Battle scars: Veterans turn to clergy for counseling

by Jane Donovan in the February 8, 2012 issue

When Mike walked into my office for an academic advising appointment, I knew something was wrong. His normally pale face was a deep lobster red. His hair was mussed, and he was carrying a large, empty cardboard box. Instead of discussing his courses he rambled incoherently about a trio of ducks that were following him around the university campus. The purpose of the box, he said, was to help him catch the ducks, take them to the banks of a nearby river and release them so that they would stop bothering him. It gradually dawned on me that he was hallucinating.

As the semester progressed, Mike's mental health deteriorated dramatically. He was expelled from two of his classes, was arrested in the student union for being disruptive, and then discharged a fire extinguisher in the back of a police car. I began to receive calls, visits and e-mails from distraught students who were in his classes. They were afraid of Mike and wanted him removed from campus. I followed the standard procedures for a student crisis, working through the university system to address Mike's situation. But as his condition rapidly worsened, the Lutheran campus chaplain decided to call Mike's parents, who rushed to campus and located a facility with the kind of mental health services that Mike so desperately needed. Mike was hospitalized for ten weeks, then took a leave of absence from the university.

Mike is one of thousands of veterans of the wars in Iraq and Afghanistan who have attended or are attending college on the new GI Bill. As a large, public university in the American heartland, West Virginia University has had significant numbers of student veterans on its campus for several years, and many of them are struggling with religious concerns and psychological conditions. The university has gone to great lengths to support its student veterans, offering veterans-only sections for some classes, an Office of Veterans Affairs to help them with GI Bill paperwork, and a student veterans club where they can meet and socialize. They are eligible for psychological services through the student mental health clinic.

As a faculty member and academic adviser, I've had several worrisome experiences with student veterans. As I search for resources to help me deal more effectively with their needs, I've realized that the United States is at the beginning of a crisis in caring for this generation of veterans.

The *Washington Post*'s 2007 series on poor conditions and insensitive care at Walter Reed Army Hospital included the story of a West Virginia veteran of the Iraq War who committed suicide while he was hospitalized. Members of the state legislature were shocked by the article and contacted the U.S. Department of Defense to request information on West Virginians who were serving in Iraq and Afghanistan. They asked how many were serving, how many had died as a result of their military service and how many were wounded. The Defense Department could not or would not answer their questions, so the legislature commissioned WVU psychology professor Joseph Scotti to study the mental health needs of veterans living in West Virginia. His findings are relevant for all of America's small towns and rural areas.

Scotti's study suggests that rural veterans may have significantly higher rates of posttraumatic stress disorder (PTSD) and clinical depression than other veterans. His research team mailed questionnaires to 6,400 veterans in the state's database of persons who have received one-time financial bonuses for military service, and the team received 1,058 completed surveys—a surprisingly high response rate. Nearly half of the respondents' answers suggested that they suffer from PTSD and/or depression. Scotti notes that many of the 50 percent who don't have a diagnosis of PTSD/depression still may need mental health services for conditions such as traumatic brain injury (TBI), panic disorder or generalized anxiety disorder. Veterans who live in rural areas—communities of 2,500 residents or fewer—have an even higher rate of PTSD/depression: 56 percent.

Although 82 percent of respondents said that professional mental health services are available to them, only 26 percent have sought care from a professional provider. Instead, 33 percent have sought out clergy for help. The more rural the area in which the veteran lives, the more likely he or she is to seek care from local clergy rather than from a mental health professional.

In general, veterans are hesitant to seek care from a mental health professional for two major reasons: stigma and access. Active-duty troops fear that they will be regarded as weak or unreliable and that their careers may subsequently be affected. Soldiers who are near the end of their tours of duty fear that admitting a mental health problem could delay their return home. Janet Salbert, pastor of a United Methodist church located a few miles from the Pentagon, confirms these assertions. She reports that veterans in her congregation are considerably more willing to seek help from the church. "For some of these folks, in the jobs they do in the military, there is an issue of confidentiality, but they also have an almost wordless allegiance to the military culture," Salbert said. "To come back and open that up is problematic. When veterans are in a room together, they are free to talk. Otherwise, they are not." In a public relations effort intended to encourage soldiers to seek mental health care, U.S. Army four-star general Carter Ham announced in *USA Today* that he has PTSD and has received counseling—not from a mental health professional, but from a military chaplain.

Access to care is also problematic. The Veterans Administration operates the largest health care system in the United States and includes hospitals, outpatient clinics and community-based clinics with specialized programs for PTSD, but many veterans resist VA care. Eligibility rules, complicated insurance arrangements and concerns about the quality of VA care can be discouraging. Some small-town veterans worry, probably unnecessarily, about issues of confidentiality. One veteran fretted, "My mom's next door neighbor works at the VA hospital. Does she have access to my file? Will she tell my mom what's in there?"

In rural areas, the disincentives are hard to overcome. Even though West Virginia boasts four VA hospitals, seven vet centers and two mobile vet centers, some areas of the state are too remote for this governmental network to reach. Parts of the state are more than three hours' drive from the nearest veterans' facility, with no public transportation available. The West Virginia legislature recently appropriated $240,000 to fund four clinical social workers, one for each of the VA hospitals, to reach out to veterans in remote areas. The hospitals also provide drivers. Even so,

some veterans still resist treatment.

Issues of stigma and access aside, the preference for pastoral care is well known in West Virginia. A licensed clinical social worker with the Veterans Administration hospital in Huntington, West Virginia, has publicly admitted that she regularly refers her patients to the hospital's chaplain or other clergy for "talk therapy." This is worrisome, as most clergy are not ready for the challenge of pastoral care and counseling for veterans who suffer from the complexities of PTSD, TBI, depression and other combat-related conditions. Very few clergy are trained mental health professionals. Ministers in denominations that require a seminary education have probably taken courses in pastoral care and completed some clinical pastoral education. But a significant percentage of the clergy in rural areas have no seminary education because their denominations and independent churches have no educational requirements for ordination. What resources, other than compassion, do they have for dealing with the mental health needs of a returned veteran who has been diagnosed with PTSD, TBI and/or depression?

In some parts of the country, caring for veterans of Iraq and Afghanistan is further complicated because many of them—more than 500,000 American combatants—were in the National Guard rather than the regular military. National Guard units normally report to the governors of the states in which they are located and deploy in situations of domestic emergency, mostly natural disasters. They report to the president of the United States in time of war, but before September 11, 2001, it was highly unusual for National Guard units to be deployed in overseas combat. Members are civilians who are employed in civilian jobs. They enlist expecting to be "weekend warriors" who train one weekend a month and are called out in a natural disaster or other national crisis.

But in the last ten years, for the first time in U.S. history, tens of thousands of National Guard members have been used as frontline combat troops, many of whom have deployed two or even three times. Some return home to find that their jobs have been filled, and they cannot find new employment in the recession. Adding to the stress of unexpected deployments is their length and frequency, often with little respite between call-ups. When they do return, National Guard units do not go to a military base but to their families and their predeployment life. They have no buffer zone, no compound full of other soldiers with whom they've shared experiences of combat and lengthy separations from their loved ones, no doctor's office or mental health clinic on the property. The abrupt change from full-time soldier to full-time

civilian is so disorienting that it takes weeks if not months before some veterans can work up the psychological strength to seek the counseling they need.

The good news is that resources for clergy are beginning to become available. Several accredited seminaries, including Wesley Theological Seminary, Iliff School of Theology and the Lutheran Theological Seminary at Philadelphia, are offering D.Min. programs for military chaplains. Routledge, Abingdon and other religious publishers are starting to produce books and other materials for clergy who are working with veterans. William Sean Lee, a chaplain with the Maryland National Guard, developed the Partners in Care program, which connects local congregations to National Guard troops and their family members in need of help and support; it has been adopted by the Guard in other states and shows great promise in helping to break down barriers of isolation for those who are not on or near a military base. Barbara Van Dahlen's Give an Hour program encourages mental health professionals to donate one hour of psychotherapy each week to a veteran. Kyria Henry, the daughter of a Vietnam veteran, founded paws4vets, which trains and places service dogs as companion animals for veterans who suffer from PTSD, TBI and other combat-related physical and psychological conditions.

These programs are effective and helpful, but we also need resources that address the spiritual concerns of combat veterans. Nearly every veteran with whom I've talked carries a burden of guilt about actions he or she took in Iraq or Afghanistan, such as a split-second decision to open fire in an uncertain circumstance that led to the death of a civilian. Others are haunted by atrocities they discovered: the practice field where the Iraqi national soccer team was executed, or the gas chamber in which Saddam Hussein's troops executed Kurds during the first Gulf War. These veterans fear for their souls and long to experience God's grace and forgiveness.

In an effort to respond to their needs, I developed an interventional Bible study curriculum using scriptures associated with the Babylonian exile of ancient Israel. I've taught it several times to groups of veterans, and they've responded positively. Bible study gets veterans talking about their combat experiences in a safe, comfortable place with other veterans who understand them, and it encourages them to bring God into the conversation. Every such initiative, no matter how modest, is a tool that can help build a safe haven for a traumatized veteran.

Mike's story has a happy ending, at least so far. He returned to classes in January 2009 and graduated from WVU. He is gainfully employed, faithfully takes his prescribed medications, understands the vigilance necessary to keep his conditions

under control and is happy and productive. But for every Mike there are also many other men and women struggling to integrate their combat experience into their lives. Ready or not, the church will be asked to help them.