staying asleep or sleeping too much, feeling sluggish or restless, a lack of energy, feelings of worthlessness or excessive guilt, difficulty focusing or making decisions, or thoughts of death or suicide. Severity of these symptoms are identified as either mild, moderate, or severe. For an individual who is experiencing Major Depressive Disorder, these symptoms are present nearly every day for at least two weeks and are not attributable to grief and loss (American Psychiatric Association, 2013).

The prevalence of depression in Vietnam veterans is higher than the prevalence among WWII and Korean War veterans (Gould et al., 2014). When compared to the non-veteran population, WWII veterans and Korean War veterans were less likely to report current distress and lifetime depression while Vietnam veterans were more likely to report current distress and lifetime depression. Lifetime depression implies experiencing depression at *some* point during life. Among Gulf War and OEF/OIF veterans, a significant difference in the prevalence of depression was not found when compared to the non-veteran population, however it is possible trends among this younger generation may shift over time. When considering factors that contribute to the higher rate of depression among Vietnam veterans, it is worth considering the length of the conflict as well as the cultural tension that existed during their service (Boakye et al., 2017).

Anxiety

Anxiety is the most commonly experienced mental health condition among the general population. It differs from fear, as fear is an emotional response to an imminent threat, while anxiety is the anticipation of a future threat. Anxiety, when experienced to a certain degree, can be considered a normal and even beneficial response to a stressful situation, keeping one vigilant and prepared. Anxiety becomes problematic, however, when experienced to a degree that is disproportionate to the situation and it interferes with one's ability to function normally in their daily life. For an individual who is experiencing an anxiety disorder, symptoms may include restlessness or feeling "on edge," fatigue, difficulty concentrating, irritability, muscle tension, and difficulty falling asleep or staying asleep. According to the DSM, these symptoms may be diagnosed as a disorder when they are present most days for at least six months, are not attributable to the use of substances or medications, and not better explained by another mental health disorder (American Psychiatric Association, 2013). Anxiety disorders include generalized anxiety disorder, social anxiety disorder (social phobia), panic disorder, agoraphobia, and separation anxiety disorder. It is worth noting the overlap of symptoms of anxiety with other conditions, including PTSD, depression, substance use, and moral injury.

Substance Use

Substance use disorders, as outlined in the DSM-5, include alcohol, cannabis, hallucinogens, inhalants, opioids, sedatives, stimulants, and tobacco. When compared to the general population, the prevalence of veteran substance use is comparable for all classes of substances, with the exception of alcohol and tobacco use. This section will focus on alcohol and tobacco use, taking special note of opioid use.

According to the DSM-5, alcohol use disorder, tobacco use disorder, and opioid use disorder are characterized by experiencing at least two of the following symptoms in a 12-month period: consumption of larger than intended quantities or over a longer than intended period of time, persistent desire or failure to limit use, excessive time spent obtaining, using, or recovering from use, a craving or desire to use, failure to fulfill obligations at work, school, or home, continued use despite interpersonal problems, giving up on social, occupational, or recreational activities, use in situations that are physically hazardous, continued use despite physical or psychological problems, increased tolerance, and experience of withdrawal symptoms. Severity is determined by number of symptoms present and considered mild in the presence of two to three symptoms, moderate in the presence of four to five symptoms, and severe in the presence of six or more symptoms.

While the overall prevalence of alcohol use disorder was significantly *lower* among the male veteran population (6.5%) compared to the civilian population (11.8%), among 18- to 25-year-old male veterans, the prevalence of alcohol use disorder was 24.7% as compared to the male civilian population, which was 20.5%. Daily cigarette use was also significantly higher than civilian use for male veterans in all age groups, except those 65 years of age and older. Among female veterans, heavy episodic drinking was significantly higher than female civilians among 18- to 25-year-olds (veterans 42.9%, civilians, 38.9%) and 35- to 49-year-olds (veterans 27.3%, civilians 22.7%). Daily cigarette use was higher among female veterans compared to female civilians in all age groups (Hoggatt et al., 2017).

From 2001 to 2009, the number of pain medication prescriptions written by military physicians quadrupled to 3.8 million (Institute of Medicine, 2013). Over the course of this time, veterans were returning home from OEF/OIF deployments. Both medical care and body armor has

improved since prior wars, which has contributed to higher survival rates of veterans sustaining injuries that would have previously been fatal (Sayer et al., 2008). As a result, veterans are experiencing higher rates of chronic pain which until 2012, had been commonly treated with opioid prescriptions (Helmer et al., 2009). In fact, nearly 25% of veterans being treated at the VA were prescribed opioids in 2012 (Gellad, Good, & Shulkin, 2017). With the recognition of a national opioid epidemic, prescriptions for opioids treating chronic pain among veterans has been reduced. As a result, however, many veterans continue to struggle to manage their pain and many have relied on other substances, such as alcohol and heroin to mitigate their chronic pain.

Comorbidity, that is the prevalence of multiple physical or mental health conditions, among veterans who use substances is particularly significant when considering PTSD. In a 2018 study, veterans who had a diagnosis for both alcohol use disorder and PTSD were more likely to positively screen for "major depression (36.8% vs. 2.3%), generalized anxiety disorder (43.5% vs. 2.9%), suicidal ideation (39.1% vs. 7.0%); to have attempted suicide (46.0% vs. 4.1%); and to be receiving mental health treatment (44.8% vs. 7.5%)" (Norman et al., 2018). Comorbidity of alcohol use disorder and PTSD illustrates the complexity mental health conditions and the gravity with which to consider an appropriate course of treatment.

Module III: Treatment & Ministry

Evidence-Based Psychotherapy

Evidence-based mental health treatments are styles of therapy that have been researched over time and shown to be effective and efficient in treating particular diagnoses or symptoms. Treatments commonly used with veterans, especially within the VA system, include cognitive behavioral therapy (CBT), cognitive processing therapy (CPT), and prolonged exposure therapy (PE). Efficacy of treatment is often tracked by administering standardized questionnaires at the

beginning, during, and the end of a course of treatment. Questionnaires use targeted inquiries that pertain to symptoms of specific diagnoses, such as those related to anxiety, depression, and posttraumatic stress disorder. While a course of therapy may be considered effective when the presence of symptoms is lessened at the end of treatment, a veteran is likely to continue experiencing symptoms of the diagnosed condition to some degree. This becomes particularly important when looking at the complex symptomology of certain veteran-specific conditions, such as PTSD – which often includes guilt and shame, as previously stated. Symptoms of guilt and shame often do not respond to evidence-based treatments for PTSD (Pyne, Rabalais, & Sullivan, 2019). This is where the collaboration between mental health clinicians and clergy becomes especially critical.

An evidence-based treatment that continues to gain traction in the field of psychology and has been effective in treating moral injury is Acceptance and Commitment Therapy, or ACT (pronounced like the word “act”). The following is a brief introduction to ACT, offered to provide those ministering to veterans with a lens through which to better understand and support them. ACT has been given the spotlight in this project because of its compatibility with the Eastern Orthodox ethos.

Acceptance and Commitment Therapy

It was during an undergraduate course on behaviorism that I first noticed a tension between my understanding of the world and the discipline of psychology. For those who have ever taken an introductory psychology course, behaviorism may call to mind words like stimulus, response, consequence, punishment, and reward. While there is great utility in understanding behaviorism, something seemed incomplete. I went to office hours to speak with the professor numerous times, attempting to reconcile a major philosophical difference between my understanding of humanity

and the empirically based science of behaviorism. By the looks of my transcript that semester, the professor did not seem to appreciate my declaration that “We are not rats! We are not machines! We have souls!” I used to think my declaration was frowned upon for being too traditional but later (*much* later) realized it was a bit too *radical*.

Over a decade later, I was introduced to Third Wave Behaviorism, sometimes called *Radical* Behaviorism, and its corresponding intervention called Acceptance and Commitment Therapy (ACT). ACT is a type of psychological intervention that falls under the umbrella of behaviorism but holds stark differences from first wave classical behaviorism (think Pavlov, a bell, food, and a drooling dog) and second wave (think learning, extinction, and relearning) in that ACT reintroduces the *psyche* to psychology. Steven Hayes, one of the founding psychologists of ACT, articulated the internal struggle I experienced when initially learning behaviorism in what he calls, “A silly poem about contextualism and behaviorism,”

> But the machine had a flaw.
> It was incomplete.
> It didn't have....
> A soul
> er, a mind ....
> er, a brain ....
> that is ....
> oh hell,
> it didn't have a soul!

I am drawn to ACT because of its compatibility to an Orthodox ethos. Three practices of ACT reflective of this include the understanding that suffering is inevitable, the focus on clarifying and articulating one’s values (or virtues), and developing a de-fused (or dispassionate) stance toward unhelpful thoughts. ACT is an approach which boasts humility, authenticity, and fullness of the person. It is an approach that honors personhood and aspects of it, including personality, behavior, and memories, while recognizing an ontological fullness of humanity. It recognizes what modern psychology has long disregarded - the soul. Exploration of one's values is a key component to ACT, and it is through pain and suffering that one discovers what is important, necessary, and

meaningful. In his Homilies on the Statutes, Saint John Chrysostom states, "Tribulation makes the strong man stronger. Who says this? It is the man who lived in tribulation, the blessed Paul, he speaks thus: suffering produces endurance, and endurance produces character, and character produces hope (Romans 5:3-4)." How many of the faithful, whether cradle or convert, committed themselves to the Church because everything was going well in their life? Or were they looking for refuge? Through the lens of ACT, one's relationship to suffering is altered – perhaps transfigured. It is through suffering one gains clarity of who they are, how they relate to others, and how to live fully.

An Overview of ACT and Relational Frame Theory

Two main goals of ACT are to accept unwanted unpleasant experiences and to engage in committed action towards a valued and meaningful life. ACT is based, in part, on a theory of language called Relational Frame Theory (RFT), which elucidates the relationship between human language and the behavior it influences. RFT explains how written language, spoken language, and physical objects become related and meaningful. For example, a child learns a certain small animal is called a "cat" (spoken word) and is the same as a C-A-T (written word). When the child is scratched by this animal and experiences pain, both the spoken word and written word also elicit a sense of fear, even though direct learning of this experience involved neither the spoken word nor the written word. While the child can effectively avoid the public experience (observable behavior) of making contact with cats in the future, it is significantly more difficult to avoid the private experience (thinking) of a cat. Our private experiences are driven by language and can elicit strong emotional experiences.

This is relevant to the context of mental health because it illustrates how humans derive language to understand, evaluate, and articulate lived experiences and tendencies, contributing to a conceptualized self (Barnes-Holmes et al., 2001). Our conceptualized self is the sense of self

based on our narratives, or the stories we tell ourselves *about* ourselves. While the product of relational framing can help in problem solving and decision making, it can be less helpful when one's understanding of the self is tethered to unpleasant experiences that threaten physical, psychological, and spiritual wellbeing. The language we use elicits emotions and behaviors, including thoughts, that may not always be helpful and may even be harmful.

The psychological impact of language as described in RFT resembles the spiritual impact of thoughts as described by the Early Church Fathers. Saint Paisios reflected, "Thoughts are like airplanes flying in the air. If you ignore them, there's no problem. If you pay attention to them, you create an airport inside your head and permit them to land." Likening unhelpful thoughts to the inevitable airplanes that will fly over (or within) our minds illustrates the external origin of these private events, or thoughts. They are a lived experience rather than an embodied part of us. According to ACT, the more one tries to stop having such thoughts, the *more they will have them.* Likewise, Saint Paisios' guidance was not to *not have these thoughts*, but rather to not give them a place to land. These thoughts are inevitable and both Saint Paisios and ACT psychologists recognize this inevitability. According to ACT, the practice of noticing such thoughts rather than clinging to them is referred to as defusion (as in de-fusing). Defusion is difficult to cultivate, however it is not impossible. The following sections will explore ways to live meaningfully even in the presence of unpleasant thoughts and feelings.

Suffering: Give me strength to bear the fatigue of the coming day…

The biomedical model of health practiced in Western society is largely based on an *assumption of healthy normality*, by which the healthy baseline of human life is one free of distress (Hayes et al., 2012). In this case, striving toward health means striving toward a life free of distress. However, this endeavor can lead toward disappointment, as anyone who is alive is bound to

experiencing suffering to some degree, at some point. A unique aspect of ACT is the *assumption of destructive normality,* the assumption that a normal human mind tends toward destructive, rather than constructive thoughts, and suggests that most human suffering is rooted in common and normal psychological processes (Hayes et al., 2012). According to ACT, suffering is not a marker of an unhealthy person, but an inevitable part of life.

Suffering can arise as a physical, psychological, or spiritual affliction that is rarely, if ever, exclusive to a single aspect of our being. Suffering is seemingly relieved by treating symptoms, at least in the hands of western medicine in which there is an analgesic for nearly any malady. In most cases, easing the pain of others is a remarkable accomplishment of humanity and an example of stewardship and love. From an Orthodox and ACT perspective, suffering is an inevitable part of life. Instead of focusing on how to avoid suffering, one can focus on how to respond to it. For example, asking "What now?" rather than "Why?" emphasizes taking action to move toward what is good, true, and beautiful – taking action to move toward healing.

A general therapeutic goal of ACT is to increase psychological flexibility, which is the willingness to experience both pleasant and unpleasant events in the context in which one exists – their environment - including their thoughts and feelings. In doing so, there occurs a change in one's *relationship* to their thoughts, rather than *changing* their thoughts. Psychological flexibility helps to mitigate the potentially catastrophic results of suffering. ACT functions to increase psychological flexibility through mindfulness and behavioral change (Sharp, 2012; Hayes et al., 2016; Harris, 2009; Wilson & DuFrene, 2008). Mindfulness is the practice of taking an aware and willing stance toward a wide range of psychological events and can be likened to the Fathers' understanding of *watchfulness.* Behavioral change is the practice of engaging with meaningful actions guided by one's identified values.

Six Core Processes of ACT

ACT is practiced as a unified process of cultivating six core processes, including psychological flexibility, including acceptance, flexible attention to the present moment, cognitive defusion, self-as-context, values, and committed action. The following sections describe the core processes and provide techniques that can be incorporated into pastoral conversations with veterans.

1. Acceptance

In his book, *The Alchemist*, Paulo Coehlo wrote, "Tell your heart the fear of suffering is worse than the suffering itself." In other words, unwillingness to experience suffering worsens the experience of suffering. On the other hand, acceptance is the willing, purposeful, and nonjudgmental stance toward experiencing *all* events, including unpleasant and painful private events. Private events include internal thoughts and feelings that are not immediately observable by others. The inverse of acceptance is avoidance, which is the unwillingness to have or experience these private events (Hayes et al, 2016). The child fearful of cats can more easily practice avoidance of the cats by moving away from them but she will likely be less effective in avoiding unpleasant private events of thoughts and feelings about cats. To make this more relevant to the context at hand, take the combat-exposed veteran who avoids certain reminders of their experience of combat. A common reminder and trigger of unpleasant private events for many veterans are fireworks on the Fourth of July. One option is to avoid the fireworks, as well as the subsequent psychological and physiological responses. Another option is to endure the fireworks and the subsequent psychological and physiological responses, remaining in the company of friends and family. While avoidance is not inherently bad, the veteran who effectively avoids the potentially triggering experience of fireworks is increasing their sense of suffering and decreasing their

engagement in life through avoidance (Harris, 2009). Avoiding fireworks on the Fourth of July also means removing oneself from friends and family, increasing isolation and perpetuating the pain of and unwillingness to experience the inevitable private events (thoughts, memories, images, physiological sensations). Important to note is that acceptance does not mean liking or enjoying an unpleasant or painful experience but being willing to experience and unpleasant or painful experience in order to be fully present and alive (Wilson & DuFrene, 2008). Avoidance becomes problematic when it interferes with living a meaningful life and engaging what is important to and valued by an individual.

2. Flexible Attention to the Present Moment

Human beings, as verbal creatures, are often focused on thoughts rather than experiencing the world around them. Becoming aware of the present moment allows for an awareness of the consequences, both punishments and reinforcements, of our behavior. In behavioral terms, a punishment is an unpleasant consequence that decreases the likelihood of repeating a behavior and a reinforcement is a pleasant consequence that increases the likelihood of repeating the behavior. Becoming more attentive to one's surroundings allows for greater flexibility in consciously responding, rather than reacting, to what is happening within and around them. With attention to the present moment, one can perceive their current circumstance with accuracy and choose, with intention, how to engage in that circumstance.

In mental health practices, mindfulness practices increase one's awareness of the present moment. Attention to the present moment is also significant within Orthodoxy. For example, the sensory elements of Orthodox worship, including the use of incense, chant, and presence of iconography, serve as reminders of the present moment, aiding the faithful to return if and when they become distracted by thoughts outside of the present experience. The deacon or priest says

"Let us be attentive" six times during the Divine Liturgy, which averages to roughly once every fifteen minutes that the faithful are reminded to be aware of the present moment. They are being called to be attentive to what they are about to hear – before the Epistle or Gospel reading, attentive to what they are about to say – before the Symbol of Faith, attentive to their posture, inner heart, and their offering – standing well and with fear during the Anaphora, and attentive to what they are about to receive – before Holy Communion.

The present moment significant to ACT is of value to Orthodox worship and life, indicating its importance in pastoral encounters as well. Attentiveness requires an intentionality in sharing time with another, inviting both the therapist, counselor, or clergy and the veteran to be attentive to their inner and outward environment. Mindfulness practices, such as noticing the feeling of our feet on the floor, our body making contact with a chair, or becoming aware of and slowing one's breathing, allow for awareness of our inner experience. Saint Nikodemos of the Holy Mountain notes the function of this awareness when he states, "By holding the breath, the usually hard and thick heart is somewhat refined and warmed through this slight suffering. Consequently, it becomes soft, sensitive, humble, and more capable of contrition and tears" (St. Nikodemos, Guarding the Mind and the Heart, Part 10)."

3. Cognitive Defusion

Cognitive defusion is the practice of distancing – or *de-fusing* – from thoughts, including memories and image (Harris, 2009). This enables an ability to look *at* thoughts rather than *through* thoughts. A person who is fused to their thoughts takes them as reality rather than a construction of cognitive processes. To revisit Saint Paisios' analogy, fusion to one's thoughts is providing a paved strip for the airplanes – or thoughts – to land. While it is impossible to control the thoughts that enter our awareness, it *is* possible to learn to recognize thoughts as constructed cognitive processes rather than understanding them as truth. The ability to notice thoughts, rather than fuse

to them, frees one from limiting their behavioral repertoire to be determined by their thoughts (Hayes et al., 2016).

ACT interventions illustrate that is it not the thought that is problematic, but rather the involuntary fusion and experiential avoidance likely to follow that is problematic (Hayes et al., 2016). By practicing defusion, an individual creates distance between themselves and their thoughts. A common defusion technique is labeling one's process of thinking or feeling. For example, a veteran who believes himself or herself to be unworthy of forgiveness will notice this thought and reframe it by stating, "I am having the thought that I am unworthy of forgiveness." In this practice, the individual no longer identifies with unworthiness but notices it as a construction of their mind.

4. Self-as-Context

Recognizing the self-as-context, or observing self, is to recognize the self as constant, stable, and unattached. This opposes self-as-content, which is evaluative, changing, and conceptual (Ciarrochi, 2011). Understanding the self-as-content promotes self-evaluation and thoughts such as "I am unworthy," "I am a failure," or "I am bad." Through understanding the self-as-context, an individual practices an unattached and non-judgmental stance towards thoughts, which allows for cognitive defusion. Self-as-context highlights a core of the self, perhaps the soul previously mentioned in Steve Hayes' poem, that has potential for restoration.

5. Values

Values are the chosen underlying qualities that guide an individual's direction in life through overt behavior (Hayes et al., 2016; Ciarrochi, 2011; Harris, 2009). Values are not goals to be achieved, but rather principles that guide our behavior. When living according to one's unique values, one lives a life of meaning and fulfillment. When fused to unpleasant thoughts that promote

avoidance behaviors, one often engages in behaviors inconsistent with their values. For example, a veteran who believes himself to be unworthy of love and forgiveness will isolate himself from others. However, is it from observing the thought that one believes they are unworthy of love and forgiveness that one can identify their values of love and forgiveness, or more specifically genuine connection to others and compassion. Through identifying and articulating values, one can begin to guide their decisions by these values, rather than unpleasant thoughts or feeling.

When exploring values, it is helpful to ask, "What is important to you?" Common answers include family, friends, job, and money. The next, and more difficult, question to follow is "What about that is important to you?" This question is surprisingly difficult for most people to answer. In a room full of veterans, it is not unlikely to sit in silence for a minute or two. If family is important, what type of relationships do you want to cultivate? If friends are important, what qualities are important to have in a friendship? If a job is important, what kind of worker do you want to be? If money is important, what would having it enable you to do? Other useful exercises used to explore values is to write one's own obituary, or to imagine having only 24 hours to live but you cannot tell anyone – how will you live those 24 hours? Who will you visit? What will you do?

6. Committed Action

Committed action is intentional and values-driven behavior. When action is guided by values, rather than by unpleasant or painful thoughts, evaluations, or fears, life becomes meaningful. Through practicing what is important at the very core of one's being, uncomfortable private experiences become endurable. Important to note is the difficulty of committed action guided by values. It may require practice, cultivation of skills, and patience. Developing an ongoing pastoral relationship with a veteran will involve accountability by which the veteran can

cultivate a sense of responsibility for the way in which they live a values-driven life, moving toward community and healing.

Next Steps

While the veteran and servicemember population is more likely to seek support of clergy and chaplains, as previously stated, it is helpful to remember you are not alone in this service of compassion and philanthropy – this *diakonia.* By now, you have been acquainted with general information about military culture, veteran mental health, and principles of ACT that can serve to guide pastoral and therapeutic conversations.

It is anticipated this program will be accessible as an intensive week-long continuing education course for clergy and lay leaders serving our veterans and active servicemembers. Though targeting the Orthodox Christian community, it will be available for non-Orthodox clergy, lay ministers, and healthcare providers to attend. Additionally, the content of the course will be accessible on an online learning management system prior to the start of the course. This program is best engaged with as an interactive course, inviting you to explore questions and ideas you may have regarding your role and next steps in ministering to veterans, military servicemembers, and their families. I encourage you to continue developing and connecting with a broad professional network of trusted clergy, mental health professionals, and program facilitators with whom to consult, refer, and continue discussing both theory and praxis.

For information regarding local veteran and ministry resources, a helpful step is contacting your local VA to connect with VA chaplains. The following resources are provided for further exploration of PTSD, moral injury, ACT, and Eastern Orthodox theology:

Key Resources

Moral Injury Project: https://moralinjuryproject.syr.edu/about-moral-injury/

National Center for PTSD: https://www.ptsd.va.gov/PTSD/professional/treat/index.asp

National Center for PTSD Clergy Toolkit: https://www.ptsd.va.gov/professional/treat/care/toolkits/clergy/spiritualityMorality.asp

Shay Moral Injury Center: https://www.voa.org/moralinjury-resources

Podcasts

Fr. David Alexander and Fr. Sean Levine discuss *Orthodoxy and War* on Ancient Faith Today*:* https://www.ancientfaith.com/podcasts/aftoday/orthodoxy_and_war

Dr. Albert Rossi interviews Fr. Sean Levine, discussing *PTSD* on Becoming a Healing Presence: https://www.ancientfaith.com/podcasts/healingpresence/post_traumatic_stress_disorder_ptsd

Dr. Albert Rossi interviews Fr. James Parnell on *Loving Our Veterans:* https://www.ancientfaith.com/podcasts/healingpresence/loving_our_veterans

Further Reading

Nieuwsma, J., Walser, R., Hayes, S., & Tan, S. (2016). *ACT for Clergy and Pastoral Counselors: Using Acceptance and Commitment Therapy to Bridge Psychological and Spiritual Care*. Oakland, CA: Context Press.

Patitsas, T. (2013). The Opposite of War is Not Peace: Healing Trauma in The Iliad and in Orthodox Tradition. *Road to Emmaus, 14*(1) 27-51.

Shay, J. (1995). *Achilles in Vietnam: Combat Trauma and the Undoing of Character.* New York: Simon & Schuster.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596.

American Psychological Association. (2017). Ethical principles of psychologists and code of conduct (2002, amended effective June 1, 2010, and January 1, 2017). http://www.apa.org/ethics/code/index.html.

Barnes-Holmes, Y., Hayes, S. C., Barnes-Holmes, D., & Roche, B. (2001). Relational Frame Theory: A Post Skinnerian Account of Human Language and Cognition. New York, NY: Kluwer Academic Publishers.

Berg, G. (2011). The relationship between spiritual distress, PTSD and depression in Vietnam combat veterans. *Journal of Pastoral Care & Counseling*, *65*(1), 1-11.

Boakye, E. A., Buchanan, P., Wang, J., Stringer, L., Geneus, C., & Scherrer, J. F. (2017). Self-reported lifetime depression and current mental distress among veterans across service eras. *Military Medicine*, *182*(3-4), e1691-e1696.

Bonanno, G.A., Galea, S., Bucciarelli, A., Vlahov, D. 2006. Psychological resilience after disaster: New York City in the aftermath of the September 11th terrorist attack. *Psychological Science, 17*, 181–86.

Bonanno, G. A., Westphal, M., & Mancini, A. D. (2011). Resilience to loss and potential trauma. *Annual Review of Clinical Psychology*, *7*, 511-535.

Chrysostom, J. (1963). Homily IV on the Statutes. *A Select Library of the Nicene and Post-Nicene Fathers of the Christian Church, Second Series* (P. Schaff, Ed.), Vol. 4, Grand Rapids, MI: Eerdmans Publishing Company. (Original work 388).

Ciarrochi, J. (2011). Acceptance and Commitment Therapy: overview and evidence. Retrieved from: http://josephciarrochi.com/wp-content/uploads/2011/08/ACT-fact-sheet-compiled by-Ciarrochi-main.pdf

Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces. (2010). *The challenge and the promise: Strengthening the force, preventing suicide and saving lives: Final report of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces*. Washington, DC.

Dohrenwend, B. P., Turner, J. B., Turse, N. A., Adams, B. G., Koenen, K. C., & Marshall, R. (2006). The psychological risks of Vietnam for US veterans: a revisit with new data and methods. *Science*, *313*(5789), 979-982.

Elliott, B. (2018). Civilian nurses' knowledge, confidence, and comfort caring for military veterans: Survey results of a mixed-methods study. *Home Healthcare Now, 36*(6), 356-361.

Fontana, A., & Rosenheck, R. (2008). Treatment-seeking veterans of Iraq and Afghanistan: Comparison with veterans of previous wars. *The Journal of Nervous and Mental Disease*, *196*(7), 513-521.

Gellad, W. F., Good, C. B., & Shulkin, D. J. (2017). Addressing the opioid epidemic in the United States: lessons from the Department of Veterans Affairs. *JAMA Internal Medicine*, *177*(5), 611-612.

Gould, C.E., Rideaux, T., Spira, A.P., Beaudreau, S.A. (2014). Depression and anxiety symptoms in male veterans and non-veterans: Health and Retirement Study. *International Journal of Geriatric Psychiatry, 30*(6), 623–30.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2016). *Acceptance and Commitment Therapy: The Process of Practice and of Mindful Change—Second Edition.* New York, NY: The Guilford Press.

Harris, R. (2009). *ACT made simple: An easy-to-read primer on Acceptance and Commitment Therapy.* Oakland, CA. CS: New Harbinger.

Helmer, D. A., Chandler, H. K., Quigley, K. S., Blatt, M., Teichman, R., & Lange, G. (2009). Chronic widespread pain, mental health, and physical role function in OEF/OIF veterans. *Pain Medicine*, *10*(7), 1174-1182.

Hoggatt, K. J., Lehavot, K., Krenek, M., Schweizer, C. A., & Simpson, T. (2017). Prevalence of substance misuse among US veterans in the general population. *The American Journal on Addictions*, *26*(4), 357-365.

Institute of Medicine. Substance Use Disorders in the US Armed Forces. (2013). Washington, DC: National Academies Press. https://www.nap.edu/catalog/13441/substance-use-disorders-in-the-us-armed-forces.

Johnson, B. S., Boudiab, L. D., Freundl, M., Anthony, M., Gmerek, G. B., & Carter, J. (2013). Enhancing veteran-centered care: a guide for nurses in non-VA settings. *The American Journal of Nursing*, *113*(7), 24-39.

Kline, A., Falca-Dodson, M., Sussner, B., Ciccone, D. S., Chandler, H., Callahan, L., & Losonczy, M. (2010). Effects of repeated deployment to Iraq and Afghanistan on the health of New Jersey Army National Guard troops: implications for military readiness. *American journal of public health*, *100*(2), 276–283. https://doi.org/10.2105/AJPH.2009.162925

Litz, B.T., Stein, N., Delaney, E., Lebowitz, L., Nash, W.P., Silva, C., & Maguen, S. (2009). Moral injury and moral repair in war Veterans: A preliminary model and intervention strategy. *Clinical Psychology Review, 29,* 695-706.

Nieuwsma, J. A., Rhodes, J. E., Jackson, G. L., Cantrell, W. C., Lane, M. E., Bates, M. J., & Meador, K. G. (2013). Chaplaincy and mental health in the Department of Veterans Affairs and Department of Defense. *Journal of Health Care Chaplaincy, 19*(1), 3-21.

Nimitz, C., (1944, June 18). [Radio broadcast]. *The church at work among the armed forces.* National Broadcasting Company.

Norman, S. B., Haller, M., Hamblen, J. L., Southwick, S. M., & Pietrzak, R. H. (2018). The burden of co-occurring alcohol use disorder and PTSD in US Military veterans: Comorbidities, functioning, and suicidality. *Psychology of Addictive Behaviors, 32*(2), 224.

Pyne, J. M., Rabalais, A., & Sullivan, A. (2019). Mental Health Clinician and Community Clergy Collaboration to Address Moral Injury in Veterans and the Role of the Veterans Affairs Chaplain. *Journal of Health Care Chaplaincy*, 25:1, 1-19, DOI: 10.1080/08854726.2018.1474997.

United States Department of Defense. (2019). *Manual for Courts-Martial.*

United States Government Accountability Office. (1988). *Gender Issues: Information on DOD's Assignment Policy and Direct Ground Combat Definition*, GAO/NSAID-99-7, 45.

United States Government Accountability Office. (2009). *VA Health Care: Preliminary Findings on VA's Provision of Health Care Services to Women Veterans.* From http://www.gao.gov/new.items/d09899t.pdf .

Ridgway, P., & Press, A. (2004). Assessing the recovery-orientation of your mental health program: A user's guide for the Recovery- Enhancing Environment scale (REE). Version 1. Lawrence, Kansas: University of Kansas, School of Social Welfare, Office of Mental Health Training and Research.

Sayer, N. A., Chiros, C. E., Sigford, B., Scott, S., Clothier, B., Pickett, T., & Lew, H. L. (2008). Characteristics and rehabilitation outcomes among patients with blast and other injuries sustained during the Global War on Terror. *Archives of physical medicine and rehabilitation, 89*(1), 163-170.

Sharp, K. (2012). A Review of Acceptance and Commitment Therapy with Anxiety Disorders. International Journal of Psychology and Psychological Therapy, 12:3, 359-372.

Shay, Jonathan. (1995). *Achilles in Vietnam: Combat Trauma and the Undoing of Character.* New York: Simon & Schuster.

Smee, D. E., McGuire, J., Garrick, T., Sreenivasan, S., Dow, D., & Woehl, D. (2013). Critical concerns in Iraq/Afghanistan war veteran-forensic interface: Veterans treatment court as diversion in rural communities. *Journal of the American Academy of Psychiatry and the Law Online*, *41*(2), 256-262.

Tedeschi, R. G., & Calhoun, L. G. (1996). The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress*, 9, 455–471.

Wilson, K.G. & DuFrene, T. (2008). *Mindfulness for two: An Acceptance and Commitment Therapy approach to mindfulness in psychotherapy.* Oakland, CA: New Haringer Publications.

World Health Organization. (2018). International classification of diseases for mortality and morbidity statistics (11th Revision). Retrieved from https://icd.who.int/browse11/l-m/en.