Chaplaincy in Mental Health Treatment

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Introduction

One day when I was visiting an external mental health treatment facility, an in-patient said to me 'Padre, I am tired of taking so many tablets. I want to talk; I want to you as a padre'. This anecdote is real and poignant. It points to and underscores the challenges around building a truly holistic regime of mental health-related treatments.[1]

It also highlights the fact that treatment and recovery can be intentionally person-centred; that is, the person may but does not necessarily receive the full range of necessary care or trans-diagnostic interventions and methods of care that should be actively available. Going further, patients have a demonstrable right to the full range of arguably inter-related and complementary treatments of a medical, psychiatric, spiritual, sacramental and psychological care.

This brief article seeks to contribute a personal chaplaincy perspective to the growing awareness of and need for currently-serving personnel and post-discharge treatment regimes. It offers emerging, experiential information and evidence that arises from collaborations with a university-based post-traumatic research centre, a literature review and my chaplaincy work in an infantry battalion from 2008 to the present.[2] It also notes that the stigma so often experienced by those seeking help or declaring there is an illness can be lessened by a chaplain's early and ongoing support alongside—and yet never at cross purposes—to the necessary work of mental care providers.[3]

The context is long-term chaplaincy involvement in pre-deployment preparations and considerable rear-detail support for deployments to Timor-Leste and Afghanistan, and associated return-to-Australia actions. This work is therefore grounded in the following:

- Preparation for overseas military deployments – readying individually and collectively; briefings, prayer, family preparation conversations; family visits;

- Chaplaincy during the deployments – spiritual and pastoral care; focus on family and partner care; linkages with other support networks; referral to agencies;

- Care for those who were not selected to deploy overseas; and

- Post-return to Australia and in the subsequent year(s) – particular attention to those experiencing the onset of symptoms relating to mental health issues; chaplaincy visits to families; assistance to external mental health treatment facilities.

While the focus is often on emergency and crisis-oriented mental health circumstances, I also acknowledge the pro-active work that occurs around building personal and unit resilience, and 'wellness' as a barrier or inoculation if you will against various stressors and trauma.

The concept of 'wellness'

Many organisations would describe wellness as 'a broad concept, and it requires everyone to think more generally about factors that may be influencing a person's overall well-being ... [albeit] not all of these factors exist in the workplace'.[4] Yet I wonder if we are prepared to consider spiritual and pastoral care in this mix of what could be used as inoculators and enablers.

I also speculate that part of the challenge lies in how people describe stressors. For example, the following definition seems to lack something to do with inner meaning and values: 'a stressor is a physical and psychological demand to which the individual responds'.[5] Where is there room to consider and treat moral, values-based or meaning-oriented stressors?

Psychological well-being is defined as:

> [Being more] than being free from stress, and not having other psychological problems. It encompasses positive self-perception, positive relations with others, environmental mastery, autonomy, purpose in life and emotions inclined towards a healthy development.[6]

While we may never be free from stressors, does well-being also relate to questions and issues of meaning, value, mortality and perhaps even belief? On this point, if we take personal recovery of the unwell seriously, then we must consider the whole person as they seek to make sense of life in many ways.[7]

The answer lies in the fact that there is another form of well-being, namely spiritual well-being. This is at least and arguably more than 'subjective experience that incorporates psychological well-being and meaning in life'.[8] To reflect this broader and more inclusive view of mental health treatment and care, Hoge *et al* assert that 'professional help [is help] … from a mental health professional, a general medical doctor, or a chaplain or other member of the clergy, in either a military or civilian treatment setting'.[9]

Despite this clear imperative, I wonder how many current mental health treatment regimes at the local and immediate level—and more broadly in national strategic planning documents—actively incorporate such multi-disciplinary thinking, let alone interventions? Certainly, there will be those who would ardently assert that we live in a post-modern, non-religious society and that there is no place for spirituality. Or perhaps they would say that we did not consider such themes as they are not represented in the evidence-based literature we have utilised. However, to accept such often powerfully-argued statements would be to discount or even ignore broader but no less crucial personal treatment-oriented evidence, themes and issues such as mission, personal meaning, continuum of care modalities and the effect of moral injury, just to name a few.

Many practitioners may have come across some or all of these themes in the therapy room. In fact, it could be argued strongly that to ignore such meaning-oriented and spiritual themes makes any mental health strategy far less effective that it could otherwise be. The other risk is that despite the stated goal of innovation in mental health treatment, other forms of care and treatment may be under-funded or ignored altogether. Moreover, unnecessary suffering may be exacerbated if underlying spiritual, values-based or meaning-oriented causes are not addressed.

According to the *Webster Dictionary*, suffering is 'misery resulting from affliction', whereas 'psychological suffering [results from] … a certain issue or event that caused great distress … [and invokes] feelings of mental or physical pain'.[10] It includes grief, burnout and job stress, and has been described as having 'no boundaries' and, in a workplace context, is a 'moral and financial concern'.[11]

For the disaffected and suffering, there are a plethora of formal, health-oriented treatments available. These include therapy and pharmacological interventions, which are all for the good. Yet these do not necessarily consider the whole person—body, mind and spirit. My survey of pastoral care developments related to the workplace over the last 40 years suggests that little progress has been made in the development of comparative psycho-spiritual praxis to do with treating 'brokenness' and offering the spiritual values of detachment, healing, forgiveness and self-love/compassion, however much these may augment self-care, self-acceptance and return to functioning. This is by no means limited to the workplace.

Is treatment truly inter-disciplinary?

Notwithstanding medical and psychological needs that arise from self-referral, screening or command concerns, issues to do with personal meaning, intimacy and suffering may be existential or spiritual in nature when it comes to mental health issues. Chaplains can testify that we often walk alongside people

trying to make sense of failure, shock and unexpected events and actions. They may have even suffered injury to do with adjusting to crisis or actions.

Recently, I participated in a full-day mental health conference oriented to treatment of serving Defence members and veterans. It was a valuable and inter-disciplinary event. Yet as I listened and collaborated, and heard many valuable treatment and interventions, I failed to hear of issues to do with personal meaning, compassion, belief, spirituality and values. Such issues and phenomena may have been inherently present but they were explicitly absent.

It can similarly be noted from recent conversations with allied health leaders and from the author's reviews of DVA-related mental health plans that there is some absence of chaplaincy and pastoral care programs. This is despite the fact that such chaplaincy work has proven vital across many theatres and operations for well over hundred years.

Even if we discount, just for a moment, the many valuable religious and overtly spiritual care activities that a chaplain offers, even from self-reports of patients and commanders it appears that chaplaincy has a demonstrable effect in supporting the suffering in many other ways and this includes pro-active work with families. This is often to assist people explore what and how they are dealing with trauma in a pastoral dialogue to do with meaning, morality, beliefs and personal ethics—sometimes with transcendence but always with a personal care focus.

For commanders, we also give support and advice about moral, ceremonial issues, the collective need to grieve and celebrate key dates/anniversaries, offer healing processes, welfare matters, care and spirituality often in times of high tempo. For individual service personnel, we are often the first point of call for issues as wide ranging as relational distress, work performance, emotional pain, making sense and addiction issues; and naturally we refer all relevant issues to medical and psychological professionals.

Yet is that where a chaplaincy role ends? Oftentimes, the chaplain has to offer a view that encourages broader thinking that goes beyond the sense of competing, success and fighting for scarce resources, and into a place of relational intimacy where peace and rest can become a viable state.

The key aspect is that a joint, multi-dimensional approach to supporting our ill soldiers is vital. The treatment of PTSD and other mental health illnesses is not an exact science and I contend that a multi-dimensional approach early can help identify the best form of treatment. A failure to ensure multi-dimensional care, including spiritual care, could mean that a chaplain is absent as a person fights through the illness.

Commanders have stated that the unit chaplain is often the most accessible person in the 'personal support plan'. This is particularly relevant when a doctor is not readily available. The chaplain provides insights and access to an individual who may be closing themselves off to others. Noting that capability and people are our highest priority means we must capitalise and embrace all treatment capabilities, particularly those that can contribute to enhancing wellness and safety.

Going further, people experience, feel and suffer at unexpected times and for unplanned reasons. At their core, when they are laid bare by trials and humbled by failure and life, inner joy and conviction seem far away. Clearly, early intervention is a key goal and it must not exclude any action that alleviates suffering, improves personal outcomes and builds personal capacity to function and hopefully return to full functioning.

In my chaplaincy experience, personal needs arose in pastoral care terms via social media, telephone conversations, attendance at mid-deployment family events, and the like. Very often (perhaps in more than 50 per cent of initiating events), it resulted in referral of medical, psychological and more complex needs to other professionals.

One could say, and in my experience in a large battalion that actively sought to care for its hurt and suffering members, that chaplains were part of the daily care and treatment mix. This also involved intentional conversations, prayer and rituals to do with grief, healing and forgiveness. Deliberate, multi-disciplinary care and connections to other support agencies (family support for example) were considered a vital part of the treatment mix for the broken. I recall that case-conferencing with the

medical practitioner, psychologist, chaplain and rehabilitation specialist meant that holistic care was the established priority.

Each specialist had a part to play in the continuum of care. Care for those seeking to integrate their experience and their sense of self, safety and place in the world raises meaning-oriented, values-based, virtue-related issues.

In terms of the broadest continuum of care approaches, well-known Franciscan priest Father Richard Rohr says—drawing on 40 years of care for prisoners, the most vulnerable in society and complex workplace needs—that '[psychological therapy] cannot [alone] deal with the ontological, metaphysical and theological self'.[12] This is not to deride therapeutic interventions, rather it is to augment and support them spiritually.[13]

How can one feel love and compassion for others let alone for self in these times? This is a key focus, noting that I fear that if I get caught into parlance and argument I will miss the dialogue that may just help contribute to an emerging anthropology where identity and inner life can be formed at least part by all of thes

Whole self: whole care

How do we as carers, commanders and as a community notice, engage and support the treatment of the 'whole' suffering self—which is body, mind and spirit as a sense making self; a unique individual who experiences and reacts. Chaplains often hear personal stories and narratives as people make sense of the situation and they relate stories of physical injury, relational impairment or personal despair. Pastorally, this can mean the story is told over and over again and people can get caught in the one even unhelpful version of the story and its outcome.[14]

Alternatively, over time, and we are dealing with a whole person, new understanding and acceptance can emerge as the person hears their own telling of what happened and moves to add new aspects or shifts the conclusion. This does not just take place in a clinical setting. In psychology too, there is a debate about too much or too little rumination; there can also be too little or too much thinking and agonising.

Barriers to treatment

Pointedly, a US study found conclusive evidence that there are real barriers to soldiers accessing treatment.[15] Whether true or not, and offering no judgment about the elicited statements, the fact remains that in this very large study (involving 5,422 participants) the following were perceived as real barriers to care:

- I don't trust mental health professionals
- I don't know where to get help
- I don't have adequate transportation
- Mental health care costs too much money
- It would be too embarrassing
- Members of my unit might have less confidence in me
- My unit leadership might treat me differently
- My leaders would blame me for the problem
- I would be seen as weak.

I argue strongly in light of the above findings that chaplaincy can be an additional and readily-accessible and often-accessed resource to ameliorate the risks of *not* getting treatment. Certainly, all access points in the care continuum must work to address barriers and these include more work with families, outreach, education, and 'changes in the models of health care delivery, such as increases in the allocation of mental health services in primary care clinic'.[16] To this I would add the active inclusion of chaplains in both serving and veteran treatment programs.

Some therapists talk about the patient as expert and empowering the ability for personal choice. Gabriel Marcel sees the self as one who can makes life-giving choices that are driven by anxiety or love, all the

while determining for themselves whether they are caught in their own pain.[17] Such an approach may not be welcome by some in the allied health world. Yet the fact that even secularists, existentialists and humanists speak of choices, sometimes of transcendence, and have something to say about the essence and importance of the self is no small point.

Chaplaincy is often part of the first response when there is a mental health or medical issue, whether it be injury, anxiety, mood or a disaffection issue. This is often in the onset or identification of major and depressive symptoms, and necessitates the conveyance to urgent medical and psychological assessment and treatment. From experience, we know that pastoral responses are often engaged at the early stages or throughout the local unit-based 'trajectory of disorder' and, more pointedly, as the treatment ensues if the person has visibility of and connection to their home workplace.

What has proven vital is low-key presence and compassion. Despite this, I note from a literature review that ideas of down-to-earth compassion, which a chaplain intentionally brings, can be absent in some research and praxis settings. Just as a starting point for later work, Schopenhauer proposed that compassion is the motivator of moral action.[18] He also does not deride the motivation for love.

To allow for those who may or may not say they are religious or overtly spiritual should not exclude compassion and care. Schopenhauer does not concern himself with the source so much as the action of loving kindness in itself, which for me links love to compassion once again. This is well represented in the following:

> The immediate *participation,* independent of all ulterior consideration, primarily in the *suffering* of another, and thus in the prevention or elimination of it; for all satisfaction and well-being consists in this. It is simply and solely compassion that is the real basis for all *voluntary* justice and *genuine* loving-kindness. Only insofar as an action has sprung from compassion does it have moral value.[19]

A way forward

Leaders, chaplains and mental health professionals need to keep the suffering person at the centre of all strategic, operational and clinical planning. If we truly remain person-centred, it is a failure not to consider questions and needs with meaning, values, virtue, belief and making sense. While a chaplain is not a mental health practitioner—aside from the vital spiritual and meaning-oriented pastoral work directed at symptoms—they can support and/or offer self-care and peer support choices.

The author plans to more closely investigate the choices, sometimes of transcendence, and have something to say about the essence and importance of the self. In this, I hope to bring chaplaincy further into dialogue with psychological treatment, particularly when life is difficult and suffering occurs.[20]

Finally, and with no wish to criticise existing and vital mental health care, I offer some positively-oriented conclusions for consideration:

- A joint, multi-dimensional approach to supporting ill soldiers is vital.

- The treatment of PTSD and other mental health illnesses is not an exact science. A multi-dimensional approach early can identify the best form of treatment.

- Commanders have stated that the unit chaplain is often the most accessible person in the 'personal support plan. This is particularly relevant when a doctor is not readily available.

- Chaplains provide insights and access to an individual who may be closing themselves off to others. People are our highest priority, so we must embrace all capabilities, especially those that contribute to wellness and safety.

- Chaplains are often a localised first responder—yet it is not clear just how often the ensuing treatment system incorporates pastoral care.

- Mental health planning processes may be inadvertently overlooking the place of pastoral care, especially to do with meaning, healing, relational forgiveness and compassion.

- It is not clear how often treatment plans and case-conferencing processes include pro-active healing and forgiveness steps in the treatment mix.

- From chaplains' observations and experiences, and feedback from commanders, chaplaincy has a demonstrable effect in its pro-active work with families and those in external treatment.

- Exercise of non-judgmental listening and ongoing compassion are often an under-explored support to treatment.

- Interventions must include the widest range of pastoral and mental health-related professionals, which includes chaplains and other member of the clergy.

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DISCLAIMER

This paper represents the author's personal views, and does not necessarily represent the views of the Australian Army or any other organisation.

NOTES

[1]   I am not for one moment discounting the need for pharmacological treatment.

[2]   Evidence has to do with testable outcomes, bearing in mind that this may vary due to the nature of comparisons, measurement, length of effort and replicability of effort.

[3]   Charles W. Hoge, Carl A. Castro, Stephen C. Messer, Dennis McGurk, Dave I. Cotting and Robert L. Koffman, 'Combat Duty in Iraq and Afghanistan: mental health problems, and barriers to care', *New England Medical Journal*, Vol. 351, No. 1, 2004.

[4]   Christopher J. Cunningham, B.L. Weathington and L.A. Burke, 'Riding the Wellness Wave: implications for organizations', *Employee Benefit Plan Review*, Vol. 63, No. 5, 2008, p. 8.

[5]   Frank J. Landy and Jeffrey M. Conte, *Work in the 21st Century: an introduction to industrial-organizational psychology*, Blackwell: Malden, 2007, p. G-19.

[6]   Halim Saricaoglu and Coşkun Arslan, 'An Investigation into Psychological Well-being Levels of Higher Education Students with Respect to Personality Traits and Self-compassion', *Educational Sciences: Theory and Practice*, 2013, which draws on C.D. Ryff, 'Psychological well-being in adult life', *Current Directions in Psychological Science*, Vol. 4, No. 4, 1995, pp. 99-104. It is noteworthy that it made particular reference to '[p]urpose in life means the properties of direction, aims and purposefulness that add meaning to their lives', yet did not examine spirituality or religion.

7   Charles Taylor, *Sources of the Self: the making of the modern identity*, Harvard University Press: Cambridge, 1989, p. 56.

8   Juanita K. Manning-Walsh, 'Psycho-spiritual Well-being and Symptom Distress in Women with Breast Cancer', *Oncology Nursing Forum*, Vol. 32, No. 3, 2005, pp. E. 56-62.

9   Hoge *et al*, 'Combat Duty in Iraq and Afghanistan', p. 19.

10   See, for example, <http://www.webster-dictionary.org/definition/suffering> accessed 9 February 2015.

11   Jane M. Lilius, Jason Kanow, Jane. E. Dutton, Monica Worline and Sally Maitlis, 'Compassion Revealed: what we know about compassion at work (and where we need to know more)', in K. Cameron and G. Spreitzer (eds.), *Handbook of Positive Organizational Scholarship*, Oxford University Press: New York, 2011, p. 4.

12   Richard Rohr, *Immortal Diamond: the search for our true self*, SPCK Publishing: London, 2013, p. 33.

13   Even philosophers argue about what constitutes the self and how this is given effect.
14   Re-telling can lead to rumination and even over-examination.

15   Hoge *et al*, 'Combat Duty in Iraq and Afghanistan', p. 21.

16   Hoge *et al*, 'Combat Duty in Iraq and Afghanistan'.

17   Gabriel Marcel, *Position et Approache: concrètes du mystère ontologique*, Editions du Cerf: Paris, 1957, p. 53.

18   Arthur Schopenhauer, *On the Basis of Morality,* translated by E.F.J. Payne, Berghahan Books: Providence, 1995.

19   Schopenhauer, *On the Basis of Morality*, p. 144.

20   I am referring to the relevancy of Gabriel Marcel and Karl Jaspers to this theological discussion on 'as thyself', although Jaspers admits the *self* concept is ambiguous; Gabriel Marcel, *Mystery of Being*, Harvill Press: London, 1951; Karl Jaspers, *Philosophy of Existence*, 1938. I also recall Heidegger here, who indicates that a sense of *being* is particular to being to human; Martin Heidegger, *Being and Time*, translated by John Macquarie and Edward Robinson, S.C.M. Press: London, 1962. In a broad sense, one's existence is primary consideration and I speculate that 'if' the self can be separate or know itself in some sense without getting involved in the philosophical debates, it must be treated as an entity worthy of personal care.