The Veteran Spiritual Struggle

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Although a considerable body of literature has been devoted to examining the physical, psychological, and social needs of veterans after their return from deployment, relatively little is known about the spiritual struggles some veterans face. In this article, we review what we know about this spiritual struggle, highlight the relevance of spirituality in clinical practice, and show examples of how a veteran’s spiritual struggle may simultaneously present alongside different suicide risk factors. Suggestions for handling this spiritual struggle are then made.

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In recent years, an unprecedented amount of time, effort, and other resources have been devoted to ensuring that former military personnel have access to health care and other supportive services (Department of Defense, 2014; The White House, 2014). As our nation strives to keep its promise “to care for him who shall have borne the battle” (Department of Veterans Affairs, 2009), our understanding of the many challenges veterans face on returning home from deployment has grown. Now more than ever, we understand and are able to more effectively respond to the diverse physical, psychological, and social concerns faced by returning veterans (Keane et al., 2013; Spelman, Hunt, Seal, & Burgo-Black, 2012). However, our understanding of the spiritual struggles some veterans face as well as the health implications of these struggles remains in its infancy.

Spiritual struggles—as with all struggles across the bio-psycho-social spectrum—represent a problem affecting the whole person (Puchalski, Vitillo, Hull, & Reller, 2014; Puchalski, 2001). Not surprisingly, supporting spiritual health and well-being is recognized as part of a comprehensive approach to suicide prevention (Department of Health and Human Services Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012). Spiritual well-being is thought to mitigate suicide risk by helping reduce dissonance in how one perceives, engages with, and experiences the external world (Kopacz, Silver, & Bossarte, 2014). However, limited guidance is available to clinicians in terms of recognizing and supporting veterans who may be struggling spiritually. In this article, we aim to review what we know about this spiritual struggle, highlight the relevance of spirituality in clinical practice, and show examples of how a veteran’s spiritual struggle may simultaneously present alongside different suicide risk factors. Suggestions for handling this spiritual struggle are then made.
A Veteran’s Spiritual Struggle

One empirically clarified definition of spirituality sees it as “a personal search for meaning and purpose in life, which may or may not be related to religion” (Tanyi, 2002, p. 506). Using this definition as a foothold, one can begin to conceptualize the spiritual struggle some veterans face. Attempts at meaning making are well documented in veteran populations, especially among those dealing with wartime trauma (MacDermott, 2010; Owens, Steger, Whitesell, & Herrera, 2009; Steger, Owens, & Park, 2015). Where old meanings fail to provide comfort and solace, they are left to look for new explanations, values, and beliefs (Taylor & Sherr, 2008; Williams, 1983). Veterans dealing with a substance use disorder may also report longing for a sense of meaning and purpose (Allen, Nieuwsma, Pollitt, & Blazer, 2014). Veterans are also known to actively seek-out pastoral care services for religious/spiritual as well as mental health support (Blosnich, Kopacz, McCarten, & Bossarte, 2014; Kopacz & Karras, 2014; Nieuwsma, Rhodes, Cantrell, et al., 2013; Nieuwsma, Rhodes, Jackson, et al., 2013). Pastoral care is defined as “a therapeutic modality distinguished by the dialogue of caregiver and careseeker that explores the possibility and implications of a religious definition of the latter’s situation” (Furniss, 1994, p. 177).

Veterans from various service eras have articulated the face validity of this spiritual struggle. Jesse Glenn Gray, a World War II combat veteran, wrote:

I strive to see at least my own life as a whole and to discover some purpose and direction in at least the major parts. Yet the effort to assimilate those intense war memories to the rest of my experience is difficult and even frightening. Why attempt it? Why not continue to forget? ... What protrudes and does not fit in our pasts rises to haunt us and make us spiritually unwell in the present. (Gray, 1959/1998, pp. 23–24)

Randy Way, in describing his combat experiences in Vietnam, talks about how “the biggest thing I can think of is this feelin’ so alone. I didn’t feel God. I didn’t even feel my friends right there. I just felt alone” (Berman, 1990, p. 77). With powerful eloquence, Daniel Somers, a soldier who served in post9/11 Iraq, also described how “there are some things that a person simply cannot come back from” (Somers, 2013). Daniel Somers tragically died by suicide in 2013.

Veteran Spirituality and Suicide

“Religious or spiritual problems” have been formally identified as an area of clinical concern (American Psychiatric Association, 1994). Spirituality also features within the bio-psycho-social model of health and illness (Engel, 1980, 1977; Smith, 2002). A preponderance of evidence finds spiritual well-being to be positively linked with health and inversely related to a number of pathologies (Miller & Thoresen, 1999; Koenig, King, & Carson, 2012). Different aspects of spiritual functioning (e.g., meaning, values, beliefs, and forgiveness) are also recognized as being essential for health outcomes research (Fetzer Institute, National Institute on Aging Working Group, 2003). Accordingly, the spiritual needs of veterans will not necessarily run separate from their clinical needs. As applied in clinical practice, we contend that assessing for and addressing the spiritual needs of their patients/clients remains the domain of all clinical service providers.

Preliminary cross-sectional research has suggested that a veteran’s spiritual struggle may be related to suicidal behavior. In one study, veterans who scored higher on a spiritual distress scale were found to have increased odds of being identified with a suicide risk factor (e.g., suicide ideation, social isolation) (Kopacz, Hoffmire, Morley, & Vance, 2014). In another study, veterans with a history of suicide ideation consistently self-rated their spiritual health as worse than that of nonideators, even when considering differences in spiritual devotion and significance ascribed to spirituality (Kopacz, 2014). Such studies, however, are not without their limitations, especially as related to the various interpretations of what falls under the domain of spirituality as well as methodological and conceptual limitations related to measuring spirituality (Koenig et al., 2012).

Spirituality in Clinical Practice

A number of genetic, neurologic, psychological, social, and cultural covariates are associated with suicidal behavior (Knox & Bossarte, 2012). Available research suggests that select suicide risk factors may be grounded in both clinical and spiritual contexts. Mitigating a given risk factor could then require remaining attentive to both of these contexts. For example,
experiences of guilt have been associated with an increased risk of suicidal behavior in veteran populations (Bryan, Morrow, Etienne, & Ray-Sannerud, 2013; Ganz & Sher, 2013; Hendin & Haas, 1991). Such guilt may be grounded in religious contexts (Exline, Yali, & Sanderson, 2000). Veterans with frequent experiences of guilt will sometimes name God as the main source of this emotion (Kopacz, McCarten, Vance, & Connery, 2015). In such cases, it might be prudent to complement clinical services with support from pastoral care providers (Farrell & Goebert, 2008; Weaver, Flannelly, Flannelly, & Oppenheimer, 2003). Some veterans may even prefer religious counseling over formal mental health services (Greenawalt et al., 2011). Chaplains affiliated with the U.S. Department of Veterans Affairs (VA) report that veterans at increased risk of suicide will oftentimes voice difficulties dealing with guilt (Kopacz, 2013).

Guilt also features prominently in moral injury, an emerging clinical construct observed in current and former military personnel. Moral injury refers to "a syndrome of shame, self-handicapping, anger, and demoralization" (Gray et al., 2012, p. 408) resulting from "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" (Litz et al., 2009, p. 700). Examples of morally injurious events include acts of betrayal and violence (Drescher et al., 2011). A relationship linking moral injury with suicidal behavior has been suggested (Maguen et al., 2012; Currier, Holland, Drescher, & Foy, 2015).

Veterans dealing with posttraumatic stress disorder (PTSD) are also recognized as being at increased risk of suicide (Pompili et al., 2013; Rozanov & Carli, 2012; Sher, Braquehais, & Casas, 2012). Several studies have reinforced the spiritual dimension of PTSD. For example, select dimensions of spiritual functioning have been used to predict PTSD symptom severity (Currier, Holland, & Drescher, 2015). Negative religious coping and forgiveness problems have been associated with greater PTSD symptom severity and chronicity (Currier, Drescher, & Harris, 2014). The search for meaning, experiences of guilt, and weakened religious faith also motivates some veterans to seek treatment for their PTSD (Fontana & Rosenheck, 2005, 2004). In a sample of Croatian veterans diagnosed with PTSD, spiritual well-being was found to be protective against suicide (Nadam et al., 2008). Ed Tick, a clinical psychotherapist with extensive experience in supporting veterans, summarized the unique nature of PTSD as “primarily a moral, spiritual, and aesthetic disorder—in effect, not a psychological but a soul disorder” (original author’s emphasis; Tick, 2005, p. 108).

The spiritual struggles of some veterans do not necessarily end in the near-term following their return from deployment. Spiritual struggles may continue and/or resurface throughout the life of the veteran. Older combat veterans represent a notable group in this regard. Research has identified that spiritual concerns often arise from changes in life roles and relationships (Pinquart, 2002). For many older adults, the death of a spouse/partner or friend, the departure of children, retirement, changes in physical ability, and/or increases in medical problems can lead to deeply spiritual questions such as “Who am I now?”, “What’s the purpose of life?”, and “What is my role in the future?”. Perceived losses of purpose and meaning in older age are associated with higher levels of depression (Hedberg, Gustafson, Alex, & Brulin, 2010; Johnson et al., 2011) as well as increases in suicide ideation (Heisel & Flett, 2006). Social isolation from others, independent of depression, also seems to have a hand in increased suicide attempts in older age (Wiktorsson, Runeson, Skoog, Östling, & Waern, 2010). Older veteran suicide decedents are more likely to have had physical health problems, less likely to have had a history of suicide attempts, and more often used a firearm at the time of suicide (Kaplan, McFarland, Huguet, & Valetstein, 2012).

Using the case of a veteran named “John” (vital details changed to ensure patient anonymity), we illustrate the example of how spiritual struggle may manifest itself in older veterans as a loss of personal meaning and purpose in life. John was a 66-year-old retired Marine, who was deployed overseas for about three years during the Vietnam War. After his return home, he was troubled by symptoms of PTSD, including nightmares, hyperarousal, and trouble controlling intrusive memories of war. After seeking treatment, John learned to cope reasonably well with his trauma, with only occasional upsurges of discomfort. As the years progressed, unexpected changes in his life brought on new concerns. His wife of many years asked for a divorce, his child moved away, and his worsening health required him to take an unwelcomed early retirement. John found that with
more time on his hands his PTSD symptoms seemed to bounce back. Of all these life changes, the worst was that John floundered with a lost sense of identity. It occurred to him that he was no longer a husband, soldier, worker, or, seemingly, even a father. He complained of a sense of purposelessness and poignantly confided in his mental health care provider “Life is just filled with days . . . what is the point of going on?” One day, John retreated to his shed where he took his own life.

Handling Spiritual Struggles

Taking a spiritual history may be particularly advantageous for clinicians who suspect that their veteran-patients/clients may be struggling spiritually. The inherent value of taking a spiritual history lies in “engaging people as equals in enquiry and discussion, using their own words, about what—at the deepest level—makes sense to them and what puzzles them, what motivates them and what holds them back” (Culliford, 2007, p. 213). Several frameworks have been proposed for taking spiritual histories, such as SPIRIT (Maugans, 1996) or FICA (Puchalski & Romer, 2000).

Where unmet spiritual needs may be identified, clinicians should consider offering complementary support options appropriate to the needs and desires voiced by the veteran. One option may include chaplaincy services, a support option with which many current and former military personnel are familiar (Nieuwsma et al., 2014; Kopacz, O’Reilly, et al., 2014). Veterans at increased risk of suicide will oftentimes look to chaplains for support (Kopacz & Pollitt, 2015; Kopacz, McCarten, & Pollitt, 2014). A number of complementary and alternative medicine modalities also fall under the rubric of “spiritual care” (Ellison, Bradshaw, & Roberts, 2012). However, only limited literature is available to guide the evidence-based applicability of these different modalities in veterans. Mindfulness-based modalities have shown particular promise in veteran populations dealing with PTSD (Bergen-Cico, Possemato, & Pigeon, 2014; Lang et al., 2012; Pigeon, Allen, Possemato, Bergen-Cico, & Treatman, 2014). There may also be therapeutic value in developing certain practices grounded in different spiritual/religious traditions, such as forgiveness or gratitude (Sansone & Sansone, 2010).

As increasing numbers of veterans return home from deployment, responding to their unique health care needs will remain a challenge for all clinical service providers. In this article we outlined the spiritual struggles some veterans face on their return home from deployment. The hope was to highlight the relevance of this struggle to general health and well-being as well as to suicide prevention efforts. An additional hope was to spur discussion related to this spiritual struggle and encourage additional research to identify strategies which could be used to most effectively help veterans in times of distress or crisis.

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