

# Chaplaincy and health care in the ADF: the relationship between body, mind and soul

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**BOTH CHAPLAINS** and health care providers have important roles in caring for service personnel before, during and after deployment operations. Here, I draw on my personal experience as the Chaplain to the Force Level Logistic Asset rotation 4 (FLLA-4) in the Middle East Area of Operations (MEAO) from February to August 2008. My aim is to explore where the relationship between Australian Defence Force health care providers and chaplains can be enhanced, in order to provide more holistic care for deployed members and their families.

The FLLA is the gateway for most Australian personnel entering and exiting the MEAO and provides induction training to the theatre of operations. Personnel also transit through the FLLA as they return to Australia for health or welfare issues or to take leave. I was located in the Regimental Aid Post with the medical and psychology teams, with whom I worked closely. The major component of my chaplaincy role was the provision of pastoral care and counselling. During my deployment I identified a number of issues that I believe merit discussion and debate, and I will seek to tease these out in light of the contribution that chaplains can make to the holistic care of service members both on operations and in Australia.

## Chaplaincy practice in the operational environment

Operational service is an environment where chaplains must grapple with the moral conflict of serving the God often portrayed as a God of peace and love, while also serving the military, an organisation whose purpose must ultimately be seen as bringing harm to people, even if it is in the defence of others. This is the “How do you serve two masters?” challenge that is often posed to chaplains, along with the question of how we can condone intentional killing. Chaplains need to have a well developed view, not a mere justification, of these real-life religious, moral and ethical issues. However, such reflection cannot be idealistic, for we know that humankind has the potential to be inhumane and that warfare is brutal and savage, assaulting our understanding of what is good as well as our moral and spiritual values. Chaplains live with the uncomfortable reality of being involved in the messy business of conflict, which can never be fully reconciled as being “good” (although it is important to note the Christian Just War philosophical discussion that attempts to reconcile this ideological conflict<sup>1</sup>), while maintaining the duty of providing pastoral care for and supporting individuals and their families.

## Abstract

- ◆ Chaplains are an important part of the health care team and need to be included as part of routine multidisciplinary management to provide holistic care for deployed service personnel and their families.
- ◆ Chaplains deployed to an operational environment must have a well developed view of the religious, moral and ethical issues that arise from the moral conflict of serving both God and the military.
- ◆ Good mental health and personal resilience are important in enabling service personnel to cope with the rigours of deployment, perform at a high standard, and return home in good emotional and psychological health. The values and beliefs that an individual holds (the essence of spirituality) are significant components of resilience.
- ◆ In operational chaplaincy practice, pastoral issues, such as bereavement or relationship breakdown, are often treated as medical or administrative problems instead of being referred to the chaplain as the first link in the care chain of command.
- ◆ Chaplaincy is an important component of deployed operational health units, but there is a need to revisit the relationships, responsibilities and information-sharing protocols between chaplains and other Australian Defence Force health care providers.
- ◆ There are opportunities to improve existing programs or adapt those used by Coalition partners to increase the resilience of service members and to better prepare them for their return home.

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In the MEAO, the values and beliefs generally held by Australian service personnel are challenged at a number of levels. There are moral questions around Australia's role in the MEAO, its effectiveness, and the shape of our future involvement. These questions are important, as they go to the justification and legitimacy of our presence in the MEAO. The MEAO is an environment where Australian cultural, religious and moral norms are often in disagreement with those held by Coalition partners and local nationals. Added to this is the harsh reality of conflict, where soldiers are killed and wounded, confront moral and ethical challenges, and suffer mental and emotional stress.<sup>2</sup> The exposure of soldiers to conflict has a significant effect on their moral framework and their ability to cope spiritually, as well as physically and psychologically.

It is well accepted that good mental health and personal resilience play an important part in the ability of service personnel to cope with the rigours of deployment, perform at a high standard, and return to Australia in good emotional and psychological health.<sup>3</sup> Significant components of resilience are the values and beliefs that an individual holds. These values and beliefs, how we make sense of the world in which we live, and our sense of meaning, purpose and legitimacy are in turn the essence of spirituality. In the MEAO, Australian service women and men are confronted with many different answers to these life questions. Not least in the array of factors contributing to this is the dominant faith tradition of the Middle East, which contains values and spiritual practices that many Australians find confronting.

If we do not acknowledge this spiritual aspect of deployment and instead treat our service personnel as only physical and psychological beings, we risk doing them significant harm. We need to provide them with spiritual support that addresses the deep issues of the heart, mind and soul, and assist with the calibration of their moral compass, especially as they enter and leave the operational area. Building resilience is one of the goals of the Chaplains Department's Character Leadership Training program, which takes service women and men through an exploration of their values, belief systems and ethical issues.

A significant part of my reflection on the chaplain's role in supporting service personnel and the care they receive comes from my experience of providing pastoral care in a public hospital. Although there are many similarities in chaplaincy practice between the military and health care, there are also differences that need to be highlighted. In particular, it is important to note two significant issues that are often overlooked or discounted in military chaplaincy in the operational environment. The first is the importance of an Australian voice to Australian service personnel. Our Coalition partners come from different cultures in many senses, not the least being the religious culture of the United States. At a significant level, Australians and Americans don't "get it" in the same way when it comes to faith, either in exploration or understanding. The second issue is that we are

not placing chaplains in deployed health care units where Australian personnel find themselves when injured on operations. This is due to an expectation that the local area chaplain will not only be aware of the Australian's presence in the health care unit but will also be in the area and able to visit. There is also a lack of appreciation in the military of the ways that health care chaplains can provide care for the medical staff and the members of the patient's unit. These roles are significantly different to that of a unit chaplain. The Royal Australian Air Force has in part recognised the need for an Australian "voice" and perspective, with the role of the aeromedical evacuation nurse being based in the FLLA but moving throughout the theatre and out-of-country medical facilities as needed.

## Military and health care chaplaincy

The essence of chaplaincy in both the military and health care is found in relationships. The chaplain's tool of trade, a pastoral conversation with another person, has at its core the idea of relationship — a pastoral relationship in which the chaplain offers the opportunity for a person to be listened to, to be heard, and to be respected and valued. It is a relationship in which the chaplain is interested in "being with", not "doing to". It is on the basis of this pastoral relationship that the chaplain has permission to offer insight, discernment, encouragement, guidance, and words of reconciliation or clarification of uncomfortable issues.

In line with other clinicians in public health, chaplains use World Health Organization codes for recording the provision of their pastoral care. The Pastoral Intervention Codes in the International classification of diseases, version 10, Australian Modification (ICD-10-AM)<sup>4</sup> use four main categories to detail the care provided:

- pastoral assessment;
- pastoral ministry;
- pastoral education and counselling; and
- pastoral ritual and worship.

A pastoral assessment guides the chaplain as to which pastoral service or combination of services (or none) should be offered. It is also the requirement of public health departments that the pastoral care provided in public hospitals be accessible to members of all faiths, including alternative spiritualities such as New Age or neo-pagan spiritual expressions.<sup>5,6</sup>

The Army chaplain's role in caring for Australian service personnel is designated as the provision of religious ministry, pastoral care, character and moral guidance, and advice to commanders and supervisors in respect of religious, morale and welfare issues. The chaplain is the resource the military uses to provide initial care for personnel; the chaplain is often located in close proximity to the Medical Officer and works cooperatively with the medical and, if available, psychological health providers.



*Chaplain Carl Aiken during his deployment to Force Level Logistic Asset rotation 4 in the Middle East Area of Operations, 2008.*

The main difference between military chaplains and those in the health sector is in how they view their ministry focus. In the military, this focus is often from a religious perspective, with the assumption that there will be a number of roles where advice on issues can be given regarding the provision of religious support; while in the health sector, the focus is on pastoral care. Health care chaplains begin with an assessment of need and respond by encouraging an exploration of the personal and spiritual questions raised by the patient's situation. In the health sector there is generally a more collegial attitude, evidenced by working in ecumenical (cooperative) chaplaincy teams — a practice with a long history.<sup>7</sup> In the military context, the important place that prayer and worship have in providing spiritual support to people should not be diminished, but neither should it be seen as the starting point. Pastoral care that engages with an individual at his or her point of need, explores the avenues of hope and despair, looks to the signposts of personal resilience and possibility, and traces glimpses of spiritual sources of strength — or, to use religious language, God's touch of life — is a more holistic and healthy practice.

Chaplains come to the military with their ministry training and formation, and, like their civilian counterparts, participate in ongoing professional development. In the military, exposure to training in leadership development and intervention programs, such as suicide prevention, critical incident responses, and alcohol and drug awareness, is a part of the fabric of chaplaincy. While training in these areas is also available to chaplains in hospitals, the training required for hospital chaplains is Clinical Pastoral Education (CPE), which is a reflective practice model using both peer groups and individual supervision. CPE is a requirement in most states for hospital chaplains, and the Australian Health and Welfare Chaplains Association runs regular training and opportunities for supervision. Hospital chaplains in some states are also expected to attend regular training sessions. The

emphasis in both CPE and the training sessions is to review personal practice in a peer-group setting that enables chaplains to develop in their professional performance. Both chaplains in the military and ordained clergy in hospitals have courses in pastoral counselling as part of their undergraduate training and ministry formation. Many continue to do postgraduate work to Masters level in counselling and related fields.

### **Observations of operational chaplaincy**

My deployment in the MEAO offered me the opportunity to reflect on and compare chaplaincy practice in my roles as an Army chaplain and as a public hospital chaplain.

### **Management of pastoral issues**

While on deployment, a number of situations that were essentially pastoral in nature, such as bereavement or relationship breakdown, were dealt with as an administrative function or “medicalised” and not referred to the chaplain. I use the term “medicalised” to describe the increasing practice of using medical, psychological and social work services inappropriately, by making them the first point of reference for any issue to do with the welfare of service personnel. The more usual practice in the units I have served in is for the chaplain to be the primary source of care, due to the relationship the chaplain has with unit members and the background information and insights into the life events affecting a member that this relationship offers. Leaving the chaplain out of the information loop results in a variety of resources — including a pastoral perspective on the situation, referral to appropriate health care services, and other supports to both the service member and the chain of command — being unavailable.

Issues of bereavement, relationship breakdown and the stresses of life are in essence a normal part of lived experience; they happen, and most people have the strength of character and resilience to deal with them, given time and appropriate support. The increasing trend on deployment to use medical or psychological services for counselling for normal life experiences has the potential to exacerbate the issues and may result in them taking on a larger place in a person's life than they otherwise would. Such medicalising of life experiences is inappropriate. It also has the potential to overwhelm the excellent but limited medical and psychological support resources available.

### **Care of the deployed member and their family**

There are a number of pastoral, health and welfare issues that affect deployed members and their families, ranging from the birth of babies to the death of loved ones. These include the illness or death of parents, siblings or children; issues with

children, such as behaviour or performance at school; issues with work, parenting, or coping for spouses; or issues of relationship breakdown. There are also injuries to the deployed member, ranging from those caused by the daily work environment to those that are battle-related. Added to this are the dynamics of stress reactions to any of these situations by either the service member or his or her family. Chaplains often have the networks that can enable the activation of a number of care resources, which may include extended family members, welfare officers, military chaplains, hospital chaplains, funeral directors, the Defence Community Organisation (DCO, which provides the social work role for the ADF), community welfare organisations, and defence or private medical and psychological providers.

Anecdotally, there have been a number of occasions when families in Australia were the subject of DCO reports with no reference to unit or area chaplains, leaving the chaplain, who should be the primary point of care for service members, to find out about an issue either through his or her proactive pastoral care or serendipitously. The inclusion of chaplains both in the deployed unit and with those caring for family members via the welfare network would provide a wider circle of care and also enable the chaplain's observations to be included in the decision making. Managers believing that they have all the information necessary to address complex life situations based only on a DCO report is a worrying trend. This practice minimalises difficult life experiences to a management issue and ignores the wider factors that may be involved, with the possible consequence of inflicting damage on the member's overall health and that of their family.

### **Documentation and shared care**

Added to this are problems concerning the passage and control of information. In a hospital environment, information about a patient is consolidated in a set of notes in which each clinical practitioner records their observations and interventions. In civilian hospital practice, a holistic approach is used to include all primary and allied health care providers in this process, including chaplains. Case conferences and "corridor consultations", where practitioners from all disciplines openly share their insights, diagnoses and concerns, are a routine part of practice. In contrast, the military's use of "in confidence" files to restrict information that would be useful to other practitioners involved in a person's care is no longer best practice. The reasons for the continuation of this practice seem to be a closed attitude to care, a misunderstanding of the ethical concepts around confidentiality and privacy, and a fear that if service members believe that other practitioners have access to clinical information, the member's care will somehow be compromised.

Despite this, the care of service personnel would be better served by a system of open and consolidated recording of interventions by all of the caring professionals; a case conference mechanism similar to that in the public hospital

system, where all members of the treating/caring team share their insights; and a willingness to refer when appropriate. A system with these elements would provide more holistic care and practice. This would be enhanced by the military adopting a multidisciplinary approach to recording the care provided to service members, with these notes being stored electronically and made available to all service professionals responsible for their care. The electronic record would be both more portable and more accessible than the current hard-copy system.

### **Insights from Coalition partners**

Being posted to the gateway through which personnel returned to Australia and observing the way that our Coalition partners assisted their returning service members raised other issues. The US Naval Construction Force (the Seabees) uses the Warrior Transition Program, which operates at Camp Moreell in the Middle East, to assist its service personnel with their reintegration to life at home.<sup>8</sup> Along with the chaplain, the program includes input from a doctor, financial advisor, and a marriage and family therapist. Aligned to this was the Battlemind<sup>2</sup> training of the US Army, which, although primarily a preparation-for-deployment program, has content that is informative.

Opportunities to enhance the "spiritual" and relationship issues for our people on return from operations — such as further developing our Return to Australia (RTA) program to be more than medical and psychological screening — merit further investigation and debate. It is interesting to note that in preparing for deployment, force preparation contains a significant amount of group training, team building and working in cooperation with others. While on deployment, service members live in an artificial community without the normal means of having private space or de-stressing. The process of subsequently preparing service personnel to return home is known as decompression. The RTA from the MEAO for Australian personnel involves 3 days with no duty after weapons and equipment have been returned. Medical and psychological screens are conducted and service members are allowed to be out of uniform and follow their individual recreation interests. On RTA, this usually includes 2 days of short leave and 3 half-days of work to complete administrative requirements prior to a period of leave or return to work. It is well worth considering a group decompression, with the chaplain assisting service members with their spiritual RTA as they move out of their deployment community and prepare to reconnect with their community at home.

In all of these observations, it seems that, as chaplains, we have not always fully advocated our role by not engaging fully with the scope of spiritualities that are evident and encountered in the military, seeking to develop a wider range of pastoral care services than are currently offered, or working as cooperatively as we might with other caring professionals. Our emphasis on the religious aspect of our role has had the effect that a holistic care model is not as developed as it could

be, nor is our pastoral and spiritual care as robust as it should be. There has been a reticence to explore multi-faith practice and the alternative spiritualities that are evident in the wider Australian community and reflected in the ADF. Aligned to this is my perception that some chaplains experience confusion about their role and at times abdicate parts of their role to other professional groups.

## Lessons for ADF health care providers

I believe that the disturbing trend to over-react and over-manage normal life experiences, such as bereavement and relationship issues, is due to a number of factors and influences. There is an unwillingness by some military leaders to use the “care chain of command”, with the result that administrative methods are instead used to “support” a member. This unwillingness is often accompanied by a belief that decisions around the care of service personnel need the justification of a psychological report.

The care chain of command should normally begin with the chaplain being asked to provide pastoral care to a service member or his or her family. On the basis of a pastoral assessment, the care path would refer the member or the family to other caring professionals (including medical, psychological and social work) as appropriate for their assessment. Chaplains need to be proactive and claim their “core business” of pastoral care and its components of counselling and attention to life issues, especially relationship and bereavement counselling. It is incumbent on all professionals responsible for the care of service personnel and their families, including chaplains, social workers, psychologists and medical officers, to be willing to work in cooperation rather than exclusively. A positive way forward would be the development of a collaborative approach where caregivers share their best insights for the benefit of the service member.

Some of the lessons learned from deployment include:

- Chaplains are an important part of the health care team and need to be included as part of routine multidisciplinary management to provide a holistic care package.
- There is greater opportunity to explore the role of character guidance and personal resilience before and after deployment.
- The use of training similar to the US Battlemind program<sup>2</sup> may help to enhance the resilience of Australian service personnel.
- ADF health care providers should be wary of medicalisation of normal feelings and experiences; chaplaincy may offer a “lower order” interventional option for such issues.
- Chaplaincy is an important component of deployed operational health units.
- There is a need to revisit the relationships, responsibilities and information-sharing protocols between chaplains and other ADF health care providers.

- Possibilities exist to better prepare service personnel for their RTA, by use of a model similar to the US Warrior Transition Program.<sup>8</sup>
- Chaplains should be trained in providing multi-faith ministry.
- Fundamentally, we need to look at the way chaplains are used in the “health care space”.
- To be effective in health care, military chaplains need to undertake training in clinical pastoral care and become aware of the pastoral care interventions used in health.

## Conclusion

A service member who is healthy in body, mind and spirit will be the best asset to themselves, their family and the ADF. It is well documented in the health literature that faith is an important individual resource that enhances resilience and a person’s ability to cope with difficult and challenging life events.<sup>9</sup> In my deployment, I was privileged to be part of an excellent team that took the care of Australian service women and men seriously. However, there remains an opportunity to improve our care, and I suggest that service chaplains adopt insights from the health care sector’s practices that offer both a model and a way forward.

## Competing interests

None identified.

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