

THE WARRIOR CULTURE: The warrior culture of the U.S. military is one that values strength, resilience, courage, and personal sacrifice. The military inculcates an identity of elitism and superiority, perhaps best captured by the military's various slogans: "Army Strong"; "The Few, The Proud"; "Do Something Amazing"; "A Global Force for Good." Mental toughness and an expectation to master stress without difficulty are developed and reinforced as a cultural norm, with an emphasis on inner strength and self-reliance in order to "shake off" injury and illness (Tanielian & Jaycox, 2008).

Couched within a culture that explicitly trains its members to "suck it up," it is not difficult to see how a warrior who admits to mental health problems and seeks out mental health care might view these actions as signs of weakness. Traditional mental health approaches, in contrast to the warrior culture, tend to talk almost exclusively in clinical language of "disordered" behavior associated with illness (e.g., symptoms and warning signs of mental health disorders). Because the warrior identity is based on strength and elitism, the use of clinical terminology is at odds with the warrior mindset and reinforces the disconnect between service members and mental health.

In traditional mental health approaches, service members who experience identified 'symptoms' of various 'disorders' are encouraged to self-identify for treatment in a location that is generally housed with a medical setting that is separated from the unit, further reinforcing an identity of illness and inadvertently contributing to stigma. For example, the military's emphasis on leader accountability for all subordinates at all times entail the expectation that service members will notify leaders when they will be absent from unit activities, and where they will be. Furthermore, sources for mental health treatment are typically located in medical settings with hours that parallel the work and training schedule of the service member. Accessing mental health services therefore requires the service member to leave the group during the very time when his absence is most obvious to others. Almost half of service members report being unable to get adequate time off from work to attend mental health appointments (MHAT-IV, 2006; MHAT-V, 2008), suggesting that mental health services that require the service member to leave during duty hours may serve, in some cases, as an unintentional barrier to care.

The warrior's reluctance to leave the group for help also reflects the warrior culture's high regard for the development of close, in-group bonds fostered from shared experiences, oftentimes in extreme or austere conditions. Leaving the group to seek out help from "outsiders" can therefore be viewed with suspicion and distrust, and in some cases can even be viewed as jeopardizing group safety (Chang & Subramaniam, 2008). In sharp contrast to the collectivist identity of the warrior culture that values emotional toughness, traditional mental health treatments predominantly adopt an individualistic, one-on-one approach in which emotional vulnerability is encouraged (Sue & Sue, 2003). They also believe talking to outsiders about combat or military-related stressors is less helpful than mental health professionals believe it to be (Capella University, 2008). It is not surprising, then, that warriors hesitate to access this system, and they are three times as likely to turn to each other first for support and encouragement as they are to access professional services (MHAT, 2003). Viewing mental health professionals as outsiders is reinforced by the geographic separation of mental health services from the military unit, and it is very likely one of the most significant contributors to service members' high level of distrust and skepticism of mental health professionals (Hoge et al., 2004; MHAT-IV, 2006). Greater limits to confidentiality within the military medical system relative to the general population further cement warriors' distrust of mental health professionals

TRAUMATIC WAR-RELATED MORAL INJURY

Training for Clergy, Caregivers and Congregations

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PART I – The Traditional Rites

Introduction

Many current service members and veterans, upon return home, continue to fight an internal, hidden war, often with little or no support. For some, the battle after the battle can be even more troublesome than the war itself. Most of the antagonists in this struggle have familiar names: post trauma stress disorder, anxiety, depression, addiction and traumatic brain injury. But, there is something very important missing from that list.

In one survey conducted in 2008, 27% of those surveyed said they had faced ethical situations during deployment in which they did not know how to respond (Mental Health Advisory Team [MHAT-V], 2008, as referenced in the article *Moral Injury and Moral Repair in War Veterans: A preliminary model and intervention strategy* (Clinical Psychology Review 29 (2009) 695-706), This well written and well documented article suggests the need to address moral injury as a separate and unique issue that requires additional intervention and strategies. In the article the authors make the compelling case that moral injury has been neglected in current treatment protocols and, they address deficiencies by suggesting therapeutic strategies and presenting their own framework to better help those suffering from moral injury. We agree with their findings. They also wrote to stimulate discussion and research with the hope of establishing evidence based practices for the treatment of war-related injury. We support these goals and offer this material as part of the discussion.

What is Moral Injury?

Moral injury is spiritual, psychological and emotional distress and damage that occurs when one transgresses deeply held core moral values. The distress and damage occurs not just in one's relationship to self and others, but also in relationship to God. War-related moral injury includes but is not limited to perpetration and participation in activities that violate these core values. Moral Injury also includes inactions like witnessing, not intervening or not preventing the actions of others.

War-related Causes of Moral Injury

War-related moral injury often involves but is not limited to: killing, exposure to and handling of dead burned, or wounded bodies, wounding, maiming, committing atrocities, raping, torturing, terrorizing, running people down, humiliating, harassing, intimidating, assaulting, destroying property and infrastructure, being shot at, being assaulted, harassed, tortured, terrorized, raped, wounded, burned, shot at, maimed, witnessing atrocities, etc. All these and many more are all too common in war, and they are experienced five primary ways: as actor, witness, perpetrator, victim, or rescuer in any and all

combinations. In addition to post trauma, depression, anxiety, addiction, panic (and more) service members can experience profound distress: a deep personal sense of moral failure, loss of confidence in one's self and others, loss of hope for the future. There are many other damaging personal and relational consequences, and the things mentioned above are just a brief list. Depending on the circumstances and the personalities of the service members involved, there are endless variations to moral injury that occur in war.

In this two part training we provide training to help clergy, caregivers and congregations provide outreach and services with a special focus on moral injury.

We will show how telling and re-telling one's story and lamenting utilizing journaling and writing can be important rehearsal and preparation for the kind of moral deliberation the often precludes individual confession and absolution. We will discuss theological distinctions of guilt that have therapeutic relevance. We will also seek to expand the church's vision role to show how some of the most important healing of moral injury can occur in the context of a community of faith as a structured part of aftercare. We will re-emphasize time-honored instructions to help clergy and caregivers prepare for their role as a safe, trusted confidant and attentive listener to those suffering war-related moral injury. We will give concrete suggestions to prevent inappropriate responses that could add to the burden of those who are already suffering excessive guilt and shame. We will show how the church can function as an important bridge for service members and their loved ones to realize their quest for peace and more satisfying participation in community life. And, finally we will present an augmented frame for traditional rites that address these concerns and incorporate these suggestions.

The following material is primarily designed to assist clergy, chaplains, confessors, pastoral counselors, spiritual directors and religious practitioners in their work with those suffering from trauma plus moral injury. We will outline the important role of congregations as a sanctuary, safe haven and bridge in the transition to more satisfying and meaningful community life.

Biblical Roots

The church has a rich therapeutic heritage in the treatment of moral injury. It is a history has its roots in the biblical writings and the prophetic and apostolic traditions. In the Hebrew Scriptures, the prophet Nathan addresses moral injury perpetrated by King David. Tradition has it that psalm 51, a penitential psalm attributed to David who abused his power to orchestrate the death of Uriah so that he could have Bathsheba as his wife, is one of the psalms recommended for reading in the rite of individual confession and forgiveness. In the New Testament record Jesus dispels the commonly held beliefs that many common ailments were punishment for moral wrongdoing. (ie. John 9). And the New Testament is full of stories of reconciliation with God and public restoration to community for many who were disconnected and isolated from their communities by illness and moral injury. The intervention, rehabilitation and reinstatement of Saul the perpetrator to Paul the apostle is an important case study.

It is germane to the topic that, in addition to the empty tomb, the cross of Jesus, a symbol and event fraught with moral injury, is a key centerpiece of the Christian faith. In the events leading up to and following the crucifixion the gospels reveal and expose the roots and tendrils of moral injury related to

this event: development of intent to harm, escalation of rhetoric, lying, slander, demonization, rabble rousing, scapegoating, betrayal, and abandonment culminating in injustice and state and church sanctioned perpetration of torture and violence. No one is innocent. Everyone has a part. The words of an old penitential hymn make the point, *“Who was the guilty? Who brought this upon thee? Alas, my treason, Jesus, hath undone thee. ‘Twas I, Lord Jesus, I it was denied thee; I crucified thee.”*

The circumstances surrounding the crucifixion, remembered and celebrated every year during Holy Week, find their culmination and meaning in the empty tomb and the practice of the Eucharist where we remember that the death of Christ caused by us becomes God’s redeeming work for us and for our salvation. In the Sundays following Easter those gathered hear the post resurrection stories. They are stories of reconciliation, rehabilitation, restoration, and reinstatement to fearful, anxious traumatized followers burdened with fear, anxiety, guilt and shame. The primary therapeutic vehicle for their recovery is the forgiveness, peace and validation they experience in their reconnection with a supportive, significant other.

This healing legacy has been actualized by congregations and generations of clergy and caregivers who have also been that significant other for those suffering from moral injury. They have provided a listening ear and reassurance of grace to anxious, depressed and traumatized service members – many of whom are also burdened with the guilt and shame of moral injury. And the Church, when it has grasped its mandate for hope and healing, has served as a safe place for rehabilitation and a bridge to help restore those suffering from moral injury to meaningful connections and participation in community life.

Texts of trauma and recovery form much of our rich scriptural legacy. These texts inform the historic therapeutic practices of the church and also form the basis of the following instruction which is designed to help chaplains, confessors, pastoral caregivers and practitioners incorporate the best of that rich heritage and legacy into current treatment of service members suffering from war-related moral injury.

While the church has a historic legacy of treatment that goes back to its very roots we realize that current evidence-based practices for the recovery of moral injury have not been established in pastoral counseling and faith-based settings. But, we do know what works. And we offer these materials for pastoral caregivers to consider in the hope that it will stimulate creative collaboration, research and the development of evidence-based practices that will continue to bring relief, hope and healing to those who suffer.

The Pressing Need for Treatment

In the meantime, we can’t sit by the sidelines and wait. Healthcare needs of service members continue to rise and exceed demands even though there has been an influx of additional military and civilian resources. Chaplains, clergy and caregivers of all denominations and backgrounds are already being pressed by necessity into this work. We know that early intervention produces better results. We also know that we need to push services and deploy our best knowledge and wisdom, now, even as we seek to improve our practice. As interest in the war wanes there will be even less sympathy and support for the growing number of those fighting the hidden war after the war. Now is the time to act.

The Veteran's Administration (VA) has a legal national mandate to serve the health needs of service members and veterans. While more resources have poured into the VA in the past few years and many services have increased and improved, rural catchment areas are still woefully underserved. And it is in these areas that large numbers of service members and veterans live and struggle with the aftermath of war.

When counseling and health care are not readily available, the burden of health care for the hidden wounds of war defaults primarily to service members and their loved ones. Too many of the people who have already borne the brunt of the burden of war end up fighting the hidden war after the war with little or no support. The larger society is still largely oblivious to this hidden war and its destructive consequences. As the war itself draws down the silent war will continue to ramp up and put increasing pressure on veterans and loved ones. And increasing numbers will seek support from their clergy and congregations. Those in rural catchment areas will feel the most pressure. How well churches respond will be directly related to how well we are prepared.

Importance of Preparation

This training module with moral injury as its focus is designed to prepare clergy and caregivers to understand the needs and the goals of veterans and loved ones who are fighting this silent war after the war. Clergy and caregivers who understand war-related moral injury and the dynamics of forgiveness and reconciliation can assist service members and veterans in their quest for inner peace. And congregations that understand their role as a safe haven and bridge will better understand how they can support service members in their transition and quest for a satisfying and purposeful community life.

Important Ecclesial and Theological Perspectives

The most common scriptural definition of sin is missing the mark, which is also technical military term for missing the bulls-eye. Sin is also defined as separation and brokenness; severe disruption and disconnection on all levels – from self, others (including creation) and God. Other common consequences of sin are: loss of faith, loss of hope, profound anxiety, separation from God, isolation from others, deep wounds to conscience, nihilism and disconnection with one's deepest sense of spirituality and personhood – sometimes referred to as the soul. These are all common and predictable consequences of war.

In the Orthodox tradition sin is not viewed as a stain on the soul that needs to be wiped out, or a legal transgression that must be set right by a punitive sentence, but rather as a mistake made by the individual with the opportunity for spiritual growth and development.

Guilt, shame and remorse are common consequences of moral injury. As difficult as these feelings may be, they are positive signs. They are signs that one's moral compass is still intact, that the conscience is still functioning. Guilt, shame and remorse carry within them seeds of hope.

From a pastoral care perspective guilt, shame and remorse are doing their work when they facilitate three moves: first, they beckon one away from the wrong, second, they invite learning from one's

mistakes, and third, they call one forward towards the good. These moves can happen simultaneously. Theologically, when this salutary movement happens it is called repentance.

There are many obstacles that block this process. Denial, delusion, deception and delay are high on the list. A person can easily get stuck in excessive guilt and shame through self-recrimination and other maladaptive patterns. When a person gets stuck in these states important learning and growth is interrupted.

Guilt, shame and remorse are not just signs that the moral compass is intact, nor are they just intrinsic signs of personal goodness, but, from the perspective of faith, they are also signs of divine presence. Soren Kierkegaard calls guilt, shame and remorse *eternity's emissaries*. (*Purity of Heart is to Will One Thing* by Soren Kierkegaard, Harper and Rowe, 1956, p. 38) For those who believe in God and understand that guilt, shame and remorse are emissaries of the eternal, there is a quantitative and qualitative shift in perspective. Guilt and shame are not viewed just as symptoms to reduce, but, more importantly, as eternity's emissaries to welcome and befriend. They come to teach and invite one to listen and learn.

The classic formula of absolution of 'pardon and peace' addresses two kinds of guilt. The first is forensic guilt. Forensic guilt is not a feeling, it's a verdict: guilty! The other kind of guilt is existential guilt, the feeling of guilt. Usually the two are in direct relation and usually the nature of the transgression directly affects the intensity and duration of existential guilt.

When absolution is granted and God's 'pardon and peace' are invoked, the pardon is directed primarily to the forensic nature of the guilt and the peace to the existential. Both complement each other. In the rite of confession and forgiveness the pronouncement of pardon presupposes the personal awareness and acceptance of forensic guilt. The penitent, confessor and God all agree on the validity of forensic guilt. And this guilt often corresponds and accepts and affirms a civil indictment. In confession and absolution, forensic guilt often has other dimensions which include guilt related to direct impacts as aftershocks ripple out and affect one's self, others (creation) and relationship to God. Awareness and naming of impacts and consequences related forensic guilt is important work for the penitent. While such work may initially increase existential guilt is important preparation for confession. Such preparation surfaces other wounds and allows them to be more fully treated.

There are also parts of our awareness that we are blind to but others see clearly. Caregivers need to raise these issues in a timely and caring manner. How the prophet Nathan approached King David is one good case study. And finally there are impacts of which no one is aware – except God. And divine pardon also embraces and includes consequences and impacts totally hidden from our awareness.

The concluding statement in the previous paragraph assumes a belief in an all-knowing God. In this section we have been talking about a series of beliefs and assumptions. Before we get too far along we need to insert a brief discussion about the importance of beliefs in the treatment of traumatic moral injury.

Beliefs are Important.

For example, this training is based on several primary beliefs or assumptions that I assume are shared by most who are reading or are participating in training. I have a basic premise – that God exists. The latest Gallup poll (2007) suggested that 87% of the American population shares a similar premise. A second major assumption is that God is love, and the third is that God loves and cares for creation and each of us, individually. These major assumptions certainly have biblical roots and support, but, it must be said very clearly that, as important as they are, they are beliefs. They are not facts that can be proven or disproven scientifically. And these beliefs connect and intertwine with other beliefs, our values, scientifically proven facts, life experiences and a multitude of stories that have, over time been loosely or more firmly integrated to form a personal belief system, a unique belief thumbprint – if you will.

Everyone has a “belief” signature or thumb print. Our belief systems are important. They color everything; what and how we think, how we behave and what we feel. Most of the world’s greatest altruism and greatest atrocities are directly related to deeply held beliefs and related ideologies. Beliefs are powerful intrinsic forces that make up a very important part of who we are.

Most versions of Cognitive-Behavior Therapy (CBT) starts from the premise that emotions and behaviors are primarily (though not always) the result of different cognitions (thoughts, inferences, assumptions, beliefs, etc.) and the way those cognitions are processed. Most pastoral counselors have long understood that knowledge and understanding of the assumptive world of the counselee and how that assumptive world functions is critical to providing respectful and effective therapy.

Endnote: Several major studies related to Cognitive-Behavior Therapy recommend additional spiritual / religious features to improve patient compliance and outcomes. We hope that chaplains and other pastoral caregivers would be on the ground floor of research and initiate studies that measure and improve the efficacy of faith-based treatment for moral injury. This would also apply to chaplains in the prison system who treat offenders wrestling with traumatic moral injury.

Endnote. The proven efficacy of CBT in relation to depression and post traumatic stress would seem to bode well for CBT that employs features related to spiritual / religious beliefs. Only one articles on the efficacy of CBT with spiritual / religious features was found. *Spiritually modified cognitive therapy: a review of the literature*, Social Work, April, 2006, by David R. Hodge. Hodge’s review, while inconclusive, surfaced some interesting findings. 1. A majority of respondents, nearly 70% of social workers surveyed, used religious language or concepts in their clinical work. Nevertheless, Hodge wrote, “few guidelines have emerged regarding their use.” 2. In the closing section on practical application Hodge there were some interesting but inconclusive findings. Regarding treatment of depression Hodge writes “that spiritually modified cognitive therapy can be used effectively with Christian clients who are interested in incorporating their beliefs and practices into therapy to address depression.” He adds, “This is a significant finding for at least two reasons. First, Christians represent the largest faith community in the United States. Second, depression is one of the most common mental health problems and its prevalence appears to be increasing (Koenig et al., 2001). Consequently, practitioners are likely to encounter a significant number of clients for whom this intervention may be an appropriate fit.” He concludes with this disclaimer. “It should also be noted that it remains unclear whether spiritually informed cognitive therapy is superior to traditional cognitive therapy with any group. Even with Christians wrestling with depression, the extant research is only suggestive, not conclusive.” 3. In a study of devout Muslims in Malaysia suffering from anxiety disorder spiritually modified CBT reported “at three months, the

experimental group (with CBT plus spiritual features) recorded significantly lower levels of anxiety. At six months, however, the gains achieved by the experimental group were matched by those of the control group (that is, no significant difference.)” It is important to note that spiritual modification resulted in a less anxious process of therapy.

Endnote: According to a nationwide survey by the American Association of Pastoral Counselors (AAPC), 83 percent of Americans believe their spiritual faith and religious beliefs are closely tied to their state of mental and emotional health. Three-fourths say it's important for them to see a professional counselor who integrates their values and beliefs into the counseling process. More people said they would prefer to see a religious counselor (29 percent) than a psychiatrist (27), psychologist (17) or family doctor (13). With God as My Shrink, Psychology Today, by Pamela Paul, May 01, 2005

The impact of pardon from God relates directly to one's belief about God. If I believe that God knows the broader consequences and impacts of my behavior for good or ill – the pronouncement of forgiveness can have a broader impact.

While pardon is meant to address forensic guilt, the impartation of peace is meant to reduce fear and anxiety. The primary fear and anxiety of the disciples who were hiding out immediately after Jesus' death, was the fear of being caught, tortured and crucified by the authorities. They did not expect Jesus to return. But, when he surprised them with his sudden appearance it's likely that he was responding to a spike in fear and anxiety when he said, "Don't be afraid," and "Peace be with you." In the post resurrection appearance Jesus employs different anxiety reduction strategies to create a learning environment.

It's important to remember that certain classic beliefs may increase fear and anxiety. Fear and anxiety may be generated by belief in an omniscient, just and holy God whose consequences include, but are not limited to, eternal separation from God and / or eternal conscious torment in hell. Service members will sometimes describe combat experiences and the experience of post trauma in hellish terms. And some may believe themselves to be such monsters that they concur, not only with the verdict of guilty, but with God's sentence of eternal conscious torment. Such beliefs may have a small benefit of acceptance of current suffering as God's righteous judgment. While the belief in Christ's descent into hell may bring comfort and hope strong belief in God's sentence of perdition usually just intensifies fear and anxiety, and entrenches recrimination. When that happens these beliefs promote fear and anxiety and maladaptive behaviors. Many get stuck in these belief / thought patterns and have a very hard time extricating themselves.

Early images induced in childhood can have a primal feel and tend to be the most abiding. If God is seen primarily as punitive then the unbidden reactions at the mention of God to treatment of moral injury will tend to provoke fear and raise anxiety. And responses will tend to be maladaptive. If God is seen primarily as gracious and merciful, slow to anger and abounding in steadfast love – the responses will tend to be helpful. With there is a positive image God's pardon can have great effect, even to those who have difficulty liking themselves. (ie... the story of the SM who believed he was a monster because of the things he did. WTH-HTH p.?)

Remorse is the sorrow that comes from awareness of the impact of moral injury to one's self, others and God. (For an illuminating discussion on remorse see *Lost Icons: Reflections on Cultural Bereavement* by Rowan Williams, Morehouse Publishing, 2000, p. 95ff:) Appropriate guilt, shame and remorse can foster an honest appraisal of one's own humanness and the humanness of others. A person's image and beliefs about God clearly become more important in the therapeutic process. And care needs to be taken to address beliefs that fuel self-recrimination and care needs to be taken against other responses that might foster maladaptive shame and guilt (ie.. excessive moralizing and scrupulosity). But there are important beliefs that foster a healing climate and encourage the quest for reconciliation. And, the most important one, one that has far-reaching therapeutic benefit for those suffering from war-related moral injury, is belief in a merciful and loving God.

It is also important to stress that many of the most difficult war-related experiences can be positive, redemptive and even life-giving. Why do many service members re-enlist or volunteer to re-deploy even when they may be experiencing severe symptoms of post trauma and anxiety? To be sure, there are economic reasons. But, there are also aspects of combat that are exhilarating; where a person experiences the feeling of breathtaking aliveness. The deep and lasting bonds of trust forged in raw intensity of combat are legendary. And part of the magnetic pull of veteran reunions is that these are places where experiences like this can be remembered, talked about and understood. They are also places where people can grieve deeply and with honor. Positive and negative are woven together. Some of the symptoms of hyper-vigilance that cause problems in everyday living find ready application in combat and contribute to the intense feelings of life. On many levels, positive and negative, war is indeed a force that gives people the kind of meaning and purpose they don't find in normal life. By comparison, life in church and society can seem apathetic and family life quite bland. Nevertheless, there is a seductive character to the intensity of war that exhibits itself in thrill seeking, excessive risk taking and riding the edge of the envelope. And when the addictive impulses of war take over, it can become a quest for meaning at a faulty spiritual address.

While learning to tolerate boredom is often an important therapeutic goal for returning service members the church is too often perceived as just too boring a place. At best it is a place lacking in adventure and imagination, at worst, a place just for wimps. Veterans who have indeed been victimized react negatively to overtures that create the perception of being coddled. To say veterans are not victims may be a slight overstatement – but not much. Most veterans don't view themselves as victims. In order to capture the imaginations of many service members, we in the Church will need to recapture the positive intensity and urgency of our own mission. And those in the church will need to challenge young men and women to give their utmost for the upward call to share the gospel and to work for peace and justice in the world. We need to recapture the intensity and excitement that can be expected from the challenge to take up the cross and follow Christ – not the least of which is the courage to face intense clusters of grief often hidden behind layers of military, cultural and even ecclesial training.

The Importance of Moral Deliberation

It is important for people to understand that the military is not an amoral, nihilistic organization where anything goes; far from it. Moral and ethical deliberation is an important part of military training.

Officers and enlisted personnel receive extensive indoctrination on codes of conduct. Rules of engagement seek to guide behavior on the battlefield. And, the military has its own internal justice system, the Uniform Code of Military Justice (UCMJ). While there are deficiencies as there are in any system, the military system levels consequences and punishments, quickly and effectively. Anyone who has stood before a magistrate or served time in a military or civil setting knows the power and effectiveness of legal institutions to stimulate reflection on one's behavior.

Legal systems in the United States tend to be heavy on retribution and light on restoration. The emphasis on retribution encourages dishonesty and secrecy to protect one's self from a guilty verdict that could result in severe punishment. Public stigma and shame associated with such behaviors also contribute to the secrecy of those who have transgressed. And the legal system commends secrecy to prevent self-incrimination. The threat of punishment and stigma of shame and blame prevent disclosures and truncate moral deliberation.

The church, in both public and military settings, continues to be a primary place for individual and collective moral ethical deliberation. Other than families, the church is the last place left in our society where people of all ages regularly gather together in intergenerational groups to reflect on their behavior and its consequences. Treatment of moral injury in the church is a natural result of that deliberation.

Roman Catholic and Orthodox communions, whose sacramental theology require participation by clergy and laity, give individual treatment of war-related moral injury much more attention. In the Roman Catholic and Orthodox communions sacramental practice of confession and absolution requires admission of wrongdoing to the priest. That admission is followed by absolution, the declaration of pardon and peace to the penitent as God's representative. Unfortunately, use of the Sacrament of Penance and Reconciliation has decreased in the Roman Catholic Church and individual confession and forgiveness has largely fallen into disuse in mainline churches. These ecclesial declines come at a time when needs of service members seeking help from war-related moral injury are sharply on the rise.

Scandals in the church and poor responses to the needs of those who suffer have greatly diminished its moral authority at a time when it is needed the most. Abuse by priests, excessive punitive responses, splits and rivalries within and between denominations and churches all diminish the sense of trust and the perception of the church as sanctuary for those in need. We need practice what we preach, step back and make a serious and sober assessment and renew the practices that restore us to spiritual health. Only in so doing will we regain the trust and confidence that people need to see the church as a place for moral deliberation and as a safe place to address moral injury.

The Three-fold Challenge for the Church

The church and its leaders face a three-fold challenge in its ministry to those suffering from war-related moral injury:

1. The church needs to revisit the historic practices of individual confession and forgiveness and carry forward the best of those practices.

2. These practices need to be augmented with knowledge and skills that safely and effectively manage other concurrent problems without causing additional damage.
3. Therapeutic, ecclesial practices that lead to the goal of restoration of faith in God and to more meaningful connections in communities of faith need to be more widely practiced and taught – especially in the current environment.

Service members suffering from war-related moral injury will need safe settings and confidants. The most recent study in the UK documented that “only a quarter of those with common mental disorders and still serving in the military were receiving any form of medical professional help. Instead, *non-medical sources of help such as chaplains / padres were more widely used.*” (King’s Centre for Military Health Research, September 2010.)

Many clergy are already behind the curve and need to play some catch up to provide adequate assistance. If we don’t we will continue to stumble along, run the danger doing more harm than good and run the risk of becoming irrelevant in this ministry. Clearly, we don’t want this to happen. Martin Luther said, “Forgiveness is the doctrine upon which the church stands or falls (*stantis et cadentis*).” (citation needed) We believe that the practice of forgiveness is central to our faith. Treatment of moral injury is one therapeutic area where the church should excel.

The continuity with historic practices in connection with this work is important. Historic practices pull us out of our own false pride – reminding us that we are not the only kids on the block, and that there may have been a time when we were not even on the block! They invite us to consider what might be helpful from other traditions as well as what might not be helpful, even from our own. The complexity and necessity of the work and the prompting of the Spirit challenge us to transcend our differences and engage this work. We also don’t need to reinvent the wheel. Ancient traditions of the Church Catholic are a repository of sound knowledge and wisdom. And we do well to reacquaint ourselves and build on these historic practices. This knowledge base that borrows from the tradition of spiritual direction has much to offer pastoral counselors and secular practitioners as they work with service members and their families.

Addressing Moral Injury

We begin by reviewing some of the traditional rites and instructions (rubrics) of individual confession and forgiveness. Seasoned confessors will also appreciate the emphases on the fundamentals of confession. The ABCs continue to provide a solid foundation and for the treatment of moral injury. The traditional rites, rightly applied, have much to offer and provide the logical starting point for discussion of pastoral practice and treatment of moral injury.

Exercise: Have participants list their ideas of the ABCs of individual confession and forgiveness. The presenter will invite participants to augment this list throughout the training, and the rest of the workshop will build on these insights. A primary goal of the training is to create the awareness that the more one studies, practices and experiences the ABCs personally, the better one will understand how to apply the ABCs to others.

The following ABC list is for the presenter's eyes only. Each item will eventually be added to the list as training goes on. And the list will be augmented with items to manage concurrent problems. (The following asterisked items have historical importance. Single asterisked items are very important, double asterisked necessary, triple asterisked – absolutely necessary):

1. Preparation
2. Welcome
3. *Contrition (Sorrow and the desire to change and do better),
4. **Confession (taking responsibility and being accountable for specific sins done or left undone)
5. ***Absolution (Declaration of God's pardon and peace)
 - a. Note: in the Roman Catholic and Orthodox tradition confession must eventually be made to a priest.
 - b. And absolution may be administered by only by someone who has the faculties (authorization and training)to do so.
6. **Penance or Satisfaction (Devotional activities, amends, etc. imposed by the priest.)
7. Some other features of the rite include:
 - a. Priestly blessing upon arrival
 - b. Reading of scripture
 - c. Pastoral conversation
 - d. Prayer of thanksgiving and praise
 - e. Dismissal and Blessing.

The historic rite has four primary goals: (handout):

Goal #1: Repentance and restoration in relationship with God (Restoration of faith and hope in God.)

Through divine assurance of mercy, pronouncement of divine pardon and the acceptance of spiritual direction personally tailored to the individual to restore trust and hope in God. (ie.. Penance traditionally administered by clergy or spiritual directors and often caricaturized as ten Our Fathers and fifteen Hail Marys) Discernment and contemplation of mercy, pardon and acceptance of God while it can initially intensify grief and remorse eventually has a tempering effect. Remorse then becomes a sober friend and can lend a seasoned maturity to a person of faith.

Goal #2: Improvement in relationship to God. (Growth in faith motivated by God's pardon and peace.)

This goal is characterized by a little more appreciation and gratitude, a little more faith, a little more hope, a little more devotion. As trust in God increases there is corresponding reduction in anxiety, guilt and shame in relation to God. Goals #1 and #2 lead to:

Goal #3: Reconnection with one's self, one's deeper personhood and one's core values.(Healing of the soul and conscience.)

This can be the hardest part – especially for those who tend to be perfectionistic, judgmental, have unrealistic expectations and / or carry a rigid, upright image of themselves – attitudes that fuel self

recrimination (a punitive recycling of blame), guilt and shame. Goal #3 is on track when guilt, blame and shame are reduced. That is, the experiences of guilt, blame and shame happen less often, with less intensity and, when they do occur, they are not as long. Stated another way, therapeutic improvement happens when over time the symptoms of guilt, blame and shame occur with less duration, less intensity and less frequency. Therapists will note a direct connection with the common therapeutic goals for the treatment post trauma, anxiety and substance abuse (relapse) therapy. For example, in relapse therapy a primary goal is that relapses become less frequent, less in duration when they do occur, and less intense. That means a person doesn't use as frequently, as intensely or as much when they do relapse.

Goal #4: Reconnection with others and community of faith. (Restoration to more satisfying participation in the life of the community.)

As a person becomes less hard on themselves they can be more open to 1) relationships and meaningful involvement with supportive others, and 2) to more meaningful and satisfying participation in broader community life.

*The four goals, while they have a sequential flavor, can occur very quickly and simultaneously. Sometimes they take years. Sometimes improvement does not occur at all. Note that these ecclesial goals correspond directly with many of the goals service members have for themselves. **The primary stated goal of service members suffering from post trauma symptoms is satisfying readjustment to community life.***

Another way of stating this goal is that *all people have the right to a life in community with dignity, safety and hope.* Lutheran Social Service of Minnesota vision statement.

This is one of the key findings of the research report, *Reintegration Problems and Treatment Interests Among Iraq and Afghanistan Combat Veterans Receiving VA Medical Care* by Nina A. Sayer, Ph.D., Siamak Noorbaloochi, Ph.D., Patricia Frazier, Ph.D., Kathleen Carlson, Ph.D., Amy Gravely, M.A., and Maureen Murdoch, M.D., M.P.H. published by PSYCHIATRIC SERVICES, ps.psychiatryonline.org, June 2010, Vol. 61, No.6. In the conclusion the report states, "One of the key findings among Iraq-Afghanistan combat veterans who already receive VA medical care with multiple current reintegration problems (ie... especially those with the probability of PTSD) is the desire for services and information to help them readjust to community life."

Invite participants to keep these goals in mind as they take a closer look at the traditional rites.

The following is the rite of individual confession and forgiveness from the Lutheran Book of Worship. This and similar rites are usually found in the pastoral handbooks and agendas of respective denominations. Prior to the workshop you can invite participants to bring a copy of the rite used in their tradition. While most churches (even non-denomination ones) have a tradition and / or rite(s) for confession – a few may not.

By studying and engaging the following exercise participants will engage some important learning, skills and, hopefully, spiritual formation. Participants will quickly appreciate the intense vulnerability and intimacy of the rite. At first, this will be very uncomfortable for some. But, the discomfort and anxiety experienced is important to appreciate the vulnerability of those making confession before engaging in

the work. Using role play some important skill building occurs: a better understanding of the role of confessor, the importance of boundaries, the importance of transparency in the presence of a supportive, authentic other, and the power of the rite itself to help re-integrate, reframe and redress deeply disturbing events – and all this and more for the purpose of restoring intimacy with God and intimacy with others.

A better understanding of the rite will help participants develop important skills. They will better understand the role, disposition and attitude of the confessor. They will gain an appreciation of the importance of ongoing spiritual formation. And they will experience gratitude for formal and informal relationship characterized by honesty, transparency, forgiveness and grace.

As confessors and caregivers mature and grow in their own intimacy with God and others they will become more adept at hearing and receiving the stories of veterans and communicating personal assurance of forgiveness with power and grace.

Confession and Forgiveness Role Play Exercise:

1. *Print and pass out the order of Individual Confession and Forgiveness.*
2. *Invite participants to pick a partner. Decide who will be the penitent and who will be the confessor.*
3. *Take five minutes to review the rite. The penitent develops a scenario around one transgression. Encourage participants to pick a transgression around which there is at least some energy – some guilt and / or shame.*
4. *Participants are instructed to find a place to administer the rite.*

**Note: There will be some resistance, some jockeying, some who won't participate. Give permission to just 'study the rite'. The fears and anxiety and other dynamics experienced are part of the training.*

5. *After completing the rite they will take a break. Recommend a gradual change of venue, some alone time, going for a walk, getting some fresh air, before re-engaging with people. This is also a good time to structure a break.*
6. *Return and have participants share any observations.*

Learning Goals: This experiential exercise contains within it the seeds of the training and will quickly underline several very important learning objectives.

1. *Acquaint participants with the traditional rite.*
2. *Increase overall pastoral sensitivity and confidence.*
3. *It will teach participants to more deeply appreciate the anxieties of penitents and the responsibilities and the role of confessor in managing anxiety.*
4. *It begins to teach the importance of being a calm, attentive, non-judgmental presence.*

5. *The importance of learning to pronounce absolution in an appropriate manner that conveys confidence and reassurance.*
6. *It will raise the therapeutic importance of different kinds of preparation and instruction for service members suffering from war-related moral injury.*
7. *Begin to raise the awareness of a personal spiritual practice and spiritual direction for those who engage in this work.*

After participants have shared their observations – revisit the ABC list and invite participants to add anything that they thought might be missing from the list. At this time the presenter will add any asterisked items that might be missing.

Make enough copies of Individual Confession and Forgiveness for all participants.

INDIVIDUAL CONFESSION AND FORGIVENESS

The confession made by a penitent is protected from disclosure. The pastor is obligated to respect at all times the confidential nature of a confession.

The pastor greets the penitent. Then the penitent may kneel.

P Are you prepared to make your confession?

R **I am.**

The pastor and penitent say the psalm together.

O Lord, open my lips, and my mouth shall declare your praise.
 Had you desired it, I would have offered sacrifice,
 but you take no delight in burnt offerings.
 The sacrifice of God is a troubled spirit;
 a broken and contrite heart, O God, you will not despise.
 Have mercy on me, O God, according to your lovingkindness;
 in your great compassion blot out my offenses.
 Wash me through and through from my wickedness,
 and cleanse me from my sin. (Psalm 51:16-18, 1-2)

P You have come to make confession before God. In Christ you are free to confess before me, a pastor in his Church, the sins of which you are aware and the sins which trouble you.

R **I confess before God that I am guilty of many sins. Especially I confess before you that...**

The penitent confesses those sins which are known and those which disturb or grieve him/her.
For all this I am sorry and I pray for forgiveness. I want to do better.

The pastor may then engage the penitent in pastoral conversation, offering admonition and comfort from the Holy Scriptures. Then they say together:

Have mercy on me, O God, according to your lovingkindness;
in your great compassion blot out my offenses.

Create in me a clean heart, O God,
and renew a right spirit within me.

Cast me not away from your presence,
and take not your Holy Spirit from me.

Restore to me the joy of your salvation,
and uphold me with your free Spirit. (Psalm 51:1, 11-13)

The pastor faces the penitent.

P Do you believe that the word of forgiveness I speak to you comes from God himself?

R **Yes, I believe.**

The pastor lays both hands on the head of the penitent.

P God is merciful and blesses you. By the command of our Lord Jesus Christ, I, a called and ordained servant of the Word, forgive you your sins in the name of the Father, and of the + Son, and of the Holy Spirit.

R **Amen**

The penitent may pray silently in thanksgiving, or may pray together with the pastor:

The Lord is full of compassion and mercy,
slow to anger and of great kindness.

He will not always accuse us,
nor will he keep his anger forever.

He has not dealt with us according to our sins,
nor rewarded us according to our wickedness.

For as the heavens are high above the earth,
so is his mercy great upon those who fear him.

As far as the east is from the west,
so far has he removed our sins from us.

As a father cares for his children,
so does the Lord care for those who fear him. (Psalm 103:8-13)

Glory to the Father, and to the Son, and to the Holy Spirit,

as it was in the beginning, is now, and will be forever. Amen

P Blessed are those whose sins have been forgiven,
whose evil deeds have been forgotten.

Rejoice in the Lord, and go in peace.

The penitent may exchange the peace with the pastor.

The traditional rites have some limitations – some would see them as glaring.

Exercise: Have participants identify limitations of the traditional rite in the previous exercise. The following are some commonly identified limitations:

- Didn't really know and trust the person I'm confessing to.
- Didn't feel safe.
- Was afraid to talk about real stuff.
- Felt too anxious.
- Don't like the feeling of not being in control.
- Gender can be a problem. (ie.. females confessing to males).
- Power dynamics.
- What about people who withhold their deepest and darkest secrets? Will they go away feeling more ashamed and guilty because they haven't disclosed everything?
- Not appropriate for victims of rape, incest, abuse.
- Don't contain guidelines for post trauma, anxiety, depression, addiction, along with those who have been victimized.
- What do you do if someone's anxiety starts escalating... or if they have a full blown panic attack?
- What about addicts who are currently using.

PART II: An Expanded and Augmented Rite

Preliminary Considerations

The Primary Importance of Safety and Trust

Feedback from those participating in the traditional rite usually identifies two primary limitations in the practice of the rite: *safety and trust. These two areas are also the two most important qualities sought by service members struggling with traumatic war-related moral injury.

People express their concern for safety in different ways. Some feel too anxious and afraid to talk. Others feel dangerously vulnerable. They feel they could be harmed rather than helped. Many in training will feel vulnerable, anxious, fear, and even distrust. These are not the dynamics desired to alleviate guilt and shame. In fact, they undermine the very purpose for which the rites exist. These

limitations and potential scenarios point out the need for additional safety precautions, guidelines and training for both those who administer the rite and as well as for those participating.

The more safety that is built into the rite the more the participants will experience therapeutic value of the rite. The important thing is not to throw out the baby with the bathwater. In this training we will augment traditional practices with guidelines and strategies that help establish perceptions of safety. When the perception of safety is high it is easier to trust. Incremental baby steps reduce anxiety and increase therapeutic benefit. When these guidelines are implemented participants will experience safety that will foster an internal emotional climate that powerfully reinforces the primary goals of reassurance of grace and reconnection with others.

**Working with Relapse Groups: Building and maintaining safety and trust through the use of metaphor, paradox and creative teaming by Linda Atkinson, John Shelton and John Sippola, 1990, unpublished manuscript.* I am indebted to two colleagues, John Shelton and Linda Atkinson for drumming home the obvious, common sense insights that should be the bread and butter of clergy everywhere: the trust (faith) and safety (salvation) which are the central tenets of the Christian faith. Unfortunately, I have discovered they are often sorely lacking both in myself and others.

Preparation for Caregivers

Before we proceed to the augmented rite itself pastoral caregivers and support group facilitators need to be prepared to respond to SMs in ways that generate an immediate sense of trust and safety. As in past generations many SMs and veterans may not seek out formal medical services. But, unlike past generations, the current cohort of service members tend to respond positively to direct offers of assistance from someone they trust – especially if they are off the record. Be assured, in the months and years ahead chaplains, clergy and caregivers in churches will be increasingly sought as care providers of first resort. As trust is established some SMs will become more amenable to referral for medical and professional assistance. But, because of the growing need a growing number of SMs will seek treatment from clergy for traumatic war-related moral injury.

First, a few quick tips:

1. When an SM approaches you and shows any indication of wanting to tell their story, don't give any negative signals. Immediately, find a confidential place, pull up a chair and JUST LISTEN. Skip meetings, skip your next appointment. This is really, really important. This is probably your only chance.
2. When negotiating a time to meet don't give negative signals. Don't begin by saying, "Well, I can't meet on...." Don't appear to make excuses. Any dodge will likely be interpreted as unwillingness or inability to hear difficult things at best, or as judgment and condemnation at worst. Be attentive. Show immediate interest and willingness to listen and help. As quickly as possible negotiate a time and place to meet. Make sure that you make ample time for that meeting.
3. Be confident and direct. If you know that the SM is dealing with some gnarly post trauma don't beat around the bush. Tell the SM that you know he or she is dealing with difficult stuff. Remind

the SM that dealing with it in the same way will bring the same results, (SOS + SOS = SOS) and avoiding dealing with it will only make matters worse. Ask if s/he wants things to improve? Sometimes a SM will make an excuse or dodge. If he says, "You don't want to hear about dead bodies and things like that." Call their bluff. "That's exactly what I want to hear about and those are exactly the kind of things you need to talk about."

4. In first meetings there may be powerful emotional reactions to the mere mention of words like God or spirituality. Sometimes mere mention of those or similar words will spike anxiety and even cause some SMs to dissociate. Dissociation and anxiety can happen in the first meeting or in subsequent contacts. Be alert for dissociation. (Later we will tell you some remedial steps to take when a person dissociates.)
5. Service members are sometimes afraid that clergy will invite them to attend church. Do not... let me repeat... do not invite the SM to attend worship and don't push church attendance. Assure the SM that church attendance is their decision. Some service members are afraid to meet with clergy because they fear being pushed to attend crowded settings that make them extremely anxious and uncomfortable. The augmented process outlined in this section encourages step by step reconnection to more satisfying participation in community life. The SM is in charge and will choose whether or not to attend.
6. That being said, caregivers need to be proactive and strategic when negotiating a place to meet. Service providers have noticed that many in this current cohort of SMs tend to bond with the place associated with positive encounters. Whereas Vietnam vets more easily accepted referrals to services provided in other facilities, many in this generation prefer to return to the same facility for additional services. Recommend a couple of options of places to meet. Choose the options with aftercare in mind. For example, if you know the person is struggling with substance abuse, choose the space where an AA or NA group also meets. If you think the person would benefit from subsequent involvement in a support group at a specific building, recommend that facility. If you think the person would eventually benefit from reconnection with a specific community of faith – recommend that church as a place to meet.
7. As a general guideline: men meet with men and women with women. If you mix genders make sure you have easy access to supportive and understanding colleagues where you are going to meet.
8. Because some of the grossest killing and destruction are common in war it is important for a caregiver to be prepared. Just as medical students and nurses observe surgery and autopsies as part of their preparation and training it is necessary for caregivers to be exposed to some of the horrendous things that happen in war prior to hearing the experiences of soldiers. Even well prepared caregivers may at times experience nausea and dizziness when hearing some stories. When that happens you are likely to dissociate yourself. Remember to deep breath and just keep nodding your head. Some suggested reading: *Welcome Them Home – Help Them Heal Wounds of War Assessment* (p. 104); *The Good Soldiers*, by David Finkel; the classic WW2 autobiography *The Forgotten Soldier*, Harper and Rowe 1990 by Guy Sajer; the documentary film *Restrepo*. Additional graphic material can be viewed on YouTube. Enter PTSD.
9. Be on time, be reliable and be attentive (ie... turn off your handheld device). Build trust by following through on your promises. Be consistent, follow through on your appointments.

10. It is important to state some service members may be ready to participate in the rite sooner rather than later. If you are a clergy or priest and feeling pressure to administer absolution ask whose needs are being met – the service member's or yours.

***Creative Use of Metaphors**

SMs often use creative personal metaphors to describe feelings of vulnerability, shame and guilt. They have a lot of therapeutic value and power. The following are some metaphors that SMs and trauma survivors have used to describe how they feel. No single metaphor can describe this all encompassing scrambling of the soul and spirit. It is a time of extreme vulnerability and danger. A safe, supportive, trusting environment is a necessity for hope and healing to occur. Some describe this disorientation phase

- like a crab that has lost its shell and feeling utterly raw and painful even to the most tender touch.
- Like a snake that has shed its skin.
- Like a porcupine... enraged and in pain with its quills constantly extended.
- Feeling the need to withdraw and, like a turtle, withdrawing into the perceived safety of one's own shell.
- Like having lost a limb.
- Like having shattered bones.
- Like having lost one's life.
- Like a zombie, unalive, but not yet dead.
- Like having one's soul scooped out like a pumpkin.
- Like an internal IED that explodes one's soul and one's faith into thousands of shards

Personal metaphors are highly descriptive and validation of metaphors is very powerful. The metaphor of the IED led to a discussion of the shards. Can these fragments... be restored? Will this restoration be enough to even move a person beyond just survival? Can the soul contain the magnitude of the blast... the depth and breadth of the wounds.

The best metaphors are the always ones the SMs comes up with for themselves. Be alert for them. Some may strike you as really funny. Feel free to laugh, laughter is healing. Here are some the funnier ones we've heard:

- lower than whale shit.
- like fucking snot on the wall.
- running a quart low.
- less than a pissy pants penny.
- like going down the hill ass over teakettle.
- feeling lower than a milk cow on diarrhea.

Some of these metaphors were taken from Working with Relapse Groups: Building and maintaining safety and trust through the use of metaphor, paradox and creative teaming by Linda Atkinson, John Shelton and John Sippola, 1990, unpublished manuscript.

Vulnerability and danger go hand in hand during this time of profound disorientation.

The process of re-orientation after war-related trauma is a time of danger and vulnerability. It is often very long and painful road as a person comes to grips with the trauma and the corresponding loss of faith in one's self, others, the world and God.

But, there is hope. With hard work (and I mean some of the hardest work a person will ever do in their lives... ie... climbing their Mt. Everest) and with good support, and over time – people can and do recover and rediscover a life worth living. Just as a person adapts and adjusts to a prosthesis or broken and shattered bones, a lost faith, or a shattered and broken faith can heal and over time... be restored.

Credit to Walter Brueggemann who uses orientation, disorientation and reorientation as a frame for understanding the Babylonian captivity.

An augmented model of the rite of confession and forgiveness for the treatment of traumatic war-related moral injury

In part two of this training we augment and expand the rite of confessions and forgiveness to address the treatment of traumatic war-related moral injury. We will introduce three elements that have high therapeutic value.

1. Writing and telling the whole story
2. The assignment of a non-judgmental caregiver or *group who accompanies the SM and supports them through the entire process, and
3. The addition of safety precautions that can be implemented every step of the way.

Different group formats and processes are helpful in working with traumatic moral injury. One such process is Healing of Memories work of Fr. Lapsley. Another process, promising with elderly veterans is reminiscence. For an enlightening treatment see Transformational Reminiscence: Life Story Work by John Kunz and Florence Gray Soltys, Springer Publishing Company, 2007 pps. 181-196 Chapter Ten, Traumatic Memories and Life Review contributed by Marvin J. Westwood and Holly B. McLean. I am grateful to my friend and colleague John Kunz for his collaboration and work over the years. He put this book in my hands at exactly the right time. I also want to thank Marvin and Holly for their affirming insights and work which also inform some of the following discussion.

Caregivers working with SMs recovering from traumatic war-related moral injury need to have training in trauma. Trauma is a common experience for service members returning from war. An understanding of the reactions associated with trauma and the interventions that lead to recovery from trauma will help all caregivers understand the need for precautions that reduce the risks of re-traumatizing those who participate in the rite.

A Quick Review of Post Trauma

We begin with a quick review of post trauma. Traumatic experiences often cause unbidden flashbacks, night terrors and hyper-vigilance. These symptoms of trauma often result in intense bouts of anxiety that leave a person feeling vulnerable and powerless. The common numbing and avoidance symptoms associated with trauma also leave a person feeling disconnected and alone. When you add intense guilt and shame associated with moral injury to intense vulnerability, powerless and isolation a person may experience a significant rise in anxiety and confusion. Increases in emotional states raise the risk of re-traumatization. To protect one's self from re-traumatization a person will often dissociate and shut down. Increased emotional volatility raises the risk of suicidal or homicidal impulses. All those attending to moral injury in returning service members need to understand and learn the following:

1. Understanding the three primary experiences of service members wrestling with trauma and moral injury: vulnerability, powerlessness and disconnection.
2. Learn preventive strategies to promote safety, reduce anxiety and prevent re-traumatization.
3. Learn the signs that signal unacceptable escalation of anxiety,
4. Learn intervention strategies to contain and calm.
5. Know what to do when a person becomes suicidal or homicidal, and
6. Know when and how to make a respectful referral.

The following training is designed to augment traditional rites of individual confession and forgiveness. We will present strategies and protocols that minimize risk and maximize safety, thus providing therapeutic benefits.

These strategies and protocols:

- Establish perceptions of safety
- Reduce anxiety
- Validate feelings
- Re-establish a sense of control by offering choice
- Utilize a supportive caregiver and / or group whose facilitators are trained in safety strategies and protocols.

The three primary negative consequences of traumatic war-related moral injury are

1. vulnerability,
2. powerlessness and
3. isolation.

Address isolation by re-connecting the service member to a trusted caregiver or group. Address powerlessness by validating feelings and re-empowering the service member through giving them choices and control of the process. Address vulnerability by establishing a safe context, by repeating messages that reinforce perceptions of safety and by employing other remedial strategies that reduce

anxiety. Elements that promote safety and trust, validate and empower, and reduce anxiety and vulnerability raise the healing benefits of the rite.

The primary vehicle for recovery in the following format is a relationship with a person or group characterized by safety and trust. Trust and safety cannot be emphasized enough. Many SMs make snap decisions based on quick scans. Is this person or group safe? Do they have the capacity to deal with the things I've experienced? Do they have the ability to help me? Bottom line, can I trust them? Am I safe?

It's not easy to develop trust in someone else when your own self confidence is sagging or at an all time low. But, SMs will test caregivers, and they will gravitate to people they perceive as safe, trustworthy, caring and competent. And healing occurs as a SM gains trust and connects with supportive others who have the capacities and competencies to walk with them through this difficult part of their journey. These relationships can form a critical bridge. In developing relationships with authentic, supportive caregivers or groups SMs forge important connections where they learn and reclaim relational competences and regain a sense of self-confidence and control. The skills and competencies learned in these relationships lay the foundation for more satisfying connections and participation in community life.

Overview and Orientation

The augmented framework includes the traditional elements:

1. Preparation
2. Confession
3. Absolution
4. Penance / Satisfaction
5. Reconnection

Historically, reconnection is part of penance / satisfaction, but because it is such an important therapeutic goal for service members we raise its profile by creating an additional section in the rite to highlight this important task.

In the following expanded narrative and commentary we offer an orientation service member to a thorough augmentation of the rite of individual confession and absolution. This orientation and overview can be adapted and used to introduce service members and caregivers to the entire process. The overview allows participants to imagine what the process might feel like, an imaginative way to try it on beforehand. The overview addresses questions and communicates answers in a direct assuring way. An overview can engender perceptions of safety and create hope by inspiring confidence in a positive outcome.

In the narrative the word caregiver is used as a generic term throughout. The functions of the role of caregiver could be addressed by Chaplains, Pastors, Priests, Befrienders, Stephen Ministers, Pastoral Counselors, Spiritual Director or anyone with ability and training for this specific work. Consider training

sponsors in the Adult Catechumenate for this work. Group facilitators could also benefit from this training.

The Two Part Process of an Augmented Rite of Reconciliation

In the following treatment we expand and augment the traditional rite. First we expand the rite and divide it into two parts. In the first part SMs craft and tell their story. In the second part SMs are invited to participate in the rite of individual confession and forgiveness. Each part can stand alone as a discrete therapeutic unit. But, they also complement each other. In crafting and telling the story morally injurious elements emerge and crystallize. When guilt and shame related to morally injurious acts and their consequences crystallize, the SM is ready to participate in the rite of individual confession and forgiveness. We include the process of developing and telling the story as part of traditional preparation for the rite.

The presence of a supportive person of group who accompanies, coaches, validates and supports the SM is the key therapeutic element in this process. The SM is assigned to a caregiver or group. A caregiver /group provides a safe therapeutic context for SMs who are experiencing the vulnerability, powerlessness and disconnection associated with trauma.

Of course, many service members know their story in detail and could readily tell it off the cuff. But, the following structured treatment will help caregivers, facilitators and SMs the better understand and appreciate the importance of safety features.

TELLING THE STORY and CONFESSION AND FORGIVENESS

A two part ritual

Part I: TELLING THE STORY

Introduction

Moral injury is a common experience of service members returning from war. In post deployment briefings service members get a lot of information about the big five: post traumatic stress, depression, anxiety, substance abuse and traumatic brain injury. Moral injury is not something that one often hears about. But, it is very common. There are many ethical challenges in war. In one survey conducted in 2008, 27% of those surveyed said they had faced ethical situations during deployment in which they did not know how to respond. If this is true for you – you are not alone. Moral injury is often intertwined with one or more of the big five. And relief from moral injury usually spells relief from other problems as well.

What is Moral Injury?

Moral injury happens when a person has experiences that transgress deeply held moral values. These include things witnessed, actions or inactions.

Many service members can pinpoint the exact time and circumstances where moral injury occurred. But, some have difficulty remembering exactly what happened. This is normal.

What are the Causes of Moral Injury?

The most common causes of moral injury are experiences around killing, handling wounded, burned or dead bodies, wanton destruction – things like that. They are the same things that can also cause traumatic reactions later on. It is common for moral injury and trauma to be mixed together. At the conclusion of this overview is a list of common causes of moral injury. Depending on the circumstances and the personalities of those involved, there are endless variations to the kinds of moral injury that occur in war.

What are the Consequences of Moral Injury?

Common consequences of moral injury include recurring feelings of guilt, shame and sadness. Those wrestling with moral injury typically avoid talking about what happened. Of course, talking about it is what usually needs to happen. Talking about it to a trusted listener is an important part of recovery from moral injury.

Other consequences include not seeing the world as a good place to be, loss of faith in the goodness of God, loss of one's image of one's self. These are very common consequences. But, with courage, persistence and good support people can and do recover from severe moral injury.

When a person experiences intense guilt and shame it can really feel awful. But, that experience, as hard as it may be, is not all negative. Those deep pangs also mean that the moral compass is intact. Of course, they are also signs of internal wounds that need healing.

How do I address Moral Injury?

The first step is awareness. A simple test is to ask, "Does this still bother me?" If it does you are probably wrestling with moral injury. You may decide to try some things on your own. That's good. And sometimes people can effectively forgive themselves for what happened and the feelings eventually subside. But, if these things continue to bother you and you avoid dealing with it, things will only tend to get worse. You may know the equation: SOS + SOS = SOS (SOS = same old shit). If the things you try don't work: don't delay. Seek help from someone you can trust. Even if you're feeling pretty hopeless, there are people who can help you with this.

What Outcomes can I Expect?

This overview outlines a process that promotes healing from war-related moral injury. You can expect outcomes to include forgiveness, peace of mind and a more satisfying life in your community. You can also expect that, over time, participation in this process will diminish feelings of guilt and shame, fear and anxiety.

What will this Require from me?

This work will require you to tell your story to a trusted confidant or group. This will require courage, persistence and patience. This can be hard work and it will take some time. Many report that this is some of the hardest work they have ever done. There are always a few who breeze through. But, don't count on it.

That can be hard to hear. But, with good support you can do it. Remind yourself that the things you have tried thus far haven't worked, and the experiences that brought you to this point will take time to heal.

What kind of Support can I expect?

You will be assigned a caregiver (or group) who will mentor and coach you through the process. These caregivers know and understand the kind of things you're up against and know how to provide support when the going gets tough.

At the end of the process people regularly report that the most important part of their treatment was the relationship and the trust they developed with their caregiver.

Rationale for Safety Precautions (for caregivers)

It is most often the case that the SM has experienced trauma in addition to moral injury. The SM will need to feel a strong measure of safety and trust for healing to occur. We employ a lot of safety measures to help both the SM and the caregiver feel less anxious and more at ease. We begin by removing as many surprises as possible. An abbreviated orientation similar to this narrative can answer many questions by outlining the healing process of telling the story and confession and forgiveness in detail.

We know that memory loss is a symptom of trauma and that caregivers forget too. Both can refer to this written material to jog the memory and remind one of the safety features, precautions and interventions that have been built into the process. Reading and re-reading the overview will give both caregiver and SM a sense of control by a thorough explanation of what to expect in the process. Emphasizing precautions, giving the SM choices and validating feelings increases sense of safety will build trust and strengthen commitment for the long haul.

What can I expect from my Caregiver?

Caregivers know about the kind of things you've experienced. While they may not have 'been there' you'll be surprised how deeply they can appreciate your experience. It's important to say that no matter what you witnessed, what you did or did not do, they will not judge you – no matter what. Their primary job is to listen, to validate your experiences, to offer support and to coach. While they are good listeners they will also remind you that you are in control and will offer you choices and options. When and if things get too intense your caregiver will coach you and remind you that you can 1) stop the process, 2) slow down, 3) breathe, or 4) take a break. Your caregiver will give you choices. Your caregiver will periodically remind you that you can fire him / her at any time. This is your journey. The caregiver is just

there to assist you. While we encourage you to hold the course you can always choose to stop at any time.

What else is expected of me?

We require a weekly contact with your caregiver during this process. And, you will be responsible for initiating this contact. If you forget, your caregiver will contact you. There are good reasons for this. At the beginning of this process there are usually some questions. We don't want you feeling overly anxious between contacts. We also know that a lot can happen in the course of a week. As time progresses the consistency of the weekly contact will help build a sense of trust and safety with your caregiver.

You get to determine the form of that contact. We recommend a combination of email, phone, and face to face meetings. And, after your initial face to face meetings for the first month we recommend a monthly face to face. If you choose your caregiver will meet more often during difficult times. The weekly structure supports primary therapeutic goals. It promotes safety, reduces anxiety, and provides an external structure that supports development of the relationship with your caregiver. The relationship with the caregiver is a training ground for the kind of skills you need in order to reconnect with others in satisfying ways.

This process will teach and empower you to take responsibility and control. We expect you to engage the process with your caregiver with courage, honesty and integrity.

How Difficult will this be?

Like we said, many report that this is the most challenging task they have ever undertaken. Even with added safety precautions and the support of a trained caregiver, the honesty, integrity and disclosure necessary to heal from traumatic moral injury can be like climbing your personal Mt. Everest.

Caregivers: Even with the assurance of absolute confidentiality, we know that moral injury often involves human on human aggression, handling human remains, even the remains of comrades or close friends. Become familiar with some of the crazy complications of war. Issues with legal implications can be among the most difficult to disclose – this includes sexual assault. Sexual indiscretions can be extremely embarrassing to talk about. We outline a way to do this that maximizes safety and minimizes anxiety and risk. But, even with the following precautions disclosing these things can be some of the hardest work in the world. But, with courage, persistence, coaching and support we know it can be done. The potential benefits will make the efforts worthwhile.

The Main Challenge: Telling Your Story

The main challenge of therapy is telling your story. Your caregiver will coach you on how you can do this in ways that reduce anxiety and increase a sense of safety. For example, we will suggest that you write your story. Why? It's a little easier to write your story for your eyes only. Writing it down in the privacy of your own room allows you to review your story before you tell it to someone else. Writing gives you the time and space to decide exactly what you want to share. And writing gives you a chance to

rehearse things in your own heart and mind. After writing and going over their story in private, some people decide to share their story in small segments. Your caregiver can meet with you to coach and support you in this process.

Caregivers: Writing gives time to rehearse and review content that might have a lot of untapped feelings connected with it. But, we err on the side of safety. We know these things help reduce anxiety and promote healing. So, we take time to prepare you to write. But, it's important for you to know that this preparation itself is an important part of the healing process.

Before you tell your story you may ask your caregiver to read all or parts of what you have written. This is your choice. The hardest part for many is the first honest telling of the story. It takes a lot of courage to tell the unvarnished truth to others. Sometimes people experience a lot of emotions when they tell their story. Some feel embarrassed even when they know that the person (usually your caregiver) or people (if this is part of a group) won't judge. The first telling of the story is a major milestone.

Caregivers: Caregivers need to learn how to rescue and take remedial steps when an SM dissociates or when their anxiety level rises to unacceptable levels. The following are signs of dissociation: the eyes grow vacant, the lights just seem to go out, the head goes down, it feels like the person is no longer really present (guess what - they aren't). The SM might express that they're feeling out of it, fuzzy, confused or not here. Sometimes a person may not even be aware that they've dissociated.

Sometimes you may detect spikes in anxiety: an increase in breathing rate or shortness of breath. There may be a flushing of the skin. The person may get very fidgety or express other visible signs of agitation and nervousness. The person may give signals that they want to leave. They may even get up and pace.

When you notice either dissociation or a significant rise in anxiety you need to take responsibility to remedy the situation. The SM may not have the skills or already be too disconnected and anxious – already past the point of no return. Remember, therapeutic benefits are nil when a person has dissociated or is too anxious or afraid.

Don't blame yourself if and when a person dissociates or gets anxious. These are often unbidden survival responses that may have little or nothing to do with what you said or did. The important thing is to take remedial actions that contain the anxiety and provide protection. Such reassurances can strengthen the relationship by reinforcing perceptions of safety and trust.

For dissociation:

- 1. You can say (calmly), "Let's take a break. How about a cup of coffee or something to drink?"*
- 2. It can be very helpful to get up and simply change the venue. That alone might be enough for the person to reconnect with themselves.*
- 3. You can change the subject, something innocuous like the weather.*
- 4. If you know the person well and touch is appropriate you can touch the person on the forearm while talking calmly.*
- 5. You can ask the person to focus on a specific object as you describe it.*

If anxiety starts rising to unacceptable levels:

1. *Change the subject and talk about the weather or any topic to change the focus off disturbing content.*
2. *If you have good trust and prior discussion about this you can remind the person to breathe while talking to them in a calm, relaxed manner.*
3. *Bring the conversation to a close.*
4. *If the person trusts you invite them to go for a walk.*

Tips from:

Working with Relapse Groups: Building and maintaining safety and trust through the use of metaphor, paradox and creative teaming by Linda Atkinson, John Shelton and John Sippola, 1990, unpublished manuscript.

Chapter Ten, of *Transformation Reminiscence: Traumatic Memories and Life Review* contributed by Marvin J. Westwood and Holly B. McLean.

The Works of Krishna Murti. Krishna Murti always used calming strategies in his conversations with people who came to him for help.

If the SM is telling their story starts getting really anxious about disturbing material you need to make a judgment call. Extreme anxiety often precedes important disclosures and important discharge of emotion. And sometimes your own anxiety can cloud your judgment. It's normally better to just continue listening. But, there may be occasions where you need to rescue. If you choose to rescue and take remedial action offer reassurance, normalize and offer a choice to stop or continue.

You can say (calmly), "Looks like you're feeling a bit anxious. It's normal to feel anxious when talking about disturbing stuff. Sometimes it can be helpful to take a little break. But, if you think it's important to continue, continue on. What do you want to do?"

In the initial contacts and interviews, SMs may come in an anxious or agitated state. When that happens use calming and containing strategies. Have a cup of coffee. Take a walk and get some fresh air with the SM. As you get to know your SM and the strength of the relationship increases there may come a time when you can suggest he or she take a walk to calm down. You'll know the relationship has arrived when your SM can tell you the same.

The work of preparation can be very healing and the first telling of the story is an important milestone. As the SM proceeds and over time you can expect that feelings of anxiety, shame and guilt will become less intense, less frequent and occur less often. These are primary goals of treatment. At different times in the process the SM may experience a rise in intensity. This is normal because feelings that have been numbed over sometimes surface on their own timetable. And, even as things improve there may be intense spikes that make that make the SM think all is in vain. The coaches job at this time is to validate the feelings, normalize the experience and encourage the SM to hold the course. Over time and with

continued work the SM will notice progress. And that progress will give the SM needed hope that there will come a time when these experiences no longer have the same power to disrupt and interfere with life and other relationships . And, in the future, when they do pop up the SM will have learned to befriend and welcome those feelings and learn to view them as an opportunity and bridge and not a barrier.

A Word about Grieving

There is a word for all the intense feelings you have. It is grief. These feelings are directly related to losses you have experienced. In war people have experienced many losses so there can be many feelings. That will feel very confusing at times. Let your caregiver know when you are feeling confused.

Most service members learn to quickly put these feelings aside in order to complete the mission. But, later these feelings can surface very powerfully and cause problems. Avoiding feelings of loss, grief, guilt and shame are a major cause of difficulties. If you don't face them they often come back to bite you. Facing them and learning to express them and let them flow is takes a lot of courage and retraining that may go against everything you've ever been taught. These feelings usually begin to surface as you write your story, and they can be quite turbulent. Snot and tears can scare the heck out of those who have been trained early on not to cry or 'be a man'. Grief can make you feel out of control. When these things happen don't shame yourself. You're not a wuss. Realize that it's not only military training you have to overcome. Sometimes you have to overcome a life time of training to face those feelings and let them flow. So, it can feel very, very awkward. Take it very slow. Remember, your caregiver will really come through and coach you through.

Caregivers: As a person laments and tells and retells the story over time the person can grieve and sort through guilt and the negative appraisals of self that generated by feelings of worthlessness and shame. This can be very important and helpful preparation that clears the mind and provides the kind of perspective needed for a more sober and accurate assessment of wrongdoing.

A Word about Honesty

Honesty is important in healing from moral injury. Honesty can be very hard – especially when a person feels shame. And denial and the power of secrets prevent a person from getting at the root causes of fear, guilt and shame. Once fully exposed a person can at last look at things as they really are. Complete honesty is an important part of healing from fear, guilt and shame.

Sharing with a Supportive Person (for the caregiver)

Usually the first telling of the story is to the caregiver. The first telling is an important step in the therapeutic process. Even with written rehearsal and the added safety of total confidentiality, the first telling of the story even to a trusted confidant can be the most fearful and anxious part of the process. As an interim step some prefer to have their caregiver read certain parts of the journal before telling the story. But, eventually, the SM will need to tell the whole story, including the full unvarnished truth and out loud. Sometimes, especially in the first telling, emotions that have been numbed over begin to flow. Grieving, which usually occurs throughout the process, is an important dimension of healing. Don't be

surprised if emotions are intense and powerful. While this can be very uncomfortable support the SM by validating and normalizing feelings.

Caregivers: Moral Injury can directly related to a person's faith and values. Values vary according to circumstances. Some SMs are able to know that in combat they were behaving in ways which valued survival. Values for most people, are not static, but can change according to the situation and over time as a person mature. What a person was OK with years before may become a problem years later.

For example, in the Korean War a soldier shot and killed an enemy soldier he confronted in close combat in a maze of trenches. On closer inspection the enemy soldier (in uniform) looked very young. Examination of the contents in the wallet of the dead youth revealed that he was only 12 years old. In the wallet was also a picture of his family, people who the soldier assumed were his parents and his little sister. He was at first able to dismiss this as the nasty business of war. The soldier got married and had children, when the soldier's son turned 12, the pathos of the event started to affect him. He was very confused about this, and he started drinking to self medicate. He became addicted, was arrested for a DWI. In treatment he started to come to grips with this event 30 years later. As he told his story, and with help from a chaplain, he began to understand that as a Father his values had changed, and he got stuck in guilt and started drinking. He began to understand how, as a Father to a 12 year old, he had revisited the wartime experience and had concluded that he could never forgive, much less accept someone who would kill his 12 year old son. Now, as his empathy for the Father of the child he killed grew, this lack of acceptance and forgiveness was now, many years later, boomeranging back on him. He defined himself as 'not a good' Catholic who only attended church on Christmas and Easter. The chaplain pointed out how his perspective had changed now that he had a 12 year old. Now, years later, he was feeling guilty and ashamed for killing the boy. They talked about and acknowledged the grief the Father and Mother may have experienced, and the important learning that was taking place. The chaplain pointed out how Jesus forgave those who killed him, and asked him to imagine what God might say to him. With some gentle nudging from the chaplain he began to find solace and impetus to take the first steps to forgiving himself.

Review, Revise and Re-tell

After the first telling you may be invited to review, revise and re-tell. Why? This doesn't mean you flunked. Often, when a person tells the story for the first time things can emerge quite differently than expected. Parts of the story that may have been lost to memory come into the picture. A surprising intensity sometimes emerges from what might have been considered a small inconsequential detail. When the story is given voice in the presence of a caring, supportive other details can emerge and connections made or deepened. Now you are in a position to review and revise, to present a new draft with a clearer story line. This alone is very therapeutic. In addition you will learn that repeating the story helps you towards therapeutic goals. And the emotional intensity gradually starts to lessen of the story is reviewed, revised and retold. There are benchmarks that tell you that you are coming to the end of the first phase of the process. The primary benchmark is that you are able to tell your story and include all the details. You are able to name and squarely face some of the consequences of what happened to you and others. Your caregiver will remind you that you have the choice to continue on the next phase

of your journey. The goal of this next phase is participating in the rite of individual confession and forgiveness.

Caregivers: One of your jobs is to remind and give the SM choices and options. The option of writing is very important and gives the SM a choice on how to begin to deal with the complexities of traumatic moral injury. The SM may opt to skip the writing and tell the whole story. That's fine. But, if the telling it's becomes obvious that the SM is unable to put the story line together you can restate the option of writing as part of the review process. Remind the SM that baby steps can be easier and bring a person to the desired outcome. Remind the SM that of the safety and sense of control that comes from writing things down. Writing is a first important step in getting things out of your own head and heart. Putting it on paper helps externalize things that may have been internalized for a long time. And when they have been internalized for a long time unidentified and intense emotional features can add confusion. Writing allows the SMs to address these items at their own pace. Writing it out give the SM space to review, rehearse and monitor difficult material privately and safely. And finally writing reduces the sense of powerlessness and vulnerability by putting the SM in charge sharing the story, entirely or in part.

Writing things out will sometimes reveal even more clearly areas that have been lost to memory. Sometimes the process of writing helps retrieve lost memories or brings attention to details that have been forgotten. The story line then becomes more clear. While some of these revelations may be quite emotional, they can also help the process of integration and assimilation of difficult material necessary for healing to occur. Writing provides personal control that promotes a sense of safety and reduces anxiety. Writing itself can be very therapeutic. It can also be a time of increased anxiety and grieving. If so, remember to validate and normalize.

Telling and retelling the whole unvarnished story to a trusted confidant or group can provide immense therapeutic benefit. Feelings that have been avoided are validated and difficult elements of the story are more easily integrated. The story, when honestly and fully written and expressed verbally will help the SM and caregiver, better understand and appreciate the roots of guilt and shame and surface interventions in the form of personally tailored metaphors and appropriate humor that minimize the intensity of those feelings and anxiety associated with them.

When the SM tells the story, the caregiver or group will see more clearly the place or places where the SM gets stuck and get clues and insights that can help the SM move forward. The broader story will provide important contextual information and details that can be creatively employed and make eventual penance and satisfaction more meaningful. All this not only increases the therapeutic benefit, but is germane preparation for part two of the journey, the rite of individual confession and forgiveness.

This is a choice point. You certainly may encourage continuing on. But, the important therapeutic move is to give the SM the choice on whether or not to proceed. Empowerment is most important.

Part II: The Rite of Reconciliation

Coaching the Service Member for the Rite (for caregivers only)

Readiness for confession is not something one must take for granted. Readiness assumes a degree of awareness and level of honesty and candor regarding one's actions or inactions, motivations, intentions and plans.

In the Roman Catholic and Orthodox traditions this is called the Sacrament of Penance and Reconciliation and may only be administered by a priest who is trained and authorized for this work. In mainline traditions the rite is usually administered by a minister, but it may be also administered by another pastoral caregiver or confidant. Administration by an ordained clergy is sometimes preferred because of the added perception of confidentiality and safety.

Go through the rite with the SM beforehand so there are no surprises. There is consideration of the degree of preparedness, and at the beginning of the rite is an affirmation of readiness. Remember, preparedness for confession includes readiness to enter a plea of 'guilty' and be able to name specific moral injury. Notice that before the pronouncement of forgiveness the liturgy directs the penitent to affirm their faith that the word of forgiveness spoken comes from God himself. This is clearly meant to stir up faith and increase acceptance of absolution in order to convey assurance of forgiveness from God.

Preparation for participation in the rite is particularly important for those who have experienced war-related trauma. The SM may feel very anxious about meeting with a clergy. And current anxiety around trauma can affect memory and recall. Remind the SM that it's OK to take some notes into confession as a safety blanket if s/he forgets or gets confuse.

If another clergy is administering the rite, the caregiver and service member should arrange to meet with the clergy beforehand so that questions can be asked and fears allayed. If you haven't done so already this is high time to dispel the myth of forgive and forget and remind the SM of the goals of the rite: 1) pardon and peace from God, 2) reconnection with God, and 3) reconnection with the community of faith. It is also a time to remind the SM that God's forgiveness doesn't overlook the wrong done and the impact on others. God's verdict reads like this: Guilty, but pardoned.

Theologically, there is forensic guilt as well as existential guilt. The two are related. God's and the service member's verdict of guilty are justified. But, God, in love and mercy grants pardon to the person who is having difficulty forgiving himself challenges that person learn from it and to get over the hump. It will become obvious after the rite that God's forgiveness of me raises the question of my forgiveness of myself. If God forgives me, who am I not to forgive myself?

It may be important to let certain SMs know that sometimes a person will feel a lot of release after the rite. Sometimes a person will feel more intense guilt and shame. Sometimes it may feel to the SM like attending veteran's court where misdemeanors and fines (punishments) are forgiven. Except this is the highest court when the sound of the gavel is heard it is God who pardons offenses and mistakes of the one confessing their sin. Remind the SM that the goal of the rite is the gradual diminishing of guilt and shame over time. The equation is less intensity, less often, and (when an episode does occur) less duration.

The caregiver needs to coach the SM about the purpose of penance and satisfaction and discuss the spiritual direction that is an important part of the amends to God. Such discussion about penance and satisfaction will prepare the SM to receive spiritual direction, called penance and satisfaction. Let the SM know that discussion of amends, reparation and restitution related to others is part of aftercare and will be discussed after the rite. Such preparation builds trust in the process and prepares the person to receive absolution that engenders a faithful response to the pronouncement of forgiveness and instruction that will lead to a more satisfying life in the community of faith.

Consideration may be given to the celebration of eucharist after the rite with the caregiver, confessor and SM all in attendance.

Affirm the SM that they're well prepared. If the SM is really anxious remind the SM of the choice to rehearse the confession with you beforehand or bring notes. Remember, this is time to leave perfectionism at the door.

Confession and Forgiveness

You are ready to make a confession and receive absolution from a priest, pastor or caregiver.

Preparation for the Confessor (for the confessor's eyes only)

First of all, liturgical rites provide the safety of a structure that have endured the test of time. The rites together with their instructions take both the confessor and the listener by the hand and lead them safely through a process that can address and absorb difficult, disturbing, traumatic material and provide a vehicle to impart important words, actions and stir up faith that can promote hope and healing for veterans and service members suffering from war-related moral injury.

You may remind the SM about your pastoral obligation to maintain confidentiality.

Some service members, especially from the Roman Catholic tradition, may approach a clergy from another denomination and assume that everything they say is 'under the Seal of the Confessional' and will never, ever be disclosed. Boundaries around confidentiality raise the critical issue of safety and trust. Before engaging in this work you must be clear about your own boundaries. It will help to ask yourself beforehand, What would you do if someone confesses rape? How would you assess if they are at risk to repeat the offense? What would do you do if you think a service member is high risk to harm self or others? To preserve the safety and trust of the confessional and to guard against entrapment you must know your boundaries and inform service members of your confidentiality boundaries before they begin talking, unloading and disclosing information you might feel obligated to report.

In this very deliberate framework a confessor with appropriate boundaries will be matched with the SM who is participating in the rite.

Just as is important for clergy and confidants to prepare by clarifying boundaries ahead of time, it is even more important to prepare for what you might hear in confessional dialogue. Training for clinical chaplains includes exposure to very sick and dying patients, burn patients, surgical procedures and the

like. Similarly, clergy hearing the confessions of service members will hear horrible things. Even seasoned confessors who have heard a lot are sometimes caught off guard by what they hear. By exposing yourself to some of terrible and repulsive things you could hear in confessional dialogue you will minimize the chance of damaging the person you are trying to help. Such exposure on the part of the listener is very important to insure that your reactions, verbal and non-verbal, don't add to already intense feelings of worthlessness and shame.

Even with extensive preparation will be times where it is appropriate to acknowledge the horror, repulsion and pain of the experience. An overly clinical and detached response can sometimes leave a person feeling alone in the experience. Empathy is important. After all, you are another human being hearing, imagining and bearing witness to moral injury directly associated with very traumatic material. If and when you do react (and sometimes you will) reassure the person that your reactions are not a judgment of their worth, but simply a normal human response to their experience.

Most contemporary confessional dialogue will tend to have a somewhat informal feel and occur perhaps around a coffee table, but face to face.

Instructions in the older rites say that the penitent may kneel. While this may be a custom in some congregations, think about the impact of posture or seating arrangements. The old image of the confessional booth and the curtain comes to mind. There might be some to considering a barrier that could add sense of anonymity, confidentiality and increase the sense of safety. In the public order of confession and forgiveness congregants stand. With a robed clergy "presiding" and "pronouncing" one can see parallels with a court setting as a person might stand before a judge or magistrate. What messages do these terms and clothing send? What do they say about the power differential? How might posture or seating arrangement affect the mood or disposition of those participating in the rite? Reflection and awareness of these dynamics can, at times, be important pastoral considerations. Normally a person wouldn't robe up. But, if you think it might help, give the SM the choice.

Conversation

Don't rush into the rite. Take time to prepare and compose yourself. Taking time to connect and some small talk and at the beginning of the rite can help reduce anxiety and promote the sense of safety for both you and the SM.

From your meeting with the SM and the caregiver you will have some sense of how the SM might respond to this time alone with you. If you know that the SM tends to be rather anxious read the caregiver instructions on anxiety. Those instructions will help tune you in and help you take preventative or remedial actions if necessary.

During confession – if you are doing a whole lot more than just listening something is wrong. While confession is indeed good for the soul, this is not a therapy session. After a person has confessed the liturgy contains a statement of contrition (sorrow for sins) and intent to improve. Depending on the emotional state of the penitent anxiety may present more strongly than sorrow or remorse. That's OK. Then, before absolution is pronounced there is a time in the rite for pastoral conversation.

While conversation before the rite may indeed help the penitent relax, feel welcome and contribute to the right mood, after confession is not the time for idle chit chat. The person has just confessed. And, while, up to this point, a lot of people are eager to have it over with, they are also usually genuinely interested in what you have to say.

Here are some guidelines.

1. Normally, the less said, the better.
2. Sometimes the penitent has entertains the false expectation that having received forgiveness from God entitles them to forgiveness from another person. (for example, an aggrieved spouse) Correct that misperception.
3. Sometimes a person will skirt a direct admission of guilt. Point it out and ask again if s/he is guilty of the offense. Sometimes yes / buts need to be explored because, in some situations sharing of guilt may be appropriate. At other times the person may simply be dodging or denying.
4. If avoidance and denial persist point it out. You may need to point out that there is important work to be done and gently but firmly end the session with the admonition to try again.
5. At the end of confession some people will ask how they did. That's normal. It's OK to affirm a good confession. But, no more.
6. Sometimes the penitent's confession shifts to grievance sustained. You may need to point out that, in addition to the items confessed, there may be more work to be done: letting go of resentments, hurt, anger, or forgiving someone else.
7. If the penitent starts playing the victim or is truly a victim and starts assuming blame for injuries received don't immediately intervene until you learn the faulty beliefs and false guilt you need to address in your conversation later.
8. In pastoral conversation it is sometimes helpful to ask what the person has learned? Ask what would s/he do differently?

While pastoral conversation may be helpful and appreciated – try to be as clear as you can on whose needs and agenda is being met – yours of the penitents.

It is important to stress that much of the time people many know exactly what they need to confess. If that's true, don't beat around the bush and proceed very quickly to absolution. When a person is prepared confession and absolution may be quite brief. That can be a good sign. You know a person is prepared when you move through the rite, transgressions are named, guilt is acknowledged, impacts on others are recognized. When that happens there is little need for explanation or conversation. Then forgiveness is pronounced, penance is imposed and the rite is over.

Brevity can reinforce that the function of guilt is simply to direct a person to learn from what happened and move on. This is healthy. Brevity, like the crisp rap of the gavel in the court room, reminds people that guilt is just a passing feelings related a forensic state and the feeling of guilt is simply there to teach you something, and forgiveness changes that state from guilty to pardoned. Brevity and a somewhat light-hearted change of conversation immediately following the rite can also be especially helpful modeling to the penitent who may have a tendency to obsess.

Confession is a great leveler. A colleague from Montana recalls how, as a little boy, everyone would go to confession about four times a year. He recalls sitting in church, swinging his little legs that still could quite reach the floor, sitting next to his uncle, Mother, Father and Grandfather. Here they were – all in the same boat – young and old alike. Confession was the great leveler – all equal in the eyes of God, all in need of forgiveness and grace.

Penance and Satisfaction

Pastoral conversation near the conclusion at the rite traditionally includes important spiritual direction. The penance, as it is sometimes called, is personally tailored to improve your relationship with God. Penance is “fruits that befit repentance” Luke 3:8; and may include prayer, devotional activity, an offering, a service project, something that entails sacrifice, etc. Matthew advocates secrecy and penance done secretly promotes spiritually healthy inwardness. Reception of penance given by the priest or pastor is a sign of willingness and consent to relate to God. The willingness and consent is symbolized by the penance.

Caregiver: Sometimes a rather dramatic penance can shake loose a person who is still stuck. Recall the movie The Mission. Acquitted of the killing, Mendoza spirals into depression. Father Gabriel, who has temporarily returned from his mission and learned of Mendoza's situation, visits and challenges Mendoza to undertake a suitable penance. Mendoza ties a rope around his waist and attaches the heavy armor and implements he used in war and climbs the steep mountain dragging the implements up behind him.

An act of (epitemia), is never formulaic, but rather is directed toward the individual and their particular problem, as a means of establishing a deeper understanding of the mistake made, and how to effect its cure.

Reconnecting

Your caregiver will talk with you about further amends, restitution or reparation. You might discuss the possibility of a service project that symbolizes and reinforces your reconnection with God and others.

If you have not been attending church or eucharist before this time your caregiver will extend an invitation to participate more fully in the life of the church.

If crowds are a problem for you and, if they were, they likely still are, your caregiver will discuss some strategies that will help you adjust and participate in this important aspect of congregational life. Your

caregiver may suggest that a supportive friend to accompany you. Sometimes sitting with a friend in a place where you can both leave unobtrusively if necessary can provide a necessary safety valve.

Involvement in a small group may be an intermediate step to worship in a larger context. Gradual, step by step exposure may be necessary. Remember, this is all the SMs choice.

If the SM chooses not to attend worship, affirm him / her.

Some may prefer to attend worship that has a more meditative, quieter format. Always remember, you are in charge.

Reconnection may include negotiating a few more meetings with the caregiver.

Discuss and listen as the SM makes decision about amends, reparation and restitution. You may need to remind the SM that s/he may not be able to make amends to people who have been harmed. They may not be available or it may not be appropriate.

But, amends can be very important to reconnection and meaningful participation in community life. Discuss different things, monetary gifts, service projects. Hands on projects, alone or working with others, often work very good for men wrestling with grief. By now you know the SM well and it will be easier to think of appropriate amends, restitution and reparation.

Consider referral to a group where the SM can both give and receive support.

Closure

Closure is very important. It's a time to celebrate. You have climbed your Mt. Everest, and in the process you have opened the door to a more meaningful and satisfying life for yourself and in relation to other.

Be sure to take time to remember and celebrate your accomplishments. This is a good time to review some of the highs and affirm the growth that took place through the lows.

It is also a time to remember and celebrate the grace that has been experienced. Of course, if prayer has been a part of your contract. A prayer of thanksgiving would certainly be appropriate.

Conclusion

By approaching confession and forgiveness from an ecclesial perspective we also want to share ecclesial wisdom that can also inform medical and mental health practitioners even as their work and research helps and improves the care of those working from a faith-based perspective.

We also believe that creative, intentional collaboration and partnerships between communities of faith, service members and their loved ones, medical practitioners, therapists, the Veterans Administration,

vet centers, employers, as well the legal system are required if service members and their loved ones are to achieve the goal of re-integration to a more satisfying life in the greater community.

We offer this training not only to provide strategies, skills and competencies to meet the above challenges, but to fulfill the church's historic mandate as a safe, hospitable place where all people can find spiritual hope and healing, peace and reconciliation, forgiveness and restoration.

This is an initial offering. It is not meant to be the final word, but intended to stimulate discussion and promote partnerships. It is meant to encourage research proposals on the subject and especially to motivate and educate clergy to regularly engage and practice this work. We hope that this offering will ultimately contribute to the improvement of pastoral practice and the quality of congregational care for all who suffer from the hidden wounds of war – especially war-related moral injury.

The healing of moral injury is a time-honored, historical practice rooted in the sacraments of the Church. We believe that renewal of the practice of individual confession and forgiveness is especially needed at this time. As traditional practices addressing moral injury in service members and veterans are updated and reinstated in parishes and congregations across America we trust that the rising climate for the care of those suffering from moral injury will be a positive leaven that will bring hope and healing to many. We invite and challenge you to learn more and engage with more confidence in this demanding yet rewarding work.

Helpful research, references and readings that relate to moral injury.

Currently, since moral injury is not a diagnostic category in the DSM-IV there is no direct research on the subject per se. We commend the following articles and resources to clergy for their bearing on the treatment of war-related moral injury:

1. *Moral Injury and moral repair in war veterans: A preliminary model and intervention strategy*, Brett T. Litz a,b, Nathan Stein, Eileen Delaney, Leslie Lebowitz, William P. Nash, Caroline Silva, Shira Maguen; *Clinical Psychology Review* 29 (2009) 695 – 706. The authors do an excellent job of summarizing relevant research that demonstrates the need for the treatment of moral injury as a special focus. They also cite extensive research that shows the direct link of morally injurious actions such as atrocities, perpetration, along with the normally prescribed killing and injuring that occurs in combat to more severe PTSD and depression with more intense suicidal / homicidal features. In addition they offer some very important insights and strategies that bear directly on forgiveness and the healing of moral injury. This article also cites research that suggests a rise in service members seeking help from the VA in dealing with guilt and loss of faith (Fontana Rosenheck, 2004). In our opinion the cumulative research also suggests that those service members with religious backgrounds may be even more at risk.
2. Catechism of the Catholic Church, Unites States Catholic Conference, Inc. – Libreria Editrice Vaticana, 1994. An online version of *Chapter Two: The Sacraments of Healing* may be accessed at the website of the United States Conference of Catholic Bishops with the following URL The website also contains informative articles on the practice of the Sacraments of Healing.
3. *Welcome Them Home – Help Them Heal: Pastoral Care and Ministry with Service Members Returning from War* by John Sippola, Chaplain, LTC, ret., M.Div., Amy Blumenshine, MSW, MA, Donald A. Tubesing, Ph.D., M.Div., Valerie Yancey, Ph.D., RN. The Wounds of War Assessment (WWA) on p. 104 is a screening tool designed to help service members and caregivers zero in on the precipitating events. The WWA can help a SM make the connection between specific events and moral injury. The WWA helps create the perception that the caregiver who administers it has heard these kind of things before and won't be overly shocked when they are disclosed.
4. *Beyond the Yellow Ribbon: Ministering to Returning Combat Veterans* by David A. Thompson and Darlene Wetterstrom.
5. King's Centre for Military Health Research: *A fifteen year report on what has been achieved by fifteen years of research into the health of the UK Armed Forces?* September 2010. <http://www.kcl.ac.uk/kcmhr/Reports/15%20Year%20Reportfinal.pdf> In a telephone survey of active reservists in the UK researchers discovered that "only a quarter of those with common mental disorders and still serving in the military were receiving any form of medical professional help. Instead, non-medical sources of help such as chaplains / padres were more widely used."
6. *Spiritually modified cognitive therapy: a review of the literature*, Social Work, 2006, by David R. Hodge

7. *Reintegration Problems and Treatment Interests Among Iraq and Afghanistan Combat Veterans Receiving VA Medical Care* by Nina A. Sayer, Ph.D., Siamak Noorbaloochi, Ph.D., Patricia Frazier, Ph.D., Kathleen Carlson, Ph.D., Amy Gravely, M.A., and Maureen Murdoch, M.D., M.P.H. published by PSYCHIATRIC SERVICES, ps.psychiatryonline.org, June 2010, Vol. 61, No.6. One of the key findings among Iraq-Afghanistan combat veterans who already receive VA medical care with multiple current reintegration problems (ie... especially those with the probability of PTSD) is the desire for services and information to help them readjust to community life.
8. *Purity of Heart is to Will One Thing: Preparation for the Office of Confession* by Soren Kierkegaard, Harper and Rowe, 1956
9. *Lost Icons: Reflections on Cultural Bereavement* by Rowan Williams, Morehouse Press, 2000.
10. *Working with Relapse Groups: The use of metaphor, paradox and creative teaming* by Linda Atkinson, John Shelton and John Sippola, 1990, unpublished manuscript.
11. *Transformational Reminiscence: Life Story Work* by John Kunz and Florence Gray Soltys, Springer Publishing Company, 2007 pps. 181-196 Chapter Ten, *Traumatic Memories and Life Review* contributed by Marvin J. Westwood and Holly B. McLean.
12. *Ethics* by Dietrich Bonhoeffer, Fortress Press, Minneapolis, 2005.
13. *GOD – The World’s Future: Systematic Theology for a New Era* by Ted Peters, Fortress Press, 2000. (Second Edition)

APPENDIX A

Sex Stuff, Little Things and Risk of Suicide / Homicide

For many, moral injury around certain sexual behaviors is very hard to acknowledge and admit. Military codes of conduct prohibit fraternization and harassment, and, if found out, serious legal consequences may occur. Caregivers need to be prepared to hear stories of harassment and rape and be prepared for the raw expression of shame, worthlessness and guilt colored by extreme vulnerability and fear.

Sexual indiscretions, fraternization and affairs are common in war. Why is this? Couples are separated for long periods of time. Sexual tensions rise. Both men and women regularly attest to strong, overpowering sexual urges associated with danger, death and destruction – especially in a war environment. These urges exacerbated by the ongoing need for comfort, consolation and the thirst for human touch all combine and contribute to produce rarified sexual environment. In this environment the theatre of war is also a playground for predation, and the lack of support for victims of sexual assault adds an even grosser moral insult to already gross moral injury.

While understandable in stressful circumstances, the service member may still in his or her conscience, regard their behavior as moral failure – especially after the fact.

Sometimes it’s the Little Things

I have known service members who can talk matter-of-factly about running down civilians with their tanks and convoys and compartmentalize these experiences as just part of the nasty business of war, while others having a similar experience suffer from the memories. Moral injury is not just related to one's personal values. A more sensitive person may be more affected by a less intense experience. Others may surprise you by what bothers them. One soldier, with extensive combat experience had no guilt or shame about his involvement in killing, but he did express shame and remorse as he reported stealing a small amount of money from his buddy. He didn't have trouble with the killing. But, he did have a lot of trouble with the stealing.

What to do with Disclosures of Suicidal / Homicidal Impulses

Disclosures that will cause some confessors the most discomfort are the spontaneous or calculated admissions of suicidal or homicidal impulses. They should cause discomfort, especially when they have even the barest outline of a plan. When a person discloses anything that indicates the serious and immediate potential to harm one's self or another person it is important for the caregiver to understand that they have chosen to move beyond the confines of confidential dialogue. This is almost always a cry for help. Treat it as such and be prepared so that you can intervene.

If you are already in a safe and secure setting (for example, a clinic or hospital) let the person know how important it is for him / her to address these suicidal and / or homicidal feelings and impulses with a therapist so as not to add more trauma by inflicting more harm to one one's self or another person. Guard against exploiting the person's vulnerability to pressure into disclosure of incriminating content, but reassure the person that there are confidential therapeutic ways to discretely address the content fueling these impulses, ways that can offer protection both for one's self and for others. Then, escort the person directly to a therapist or qualified hospital staff. Then sit and support the person (prompting when necessary) while s/he talks about these impulses and plans. This is a judgment call, but a critical one that confessors need to be prepared to make.

It is important to note that if you are not in a secure setting, escort the service member personally to a mental health clinic or a VA center – even if it means a long drive. Sit with the service member as he or she talks and discloses the suicidal / homicidal impulse and plan with a therapist or qualified staff.

In a very few rare instances someone with psychopathic tendencies will disclose something to intimidate and watch a confessor squirm. You will know the difference because the disclosure will be accompanied by an invitation to secrecy usually with veiled threat. If this happens do not feel ashamed to expand the boundaries of confidentiality to include a trusted and wise colleague who can help determine the level of risk and decide what to do.

Homicide / Suicide Safety Precautions (for caregivers)

Assessing and managing the risk of suicide and homicide are important skills for clergy and caregivers in general. But SMs seeking forgiveness are at higher risk for suicidal and homicidal impulses when associated with depression and especially when the SM abuses substances (usually alcohol). Excessive

fear, shame and guilt associated with moral injury can sometimes spike into a suicidal / homicidal (major depressive) episode.

Clergy / caregivers need to get comfortable having frank conversations with SMs and their loved ones about suicide / homicide. Basic training in suicide screening, assessment, action and prevention protocols are needed:

1. to ascertain and address immediate risk and
2. to address and prevent potential suicide risk during treatment of Moral Injury.
 - a. Education of SM and LO
 - b. Development of suicide / homicide prevention plan with LO.

Explain that during this process occasionally strong suicidal and homicidal impulses can surface and you need to ask some important questions to determine the level of risk. Explain that the questions are not meant to be shaming or blaming in any way but are meant to assess possible risks and help institute suicide / homicide safety precautions.

Ask the SM if s/he has ever thought about killing themselves or others. If they say they have, you need to tell them that you need to take important suicide homicide precautions before going through this process. When you are giving the following instructions pay attention to the SM. Sometimes a person will fuzz out when talking about suicide. You may need to repeat what you say.

Explain again that sometimes the material s/he is dealing with may be indirectly or directly connected with suicidal thoughts. Ask directly if there is any kind of a connection with suicidal thought to the kind of moral injury s/he is dealing with. Ask three things. Ask how strong those impulses are, how often they occur and how long they are when they do occur.

Explain that the risk of suicide / homicide is higher when a person has considered it before and, especially with men the risk of homicide followed by suicide is higher, and that it is important for you to have this conversation ahead of time to institute preventative measures and safety precautions.

If a person has strong impulses ask if s/he has ever talked about it with a therapist. Hear the SM out. If you have any reasonable doubts that the SM is at explain that you need the SM to get a good handle on this and s/he needs to get a good assessment before you go on. If the SM has had a strong suicidal impulse within the last two week escort the SM to a place where s/he can get an assessment and be stabilized.

Here are some following precautions:

1. Instruct the SM that if s/he has any suicidal or homicidal thoughts s/he is to call you immediately. If you are not available s/he need to call the suicide prevention hotline.
2. If s/he is close to a hospital or mental health facility s/he should to go the emergency room immediately.
3. Spouses need to be instructed to politely, but firmly disengage and walk away. She (normally it's a she) may need to leave the premises and must do so if he has had some alcohol. Whatever she

does it is important not to escalate things. Arguing, getting in his face, raising her voice can be very dangerous when someone is having a homicidal episode. If the couple tends to fight then they may need some practice sessions where she walks away. This will also be good for their relationship in general.

4. Ask if there is any alcohol use. If so, explain that during this process guns need to be removed from the house. If it is hunting season, provisions can be made for hunting. But, removing potential means is important – especially for SMs.
5. Ask if the person is on any medications. If so ask him to double check if there is any risk of side effects that could potentially be suicidal. If so then be sure to institute these precautions during this process.
6. Tell the SM that the next question is not meant to shame or blame anyone, but needs to be asked because it is important suicide / homicide risk assessment question. Check to see if there is any history of shouting, yelling or hitting in the relationship. If there is then explain that the couple must practice suicide / homicide prevention strategies as part of the process. Any hitting must be reported to the caregiver.
7. Again, remind the SM that this is not meant to be shaming. If there is yelling, shouting, or hitting in the relationship ask if alcohol or drugs are ever part of the process. Ask if it makes things worse (it almost always does). Remind the SM that alcohol / drugs takes away the inhibitions and risk of suicide / homicides rise significantly when alcohol or drugs are used. Ask directly, in the presence of the significant other, if possible, if drugs or alcohol cause problems in the relationship. Ask a couple of key screening questions. Ask about use patterns and blackouts. If you suspect a significant problem be very firm about a CD screening before starting this process.
8. If there are any suicidal / homicidal thoughts ask that the SM either use only at mealtimes, but abstain from drinking in the evenings. Total abstinence may be best. If alcohol or drugs ever cause escalation in an argument during this process they are to call you.

Example: A colleague I know was on medications and one evening he suddenly had strong impulse to kill his wife. (A side effect of the medications he was on.) He started to go after his wife verbally. His wife, a retired counselor, had the common sense to just walk away. He considered committing himself, but the impulse subsided and he was able to regain composure. He talked to the doc about it and the meds were adjusted.

It is very important that caregivers understand that this population is at higher risk for suicide / homicide. And, as tragic as it can be, people sometimes do succeed in killing themselves and / or someone else. Suicide / homicide precautions with this cohort of SM are important. Be sure to take them.

An SM may ask you if s/he kills himself will s/he go to hell. Answer immediately, “If you do, Yes! It’s premeditated! “ In order to add a layer of prevention this would be one time to ‘play the hell card’.

ANXIETY SCREENING (GAD-7)

How often during the past 2 weeks have you felt bothered by:

1. Feeling nervous, anxious, or on edge?

0 = not at all 1 = several days 2 = more than half the days 3 = nearly everyday

2. Not being able to stop or control worrying?

0 = not at all 1 = several days 2 = more than half the days 3 = nearly everyday

3. Worrying too much about different things?

0 = not at all 1 = several days 2 = more than half the days 3 = nearly everyday

4. Trouble relaxing?

0 = not at all 1 = several days 2 = more than half the days 3 = nearly everyday

5. Being so restless that it is hard to sit still?

0 = not at all 1 = several days 2 = more than half the days 3 = nearly everyday

6. Becoming easily annoyed or irritable?

0 = not at all

1 = several days

2 = more than half the days

3 = nearly everyday

7. Feeling afraid as if something awful might happen?

0 = not at all

1 = several days

2 = more than half the days

3 = nearly everyday

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

Scoring: Add the results for question number one through seven to get a total score.

If you score 10 or above you might want to consider one or more of the following: discuss your symptoms with your doctor, contact a local mental health care provider or talk with your pastor or parish nurse. Although these questions serve as a useful guide, only an appropriate licensed health professional can make the diagnosis of Generalized Anxiety Disorder.

Primary Care PTSD Screen (PC-PTSD)

The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the VA. The screen includes an introductory sentence to cue respondents to traumatic events. The authors suggest that in most circumstances the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any 3 items. Those screening positive should then be assessed with a structured interview for PTSD. The screen does not include a list of potentially traumatic events.

Instructions

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?

YES / NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

YES / NO

3. Were constantly on guard, watchful, or easily startled?

YES / NO

4. Felt numb or detached from others, activities, or your surroundings?

YES / NO

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items.

Patient Health Questionnaire – PHQ-9

Patient name: _____ Date: _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
a. Little interest or pleasure in doing things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling/staying asleep, sleeping too much.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching TV.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult
at all

Somewhat
difficult

Very
difficult

Extremely
difficult

TOTAL SCORE _____

Instructions – How To Score The PHQ-9

Major depressive disorder is suggested if:

1. Of the 9 items, 5 or more are checked as at least ‘more than half the days’
2. Either item a. or b. is positive, that is, at least ‘more than half the days’

Other depressive syndrome is suggested if:

1. Of the 9 items, a., b., or c., are checked as at least ‘more than half the days’
2. Either item a., or b. is positive, that is, at least ‘more than half the days’.

Also, PHQ-9 scores can be used to plan and monitor treatment. To score the instrument, tally each response by the number value under the answer headings, (not at all=0, several days=1, more than half the days=2, and nearly every day=3). Add the numbers together to total the score on the bottom of the questionnaire. Interpret the score by using the guide listed below.

Guide for Interpreting PHQ-9 Scores

Score	Action
0-4	The score suggests the patient may not need depression treatment
5-14	Mild major depressive disorder. Physician uses clinical judgment about treatment, based on patient’s duration of symptoms and functional impairment.
15-19	Moderate-major depressive disorder. Warrants treatment for depression, using antidepressant, psychotherapy or a combination of treatment.
20 or higher	Severe major depressive disorder. Warrants treatment with antidepressant, with or without psychotherapy, follow frequently.

Functional Health Assessment

The instrument also includes a functional health assessment. This asks the patient how emotional difficulties or problems impact work, things at home, or relationships with other people. Patient responses can be one of four: Not difficult at all, Somewhat difficult, Very difficult, Extremely difficult. The last two responses suggest that the patient’s functionality is impaired. After treatment begins, functional status and number score can be measured to assess patient improvement.