

LIBERTY UNIVERSITY BAPTIST THEOLOGICAL SEMINARY

PROFESSIONAL NAVAL CHAPLAINCY:  
THE MINISTRY OF THE NAVY CHAPLAIN IN A  
U.S. NAVY BUREAU OF MEDICINE AND SURGERY HOSPITAL

A Project Proposal Submitted to  
Liberty Theological Seminary  
in partial fulfillment of the requirements  
for the degree

DOCTOR OF MINISTRY

By

Russell A. Hale

Chatan-cho, Okinawa, Japan

May 2013



LIBERTY UNIVERSITY BAPTIST THEOLOGICAL SEMINARY

THESIS PROJECT APPROVAL SHEET

---

GRADE

---

Dr. Charles N. Davidson  
Director, Doctor of Ministry Program  
Associate Professor of Counseling  
Mentor

---

Dr. David Hirschman  
Associate Dean  
Assistant Professor of Religion  
Reader

**Dear God, where do we get such men? What loving God has provided, that each generation, afresh, there should arise new giants to walk in the land. Were we to go but a single generation without such men, we would surely be both damned and doomed**

Anonymous military officer to Lt.Col. Dave Grossman, USMC (Ret), in *On Killing*

**We sleep soundly in our beds because rough men stand ready in the night to visit violence on those who would do us harm.**

Sir Winston Churchill

**Then I heard the voice of the Lord saying, “Whom shall I send? And who will go for us?” Then I said, “Here am I. Send me!”**

Isaiah 6:8

## ACKNOWLEDGMENTS

One of the sayings I have grown fond of using when speaking with Marines and Sailors is this: All that you are and have achieved is possible only because of those who have gone before you. The same statement is true for me. The Marines and Corpsmen of 2nd Battalion, 7th U.S. Marine Regiment did as much for me as they credit me for having done for them. Capt. Eric “D-Ring” Terhune, USMC and HN Dustin “Doc” Burnett, USN and my other eighteen brothers at arms who gave up the rest of their tomorrows so that we may have today, you have taught me the truth of “There is no greater love than this: that a person would lay down his life for the sake of his friends” (John 15:13, APBE). LCpl Richard Weinmaster, USMC, and LCpl Brady Gustafson, USMC, and the rest of my 2/7 flock who came home with pieces of your body and soul missing: the Navy Cross and other medals speak to the extraordinary heroism and love displayed by many of you; in several of those instances your actions kept me safe and alive. The wooden Cross of Calvary speaks of the ultimate heroism and love, and to the One who promised, and is able to mend our broken bodies and heal our wounded souls. “For I will close up thy scar, and will heal thee of thy wounds, saith the Lord” (Jeremiah 30:17, DRB). And though our wounds may heal slowly, He is faithful.

A special thank you to Dr. D. Kim Neilsen for inviting me to rejoin the human race; to Alan, Tracy, Leslie, Jim, and David “You don’t say ‘No’ to the Holy” *puer eternus*.

And to Becky, Taylor, and Samantha: You have all given more than a husband and father should ever ask for: Texas, Oklahoma, Japan, Virginia, Iraq, California, Afghanistan, Romania, Virginia, and now Okinawa—all within the past twelve years. I adore you and love you with all of my being.

## ABSTRACT

### PROFESSIONAL NAVAL CHAPLAINCY: THE MINISTRY OF THE NAVY CHAPLAIN IN A U.S. NAVY BUREAU OF MEDICINE AND SURGERY HOSPITAL

Russell A. Hale

Liberty Theological Seminary, 2013

Mentor: Dr. Charles N. Davidson

Through a review of the literature and personal experiences, it was found that many U.S. Navy chaplains do not see the potential opportunities and value in ministering to personnel, dependents, and retirees in a U.S. Navy hospital setting. Based on the findings of a quantitative survey sent to clinical staff, ancillary staff, Marines, and Sailors serving at the U.S. Naval Hospital in Okinawa, this project reviews historical paradigms and present institutional perspectives and attitudes regarding the value of the chaplain ministering in a U.S. Navy hospital. Since the chaplain ministers as a member of the interdisciplinary care team, it then reviews the Outcome Oriented Chaplaincy model in a clinical setting, and the potential impact of the Navy chaplain ministering as the spiritual fitness leader in a clinical setting.

Abstract length: 159 words.

## ILLUSTRATIONS

### Figures

2.1	Primary view of the chaplain .....	32
2.2	Primary and secondary expectations of the chaplain .....	34
2.3	Pastoral care/chaplain's work is "Mission Essential" .....	35
2.4	Value of chaplain input to the care team .....	36
2.5	Value of chaplain input in the patient's medical record .....	37
2.6	Respondents personal value of religion and/or spirituality .....	38
2.7	Respondents personal value of having a chaplain as a spiritual advisor .....	39
2.8	Respondents personal value of privileged communication .....	40
2.9	Respondents level of trust in the chaplain to provide spiritual care .....	41
4.1	The Discipline for Pastoral Care .....	93
4.2	U.S. Naval Hospital Okinawa R/S screening protocol .....	108
4.3	Fitchett's 7x7 Model .....	112
4.4	Value of clinical input from the chaplain .....	124
4.5	The value of chaplain input into the patient's medical record .....	127
5.1	The chaplain is best qualified to treat spiritual/moral injuries .....	148

### Tables

2.1	Total survey responses and percentages by rank/rate .....	29
2.2	Respondents by pay-grade .....	29
2.3	Respondents by gender .....	30
2.4	Respondents by service branch .....	30
2.5	Respondents primary view of the chaplain .....	31

Table

2.6	Respondents primary understanding of “ministry of presence” .....	33
2.7	Respondents primary and secondary expectations of the chaplain .....	33
2.8	Respondents view & value of Pastoral Care Services .....	35
2.9	Respondents value of chaplain input to the care team .....	36
2.10	Respondents value of chaplain input in the patient’s medical record .....	37
2.11	Respondents personal value of religion and/or spirituality .....	38
2.12	Respondents personal value of having a chaplain as a spiritual advisor .....	39
2.13	Respondents personal value of privileged communication .....	40
2.14	Respondents level of trust in the chaplain to provide spiritual care .....	41



## ACRONYMS AND ABBREVIATIONS

AMA	American Medical Association
ANA	American Nursing Association
APHA	American Protestant Hospital Association
APA	American Psychiatric Association's
ACPE	Association for Clinical Pastoral Education
APC	Association of Professional Chaplains
BCC	Board Certified Chaplain
BJH	Barnes-Jewish Hospital-Washington University Medical Center
BUMED	Bureau of Navy Medicine and Surgery
C-PTSD	Complex Posttraumatic Stress Disorder
CBT	Cognitive Behavioral Therapy
COSC	Combat Operational Stress Control
CgOSC	Care giver Occupational Stress Control
CHC	U.S. Navy Chaplain Corps
CJCS	Chairman of the Joint Chiefs' of Staff
CJCSINST	Chairman of the Joint Chiefs' of Staff Instruction
CMC	Commandant of the U.S. Marine Corps
CNO	Chief of Naval Operations
COSC	Combat and Operational Stress Control
CPE	Clinical Pastoral Education
CPSP	College of Pastoral Supervision and Psychotherapy
DoD	Department of Defense

DoN	Department of the Navy
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4 <sup>th</sup> Edition
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5 <sup>th</sup> Edition
EMR	Electronic Medical Record
ICU	Intensive Care Unit
MLC	Japanese Military Labor Contract
mTBI	Mild Traumatic Brain Injury
MTF	Military Treatment Facility
NACC	National Association of Catholic Chaplains
NAJC	National Association of Jewish Chaplains
NICU	Neonatal Intensive Care Unit
NIMH	National Institute of Mental Health
NIC	Nursing Intervention Classification
NOC	Nursing Outcomes Classification
NMCP	Naval Medical Center, Portsmouth
NMCSD	Naval Medical Center, San Diego
OCC	Outcome Oriented Chaplaincy
OCPP	Outpatient Crisis Prevention Program
PCR	Pastoral Care Residency
PREP	Prevention and Relationship Enhancement Program
PTED	Posttraumatic Embitterment Disorder (PTED)
PTSD	Posttraumatic Stress Disorder
OPNAVINST	Operational Navy Instruction (Policy instruction from the Chief of Naval Operations)

OSCAR	Operational Stress Control and Readiness
PE	Prolonged Exposure therapy
PICU	Pediatric Intensive Care Unit
PCR	Pastoral care residency
RIOAP	Run In On A Prayer (Reason for Visit, Intervention, Outcome, Assessment, Plan of Care)
SECNAVINST	Secretary of the Navy Instruction (Policy instruction from the Secretary of the Navy)
SOFA	Status of Forces Agreement
SPRINT	Special Psychiatric Rapid Intervention Team
TBI	Traumatic Brain Injury
USNH	U.S. Naval Hospital, Okinawa (also USNHOKi)
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center

## TABLE OF CONTENTS

ACKNOWLEDGEMENTS .....	v
ABSTRACT .....	vi
ILLUSTRATIONS .....	vii
ABBREVIATIONS & ACRONYMNS .....	ix
CONTENTS .....	xii
CHAPTER 1: INTRODUCTION .....	1
Statement of the Problem .....	7
Definition of Terms .....	8
Statement of Limitations .....	10
Theoretical Basis for this Project .....	11
Statement of Methodology .....	12
Review of the Literature .....	15
CHAPTER 2: RESEARCH RESULTS .....	23
Introduction & Research Design .....	23
Research Results .....	28
Summary .....	41
CHAPTER 3: HISTORIC PARADIGMS OF HOSPITAL CHAPLAINCY .....	43
Hospital Chaplaincy Origins .....	45
<i>Cura Animarum</i> : A Response to Individual Sin .....	47
Person-Centered Therapy .....	58
Ministry of Presence .....	64
Late Twentieth Century Thought on Sin & Suffering .....	67

Pastoral Care and Counseling in Postmodernity .....	71
Postmodern Pastoral Care .....	75
Narrative Pastoral Care .....	80
Sea Services Chaplaincy in the Twenty-First Century .....	82
Professional Naval Chaplaincy in the U.S. Navy Bureau of Medicine and Surgery .....	83
Summary .....	86
<b>CHAPTER 4: OUTCOME ORIENTED CHAPLAINCY .....</b>	<b>88</b>
Beginnings of Outcome Oriented Chaplaincy .....	89
Outcome Oriented Chaplaincy and Evidence-Based Spiritual Care .....	91
The Discipline for Pastoral Care .....	93
Standards of Practice .....	95
Run In On A Prayer .....	96
Spiritual Screening .....	107
Spiritual History .....	107
Spiritual Assessment .....	109
Spiritual Care Plan .....	114
Chaplaincy Research .....	115
Documentation .....	118
Board Certified Chaplaincy .....	119
Results of Research .....	121
Summary .....	125
<b>CHAPTER 5: SPIRITUAL FITNESS .....</b>	<b>127</b>
Components of Spiritual Fitness .....	134

Core Beliefs and Values .....	140
Spiritual Injuries .....	142
Spiritual Exercise, Resiliency, & Growth .....	144
Support Spiritual Beliefs .....	145
Prescribe Religious/Spiritual Activities .....	146
Results of Research .....	147
CONCLUSION .....	149
APPENDIX A: SURVEY INSTRUMENT .....	155
APPENDIX B: STANDARDS OF PRACTICE FOR PROFESSIONAL CHAPLAINS ..	159
APPENDIX C: SPIRITUAL ASSESSMENT TOOLS .....	165
APPENDIX D: ESSENTRIS CHAPLAIN ASSESSMENT & NOTE .....	167
APPENDIX E: PROJECT POWERPOINT BRIEF .....	168
BIBLIOGRAPHY .....	185
VITA .....	195
INTERDISCIPLINARY REVIEW BOARD APPROVAL .....	196

## CHAPTER 1

### INTRODUCTION

The realm of ministry in which today's Navy chaplain may find himself<sup>1</sup> is unlike any other type of ministry being conducted, whether in the local church or other branches of the armed forces. This student, for instance, has provided ministry to Sailors far out at sea in the bluest of blue water on numerous naval surface platforms, for example, aircraft carriers, guided missile destroyers and cruisers, and amphibious landing and docking ships. Likewise, this student has served Marines and Sailors during intense ground combat in both Iraq and Afghanistan. Finally, this student has served in forward deployed/overseas base chapels in the Far East; he has ministered to HIV-positive orphaned children in Eastern Europe and has been blessed to have preached the Gospel in more than twenty-five different countries. These experiences are so unique that neither a pastor in a local church nor a chaplain in another service branch would likely enjoy such diversity in his ministry setting.

It is because of this student's experiences in Afghanistan that he now finds himself serving at the U.S. Naval Hospital, Okinawa (USNHOKi). The overwhelming majority of military commanders who have been in combat will be able to share the value of having a God-fearing, people-loving chaplain within a military unit. Stress is high, friends are being killed, questions of eternal importance are raised, young men and women are discovering freedom from their parents for the first time, marriage difficulties arise from deployment separation. Worldviews are challenged as true evil is confronted, and these young Americans are learning the harsh realities of a fallen world. They need guidance, support, and a sympathetic ear; they

---

<sup>1</sup> The use of the male gender as a personal pronoun by this student is in no way intended to exclude female chaplains who have, and continue to, serve with distinction in the U.S. Navy.

want someone to remind them that this world is not all there is and a more promising future awaits. When life is at its darkest they want light and hope; they rely upon their chaplain to provide for these needs. A good chaplain is indispensable in these kinds of situations, which are normal occurrences in the operating forces. But what about in a hospital or clinical setting, are the needs the same? What does the Navy chaplain have to offer that cannot be provided by the physician or nurse? What about the psychiatrist, psychologist, or social worker? Does the chaplain bring additional value to an institution staffed with so many other learned specialists? Hence, the subject of this dissertation: What is the value of the U.S. Navy chaplain serving in a U.S. Navy Bureau of Medicine and Surgery (BUMED) hospital?

Navy chaplains typically have more formal education and interpersonal skills than the line officers have in the Sea Services<sup>2</sup> and are respected as professionals who are competent in caring for Sailors and Marines. However, in a hospital or clinical setting in which the entire officer population is comprised of staff corps officers, for example, physicians, nurses, specialists, etc. with advanced degrees and professional skill sets: do these officers value and accept the chaplain as a professional peer? It is easy for the chaplain to withdraw from truly affecting patients and staff in his care due to a sense of inadequacy when working alongside such gifted healers. There can be a temptation to simply offer religious care or to hide behind the chaplain's collar device, as no other individual in the service is uniquely qualified or authorized to provide such care. The temptation may also exist to only reach out to those who share a

---

<sup>2</sup> Historically, the Department of the Navy, which is comprised of both the U.S. Navy and U.S. Marine Corps has collectively been referred to by its members and political leaders as the Sea Services.



common faith. This student has certainly had similar thoughts and cannot possibly be alone in this type of thinking. Scripture teaches that it is “by his stripes” that all people are truly healed.<sup>3</sup> Perhaps this is physical healing, but the intent of the scripture writer is to address the spiritual sickness from which all humans suffer. Who is better equipped to address this soul sickness than the chaplain? “Healthy people don’t need a doctor, sick people do. I have come to call not those who think they are righteous, but those who know they are sinners.”<sup>4</sup> As death is the last enemy to be faced by humans, who is more qualified than the chaplain to guide weary souls into eternity without fear and with peace of heart, i.e., to put on immortality?<sup>5</sup> God is looking for those to go for him. “Then I heard the Lord asking, ‘Whom should I send as a messenger to this people? Who will go for us?’ I said, ‘Here I am. Send me.’”<sup>6</sup> The chaplain certainly does have an important function, and it is not only to meet religious needs.

It was during a nine-month deployment to southern Afghanistan in 2008 that this student had a true “taste” of hospital chaplaincy. Alone but unafraid, he was the only U.S. Navy chaplain in Helmand province and provided chaplain coverage to more than 1,800 Marines and Sailors as well as a company of U.S. Army Special Forces soldiers who had no chaplain organic to their unit. As the Task Force 2/7 chaplain, his responsibility was to care for all personnel who were spread across Helmand, Farah, and Herat provinces. There were ten forward operating bases

---

<sup>3</sup> Isaiah 53:5; 1 Peter 2:24, NLT.

<sup>4</sup> Mark 2:17, NLT.

<sup>5</sup> 1 Corinthians 15:54-57, ESV.

<sup>6</sup> Isaiah 6:8, NLT.

(FOBs) that spanned more than 27,000 square kilometers, the area normally covered by a regimental combat team with a complement of five to six chaplains. Providing ministry to Task Force 2/7 required extensive travel, with most of it via ground vehicle and all of it under the threat of enemy fire and improvised explosive devices (IEDs). As this task force was the first ever U.S. Marine corps combat unit in these hostile areas, the conditions were Spartan in nature. For example, in eight of the Task Force 2/7 FOBs, both laundry and personal hygiene were exercised via two-gallon plastic buckets for all nine months of deployment; there were no bathrooms or running water, and waste was collected daily and burned.

Task Force 2/7 was based out of a British compound known as Camp Bastion that had been constructed early in the invasion of Afghanistan in 2002–2003. Camp Bastion was large and well-fortified and had the capability to land Air Force C-17 aircraft. The cleared fields of fire on three sides of the camp were more than ten miles. The two greatest claims of this camp were (1) it was home to the only Role-3 hospital<sup>7</sup> in the southern area of operations, and (2) it was located on the only coalition base in all of Afghanistan never to have been attacked by enemy forces. This would soon change. The temperatures in this location varied from 130 degrees Fahrenheit in August to below freezing with snow in December. The hospital, which had several

---

<sup>7</sup> NATO classifies medical treatment capabilities on a scale of 1 to 4; 1 is the most basic of capabilities, normally at the small unit level, e.g., battalion aid station, and 4 is theatre level care. The Role-3 hospital, which existed at this student's location, provided support at division level. This level of care provides additional capabilities, including specialist diagnostic resources, specialist surgical and medical capabilities, preventive medicine, food inspection, dentistry, and operational stress management teams not provided at level 2. The holding capacity of a level 3 facility will be sufficient to allow diagnosis, treatment, and holding of those patients who can receive total treatment and be returned to duty within the evacuation policy laid down by the force surgeon for the theatre.

surgical suites and a temporary mortuary, was the single best air-conditioned structure in the entire province and a place this student would frequent when not pushed out to a FOB. Because Task Force 2/7 had the highest casualty rate of any U.S. Marine combat unit during 2008, this student found himself at the Role-3 hospital more than he could have ever imagined. It was overwhelming to be tasked with counseling a young Marine, who, in addition to losing both legs, was grieving the loss of his best friend who died en route to the hospital. Finding the right words seemed impossible; “God loves you and has a wonderful plan for your life”<sup>8</sup> was wholly inadequate at the time. This student began a relationship with the UK hospital Padre<sup>9</sup> and sought guidance and advice on how to handle these types of conversations, which had become the rule rather than the exception. It was in working with and observing the UK padre’s ministry to the staff that had to deal with numerous catastrophic injuries every day, that the task of hospital chaplaincy became more than merely holding the hands of old ladies and praying.

On July 15, 2008, everything changed. While traveling via ground convoy to Sangin, Afghanistan, enemy forces ambushed and attacked this student’s vehicle. The small arms fire and machine gun fire were survivable in a Mine Resistant Ambush Protected (MRAP) vehicle, but rocket propelled grenades (RPGs) were different. During the course of the battle, one RPG exploded two meters in front of his vehicle, and a second struck the bottom edge of the vehicle frame but did not explode until it hit the ground underneath. This student was shaken greatly, not

---

<sup>8</sup> This is the first of the Four Spiritual Laws developed in the 1950’s by Bill Bright and Campus Crusade for Christ which is still used extensively today as an evangelism tool. For more information see: <http://www.campuscrusade.com/fourlawseng.htm>.

<sup>9</sup> Most every other coalition military force in existence today refer to the chaplain in the less formal “Padre” while within the Sea Services the chaplain is typically addressed as “Chaps.”

in the fearful sense, but in the literal sense, and suffered a mild traumatic brain injury (mTBI). As the rules for receiving the Purple Heart were much more restrictive at that time; this student believed that any complaints of side effects to medical personnel would be viewed as “a chance to get another ribbon.” Even more significantly, his complaints might lead to a forced return to the U.S. away from his Marines, leaving them with no chaplain. Therefore, treatment for mTBI was not sought until 2010. Upon return to the U.S. in December 2008, the true effects of combat and that explosion began to manifest in the form of Posttraumatic Stress Disorder (PTSD) and memory problems. This student needed help but also wanted to be better able to provide meaningful ministry to Marines and Sailors suffering from the same condition.

In May 2009, this student applied for admission into the BUMED pastoral care residency (PCR). In November 2009, this student was notified he had been selected to attend the BUMED PCR at the naval medical center in Portsmouth, Virginia. This residency required completing four units of clinical pastoral education (CPE), which included 1,600 hours of supervised residency and a six-month assignment at the Hampton Roads Veteran’s Affairs Medical Center (VAMC) where he served in the PTSD with addictions outpatient clinic and the inpatient psychiatric unit. This experience completely changed the view and methodology of ministry for this student. Much more was expected of the chaplain by the CPE supervisor than had been expected of the chaplain in the Fleet U.S. Marine Force or Surface Warfare communities; here, ministry of presence was not enough.

The concept of outcome-oriented chaplaincy (OOC) was introduced to the PCR students late into the residency. In attempting to integrate this ministry model into the naval medical center, this student found that many of the professional healthcare providers either ignored the

input of the chaplain or were unaware of the potential usefulness of chaplaincy care<sup>10</sup> as the medical staff provided holistic medical care to service members and authorized recipients.

### **Statement of the Problem**

The purpose of this thesis is to determine the attitudes of professional hospital staff and ancillary staff regarding the role and value of the U.S. Navy chaplain in a U.S. Naval hospital (USNH). In the book *Chaplaincy Today*, John Gleason describes the evolution of hospital chaplaincy as occurring in three major movements in the twentieth century.<sup>11</sup> The first movement, which began at the turn of the twentieth century, would be best described as a pastoral response to the sin of the individual. As psychiatry and psychology became their own academic disciplines in the 1930s, the second movement, the client-centered approach to counseling proposed by Carl Rogers, influenced the CPE method, and ministry of presence became the popular intervention practiced by hospital chaplains. Finally, in the late 1990s, although in conflict with the older and still practiced Rogerian/CPE approach,<sup>12</sup> the evidence-

---

<sup>10</sup> The term “chaplaincy care” is to be differentiated from both pastoral care and spiritual care. Chaplaincy care is provided by a board-certified chaplain or student in an accredited CPE program and includes such care as spiritual, emotional, religious, pastoral, ethical, and existential care. For a more in-depth explanation see: Peery, Brent, “What’s in a Name?” *Plainviews* 6, no. 2 (2009) <http://plainviews.healthcarechaplaincy.org/Issue2/Whats-in-a-Name.aspx> Accessed online on April 12, 2013.

<sup>11</sup> John J. Gleason, “An Emerging Paradigm in Professional Chaplaincy,” *Chaplaincy Today*, vol. 14 no. 2 (1998): 10.

<sup>12</sup> Gleason, 11.

based and outcome-driven model, i.e., a response to individual need, was introduced and is currently the preferred practice used by hospital chaplains in the U.S. Navy.<sup>13</sup>

### **Definition of Terms**

This project will address several topics within the context of naval chaplaincy. As such, the use of Navy or military acronyms will be, kept to a minimum, as much as possible. However, in discussing the different types of pastoral care delivered by individuals within the military healthcare system, OOC will refer to a method of chaplaincy care that emphasizes achieving, describing, measuring, and improving outcomes that result from a chaplain's work. Its primary components include chaplaincy assessment, chaplaincy interventions, and chaplaincy outcomes.<sup>14</sup>

This new paradigm also requires a more specific understanding of chaplaincy care, pastoral care, and spiritual care. These terms, in the past, have been used interchangeably, but that is no longer the case. Chaplaincy care will refer to care provided by a board-certified chaplain or by a student in an accredited clinical pastoral education program. Examples of such

---

<sup>13</sup> U. S. Navy Bureau of Medicine and Surgery, "BUMEDINST 1730.2A: Navy Medicine Plan for Religious Ministries including Pastoral Care Services," (2011), <http://www.med.Navy.mil/directives/Pages/BUMEDIInstructions.aspx>, accessed April 14, 2012.

<sup>14</sup> Brent Peery, "Outcome Oriented Chaplaincy: Intentional Caring." In *Professional Spiritual and Pastoral Care: A Practical Clergy and Chaplain's Handbook*, ed. Stephen B. Roberts (Kindle Edition, Woodstock, VT: Skylight Paths Publishing, 2012), location 7302 of 10946.

care include emotional, spiritual, religious, pastoral, ethical, or existential care. Pastoral care comes out of the Christian tradition and is described by LaRocca-Pitts as:

...pastoral care developed within the socially contracted context of a religious or faith community wherein the ‘pastor’ or faith leader is the community’s designated leader who oversees the faith and welfare of the community and wherein the community submits to or acknowledges the leader’s overseeing. The faith they share is mutually received and agreed upon system of beliefs, actions, and values. The faith leader’s care for his community is worked out within a dialectical relationship between the person’s unique needs, on the one hand, and the established norms of the faith community, as represented by the pastor, on the other.<sup>15</sup>

The third type of care provided to those within the realm of hospital chaplaincy is spiritual care. These are defined as interventions, either individual or communal, that allow each person to express the integration of body, soul, and spirit to achieve wholeness, health, and a sense of connection to self, to others and to that which is sacred for that person. Spiritual care forms a portion of the care provided in chaplaincy care.<sup>16</sup>

Within the U.S. Navy chaplaincy there are four primary responsibilities<sup>17</sup> of which every Navy chaplain is aware. These responsibilities, according to Handzo, also translate into four

---

<sup>15</sup> George Handzo, “A General Theory for Providing Spiritual/Pastoral Care Using Palliative Care as a Paradigm.” In *Professional Spiritual and Pastoral Care: A Practical Clergy and Chaplain’s Handbook*, ed. Stephen B. Roberts (Kindle Edition, Woodstock, VT: Skylight Paths Publishing), location 649 of 10946.

<sup>16</sup> Ibid., location 657 of 10946. Handzo combines portions of definitions that are found in *Faith and Community Nursing: Scope and Standard of Practice* by the American Nurses Association & Health Ministries Association and *Standards of Practice for Professional Chaplains in Acute Care Settings* by the Association of Professional Chaplains.

<sup>17</sup> SECNAVINST 1730.7D: *Religious Ministry Support within the Department of the Navy* (August 2008). <http://doni.daps.dla.mil/allinstructions.aspx> (accessed April 1, 2012).

models of chaplaincy.<sup>18</sup> First, there is the role of facilitator. The Navy chaplain makes sure that religious and spiritual care is provided for all service members and authorized personnel, including family and staff. Second is the role of provider. The Navy chaplain personally provides religious and spiritual care to those of like faith groups. In addition, the chaplain provides active care when requested, in the form of visitation and rites, to those of the same faith groups. Third, the Navy chaplain is a caregiver. In caring for all, the chaplain provides services that fall within a general category of spiritual counseling, care, or consultation. The chaplain accompanies patients who are dying as they transition into the next life, provides ethical advice to the commander or staff, and makes spiritual assessments as part of formulating a plan of care. Finally, the fourth role of the Navy chaplain is that of advisor. The chaplain advises the commanding officer, the care team, and others, as is appropriate, on matters of religion, morals, ethics, and morale. This would include religious sensitivities and any cultural distinctive that may impact delivery of the best care possible.<sup>19</sup>

### **The Statement of Limitations**

This project will only be a study of the role and value of the U.S. Navy chaplain at USNHOKI. In other words, this project will not include studies, evidence, or research from the three largest naval medical centers located in the continental United States (CONUS). Aspects of naval hospital chaplaincy, such as administering a clinical pastoral education program,

---

<sup>18</sup> Handzo, location 848 of 10946.

<sup>19</sup> Ibid., location 858 of 10946.



administering pastoral care for a wounded warrior battalion, or administering and providing pastoral care within a substance abuse program, are vital ministries and functions within large naval medical centers. This project, however, will be limited to research conducted at a medium-sized, overseas military treatment facility (MTF).

Not all chaplains will agree with the ideas and conclusions of this student. All chaplains currently serving on active duty have been screened and selected to represent their respective faith group and are considered to be fully qualified to serve as a chaplain by the U.S. Department of Defense (DoD). However, all who volunteer to serve within BUMED at a military treatment facility must adhere to the standards of practice and care for chaplains as determined by the Surgeon General of the United States Navy

### **Theoretical Basis for this Project**

In 1982, John R.W. Stott penned the classic *Between Two Worlds*,<sup>20</sup> which describes the chasm between the biblical world and the modern world. Stott argues that this chasm is bridged through the preaching and proclamation of the Word of God. It is the preacher, empowered by the Spirit, who stands in the gap between these two worlds. Through preaching, the Word of God is brought into the world of a modern audience, and modern culture is confronted with the living

---

<sup>20</sup> Stott, John R.W., *Between Two Worlds: The Challenge of Preaching Today*, (Grand Rapids, MI: Wm. B. Eerdmans Publishing Company, 1982). According to one review of this book, Stott presents the role/responsibility of the preacher as a high and lofty task. Not only is the preacher to know the Bible but he also must know his congregation and the world in which they exist. The preacher must be a man of the Bible and a man of the newspaper. It is the task of preaching to bridge the chasm, which exists between the Biblical world (or kingdom) and the modern world to impact eternity and do the work of the kingdom.

Word. Likewise, within the BUMED hospital, it is the chaplain who stands between the chasm of faith and science, the rational and miraculous, and ultimately the temporal and eternal. Because of the unique position held by the Navy chaplain, for example the chaplain is probably the only staff member that does not view death as a failure of his own abilities, further study of this subject and educating providers is warranted. Far too many providers do not have a solid grasp of all the tools and experience that the chaplain has to offer, which leads this student to ask the question: What is the role and value of a Navy chaplain in a BUMED hospital?

### **Statement of Methodology**

The first chapter of this project will serve as an introduction to the subject, the reason this student pursued the study of the subject, and subsequent development of the thesis statement. In the second chapter of this project, the focus will be geared toward helping the reader understand the history, general nature, and guiding principles of the practice of hospital chaplaincy. In order to provide the proper frame of reference, several criteria must be examined. This first chapter will offer an introduction, statement of the problem, theoretical basis for this project, description of the methodology, and a survey of the relevant literature. Chapter 2 will detail the research conducted, to include: research design, methods, statistical analysis, relevance to military operations, data analysis plan, subject population, protected population, method of subject identification and recruitment, and finally research results.

Chapter 3 will begin with an overview of the historic paradigms of hospital chaplaincy. Section 1 will give a summary of the history of pastoral care in America and how the earliest response from clergy was to view sickness as a result of sin. The second section will cover the

most familiar of the historic chaplaincy paradigms. It is the client-centered approach that was championed by humanist and existentialist psychologists beginning in the middle of the twentieth century. Ministry of presence will be discussed in detail, as it arose out of this background to the prominence it currently holds among the more senior practicing CPE supervisors. Most, if not all, military chaplains are familiar with the phrase “ministry of presence.”<sup>21</sup> Ministry of presence is a result of blending client-centered counseling with the pastoral care of the chaplain. St. Francis once said that his brother friars should, “Preach the Gospel always. If necessary, use words.”<sup>22</sup> Hence, a ministry of presence can be about living the Gospel as reflected in our actions and deeds; “By this all people will know that you are my disciples, if you have love for one another.”<sup>23</sup> Ministry of presence can be a method of sharing the Gospel message by giving of ourselves and our time. But for those who are already Christian or of a completely different faith tradition, there is also a method to ministering that does not

---

<sup>21</sup>Peery, locations 7383-7386 of 10946. Peery, summarizing Gleason, writes that in the 1960s, as societal norms and institutions enjoyed far less consensus, there arose a new paradigm for professional chaplaincy. It was based upon the client-centered therapy of Humanist psychologist Carl Rogers. Many chaplains embraced this method of caregiving built primarily on the three principles of congruence/genuineness by the helper, paired with empathic understanding of and unconditional positive regard for the client. Hence, the term “ministry of presence” which stresses the healing sufficiency of a calm and caring chaplain.

<sup>22</sup> This is a quote attributed to St. Francis of Assisi, who, born in 1181/1182 (sources vary) was the founder of the Franciscan order of monks. However, while it appears that he never actually said this, it does correspond with much of this Roman Catholic saint’s theology.

<sup>23</sup> John 13:35, ESV.

involve trying to “save the elect”<sup>24</sup> or proselytizing to those of different religions (and thus violate the *Armed Forces Chaplains’ Code of Ethics*). The last section of Chapter 3 will examine the role of the chaplain in the context of professional naval chaplaincy and BUMED.

Chapter 4 will cover the current paradigm that is promoted by the six major certifying bodies of professional chaplains. The OOC model and its subcomponents will be examined in detail to include spiritual assessment, pastoral interventions, desired outcomes, and pastoral care plans. Along with those, the concept of best practices and documenting the contributions of pastoral care effectively in the appropriate records, especially as it relates to privileged communication and confidentiality, will be discussed. Finally, six of the thirteen standards of practice codified by both the Association of Professional Chaplains (APC) and BUMED will be examined as they relate to professional chaplaincy and U.S. Navy chaplaincy.

Chapter 5 will examine the concept of spiritual fitness within the Department of the Navy (DoN). Spirituality will be looked at in depth, as it is considered by the secular medical providers to be the fourth pillar of total wellness<sup>25</sup> in the lives of all humans. A separate section will deal with the concept of spiritual wounds, and the last three sections of this chapter will examine the ideas of spiritual first-aid, spiritual recovery, and the spiritual fitness continuum developed by

---

<sup>24</sup> By *save the elect*, this student is referencing those individual Christian chaplains who are compelled to evangelize other Christians who may come from a different denomination or tradition than the chaplain’s own.

<sup>25</sup> SECNAVINST 1730.7D: *Religious Ministry Support within the Department of the Navy* (August 2008). <http://doni.daps.dla.mil/allinstructions.aspx> (accessed April 1, 2012). Spirituality is also included as paramount in the instruction of the Chairman of the Joint Chiefs of Staff regarding combat/operational stress control of September 2011.

the Office of the Chaplain of the Marine Corps as a means for self-examination by personnel within the DoN and USMC.

### **A Review of the Literature**

A survey of the literature confirms that very little material has been written addressing the specific and contemporary issues related to U.S. Navy chaplaincy within a BUMED hospital. As this is the case, this student proposes to begin this project with a general historical overview of pastoral care in America, to be followed by a more detailed examination of the paradigms in practice during the last century.

E. Brooks Holifield penned the comprehensive guide that traces the history of pastoral care in the United States. He believes that every pastor adopts, wittingly or unwittingly, some theory of pastoral counseling. He suggests that many pastors have no preferred model, or they follow models that are deprived of biblical and historical substance. In some ways, Holifield's offering serves as a rebuttal to Carrie Doehring and offers a more biblical approach to pastoral care for a hospital chaplain.<sup>26</sup> Gleason's article<sup>27</sup> and Holifield's offering will be used extensively in Chapter 2 as the history of pastoral care in America is explored.

With the release of BUMEDINST 1730.1 in March 2011, there is now broad guidance and direction provided as to "what" is expected from BUMED chaplains, but not "how" this is to be accomplished. BUMED has adopted the standards of practice from the Association of Professional Chaplains, which is congruent with expectations from the

---

<sup>26</sup> E. Brooks Holifield, *A History of Pastoral Care in America: From Salvation to Self-Realization* (Eugene, OR: Wipf & Stock Publishers, 2005).

<sup>27</sup> Gleason, 9–14.

National Association of Catholic Chaplains (NACC), the National Association of Jewish Chaplains (NAJC), and the Association for Clinical Pastoral Education (ACPE). Further, BUMED requires that all Navy chaplains assigned to hospital billets be eligible to sit for board certification.<sup>28</sup>

While U.S. Navy chaplains are offered a one-year pastoral care residency through BUMED, which satisfies the basic requirements for board certification, there is an additional requirement from the APC for 2,000 hours of post-CPE supervision and an appearance before a certification committee to demonstrate the twenty-nine competencies found in the Common Standards.

To address these previously mentioned competencies, Rabbi Stephen Robert's volume, *Professional Spiritual and Pastoral Care: A Practical Clergy and Chaplain's Handbook*,<sup>29</sup> is a compilation of work by several APC board certified chaplains (BCC) that helps to guide the pastor or chaplain in a healthcare setting and helps to meet the competency requirements to become a BCC. Robert's book is an essential resource that integrates the classic foundations of pastoral care with the latest approaches to spiritual care. Roberts and his contributors offer the latest theological perspectives and tools, along with basic theory and skills from the best pastoral and spiritual care texts, research, and concepts. It is not a step-by-step or "how to" book; rather, it points the individual in the right direction to further his own understanding of the theological and spiritual basis for chaplaincy.

---

<sup>28</sup> BUMED will accept board certification from the APC, NACC, NAJC, and the College of Pastoral Supervision and Psychotherapy (CPSP).

<sup>29</sup> Stephen B. Roberts, ed, *Professional Spiritual and Pastoral Care: A Practical Clergy and Chaplain's Handbook* (Woodstock, VT: Skylight Paths Publishing, 2012).

Larry VandeCreek and Art Lucas's *The Discipline for Pastoral Care Giving: Foundations for Outcome Oriented Chaplaincy*<sup>30</sup> is considered essential reading for the professional chaplain. Hospital administrators and other ancillary professionals on care teams often need help to grasp the contributions and value of chaplaincy care in outcome oriented, observable, documentable, changes for the better terms. This book was the first to develop and describe the foundations of the new paradigm for hospital chaplaincy now being embraced by BUMED. VandeCreek and Lucas's approach enhances supportive, effective spiritual care for service members and authorized personnel and communicates substantive outcomes to leaders and clinicians alike. Roberts's book and VandeCreek and Lucas's offering will be used as the foundational sources for Chapter 3 in which the OOC paradigm and BUMED expectations for U.S. naval chaplains are explained. Fitchett's,<sup>31</sup> Hodge's,<sup>32</sup> Koenig's,<sup>33</sup> and Puchalski's<sup>34</sup> writings will be used to address the topic of spiritual assessments in this same chapter.

---

<sup>30</sup> Larry VandeCreek and Arthur M. Lucas, eds., *The Discipline for Pastoral Care Giving: Foundations for Outcome Oriented Chaplaincy* (New York: Haworth Press, 2007).

<sup>31</sup> George Fitchett, *Assessing Spiritual Needs* (Lima, OH: Academic Renewal Press, 2002).

<sup>32</sup> David R. Hodge, "A Template for Spiritual Assessment: A review of the JCAHO requirements and guidelines for implementation," *Social Work* 51 (2006): 317-326.

<sup>33</sup> Harold G. Koenig, M.D., "Taking a Spiritual History," *Journal of the American Medical Association* 291, no. 23 (2004): 2881.

<sup>34</sup> Christina M. Puchalski, "Spiritual Assessment in Clinical Practice," *Psychiatric Annals* 36 (2006): 150-155.

There seem to be numerous recent offerings that address the role of spirituality in the provision of healthcare. Christina Puchalski, M.D.<sup>35</sup> The providers at the George Washington Institute of Spiritual Health (GWISH, a branch of the George Washington University School of Medicine) have compiled an excellent offering to address this vital need. Likewise, John Peteet and Michael D'Ambra's<sup>36</sup> offering also speaks to physicians and mental health professionals, using evidenced-based outcomes to demonstrate the validity and vital importance of addressing the spiritual aspect of the patient to promote holistic healing. These two offerings are valuable because they provide the chaplain with a scientific basis for approaching members of the care team because the theological and spiritual aspects of care are included in the conversation. Both Puchalski's work and Peteet and D'Ambra's work will be used as the primary sources for Chapter 4 in which spiritual fitness is addressed.

*Theory and Practice of Counseling and Psychotherapy*<sup>37</sup> by Gerald Corey is a college freshman level introduction to the numerous approaches to counseling and psychotherapy that includes a very beneficial historical overview of the founders of the individual approaches. This volume is easy to understand for those who do not have a background in psychology or the social sciences.

---

<sup>35</sup> Christina M. Puchalski, M.D. and Betty Ferrell, RN, PhD. *Making Health Care Whole: Integrating Spirituality in Patient Care* (West Conshohocken, PA: Templeton Press, 2010).

<sup>36</sup> John R. Peteet M.D. and Michael N. D'Ambra, M.D., *The Soul of Medicine: Spiritual Perspectives and Clinical Practice* (Baltimore, MD: The Johns Hopkins University Press, 2011).

<sup>37</sup> Gerald Corey, *Theory and Practice of Counseling and Psychotherapy*, 8th ed. (Belmont, CA: Brooks/Cole, 2009).



As the hospital chaplain is the ethics advisor to the command, a foundation in healthcare ethics is needed. The book, *Principles of Biomedical Ethics*,<sup>38</sup> serves as a guide to ethics and morality in the health professions. Tom Beauchamp and James Childress have revamped their earlier work and proposed four principles that lie at the core of moral reasoning in healthcare: respect for autonomy, nonmaleficence, beneficence, and justice. They consider what constitutes moral character and address the problem of moral status: what rights are due to people and when. This book also examines the professional-patient relationship, surveys major philosophical theories—including utilitarianism, Kantianism, rights theory, and communitarianism—and describes methods of moral justification in bioethics. This book is a required reading for the hospital chaplain. *Care of the Soul in Medicine*<sup>39</sup> is Thomas Moore's manifesto about the future of healthcare. In his new vision for healthcare, the author addresses the importance of healing a person rather than simply treating a body. He gives advice to healthcare providers and patients for maintaining dignity and humanity, as well as provides spiritual guidance for dealing with feelings of mortality and threats to health, and encouraging patients not only to take an active part in healing but also to view illness as a positive passage to new awareness. While researchers do not fully understand the extent to which healing depends on attitude, it has been shown that healing needs to focus on more than the body. The future of medicine is not only in new

---

<sup>38</sup> Beauchamp, Tom and James F. Childress. *Principles of Biomedical Ethics*, 6th ed. (Oxford: Oxford University Press, 2009).

<sup>39</sup> Thomas Moore, *Care of the Soul in Medicine: Healing Guidance for Patients, Families, and the People who Care for Them*. New York: Hay House, Inc., 2010.

technical developments and research discoveries, it is also in appreciating the state of soul and spirit in illness.

This student first read John Patton's offering, *Pastoral Care: An Essential Guide*, during his pastoral care residency and was struck by its simplicity. Patton opines that the essentials of pastoral care involve the pastor or chaplain's distinctive task of caring for those who are estranged—the lost sheep. He uses the biblical image of the shepherd to demonstrate how the pastor, by virtue of his professional calling, cultivates sage judgment in order to “hear” those who are hurting and offer guidance, reconciliation, healing, sustaining presence, and empowerment to those in need. By discussing four major kinds of loss—grief, illness, abuse, and family challenges—this book further outlines the quintessential elements clergy of all offices need in order to wisely minister in today's context.<sup>40</sup>

Doehring's postmodern approach encourages counselors and chaplains to view their ministry through “trifocal lenses and include approaches that are premodern (apprehending God through religious rituals), modern (consulting rational and empirical sources), and postmodern (acknowledging the contextual nature of knowledge).”<sup>41</sup> Doehring describes the basic ingredients of a caregiving relationship, suggests how the caregiver's life experience can be used as a source of authority, and demonstrates how to develop the skill of empathic listening and establish an

---

<sup>40</sup> John Patton, *Pastoral Care: An Essential Guide* (Nashville: Abingdon Press, 2005).

<sup>41</sup> Carrie Doehring, *The Practice of Pastoral Care: A Postmodern Approach* (Westminster: John Knox Press, 2006), 2.

authentic relationship with the patient.<sup>42</sup> For the purposes of this project, both Patton and Doehring's books will be used to give an introduction to postmodern pastoral care.

The *magnum opus* for understanding the relationship between medicine and religion is Dr. Harold Koenig's newly released *The Handbook of Religion and Health*.<sup>43</sup> This text has become the formative research text on religion, spirituality, and health, outlining a rational argument for the connection between religion and health. This second edition completely revises and updates the first edition that was released in 2001. What makes this work so influential is the fact that its authors are physicians: a psychiatrist and geriatrician, a primary care physician, and a professor of nursing and specialist in mental health nursing. The authors use clinical methods and an evidence-based approach in presenting their research and findings. The opening chapter surveys the historical connections between religion and health, and grapples with the distinction between the terms "religion" and "spirituality" in research and clinical practice. It reviews research on religion and mental health, as well as far-reaching research literature on the mind-body relationship, and he develops a model to explain how religious involvement may impact physical health through the mind-body mechanisms. It also explores the direct relationships between religion and physical health, covering topics related to religion and specific organ systems and functions. The authors observe the significances of illness and quality of life. Finally, this book reviews research methods and addresses applications to clinical practice.

---

<sup>42</sup> Ibid.

<sup>43</sup> Koenig, Harold, Dana E. King, and Verna Benner Carson, *The Handbook of Religion and Health*, 2nd ed. (New York: Oxford University Press, 2012).

Various theological perspectives are concomitant throughout the entire book. *The Handbook of Religion and Health* and the newly released *Oxford Textbook of Spirituality in Healthcare*<sup>44</sup> are the two most insightful and authoritative resources available to anyone who wants to understand the relationship between religion and health.

---

<sup>44</sup> Cobb, Mark, Christina Puchalski, and Bruce Rumbold, *Oxford Textbook of Spirituality in Healthcare*, (Oxford, UK: Oxford University Press, 2012)

## CHAPTER 2

### THE RESEARCH

#### **Introduction**

The following describes the research design employed in this project and includes the identification and rationale for the selection of participants, the approach to the research, the instruments used in collecting data, and the interpretive methodology employed in analyzing the data collected.

#### **Research Design**

##### General Approach

This project is a quantitative, cross sectional study<sup>1</sup> that will use an electronic survey instrument to obtain basic demographic information about the medical and ancillary staff at USNHOKI and to quantitatively and qualitatively characterize the importance of the Navy

---

<sup>1</sup> Cross-sectional studies used in survey research make up the vast majority of studies in religion/spirituality and healthcare. Dr. Harold Koenig describes this type of design as involving “taking a snapshot of the association between two characteristics at one point in time.” For example, in this project, this student develops a questionnaire that asks about rank/rate, gender, spiritual values, chaplain experiences, and spiritual experiences, and sends out the questionnaire via email to twelve hundred people. Of those who receive the questionnaire, two hundred and fifty fill it out (20 percent response rate, which is typical for a single mailed survey) and send it back to this student. This student enters the data into a data file and then analyzes the relationship between religious values and rank/rate, controlling for professional qualifications and gender. Since there is no follow-up and the questionnaire has only been administered once, this is a cross-sectional study. For more detailed information on the different types of research being conducted in spirituality and healthcare see: Harold G. Koenig, *Spirituality and Health Research: Methods, Measurements, Statistics, and Resources* (West Conshohocken, PA: Templeton Press, 2011).

chaplain in responding to the emotional and moral needs and/or injuries of members and their families. Seven questions collect data using a Likert scale format; the other three questions are phenomenological and ethnographic in design.

### Methods

Participants were asked to share their opinions of and experiences with Navy chaplains within the BUMED or clinical setting, particularly at the USNH. The survey instrument, an online electronic survey, was designed to provide a series of general and specific questions (subjectively) that allowed the participant to demonstrate their knowledge on the role/value of the chaplain. The questions were derived from the general and specific duties, role, and expected practices of a BUMED chaplain that are found in BUMED Instruction (BUMEDINST) 1730.2A, *Navy Medicine Plan for Religious Ministries including Pastoral Care Services*.

### Statistical Analysis

This project solicited the input of up to 1,200 personnel with an expected participation of 20% (240) and a minimum of twenty respondents per category. There were three categorical variables, i.e., officer, enlisted, and civilian. Of most importance to this student are the responses of fellow officers (officers will be the reference category). Using “dummy” variables (k-1 binary variables), the study will compare officers to enlisted, officers to civilian, and enlisted to civilian responses. A simple chi-square test ( $\chi^2$ ) will be applied to determine statistical differences between each category. All tabulations will be presented as bar charts. Any lessons learned from the charts will be noted and addressed in the results. Any cross tabulation will be presented in tables.

These tables may compare responses to questions 5 through 14, filtered by all combinations of the demographic tables established in questions 1 through 4. These filters

include: rank, gender, military occupational specialty/rating, service branch, and professional qualifications. The study will look to identify statistical significance within each respective demographic group and discuss any findings and possible interpretations in the results.

#### Military Relevance and Operational Implications

The medical importance of this research project is the potential increase in quality of care provided to patients, family, and staff members who are assigned to or receive medical care in or through the USNH. As spirituality is considered to be the fourth pillar of total wellness by both medical and psychological providers, it will serve all BUMED chaplains to have an understanding of what their colleagues, fellow officers, staff, and ancillary staff understand the role of the chaplain to be; it will also provide the chaplain a baseline to begin educating his colleagues as to how spiritual care can best be incorporated into the care of the patient. Operationally, this same increase in quality of chaplaincy, pastoral, and spiritual care delivered to those forward deployed or serving in combat zones or in overseas fleet hospitals and medical facilities is equally possible.

#### Data Analysis Plan

There is no data safety monitoring board involved with this project. Data analysis will not occur until after the end date given. There will be no interim analysis of the data at any point of the study; however, the total number of participants will be monitored to ensure maximum participation from all eligible personnel. There are no pre-set criteria to dictate early discontinuation of this study.

### Subject Population

Subject Inclusion Criteria: The subject population was comprised of U.S. military personnel and U.S. government employees who are eligible for status of forces agreement (SOFA) status (male & female). The survey was offered to all personnel assigned to a USNH, including all services and ranks/rates attached/assigned to the USNH. No patients or minors participated in this study. Ages ranged from eighteen years and up. Health status was not a consideration for participating in this study. Subject Exclusion Criteria: Patients, minors, and non-SOFA employees, specifically Japanese military labor contract (MLC) employees were not solicited nor allowed to participate in this research project.

### Protected Population

Participants who could possibly qualify as members of a protected (or vulnerable) population<sup>2</sup> were included in this survey, specifically those members of the command who may have been or were pregnant at the time they completed this survey. However, such a condition was not relevant to this study. In 45 CFR 46 Subpart B, §46.204 Research Involving Pregnant Women or Fetuses (sections [a] through [j]), the conditions that must be met to conduct research involving pregnant women is described, as these are “subjects likely to be vulnerable to coercion or undue influence.” The required appropriate additional safeguards to protect their rights and

---

<sup>2</sup> Vulnerable populations include children, prisoners, pregnant women, mentally disabled persons, or economically or educationally disadvantaged persons. These groups are considered protected/vulnerable due to the potential of coercion, harm, and general lack of ability to protect themselves due to their current life circumstances. As such, individuals in these categories are afforded special consideration and protection by federal law when involved as research subjects. For more detailed information see: The Liberty University IRB Handbook available at <http://www.liberty.edu/index.cfm?PID=12606>.



welfare were included in that their pregnancy status was inconsequential for the purposes of this study. There was no more risk to mother and fetus than there was to any non-pregnant female or any male. This is a less-than-minimal risk study.

#### Method of Subject Identification and Recruitment

All Status of Forces Agreement<sup>3</sup> (SOFA), Navy, Air Force, Marine Corps, and Army personnel assigned to the U.S. Naval Hospital (USNH) and its outlying branch clinics were eligible to participate. Recruitment was based on information derived from the USNH Command Alpha Roster.<sup>4</sup>

#### Consent Process

Informed consent information was included in the email instructions sent to participants. By proceeding to the survey website participants acknowledged that they had read through participant instructions to include the purpose, scope, and method that data was to be gathered. The survey instrument is administered electronically and no signature is needed.<sup>5</sup>

---

<sup>3</sup> U.S.–Japan Status of Forces Agreement or SOFA status is special diplomatic standing that governs the treatment of U.S. Armed Forces stationed in Japan. The official title is the *Agreement under Article VI of the Treaty of Mutual Cooperation and Security between Japan and the United States of America, Regarding Facilities and Areas and the Status of United States Armed Forces in Japan*. This agreement between Japan and the U.S. was approved and enacted in 1960 as stipulated in article VI of the *U.S.-Japan Security Treaty*, signed January 19, 1960 in Washington.

<sup>4</sup> An Alpha Roster is a document that contains the names of all personnel, military or civilian that are assigned to a Department of Defense activity.

<sup>5</sup> See APPENDIX A for the actual message sent to recruit participants.

### Research Material Collected

The survey data was collected between March 21 and April 5, 2013. The survey sample population for this study included a diverse group of military personnel, all ranks and ethnic backgrounds. This student considered the following in interpreting the research: commissioned officer versus chief petty officer versus enlisted versus civilian. These population groups comprise the medical, ancillary, enlisted, and civilian staff of the USNH. No patient(s), either inpatient or outpatient, was included in the survey sample. Japanese MLC civilians were also excluded from this survey; only those employees with SOFA status were offered participation in this survey. This data was collected via electronic survey and the survey was designed under the guidance of Dr. Robert Riffenburg, Ph.D., Naval Medical Center, San Diego (NMCSD) Command Statistician.

### Research Results

The results of the research reveal that USNH personnel share many generalized ideas concerning the role and value of the chaplain. As this survey is quantitative in design and no formal interviews were conducted with any of the participants, the conclusions drawn are based on both the median scores and modal scores, and the informal conversations related to this project with staff members and members of the command research committee.

### Survey Instrument Results

The following table represents the demographic make-up, in terms of rate, medical specialty or civilian status of the staff of USNHOKi participants in this research project. Table 2.1 also reflects the total number of responses of all participants.

Table 2.1. Total responses and percentages by rank/rate

<i>Please list your branch (officers, e.g., MC, NC, DC, MSC, etc.) or rate (enlisted, e.g., corpsman, MA, OS, etc.)</i>		
Answer Options	Response Percent	Response Count
Medical Corps (MC)	12.4%	31
Nurse Corps (NC)	14.8%	37
Dental Corps (DC)	0.4%	1
Medical Service Corps (MSC)	12.8%	32
Hospitalman (all ranks)	38.0%	95
Civilian	17.6%	44
Other	3.6%	9
<i>Answered question</i>		250
<i>Skipped question</i>		0

Table 2.2 depicts, by pay-grade, the staff of USNHOKi who chose to participate in this research project.

Table 2.2. Respondents by pay-grade

Pay grade	# Respondents	Percentage of Respondents
E1-E3 (Lower Enlisted)	31	12.4%
E4 to E6 (Petty Officer)	57	22.8%
E7 to E9 (Chief Petty Officer)	11	4.4%
O1 to O3 (Company Grade)	53	21.2%
O4 to O6 (Field Grade)	52	20.8%
GS1 to GS5	1	>1%
GS6 to GS7	1	>1%
GS8 to GS9	8	3.2%
GS10 to GS13	18	7.2%
Contractors	14	5.6%
Civilian	4	1.6%
<b>TOTAL</b>	<b>250</b>	<b>100%</b>

Table 2.3 (see below), is a representation by gender of the staff of USNHOKi that chose to participate in this research project. This is an excellent result in terms of participation by female members, as approximately 17% of the total active naval service is comprised of female officers and Sailors. Fifty-eight total active duty females or 28.2% completed this survey. One hundred and one total responses were by females which comprised 40.2% of all participants.

Table 2.3. Respondents by gender

<i>What is your gender?</i>		
Answer Options	Response %	Response Count
Female	40.2%	101
Male	59.8%	148
<i>Answered Question</i>		249
<i>Skipped Question</i>		1

Table 2.4, (following page), is a statistical breakdown of survey participants by branch of military service. Seven participants skipped this question by selecting “Other” but subsequently failed to identify themselves even though the option to write in an affiliation was available.

Table 2.4. Respondents by service branch

<i>What is your branch of service? service branch (if any)</i>							
Answer Options	USN	USAF	USMC	USA	USCG	Civilian	Response Count
(Select one)	<b>199</b> <b>82.2%</b>	10 4.1%	2 0.8%	0	0	31 12.8%	242
<i>Answered Question</i>							242
<i>Skipped question</i>							8

Table 2.5 (below), is a statistical breakdown of the initial view of the role/work that the chaplain performs as a member of the USNH care team. This is the first of three qualitative or phenomenological questions seeking to have the respondent identify the chaplain with a particular role or function in which all BUMED chaplains are already associated. “When the word ‘chaplain’ is used in my presence, I generally think of...” The respondents were provided four possible answers and a fifth option to write-in an answer of “Other.”

Table 2.5. Primary view of the chaplain

<i>When the word “chaplain” is used in my presence, I generally think of:</i> (Select One)		
Answer Options	Response Percent	Response Count
a. Skilled Clinician	1.6%	4
b. Professional Colleague	8.0%	20
<b>c. Pastor/Priest</b>	<b>85.2%</b>	<b>213</b>
d. Another Naval Officer	1.6%	4
e. Other	3.6%	9
<i>Answered question</i>		250
<i>Skipped question</i>		0

Figure 2.5, on the following page, is a column chart representing of the initial view of the role/work that the chaplain performs as a member of the USNH care team. The identity of pastor/priest is the overwhelming view of the chaplain held by all respondents across all possible variables who participated in this survey.

Fig. 2.1 Primary view of the chaplain

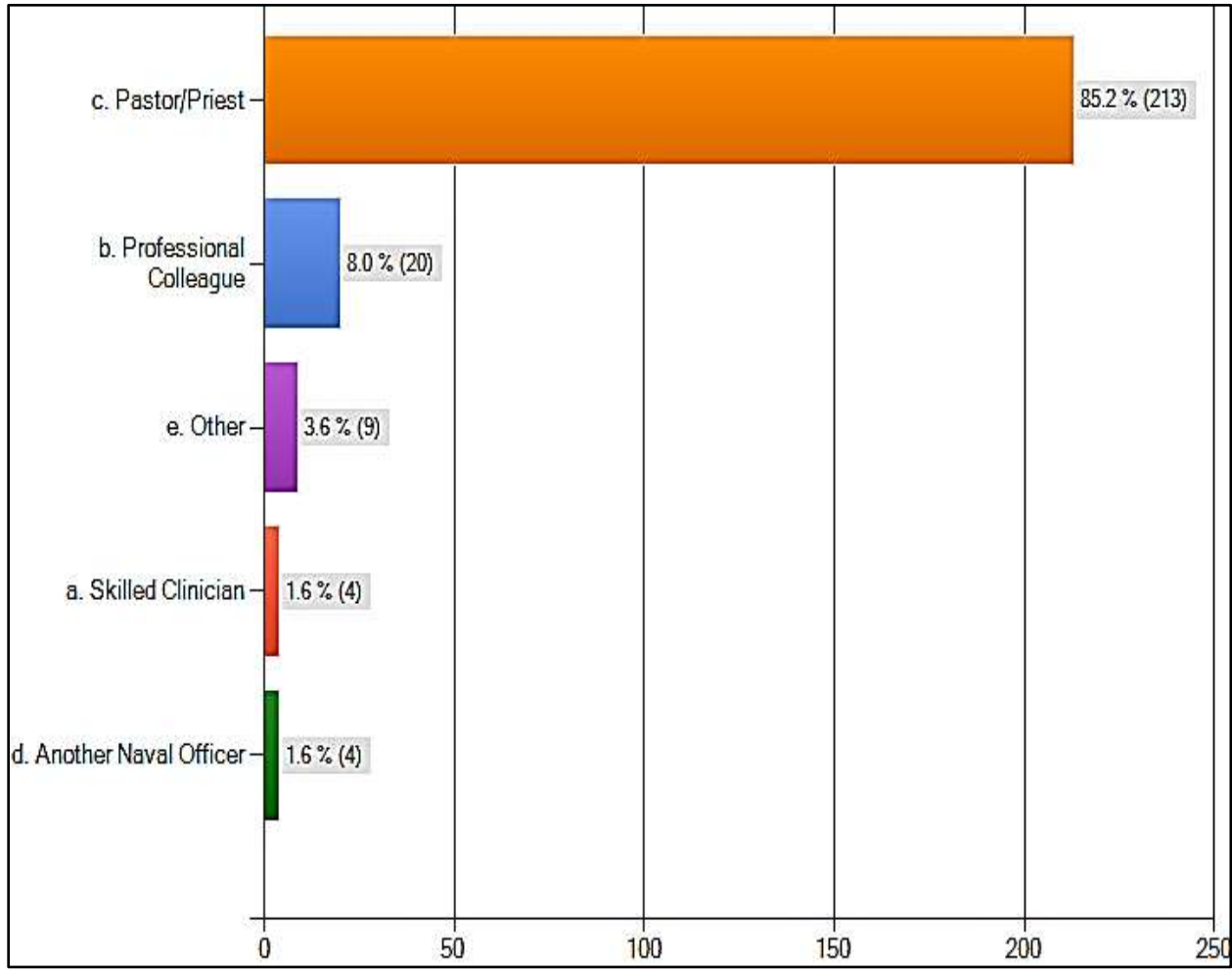


Table 2.6 is a statistical breakdown of the understanding of the phrase “ministry of presence” by members of the USNH Care Team. This is the second of three qualitative or phenomenological questions seeking to have the respondent state their understanding of a phrase that all Navy chaplains are familiar with. While the Navy chaplain would most identify with answer (a) *a visible reminder of the presence of the Sacred*, the respondents, in contrast, chose a more proactive answer in (b) *a chaplain being available to sit with the ill or injured*, as their primary understanding of ministry of presence.

Table 2.6. Primary understanding of “ministry of presence”

<i>For me, “Ministry of Presence” is best described as:</i>		
Answer Options	Response %	Response Count
a. A visible reminder of the presence of the Sacred	24.0%	60
<b>b. A chaplain being available to sit with the ill or injured</b>	<b>41.2%</b>	<b>103</b>
c. I am unsure/never heard this term before	40.0%	100
d. Other	5.2%	13
<i>Answered question</i>		<b>250</b>
<i>Skipped question</i>		0

Table 2.7 is the statistical breakdown of the third of three qualitative/phenomenological questions seeking to have the respondent state their personal expectations in regards to the works of the Navy chaplain at the USNH. The Navy chaplain would most identify with answers (a) and (e), i.e., provides pastoral care and counsel to patients and provides pastoral care and counsel to staff. However, the respondents chose (a) and (b) *provide religious ministry and chapel services* as their greatest expectations of the chaplains assigned to a USNH. These responses are more in line with a view of hospital chaplaincy that was most prevalent until about 1950, but not necessarily that which a professional hospital chaplain in the civilian sector today would find himself in agreement.

Table 2.7. Primary and secondary expectations of the chaplain

<i>My greatest expectation(s) from my chaplain is: (select two)</i>		
Answer Options	Response %	Response Count
<b>a. Provide pastoral care/counsel to my patients</b>	<b>66.0%</b>	<b>165</b>
<b>b. Provide religious ministry and chapel services</b>	<b>44.0%</b>	<b>110</b>
c. Listen to my problems empathically/non-judgmentally	30.0%	75

d. Provide pastoral care/counsel to my family members	15.6%	39
e. Provide pastoral care/counsel to hospital staff	32.8%	82
f. Advise members of the hospital staff	20.4%	51
g. Other	4.0%	10
<i>Answered question</i>		<b>250</b>
<i>Skipped question</i>		0

The data collected for Table 2.7 is presented in a final form in Figure 2.2. Using a bar chart, provides a visual/graphic representation of the importance of the two greatest expectations of the chaplain as ranked by the staff of U.S. Naval Hospital that participated in the research.

Fig. 2.2. Primary and secondary expectations of the chaplain

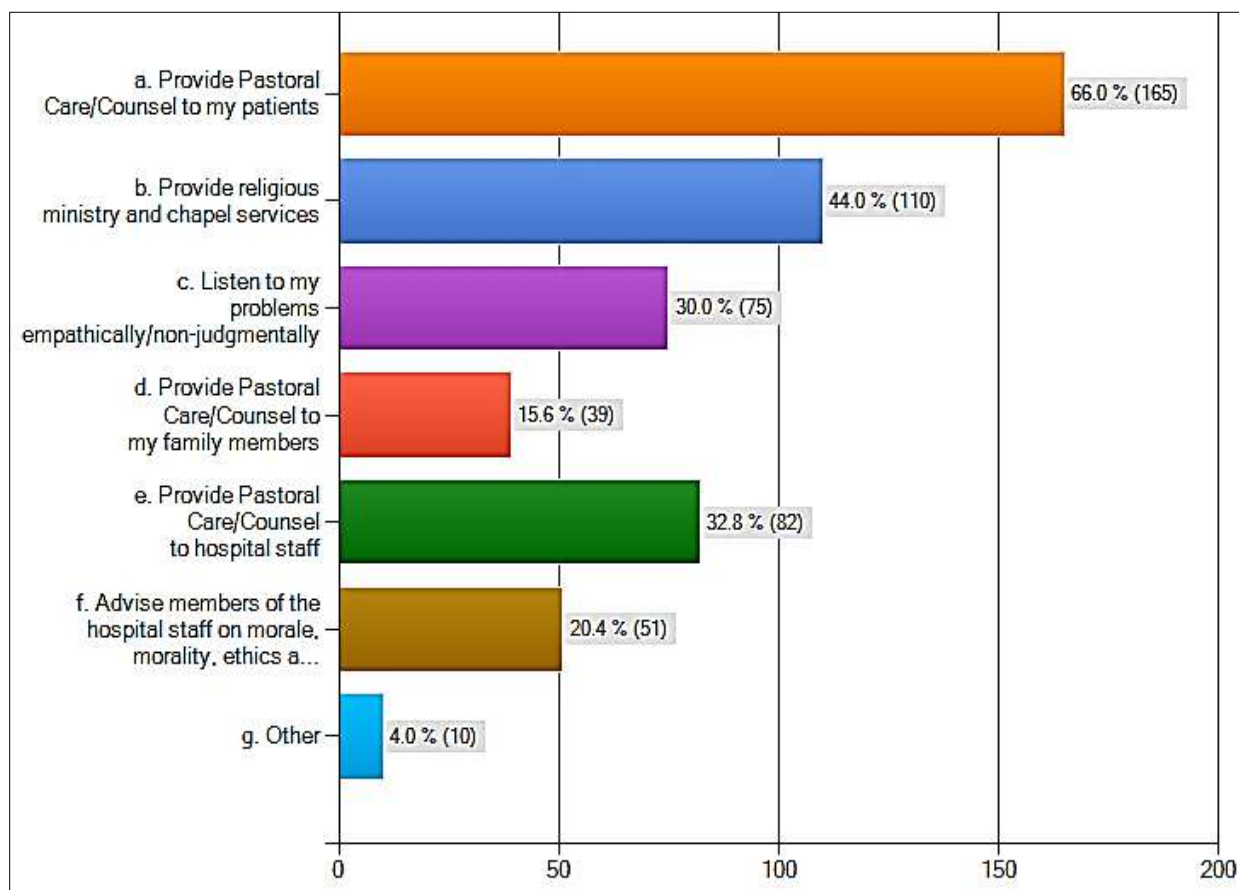




Table 2.8. Respondent's view/value of pastoral care services

<i>"Pastoral care services and chaplains at U.S. Naval Hospital Okinawa is mission essential"</i>							
Answer Options	Strongly Disagree	Disagree	Neither Agree/Disagree	Agree	Strongly Agree	Rating Average	Response Count
Responses	3	3	17	76	<b>151</b>	<b>4.48</b>	<b>250</b>
Mean= 4.48, Median= 5, Mode= 5, Range= 4						<i>Answered question</i>	250
						<i>Skipped question</i>	0

The data collected from the survey instrument is presented in a final form in Figure 2.3 (see below) which provides a graphic representation of the personal belief of whether the work of the chaplain is understood to be mission essential as determined by the staff of the USNH that participated in the research. Using a Likert scale with a range of 1 being Strongly Disagree and 5 being Strongly Agree, the mean score is 4.48 with the mode being 5-Strongly Agree.

Fig. 2.3 Pastoral care/chaplain's work is "mission essential"

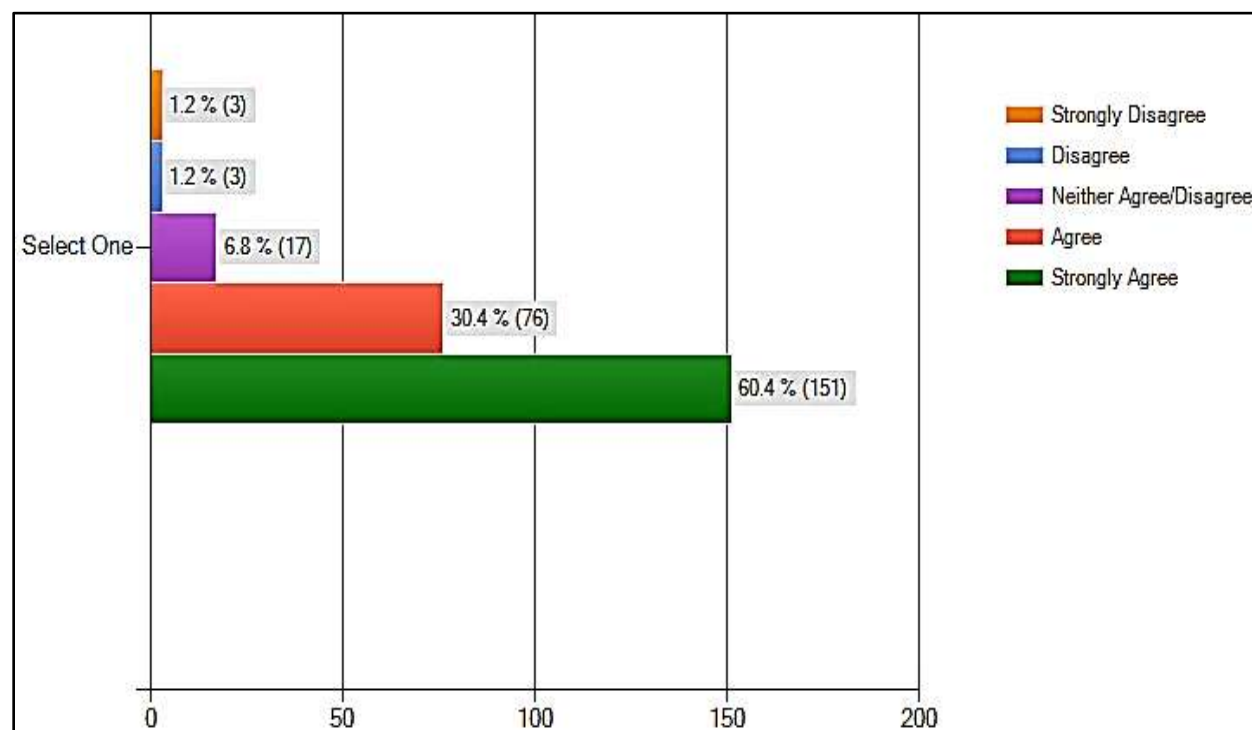


Table 2.9. Value of chaplain input to the care team

<i>"I believe the clinical input regarding patient care provided by my chaplain to me and members of the care team is important."</i>							
Answer Options	Strongly Disagree	Disagree	Neither Agree/Disagree	Agree	Strongly Agree	Rating Average	Response Count
Responses	4	10	30	<b>109</b>	97	<b>4.14</b>	<b>250</b>
Mean= 4.14, Median= 4, Mode= 4, Range= 4						<i>Answered question</i>	<b>250</b>
						<i>Skipped question</i>	0

The data collected from the survey instrument is presented in a final form in Table 2.9 and Figure 2.4 (see below), which provides a graphic representation of the personal belief of whether the chaplain's input to the care team is valuable, as ranked by the staff of the USNH that participated in the research. Using a Likert scale, with a range of 1 being Strongly Disagree and 5 being Strongly Agree, the mean score is 4.14 with the mode being 4-Agree.

Fig. 2.4 The value of the chaplain's input to the care team

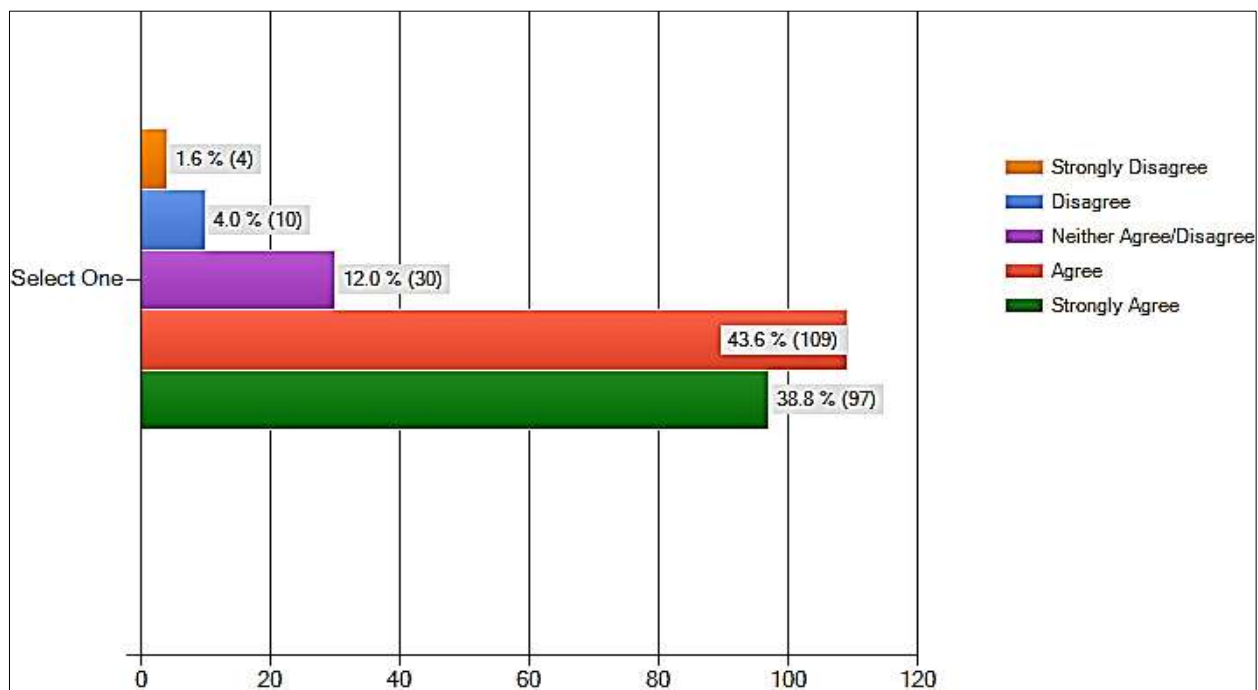


Table 2.10. The value of chaplain input to the patient's medical record

<b><i>"The clinical input regarding patient care provided by my chaplain in the patient's medical record is important."</i></b>							
Answer Options	Strongly Disagree	Disagree	Neither Agree/Disagree	Agree	Strongly Agree	Rating Average	Response Count
Responses	13	23	75	<b>83</b>	56	<b>3.58</b>	<b>250</b>
Mean= 3.58, Median= 4, Mode= 4, Range= 4						<i>Answered question</i>	<b>250</b>
						<i>Skipped question</i>	0

The data collected from the survey instrument is presented in a final form in Table 2.10 (above) and Figure 2.5 (see below), which provides a graphic representation of the personal belief of whether the chaplain input to patient's medical record is valuable, as ranked by the staff of U.S. Naval Hospital which participated in the research. Using a Likert scale, with a range of 1 being Strongly Disagree and 5 being Strongly Agree, the mean score is 3.58 with the mode being 4-Agree.

Fig. 2.5. The value of chaplain input to the patient's medical record

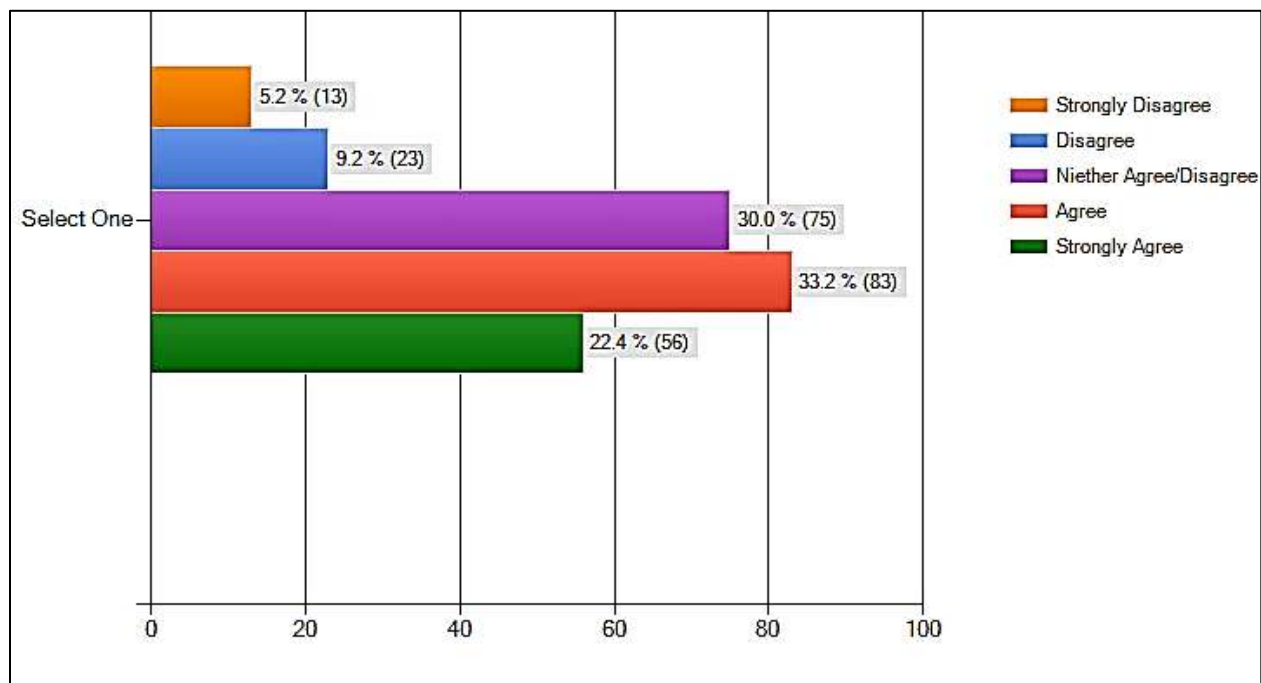


Table 2.11. Respondent's personal value of religion/spirituality

<i>"For me personally, religion/spirituality is important."</i>							
Answer Options	Strongly Disagree	Disagree	Neither Agree/Disagree	Agree	Strongly Agree	Rating Average	Response Count
Responses	16	10	36	68	<b>120</b>	<b>4.06</b>	<b>250</b>
Mean= 4.06, Median= 4, Mode= 5, Range= 4						<i>Answered question</i>	<b>250</b>
						<i>Skipped Question</i>	0

The data collected from the survey instrument is presented in a final form in Table 2.11 (above) and Figure 2.6 (see below), which provides a graphic representation of the personal belief of whether the chaplain input to patient's medical record is valuable, as ranked by the staff of U.S. Naval Hospital which participated in the research. Using a Likert scale, with a range of 1 being Strongly Disagree and 5 being Strongly Agree, the mean score is 4.06 with the mode being 5-Strongly Agree.

Fig. 2.6 Respondent's personal value of religion/spirituality

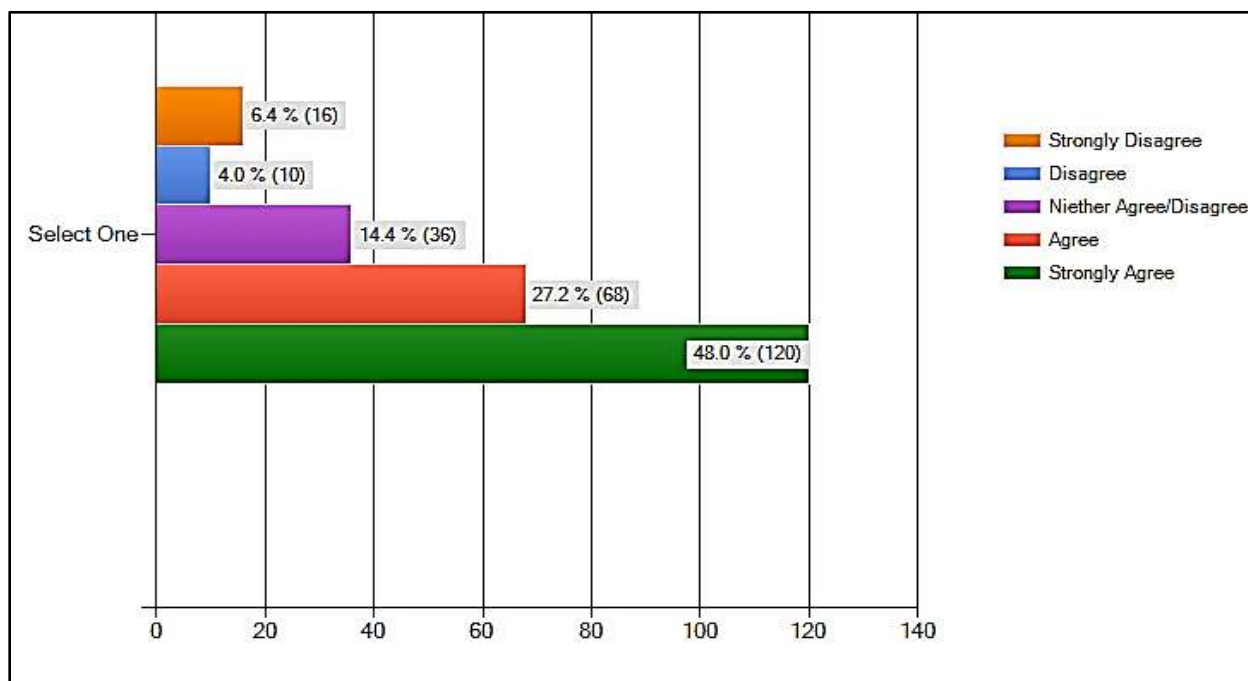


Table 2.12 Respondent's personal value of having a chaplain as a spiritual advisor

<b><i>"Having my chaplain available to provide spiritual guidance and emotional comfort when I have personal problems is important."</i></b>							
Answer Options	Strongly Disagree	Disagree	Neither Agree/Disagree	Agree	Strongly Agree	Rating Average	Response Count
Responses	11	11	31	84	<b>113</b>	<b>4.11</b>	<b>250</b>
Mean= 4.11, Median= 4, Mode= 5, Range= 4						<i>Answered Question</i>	<b>250</b>
						<i>Skipped question</i>	0

The data collected from the survey instrument is presented in a final form in Table 2.12 (above) and Figure 2.7 (see below), which provides a graphic representation of the personal belief of whether the chaplain input to patient's medical record is valuable, as ranked by the staff of the USNH that participated in the research. Using a Likert scale, with a range of 1 being Strongly Disagree and 5 being Strongly Agree, the mean score is 4.11 with the mode being 5-Strongly Agree.

Fig. 2.7. Personal value of the chaplain as a spiritual advisor

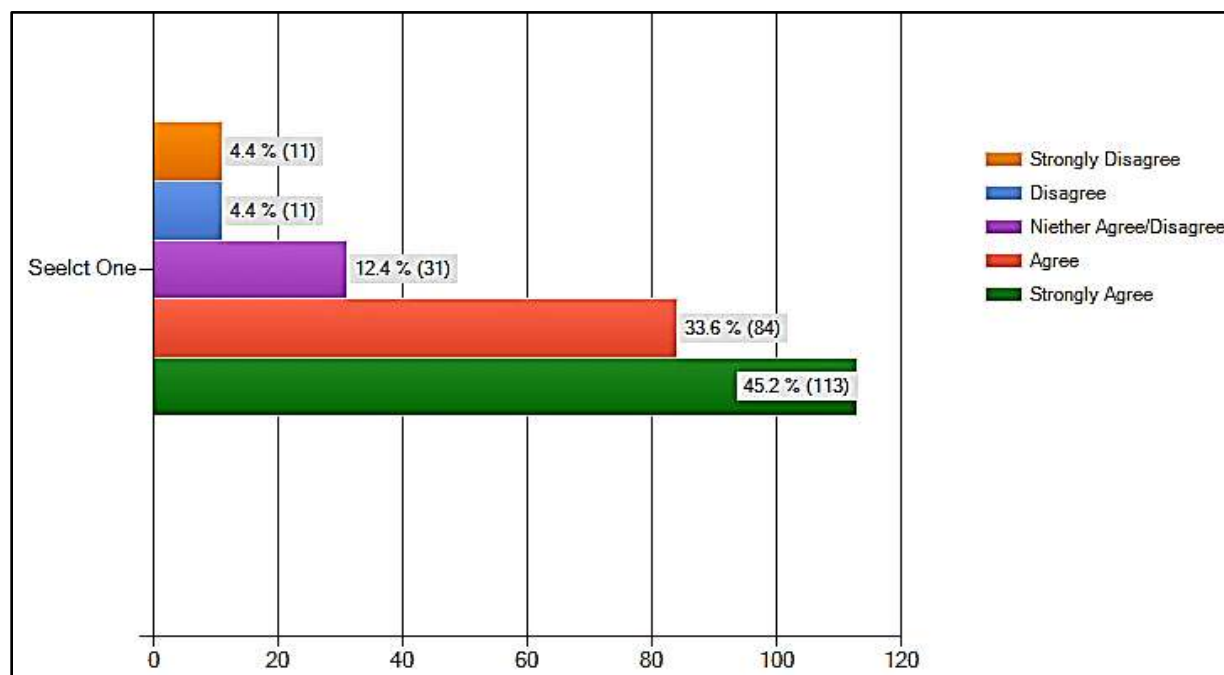


Table 2.13. Respondent's value of privileged communication

<b><i>"Knowing I can share personal issues or issues about my command with my chaplain and know that my information goes no further is important."</i></b>							
Answer Options	Strongly Disagree	Disagree	Neither Agree/Disagree	Agree	Strongly Agree	Rating Average	Response Count
Responses	5	5	28	64	<b>148</b>	<b>4.38</b>	<b>250</b>
Mean= 4.38, Median= 5, Mode= 5, Range= 4						<i>Answered question</i>	<b>250</b>
						<i>Skipped question</i>	0

The data collected from the survey instrument is presented in a final form in Table 2.13 (above) and Figure 2.8 (see below), which provides a graphic representation of the participant's personal belief of whether the chaplain's guaranteed absolute privileged status of any communications made to the chaplain is valuable, as ranked by the staff of the USNH which participated in the research. Using a Likert scale, with a range of 1 being Strongly Disagree and 5 being Strongly Agree, the mean score is 4.38 with the mode being 5-Strongly Agree.

Fig. 2.8. Respondent's value of privileged communication

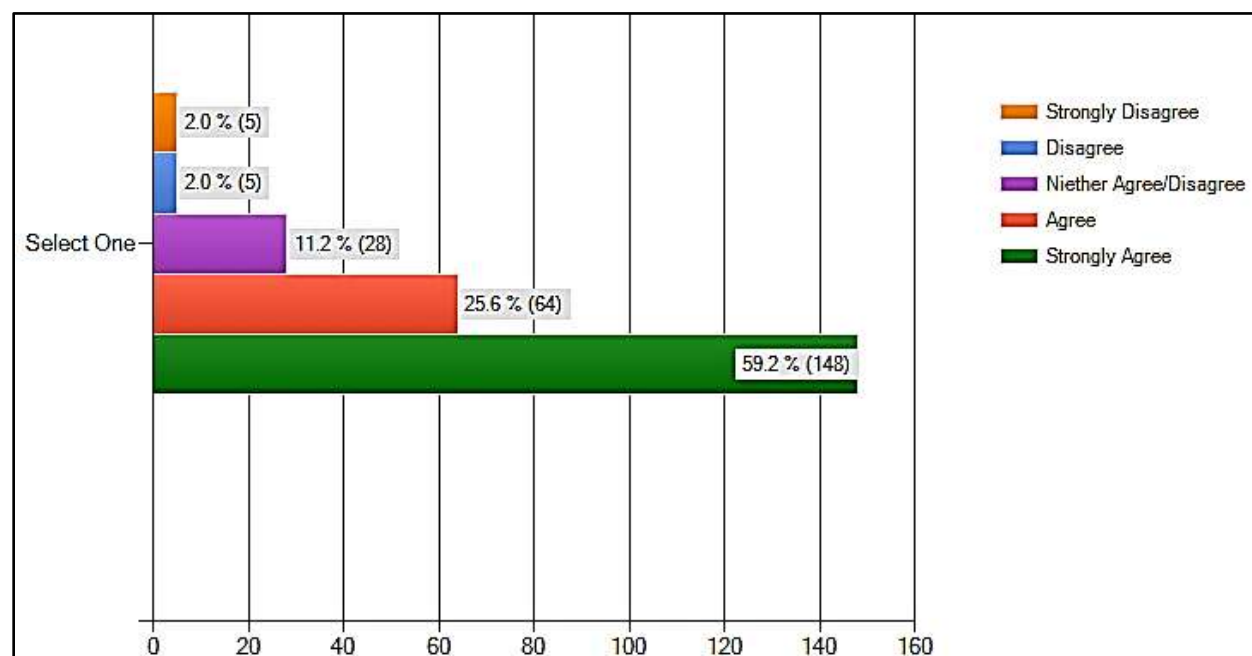
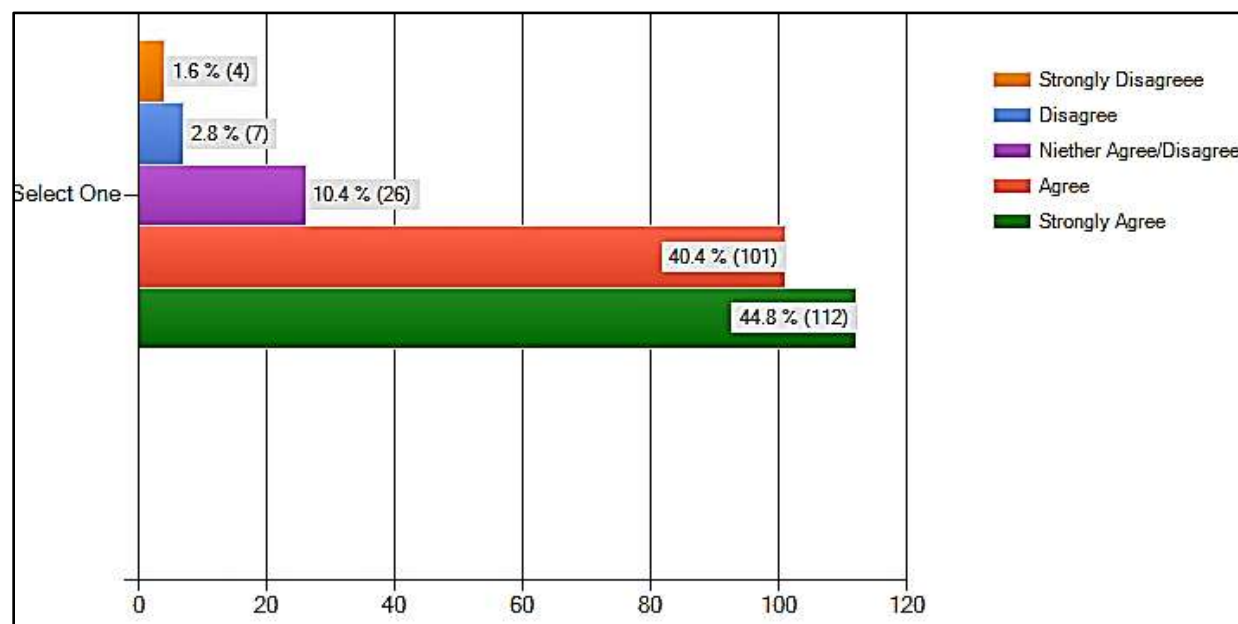


Table 2.14. Respondent's level of trust in the chaplain to provide spiritual care

<i>"My chaplain/pastoral Care Services is best qualified to treat spiritual/moral injuries."</i>							
Answer Options	Strongly Disagree	Disagree	Neither Agree/Disagree	Agree	Strongly Agree	Rating Average	Response Count
Responses	4	7	26	101	<b>112</b>	<b>4.24</b>	<b>250</b>
Mean= 4.24, Median= 4, Mode= 5, Range= 4						<i>Answered question</i>	<b>250</b>
						<i>Skipped question</i>	0

The data collected from the survey instrument is presented in a final form in Table 2.14 (above) and Figure 2.9 (see below) provides a graphic representation of the participant's personal belief of whether the chaplain is the best qualified member of the care team to provide care to those suffering spiritual or moral injuries, as ranked by the staff of U.S. Naval Hospital which participated in the research. Using a Likert scale, with a range of 1 being Strongly Disagree and 5 being Strongly Agree, the mean score was 4.24 with the mode being 5-Strongly Agree.

Fig. 2.9. Level of trust in the chaplain to provide spiritual care



## Summary

It would be unreasonable to expect unanimous agreement among any group as diverse as the U.S. Navy, especially when addressing such topics as religion and spirituality. However, in terms of expectations of the chaplain, the respondents certainly expressed near unanimity in their responses; more than 90% agreed that pastoral care services and chaplains are mission essential in the provision of care for patients. In addition, 85% stated their belief that the chaplain's primary identity is that of a representative of the sacred, i.e., God as a pastor/priest; 82.6% agreed that the input to the interdisciplinary care team is valuable; 55.5% agreed that charting this input into the medical record was valuable. Finally, 85% agreed that the chaplain is the best qualified individual within the MTF to provide care and treatment to those individuals suffering from spiritual and moral injuries. In the near future, this fact will become more significant as the long awaited fifth edition of the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is released. (It is due for publication in May 2013 and will supersede the DSM-IV which was last revised in 2000.) The updated diagnosis criteria for PTSD, acute stress reaction, etc. will include the category of moral/spiritual injury as a mechanism of injury. The following are proposed new diagnosis related to the same mechanism of injury: Posttraumatic Embitterment Disorder (PTED) and Complex Posttraumatic Stress Disorder (C-PTSD). The chaplain is far more qualified to address these types of injuries, especially when related to combat trauma and loss or issues of theodicy; the medical staff surveyed in this study agrees.



CHAPTER 3  
HISTORICAL PARADIGMS IN CHAPLAINCY

**Introduction**

Knowing the religious and theological history of pastoral care and counseling is essential to understanding its method and identity in the interdisciplinary world of the twenty-first century. Pastoral care and counseling have a long history that is rooted in ancient biblical faith and tradition and are most identified with the religious traditions of Judaism and Christianity. St. Ambrose of Milan, one of the Post Nicene fathers, wrote and practiced what Asquith describes as the five modern regions of pastoral care: (1) counseling and soulcare for the bereaved and mourning, the misguided, those seeking perfection, the virgins dedicated to God; (2) worship and homiletics: lively and inspiring, singing-oriented services; well-crafted, Bible-based preaching; (3) outreach/social ministry: giving funds (including his personal wealth) to the poor, special care for the helpless, patron of the orphans; (4) pastoral care and ethics: criticizing the excesses of the upper classes and holding the state morally accountable; insisting on separation between church and state; submission of state to church in matters of faith; practical application of morality and stressing of the four cardinal virtues; and (5) congregational ministry: a strong emphasis on a sense of community among believers, care of the common good against troublemakers, assistance to the needy, affirmation of good members.<sup>1</sup> During the life of St. Ambrose (ca. 339–97) lived another saint whose story has become legendary; his name is St. Martin of Tours (ca. 316–97).

---

<sup>1</sup> Glenn H. Asquith Jr., *The Concise Dictionary of Pastoral Care and Counseling* (Kindle Edition, Abingdon Press), location 1003–1007 of 5402.

In order to understand modern military chaplaincy, one must begin with a look to the past and the legend of St. Martin of Tours. By the use of the word legend, this student does not mean to imply that the story of St. Martin is a fairy tale or not true; rather, it is used in a more formal and academic understanding:

A legend (Latin, *legenda*, “things to be read”) is a narrative of human actions that are perceived both by teller and listeners to take place within human history and to possess certain qualities that give the tale verisimilitude. Legend, for its active and passive participants, includes no happenings that are outside the realm of “possibility,” defined by a highly flexible set of parameters, which may include miracles that are perceived as actually having happened, within the specific tradition of indoctrination where the legend arises, and within which it may be transformed over time, in order to keep it fresh and vital, and realistic. A majority of legends operate within the realm of uncertainty, never being entirely believed by the participants, but also never being resolutely doubted.<sup>2</sup>

The word chaplain is derived from the Anglo-Norman and old French *chapelain*, which is derived from the Medieval Latin *cappellanus*. The word was originally associated with the temporary structure used to house both the cloak and the guardian of the cloak of Saint Martin of Tours. There are numerous accounts with varying degree of detail concerning St. Martin’s legend. For the purposes of this project, the following rendition of this legend will suffice.

Born about AD 316, Martin entered a world in transition. Martin’s father, a Roman army officer, remained faithful to the old religion and suspicious of the new Christian sect, as did Martin’s mother. Martin’s own spiritual yearning and hunger led him, at age ten, to knock secretly on the door of a Christian church and beg to become a catechumen. Martin was still unbaptized when forced to join the Roman army at age 15. He was assigned to a ceremonial cavalry unit that protected the emperor and rarely saw combat. He soon became an officer and was assigned to garrison duty in Gaul. Here, the event took place that has been portrayed in art throughout the ages. On a bitterly cold winter day, the young Roman Tribune (now age 18) rode through the gates, probably dressed in the regalia of his unit with gleaming armor and a beautiful lined cloak. Martin saw a beggar with clothes so ragged that he was practically naked and suffering from the cold. Overcome with compassion, Martin took off his mantle or *cappel*. With a quick stroke of

---

<sup>2</sup> Georges, Robert and Michael Owens, *Folkloristics* (United States of America: Indiana University Press, 1995), 7.

his sword, he slashed the lovely mantle in two, handed half to the freezing man, and wrapped the remainder on his own shoulders. That night Martin dreamed that he saw Jesus wearing the half mantle given the beggar. Jesus said to the angels and saints that surrounded him “See! This is the mantle that Martin, yet a catechumen, gave me.” When he woke he went immediately to be baptized. The cloak eventually became a sacred relic that was carried into battle. The keeper of the Saint Martin’s cloak, the one who carried it into battle, was the chaplain or *cappellanus*.<sup>3</sup>

Historically, all chaplains, whether civilian or military, have been, and still are, the “keepers of sacred things.”<sup>4</sup> The modern day Navy chaplain is exactly that—the guardian and keeper of the sacred in the Sea Services.

### **Hospital Chaplaincy Origins**

The majority of the earliest hospitals were established and run by people of faith or religion. Some were run by monks or priests and some by nuns, but all tended to be affiliated with a religious organization. The early caregivers, whether Christian, Buddhist, or Jewish, were individuals who believed that, “every human being was of infinite value and had a right to be cared for and loved back to health and wholeness, or to be looked after until they died. The aim was to ensure that the sick and injured were not alone when they came to the end of their life.”<sup>5</sup> The inn on the road to Jericho described by Jesus in his parable of the Good Samaritan (Gospel

---

<sup>3</sup> Herman Keizer, Jr., “Caring for the Reputation of Chaplaincy,” *The Military Chaplain* Vol. LXXIX, no. 5 (October 2006): 4  
<http://mca-usa.org/wp-content/uploads/2009/09/October2006.pdf> (accessed April 28, 2012).

<sup>4</sup> *Ibid.*, 4.

<sup>5</sup> ICHC History, <http://www.ichc.org.nz/Hist.htm> (accessed April 28, 2012).

of St. Luke 10:29-37) was, in a way, the equivalent of a first-century AD hospital or hospice of today.<sup>6</sup>

Among the early, well-documented healthcare facilities were the Roman military hospitals.<sup>7</sup> The plans for the one in Vindossa (so called in present-day Switzerland), which was built in the first-century AD, show small patient rooms with ante-rooms built around courtyards. Each room was thought to hold three beds, indicating that the ward concept was used early in the history of hospital development. Some believe that similar hospitals may also have been built for gladiators and slaves due to their financial value; however, there is no evidence that public hospitals were available at that time.<sup>8</sup>

As the Roman Empire turned to Christianity, ca. 325 AD, the Church's role in providing for the sick began to be recognized. During the Middle-Ages, many monasteries were constructed that generally included accommodations for travelers, the poor, and the sick. In the sixth century, Holy Roman Emperor Charlemagne decreed that a hospital was to be attached to every cathedral that was built in his empire.<sup>9</sup> During the Middle-Ages, religious institutions continued to provide most of the healthcare to the poor in large, open wards, while physicians

---

<sup>6</sup> E. Brooks Holifield, *A History of Pastoral Care in America: From Salvation to Self-Realization* (Eugene, OR: Wipf & Stock Publishers, 2005), 14.

<sup>7</sup> Tom Gormely, "The History of Hospitals and Wards," *Healthcare Design* 10, no. 3 (March 2010): 50.

<sup>8</sup> *Ibid.*, 51.

<sup>9</sup> L. Cilliers Retief, "The evolution of hospitals from antiquity to the Renaissance," *Acta Theologica*, Supplementum 7, Vol 26, No 2 (2006): 224.

continued the practice of making house calls to the upper class.<sup>10</sup> Eventually, these hospitals became separate institutions, and the clergy who provided spiritual care and ministry to the sick adopted the title of chaplain. Perhaps this originated with the military priests and their ministry during battles. Likewise, the hospital chaplain was not a diocesan priest who ministered to the general public; rather, his ministry was dedicated to the specific hospital in which they were responsible.<sup>11</sup>

### ***Cura Animarum: A Response to Individual Sin***

#### Early American Pastoral Care

For the first nineteen centuries of the Church's existence, pastors were engaged in the "cure of souls," which was the traditional term for pastoral care.<sup>12</sup> The etymology of this Latin phrase is comprised first of *cura* or "cure," although it also can describe the action or feeling of "care" or "caring."<sup>13</sup> The word "cure" comes from Middle English and is defined as: (1) restoration of health, recovery from disease; (2) a method or course of medical treatment used to restore health; (3) an agent, such as a drug, that restores health, a remedy; and (4) something that

---

<sup>10</sup> Ibid.

<sup>11</sup> Ibid., 51.

<sup>12</sup> John Hannah, "The Cure of Souls; or, Pastoral Counseling: The Insight of John Owen," *Reformation and Revival: A Quarterly Journal for Church Leadership* Vol. 5, No. 3 (Summer 1996): 71.

<sup>13</sup> J.T. McNeill, *A History of the Cure of Souls*, (New York, NY: Harper and Bros., 1951), vii.

corrects or relieves a harmful or disturbing situation.<sup>14</sup> This medical motif for curing or healing in relation to humans is used by Jesus in all three of the synoptic Gospels: “When Jesus heard this, he told them, ‘Healthy people don’t need a doctor—sick people do. I have come to call not those who think they are righteous, but those who know they are sinners’”<sup>15</sup> The words “sick people do” κακῶς ἔχοντες, can be translated to “those who are ill” or “those with illnesses.”<sup>16</sup> Those individuals are the ones referred to by Jesus in this passage as ἁμαρτωλούς, or “who are sinners.”

*Anima* (*animarum*) is the most common Latin translation of the Hebrew word נֶפֶשׁ (*nephesh*)<sup>17</sup> and can be translated as a soul, living being, life, self, person, desire, passion, appetite, emotion, or breath. It is also the common translation for the Greek word ψυχή, which can be translated as life, lives, [your] souls, of life, of soul, person, or people. However, the primary New Testament (NT) of “soul” stands for the essential human being, with emphasis on its transcendent destiny.<sup>18</sup> The care or cure of souls, then, is to be differentiated from other valid

---

<sup>14</sup> *Collins English Dictionary – Complete and Unabridged*. s.v. "cure." Retrieved April 10, 2013 from <http://www.thefreedictionary.com/cure>

<sup>15</sup> Mark 2:17, NLT.

<sup>16</sup> NLT Interlinear, “Mark 2: 1-28”, <http://nltinterlinear.com/Mark.2.1-28/interlinear> (accessed May 15, 2012).

<sup>17</sup> Google translate Hebrew to Latin to Greek to English.

<sup>18</sup> Glenn H. Asquith, Jr., “Care of Souls,” *The Concise Dictionary of Pastoral Care and Counseling* (Kindle Edition, Abingdon Press, 2010), location 383–400 of 5402.

helping enterprises, for example, medicine or law, as it is concerned with ultimate meaning, which is the eternal destiny of the soul.<sup>19</sup>

According to Asquith, the term “care of souls” or “cure of souls” historically is used in three ways:

1. Its broadest use sums up the work of the office of priest, including leading worship, preaching, visiting, and organizing parish life. In this sense, “care of souls” acknowledges that all acts of ministry have as their ultimate aim the salvation and perfection of persons under God. In the Roman Catholic and Episcopal traditions a “curate” was one who had received the cure of souls by legitimate appointment to the office of parish pastor or assistant pastor. The bishop, likewise, exercised this care toward the diocese, and the pope toward the whole church.
2. In a narrower sense, “care of souls” describes a particular strand of pastoral care tradition, Seelsorge, stemming from the Reformation and especially prominent in Lutheran pastoral theology. According to J. T. McNeill, Lutheran practice rejected the compulsory nature of the confessional, but maintained it as a searching personal conversation on religious problems. Pastors gave priority to visiting the sick, the dying, and prisoners. Most important, they implemented Luther’s recovery of the NT idea of mutual correction and encouragement, the “care of all for the souls of all,” states McNeill.<sup>20</sup>
3. The “care of souls” is sometimes used as a synonym for pastoral care. W. A. Clebsch and C. R. Jaekle (1975) define the care of souls as “helping acts done by representative Christian persons directed toward the healing, sustaining, guiding, and reconciling of troubled persons whose troubles arise in the context of ultimate meanings and concerns.”<sup>21</sup>

In a review of three hundred years of Protestant pastoral care in America, Holifield concluded that “Pietism’s preoccupation with the welfare of the individual soul became the seedbed for the

---

<sup>19</sup> McNeill, 108.

<sup>20</sup> Ibid.

<sup>21</sup> Asquith, location 383–400 of 5402.

growth of popular psychology. In turn, the new psychology reshaped the Protestant vision of the self, so that the goal of pastoral care moved “from salvation to self-realization” under God.”<sup>22</sup>

And Asquith reminds the chaplain that the ancient term cure of souls, “stands to remind clergy in the twenty-first century of their apostolic forbearers who, in the spirit of Jesus, met human pain with compassion and human guilt with grace and forgiveness.”<sup>23</sup>

#### Emmanuel Movement

In 1904, an organization was formed with the goal of bringing together the disciplines of medicine, science, and religious faith to stimulate the healing of both mind and body. This union of well-intentioned clergy and physicians was persuaded by and operated under the conviction that the physical healing power of Jesus Christ was accessible in the contemporary world, just as it was in the Gospels. Rev. Dr. Elwood Worcester, the rector of the Emmanuel Episcopal Church in Boston, is credited with pioneering this movement.<sup>24</sup> Worcester, with the aid of and in cooperation with several prominent New England physicians, established a clinic for spiritual healing. All of the clinic’s activities were based out of Worcester’s church, and were immediately labeled by local reporters as the “Emmanuel movement.”<sup>25</sup> It has been suggested that this movement was, perhaps, the earliest experiment in a faith-based, psycho-religious clinic. All would agree that it was the first attempt to treat alcoholism with a combination of individual

---

<sup>22</sup> E. Brooks Holifield, *A History of Pastoral Care in America: From Salvation to Self-Realization* (Eugene, OR: Wipf & Stock Publishers, 2005), 356.

<sup>23</sup> Asquith, location 396 of 5402

<sup>24</sup> Ibid, location 1173 of 5402.

<sup>25</sup> Ibid.



and group therapy, as well as the first attempt to combine the resources of depth psychology and religion in a systematic therapeutic endeavor. From insight gained through analysis of alcoholics, Worcester arrived at a profound understanding of alcoholism and helped to further its treatment.

He expressed his feelings on the subject when he stated:

The analysis, as a rule, brings to light certain experiences, conflicts, a sense of inferiority, maladjustment to life, and psychic tension, which are frequently the predisposing causes of excessive drinking. Without these, few men become habitual drunkards. In reality drunkenness is a result of failure to integrate personality in a majority of cases. Patients, however darkly, appear to divine this of themselves, and I have heard some fifty men make this remark independently: "I see now that drinking was only a detail. The real trouble with me was that my whole life and my thoughts were wrong. This is why I drank."<sup>26</sup>

During its existence, Worcester's program attracted many suffering from alcoholism and became well known for its success in treating them. Because of its initial success, Emmanuel was drawn into the national spotlight.

By 1908, this movement was in full swing and Worcester, along with Rev. S. McComb and Dr. I. Coriat, a prominent physician in the faculty of Tufts Medical School, published *Religion and Medicine: The Moral Control of Nervous Disorders*. Demand for this book, a volume that set down clearly the philosophy undergirding the movement, was so great that it went through nine printings in the first year of publication.<sup>27</sup> The Emmanuel movement, unlike

---

<sup>26</sup> Howard J. Klinebell, "The Emmanuel Movement: Religion Plus Psychotherapy," *Understanding and Counseling the Alcoholic* (1956), [http://silkworth.net/emmanuel\\_movement/01003.htm](http://silkworth.net/emmanuel_movement/01003.htm) (accessed April 30, 2012).

<sup>27</sup> Worcester, E., S. McComb, and I. Coriat, *Religion and Medicine: The Moral Control of Nervous Disorders*, (Norwood, MA: Plimpton Press, 1908). This book is available online at Amazon.com and the printing record is given within the book itself with two printings in May, two in June, two in August, two in September and one in October 1908. It is available in reprint by Kessinger Publishing (January 1, 2003).

other “miracle” ministries of the same time period, was built on informed and erudite philosophies of medicine, psychology, and religion. Its approach to healing was based on four principles:

- (1) The person is a composite of mind and body.
- (2) Religion should clearly and emphatically value the therapeutic efficacy of medical treatment of organic disorders.
- (3) The relation between organic and functional disorders should be a legitimate domain for spiritual healing.
- (4) The contributions of the medical profession to health and welfare are in no sense to be minimized.<sup>28</sup>

As Worcester was later to summarize it: “What distinguishes this work from all healing cults. . . is its frank recognition of Religion and Science as the great controlling forces of human life and the attempt to bring these two highest creations of man into relations of helpful cooperation.”<sup>29</sup>

Even so, with the honorable intent of this movement, it was certainly not without its critics. Early during its existence, Dr. Sigmund Freud visited the United States. The year was 1909, and the movement was experiencing the height of positive media coverage. In an interview with a reporter for the *Boston Evening Transcript* on September 11, 1909, Freud admitted to being skeptical of the movement when he stated, “this undertaking of a few men without medical, or with very superficial medical training, seems to me at the very least of questionable

---

<sup>28</sup> Ibid.

<sup>29</sup> Asquith, 1191–1200 of 5402.

good.”<sup>30</sup> Despite these serious intentions to relate high scholarship in both medicine and religion to the area of praxis, the movement was sputtering by the early 1930s and shut down with Worcester’s death in 1940. However, as fate would have it, at the same time another self-help program was rising to replace it on a scale of influence that Worcester could only dream of; this new movement became known as Alcoholics Anonymous.

As an event in the history of the medicine-religion dialogue, the Emmanuel movement holds a minor but nevertheless important place, particularly in the development of holistic tendencies in medicine and health care. This student openly admits to never having heard of or read about this movement until work began on this dissertation. That being the case, this movement’s significance, from the viewpoints of both pastoral care and the healthcare chaplaincy movements, was its outgrowths in the mental hygiene movement, the hospital care offered by chaplains, and the establishment of CPE as part of theological education.<sup>31</sup>

#### Boisen, Cabot and Dicks: Clinical Pastoral Education Begins

In 1925, the form of theological education known as CPE began to be developed by Dr. William A. Bryan, superintendent of the Worcester State Hospital, Worcester, MA, and Rev. Anton T. Boisen, when Boisen was appointed to become the new hospital chaplain.<sup>32</sup> As a former mental patient, Boisen felt a calling to “break down the dividing wall between religion

---

<sup>30</sup> Nathan G. Hale, *Freud and the Americans: The Beginnings of Psychoanalysis in the United States, 1876-1917*, 1<sup>st</sup> ed., (New York: Oxford University Press, 1971), 226.

<sup>31</sup> Ibid.

<sup>32</sup> Robert David Leas, *Anton Theophilus Boisen: His Life, Work, Impact, and Theological Legacy* (United States: Journal of Pastoral Care Publications, 2009), 2.

and medicine.”<sup>33</sup> Boisen invited four students to spend the summer of 1926 with him at the hospital to begin training for ministry in a psychiatric treatment center. At the same time, Dr. Richard C. Cabot, M.D., a noted Boston physician, author, part-time teacher at Harvard Divinity School, and acquaintance of Boisen, published an article in the *Survey Graphic* in which he proposed, “that something radical be done about the need for better prepared pastors.” Cabot opined, “that every student preparing for vocational ministry needed to receive clinical training for pastoral work similar to the clinical training a medical student receives during his internship.”<sup>34</sup>

In 1926, Boisen was a middle-aged Presbyterian minister who had recently recovered from a nervous breakdown that confined him to a mental hospital for several months. It was upon his recovery that his passion to provide pastoral care to the medically impaired and confined was sparked. Boisen then began his pursuit for a better way to provide ministry to those who were hospitalized. Boisen’s personal lineage included college teachers, academics, and university presidents, and Boisen himself was a graduate of Indiana University, Yale Forestry School, and Union Theological Seminary of New York. Further, Boisen had also received a master’s degree from Harvard University and had worked as a sociological investigator for the Presbyterian Department of Country Church Work. Being a scholar, Boisen began studying his

---

<sup>33</sup> Ibid.

<sup>34</sup> Rodney J.R. Stokoe, “Clinical Pastoral Education,” *The Nova Scotia Medical Bulletin* 53, no. 1 (1974): 26, [http://www.cappe.org/association/download/cpehistory\\_stokoe.pdf](http://www.cappe.org/association/download/cpehistory_stokoe.pdf) (accessed April, 26, 2012).

own case and those of his fellow patients, and upon his release from the hospital, he enrolled in Harvard University to further study the condition that had confronted him.

While at Harvard, Boisen connected with a group of medical doctors and professors who embraced his thinking and proposed pastoral care methodology, including Dr. Richard Cabot, M.D. With Cabot's help and the help of other professors, he began to prepare himself for a ministry to the mentally ill and, at the same time, for further research that would become the foundation for this more effective training of future ministers.<sup>35</sup> It was also at this time that Boisen began to use the term that patients were to read as "Living Human Documents."<sup>36</sup> This concept is still used today by the Association for Clinical Pastoral Education (ACPE) supervisors in training their Level-1 CPE students. As the chaplain of Worcester State Hospital (which at that time had more than 2200 mental patients), Boisen demonstrated that a chaplain who provided full-time, thoughtful, daily ministry to hospitalized patients, both individually and in groups, was more effective than the schema for most mental hospitals of the time, which simply meant having local pastors come in every Sunday to conduct a worship service.

By the beginning of World War II, the educated clergy were learning, reading about, and researching a new discipline that became known as pastoral psychology. This was due, in part, to

---

<sup>35</sup> Ibid.

<sup>36</sup> A term first used by Anton Boisen to describe the individual human experience, especially of people in crisis. In caring for them, Boisen opined, humans should be "read" by theological students and pastors alongside the classical texts of theology and biblical study in order to test theological assumptions and develop a complete, holistic theological understanding. For more detail see the article "Living Human Document" in Asquith's *The Concise Dictionary of Pastoral Care and Counseling*, (Abingdon: Kindle Edition, 2010), location 574 of 5402.

the continued efforts of Cabot and Methodist minister Russell Dicks.<sup>37</sup> While working at Massachusetts General Hospital in Boston, Dicks, like Boisen, was introduced to Cabot, who immediately took a serious interest in Dick's ministry. In 1936, these two collaborated to publish the landmark book, *The Art of Ministering to the Sick*.<sup>38</sup> This offering explained how to effectively provide the proper type of pastoral counsel to discover the parishioner's "growing edge" through "good listening." In order to do this, the counselor or pastor first developed his own sense of awareness via the action-reflection-action model of learning. According to Holifield, "Amateurish advice giving was out."<sup>39</sup> By the time Rollo May published his book, *The Art of Counseling*, in 1939, most, if not all of the major seminaries had begun to insert some type of psychology course into their respective curricula.

In 1939, Dicks presented his paper, *The Work of the Chaplain in the General Hospital*, at the annual gathering of the American Protestant Hospital Association (APHA). So powerful was

---

<sup>37</sup> A Methodist minister, Dicks served as a hospital chaplain at Massachusetts General Hospital and other hospitals, as well as a professor of pastoral care at Duke University Divinity School. As one of the first chaplain supervisors of CPE in a general hospital, Dicks pioneered in the supervisory use of written "verbatim", word-for-word transcriptions, of pastoral conversations. He believed that study of the direct encounter between a student and a patient could reveal whether or not the student understood what was happening in the interchange. Dick's method represented a departure from Boisen's practice of having students in clinical settings write detailed case histories of the patient's physical and emotional development. The verbatim is still the primary learning tool used for learning using the action-reflection-action model of CPE. For more detail see the biographic article "Russell Dicks" in Asquith's *The Concise Dictionary of Pastoral Care and Counseling*, Kindle Edition (2010), location 1138 of 5402.

<sup>38</sup> Cabot, Richard, and Russell Dicks, *The Art of Ministering to the Sick* (New York: Macmillan Company, 1936)

<sup>39</sup> Holifield, Brooks E., *A History of Pastoral Care in America: From Salvation to Self-Realization* (Eugene, OR: Wipf & Stock Publishers, 2005), 224.

his influence on this meeting of medical providers, he was appointed to lead a committee on the adoption of professional standards for hospital chaplains, known at the time as the Commission to Study Religious Work in Hospitals.<sup>40</sup> In 1940, Dicks began working with a small committee to prepare a set of standards of practice for hospital chaplains, which were later adopted by the APHA. By 1945, Dick's committee had developed a series of recommendations for the APHA to consider in amending its constitution and by-laws to provide for a chaplain's section. Though World War Two required the cancellation of the meeting, the new proposals were later adopted at the 1946 convention during which the chaplains' section of the APHA was officially organized. By 1950, APHA standards were adopted, which included two units of CPE, and the certification process officially began.<sup>41</sup>

Due to the influence of Boisen, Cabot, and Dicks, the CPE training model was in full swing by the middle of the 1950s. At that time, more than 4,000 Protestant clergy had been trained. In 1967, the ACPE was formed by a merging of several smaller CPE certification groups. It would serve as the primary organization in the U.S. for establishing standards of training and practice for CPE students. ACPE continues to be the preeminent certifying body in the U.S. today. As a testament to the influence and standing the ACPE had in relation to training

---

<sup>40</sup> Stephen King, PhD, "The Standards of Practice for Professional Chaplains in a Health Care Setting," *PlainViews* 6, no. 2 (2008): 6. <http://plainviews.healthcarechaplains.org/archive/AR/c/v6n2/sp.php> (accessed April 26, 2012).

<sup>41</sup> Association of Professional Chaplains, "Russell Dick's Article on Standards of Practice." <http://www.professionalchaplains.org/index.aspx?id=1210> (accessed April 28, 2012).

clergy, eighty-one seminaries initially applied for affiliation.<sup>42</sup> However, it is also worth noting that in 1957, the Southern Baptists, the largest of the Evangelical Protestant denominations, had already formed their own CPE association. The Southern Baptist Association of Clinical Pastoral Education was developed by Dr. Wayne Oates at the Southern Baptist Theological Seminary in Louisville, Kentucky. Primarily, this association provided training and education for Southern Baptist and other conservative chaplains entering into hospital and military ministry.<sup>43</sup>

CPE is international today, with clergy and graduate students in theology coming from a number of countries throughout the world. There is also a certification program for international clergy. CPE has grown in eighty years to include over 3,300 members that make up the ACPE, with some 350 ACPE accredited CPE Centers, and about 600 ACPE certified faculty members (called CPE Supervisors). Today, there are 118 theological schools as members and twenty-one faith groups and agencies that partner with ACPE. This stands as a testament that the model of education that CPE represents is a vital part of theological education today.<sup>44</sup>

## **Person-Centered Therapy**

Carl Ransom Rogers

Carl Ransom Rogers was born on January 8, 1902, in the suburbs of Chicago in Oak Park, Illinois. His father, Walter A. Rogers, was a civil engineer and his mother, Julia M.

---

<sup>42</sup> Association for Clinical Pastoral Education, "A Brief History," <http://www.acpe.edu/WhoWeAreHistory.html> (accessed April 28, 2012).

<sup>43</sup> Ibid.

<sup>44</sup> Ibid.



Cushing, was a housewife and devout Christian. Rogers, the fourth of their six children, was intelligent and able to read well before beginning kindergarten.<sup>45</sup> As a result of an education in a strict religious and ethical environment, Rogers became a rather isolated, independent, and disciplined person. Consequently, he also developed an appreciation for the scientific method in a practical world. Based on Rogers's childhood experience of parents who were overly judgmental of all their children, Corey suggests that Rogers began early on to develop and champion a nonjudgmental worldview that would eventually affect his thoughts as he developed his client-centered approach to therapy.<sup>46</sup> According to his daughter and biographer,<sup>47</sup> Rogers's first career choice was agriculture. He attended the University of Wisconsin–Madison from 1919–1924 and, while there, changed his major from agriculture to history and then religion. Following a 1922 trip to China to attend a ministry conference, Rogers began to doubt the Pentecostal religious convictions of his childhood. After graduating from the University of Wisconsin with his degree in history, however, he still pursued a graduate level theological education. His interest in caring for those in need of psychological and psychiatric interventions had its origins in the time he was a student at Union Theological Seminary, New York. He left the seminary in 1926, after two years, and earned his M.A. and his Ph.D. degrees from Columbia

---

<sup>45</sup> *Encyclopædia Britannica Online*, s. v. "Carl R. Rogers", accessed April 15, 2012, <http://www.britannica.com/EBchecked/topic/506798/Carl-R-Rogers>.

<sup>46</sup> Gerald Corey, *Theory and Practice of Counseling and Psychotherapy*, 8th ed. (Belmont, CA: Brooks/Cole, 2009), 165.

<sup>47</sup> Dr. Natalie Rogers, a renowned psychologist in her own right and daughter of Carl and Helen Rogers gives a brief biographical sketch and timeline for her father's life on her personal website located at: <http://www.nrogers.com/carlrogersevents.html> (accessed April 21, 2012).

University's Teachers College.<sup>48</sup> It is interesting to note that during his seminary time, Rogers served as a visiting pastor in Vermont.

For more than fifty-six years, Rogers contributed to the discipline of psychiatry and psychology. Some have argued that he is, perhaps, the single most influential person in his field up to this point.<sup>49</sup> For Rogers's lifetime of professional work, he was presented the Award for Distinguished Professional Contributions to Psychology by the APA in 1972. Towards the very end of his life, in January 1987, Rogers was nominated for the Nobel Peace Prize by Congressman Jim Bates of California for his work with national inter-group conflict in South Africa and Northern Ireland.<sup>50</sup>

### Person-Centered Counseling

Rogers first introduced his client-centered approach to counseling during the 1940s while lecturing to the Minnesota Psychological Society. During this lecture, Rogers first hinted at the suggestion that the client, not the therapist, is the one with the resources to determine and confront life's difficulties and gain the insight necessary to restructure his or her own life. His

---

<sup>48</sup> Ibid.

<sup>49</sup> Haggbloom, S.J. et al. "The 100 Most Eminent Psychologists of the 20th Century", *Review of General Psychology*, Vol. 6, No. 2, (2002), 139. Haggbloom et al. combined three quantitative variables: citations in professional journals, citations in textbooks, and nominations in a survey given to members of the Association for Psychological Science, with three qualitative variables (converted to quantitative scores): National Academy of Science (NAS) membership, American Psychological Association (APA) President and/or recipient of the APA Distinguished Scientific Contributions Award, and surname used as an eponym. Then the list was rank ordered. Also see Corey, 165.

<sup>50</sup> Corey, 165.

theory was further developed and published in his first book, *Counseling and Psychotherapy*,<sup>51</sup> in 1942. In tracing Rogers's contributions to counseling, scholars list four major periods as turning points, with this being the first. Rogers initially labeled his approach as "non-directive counseling,"<sup>53</sup> which was wholly opposed to the mainstream thought of the day in regards to therapy. His basic assumptions were:

- (1) People are basically good or trustworthy.
- (2) People possess the intrinsic potential for understanding themselves and resolving their own problems without a direct intervention on the therapist's part.
- (3) People are capable of self-directed growth if they are involved in a specific kind of therapeutic relationship.<sup>54</sup>

Further, Rogers's theory went on to state that the therapist's knowledge of theory and technique was of secondary concern, much to the chagrin of his peers. Rogers did not, however, present his approach as a rigid dogma. Rather, he hoped others would use his approach as a set of tentative principles that related to how the therapy process develops. Rogers was open to development and expected others to contribute to his model as it evolved.<sup>55</sup>

The second phase of Rogerian thought began in 1951 with the publication of his book, *Client-Centered Therapy*<sup>56</sup>. Rogers had renamed his "non-directive counseling" "client-centered

---

<sup>51</sup> Carl Rogers, *Counseling and Psychotherapy* (Cambridge, MA: The Riverside Press, 1942)

<sup>53</sup> Corey, 166.

<sup>54</sup> Ibid.

<sup>55</sup> Ibid.

<sup>56</sup> Carl Rogers, *Client-Centered Therapy* (London, UK: Constable & Company, 1951).

therapy” to emphasize the client not the “non-directive” methods. Corey states that during this period there was “a shift from clarification of feelings to a focus on the phenomenological world of the client.”<sup>57</sup> To understand how a person behaves, Rogers believed the best vantage point was from within the client’s internal frame of reference, i.e., the actualizing tendency of the individual was the motivational force that leads to client change.

Becoming one’s experience is the best way to describe the third major period in the development of Rogerian thought. From sometime during the late 1950s until the mid-1970s, Rogers focused on the concept of “becoming the self that one truly is” or “becoming one’s experience,” which was described in his 1961 book, *On Becoming a Person*.<sup>58</sup> This concept can be described as: (1) openness to experience, (2) trust in one’s experience, (3) internal locus of control, and (4) willingness to be in the process. These aspects of becoming a person emphasized Rogers’s interest in how individuals effectively progressed in psychotherapy, and how the client-therapist relationship served as the means to personality change in the client.<sup>59</sup>

Finally, Corey describes the fourth and last phase of Rogers’s influence as the “Person-centered approach.”<sup>60</sup> This movement began sometime in the 1980s and continued through the 1990s. This approach was again a broadening of the prior movement and focused on the

---

<sup>57</sup> Corey, 167.

<sup>58</sup> Carl Rogers, *On Becoming a Person: A Therapist's View of Psychotherapy* (New York, NY: Houghton Mifflin, 1961).

<sup>59</sup> Corey, 168.

<sup>60</sup> Ibid.

application of Rogers's theories in education, industry, conflict resolution, groups, and world peace.<sup>61</sup> As an overview of more than sixty years of research and review of Rogers's

contributions, Corey sums up Rogers's person-centered approach with the following conclusion:

In the earliest years of the approach, the client rather than the therapist was in charge. This style of nondirective therapy was associated with an increased understanding of self, greater self-exploration, and improved self-concepts. Later, a shift from clarification of feelings to a focus on the client's frame of reference developed. Many of Rogers's hypotheses were confirmed, and there was strong evidence for the value of the therapeutic relationship and the client's resources as the crux of successful therapy. Lastly, as person-centered therapy developed further, research centered on the core conditions assumed to be both necessary and sufficient for successful therapy. The attitude of the therapist, an empathic understanding of the client's world and the ability to communicate a nonjudgmental stance to the client was found to be basic to a successful therapy outcome.<sup>62</sup>

#### Rogerian Influence on Pastoral Care & Counseling

Although Rogerian assumption about the basic goodness of man and man's ability to overcome adversity and be self-directive is not in agreement with the anthropology and hamartiology of Reformed/Evangelical theology, the practical approach of empathic listening and a non-directive counsel impacted all denominations. Pastoral counseling was the topic that seemed to be on the minds of all seminary professors. The National Institute of Mental Health (NIMH) conducted a survey and reported that 42% of all people who desired counseling for

---

<sup>61</sup> Ibid.

<sup>62</sup> Bozarth, J.D., F.M. Zimring, R. Tausch, "Client-Centered Therapy: The Evolution of a Revolution," In *Theory and Practice of Counseling and Psychotherapy*, 8th ed., Gerald Corey, edit. (Belmont, CA: Brooks/Cole, 2009), 167–168.

personal or emotional problems first turned to their pastor.<sup>63</sup> As a response, in the 1950s, almost every seminary offered courses in pastoral counseling and 80% offered courses in psychology. Observers of the schools opined that this new focus on psychology and counseling would change the direction of theological training and begin a new era for educating those preparing to enter into professional ministry.<sup>64</sup> This new approach to care and counsel insisted that the most influential type of counseling was non-directive and that the individual would be able to discern the answers and guidance they sought from within themselves. This influence was not confined to the moderate and liberal mainline denominations. W.A. Criswell, longtime pastor of the First Baptist Church of Dallas, Texas, and the father of the conservative resurgence in Southern Baptist life, wrote in his guidebook for pastors concerning hospital ministry and pastoral counseling that when visiting with the sick “we ought to let them tell us what is on their hearts and be sympathetic in listening.”<sup>65</sup> As for pastoral counseling, Criswell wrote:

The second rule of counseling is to be a good listener. Many times healing and help come from allowing a parishioner to pour out of his heart all his troubles. He does not expect you to do anything about it. Maybe you cannot. But he wants you to listen and by listening to his sorrows or problems, he finds the strength to face them. Possibly the reason the confessional booth of the Roman Catholic Church has endured through the years is because people need to find help through a listening ear.<sup>66</sup>

---

<sup>63</sup>Gurin, G., Verofl, I., and S. Feld, “How Americans View Their Mental Health: A National Survey.” In “The Clergy as a Resource for Those Encountering Psychological Distress,” Paul Chalfant, et al., *Review of Religious Research* 31, no.3 (March 1990), 306.

<sup>64</sup> Holifield, Brooks E., *God’s Ambassadors: A History of the Christian Clergy in America* (Grand Rapids, MI: Eerdmans Publishing, 2007), 242.

<sup>65</sup> W.A. Criswell, *Criswell’s Guidebook for Pastors* (Nashville: Broadman Press, 1980), 277.

<sup>66</sup> *Ibid.*, 279.

## Ministry of Presence

In this section this student will provide a brief review of how the concept of “ministry of presence” is viewed, approached, and defined by the U.S. Armed Services. Second, the discussion will shift to how the rise of Rogerian person-centered therapy in the mid-twentieth century affected the meaning and practice of ministry of presence.

Every Navy chaplain has heard the term “ministry of presence” and, at one time or another, used it to describe his work. Irrespective of the type of environment in which the Navy chaplain should find himself ministering, for example, Ships Company, Fleet U.S. Marine Forces, or shore duty, ministry of presence means being present with the troops.<sup>67</sup> This is especially true when forward deployed in a combat zone.

The chaplain should maintain a *ministry of presence*, moving between the unit on the line and the units in reserve. This is not the time to hold a formal divine service. The chaplain will mostly be offering quick words of encouragement, prayers, etc. If there is a reconnaissance patrol going out, the chaplain will be available to be present with them before they step off... If dug in and not taking casualties, the RMT should move from company to company providing *ministry of presence*, taking meals, spending the night, etc. However, if the command is taking casualties, the RMT should stay at the casualty collection point or battalion aid station and provide ministry to the wounded.<sup>68</sup>

In the previous passage from U.S. Marine Corps Reference Publication 6-12A, *Religious Ministry Team Handbook*, actions are described that reflect the practice of ministry of presence but do not define what it is or why it is important. In terms of ministry of presence, this student will rely upon a definition provided by a Canadian Army chaplain/colleague during a pastoral

---

<sup>67</sup> MCRP 6-12A, 1-7, 8.

<sup>68</sup> Ibid.

care residency at the naval medical center in Portsmouth, Virginia. The Department of National Defence (Canada) defines the ministry of presence as “being available to, and known by, the soldier, being available for a comforting chat, developing a relationship with the members of the unit, and participation in unit life.... [This ministry] makes the chaplaincy an outward and visible sign of the church who cares and consoles.”<sup>69</sup> Chaplain Bruce Crouterfield, in his study of naval chaplaincy in the Fleet U.S. Marine Forces, determined ministry of presence, or what he labels the “Emmanuel Factor” or the “God with us factor” as invaluable in the life of Sea Services personnel.<sup>70</sup> “When the chaplain’s presence is known, the presence brings a sense of comfort; it causes people to change their behavior. People are reminded of the presence and significance of God.”<sup>71</sup>

There is a biblical precedent for this practice that correlates with the concept of incarnational ministry. In this student’s own tradition, the incarnational ministry of the Gospel is demonstrating ministry to human needs with material signs and symbols.<sup>72</sup> The ultimate

---

<sup>69</sup> Department of National Defence, Canada, “Chaplains: What They Do,” *41 Canadian Brigade Group*. January 30, 2003. [http://www.army.dnd.ca/41cbg\\_hq/61chaplain.htm](http://www.army.dnd.ca/41cbg_hq/61chaplain.htm) (accessed May 6, 2012).

<sup>70</sup> Bruce W. Crouterfield, “The Value of the Naval Chaplain in the Fleet U.S. Marine Force Environment,” (D. Min. diss., Liberty Baptist Theological Seminary, 2009), 31.

<sup>71</sup> Ibid.

<sup>72</sup> In the contemporary church the use of sign and symbol serves as a representative of a greater truth. God has always used creation itself to declare his presence and being (Romans 1). The sacramental reality was experienced in God's use of physical and symbolic signs and instruments through which He conveyed His power, Presence, and sustaining enablement, which we call grace. Means such as the snake wrapped around the pole for healing in the desert the dead man springing to life again merely by coming in contact with the bones of the long dead prophet Elisha; the divine deliverance experienced by the eating of the Passover lamb; water



incarnation took place in the form of Jesus Christ, the Living Word, or God in the Flesh. This theological doctrine was established at the First Council of Nicaea (ca. AD 325), when all theological theories, specifically Arianism, that regarded Christ as anything less than fully God/fully Man were rejected. One of the three great creeds of Christendom came out of this council, i.e., the Nicene Creed, which used language such as “True God from True God” to firmly establish the orthodox Christological position of the incarnation. Fackre, in the *Dictionary of Pastoral Care and Counsel*, affirms the concept of ministry of presence in terms of the incarnation of Christ.

The ministry of Christian presence is grounded in the doctrine of the Incarnation, sometimes in its kenotic form. . . . The identification of the ministrant with the condition of those in need is viewed as a continuation of the ministry of Christ who “emptied himself, taking the form of a servant . . . and became obedient unto death” (Phil. 2:7a–8a). This ministry of participation follows that of Christ, who “partook of the same nature, that through death he might . . . be made like his brethren in every respect, so that he might become a merciful and faithful high priest in the service of God. . . . For because he himself has suffered and been tempted, he is able to help those who are tempted” (Heb. 2:14a, 17a, 18).<sup>73</sup>

### **Late Twentieth Century Thought on Sin & Suffering**

Many have attempted to dismiss the notion that sin and suffering have any connection. That ideology is very prevalent today in the modern healthcare system and, to some degree,

---

from the rock, etc. - all these experiences were sacramental; that is, God used outward and visible means by which to convey inward and spiritual grace, power and life to those who received. For more information see: “The Tapestry of Historic Christian Worship” by the Most Reverend Wayne Boosahda, available at <http://thecciusa.com/documents/>.

<sup>73</sup> G. Fracke, “Ministry of Presence,” *Concise Dictionary of Pastoral Care and Counseling*, Glenn H. Asquith, ed. (Kindle Edition, Abingdon Press, 2010), location 736 of 5702.

receives theological support from several of the liberal Christian denominations who would deny any suggestion that human suffering may be caused by sin. In our age of sophistication, every medical, psychological, or sociological ill can be explained by science. This line of thought, especially in the U.S., has more to do with the reductionist approach to sin as moralistic and personalistic.

From the time of the Reformation to the present, many forms of fundamental Christian thought teach that all sickness or illness is God's pronouncement of judgment on the sufferer.<sup>74</sup> Through the Reformation and Enlightenment periods, it only makes sense that theologians would begin to question and rethink earlier schemas related to human suffering; however, many of the Reformers went too far. Calvin believed and taught that pestilence, war, etc. were the chastisement of God because of our sin.<sup>75</sup> One scholar writes:

There is little doubt that the Reformation strengthened theology's sadistic accents. The existential experience developed in [later medieval] mysticism that God is with those who suffer is replaced by a theological system preoccupied with judgment day.... The

---

<sup>74</sup> John D. Hall, *God and Human Suffering: An Exercise in the Theology of the Cross* (Kindle Edition, Minneapolis: Augsburg Publishing House, 1986), location 1074 of 3189. Hall writes, "...earlier forms of Christian "orthodoxy" had made the connection between sin and suffering all too explicit. So explicit was the causal connection between sin and suffering in many forms of preliberal Christianity that every pious sufferer, under the influence of such stern and doctrinaire codes of religion, was driven to inquire after the personal wickedness by which that suffering must have been caused—often in the process, of course, vastly complicating the suffering itself by adding to it a gruesome weight of guilt. The belief that suffering is punishment for sin, inflicted by a God whose judgment or purgation begins already in this life, is firmly rooted in almost all the forms of empirical Christianity."

<sup>75</sup> *Ibid.*, location 1076 of 3189.

situation is not viewed from the standpoint of the sufferer; rather it is through God's eyes that things are seen and, above all, judged.<sup>76</sup>

This type of theology was alive and well in the late twentieth century and still is today. It can be found in the teachings that “affirming that nuclear weapons are God's response to ‘godless communism,’” or that the dreaded disease, AIDS, is “divine punishment on homosexual persons.”<sup>77</sup> Both in the book of Job and in Jesus' flat rejection of his disciples' suggestion that a man's blindness must have been caused either by his own or his parents' sin (John 9:10), and in many other places and ways, the Christian Scriptures refute this argument. Referring to this subject, Hall writes concerning those who still propagate this errant theology:

They must do so, obviously enough, because just this assumption is a recurrent motif of “religion,” and a kind of preoccupation of the human psyche. It belongs to that familiar tit-for-tat approach to both religion and life, which prefers jurisprudence to grace, and which Luther accurately and frankly named “justification by works.” To the smug thought that one is being justified by one's “good” works there always corresponds, in this brand of religion, the (usually pleasurable!) sense that others are being damned by their wickedness; and it is seldom that such religious zeal is willing to leave the working out of its neat conception of divine justice to the last judgment! Given the power of this religious assumption throughout human history, and given the damage done to so many human lives by this hoary attempt to explain suffering through direct reference to sin and guilt, the determination of modern forms of Christian theology to reject the connection outright is understandable.<sup>78</sup>

But as the fundamentalist theologians went too far, the liberal theologians failed to go far enough in attempting to understand the relationship between sin and suffering. Sadly, these well

---

<sup>76</sup> Ibid.

<sup>77</sup> Ibid.

<sup>78</sup> Ibid., location 1078 of 3189.

intentioned and misguided Christians dismissed the association between sin and suffering altogether.

Beginning in the early twentieth century, a new understanding of the relationship between suffering and sin was sought. The horrible experiences of two world wars (and the holocausts in both Nazi Germany and the Soviet Union) were enough to cause liberal Christianity to discard many of the “pie in the sky” thoughts about the innate goodness of man and to readdress the hamartiological concept of sin and suffering. Responsible, neo-orthodox Christian scholars like Karl Barth, Paul Tillich, Dietrich Bonhoeffer, Reinhold Niebuhr, and Evangelical scholars such as Donald Barnhouse, F.F. Bruce, John R.W. Stott, and Carl F. H. Henry have helped to reign in much of the existing errant thought. F.F. Bruce writes in a Scripture lesson on Job:

It is easy to answer the question ‘Why do men suffer?’ by saying that they suffer because they sin—easy, so long as the thinker holds himself aloof from the real facts of human experience and is content to view the whole subject in abstraction... Job in the days of his ease was well content to accept the conventional solution of suffering with which he had been brought up—that a man’s suffering was proportioned to his sin. But when he himself was involved in the, mystery of undeserved suffering, it assumed quite a different aspect. And the reason for the perennial appeal of the story of Job lies in the fact that the problem with which he had to grapple—and for which he found no satisfactory solution—is perhaps the most poignant problem with which ordinary men and women still have to grapple.<sup>79</sup>

For this student, the most meaningful and beautiful instruction on the meaning of suffering and its relationship to sin is found in the Apostolic Letter *Salvifici Doloris* (lit. salvific suffering) written by the Holy Father John Paul II. Ultimately, he reminds us, that physical and mental

---

<sup>79</sup> F.F. Bruce, “The Wisdom Literature of the Bible: The Book of Job,” *The Bible Student* ns 23, no. 2 (April 1952), 57–60.

suffering may or may not be related to sin. However, for a Christian, it can provide an opportunity to share in our Lord's salvific sacrifice, to better understand the nature of our earthly existence, and to reflect on the dependence that inheres in human existence. The Pontiff goes into great detail in reference to Job, suffering, and sin by describing the purpose of suffering as a mystery:

Already in the Old Testament... suffering has a meaning only as a punishment for sin, insofar as it emphasizes at the same time the educational value of suffering as a punishment. Thus in the sufferings inflicted by God upon the Chosen People there is included an invitation of his mercy, which corrects in order to lead to conversion... Job however challenges the truth of the principle that identifies suffering with punishment for sin... In the end, God himself reproves Job's friends for their accusations and recognizes that Job is not guilty. His suffering is the suffering of someone who is innocent and it must be accepted as a mystery.<sup>80</sup>

It is only through Christ and in Christ that the mysteries of sorrow and suffering, and discipline, and death become meaningful, for they lead to deliverance.

### **Pastoral Care and Counseling in Postmodernity**

#### What is Postmodernity?

Between 1947 and 1949, conservative Christian philosopher and theologian Monsignor Romano Guardini (1885–1968) delivered a set of lectures at both the University of Tübingen and the University of Munich, at which time he opined that humanity had reached its end. He told his listeners how, for all practical purposes, the end of modernity had occurred.

---

<sup>80</sup> John Paul II, “*Salvifici Doloris*: On the Christian Meaning of Human Suffering,” (Apostolic Letter, St. Peter’s Cathedral, The Vatican, November 2, 1984).

These lectures are as relevant today as when they were first delivered. The epoch that now lies before us is so new, Guardini argued, that Christians cannot either “go back” or “go forward” but could only make a fresh start, a new beginning. This new epoch is known as postmodernity.

Perhaps no single theoretical worldview has affected the twenty-first century Church more than postmodernism. As this term is used frequently, most individuals believe they have a grasp on its meaning, however, they do not. The heart of postmodernism is the belief that reality cannot be known nor described objectively. Postmodernism seeks to correct the imbalances of modernism. It reminds humanity that we do not possess an unlimited potential to understand and change the world for our own purposes. Rather, humans exist in the world and in relation to it. Modernism or modernity is the belief that came about in the Newtonian era regarding science, rationality, higher learning, and reason. Along with these beliefs came the rise of biblical criticism and the marginalization of religion and faith. Some would even argue that religion became privatized<sup>81</sup> at this time as well.

Fundamentalist Christians view postmodernism with contempt and as heretical, and rightly so in some cases. Liberal Christians embrace it as a way to relate to those people and groups (in the religious sense of the term) that are not Christian. Conservatives and moderates are still seeking to understand the depths and the potential impact this new philosophical era has

---

<sup>81</sup> David Lyall, “Clinical Pastoral Counselling in a Postmodern Context,” *Counselling in Pastoral Settings*, ed. Gordon Lynch (Kindle Edition, New York: Routledge, 2004) location 255 of 3406. By “privatized” Lyall is inferring that religion and faith became subjects and ideas that were not discussed in the public arena, as personal beliefs regarding religion were “private” matters.

created, exactly what are its pros and cons? Certainly, this worldview, when taken to its logical conclusion, is opposed to the word of God. The Apostle Peter in his great *kerygma*, in terms of salvation and referring to Christ, states, “And there is salvation in no one else, for there is no other name under heaven given among men by which we must be saved”<sup>83</sup>. What then does that mean for the Navy chaplain who works and ministers in an institution where the “truth,” as far as religion is concerned, is not something with which the institution is concerned? Proselytizing is strictly forbidden.<sup>84</sup>

The clinical paradigm of pastoral care practiced in the U.S. Navy today reflects many modern American values: personal autonomy, individual freedom, and a belief in progress, along with a non-moralistic use of spirituality that focuses on self-actualization and personal growth.<sup>85</sup> The stance taken by the U.S. Navy does ensure that the First Amendment right to the free exercise of, and, no institutional endorsement of a particular religion is adhered to, which means, literally, that the Navy chaplain finds himself ministering in a very pluralistic environment. D.A. Carson eloquently describes this situation that the twenty-first century Navy chaplain ministers in:

Instead of a rich diversity of claims arguing it out in the marketplace (i.e., empirical pluralism), in what Neuhaus calls “the naked public square,” and instead of this diversity being cherished as the best way to ensure freedom and to pursue truth (cherished

---

<sup>83</sup> Acts 4:12, ESV.

<sup>84</sup> Office of the Chief of Navy Chaplains, *Professional Naval Chaplaincy*, “Professional Standards for PNC,” 63.

<sup>85</sup> U. S. Navy Bureau of Medicine and Surgery, “BUMEDINST 1730.2A: Navy Medicine Plan for Religious Ministries including Pastoral Care Services,” (2011), 2, <http://www.med.Navy.mil/directives/Pages/BUMEDInstructions.aspx>, accessed April 14, 2012.

pluralism), the pressures from philosophical pluralism tend to squash any strong opinion that makes exclusive truth claims—all, that is, except the dogmatic opinion that all dogmatic opinions are to be ruled out...<sup>86</sup>

The other side of postmodern thought, however, interprets its existence as something that is good and that corrects some of the evils of the past that various religions have perpetrated, accepted, or blindly ignored. Leonard Sweet writes, “Postmoderns have had it with religion. They’re sick and tired of religion. They’re convinced the world needs less of religion, not more. They want no part of obedience to sets of propositions and rules required by some ‘officialdom’ somewhere.”<sup>87</sup>

This prevailing attitude must be recognized and understood by all of those who would serve with any type of effectiveness in the twenty-first century Navy. Postmodernity and pluralism are the reality in which our nation now finds itself. Lesslie Newbigin writes along those same lines:

We now know, if we are not willfully blind and deaf, that we live in a religiously plural world in which the other great world religions show at least as much spiritual vitality as does Christianity... an aggressive claim on the part of one of the world’s religions to have the truth for all can only be regarded as treason against the human race. Even if it is granted that this exclusive claim has been the claim of the Church through nineteen centuries, we must face the fact that it is not now tenable... so now the Church... must recognize that God’s grace is at work with indiscriminating generosity among all peoples and in all the great religious traditions, and therefore abandon the claim to be the sole possessor of the truth. This view is now so widely shared that it has become in effect the contemporary orthodoxy. Pluralism is the reigning assumption, and if one declines to accept it, as I do, one must give reasons.<sup>88</sup>

---

<sup>86</sup> D. A. Carson, *The Gagging of God: Christianity Confronts Pluralism* (Grand Rapids: Zondervan, 1996), 33.

<sup>87</sup> Leonard Sweet, *Post Modern Pilgrims: First Century Passion for the 21<sup>st</sup> Century World* (Nashville: Broadman, 2000), 112.

<sup>88</sup> Lesslie Newbigin, *The Gospel in a Pluralist Society* (Grand Rapids: William B. Eerdmans Publishing, 1989), 156.



How then do postmodernism and pluralism affect pastoral care in a Navy hospital? To answer this question, one must get beyond any dogmatic religious truth in terms of providing pastoral care to the sick, infirmed, and injured. Although this student is not, in any terms, validating modern thought or pluralism, serving in a postmodern pluralistic Navy is reality. Having an understanding of the philosophy and psychology of religion is paramount to the Navy chaplain if he is to be successful. This includes understanding, beyond what the fundamentalist would have one believe, this new reality from the viewpoint of the postmodern pluralist. In *Toward a Positive Psychology of Religion: Belief in Science in the Postmodern Era*, Robert Cottone describes this very idea:

Postmodernism is an intellectual movement in the social and behavioral sciences, in literature and in art. It is contrasted with “modernism,” which I equate with concrete thinking. What is concrete is known unto itself—everything has objective characteristics which can be known in exactly the same way by all human beings. A block of concrete is a block of concrete, no matter who views it. That is modernism. Postmodernism is non-concrete. It allows for variation in understanding about what may be viewed as concrete. A concrete block may be viewed by some as a building block, but it can be viewed by others a dinner table. The meaning of the thing we call a concrete block comes not from the nature of the block itself, but from the definition that humans give the block as they act around it. Another example, consider that a sharp blade is a weapon; however, a wood carving apprentice is taught that a sharp blade is a tool to create art. A vision of a sharp blade, therefore, has different meaning for the warrior and the wood carver. Postmodernism allows an infinite number of definitions around the experiences that humans share... Postmodernism, then, is all about meaning. It is all about understanding. It’s not about whether there is a sun in the sky, for example. But it is about how people define and understand the sun. The sun means something different to a sun worshipping community than it does to an astronomer. Postmodernism allows for diverse understanding of human experiences. It allows for interpretation and narration around shared phenomena. It does not deal with concrete truth. It deals with “*consensualized truth*”—truth that comes from people sharing their most profound understanding of their experiences.<sup>89</sup>

---

<sup>89</sup> Robert Cottone, *Toward a Positive Psychology of Religion: Belief in Science in the Postmodern Era* (Kindle Edition, O-Press, 2011), location 162 of 2204.

Using Cottone's explanation of postmodernism makes it somewhat clearer, in terms of pastoral care, how the chaplain can approach ministry in a Navy hospital without violating the tenets of his own beliefs.

### **Postmodern Pastoral Care**

Today, ancient ways are more relevant than ever. The mystery of how ancient words can have spiritual significance in this new world is evident in the cultural quest for "soul" and "spirit." The very talk of soul and spirit is the talk of a very ancient language, a first-century language largely abandoned by the modern world but a language more fitting today than ever.<sup>90</sup>

Carrie Doehring, in her book, *The Practice of Pastoral Care: A Postmodern Approach*, has suggested that chaplains or those providing pastoral care should consider viewing their ministry through "tri-focal lenses that include premodern, modern, and postmodern approaches to knowledge."<sup>91</sup> In using the premodern lens, the chaplain operates from the assumption that God, or that which is Sacred, can be known through sacred rituals, rites, texts, traditions, and experiences. She suggests that this is in line with "the way transcendent realities seemed to be known within the ancient and medieval church prior to the use of critical approaches to knowledge introduced by Enlightenment thinkers."<sup>92</sup> Next would be the use of the "modern lens." By this, it is suggested that the chaplain use current theory, e.g., evidence-based

---

<sup>90</sup> Leonard Sweet, *Postmodern Pilgrims: First Century Passion for the 21st Century Church* (Kindle Edition, Nashville: B&H Publishing), location 77 of 3,654.

<sup>91</sup> Carrie Doehring, *The Practice of Pastoral Care: A Postmodern Approach*. (Westminster: John Knox Press, 2006), 6.

<sup>92</sup> Ibid.

knowledge, especially in regards to medicine and science, and more traditional analytical and empirical methods in terms of hermeneutics and interpretation for sacred scripture. Finally, the chaplain uses the postmodern lens to bring into focus “the contextual and provisional nature of knowledge, including knowledge of God.”<sup>93</sup>

Along with Doehring, Lyall adds that, in attempting to understand the postmodern mindset, one must understand the backdrop that modernism is indeed no more: there is a return from the written to the oral, a return from the general to the local, a return from the universal to the particular, and from the timeless to the timely.<sup>94</sup> This reversal of modernity, argues Lyall, has at least three implications for the pastoral caregiver and counselor:

- (1) The growth of the counseling movement itself is understandable in the context of postmodern society.
- (2) In the context of the postmodern world of competing narratives, the Christian narrative has its own integrity and value in relation to pastoral counseling.
- (3) In the context of the counseling relationship, the Christian narrative may be expressed in ways that stir the imagination (i.e., parabolically and poetically).<sup>95</sup>

---

<sup>93</sup> Ibid.

<sup>94</sup> Lyall, location 280 of 3406. Lyall is using the work of Stephen Toumlin, *Cosmopolis: The Hidden Agenda of Modernity* (1990), as the foundation for his argument. Toumlin believes that modernity can be identified by four characteristics in which postmodernism has overturned. As Europe was coming out of Medieval times into Enlightenment, he opines there was a movement from an oral tradition to a written in terms of education, from a particular to a universal in the field of ethics, from local to general in terms of human behavior and philosophy, and, finally, from the timely to the timeless in terms of medicine and law. If Toumlin is correct, Lyall then argues that postmodernity is a reversal of modernity that strongly resembles premodernity.

<sup>95</sup> Ibid., location 341 of 3406.

Assuming these implications are correct, this postmodern context does provide a highly fertile ground for the pastoral caregiver to thrive and plant seeds. Why? Because counseling occurs in form of oral communication—people have to talk. John Patton writes that pastoral care and counsel involve “assisting persons to move from talking generally about themselves and specifically about their problems to talking specifically about themselves and generally about their problems.” Then, as the chaplain engages with the careseeker, the chaplain may use one of three approaches in terms of his own faith: exclusivism, inclusivism, or pluralism. The Christian narrative should be used to formulate his questions and responses. Lyall believes it is okay and should be expected for the Christian chaplain to apply biblical narrative and symbols to inform his approach; he is not addressing the content of the conversation. Our identity as Christians is formed through an understanding of both the Old Testament and New Testament. As the narratives of Creation and God’s blessing thereof, the Fall, and the furious pursuit of a loving God to redeem us as His children are considered, it is clear that the concept of “acceptance” existed far earlier than the writings of Carl Rogers. Acceptance is an emulation of the incarnation; it is living out the love of God. This student would agree with this thought as the incarnation is indeed the greatest act of love and acceptance to ever happen, and it is the culmination of the Christian narrative.

The context of knowledge for a Sailor or a Marine in today’s Navy is decidedly postmodern. The average age for a sailor is twenty years old, meaning that he was born during the Clinton administration; he has never lived in a world without cell phones, iPods, or the

Internet; he has always lived in a world with AIDS.<sup>96</sup> For him, knowable truth always comes from sharing experiences with others. For the Christian, faith comes from sharing our most profound experiences with others, e.g., evangelism. In both cases, however, truth becomes known only within the framework of social interaction and connectedness. This connectedness occurs only when the chaplain accompanies the patient on their journey, wherever it may lead.

Sweet says:

Try before you buy postmoderns will not first find the meaning of faith in Christ and then participate and then discern the meaning of faith for their life. Truths about Christ must first be lived before they can be embraced. We must recognize that a spiritual journey begins long before conversion. (This is a principle that Reformed theology embraces much better than mainstream Southern Baptists.)<sup>97</sup>

Using Doehring's model, pastoral care occurs along the premodern, modern and postmodern axes. The chaplain uses the premodern lens, initially, to gain an understanding of what the patient considers sacred or how he or she connects to God. Likewise, the chaplain relies upon the modern lens approach in terms of understanding the patient's medical and psychosocial situation. In terms of postmodernity then, the questions become, "What do I not know?" and "How have my personal experiences shaped me?" and "What is the context of where I am providing pastoral care; where am I?" Again, Doehring expounds on this approach as she writes concerning pastoral caregivers:

---

<sup>96</sup> Official U.S. Navy website.  
<http://www.Navy.mil/navco/display.asp?page=leaders.html> (accessed May 3, 2012). The point here is that the average sailor or Marine was born in 1993; the disease Acquired Immune Deficiency Syndrome (AIDS) was first used by the Centers for Disease Control (CDC) in 1981.

<sup>97</sup> Leonard Sweet, *Soul Tsunami: Sink or Swim in a New Millennium Culture* (Grand Rapids: Zondervan Publishing House, 1999), 215.

Their premodern lens gives them access to the long and rich history of religious traditions in the ancient and medieval historical periods. Using the modern lens, they draw upon the vast knowledge generated by rational and scientific methods, notably biblical critical methods, systematic modern theologies, and medical and social scientific theories about human experience. A postmodern lens brings into focus the contextual, provisional nature of knowledge and how knowledge is socially constructed...<sup>98</sup>

Whether or not the chaplain accepts the premises and teachings of post-modern thought or reason, its existence is reality, and one must learn to navigate its hazards with hope.

### **Narrative Pastoral Care**

One of the most interesting developments in recent theological thinking has been the extraordinary significance accorded to ‘narrative’ by conservative, radical, and liberal theologians alike. This narrative turn, no doubt born of a postmodern skepticism towards abstract, propositional truth claims, is of particular importance for pastoral theologians and practitioners. It is now frequently claimed that the work of storytelling lies at the heart of the healing encounter between those who suffer and those who seek to meet this suffering with the resources of faith.<sup>99</sup>

Heather Walton’s opening words regarding narrative pastoral care perfectly support the theses put forth by Rogers, Corey, Lyall, and Sweet, as previously mentioned.

In canonical narrative theology meaning is to be found as human narratives are incorporated into God’s greater story.<sup>100</sup> However, in constructive forms of narrative theology it is in the human capacity for storytelling itself, rather than in a pre-existing grand narrative, that redemptive power is located. In this perspective human beings are seen as story formed creatures whose lives take

---

<sup>98</sup> Doehring, 6.

<sup>99</sup> Heather Walton, “Speaking in Signs: Narrative and Trauma in Pastoral Theology,” *Scottish Journal of Healthcare Chaplaincy*, vol. 5, no. 2 (2002): 2.

<sup>100</sup> *Ibid.*, 3.

shape as they begin to employ the resources of narrative traditions to give shape to their own lives...<sup>101</sup>

The postmodern careseeker needs to be heard, and he or she relates to others through story, narrative, or history. It is in sharing experiences with others that the careseeker is able to find meaning in suffering and the means to heal. Walton expresses the thoughts of sociologist Arthur Frank in regards to the constructive power of narrative. Frank, she says, uses Christian imagery and language to describe these “wounded storytellers.” “They are suffering servants who bear the marks of pain and embody ‘atonement’ for others. Through recovering their own voices they are able to bear testimony on behalf of others who are robbed of speech. The wounded storyteller is a moral witness re-enchanting a disenchanting world.”<sup>102</sup>

As it is the role of the Navy chaplain to provide pastoral care to an institution that has been at war for the past ten years and in which the average member’s age is twenty years old, the pastoral implications of this view of narrative are obvious. Making a story that weaves painful circumstances into a wider framework is an act of hope and faith that is of real benefit to the careseeker, their families, and the wider community. Contemporary literature in spiritual and

---

<sup>101</sup> Ibid. Walton differentiates between “canonical narrative theology,” which she states is based in scriptural accounts of the life of Jesus. Many practitioners of narrative theology attribute the influence of Karl Barth in their personal lives and his view of the Gospel, which regarded the story of Jesus as “a divinely authorized narrative in which the truth concerning human history is made evident.” The Gospel story has a scope so encompassing that every human story can find its meaning within its frame. Canonical narrative theologians imagine the Christian faith as the continuing dynamic outworking of this narrative as believers find their place within the sacred drama. We experience sanctification, it is argued, as “learn[ing] to play our own parts in the story of Christ’s passion and resurrection.”

<sup>102</sup> Ibid.

pastoral care encourages pastoral practitioners to see themselves as those who may hear others in speech and assist in the re-assembly of shattered worldviews and fragmented lives. In fact, this model of pastoral care is very similar to the psychological care model known as Prolonged Exposure therapy (PE). PE is a type of Cognitive Behavioral Therapy (CBT) that is used extensively by mental health providers in the DoD to treat returning service members suffering from acute stress reaction or PTSD. This treatment is characterized by re-experiencing the traumatic event through the remembering and re-telling of the traumatic experience, i.e., story, multiple times by the careseeker. PE is evidence-based and has over twenty years of solid research to validate its effectiveness; it produces clinically significant improvement in about 80% of patients with chronic PTSD.<sup>103</sup> Who then is better equipped than a chaplain to listen and incorporate the narrative of spiritually and emotionally wounded souls and then help to make sense of the senseless and provide hope through the ancient narrative of death and resurrection? No one.

### **Sea Services Chaplaincy in the Twenty-First Century**

#### Professional Naval Chaplaincy

Professional Naval Chaplaincy (PNC) is a relatively new term that was first coined and used in 2011; it is defined as follows in SECNAVINST 5351.1, *Professional Naval Chaplaincy*:

The field of endeavor in which Navy chaplains deliver to the Naval Service and authorized recipients religious ministry characterized by cooperation, tolerance, mutual

---

<sup>103</sup> Eftekhari, Afsoon., Lisa R. Stines, and Lori A. Zoellner, L.A., “Do You Need to Talk About It? Prolonged Exposure for the Treatment of Chronic PTSD,” *The Behavior Analyst Today* 7, no.1 (2006):70–83.



respect and respect for diversity. It is further characterized by an understanding of both the pluralistic nature of the environment and the processes and structures of the organizations and institutions served. PNC includes the full range of responsibilities inherent in positions of leadership and authority in the Navy, as well as the standards and codes of behavior established for chaplains by the DoN and those found in civilian religious professional life. Implicit in the PNC is the expectation that chaplains will not compromise the standards of their RO (Religious Organization).<sup>104</sup>

The PNC community comprises Navy chaplains, RPs, civilian employees, contractors, and volunteers engaged in providing all facets of religious ministry within the DoN, to include BUMED. Specifically, given the litigious nature of American society<sup>105</sup>, PNC is the means by which the Navy chaplain facilitates the free exercise of religion by ensuring that religious ministry is offered in a professional manner that does not have an adverse impact on military readiness, individual or unit readiness, unit cohesion, health, safety, discipline, or mission accomplishment. It is the vehicle by which the chaplain corps (CHC) meets validated religious ministry requirements through the delivery of its four core capabilities:

**Facilitate** the religious requirements of personnel of all faiths.

**Provide** faith-specific ministries.

**Care** for all service members, including those who claim no religious faith.

**Advise** the command.

But above all, PNC is the means by which the CHC's motto *Vocati ad Servitium*, "Called to Serve" is fulfilled. In short, Navy chaplains, aided by RPs, are called:

---

<sup>104</sup> SECNAVINST 5351.1, *Professional Naval Chaplaincy*, Dtd April 2011. <http://doni.daps.dla.mil/allinstructions.aspx> (accessed April 1, 2012).

<sup>105</sup> Hans Zieger, "Why Does the U.S. Military Have Chaplains?" *Pepperdine Policy Review*, Vol. II (2009), Article 4. <http://publicpolicy.pepperdine.edu/policy-review/2009v2/why-does-us-military-have-chaplains.htm>, (accessed April 12, 2013). The constitutionality of military chaplaincy has been challenged numerous times in the past 30 years.

- (1) to serve our people—ensuring they and their families are ready for the demanding life of military service;
- (2) to serve the naval service—by working with its leadership as professional partners to support the readiness and resiliency of the force; and
- (3) to serve each other—supporting chaplains and RPs who carry out the sacred mission of taking care of our people.

### **Professional Naval Chaplaincy in BUMED**

PNC identifies the chaplain of Navy medicine (BUMED-M00G) as one of ten domain leaders in the hierarchy of the Navy chaplain corps. As such, the chaplain of Navy medicine is a special assistant to the Navy's surgeon general. The current chaplain of Navy medicine ensures that all chaplains assigned to BUMED billets act as lead agents, responsible for ensuring that pastoral care, religious ministry, and related staff tasks are delivered to the commanding officers of the Navy's three medical centers and twenty-six hospitals and MTF's. To assist the chaplain of Navy medicine, there will be four senior chaplains assigned as regional chaplains under the guise of Navy Medicine East, Navy Medicine West Navy, Navy Medicine National Capitol Area, and Navy Medicine Support Command.

The Navy Medicine East commander exercises command oversight of Naval Medical Center Portsmouth, Naval Health Clinic Cherry Point, NC, Naval Hospital Camp Lejeune, NC, Naval Hospital Charleston, SC, Naval Hospital Beaufort, SC, Naval Hospital Jacksonville, FL, Naval Hospital Guantanamo Bay, Naval Health Clinic Corpus Christi, TX, Naval Health Clinic New England, Naval Hospital Naples, Italy, Naval Hospital Rota, Spain, and Naval Hospital Sigonella, Sicily, and the CAPT James A. Lovell Federal Health Care Center (FHCC) at Great Lakes, IL.

The Navy Medicine West commander exercises command oversight of Naval Hospital Camp Pendleton, Naval Hospital Bremerton, Naval Hospital Lemoore, Naval Hospital Oak Harbor, Naval Hospital Twentynine Palms, Naval Health Clinic Hawaii, Naval Hospital Guam, Naval Hospital Okinawa, Naval Hospital Yokosuka, Naval Dental Clinic Camp Pendleton, and the Naval Dental Clinic Okinawa.

The Navy Medicine National Capitol Area commander exercises command oversight of Walter Reed National Military Medical Center, Bethesda, MD, Naval Medical Clinic, Annapolis, MD, Naval Medical Clinic, Patuxent River, MD, and Naval Medical Clinic, Quantico, VA. Most noteworthy is the Walter Reed National Military Medical Center in Bethesda; besides providing care to the president of the United States, it is also the world's largest military medical center. It is located on 243 acres, has more than 2.4 million square feet of clinical space, and provides care and services to nearly one million beneficiaries per year.

According to Navy instruction, in order to deliver this ministry, Navy chaplains must employ two distinct but overlapping sets of competencies—religious ministry professional and Navy staff officer. In addition to these competencies, there are requirements and expectations that apply to BUMED chaplains that do not apply to other chaplain billets. To be fully qualified to deliver clinical pastoral care to patients, BUMED chaplains must meet the standards (*the Common Standards for Professional Chaplaincy*, see Appendix B) that reflect the core competencies for healthcare chaplaincy. The Common Standards for Professional Chaplaincy represent the minimum requirement for board eligibility with most national certifying bodies. Four units of CPE from an accredited, national certifying body are the minimum requirements for board eligibility. Graduates of the Navy medicine pastoral care residencies meet the criteria

and are considered board-eligible by most national certifying bodies. There is a requirement of 2,000 hours of supervised post-CPE experience needed to become fully board-certified; however, it is possible to obtain a provisionally certified status while working the necessary hours for full certification. Navy chaplains who do not meet these standards will work under the direct clinical supervision of a board-eligible or board-certified chaplain, or be enrolled full-time in a CPE program approved by BUMED-M00G, or participate in a structured peer review program approved by BUMED-M00G.

Finally, all BUMED chaplains must be current in locally required Health Insurance Portability and Accountability Act (HIPAA) training and command orientation requirements, as this is required by the Joint Commission. BUMED chaplains, in the same manner as physicians, nurses, and other professional staff, are further required to participate in ongoing inter-disciplinary peer review and case review.

### **Summary**

In this chapter, a broad overview of the history of pastoral care leading to the current PNC initiative within the DoN was presented. Beginning with the origin of the word “chaplain” and the roots of hospital chaplaincy, it has been shown that in the first nineteen centuries of the Church’s existence, pastoral care was provided under the auspices of a response to individual sin. Next, the beginnings of twentieth century pastoral care and counsel were discussed. In the middle of the nineteenth century, with the contributions of individuals such as Freud and Jung, the rise of the psychosocial sciences began. These new theories provided insights into the human psyche that caused the old paradigm of illness or suffering due to sin to be questioned and then

addressed pastorally in a non-prescriptive manner. In the early part of the twentieth century, influenced by the early pioneers of mental health, Boisen, Cabot, Dicks, and Rogers developed a new way to train pastors in providing care outside of the pulpit that became known as CPE. This new model required the pastor to consider his own experiences and how they affected the type and quality of care he could provide. In particular, Rogers's person-centered therapy encouraged pastors to do more listening and less prescribing and encourage the careseekers to look within themselves to provide resolution for their internal conflicts. Briefly, it was also mentioned how the Emmanuel movement helped to birth a faith-based approach to mental hygiene and treating alcoholism.

The age-old questions of theodicy, sin, and suffering and their meaning, has plagued man from his earliest writings. There is no answer that is fully acceptable to man and, perhaps, there never shall be. A return to the first century Church teachings that allow spiritual growth through suffering would help to assuage, at least for the faithful, some of these most painful questions.

The rise of postmodernity and the effect it has had, and continues to have, has been examined. While there are certainly aspects of the postmodern philosophy that do not line up with the teachings of Christian scripture, the subsequent return to a premodern, oral, narrative tradition provides an opportunity for pastoral care and counsel that is unparalleled if the pastor is willing to journey first and experience the wounds of the careseeker before trying to make sense of a nonsensical human experience.

Finally, the PNC initiative within the DoN will be the primary *modus operandi* for U.S. Navy chaplains for the next several decades. As the PNC has been codified by a secretary of the Navy instruction it is, essentially, chiseled into the granite that is the foundation of U.S. Navy chaplaincy.

## CHAPTER 4

### OUTCOME ORIENTED CHAPLAINCY

#### **Introduction**

The single most significant influence of the twentieth century on pastoral care was the emergence, and prominence, of the psychological sciences.<sup>1</sup> One must consider the fact that the rise of these new fields of study influenced and promoted an emphasis on pastoral care to such extent that H. Richard Niebuhr described this rise of psychology in 1955 as “the most important movement in theological education.”<sup>2</sup> In addition, their rise and acceptance indicated an attenuation of previously accepted spiritual understandings of the human experience and offered an alternate view of human suffering and of its relief. The efforts of clergy, theologians, and theological educators to navigate through waters of uncertain theological assertions and the secularization of care has shaped pastoral care’s recent history, especially in institutional settings.

Distinguished church historian E.B. Holifield sums up the courtship and marriage of ministry and medicine in this way:

From the beginnings of church history, Christian theologians have enriched pastoral care by exploiting the resources of Western philosophy, medicine, and psychology. Even the letters of Paul reflect the philosophical tradition of “psychagogy” that defined pre-Christian Western methods of spiritual direction. Sixteenth-century casuists appropriated innovations in Renaissance philosophy and logic in much the same way that twentieth-century pastoral theologians read Freud, Adler, and Jung. Earlier pastoral writers also studied medical treatises to enrich their practice of the pastoral arts, as when seventeenth-century English

---

<sup>1</sup> Glenn H. Asquith, Jr., “Care of Souls,” *The Concise Dictionary of Pastoral Care and Counseling* (Kindle Edition, Abingdon Press, 2010), location 1614 of 5402.

<sup>2</sup> *Ibid.*, location 1625 of 5402.

Calvinists incorporated in their pastoral handbooks the standard medical analysis of such ailments as melancholia. From one perspective, the pastoral care movement simply represented a significant twentieth-century form of this time-honored practice of appropriating secular psychological and medical wisdom for a ministry of healing.<sup>3</sup>

In the early part of the 1990s, the spiritual care services department at Barnes-Jewish Hospital-Washington University Medical Center (BJH) developed a discipline-based, *outcome-oriented* model for chaplaincy. This chapter will introduce the elements of OOC, its development process, the effects on chaplaincy that can be attributable to its regular use, and implications for the future. Through OOC, many of the assumptions about chaplaincy are being challenged. It is the opinion of this student, through personal experience, that a disciplined, outcome-oriented model in the practice of chaplaincy can deepen relationships with patients and significantly increase the chaplain's integration into the care teams of the hospital.

### **Beginnings of Outcome Oriented Chaplaincy**

The actual term, "Outcome Oriented Chaplaincy" was first introduced by Vandecreek and Lucas in their book *The Discipline for Care Giving: Foundations for Outcome Oriented Chaplaincy*,<sup>4</sup> which was released in 2001. A casual review of the literature, however, will clearly show that this idea was written about and discussed for several years even before the BJH chaplains began to develop and then perform their version of OOC. The best descriptive definition of OOC was put forward by Dr. Brent Peery. "It is a method of chaplaincy care that

---

<sup>3</sup> E.B. Holifield, "Pastoral Care Movement," *The Concise Dictionary of Pastoral Care and Counseling*. Glen H. Asquith, ed. (Kindle Edition, Abingdon Press, 2010), location 1763 of 5402.

<sup>4</sup> Larry Vandecreek and Art Lucas, eds., *The Discipline for Pastoral Care Giving: Foundations in Outcome Oriented Chaplaincy* (Binghamton, New York: Haworth Press, 2001).

emphasizes achieving, describing, measuring, and improving outcomes that result from a chaplain's work. Its primary components include chaplaincy assessment, chaplaincy interventions, and chaplaincy outcomes.”<sup>5</sup> As Lucas began to implement this model of intentional caring at BJH, the results were virtually immediate and quantifiable by the Lucas and the pastoral care staff. The results, as described by Lucas, can be generalized as an improved assessment of the patient by the chaplain; an improvement of pastoral care provided to the patient; a capacity to communicate more effectively with others, especially other members of their care teams; and the ability to identify a commonality of patterns in patients as they struggled to cope and heal.<sup>6</sup>

In 2010, as this student was introduced to this concept, there was a tremendous amount of skepticism on his part. “How can one measure the work of the Holy Spirit?” or “Am I genuinely expected to quantify the emotional experiences of pastoral contacts?” After all, those sacred moments are acutely subjective, but establishing credible data for measuring metrics using at least from a sound scientific approach requires that the researcher be objective in his approach to research. Other chaplains in this student's cohort, who were also residents in the U.S. Navy pastoral care residency at the naval medical center in Portsmouth and the Hampton Veterans Administration Medical Center, agreed with this student. Upon further examination and

---

<sup>5</sup> Stephen B. Roberts, ed. “Outcome Oriented Chaplaincy: Intentional Caring.” In *Professional Spiritual and Pastoral Care: A Practical Clergy and Chaplain's Handbook* (Woodstock, VT: Skylight Paths Publishing), 342.

<sup>6</sup> Larry VandeCreek and Art Lucas, eds., *The Discipline for Pastoral Care Giving: Foundations in Outcome Oriented Chaplaincy* (Binghamton, New York: Haworth Press, 2001) 2–3.



reflection, however, it became clear to us residents that the data needed, being collected, and reflected upon in a disciplined approach was not as concerned with the “how or why” these sacred moments and interactions would occur. Rather, this process was seeking to understand the “what and when” in these holy moments. More specifically, the locus of understanding for Lucas was what the chaplain was doing in the form of pastoral care and when this care was delivered in order to develop successful intervention strategies to care for other patients in similar situations in the future. This approach is one that can be researched and tested objectively, without attempting to define the mystery that is the work of the Holy Spirit.

### **Outcome Orientated Chaplaincy and Evidence-based Spiritual Care**

Recently, in medical care, especially the arenas of mental health and social work, there has been a shift to an evidence-based approach as the best way to treat the patient. This change is due to the required implementation of “best practices” by many (probably all) institutions and healthcare organizations. Likewise, professional chaplaincy must shift to this same method to be relevant and taken seriously by providers. In the past, ideologies such as tradition, policy, personal experience and intuition were used by chaplains in informing their feelings and decisions as to what constituted “good” spiritual care. Today, all professional chaplains, this student included, will admit that there are instances when the aforementioned ideologies are exactly what are needed by the patient in order to have his or her spiritual needs met.

Today, however, evidence-based is fast becoming accepted as the norm. O’Connor describes evidence-based spiritual care as “the use of scientific evidence on spirituality to inform

the decisions and interventions in the spiritual care of persons.”<sup>7</sup> Recent research in pastoral care has begun to consider how quality spiritual care results in measurable outcomes, i.e., evidence-based. Much of this attention, as is appropriate, is focused on patient-specific outcomes, such as decreased levels of anxiety and depression, overall reduction of the number of days in the hospital, and an increased sense of “being heard.” Further, there was a corresponding reduction in lawsuits and an increase in the patient’s likelihood to choose the same hospital again when future needs arise;<sup>8</sup> all of these issues are especially relevant to administrators in terms of bottom-line individual hospital expenditures, which affect chaplaincy funding. This outcome-oriented, evidence-based method and its resulting research provide the professional chaplain real data to present to administrators when the budget axe falls.

Currently, BUMED has adopted the definition posited by the APA in defining evidence-based chaplaincy care for its assigned PNCs. “Evidence-based practice is... the integration of the best available research, with clinical expertise, in the context of patient characteristics, culture and preferences.”<sup>9</sup> Along with this new definition, in March 2011, BUMED went even further and adopted the APC standards of practice for PNCs serving in BUMED treatment facilities. The APC standards are comprised of thirteen different standards. Of these thirteen standards, Standard 12 addresses evidence-based practice. It states: “The chaplain practices evidence-based

---

<sup>7</sup> Thomas O’Connor, “Is Evidence-Based Spiritual Care an Oxymoron?” *Journal of Religion and Health* 41, no. 3 (2002): 253–62.

<sup>8</sup> Stephen B. Roberts, “Assessments.” In *Professional Spiritual and Pastoral Care: A Practical Clergy and Chaplain’s Handbook*. Stephen B. Roberts, ed. (Woodstock, VT: Skylight Paths Publishing), 57.

<sup>9</sup> Quoted by Dr. George Fitchett in his EBP lecture at the Navy Medicine West Chaplain Symposium in San Diego, CA, May 16, 2012.

care including ongoing evaluation of new practices and when appropriate, contributes to or conducts research.” Clearly, OOC is an evidence-based approach to spiritual care; it is indeed moving from “presence” to “prove it.”<sup>10</sup>

### The Discipline for Pastoral Care

Lucas writes that as the staff chaplains at BJH “began to observe patterns among the patients, I, as the department director began to observe patterns within the chaplaincy.”<sup>11</sup> These patterns led to the development of the following process as depicted in the following diagram.

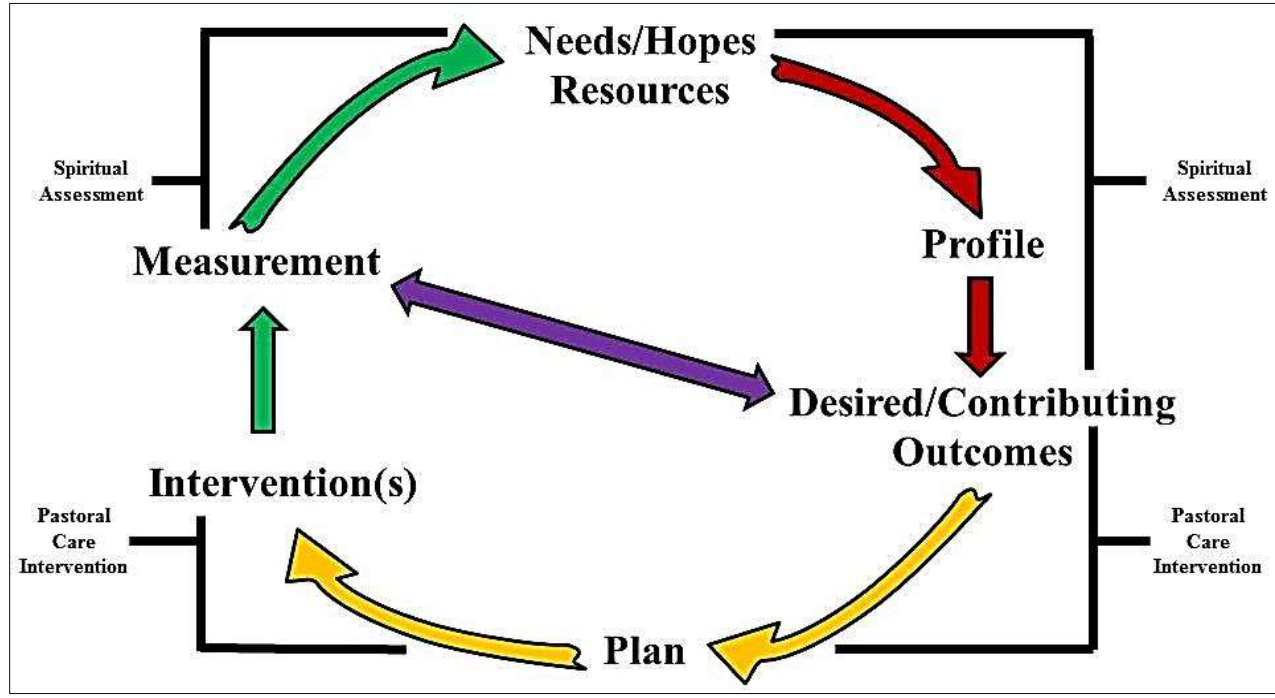


Fig. 4.1 The discipline for pastoral care

<sup>10</sup> Roberts, 57.

<sup>11</sup> VandeCreek, 6.

This approach, which is known to many as “The Discipline,” soon became known as OOC. A step by step summary of this OOC process begins by focusing completely on the patient. The chaplain must begin with the *needs/hopes/resources* of the patient in four different areas that include the spiritual, emotional, physical, and social aspects of the patient’s life. The chaplain is then able to understand and develop a *profile* of the patient that demonstrates how faith functions in the life of the patient and thus understand the patient’s concept of holy, meaning, hope, and community. Once completed, the chaplain can then ask himself, “What can my ministry contribute to the healing process of this patient?” or “What difference can I make in this person’s life?” This leads to the development of *desired contributing outcomes*. A desired contributing outcome refers to the measurable changes in a patient’s or family’s experience, healing, or well-being that can be attributed to a specific intervention,<sup>12</sup> e.g., patient is able to share a hopeful aspect of their future that includes consideration of their medical condition. Once the chaplain understands what exactly he hopes to achieve with the patient, he is then able to develop a *plan of care* to achieve those outcomes. After the chaplain develops this plan of care, he develops courses of action (COAs), which are known in the vernacular of modern medicine and nursing as *interventions*. Finally, once the plan and interventions are implemented, the chaplain is now able to evaluate and assess the success of those interventions in relation to the desired outcomes. This in turns brings the OOC process full circle to the point of a new assessment of the patient’s needs, hopes, and resources.

---

<sup>12</sup> Roberts, location 817–819.

## Standards of Practice

In the modern professions of today, the practitioners of these various arts and sciences have come together to establish standards of practice to guide them in these practices. In modern healthcare, the physicians, nurses, and all other allied and ancillary staff have standards of practice that serve as the framework or outline of their respective scopes of work. Until recently, professional chaplains had established standards for certification and a code of ethics; however, there was no standard of practice. To advance professional chaplaincy towards a standard of practice, the APC's Commission on Quality in Pastoral Services assembled and sought input from various practitioners of healthcare chaplaincy to develop a consensus in establishing a minimum set of *Standards for the Practice of Professional Chaplaincy in Acute Care Settings*. Models in nursing, social work, both Canadian and Australian chaplaincy were examined, and practices were extrapolated.

In the spring of 2010, the APC work group completed Standards of Practice for Professional Chaplains in Acute Care Settings.<sup>13</sup> This document articulated expectations regarding the ongoing work of a professional chaplain in an acute care hospital setting. These standards focus on pertinent patient, individual, or resident care and management functions that are essential to providing safe, high quality care. Of the thirteen standards, Peery believes that six of them strongly and specifically reiterate principles of OOC, which is the current practice in use by BUMED:

Standard 1: Assessment: The chaplain gathers and evaluates relevant data pertinent to the patient's bio-psycho-social-spiritual/religious health.

---

<sup>13</sup> See Appendix B, for the complete Standards of Practice for Professional Chaplains in Acute Care Settings.

Standard 2: Delivery of Care: The chaplain develops and implements a plan of care to promote patient well-being and continuity of care.

Standard 3: Documentation of Care: The chaplain enters information into the patient's medical record that is relevant to the patient's medical, psychosocial, and spiritual/religious goals of care.

Standard 4: Teamwork and Collaboration: The chaplain collaborates with the organization's interdisciplinary care team.

Standard 11: Continuous Quality Improvement: The chaplain seeks and creates opportunities to enhance the quality of chaplaincy care practice.

Standard 12: Research: The chaplain practices evidence-based care including ongoing evaluation of new practices and, when appropriate, contributes to or conducts research.<sup>14</sup>

### **Run In On A Prayer Method**

The OOC model that is currently used by BUMED is known as the *Run In On A Prayer* model. This model of pastoral care was developed by the Rev. Brent Peery, D. Min, BCC; Peery currently serves as the director of the Chaplaincy Services Department for Memorial Hermann–Texas Medical Center in Houston, Texas. The *Run In On A Prayer* model is a mnemonic device developed by Peery that stands for:

1. **R** Reason for the chaplain's visit
2. **I** Interventions
3. **O** Outcomes
4. **A** Assessment

---

<sup>14</sup> Brent Peery, "Outcome Oriented Chaplaincy: Intentional Caring." In *Professional Spiritual and Pastoral Care: A Practical Clergy and Chaplain's Handbook*. Stephen B. Roberts, ed. (Kindle Edition, Woodstock, VT: Skylight Paths Publishing, 2012), location 7398 of 10946.

## 5. Plan of care

### Reason for Visit

It may seem obvious and reasonable to outsiders that the chaplain should seek to visit each and every patient; in fact, it may even be expected. The outsider would be equally hard pressed, perhaps, to think of a compelling reason why the chaplain should not visit every admitted patient. The truth is that there is not a single hospital, military or civilian, that could not use an extra chaplain or two, and not all patients need or even request pastoral care. Because of this, every patient in a Navy hospital is not visited every day. This student will use USNHOKi to demonstrate why this is the case.

USNHOKi has a staff of 875 military personnel, both officer and enlisted, and has staff members from all four services of the DoD. These personnel are located on seven different camps over a distance of ninety kilometers from Camp Schwab to the north and Camp Kinser to the south. The average patient load at USNHOKi is forty-five inpatients, located in the following wards: general medical, mental health, ambulatory procedures, intensive care, pediatric ICU, neonatal ICU, surgery/PCU, and post-partum recovery. The USNH does have a labor and delivery unit that, as of June 1, 2012, has delivered 508 healthy babies; that is an average of three babies per day not including intrauterine fetal demise (IUFD, babies born before the twenty-second week of gestation) or stillborn births. If this student were to visit each patient and new parent for fifteen minutes,<sup>15</sup> that would consume twelve hours. If the average time to chart a note for a single patient were five minutes, the total time spent charting patient encounters would be

---

<sup>15</sup> George Handzo, et al., “What Do Chaplains Really Do? Visitation in the New York Chaplaincy Study,” *Journal of Healthcare Chaplaincy* 14, no. 1 (2008): 20–38. According to the findings of this study, the average chaplain/patient encounter was 14.1 minutes in duration.

3.75 hours. The average encounter with staff members who are seeking pastoral care or counsel is three per day (.037%) for thirty minutes for a total of 1.5 hours. By the time physical fitness (two hours), meetings (one hour), travel time to the other camp locations (one hour), administrative time (1.5 hours), teaching classes (one hour) and sermon preparation (one hour) are accounted for, this would add up to 24.75 hours per day. That is an impossible schedule. If the average patient encounter is fifteen minutes, and only half of the patients are visited, then that would drop the required time to 19.5 hours per day. Just as every patient is medically triaged upon admission, a spiritual triage must take place as well if the chaplain is to provide meaningful ministry.

Triage is, at times, the most difficult aspect of providing pastoral care. For example, the chaplain is paged to the Emergency Room (ER) to minister to a young mother (whose husband recently deployed) whose six-year-old son has died as a result of his skull being crushed by a falling television at her home; while making his way to the ER, he is paged to the ICU as a sixty-eight-year-old wife of a retired, deceased service member has suffered cardiac arrest; who receives pastoral care first? This student has experienced this exact type of situation. As a general principle, Handzo and Roberts suggest the following guidelines for establishing a protocol for pastoral care:

Chaplaincy care resources are targeted to particular services or patient populations chosen for their strategic importance to the institution and/or the demonstrated impact of chaplaincy care on those patients and staff. This is preferred to having chaplains cover all parts of the hospital equally. Generally, the clinical service lines chosen reflect high volume and/or high acuity. Intensive care units often receive priority coverage along with cardiac and cancer units, where spiritual issues related to mortality and the meaning of life are common. Emerging standards of practice suggest a dedicated chaplain on palliative care teams.<sup>16</sup>

---

<sup>16</sup> Peery, 342.



While the Handzo and Roberts model is preferable, it is highly unlikely that any local or county type hospital will have the resources to fund a pastoral care staff of more than one chaplain. Most hospitals, especially those with fewer than 100 beds, rely on local clergy and volunteer/on-call chaplains to meet the spiritual needs of the patients. In BUMED, only the three naval medical centers—Portsmouth, Balboa, and Bethesda—have more than two chaplains assigned.

### Interventions

A spiritual intervention, from the Nursing Intervention Classification (NIC), can best be defined as the facilitation of growth in a patient's capacity to identify, connect with, and call upon the source of meaning, purpose, comfort, strength, and hope in his or her life.<sup>17</sup> This is an excellent technical definition that is to be the intended meaning throughout this dissertation. From the NIC, it is apparent then that spiritually-based interventions are now part of mainstream practice in Western medicine.

Perhaps the most prominent examples are those found in the numerous twelve-step programs and their approaches to treatment of addictive disorders. The original twelve-step approach to recovering from alcoholism included in steps two and three a belief that there is a power greater than oneself that could restore one to sanity, and the decision to turn one's will and life over to the care of God as one understood Him. The local governance or Twelve Traditions

---

<sup>17</sup> From *Mosby's Medical Dictionary*, 8th ed., (2009), Elsevier. <http://medical-dictionary.thefreedictionary.com/spiritual+growth+facilitation> (accessed April 12, 2013).

of an AA chapter include, as tradition number two, the practice: “for our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience.”<sup>18</sup>

Another form of intervention currently used in Western medicine is an ancient practice. Mantra or repetitive chanting practices are used to treat conditions ranging from anxiety to personality disorders. Phrases from Christian scripture and tradition, e.g., *Pater Noster* or the Apostles Creed, are used to refocus and comfort the individual in times of stress.

Today, in palliative care, the relief of spiritual distress for those at the end of their lives is a growing area of practice best addressed by the chaplain. Peteet and D’Ambro state, “There are many other areas of intervention, including forgiveness-based treatment and spiritually integrated psychotherapy, which are accruing an ever-growing evidence base, while still other interventions are used as complementary or alternative therapies.”<sup>19</sup> Building on this idea of spiritually integrated psychotherapy, Pargament provides a theory for the ways that people use their spirituality to cope during difficult times. He identifies some primary ways of coping, which are: (1) spiritual coping to conserve the sacred, which is to maintain/retain valued objects and ideals; and (2) spiritual coping to transform the sacred, or to come to a new understanding of what is transcendent, boundless, and ultimate.<sup>20</sup> Who then is better equipped to encourage hope and journey with the spiritually wounded than the professional chaplain?

---

<sup>18</sup> The *Twelve Steps and Traditions* are available in innumerable forms and types of media. *The Big Book* online is available at <http://www.aa.org/bigbook/>.

<sup>19</sup> John R. Peteet; Michael N. D’Ambra, *The Soul of Medicine: Spiritual Perspectives and Clinical Practice* (New York: Johns Hopkins University Press, 2011), 217.

<sup>20</sup> Kenneth Pargament, *Spiritually-integrated Psychotherapy: Understanding and Addressing the Sacred* (New York: The Guilford Press, 2007), 98.

Practically, and from the chaplain's perspective, interventions are "the means through which those for whom we care benefit from all of our knowledge, skill, and experience."<sup>21</sup> Interventions are paired with the resources of the patient to address their needs and/or move toward their hopes. Peery observes that, typically, the chaplain is quite capable of "doing" interventions; the weakness related to this is the ability of the chaplain to articulate (verbally or written in the chart) what measurable action/care has been provided. In May of 2012, BUMED affected the RIOAP model to chart chaplain/patient encounters in Essentris®.<sup>22</sup> The model uses a redacted version of Peery's intervention list as the basis to chart a note in the electronic medical record. On a related note, Gleason has worked on research titled the "Ideal Intervention Project." It is through his research and gathering of data from numerous chaplains that evidence demonstrating the efficacy of various chaplaincy interventions is being collected and collated for later publication.<sup>23</sup>

### Outcomes

In an attempt to understand the implementation of chaplaincy outcomes and perhaps even interventions, one can look to the American Nursing Association (ANA) and the North American Nursing Diagnosis Association (NANDA). The ANA traces its beginning to 1898, while NANDA began in 1973. Both of these organizations are committed to professional excellence

---

<sup>21</sup> Peery, 351.

<sup>22</sup> Essentris® is an electronic medical charting program/system developed by the CliniComp Corporation and adapted by the DoD for all military healthcare facilities and services to use in the inpatient healthcare environment. Eventually, both the DoD and VA will be using this program to allow a transparent transition for service members from active duty to veteran/retiree status in regards to healthcare records.

<sup>23</sup> Peery, 351.

and standards in the practice of nursing. As a result of the work of these two groups, the Nursing Outcomes Classification (NOC) was developed and is taught to and used by all registered nurses in the United States. The NOC is a comprehensive, standardized classification of patient/client outcomes that was developed to assist providers in evaluating the effectiveness of nursing interventions. Today, these standardized outcomes are used for documentation in electronic medical records, for use in healthcare data systems, for the development of nursing skills, and for the education of nursing students. NANDA defines an outcome as “a measurable individual, family, or community state, behavior or perception that is measured along a continuum and is responsive to nursing interventions. The outcomes are developed for use in all settings and with all patient populations.”<sup>24</sup> NANDA diagnosis #1055 is *Spiritual Distress*, which can be defined as a disruption in the life principle that pervades a person’s entire being and that integrates and transcends one’s biological and psychological nature; there are similar diagnoses used by physicians, psychologists, and social workers. This type of approach and practice by professional chaplains in providing evidence-based and measurable care have been virtually non-existent.

Traditional seminary classes and CPE centers focus on providing their students with the basic tools of pastoral care, which tend to emphasize active listening skills over an spiritual treatment process. Contrarily, today, nearly every profession (healthcare, business, and the military included) is focused on measurable outcomes, substantiated by the ethical mandate to be faithful stewards of diminishing resources—the Department of Defense is a metrics-driven

---

<sup>24</sup> University of Iowa College of Nursing, “CNC Overview: Nursing Outcomes Classification (NOC),” U.S. Naval Hospital, Okinawa, <http://www.nursing.uiowa.edu/cncce/nursing-outcomes-classification-overview> (accessed May 28, 2012).

organization, and military chaplains providing pastoral care are not exempt. Listening skills are, frankly, not enough to justify existence. Professional Naval Chaplaincy, especially in the military healthcare setting, is no longer comprised of institutional clergy providing ministry of presence. While the empathic listening skill of the chaplain will always be the primary skill needed in making assessments, the professional chaplain must be able transform this sacred knowledge into interventions and outcomes. But in the U.S. Navy, Professional Naval Chaplaincy within BUMED is an ever-evolving profession requiring the mastery of competencies outside of religion-specific clergy services and the competent practice of an interdisciplinary approach to patient care.

#### Assessments

*Standard 1: Assessment: The chaplain gathers and evaluates relevant data pertinent to the patient's situation and/or bio-psycho-social-spiritual/religious health.*<sup>28</sup>

At one time or another, each one of us has experienced a visit to the physician's office for some type of ache, pain, or illness. When this happens, the patient is normally escorted to an exam room where he or she is triaged by the nurse; this typically involves being weighed, having one's temperature and blood pressure taken, etc. Afterward, the physicians will come into the room and read the chart, evaluate the current set of vitals, and ask the patient questions in order to arrive at a diagnosis. This entire process is assessment. The formal definition of assessment is an evaluation or estimation of the nature, quality, or ability of someone or something. Before a

---

<sup>28</sup> Association of Professional Chaplains. "Standards of Practice for Professional Chaplains in Acute Care Settings," U.S. Naval Hospital Okinawa, <http://professionalchaplains.org/uploadedFiles/pdf/commonstandardsprofessionalchaplaincy.pdf> (accessed April 1, 2012).

course of treatment to correct, repair, or heal someone or something, one must first make an assessment so as to prescribe the proper remedy (and by remedy it is implied to be both effective and affective). The physician accomplishes this by following a straightforward process of listening, observing, evaluating, and then determining.

Because of the Rogerian influence, in particularly on the specialized work of CPE, there has been a slow adaptation of an assessment mentality on the part of professional chaplains. In the past few years, however, or at least since the formation of the APC in 1998, several pastoral care professionals and researchers have encouraged healthcare chaplains (actually all chaplains) to adopt a similar methodology for making a spiritual assessment.

Harold Koenig, a physician and researcher at Duke University Medical Center, suggests the physician, as head of the healthcare team, should take responsibility for initiating the spiritual history to determine patient needs that require further attention. Much of the information gleaned relates to medical care and medical decisions, especially in palliative care. It is here that the physician is ideally positioned to conduct a spiritual history during admission or as a part of a new evaluation of a chronically ill patient. For 93% of physicians, this does not occur.<sup>29</sup> If the physician fails to act and a professional chaplain is not involved or unavailable, assessing the patient falls typically to the nurse.<sup>30</sup> As previously mentioned, the ANA does recognize spiritual distress as a diagnosis, and, as such, it falls upon the nursing staff to develop interventions and

---

<sup>29</sup> D.E. King and B.J. Wells, "End of Life Issues and Spiritual Histories," *Southern Medical Journal* 96 (2003): 391-93. According to King and Wells only 7% of all patients have a documented spiritual assessment included in the physician's notes within the medical record.

<sup>30</sup> Harold G. Koenig M.D., *Spirituality in Patient Care: Why, How, When, and What* (Kindle Edition, Chicago Distribution, 2009), location 102 of 2441.

outcomes to alleviate the spiritual distress of the patient. However, Koenig asserts that the type and quality of spiritual assessment performed by the average nursing staff is far from the expectations of the Joint Commission.<sup>31</sup>

Because most hospitals today do not meet the minimal requirements established by the Joint Commission for assessing spiritual history, it is not surprising that patient satisfaction surveys find that the meeting of emotional and spiritual needs during hospitalization is among the lowest ranked of all clinical care indicators and highest in need of quality improvement.<sup>32</sup> Numerous studies and much literature available today demonstrate how the spiritual condition of the patient can play a crucial role in recovery. This presents a tremendous opportunity for professional chaplains to demonstrate to administrators and other members of the care team their value as team members, as reducing the length of stay and increasing patient satisfaction is a win-win situation for all involved.

However, many chaplains have been wary of using clinical language to describe what it is exactly that they do in caring for the patient as a means to give insight to rest of the care team. Some have suggested that doing so would violate the sacred trust between themselves and the patient. Others posit that developing outcomes and interventions, based on the assessment, violates the spirit of Boisen and his model of clinical pastoral care.<sup>33</sup>

---

<sup>31</sup> Ibid.

<sup>32</sup> Clark, A., M. Drain, and M. P. Malone, "Addressing Patients' Emotional and Spiritual Needs," *Joint Commission Journal on Quality and Safety* 29 (2003): 659–70.

<sup>33</sup> George Handzo, "A General Theory for providing Spiritual Pastoral Care using Palliative Care as a Paradigm" In *Professional Spiritual and Pastoral Care: A Practical Clergy and Chaplain's Handbook*, ed. Stephen B. Roberts (Kindle Edition, Woodstock, VT: Skylight Paths Publishing, 2012), location 589 of 10946.

Today in BUMED, in theory, this is no longer the case.<sup>34</sup> The practice of spiritual screening by ancillary staff, spiritual history taking by providers, and spiritual assessment by the chaplain is emerging as the new standard of care for all inpatient admissions and subsequent treatments. However, as previously discussed not every patient can be seen and assessed. Thus, when a chaplain is not available, the question “would you like to see a chaplain” is in the nursing intake assessment and qualifies to meet the JC requirement for spiritual assessment. This is an area to be improved upon, for sure, which will require the chaplain to provide education and training to the providers and ancillary staff that covers spiritual screening, histories, and assessment.

The wariness of the chaplain to share the contents of individual patient encounters has been alleviated by the implementation of the Essentris® Chaplain Assessment and Note. This Electronic Medical Record (EMR) tool allows the professional chaplain to input clinical information to the care team and hold the personal, sacred, and confidential elements of the encounter in the privileged manner that is expected by the patient and demanded by regulation. This EMR is being used by all service branches and will allow for a higher level of pastoral care to be provided to all service members and their families using an MTF for inpatient care.

---

<sup>34</sup> BUMEDINST 1730.2A states, “The RMT entries in patient records, orally conveyed to other medical team members, or otherwise used for health care operations purposes, are considered part of the medical record and are not, therefore, considered confidential by most clergy-client ethical standards. It is important to note that the patient’s expectation that information shared with chaplains and other members of the RMT be kept private, and the health care team’s need to have access to relevant clinical information to properly treat the patients are independent expectations of privacy and confidentiality, and the ability to use or disclose such information is governed by different standards.”



### **Spiritual Screenings**

A spiritual screening is much like the emergency assessment conducted by an emergency medical technician (EMT). When arriving on the scene of a call, the EMT will make an initial assessment of the patient. This is normally a fairly quick exam, involving checking the ABC's (airway, breathing, and circulation) in order to stabilize the patient for transport to a higher level of care. Likewise, the spiritual screening is a triage to determine if an individual is experiencing spiritual trauma or distress and needs to be referred to a professional chaplain. The screening can be performed by any of the intake staff and is not an interview per se. Fitchett and Risk suggest that the screening can be as easy as asking, "How important is religion or spirituality in your coping?" and "How well are those resources working for you at this time?" Depending upon the answers provided, the provider may, or may not, conduct a more extensive spiritual history.

### **Spiritual History**

Spiritual history-taking is the process of interviewing the patient and asking questions about his or her life in order to develop a better understanding of the patient's spiritual needs and resources. If the screening is similar to the triage of the patient, then the history may be likened to the interview with the physician. The provider will ask specific questions that ascertain the needs, hopes, and resources of the patient as he or she attempts to identify any spiritual, religious, or existential distress in the patient. The history should be performed by a provider or someone who has the ability to make referrals to a professional chaplain as well as understand the context in which the spiritual condition affects the physical and psychological well-being of the patient. As this is the case, the spiritual history must be taken by someone with a level of training that is much greater than that of the individual administering the spiritual screening.

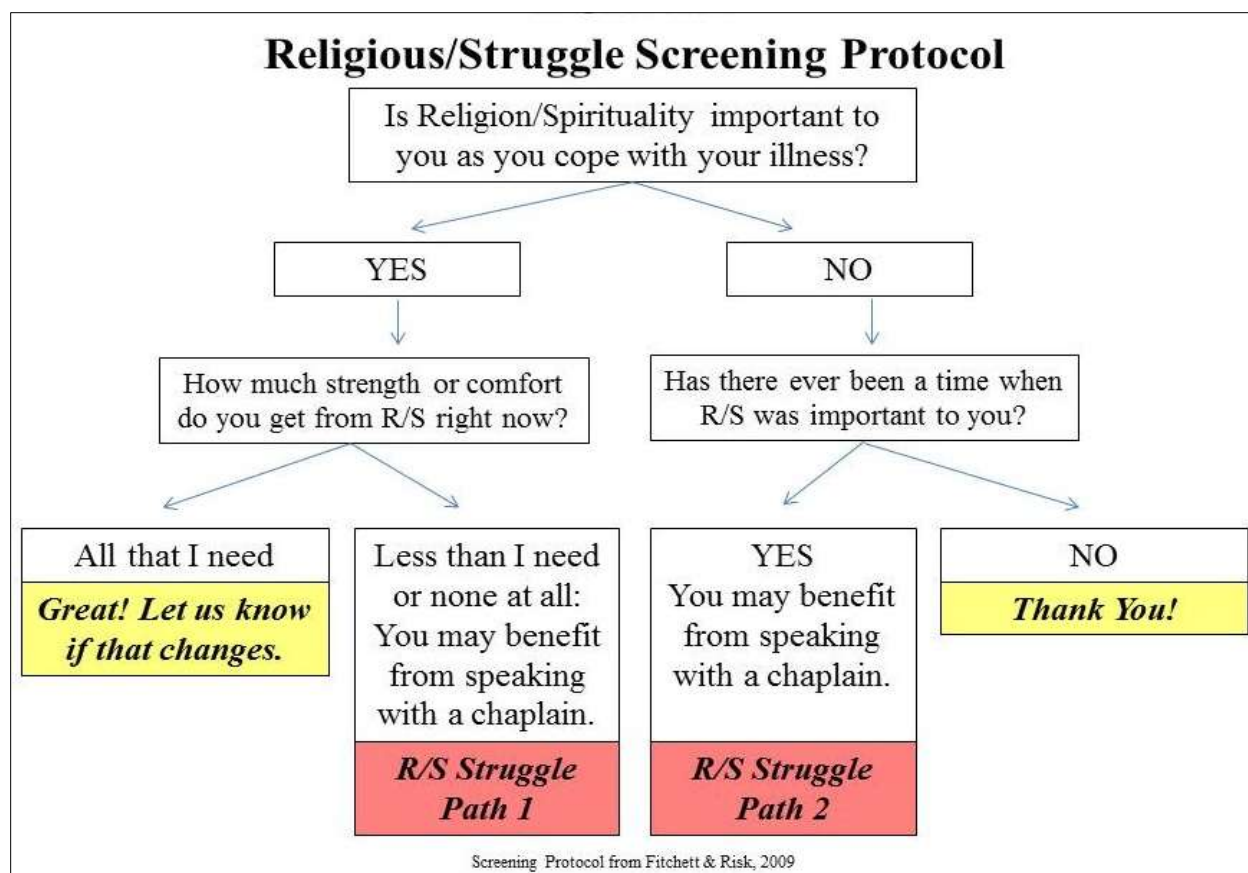


Fig. 4.2 U.S. Naval Hospital Okinawa R/S screening protocol

Romer developed the FICA model for use by providers, not chaplains, to use in taking a spiritual history.

**F** – Faith, Belief, Meaning: “Do you consider yourself spiritual or religious?” or “Do you have spiritual beliefs that help you cope with stress?”

**I** – Importance or Influence of religious and spiritual beliefs and practices: “What importance does your faith or belief have in your life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in regaining your health?”

**C** – Community Connections: “Are you part of a spiritual or religious community? Is this of support to you and how? Is there a group of people you genuinely love or who are important to you?”

**A** – Address/Action in the context of medical care: “How would you like me, your healthcare provider, to address these issues in your healthcare?”

The value of using the FICA instrument for taking a spiritual history, according to Koenig, is that it is brief, has reasonably compelling content, is patient-centered, has been published in a peer-reviewed medical journal, is easy to remember, and meets all five qualities needed in an assessment tool.<sup>35</sup> It is ideal for conducting a spiritual history in outpatient settings. This instrument has recently been submitted for use in the nursing intake assessment for all inpatients in Navy medical centers and MTFs. This is far superior to the old model of, “Do you want to see the chaplain?” which is currently being used (although this question does meet the Joint Commission requirement of consideration for the spiritual care of the patient). There are numerous other models used in other institutions, which require chaplaincy care for patients in spiritual distress; these other models can be found in Appendix 3.

### **Spiritual Assessment**

As previously stated, the ability to “formulate and utilize spiritual assessments” is also one of the standards for professional chaplains (see Standard 1). Spiritual assessment, as contrasted with spiritual screening and history, refers to a more extensive process of empathic listening to the story of the patient, as it develops in the context of a relationship with a professional chaplain. It is summarizing the hopes, needs, and resources that emerge in that process; it is a central task of providing exceptional spiritual care and helps ensure that the care being provided is patient-centered. In legal terms, a spiritual assessment is required as part of an overall patient assessment by the Joint Commission on the Accreditation of Healthcare Organizations.

---

<sup>35</sup> Koenig, 43.

It is crucial to understand that in some circumstances, as the chaplain assesses the patient, he or she will not necessarily talk about God or religious topics. Instead, the chaplain will listen and then use the same language of the patient as he explores the things that are sacred to the patient. As mentioned previously, the patient may have concerns about loved ones, family, meaning or purpose, pain or suffering, or fears related to death, etc.; these may be the sacred objects or beliefs of the patient. It may be hard for the typical Evangelical pastor to comprehend, but the chaplain may not even pray with the patient unless this is something the patient wants and/or asks for. The chaplain, before any spiritual intervention, must seek permission from the patient. Depending on the patient's particular needs and preferences, the chaplain may or may not refer to another faith-specific chaplain or contact the patient's local pastor. As with interventions, the assessment is always patient-centered. After assessing, the chaplain will honor the patient's faith tradition, whatever that may be, and will never evangelize patients, impose the religious practices of the chaplain, or compel patients to accept as true the idea the patient must believe in a certain way.

#### 7 x 7 Model of Spiritual Assessment in BUMED<sup>36</sup>

As described above, the spiritual dimension of life can best be described by a model that deals with beliefs, behavior, emotions, relationships, and practices. We call this a multi-dimensional approach to spiritual assessment. It can be contrasted with one-dimensional models.

---

<sup>36</sup> George Fitchett, *The 7 x 7 Model for Spiritual Assessment: A Brief Introduction and Bibliography*. The entirety of this 7 x 7 Model section is taken from a document handout from Dr. Fitchett during his "Evidence Based Practice" lecture at the Navy Medicine West Chaplain Symposium in San Diego, CA, May 16, 2012. The entirety of this document, including sources, is available online on the Rush University website at:

<http://www.rushu.rush.edu/servlet/Satellite?blobcol=urlfile&blobheader=application%2Fpdf&blobkey=id&blobnocache=true&blobtable=document&blobwhere=1144357138306&ssbinary=true>

For example, a model that describes what church a person is a member of, or a model that describes a person's beliefs about God. Within BUMED, the 7 x 7 assessment model is implemented by professional chaplains assigned with the organization.

The 7 x 7 model employs a functional approach to spiritual assessment. A functional approach to spiritual assessment is concerned with how a person finds meaning and purpose in life and with the behavior, emotions, relationships, and practices associated with that meaning and purpose. The functional approach to spiritual assessment can be contrasted with a substantive approach. The former inquires in an open-ended way about a person's ultimate concern. An example of the latter would be to ask whether or not a person believes in God. In a spiritually pluralistic context, such as a hospital, the functional approach to spiritual assessment is preferable. It offers a greater possibility that a person can share their spiritual story on their own terms versus having to organize their story around the ideas of a particular religious-spiritual worldview. The spiritual dimension of life affects and is affected by other dimensions of life. Spiritual assessment must be undertaken in the context of a multidisciplinary, holistic assessment.

#### Description of the 7 x 7 Model

The 7 x 7 model for spiritual assessment has two broad divisions: a holistic assessment and the multidimensional spiritual assessment. These are illustrated in Figure 4.3 on the following page.

<b>Holistic Assessment</b>	<b>Spiritual Assessment</b>
Medical (biological) dimension	Beliefs and meaning
Psychological dimension	Vocation and obligations
Family systems dimension	Experience and emotions
Psycho-social dimension	Courage and growth
Ethnic, racial, cultural dimension	Rituals and practice
Social issues dimension	Community
Spiritual dimension	Authority and guidance

Fig. 4.3 Fitchett's 7 x 7 model

The holistic assessment portion looks at six dimensions of a person's life.

- (1) *Medical Dimension.* What significant medical problems has the person had in the past? What problems do they have now? What treatment is the person receiving?
- (2) *Psychological Dimension.* Are there any significant psychological problems? Are they being treated? If so, how?
- (3) *Family Systems Dimension.* Are there at present, or have there been in the past, patterns within the person's relationships with other family members that have contributed to or perpetuated present problems?
- (4) *Psycho-Social Dimension.* What is the history of the person's life, including place of birth and childhood home, family of origin, education, work history, and other important activities and relationships? What is the person's present living situation and what are their financial resources?
- (5) *Ethnic, Racial, or Cultural Dimension.* What is the person's racial, ethnic, or cultural background? How does it contribute to the person's way of addressing any current concerns?
- (6) *Social Issues Dimension.* Are the present problems of the person created by or compounded by larger social problems?

#### Spiritual Assessment

The spiritual assessment portion looks at seven dimensions of a person's spiritual life.

- (1) *Belief and Meaning.* What beliefs does the person have that give meaning and purpose to their life? What major symbols reflect or express meaning for this person? What is the person's story? Do any current problems have a specific meaning or alter established meaning? Is the person presently or have they in the past been affiliated with a formal system of belief (e.g., church)?
- (2) *Vocation and Obligations.* Do the person's beliefs and sense of meaning in life create a sense of duty, vocation, calling, or moral obligation? Will any current problems cause conflict or compromise in their perception of their ability to fulfill these duties? Are any current problems viewed as a sacrifice or atonement or otherwise essential to this person's sense of duty?
- (3) *Experience and Emotion.* What direct contacts with the sacred, divine, or demonic has the person had? What emotions or moods are predominantly associated with these contacts and with the person's beliefs, meaning in life, and associated sense of vocation?
- (4) *Courage and Growth.* Must the meaning of new experiences, including any current problems, be fit into existing beliefs and symbols? Can the person let go of existing beliefs and symbols in order to allow new ones to emerge?
- (5) *Ritual and Practice.* What are the rituals and practices associated with the person's beliefs and meaning in life? Will current problems, if any, cause a change in the rituals or practices they feel they require or in their ability to perform or participate in those which are important to them?
- (6) *Community.* Is the person part of one or more, formal or informal, communities of shared belief, meaning in life, ritual, or practice? What is the style of the person's participation in these communities?
- (7) *Authority and Guidance.* Where does the person find the authority for their beliefs, meaning in life, vocation, and rituals and practices? When faced with doubt, confusion, tragedy or conflict where do they look for guidance? To what extent does the person look within or without for guidance?

Certainly, not every question asked above will be asked of all patients. Some of the information may be found in the EMR, some information may be divulged by staff, and some may be gleaned from family members. In fact, most of the holistic assessment can be made by observation of the patient and the interactions they may have with others they encounter. Thus, the 7 x 7 model above is typically administered in both a formal and informal manner. Once the

professional chaplain has answers to fill in this matrix, his attention can now be turned to developing the spiritual care plan.

### **Spiritual Care Plan**

*Standard 2: Delivery of Care: The chaplain develops and implements a plan of care to promote patient well-being and continuity of care.<sup>37</sup>*

After assessing the patient, the chaplain will create a spiritual care plan personalized to the patient's needs. The care plan must be able to be easily and fully incorporated into the larger care plan and must also be clear so that the information within the care plan is understood by members of the interdisciplinary team when they refer to it. In some instances, the chaplain may not talk about God, religion, or faith-specific topics when speaking with the patient, but will instead use whatever language the patient uses to explore the meaning and whatever beliefs or experiences are relevant to the patient, e.g., concerns about loved ones, physical pain or suffering, fears about death or dying, etc. There are many times that the chaplain may not even pray with the patient unless this is something the patient requests or indicates is desired: the patient's needs and preferences take priority. Before any spiritual intervention, including personal prayer, the chaplain should seek permission from the patient. Likewise, the chaplain should not contact the patient's clergy unless this is specifically requested by the patient or the family of the patient.

As with assessment, the chaplain interventions that produce the spiritual care plan are always patient-centered. The chaplain will adjust assessments and interventions to the patient's faith tradition, whatever that may be, and will never proselytize to patients or coerce patients to

---

<sup>37</sup> APC Standards of Practice for Professional Chaplains in Acute Care Settings



believe or practice in a certain way. Roberts and Handzo recommend at least four areas be considered and be included in a basic spiritual care plan.

- (1) What exactly are the spiritual/pastoral issues assessed that need treatment?
- (2) How long have the various issues been going on (did it start as a result of this hospitalization/illness or was it there previously)?
- (3) What is most likely causing each issue?
- (4) How does the issue impact the patient/resident and his or her care?<sup>38</sup>

To summarize, the care plan must be succinct, reasonable, and comprehensible by the providers, nurses, and other chaplains who may read the chart. Most importantly, however, the care plan is a collaborative effort between patient and the chaplain. As such, the chaplain must unequivocally respect the patient's freedom of choice and will always serve as the advocate of the patient in healthcare related matters.

### **Chaplaincy Research**

*Standard 12: Research: The chaplain practices evidence-based care including ongoing evaluation of new practices and, when appropriate, contributes to or conducts research.*<sup>39</sup>

With the advent of organizations such as the APC, NACC, and College of Pastoral Supervisors and Psychotherapy (CPSP), there is a growing consensus about the importance of research for the future of professional chaplaincy. Within the medical and military cultures there is a prevalent attitude that any worthy intervention, either spiritual or psychological, on behalf of another person must be evidence-based. This is due to the fact that these various interventions

---

<sup>38</sup> Roberts, 1705.

<sup>39</sup> Ibid.

have produced predictable outcomes and are known to be effective. If professional chaplains look to the other professions, e.g., medicine and law, it is easily recognizable that both of these groups have developed case studies, or case law, that provide guidance and direction for the practitioners of those respected professions. Likewise, the professional chaplain would benefit from such chaplaincy research if it existed. Fitchett believes:

...chaplaincy needs to develop a body of published case studies. Chaplains need these case studies to provide a foundation for further research about the efficacy of chaplains' spiritual care. Case studies can also play a prominent role in training new chaplains and in continuing education for experienced chaplains, not to mention educating healthcare colleagues and the public about the work of healthcare chaplains.<sup>40</sup>

The commitment by the leadership of such organizations as the APC, NACC, NAJC, and CPSP to transform professional chaplaincy into a research-informed profession has recently begun to pick up enthusiasm amongst their respective memberships. Most notably, this newfound energy is best reflected in *The Standards of Practice for Professional Chaplains in Acute Care* recently affirmed by the APC in 2009. Specifically, Standard 12 states, "The chaplain practices evidence-based care including ongoing evaluation of new practices and, when appropriate, contributes to or conducts research." At the rudimentary level, it proposes that all chaplains need to be familiar with existing evidence and to even present it to their professional colleagues from other disciplines. This requires that the time be set aside to read and reflect on new research's potential to change and enhance their ministry. Further, the professional chaplain must be willing and able to assimilate that which is better for patients, families, or staff.

---

<sup>40</sup> George Fitchett, "Making our Case(s)," *Journal of Health Care Chaplaincy* 17, no. 1–2 (2011): 3–18.

However, Fitchett, Handzo, Peery, et al. would argue Standard 12 also describes the opportunity for more extensive participation in chaplaincy research.

As this student has learned through the preparation of this dissertation, proper research is time consuming, especially when doing any clinical research involving human beings, even if the research is an easy, qualitative opinion survey. But before a professional chaplain undertakes any complicated clinical trials to study their provision of spiritual care, the few chaplaincy researchers working today seem to agree that professional chaplaincy first needs to produce compelling case studies describing their work.<sup>41</sup>

Present day chaplaincy researchers suggest at least two other reasons why chaplains should be writing and publishing case studies. These reasons are:

It would improve the training of new chaplains and the continuing education of experienced chaplains if we had a body of published case material that we could read and critique. Right now new chaplains mostly learn from cases written by the least experienced members of our profession, the cases they and their peers share in their clinical pastoral education programs. In addition, published case studies would provide colleagues in other health professions with a better understanding of what chaplains do, especially if some of the cases are published in journals that our colleagues are regularly reading.<sup>42</sup>

Finally, most professional chaplains would agree that the majority of professional colleagues have little or no education to help them gain a meaningful appreciation for what the professional chaplain does and can contribute to the care of patients and their families. As this is the day of budget cuts and downsizing, it would seem most prudent that the professional chaplain must be persistent and creative in looking for ways to tell the story of who he is and what he does.

---

<sup>41</sup> Ibid., 4.

<sup>42</sup> Ibid., 7.

Research articles and case studies that are worth being presented at the meetings of other professions, e.g., AMA, APA, ANA, etc. and published in the journals of those same professions, can be an extremely effective way to help colleagues develop a better understanding of what a professional chaplain brings to the table of care.

### **Documentation**

*Standard 3: Documentation of Care: The chaplain enters information into the patient's medical record that is relevant to the patient's medical, psychosocial, and spiritual/religious goals of care.*<sup>43</sup>

A section of the EMR should be designated for the documentation done by pastoral care. Having this will help avoid the problem of several people taking a spiritual history, duplicating each other's work, and overwhelming or irritating the patient. Any provider or staff can simply turn to this section of the medical record to see if the spiritual history has been taken and what was learned. The introduction of the Essentris EMR record into MTF settings will help to make such documentation easier and faster to locate.

In providing pastoral care to patients, professional chaplains are to use skilled discretion regarding any details communicated by the patient in order to provide applicable data to other care team members while respecting the patient's privacy. This must be restricted to information that is clinically relevant to the patient's care. Professional chaplains must also inform the patient of their dual role as both a pastoral caregiver and a member of the treatment team. The patient must also be advised that certain information communicated to the chaplain may be shared with other members of the treatment team or in a clinical supervisory session unless the patient

---

<sup>43</sup> APC Standards of Practice for Professional Chaplains in Acute Care Settings.

specifically requests that such information remain in confidence with the chaplain. The expectation of confidential communication will always surpass any requirement to document patient encounters and care must be used to distinguish confidential communications from general pastoral care interventions. Figure 3.4 is an example of the Essentris Chaplain Assessment and Notes; of particular interest is the RIOAP outline developed by Peery. The drop-down menus allow the chaplain to choose from more generalized interventions, outcomes, assessments, and spiritual care plans. This is done to allow the chaplain to have input into the patient record but is general enough to not cross the boundary of the privileged communication held by the patient. For patients who are agreeable to allowing more input by the chaplain, the “other” box allows “stream of thought” entry by the chaplain. See APPENDIX F for an example of the Essentris Pastoral Care Note and Assessment.

### **Board Certified Chaplaincy**

As of March 2011, to be fully qualified to provide clinical pastoral care to patients, staff, and family members, PNCs must meet the common standards for chaplaincy as established by the principal chaplain certifying organizations.<sup>44</sup> The Surgeon General of the United States Navy in consultation with the BUMED chaplain agreed that these standards reflect the core competencies for healthcare chaplaincy in Navy MTFs. Graduates of the Navy medicine PCR meet the common standards for chaplaincy and are considered board eligible by the national

---

<sup>44</sup> BUMEDINST 1730.2 was released March 11, 2011 and addresses these requirements. The major board certifying organizations for chaplains in the U.S. are the Association of Professional Chaplains, National Association of Catholic Chaplains, National Association of Jewish Chaplains, and the College of Pastoral Supervision and Psychotherapy.

certifying bodies. Furthermore, Navy chaplains who do not meet these standards must work under the direct clinical supervision of a board-eligible<sup>45</sup> or board-certified chaplain, or be enrolled full-time in a CPE program, e.g., the Navy medicine PCR program. These requirements are in place to ensure the level of pastoral care provided to patients meets the requirements of the Joint Commission, as well as the BUMED requirement that its chaplains possess the subspecialty code of 1440N-Pastoral Counselor.

The requirements to become a board certified chaplain are much like those required to serve on active duty in the DoD as a chaplain. The chaplain must have a graduate level education and have completed four units (1,600 hours) of clinical pastoral education (CPE) through the ACPE, which is accredited by the U.S. Department of Education. Upon completion of the CPE requirements, the chaplain must obtain a minimum of 2,000 hours of work experience as a chaplain in addition to CPE training or residency. The 2,000 hours of work experience as a chaplain following the completion of CPE. Apart from CPE training or residency, requirements are typically met by candidates when a substantial part of their duties include ministry commonly performed by chaplains in specialized settings, such as a military chaplain candidate program or in healthcare settings. Finally, the chaplain must hold an ecclesiastical endorsement from a recognized endorsing agency.

---

<sup>45</sup> The DoD cannot require chaplains to meet requirements for service that are not agreed upon by the various endorsing agencies, the Armed Forces Chaplains Board, and the National Conference on Ministry to the Armed Forces. For example, if the archdiocese for the Armed Forces certifies and endorses a priest as a chaplain, BUMED, as a sub-command with the DoN, may not require that that priest obtain additional credentials, e.g., board certified status. However, BUMED may require additional training or education to fill billets that require a subspecialty Code (SSP).

The final step for those working towards becoming a board-certified chaplain is for the individual to appear before a committee of seasoned board certified chaplains to demonstrate competency in twenty-nine areas within the field of professional chaplaincy. These twenty-nine competencies include a chaplain's ability to assess patients' needs; provide effective care that contributes to the well-being of patients, families and staff; establish professional and interdisciplinary relationships; respect diverse cultures, lifestyles and faith traditions; behave in a professional manner; care for oneself; and promote ethical decision making and care.

### **Results of Research**

In an attempt to answer the question, "What is the value of the PNC serving in a BUMED hospital?" a total of 126 medical providers, corpsmen, and ancillary staff were interviewed and asked fourteen questions to ascertain their understanding of the role and value of the Navy chaplain serving within a Navy hospital. Question #9 asks the respondent to indicate their level of agreement with the following statement: *"I believe the clinical input regarding patient care, provided by my chaplain to me and members of the Care Team, is important."* This question was asked in light of the APC *Common Standards for Professional Chaplaincy*: Standard 4: *Teamwork and Collaboration: The chaplain collaborates with the organization's interdisciplinary care team.*

Using a Likert scale, the respondents were given a selection of five possible answers to indicate their level of agreement with a range of strongly disagree, disagree, neither agree/disagree, agree, and strongly agree. The results for this question are displayed below in Figure 4.4.

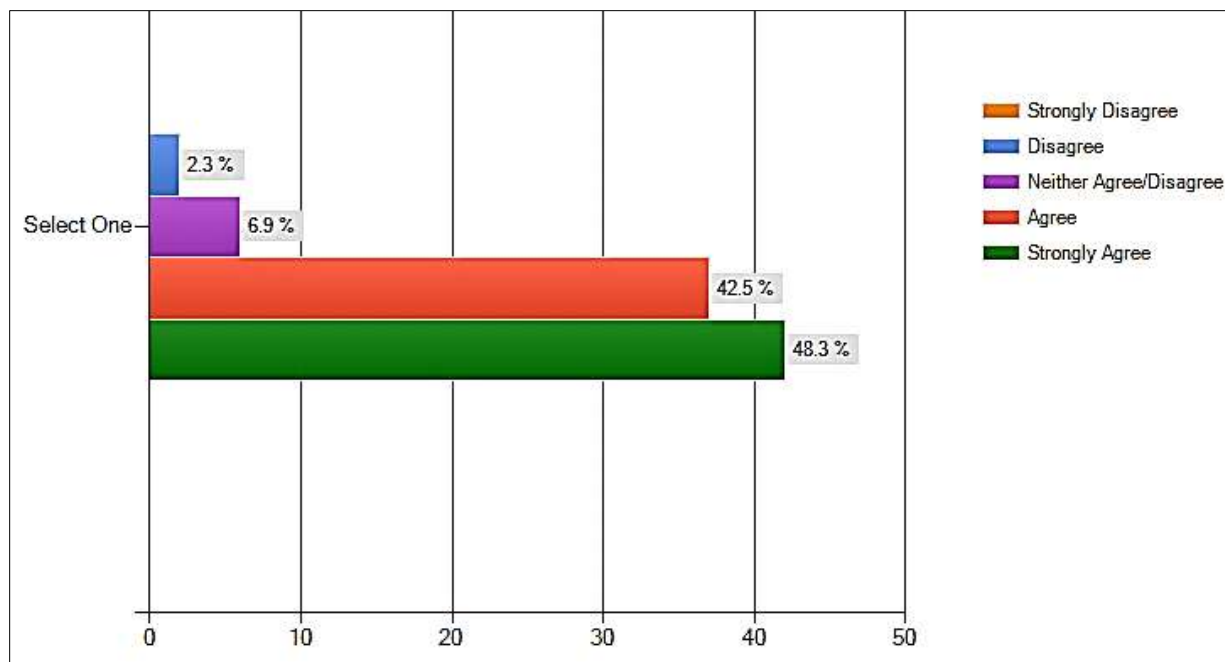


Fig. 4.4 Value of clinical input provided by the chaplain

Of all respondents, 90.8% either agreed or strongly agreed that the clinical input provided by the Navy chaplain to members of the interdisciplinary care team (IDCT) is valuable. By participating on the IDCT, the chaplain provides valuable information, e.g., a spiritual assessment, or perhaps family dynamics, which providers from the other care team disciplines may use as they formulate their respective plans of care. This is especially important in situations involving palliative care or End-of -Life (EOL) care for the patient and/or the family of the patient. When the data is extrapolated to consider the responses of naval officers only, 82.2% were in agreement with this statement while a mere 5.4% disagreed in any form. Of those officers who provided direct care to the patient, the breakdown was follows: 94.1% of medical corps officers (physicians) agreed with this statement; 80% of nurse corps officers (registered nurses) agreed while only 5% disagreed. These responses leave a void in between of uncertainty in that a mere 5.9% of medical corps officers neither agreed nor disagreed and 0% outright disagreed; 15% of



nurse corps officers were equally uncertain, and 5% outright disagreed. It is impossible to make an accurate interpretation of Medical Service Corps Officers (MSC) responses as some provided direct patient care and interact with chaplains, e.g., physician assistants, social workers, and psychologists while others, e.g., optometrists, nutritionists, pharmacists, audiologists, industrial hygienists, and healthcare administrators interact with Navy chaplains but not in a clinical context.

Question #10 asks the respondent to indicate their level of agreement with the following statement: *“I believe the clinical input regarding patient care, provided by my chaplain in the patient's medical record, is important”* This question was asked in light of the APC Common Standards for Professional Chaplaincy: Standard 3: *Documentation of Care: The chaplain enters information into the patient's medical record that is relevant to the patient's medical, psychosocial, and spiritual/religious goals of care.* Using a Likert scale, the respondents were given a selection of five possible answers to indicate their level of agreement with a range of strongly disagree, disagree, neither agree/disagree, agree, and strongly agree. The results for this question are displayed on the following page in Figure 4.5.

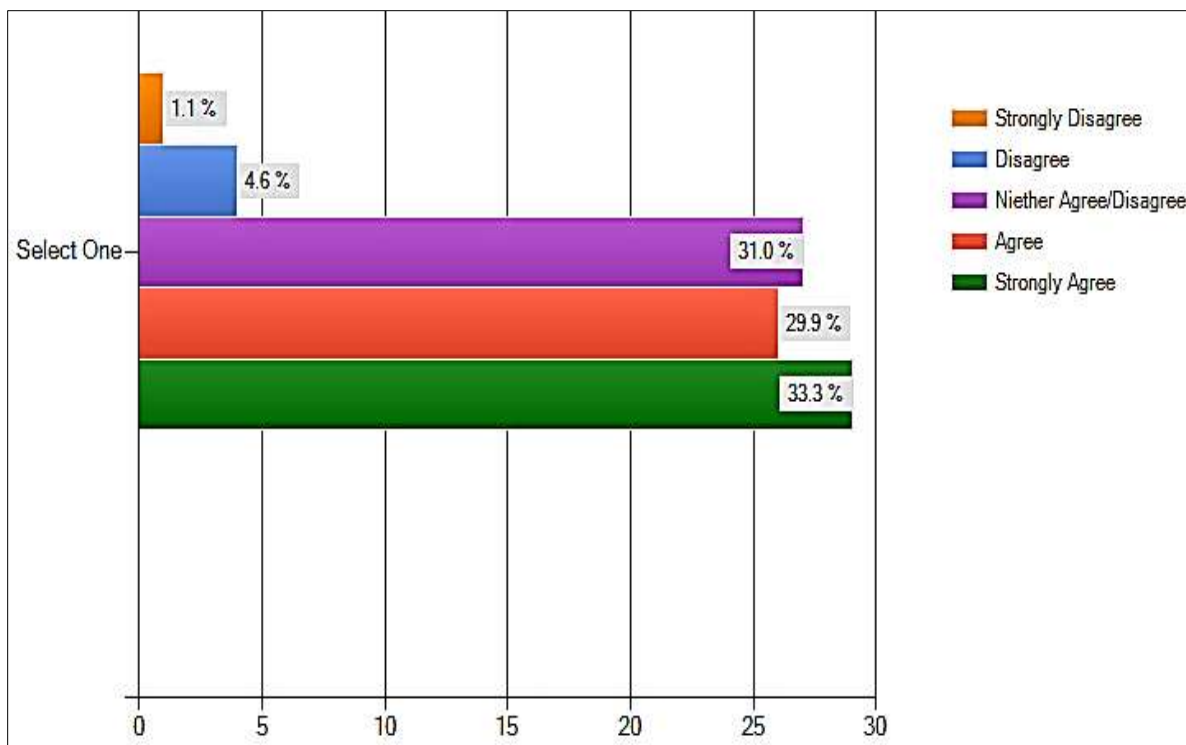


Fig. 4.5 The value of chaplain input to the patient's medical record

Of all respondents, 63.2% either agreed or strongly agreed that the input provided by the Navy chaplain into the patient's medical record is important. By doing this, the chaplain is providing valuable information, e.g., a spiritual assessment that providers from the other care team disciplines may use as they formulate their respective plans of care. This is especially important in situations involving palliative care or End-of-Life (EOL) care for the patient and/or the family of the patient. When the data is extrapolated to consider the responses of naval officers only, there is a 50/50 split between agreement with this statement and those who either disagree or strongly disagree. Of those officers, those who provide direct care to the patient, the break down as follows: 47% of medical corps officers (physicians) agreed with this statement while only 11% of the disagreed; 65% of nurse corps officers (registered nurses) agreed while only 11% disagreed. These responses leave a void in between of uncertainty in that 48% of medical corps

officers neither agreed nor disagreed; 24% of nurse corps officers were equally uncertain.

Perhaps this can be attributed to the fact that many Navy chaplains are still very uncomfortable making entries into the patient record and the providers have no basis to make a judgment as to the values of the chaplain's contribution into the record.

### **Summary**

In this chapter, the historical roots of OOC were discussed. Lucas and VandeCreek pioneered this approach in the early 1990s and codified this approach and the term itself in the early 2000s with the release of their book, *The Discipline for Pastoral Care*. Their work affected the practice of healthcare chaplaincy in a tsunamic fashion and the reverberations are still being felt today by chaplains in numerous settings.

Standards of practice for professional chaplains were also given consideration. The practices of professional organizations to require a certain degree of skill for practitioners of professional disciplines have existed as far back Hippocrates in ancient Greece. Within the U.S., credentialing organizations such as the American Medical Association (AMA) (1847), American Bar Association (1886), and ANA (1896) have only come into being within the last 160 years. Chaplaincy, however, is a latecomer to this group of credentialed professionals and only within the past five years has established common standards.

Moving from history to practice, Peery's *Run In On A Prayer* outline, which is used to remember the components of quality patient chaplaincy care, was examined. Though many chaplains are still hesitant to chart notes on patient visits, perhaps the shift from "Presence to Prove it" and evidence-based practice will become more accepted (especially as budgets shrink and administrators only keep assets that increase profits by reducing the length of hospital stays).

The professional chaplain within BUMED is required by regulation to make spiritual assessments, develop interventions, determine desired outcomes, and develop and implement spiritual care plans. This process begins upon the initial triage of a patient as spiritual screening and histories are taken by providers and referrals are made to the chaplain. The 7 x 7 assessment model is recommended by BUMED, as it is remarkably thorough and easily remembered.

The idea of chaplaincy research was examined. Many of the prominent chaplaincy researchers are convinced that chaplains have failed in this area. Fitchett and Handzo both advocate the development of chaplaincy cases studies in order to better train new chaplains and to lend credibility to professional chaplaincy in the eyes of other care team members. Only when a substantial number of case studies are completed will any quantitative studies be possible by more experienced researchers.

Finally, the concept of board certification was discussed. Again, much like research, this movement seeks to improve the level of care provided by the chaplain as well as provide an understanding of the work of the professional chaplain among professional colleagues. In the same vein of “You might be a redneck,” it has been said that, “If you wake up on Sunday morning craving fried chicken, you might be called to preach.” While many pastors and preachers may chuckle at this, the truth is that in America, because of the First Amendment nearly, anyone can obtain “religious credentials” with little or no training, e.g., website ordinations. This is simply not true within medicine, nursing, law, and even the military. Similar to the relationship between endorsing agencies and the Armed Forces Chaplains’ Board (AFCB), there is a place for a professional chaplaincy board certifying organization(s) to exist and relate to secular organizations, establish standards of practice and enforce an ethical code of conduct for those claiming the title of “professional chaplain.

## CHAPTER 5

### SPIRITUAL FITNESS

*Keep yourself in training for a godly life. Physical exercise has some value, but spiritual exercise is valuable in every way, because it promises life both for the present and for the future. This is a true saying, to be completely accepted and believed.*

I Timothy 4:7-9, GNT

#### **The Professional Naval Chaplain as the Spiritual Fitness Leader**

##### Introduction

Spirituality, as distinct from psychological and other variables, is now recognized as a critical component in the total force fitness of service members. In fact, it is considered one of the four pillars of total wellness, the others being physical health, social health, and mental or psychological health.<sup>1</sup> While there is extensive literature available for the development of evidence-based policies, programs for spiritual support, and treatment of spiritual distress and moral injury, to date, nearly all of the research has been conducted by non-chaplains or non-faith based researchers. Of even greater importance for this student is the fact that these programs are being administered by non-chaplains.

Within the Navy, chaplains are best equipped to assume this responsibility, as the realm of the soul and soul care has traditionally fallen to the clergy. The chaplain provides a key resource that operates within integrated teams of medical staff and care teams. This has not been the case historically: only the leadership of commanders and attitudes of chaplains can bring about the needed change. Spiritual fitness programs should utilize existing instruments for

---

<sup>1</sup> Chairman of the Joint Chiefs of Staff Instruction 3405.01, *Chairman's Total Force Framework*, (September 2011) A-2.

monitoring purposes, e.g., combat and operational stress control, but should also include proactive plans for service members before deployment and whenever events such as mass casualties increase the overall risk of spiritual distress. Mental health and deployment health experts should be employed in a joint role with chaplains in developing spiritual fitness programs. All military leaders, at all levels, should receive introductory training in cultural competence and spiritual diversity to provide the necessary support for spiritual fitness program development.

### What is Spirituality?

The use of the word “spiritual” and related terms have differed among religious leaders for many years. So it should come as no surprise that there have been, in the past, serious problems defining spirituality and conducting research on spirituality and health. “Fencing” the meaning or defining spirituality can be a highly subjective endeavor, as some equate spirituality with organized religion, while others, like Fuller, have a much broader and more inclusive use of the word:

Spirituality exists wherever we struggle with the issues of how our lives fit into the greater scheme of things. This is true when our questions never give way to specific answers or give rise to specific practices such as prayer or meditation. We encounter spiritual issues every time we wonder where the universe comes from, why we are here, or what happens when we die. We also become spiritual when we become moved by values such as beauty, love, or creativity that seem to reveal a meaning or power beyond our visible world. An idea or practice is “spiritual” when it reveals our personal desire to establish a felt-relationship with the deepest meanings or powers governing life.<sup>2</sup>

---

<sup>2</sup> Robert C. Fuller, *Spiritual, but not Religious: Understanding Unchurched America* (New York: Oxford University Press, 2001). Excerpt located on beliefnet.com accessed July 21, 2012.

<http://www.beliefnet.com/Entertainment/Books/2002/07/Spiritual-But-Not-Religious.aspx?p=2>

Today, with more than 72% of Millennial Americans (ages 18–29; the largest age segment within the active military) identifying themselves as spiritual but not religious, care providers often use the words spiritual and spirituality broadly to capture an array of domains including values, feelings, aspirations, etc., which typically reflect common theological assumptions about the human spirit.<sup>3</sup>

For this student, spirituality is that which allows a person to experience transcendent meaning in life. This is often expressed as a relationship with God, but it can also be about nature, art, music, family, or community—whatever beliefs and values give a person a sense of meaning and purpose in life. Simply put, it is about relationship: (1) relationship with self, e.g., self-awareness, (2) relationship with others, e.g., family, friends, pets, etc., and (3) relationship with that which is sacred. The sacred or transcendent can be anything, anyone, or any practice that gives meaning, or provides hope in the life of the individual. This can be appropriate and useful in the context of care, such as that offered by military chaplains.

However, in clinical research it is necessary to make use of a definition that is more precise and standardized (to allow comparison among different studies and different populations) that helps to differentiate spirituality from psychology, that is germane to its varied expressions in diverse religions, and that reflects everyday usage of the term by the subjects being studied.

***Spirituality***: the quality or condition of being spiritual

***Spiritual***: of, pertaining to, or affecting the spirit or soul, especially from a religious aspect

---

<sup>3</sup> In *USA Today* article “Survey: 72% of Millennials ‘more spiritual than religious’” (April 27, 2010), based on the results of a Lifeway Research study, Cathy Grossman discusses the trend among Millennials to identify less with a specific religion and more as “spiritual.”

*Spirit*: (1) the animating principle in humans and animals; (2) the immaterial part of a corporeal being.<sup>4</sup>

The above listed are the definitions of “spiritual” and its cognates that are most common in English language usage and most useful in spirituality research. However, in translating the results of clinical research into a more practical lingo or understanding for the average twenty-year-old sailor or U.S. Marine, the threefold definition previously given by this student is more useful.

For most individuals, spiritual factors make sense only within specific spiritual traditions. Within military culture, spirituality affects total fitness primarily as it interacts with other domains, especially psychology. Copious amounts of research have established strong links between spirituality and physical, psychological, and medical health,<sup>5</sup> most of them positive but a small number of them negative; these results vary depending on the individual’s specific beliefs and practices.

The outcomes that have been examined have in one way or another been affected by the social and/or behavioral aspects of the individual’s spirituality. To describe the domain in which the spiritual intersects and interacts with the other domains, military care providers use the term “psychospiritual.”<sup>6</sup> This is, in part, to acknowledge that psychological and spiritual dissimilarities will be described differently by different people based on their respective

---

<sup>4</sup> David J. Hufford , Matthew J. Fritts , and Jeffrey E. Rhodes, “Spiritual Fitness,” *Military Medicine* 175, no. 8 (August Supplement 2010): 74–75.

<sup>5</sup> Harold G. Koenig, Dane E. King, and Verna B. Carson, *Handbook of Religion and Health*, 2nd ed. (New York: Oxford University Press, 2012). In this second edition of Koenig’s landmark work he references more than 1,200 clinical studies conducted since 2000 that examine the link between religion/spirituality and positive/negative health outcomes.

<sup>6</sup> Hufford, Fritts, and Rhodes, 75.



practices. While adopting policies and developing interventions and strategies favoring the spiritual practices of one religious tradition over another would be both unethical and illegal, it is more than appropriate for chaplains and mental health providers to develop reasonable psychospiritual policies, programs, and interventions that foster spiritual fitness regardless of one's religious or spiritual tradition.

### What is Religion?

Religion is defined as:

A set of beliefs concerning the cause, nature, and purpose of the universe, especially when considered as the creation of a superhuman agency or agencies, usually involving devotional and ritual observances, and often containing a moral code governing the conduct of human affairs; further it is a specific fundamental set of beliefs and practices generally agreed upon by a number of persons or sects.<sup>7</sup>

As the search for, encounter and response to God, spirituality is an inner, personal experience, universal and without boundaries. Religion, however, is communal, particular and defined by boundaries. It is spirituality incarnated at the social and cultural level. Religion takes the boundless and binds it to the limitations of language and culture, even as it may also transform culture.

Defining "religion" has been, at times, a challenge. In the same way that "spirituality" seems to elude a consistent meaning and usage, the term "religion" has suffered from a multiplicity of definitions. Most modern scholars favor the derivation from *ligare*, "bind, connect," probably from a prefixed *re-ligare*, i.e., *re* (again) + *ligare* (connect) or "to reconnect," which was made prominent by St. Augustine. Within specific traditions, for example, religion is

---

<sup>7</sup> religion. Dictionary.com. *Dictionary.com Unabridged*. Random House, Inc. <http://dictionary.reference.com/browse/religion> (accessed: April 12, 2013).

man's attempt to "reconnect" with God. Historically, "religiosity" was used in ways that were indistinguishable from what is now called "spiritually." The term "religion" is increasingly used by secular scholars and leaders in a narrow and even pejorative sense of institutionally-based dogma, rituals, and traditions. As a means of building resilience and coping skills, medical, psychological, and sociological researchers have found otherwise. The renowned researcher on religious coping, Kenneth Pargament, after studying the various ways of defining and describing religion, argues for a broader definition of religion as, "The search for significance in ways related to the sacred, encompassing both the personal and social, traditional and non-traditional forms of the religious search."<sup>8</sup> Pargament uses the term "spirituality" to describe what he calls the central function of religion—the search for the sacred.<sup>9</sup>

#### Religion Without of Spirituality

Religion and spirituality are not one and the same, yet the symbiotic relationship these two words share in the English vernacular does make it important to differentiate between the two words. Religion is not necessarily in and of itself spiritual. It is clear that the beliefs, rituals, and institutions of religion, e.g., the Church, Conventions, Synods, etc. can take on a life of their

---

<sup>8</sup> Kenneth Pargament, *The Psychology of Religion and Coping: Theory, Research and Practice* (New York: The Guilford Press, 2001), 32.

<sup>9</sup> Kenneth Pargament, *Spiritually Integrated Psychotherapy: Understanding and Addressing the Sacred* (New York: The Guilford Press, 2011), 34. This student believes the bigger problem for mental healthcare providers is a lack of knowledge about spirituality. In the 1990s only 5% of clinical psychologists reported any professional training on religious or spiritual issues (Shafranske & Maloney, 1990). Without a proper education, many counselors are left, in essence, spiritually illiterate, unable to understand spirituality, unappreciative of diverse religious traditions, unfamiliar with the empirical literature in the psychology of spirituality, unequipped to evaluate spirituality, and unskilled in addressing the spiritual dimension in psychotherapy. With the efforts of Pulchalski, Koenig, etc. and the advent of the civilian hospitals requiring board certification for their chaplains, this trend is slowly reversing.

own and exist apart from their spiritual purpose. Chaplains must understand the difference between the two words. In one circumstance the chaplain may function as a “religious cartographer,” while in a different circumstance he may simply be a pilgrim going on a journey with a troubled soul. Thus, religion may exist without spirituality; however, if that is the case, then one is left with only the empty observance of rites, rituals, and traditions. It is possible for an individual to practice a form of religiosity that supplants spirituality. In this case, religious practices such as going to church, temple, synagogue, etc. are done for external purposes, e.g., to gain social advantage or make business contacts. Contrarily, there is a form of “deep-down” religiosity, that when infused with a genuine internalized spirituality results in a core beliefs system that is related to positive health outcomes.<sup>10</sup>

#### Spirituality Without of Religion

It is also possible to undertake a spiritual journey without the “map” provided by a religious cartographer as mentioned above. Although spirituality is usually cultivated within the context of a specific faith tradition, in the postmodern world there are an untold number of persons whose spirituality is either superficial or not at all connected with an established religion or faith group. Many of these spiritually homeless (or spiritually schizophrenic) have little or no formal religious background; many others, especially within the DoN, have rejected the religion in which they were raised because of their combat experiences. Nonetheless, this student has observed that these “wandering” individuals still have spiritual aspirations. Today’s Marines and Sailors have no spiritual map in their possession. There is a strong feeling of alienation from the organized religions of their youth and a conclusion that all that hypes itself as religion is barren

---

<sup>10</sup> Jeffrey Levin and Preston L. Schiller, “Is there a Religious Factor in Health?” *Journal of Religion and Health* 26, no. 1 (Spring 1987): 18.

of spirituality. It is then that they hazard out alone or begin to search for spiritual help wherever they can find it. While not associating with any structured religious group or faith tradition, the spiritual life of such individuals, nevertheless, contains elements of religion under the aforementioned all-encompassing definition.

Even inner, private experience is not divorced from social and historical context. Indeed, raw experience is cognitively interpreted the instant we reflect on it. We do not invent out of thin air the framework of understanding and practices, however rudimentary, that we bring to our spirituality. These come out of our cultural and religious background. As soon as we think or speak about or act upon our spirituality in any way, even to pray or meditate silently, we are instantly thrust into the historical and social world of language and praxis, and thus religion. A “pure” spirituality that is utterly without content or practice may not even exist, and if it did, it would be difficult to measure.<sup>11</sup>

### **Components of Spiritual Fitness**

The spiritual fitness component of total wellness, while a relatively new academic discipline, is certainly one about which there is no shortage of opinions. Its development is also one that provides all service members with a valuable means to fortify resilience to stress and recovery from stress injuries whether they realize it or not. For far too many, spirituality is ignored as it has somehow become synonymous with monotheistic religious practices based on a faith in God. It is true that for many service members, Divine worship as part of a faith-specific community provides resources for coping. Spirituality, though, has a broader definition that applies even to those individuals who do not believe in a monotheistic God or do not belong to or practice an organized form of religion. It is this broader view of spirituality that helps define and

---

<sup>11</sup> John K. Testerman, “Spirituality vs. Religion: Implications for Healthcare,” (paper presented at 20th Annual Adventist Faith and Learning Seminar, at Loma Linda, California, June 15–27, 1997).

build the concept of spiritual fitness. The spiritually fit individual possesses and practices a belief system that provides meaning and purpose that transcends the day-to-day struggles of the individual. The DoN strongly encourages the use of religious and spiritual practices for its members because its leadership has recognized it is an institution comprised of spiritual beings.

In this broader sense, the Navy and U.S. Marine Corps are inherently spiritual organizations and their traditions and core values help Marines, Sailors, and their family members find meaning and value in all that they do. Unit leaders and chaplains can be spiritual teachers to the extent that they mentor their Marines and Sailors to trust in their organization's values and to find meaning in their experiences.<sup>12</sup>

Spiritual fitness is vital for Sailors and Marines as the United States is now into the eleventh year of the War on Terror. This student has personally accrued during this time period more than three years of deployment time, all in support of Operation Enduring Freedom, as well as four years of forward deployed operations in Asia and the Western Pacific. This type of operational tempo is now the norm for Sea Services personnel. It requires both resolute determination and resilience in the domain of the spirit as well as the mind of all service members.

No one individual possesses limitless quantities of courage and perseverance, thus all Sailors and Marines need to enlarge their internal capacity for resilience by continually connecting to resources beyond themselves that are venerated and trustworthy, such as peer groups, leaders, and the Divine. Faith and belief that one is on the right side of a conflict is essential in fostering spiritual fitness and resilience in Sea Services personnel. Spiritual fitness and its resulting resilience are based on an unyielding trust in personal moral values and ethics. It is incumbent upon all leaders, especially the chaplain, to develop, deepen, and strengthen the spiritual fitness and resilience of their personnel.

---

<sup>12</sup> MCRP 6-11C, *U.S. U.S. Marine Corps Combat and Occupational Stress Control* (December 2010), 3-26.

## Spiritual Beliefs

Beliefs are ideas or propositions held to be true by the individual. Alive and well in most nearly every culture today, especially in the United States, is the belief in the reality and omnibenevolence of a transcendent deity. Central to most religious traditions is the belief that the human spirit (soul) is real; it transcends death and is capable of moving to a different plane of existence. It is these types of belief systems that advocate the existence of a transcendent or non-physical dimension that function dogmatically in the development of individual spirituality. It is the spiritual beliefs of the individual that define and describe his or her core beliefs and values. As a part of these beliefs, the typical individual addresses the deeper questions of his or her existence, such as what is the meaning of life and what is his or her purpose in it. This is not to say that the answers to these questions will come easily or without some type of struggle. It is through the spiritual component of the individual that their understanding of the world and their place in it is developed. Cultivating the spiritual component is essential to becoming spiritually fit. These beliefs provide support in times of stress as the individual looks beyond his own abilities and capabilities and finds hope, and the ability to cope and persevere during difficult times. Thus, spiritual fitness requires both positive and helpful beliefs, as well as beliefs that are capable of remaining stable when individual worldviews are disrupted or even shattered.

Within the context of the Navy and U.S. Marine corps, leadership at all levels, along with their supporting staff, especially chaplains, is necessary to provide stability before, during and following combat operations. For the contemporary PNC this is no simple task. There are currently more than 230 different faith traditions represented in the Navy chaplain corps and even more faith traditions within the DoN. It is not hard to discern that because of the religious

and spiritual diversity within the Navy that the commanders will need expert guidance regarding this diversity and the best approach to developing spiritually fit personnel.

### Spiritual Values

As the previous section began with a brief definition of “belief,” it is appropriate that this section also begin with a brief definition of the word “values.” This is necessary, as within the context of spiritual fitness both morality and ethics find their meaning and practical application determined by the individual’s values. The word “value” comes from the Latin *valere*, which means to possess worth or that which makes something desirable. This includes the worthiness and desirability of individual thoughts, words, and actions. Within the general context of humanity, it is values that provide the rubrics for making right decisions and acceptable behaviors in society. Within the context of the DoN, it is the core values of Honor, Courage and Commitment that serve as the foundation for all actions taken, or not taken, by every sailor and U.S. Marine in every circumstance. It is important, however, for leadership to take into account that while morality and ethics are sets of such institutional values, the individual values of service members may vary from one individual, culture or social group to another. Notwithstanding, moral conduct, as determined by the institution, is crucial to unit cohesion, good order and discipline, and compliance with all applicable laws governing conduct during war. It is the chaplain who is charged with advising the commander on all issues related to religion, morale, ethics, and morality. As a necessary result of this charge to the chaplain, it is he who is tasked with teaching, through word and deed, appropriate morals and ethics to all members of his respective unit. The Navy (and DoD) is a secular/pluralistic organization and any moral or ethics training must be presented as detached from specific religious traditions. Despite this requirement, however, spiritual fitness training may provide affirmation of particular values

that are considered universal, and considered to be essential by any number of religious traditions. Both clinical studies and experience have consistently demonstrated that strong morals in a religious framework promote total wellness of the individual by reducing unhealthy and risky behavior, e.g., alcohol abuse, illegal drug use, smoking, and risky/promiscuous sexual behavior, to name a few. Religious practices can help develop spiritual fitness and increase individual resiliency. Increased spiritual fitness and individual resiliency are indispensable to mission readiness and should be welcomed by commanders at every level of command.

### Spiritual Practices

The chaplain is tasked with providing religious ministry in the U. S. Navy, including: “the free exercise of religion; attends to the sacred, spiritual, and moral aspects of life; and serves to enhance the resilience of service members, civilians and their families, who form the foundation of the Navy’s readiness.”<sup>13</sup> The chaplain performs these tasks on behalf of the commander, who is legally charged with providing for the free exercise of religion. Leaders and chaplains alike can be spiritual coaches to the extent that they mentor their personnel to trust in their organization’s values and to find meaning in their experiences. Studies have shown that a strong faith in the Sacred can add significantly to resilience, regardless of how that which is sacred is understood or worshipped.<sup>14</sup> Current operational stress control (OSC) doctrine states:

If unit or family members abandon their faith in God and goodness due to their inability to reconcile war zone experiences with their previous beliefs, unit leaders may team up with unit or base chaplains to address such losses of faith and to try

---

<sup>13</sup> OPNAVINST 1730.1E *Religious Ministry in the Navy* (April 2012).

<sup>14</sup> MCRP 6-11C, *U.S. U.S. Marine Corps Combat and Occupational Stress Control* (December 2010), 3-31.



to restore belief systems and religious practices. The restoration of faith, even in an altered and, perhaps, more mature form, can contribute significantly to current psychological health and future resilience.<sup>15</sup>

As demonstrated previously, religious activity may provide numerous spiritual practices that are the behavioral expression of individual spirituality. Spiritual practices from the monotheistic religions, i.e., Christianity, Judaism, and Islam include prayer, sacred scripture study, worship, music, fasting, practicing charity, and service to community. Within the DoN, commanders at all levels are instructed to encourage their subordinates to practice and exercise their respective religious traditions as a means to increase spiritual fitness and resiliency.

Encourage Religious Practice: For those unit members motivated to do so, participating in worship services as part of a faith community and reading sacred texts, such as the Bible, Tanakh, or Koran, can provide valuable spiritual resources for resilience. Unit leaders can make such spiritual resources more readily available to unit members by creating a culture of respect for religious practice and tolerance for religious diversity and by setting aside time in weekly schedules for religious worship.<sup>16</sup>

At the other end of the spectrum, the spiritual practices from non-theistic belief systems must be taken into consideration. The commander and chaplain should provide opportunities for the non-religious to develop spiritually. These opportunities include, but are not limited to: social activism, work, education, and mindfulness. Community relations projects (COMRELs) are an excellent way to develop spiritual fitness, as they include opportunities for both the religious and non-religious members of the command. These types of projects should be set up by the

---

<sup>15</sup> Ibid.

<sup>16</sup> Ibid.

chaplain, funded by the command, and participation opportunities offered to all members of the command.

In addition, non-faith specific spiritual practices should be made available to all personnel. Many of these practices come from Eastern cultures, and include techniques to enhance the mind's capacity to affect symptoms and physical functioning. Examples are breathing exercises, mantra exercises, relaxation-response, prayer, meditation, yoga, and various other creative channels such as art, music, or journaling. These mind/body skills can be practiced by service members with little or no equipment in a variety of settings and with little to no cost. Units can include mind-body skills training in standard pre-deployment routines to improve functioning and performance, enhance concentration and focus, and prevent and treats a variety of stress-related diseases. The chaplain may or may not teach these techniques to service members, but for those who do not, these resources are available through the respective mental health departments and should be facilitated through the Chaplain's Office or Pastoral Care Services Department.

### **Core Beliefs and Values**

Who am I? Why am I here? What is my purpose in life? What happens after I die? Why did my friend have to die? Why didn't I die? These are universal mysteries about the meaning and purpose of life; they are ancient in origin and powerful as existential questions. From one point of view, the answers to the meaning of these mysteries are straightforward and apparent: the purpose of life is what you make of it; after you die, nothing happens—you're just gone. Religious and spiritual beliefs, however, posit more byzantine, and usually more encouraging, remedies. The belief that spirit is real, and that there is a Divine plan behind the seemingly random events of the world, gives rise to meanings with far-reaching implications. After these

many years of war, untold hundreds-of-thousands have experienced combat situations. These individuals have affected, failed to prevent, or observed atrocious acts that transgress the deepest of held values; individual beliefs about the purpose and meaning of life have been abolished. Today, “moral injury” is the leading cause of PTSD and the inability for OEF/OIF combat veterans to adjust to post-combat operations.<sup>17</sup> As one possible intervention, leaders can help alleviate moral conflict and injury by using the services of their chaplains in:

Encouraging advance preparation for the horrors of war through facilitated pre-deployment discussions with family members and loved ones about the possibility of moral conflict, severe disability and death; using after-action reviews [*Critical Incident Stress Management programs*] to assist service members who have seen or done things that lead to serious moral conflict; and honoring the fallen through memorial services.<sup>18</sup>

From the time of Moses and the Children of Israel, questions of theodicy have troubled the mind and spirit of man, i.e., “How could an omnibenevolent God allow such evil things to happen?” This question has become predominant in the minds of service members who take part in or witness experiences that shatter their worldview. Therefore, as a means of increasing spiritual fitness and resiliency, leaders and chaplains have a legal and moral obligation to help cultivate an understanding and acceptance of suffering that involves mystery and may be beyond complete human understanding.<sup>19</sup>

---

<sup>17</sup> In *USA Today* article “Modern Wars influence Psychiatric Thought,” (Feb. 28, 2012), Gregg Zoroya discusses the results of the study referenced above. The results of this study were released in November 2011 by the VA National Center for PTSD.

<sup>18</sup> *Ibid.*, 3–28, 29. Italics are this student’s own.

<sup>19</sup> *Ibid.*

## Spiritual Injuries

As one who has served on the front lines, this student can attest to the fact that spirituality, belief, and religious practices are the only “sanctuary” amidst intense operational or war experiences; these experiences will definitely try one’s faith. The truth is, moral trauma is real, and, when left unaddressed, it can set off a downward spiral of physical, psychological, and social problems in the life of the service member, their families, and their units.

“Vexing” is a fitting description of the protracted effects of moral trauma or combat stress injury, the symptoms of which manifest in a variety of ways that can exact an immense toll on the body, mind, and spirit. Even so, the term does not go far enough in expressing the depth of angst so many service members experience. Recent studies suggest that service members with prolonged, intense combat exposure are more likely to seek support services due to guilt and loss or weakening of their religious faith than PTSD or lack of social support.<sup>20</sup> While providers will address the issues associated with the physical and behavioral aspects of the wound, it is the chaplain who will be called upon to provide care to those suffering from a wounded spirit.

As previously discussed, the recent movement to address moral injury from a clinical perspective has provided much literature and research to the field of pastoral care and counseling. These new inquiries provide invaluable insight into the treatment of spiritual injury. The literature and research from the clinicians addressing issues of trauma and recovery have equipped the chaplain to attend to spiritual distress and suffering. This is made evident by the development of the *U.S. Marine Corps and Navy Combat and Operational Stress Continuum*

---

<sup>20</sup> Brett T. Litz, et. al., “Moral Injury and Moral Repair in War Veterans: A Preliminary Model and Intervention Strategy,” *Clinical Psychology Review* 29, no. 8 (December 2009): 204.

*Model: A Tool For Leaders*, which positions the chaplain solidly within the spectrum of care and further demonstrates BUMED's understanding of the importance of an integrated approach among the disciplines.

It is essential that chaplains be considered an integral part of the care team, especially since service members have shown a tendency to present their psychological problems to chaplains to avoid the perceived stigma that goes with consulting a mental health professional. The work of chaplains can be optimized by teaming them with psychologists and social science experts in the field of spirituality and health.<sup>21</sup>

This being the case, the chaplain must have some degree of familiarity with the clinical language, diagnostic criteria, and techniques of the medical community, as the Combat Operational Stress Control Continuum (COSC) was developed by clinical practitioners.

Spiritual care for the service member oftentimes begins without an official diagnosis of operational stress injury, acute stress reaction, etc. Within the military, the chaplain will often be the first person from whom they seek help. This makes it even more important that the chaplain be familiar with the diagnostic criteria and clinical language. The chaplain's ability to identify clinical symptoms can help to ensure the service member receives all of the services necessary to heal and recover, especially for those who might otherwise be resistant to mental health care.

It is important to note that in cases involving severe depression, anxiety, and/or substance abuse, chaplains can do little to effectively relieve spiritual distress until these other symptoms are effectively addressed. The first order of business then is the ability to recognize

---

<sup>21</sup> Hufford, Fritts, and Rhodes, 84.

manifestations of injury and refer as necessary.<sup>22</sup> Establishing solid, collegial relationships with the medical and mental health professionals in the command fosters an environment conducive to holistic healing and augments the likelihood that care team members will in turn refer back to the chaplain whenever issues of spiritual distress materialize.<sup>23</sup> Once the possible issues of depression, anxiety, substance abuse, or any type of psychosis have been attended to by mental health professionals, pastoral counseling can continue.

### **Spiritual Exercise, Resiliency, & Growth**

As emphasized in Chapters 3 and 4, professional chaplains are the true spiritual care experts in the health care setting. A Navy chaplain serving in a BUMED MTF has undergone an enormous amount of specialized clinical training; those certified by the APC (or by another recognized national chaplaincy organization) have gone through even more extensive training to meet the spiritual needs of medical or psychiatric patients. Dr. Harold Koenig suggests at least two areas that those providing spiritual care should focus on as care is offered to the careseeker: support spiritual beliefs and prescribing religious activities. There is a third area to be addressed by Koenig, i.e., linking with religious communities,<sup>24</sup> but in the case of the Navy chaplain

---

<sup>22</sup> See Figure 4.1. This chart was developed by the Office of the Chaplain of the USMC in collaboration with BUMED for service members to use in self-evaluation.

<sup>23</sup> See Figure 4.2. This flow chart was developed for BUMED providers to help educate them on the ever expanding role that chaplains play as members of the treatment team.

<sup>24</sup> Harold G. Koenig, *Spirituality in Patient Care: Why, How, When, and What* (Kindle Edition, Chicago Distribution), location 745 to 845 of 4221.

serving in a BUMED billet, this can best be done with a turnover of the careseeker with their respective unit chaplain.

### **Support Spiritual Beliefs**

As the chaplain takes the spiritual history or makes a spiritual assessment and learns about how a patient's spiritual beliefs are used to cope with their spiritual injury, it is important to be respectful and to first seek understanding. This, perhaps, is where most, if not all, Evangelical oriented chaplains will struggle. The tendency for most is to be prescriptive and overly zealous in declaring that "Jesus is the answer." (This is especially unproductive when the careseeker has a relationship with God and is struggling with issues of theodicy.) This can hinder or impede the relationship, shutting it down before it has a chance to begin. Even if the patient's beliefs are unfamiliar to the chaplain, different from what the chaplain believes, or even conflict with the medical, nursing, or rehabilitation care plan, the goal of the chaplain is to enter into the worldview of the patient in order to understand why the patient believes the way he or she does. It is only then that the chaplain, having made a full spiritual assessment, can begin to offer prescriptive advice or practices; if a physician operated in this manner and offered prescriptions and therapies without first assessing the patient and determining the source of illness or injury, they would soon find themselves without a medical license.

Religion can provide higher-order schemas that can serve to preserve and give meaning in/to life when the events or circumstances are the very worst, seem senseless, are "evil" and are tragic. To prevent traumatic events and the resulting spiritual injury from overcoming the sense of meaning, an individual's sense of purpose and value must be universal and enduring. When traumatic events do overcome the individual it is usually because the illusion that those things are fixed or permanent is shattered. Hence, when important beliefs or relationships are

threatened, a belief system that is fixed and stable is most useful. This is where a belief system, spirituality and religion are beneficial as religion deals in universal truth and enduring values; it can preserve meaning in the face of the greatest of violations of the illusion of permanence or invulnerability, e.g., we can ward off disease, our children will never get sick and will survive us, our homes/jobs are secure against crime and natural disaster, or only the “bad guys” die in war. As one bereaved respondent put it in a study, “If I didn’t believe in the resurrection nothing would any longer make sense.”<sup>25</sup>

### **Prescribe Religious/Spiritual Activities**

If the effects of religious beliefs and practices on spiritual fitness are equivalent to not smoking cigarettes, a proper diet, or to physical training,<sup>26</sup> perhaps then chaplains should begin prescribing religious activities and spiritual exercises as members of the care team. Religious beliefs have been shown in numerous studies to facilitate patients’ coping with medical illness,<sup>27</sup> which may ultimately influence compliance with treatment and medical outcomes, thus it is appropriate to support the religious beliefs of the patient that bring comfort, hope, and meaning. The ethical chaplain is the chaplain that is not introducing new beliefs or encouraging practices that are foreign; the ethical chaplain is nurturing and supporting the patient’s own faith, whatever it is and however much of it there is—at all times being guided by cues from the patient. Besides

---

<sup>25</sup> Richard Tedeschi and Lawrence Calhoun, *Trauma & Transformation: Growing in the Aftermath of Suffering* (Thousand Oaks, CA: Sage Publications, 1995), 73.

<sup>26</sup> Ibid.

<sup>27</sup> For a comprehensive source that provides more than 1,200 studies and sources related to spirituality and health, see Koenig’s *Handbook of Religion and Health* or *Faith and Mental Health: Religious Resources for Healing*.



the traditional spiritual disciplines of prayer, meditation, scripture, sacramental acts, etc. the chaplain may also include such activities as acts of service, journaling, creative acts involving fine arts, e.g., music, painting, or simply connecting with “nature.” (See Romans 1, Psalm 19, Colossians 1, Revelation 4, etc. for scripture that confirm God reveals himself in the created order, i.e., nature.)

Religion and spiritual care (some could rightly argue the chaplain becomes a spiritual director at this point) offer particular activities that are prescribed for certain occasions or events. These rituals and the institutions that support them have a solidified relationship with that which is enduring or eternal, and therefore can provide powerful means and ways in providing meaning to that which is disruptive, extraordinary, or traumatic. These rituals, rites, or sacraments provide for the individual an outlet for expression of their emotions; the institution offers social support, and provides meaningful activity that can make a situation feel more controllable or manageable. The careseeker is again reminded of the sacred eternal and hope from beyond what humanity and medicine can offer; in summary, religious beliefs, rituals, and practices help to protect individuals against the most negative aspects of spiritual or moral injuries.

### **Results of Research**

The survey instrument queried providers and staff alike in attempting to determine attitudes, beliefs, and understandings about the chaplain and his work within the naval hospital. Question #14 asks: *My chaplain/pastoral care service is best qualified to treat spiritual/moral injuries.* The respondent, using a Likert scale, was given a selection of five possible answers to indicate their individual level of appreciation and value of contributions made by the chaplain as it relates to the clinical treatment and spiritual care of the patient. Of the possible answers, 44.9%

responded by selecting 5-Strongly Agree; 40% responded by choosing 4-Agree for a total of 84.9% either strongly agreeing or agreeing that, indeed, the chaplain is best qualified to deal with spiritual injuries. Figure 4.3 is a bar chart that provides a visual interpretation for Question #14. These percentages should come as no surprise as 85% of the 245 respondent's best identified the chaplain in the role of pastor/priest. Some of the other answers provided include, "chaplains provide access to services that can meet religious needs," and, "a person whom is a reflection of Christ." Such overwhelming percentages in both of these questions leads to the conclusion the Navy chaplain is considered, primarily, to be a person of faith, religion, spirituality—a reminder of the Sacred and the Eternal.

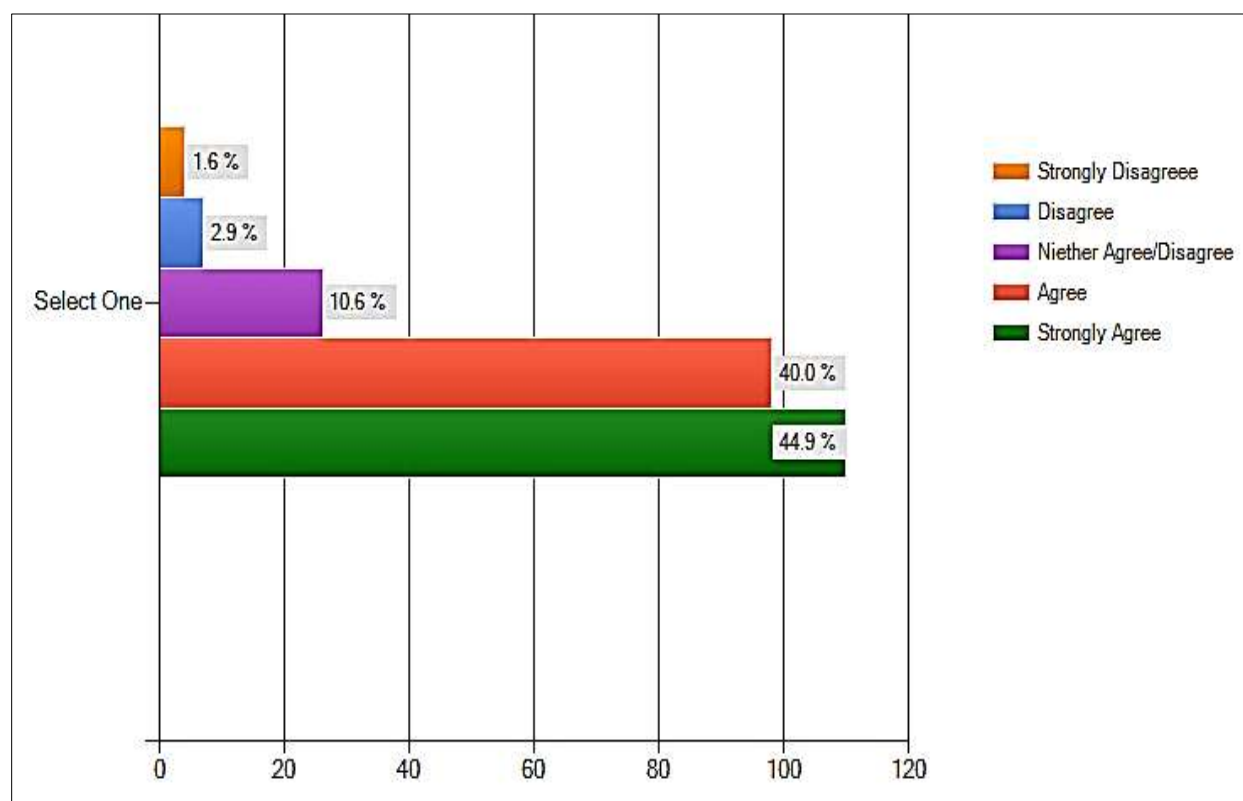


Fig. 5.1 The Chaplain is best qualified to treat spiritual/moral injuries

## CONCLUSION

*Out of every hundred men, ten shouldn't be there, eighty are just targets, nine are the real fighters, and we are lucky to have them, for they make the battle. Ah, but the one, one is a warrior, and he will bring the others back.*

Heraclitus, ca. 540 B.C.

War has always presented warriors with complex and difficult spiritual issues. The irregular nature of combat facing Sailors and Marines today along with the increasing role of religious ideology in current operations makes formal attention to spirituality and spiritual fitness by Navy leadership more crucial than ever. Fortunately, there are many existing programs within the DoN, in which spiritual fitness fundamentals can be assimilated. Chaplains are on the point in this endeavor, but with the numbers of personnel requiring training, counseling, and care juxtaposed against the number of chaplains available, this work and spiritual fitness in general need to be better integrated with medical staff. Some spiritual fitness practices/exercises that are very beneficial to service members, such as yoga and meditation, may be most usefully located in areas set aside for physical exercise or recreation, as teachers may not be chaplains. Other spiritual fitness practices such as proper nutrition or art therapy would be better taught by a nutritionist and occupational therapist, respectively.

It is imperative that there be an integrated team approach to support. Commanders at every level must understand this is mission essential to operational readiness and developing both unit and individual resiliency. Chaplains and other care team members must be given the training and tools to develop, implement, and support interdisciplinary care teams. In the Navy and Marine Corps of the twenty-first century, the force is a mosaic of spiritually diverse individuals. The chaplain and commanders have a vital role in ensuring First Amendment rights are upheld so that alternative faith traditions are not disadvantaged and to ensure all personnel

going forward, into the fight, are not only physically, mentally, and socially fit, but spiritually fit as well.

Spiritual fitness planning and training must be evidence-based, just like medical and psychological practices. It must also be as inclusive as possible to reach as many as possible. As mentioned, the research literature on spirituality and health is relatively young, but it is extensive and includes data that can support the planning of policies and programs in the DoN; especially BUMED. Necessarily then, practices and programs that are taught to service members as a means to be spiritually fit must include quantitative evaluative research and frequent qualitative feedback, not only to gauge effectiveness, but also to allow the fine tuning of religious and spiritual interventions to the specifics of the respective ministry setting and military service branches.

Many chaplains will disagree in defining what it means to serve as a Professional Naval Chaplain in a BUMED hospital. While some progress has been made towards a view that is more similar to the civilian models, for example, the APC, NACC, and NAJC, there has also been resistance in terms of assessments and interventions. Perhaps this is because of the belief that using such language takes away from the sacred nature of ministry and the influence of pastors, for example, Dr. John Piper of *Desiring God*<sup>28</sup> notoriety, is opposed to describing pastoral ministry as a professional vocation. Piper goes as far as saying that:

We pastors are being killed by the professionalizing of the pastoral ministry. The mentality of the professional is not the mentality of the prophet. It is not the mentality of the slave of Christ. Professionalism has nothing to do with the essence and the heart of the Christian ministry. The more professional we long to be, the more spiritual death we

---

<sup>28</sup> John Piper, *Desiring God: Meditations of a Christian Hedonist*, (Colorado Springs, CO: Multnomah Publishing, 1986).

will leave in our wake. For there is no professional childlikeness, there is no professional tenderheartedness; there is no professional panting after God.<sup>29</sup>

In an eBook recently released by Piper, he continues to promote this narrowed view of ministry and discontent with the idea of professional ministry; He writes:

Why do we choke on the word professional in these connections? Because professionalization carries the connotation of an education, a set of skills, and a set of guild-defined standards which are possible without faith in Jesus or the power of the indwelling Spirit of God. Professionalism does not usually carry the connotation of being supernatural. But the heart of ministry is supernatural... The goals are supernatural, and the means are supernatural. Conversions and conformity to Christ are the supernatural fruit of serving in the supernatural strength of Christ. Only Christ can do this. Ministry is discovering how to live happily in the all-accomplishing hands of the risen Christ...

Whatever gifts and eloquence a pastor may have, whatever preparations he makes, he looks away from them all to God for every spiritual effect. He knows what he is after. And he knows that no human effort and no human excellence can bring it about. He wants people to be raised from the dead (Ephesians 2: 5). He wants people to be set free from lifelong bondage (2 Timothy 2: 25– 26). He wants camels to pass through the eyes of needles (Mark 10: 25– 27). Therefore, at every turn, he seeks to “serve by the strength that God supplies— in order that in everything God may be glorified through Jesus Christ, to whom belong glory and dominion forever and ever.”<sup>30</sup>

Certainly, Piper raises valid points for consideration and concern; any chaplain who does not recognize it is only the supernatural power of God that truly fuels the ministry in which he may be serving will never make an eternal difference in the lives of their patients. However,

---

<sup>29</sup> Desiring God: God Centered Resources from the Ministry of John Piper. “Brothers, We are not Professionals: A Plea to Pastors for Radical Ministry by John Piper.” <http://www.desiringgod.org/resource-library/books/brothers-we-are-not-professionals> (accessed April 5, 2013). This excerpt of Piper’s original work first published in 2003 and available on Piper’s website listed above.

<sup>30</sup> John Piper, Douglas Wilson, R. C. Sproul, Jr., Daniel L. Akin, Thabiti Anyabwile, Jeff Vanderstelt, Sam Crabtree, Raymond C. Ortlund, Jr., Mike Bullmore, “Brothers, the ministry is supernatural.” In *Still Not Professionals: Ten Pleas for Today's Pastors* (Minneapolis, MN: Desiring God, Kindle Edition, 2013), location 117-129 of 597.

professional training and learning to speak with intelligence on any number of topics, in particular those related to patient care (especially in terms of mental health) is not just a nicety for the BUMED chaplain: it is a requirement. The simplistic adage of a “scripture a day keeps the devil away” is unequivocally false and juvenile in its mentality. In the book of Daniel, the account of Daniel, Shadrach, Meshach, and Abednego begins with a narrative passage describing the beginning of their ministry:

Then the king ordered Ashpenaz, his chief of staff, to bring to the palace some of the young men of Judah’s royal family and other noble families, who had been brought to Babylon as captives. “Select only strong, healthy, and good-looking young men,” he said. *“Make sure they are well versed in every branch of learning, are gifted with knowledge and good judgment, and are suited to serve in the royal palace. Train these young men in the language and literature of Babylon.”*

*God gave these four young men an unusual aptitude for understanding every aspect of literature and wisdom. And God gave Daniel the special ability to interpret the meanings of visions and dreams...* When the training period ordered by the king was completed, the chief of staff brought all the young men to King Nebuchadnezzar. The king talked with them, and no one impressed him as much as Daniel, Hananiah, Mishael, and Azariah. So they entered the royal service. Whenever the king consulted them in any matter requiring wisdom and balanced judgment, he found them ten times more capable than any of the magicians and enchanters in his entire kingdom.<sup>31</sup>

Although not stated, it is easily assumed that all four of these individuals were gifted by God for learning and service and as such this leads to their being singled out and chosen by Ashpenaz for service to the king. But the place of their service was Babylon, a very foreign place from what they were used to as Jewish men from Jerusalem. Yet in order for God to use these young men, it was required that they learn to speak Babylonian, both literally and proverbially. Daniel and the other three young men underwent three years professional training in order to serve in the royal court of Nebuchadnezzar which they do so with distinction. The Navy chaplain serving in a BUMED billet likewise needs to become educated in numerous professional aspects

---

<sup>31</sup> Daniel 1:3-4; 18-20, NLT (italics my own).

of medicine, nursing, law, and care team procedures in order to effectively serve in the “Babylon” of healthcare. Piper’s belief that “professionalization carries the connotation of an education, a set of skills, and a set of guild-defined standards which are possible without faith in Jesus or the power of the indwelling Spirit of God” is tragically far off of the mark- in the case of Daniel, professionalization carries the connotation of an education, a set of skills, and a set of guild-defined standards which are possible because of faith the power of the living God. It could be argued, perhaps, that Saul’s conversion experience on the road to Damascus and subsequent three years of preparation before emerging as Paul the Apostle was a time of professional training. Certainly Paul’s familiarity with Greek culture, Roman culture and Roman citizenship, all acquired before his conversion is very valuable as he is commissioned by God as the Apostle to the Gentiles.<sup>32</sup> Hence, Piper and his followers have misconstrued and used the term professional to mean something that has more to do subjective authority rather than orthopraxy or orthodoxy in theological practices and beliefs. The professional chaplain serving in BUMED is accountable to both God and the institution in which he is called to serve and as such must live in the dynamic tension created by serving God in a secular organization.<sup>33</sup> A truly called

---

<sup>32</sup> Romans 11:13, KJV, “For I speak to you Gentiles, inasmuch as I am the apostle of the Gentiles.”

<sup>33</sup> Richard G. Hutcheson, CAPT, CHC, USN (Ret), *The Churches and the Chaplaincy* (U.S. Government Printing Office, 1975). This book is required reading for all newly accessed Navy chaplains while attending the Professional Naval Chaplain Basic Leadership Course (PNC-BLC). In it, Hutcheson points out that that there will always be a “dynamic tension” that exists for all who serve God and Country as a military chaplain.

professional chaplain will serve God, regardless of place of service, without compromising his calling, his conscience, or faith values.<sup>34</sup>

Finally, the ministry opportunities for the Navy chaplain who serves in a BUMED are unlimited and are only going to grow in importance as the Navy and Marine Corps is wrapping up major combat operations in Iraq and Afghanistan. After eleven years of intense ground combat many of the staff NCOs, Chief Petty Officers, and senior company grade officers and higher have multiple deployments without ever having time to assimilate back into the pre-911 peacetime routine of a military not at war. As these warriors transition back into a peacetime military, this student, based on personal experience, believes the military healthcare system, especially mental healthcare, will become overwhelmed with the sheer numbers of those who come forward to seek treatment. It will not be the physical wounds that need attended nearly as much as it will be the wounded spirits and injured souls. A professionally trained chaplain will be equipped to journey into the heart of pain and anguish; to serve at the proverbial tip-of-the-spear in the spiritual war on souls, which will be fought daily, and is fought daily in BUMED MTFs.

---

<sup>34</sup> In the Daniel 3 narrative of the story of Shadrach, Meshach and Abednego, these three men have their faith tested, and by careful discernment, they determine just how far their faith allows them to serve in the court of the king. Likewise, the professional chaplain serving in BUMED or contemplating service in BUMED must discern what is permissible according to their faith, their conscience, and allowed by their endorsing agent. For those who cannot, in good conscience, meet the requirements laid out in BUMEDINST 1730.2, they should, perhaps, seek a place of service elsewhere within the Navy.



## APPENDIX A

### Survey Instrument Consent Form

Shipmates,

Thank you for agreeing to participate in this research project. The actual time it takes you to read through this information for a better understanding of the research will take longer than completing the actual survey. The link to take the survey is at the end of this document.

Again, thank you for your participation.

Blessings,

Chaplain Hale

#### **Background Information:**

This study/research/survey is being carried out by me, Chaplain Hale, as a requirement to complete my dissertation for the Doctor of Ministry degree at Liberty Theological Seminary and Graduate School. The survey results and completed dissertation will be available/shared with USNH Command Suite, NMC San Diego, NAVMEDWEST, BUMED, and any of you who request to view the results.

#### **Risks and Benefits of participating in the study:**

**There is no more risk involved in participating in this survey than in any other activity you may participate in during the course of your day.** Participation in this study will offer no direct benefit to you. Non-participation involves no penalty or loss of benefits, punitive action, etc. You may drop-out or quit/log-off at any time during the survey.

The survey is completely anonymous and is comprised of fourteen questions, four of which are for demographics. While no direct identifiers are being utilized, the collection of gender, pay grade, branch of service, and branch/rate are all ways of identification. In the unlikely event that someone other than the PI were to gain access to the collected raw data, it is theoretically possible to piece together the demographic information to identify individuals who are in very specialized billets, e.g., female, 0-3, JAG.

#### **By responding to this request and taking the survey you are acknowledging informed consent.**

The completion time for the survey is approximately five minutes. Participation in this study will offer no direct benefit to you. The benefits to participation are providing direct feedback to the USNHOKI Pastoral Care Services which will allow us to meet needs we may be missing and to provide a higher quality of care than we already provide!

#### **Compensation:**

You will not receive financial compensation for participating.

## APPENDIX A (Cont'd)

**Confidentiality:**

DoDD 6025.18R *Privacy of Individually Identifiable Health Information* will govern the protection of any/all collected data, to include the “double lock” rule for any printed or digitally stored materials. These materials will be stored within the Pastoral Care Services offices within the USNHOKi. The records of this study will be kept private. In my final dissertation, I will not include any information that will make it possible to identify any subject. Research records will be stored securely and only researcher(s) will have access to the records.

**Voluntary Nature of the Study:**

Participation is completely **voluntary**; there is no risk involved on the part of any participant. Non-participation involves no penalty or loss of benefits, etc. You may drop-out of the survey at any time. If you have any concerns regarding participation you may contact me at russell.hale@med.Navy.mil or 646-7162.

**Contacts and Questions:**

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher(s), **you are encouraged** to contact the following Liberty University officials: Dr. Charles Davidson, Director for Doctor of Ministry programs at cdavidson@liberty.edu, or the Liberty University Institutional Review Board, Dr. Fernando Garzon, Chair, 1971 University Blvd, Suite 1837, Lynchburg, VA 24515 or email at fgarzon@liberty.edu. At USNHOKi, please contact CAPT Janet Myers, Research Coordinator at janet.myers@med.Navy.mil.

**Procedures:**

**If you agree to participate in this study, please do the following:**

**Go to: [https://www.surveymonkey.com/s/naval\\_chaplaincy](https://www.surveymonkey.com/s/naval_chaplaincy) and follow the instructions.**

**(Ctrl + click on this link OR copy and paste the link into your web browser)**

## APPENDIX A (Cont'd)

## Survey Instrument

1. Please list your branch (officers, e.g., MC, NC, DC, MSC, etc.) or rate (enlisted, e.g., corpsman, MA, OS, etc.)

2. What is your current pay-grade or scale?

**E-1/3 E-4/6 E-7/9 O-1/3 O-4/6 GS-1/5 GS-6/7 GS-8/9 GS-10/13 Contractor**

3. What is your gender? **Male or Female**

4. What is your Branch of Service? **USN USAF USMC USA USCG Civilian**

5. When the word "chaplain" is used in my presence, I generally think of:

**Skilled Clinician Professional Colleague Pastor/Priest Naval Officer Other**

6. For me, "ministry of presence" is best described as:

- a. A visible reminder of the presence of the Sacred**
- b. A chaplain being available to sit with the ill or injured**
- c. I am unsure/never heard this term before**
- d. Other**

7. My greatest expectation(s) from my chaplain is: (select two)

- a. Provide pastoral care/counsel to my patients**
- b. Provide religious ministry and chapel services**
- c. Listen to my problems empathically/non-judgmentally**
- d. Provide pastoral care/counsel to my family members**
- e. Provide pastoral care/counsel to hospital staff**
- f. Advise members of the hospital staff on morale, morality, ethics, and religion**
- g. Other**

8. Please indicate your level of agreement with the following statement: "Pastoral Care Services and chaplains at U.S. Naval Hospital Okinawa is mission essential"

**Strongly Disagree Disagree Neither Agree/Disagree Agree Strongly Agree**

9. Please indicate your level of agreement with the following statement: "I believe the clinical input regarding patient care, provided by my chaplain to me and members of the care team, is important."

**Strongly Disagree Disagree Neither Agree/Disagree Agree Strongly Agree**

## APPENDIX A (Cont'd)

10. Please indicate your level of agreement with the following statement: "I believe the clinical input regarding patient care, provided by my chaplain in the patient's medical record, is important."

**Strongly Disagree    Disagree    Neither Agree/Disagree    Agree    Strongly Agree**

11. Please indicate your level of agreement with the following statement: "For me personally, religion/spirituality is important."

**Strongly Disagree    Disagree    Neither Agree/Disagree    Agree    Strongly Agree**

12. Please indicate your level of agreement with the following statement: "Having my chaplain available to provide spiritual guidance and emotional comfort when I have personal problems is important."

**Strongly Disagree    Disagree    Neither Agree/Disagree    Agree    Strongly Agree**

13. Please indicate your level of agreement with the following statement: "Knowing I can share personal issues or issues about my command with my chaplain and know that my information goes no further is important."

**Strongly Disagree    Disagree    Neither Agree/Disagree    Agree    Strongly Agree**

14. Please indicate your level of agreement with the following statement: "My chaplain/pastoral care services is best qualified to treat spiritual/moral injuries."

**Strongly Disagree    Disagree    Neither Agree/Disagree    Agree    Strongly Agree**

## APPENDIX B

### Common Standards for Professional Chaplaincy

This document is one of four foundational documents affirmed by the constituent boards of the Council on Collaboration on November 7, 2004 in Portland, Maine. Collectively, these documents establish a unified voice for the six organizations that have affirmed them and describe what it means to these organizations to be a professional pastoral care provider, pastoral counselor or educator. The four documents are:

- Common Standards for Professional Chaplaincy
- Common Standards for Pastoral Educators/Supervisors
- Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators and Students
- Principles for Processing Ethical Complaints

The membership of the participating groups represents over 10,000 members who currently serve as chaplains, pastoral counselors, and clinical pastoral educators in specialized settings as varied as healthcare, counseling centers, prisons or the military. The complete documents and information about each of the collaborating groups can be found on the following websites:

- **Association of Professional Chaplains (APC)** - [www.professionalchaplains.org](http://www.professionalchaplains.org)
- **American Association of Pastoral Counselors (AAPC)** - [www.aapc.org](http://www.aapc.org)
- **Association for Clinical Pastoral Education (ACPE)** - [www.acpe.edu](http://www.acpe.edu)
- **National Association of Catholic Chaplains (NACC)** - [www.nacc.org](http://www.nacc.org)
- **National Association of Jewish Chaplains (NAJC)** - [www.najc.org](http://www.najc.org)
- **Canadian Association for Spiritual Care (CASC)** - [www.spiritualcare.ca](http://www.spiritualcare.ca)

For more information on the foundations of professional pastoral care see "*Professional Chaplaincy: Its Role and Importance in Healthcare*" available at <http://www.professionalchaplains.org/professional-chaplain-services-resources-reading-room-hc-role.htm>.

### Qualifications of Professional Chaplaincy

The candidate for certification must:

- QUA1: Provide documentation of current endorsement or of good standing in accordance with the requirements of his/her own faith tradition.
- QUA2: Be current in the payment of the professional association's annual dues.
- QUA3: Have completed an undergraduate degree from a college, university, or theological school accredited by a member of the Council for Higher Education Accreditation ([www.chea.org](http://www.chea.org)); and a graduate-level theological degree from a college, university or theological school accredited by a member of the Council for Higher Education Accreditation. Equivalencies for the undergraduate and/or graduate level theological degree will be granted by the individual professional organizations according to their own established guidelines.

## APPENDIX B cont'd

- QUA4: Provide documentation of a minimum of four units of Clinical Pastoral Education (CPE) accredited by the Association for Clinical Pastoral Education (ACPE), the United States Conference of Catholic Bishops Commission on Certification and Accreditation, or the Canadian Association for Pastoral Practice and Education (CAPPE/ACPEP). Equivalency for one unit of CPE may be considered.

### **Section I: Theory of Pastoral Care**

The candidate for certification will demonstrate the ability to:

- TPC1: Articulate a theology of spiritual care that is integrated with a theory of pastoral practice.
- TPC2: Incorporate a working knowledge of psychological and sociological disciplines and religious beliefs and practices in the provision of pastoral care.
- TPC3: Incorporate the spiritual and emotional dimensions of human development into the practice of pastoral care.
- TPC4: Incorporate a working knowledge of ethics appropriate to the pastoral context.
- TPC5: Articulate a conceptual understanding of group dynamics and organizational behavior.

### **Section II: Identity and Conduct**

The candidate for certification will demonstrate the ability to:

- IDC1: Function pastorally in a manner that respects the physical, emotional, and spiritual boundaries of others.
- IDC2: Use pastoral authority appropriately.
- IDC3: Identify one's professional strengths and limitations in the provision of pastoral care.
- IDC4: Articulate ways in which one's feelings, attitudes, values, and assumptions affect one's pastoral care.
- IDC5: Advocate for the persons in one's care.
- IDC6: Function within the Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators and Students
- IDC7: Attend to one's own physical, emotional, and spiritual well-being.
- IDC8: Communicate effectively orally and in writing.
- IDC9: Present oneself in a manner that reflects professional behavior, including appropriate attire and personal hygiene.

## APPENDIX B cont'd

**Section III: Pastoral**

The candidate for certification will demonstrate the ability to:

- PAS1: Establish, deepen and end pastoral relationships with sensitivity, openness, and respect.
- PAS2: Provide effective pastoral support that contributes to well-being of patients, their families, and staff.
- PAS3: Provide pastoral care that respects diversity and differences including, but not limited to culture, gender, sexual orientation and spiritual/religious practices.
- PAS4: Triage and manage crises in the practice of pastoral care.
- PAS5: Provide pastoral care to persons experiencing loss and grief.
- PAS6: Formulate and utilize spiritual assessments in order to contribute to plans of care.
- PAS7: Provide religious/spiritual resources appropriate to the care of patients, families and staff.
- PAS8: Develop, coordinate and facilitate public worship / spiritual practices appropriate to diverse settings and needs.
- PAS9: Facilitate theological reflection in the practice of pastoral care.

**Section IV: Professional**

The candidate for certification will demonstrate the ability to:

- PRO1: Promote the integration of Pastoral / Spiritual Care into the life and service of the institution in which it resides.
- PRO2: Establish and maintain professional and interdisciplinary relationships.
- PRO3: Articulate an understanding of institutional culture and systems, and systemic relationships.
- PRO4: Support, promote, and encourage ethical decision-making and care.
- PRO5: Document one's contribution of care effectively in the appropriate records.
- PRO6: Foster a collaborative relationship with community clergy and faith group leaders.

**Requirements for the maintenance of certification**

In order to maintain status as a Certified Chaplain, the chaplain must:

## APPENDIX B cont'd

- MNT1: Participate in a peer review process every fifth year.
- MNT2: Document fifty (50) hours of annual continuing education. (Recommendation that personal therapy, spiritual direction, supervision, and/or peer review be an acceptable options for continuing education hours.)
- MNT3: Provide documentation every fifth year of current endorsement or of good standing in accordance with the requirements of his/her own faith tradition.
- MNT4: Be current in the payment of the professional association's annual dues.
- MNT5: Adhere to the Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators and Students.
-



## APPENDIX B cont'd

**Standards of Practice for Professional Chaplains in Acute Care Settings****Introduction**

**Preamble:** Chaplaincy care is grounded in initiating, developing and deepening, and bringing to an appropriate close a mutual and empathic relationship with the patient, family, and/or staff. The development of a genuine relationship is at the core of chaplaincy care and underpins, even enables, all the other dimensions of chaplaincy care to occur. It is assumed that all of the standards are addressed within the context of such relationships.

**Section 1: Chaplaincy Care with Patients and Families**

Standard 1. Assessment: The chaplain gathers and evaluates relevant data pertinent to the patient's situation and/or bio-psycho-social-spiritual/religious health.

Standard 2. Delivery of Care: The chaplain develops and implements a plan of care to promote patient well-being and continuity of care.

Standard 3. Documentation of Care: The chaplain enters information into the patient's medical record that is relevant to the patient's medical, psycho-social, and spiritual/religious goals of care.

Standard 4. Teamwork and Collaboration: The chaplain collaborates with the organization's interdisciplinary care team.

Standard 5. Ethical Practice: The chaplain adheres to the *Common Code of Ethics*, which guides decision making and professional behavior.

Standard 6. Confidentiality: The chaplain respects the confidentiality of information from all sources, including the patient, medical record, other team members, and family members in accordance with federal and state laws, regulations, and rules.

Standard 7. Respect for Diversity: The chaplain models and collaborates with the organization and its interdisciplinary team in respecting and providing culturally competent patient-centered care.

**Section 2: Chaplaincy Care for Staff and Organization**

Standard 8. Care for Staff: The chaplain provides timely and sensitive chaplaincy care to the organization's staff via individual and group interactions.

Standard 9. Care for the Organization: The chaplain provides chaplaincy care to the organization in ways consonant with the organization's values and mission statement.

## APPENDIX B Cont'd

Standard 10. Chaplain as Leader: The chaplain provides leadership in the professional practice setting and the profession.

**Section 3: Maintaining Competent Chaplaincy Care**

Standard 11. Continuous Quality Improvement: The chaplain seeks and creates opportunities to enhance the quality of chaplaincy care practice.

Standard 12. Research: The chaplain practices evidence-based care including ongoing evaluation of new practices and, when appropriate, contributes to or conducts research.

Standard 13. Knowledge and Continuing Education: The chaplain assumes responsibility for continued professional development, demonstrates a working and current knowledge of current theory and practice, and integrates such information into practice.

## APPENDIX C

### Spiritual History & Assessment Tools

#### **CSI-MEMO (Koenig, 2002)**

- CS – Do your religious/spiritual beliefs provide Comfort, or are they a source of Stress?
- I – Do you have spiritual beliefs that might Influence your medical decisions?
- MEM – Are you a MEMber of a religious or spiritual community, and is it supportive to you?
- O – Do you have any Other spiritual needs that you'd like someone to address?

#### **HOPE (Anandarajah & Hight, 2001)**

- H – Sources of hope, meaning, comfort, strength, peace, love, and compassion: What is there in your life that gives you internal support? What are the sources of hope, strength, comfort, and peace? What do you hold on to during difficult times? What sustains you and keeps you going?
- O – Organized religion: Do you consider yourself as part of an organized religion? How important is that for you? What aspects of your religion are helpful and not so helpful to you? Are you part of a religious or spiritual community? Does it help you? How?
- P – Personal spirituality/practices: Do you have personal spiritual beliefs that are independent of organized religion? What are they? Do you believe in God? What kind of relationship do you have with God? What aspects of your spirituality or spiritual practices do you find most helpful to you personally?
- E – Effects on medical care and end-of-life issues: Has being sick (or your current situation) affected your ability to do the things that usually help you spiritually? (Or affected your relationship with God?) As a doctor, is there anything that I can do to help you access the resources that usually help you? Are you worried about any conflicts with your medical situation/care decisions? Are there any specific practices or restrictions I should know about in providing your medical care?

#### **FAITH (King, 2002)**

- F – Do you have a Faith or religion that is important to you?
- A – How do your beliefs Apply to your health?
- I – Are you Involved in a church or faith community?
- T – How do your spiritual views affect your views about Treatment?
- H – How can I Help you with any spiritual concerns?

#### **SPIRIT (Abridged: Maugans, 1997; Ambuel & Weissman, 1999)**

- S – Spiritual belief system: Do you have a formal religious affiliation? Can you describe this? Do you have a spiritual life that is important to you?
- P – Personal spirituality: Describe the beliefs and practices of your religion that you personally accept. Describe those beliefs and practices that you do not accept or follow. In what ways is your spirituality/religion meaningful for you?

## APPENDIX C

## Spiritual History &amp; Assessment Tools Cont'd

- I – Integration with a spiritual community: Do you belong to any religious or spiritual groups or communities? How do you participate in this group/community? What importance does this group have for you? What types of support and help does or could this group provide for you in dealing with health issues?
- R – Ritualized practices and Restrictions: What specific practices do you carry out as part of your religious and spiritual life? What lifestyle activities or practices do your religion encourage, discourage, or forbid? To what extent have you followed these guidelines?
- I – Implications for medical practice: Are there specific elements of medical care that your religion discourages or forbids? To what extent have you followed these guidelines? What aspects of your religion/spirituality would you like to keep in mind as I care for you?
- T – Terminal events planning: Are there particular aspects of medical care that you wish to forgo or have withheld because of your religion/spirituality? Are there religious or spiritual practices or rituals that you would like to have available in the hospital or at home? Are there religious or spiritual practices that you wish to plan for at the time of death or following death? As we plan for your medical care near the end of life, in what ways will your religion and spirituality influence your decisions?

**FACT (LaRocca-Pitts, 2008ab)**

- F – Faith (or Beliefs): What is your Faith or belief? Do you consider yourself a person of Faith or a spiritual person? What things do you believe that give your life meaning and purpose?
- A – Active (or Available, Accessible, Applicable): Are you currently Active in your faith community? Are you part of a religious or spiritual community? Is support for your faith available to you? Do you have Access to what you need to Apply your faith (or your beliefs)? Is there a person or a group whose presence and support you value at a time like this?
- C – Coping (or Comfort); Conflicts (or Concerns): How are you Coping with your medical situation? Is your faith (your beliefs) helping you Cope? How is your faith (your beliefs) providing Comfort in light of your diagnosis? Do any of your religious beliefs or spiritual practices Conflict with medical treatment? Are there any particular Concerns you have for us as your medical team? Up to this point, FACT fits well with the spiritual history genre: it is brief, it is using a memorable acronym, and it is obtaining appropriate information. But with the next step, the
- T – Treatment plan, FACT moves beyond the content and purpose of the generic spiritual history and asks for a judgment. Instead of obtaining information only, as with a generic spiritual history, FACT asks the clinician to make an assessment upon which the clinician provides an intervention.

APPENDIX D

Essentris Pastoral Care Note and Assessment

Chaplain Assessment and Notes	
<b>Patient Information</b>	
Diagnosis:	**Imported from H&P**
Religion:	**Imported from CHCS**
Religion: <input type="text" value="Pentecostal Druid"/>	**Specify as Needed**
<b>Chaplain Assessment and Initial Care Plan</b>	
<b>Reason:</b>	
Type of Pastoral Visit:	<input type="text" value="Initial Visit,"/>
Pastoral Visit Requested By:	<input type="text" value="Medical Staff"/>
<b>Interventions:</b>	
Patient:	<input type="text" value="Provided pastoral care and counseling, explored issues of faith and belief, provided empathic listening, identified and evaluated spiritual resources, provided anxiety containment."/>
<input type="checkbox"/> Family:	
<input type="checkbox"/> Other:	
Comments:	<input type="text" value="Spent approximately 45 minutes with Pt."/>
<b>Outcomes:</b>	
Patient:	<input type="text" value="Debrief significant experiences and emotional events, pt was able to verbally process anxiety regarding hospitalization, pt identified needs/hopes/resources."/>
<input type="checkbox"/> Family:	
<input type="checkbox"/> Other:	
Comments:	<input type="text"/>
<b>Assessment:</b>	
Emotional Distress:	<input type="text" value="High"/>
Spiritual Distress:	<input type="text" value="High"/>
Source of Support:	<input type="text" value="Friend"/>
Quality of Support:	<input type="text" value="Minimal"/>
Present Coping Level:	<input type="text" value="Low"/>
Active in faith community:	<input type="text" value="Low"/>
Active in cultural community:	<input type="text" value="Low"/>
Concern about death and dying issues:	<input type="text" value="None"/>
<input checked="" type="checkbox"/> Challenges:	<input type="text" value="Pt is estranged from family of origin and has no familial support available."/>
Ongoing Pastoral/Spiritual Needs:	<input type="text" value="Referral to specific faith group,"/>
Comments:	<input type="text" value="Pt was referred to high priest of the local Druid community for spiritual resources and support. Chaplain arranged meeting for Pt and high priest."/>
<b>Plan:</b>	
Desired Outcomes:	<input type="text" value="Debrief significant experiences and emotional events, pt was able to verbally process anxiety regarding hospitalization, pt identified needs/hopes/resources; More hopeful, less anxious, less angry."/>
Chaplaincy Plan:	<input type="text" value="Follow as needed,"/>
Comments:	<input type="text"/>
Note By:	<input type="text" value="Male, Russell A LCDR"/>
Time/Date:	<input type="text" value="0855 22MAY12"/>
<input type="checkbox"/> Co-signed:	

## APPENDIX E

### Project Brief

# Background



Through a review of the literature and personal experience it was found that many U.S. Navy chaplains do not see the potential value they bring in ministering to personnel, dependents and retirees in a U.S. Navy hospital setting.

*"If God has called you to preach, do not stoop to be a king..."*

C.H. Spurgeon, *Lectures to my Students*

## APPENDIX E Cont'd

## Background



As a corollary, many medical and ancillary staff personnel are not aware of the potential positive impact on patient care and interdisciplinary care teams that a Professional Naval Chaplain may have when properly utilized.

## Background



In 2010, the *Standards of Practice for Professional Chaplains in Acute Care Settings* was developed by the Association of Professional Chaplains and is the standard for Professional Naval Chaplaincy in BUMED. Six of the thirteen standards strongly reiterate the principles of Outcome Oriented Chaplaincy:

Standard 1, Assessment: The chaplain gathers and evaluates relevant data pertinent to the patient's situation and/or bio-psycho-social-spiritual/religious health.

Standard 2, Delivery of Care: The chaplain develops and implements a plan of care to promote patient well-being and continuity of care.

Standard 3, Documentation of Care: The chaplain enters information into the patient's medical record that is relevant to the patient's medical, psycho-social, and spiritual/religious goals of care.

**Standard 4, Teamwork and Collaboration: The chaplain collaborates with the organization's interdisciplinary care team.**

Standard 11, Continuous Quality Improvement: The chaplain seeks and creates opportunities to enhance the quality of chaplaincy care practice.

**Standard 12, Research: The chaplain practices evidence-based care including ongoing evaluation of new practices and, when appropriate, contributes to or conducts research.**

## APPENDIX E Cont'd

## Study design, procedures, and time schedule



### *Professional Naval Chaplaincy: The Role of the Navy Chaplain in a U.S. Navy BUMED Hospital*

- **Phenomenological and ethnographic in design; the PI places great value on subjectivity.**
- **Quantitative study: Cross Sectional- simple survey using Likert items/scale.**
- **Up to 1,200 personnel from the U.S. Naval Hospital, Okinawa; anticipated participation of 20% (240) of personnel assigned.**
- **Survey conducted March 21 to April 5, 2013.**

## Population characteristics



**The survey sample population will:**

- **Include a diverse group of military personnel, all ranks and ethnic backgrounds...**
- **Consider the following in interpreting the research:  
*Commissioned Officer vs. Chief Petty Officer vs. Enlisted; Male vs. Female; Professional attitudes, i.e. Medical Corps vs. Nurse Corps vs. Dental Corps vs. Medical Service Corps, etc; Civilian/GS employee attitudes...***

**NO PATIENTS OR NON-SOFA PERSONNEL WILL BE SURVEYED!**



## APPENDIX E Cont'd

## Procedure & Informed Consent



**Procedures:** The initial contact/email will explain the project and provide a link to a SurveyMonkey URL in which participants may anonymously complete the questionnaire.

A statement of Informed Consent, and explanation sheet for the survey will be included in the email instructions sent to participants. The participant will need to open the informed consent attachment to access the embedded site link.

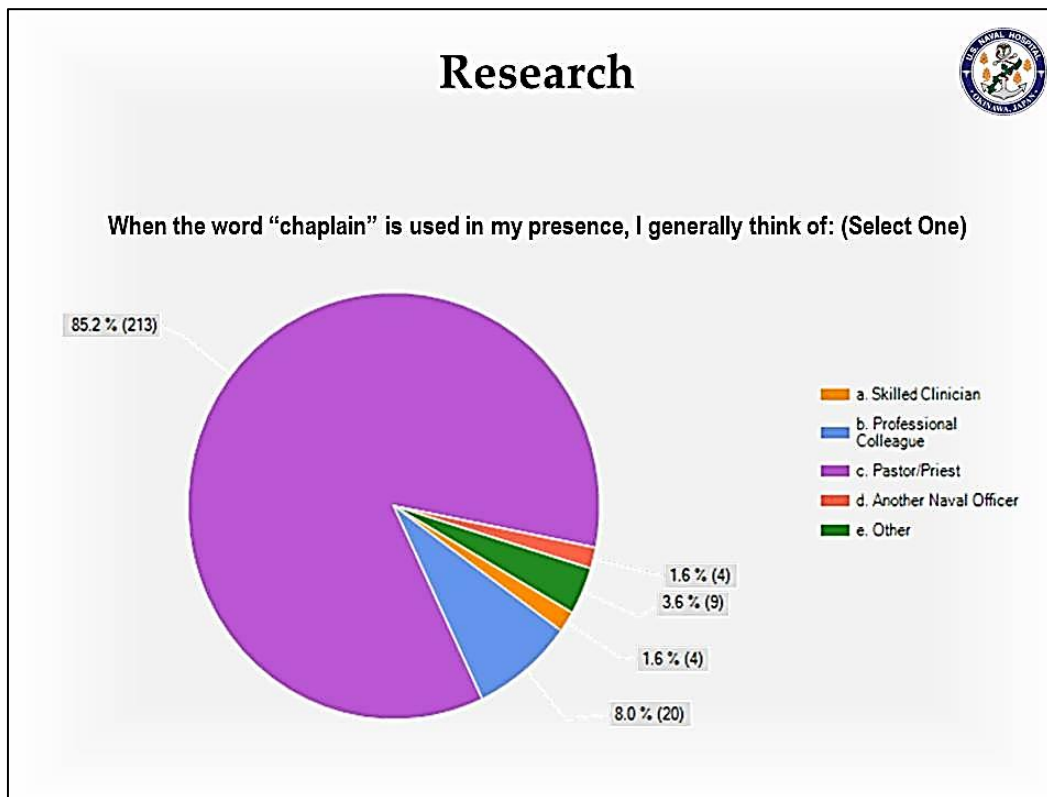
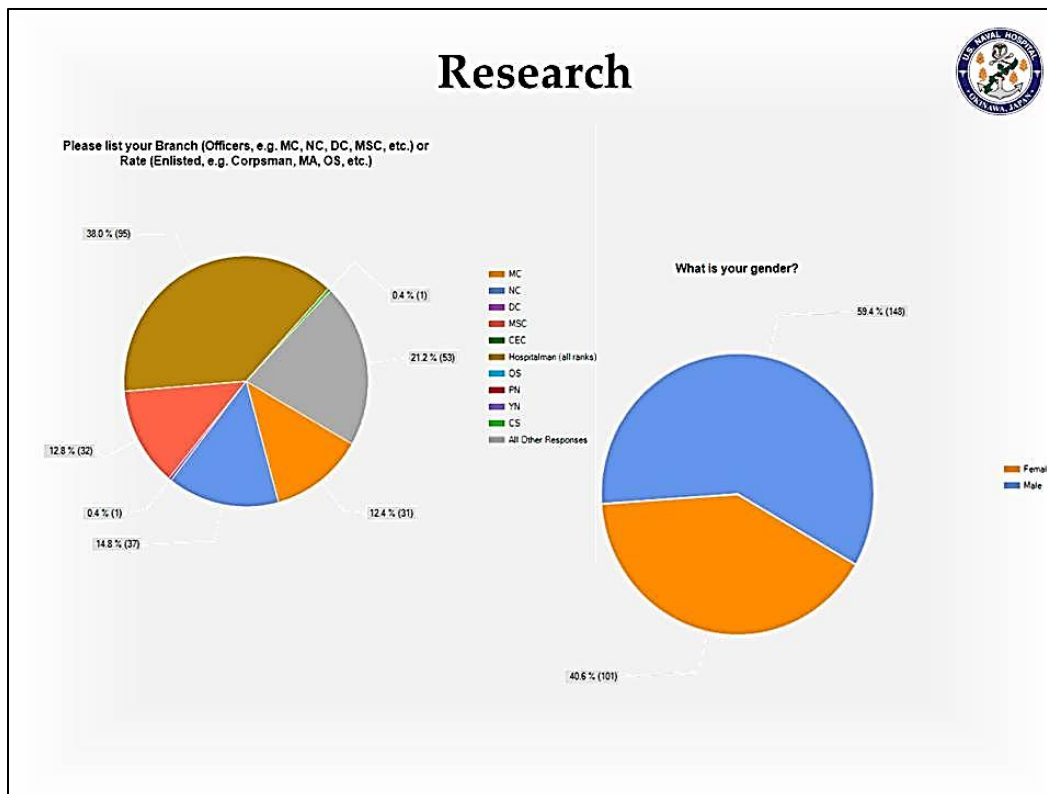
## Controls & Supervision



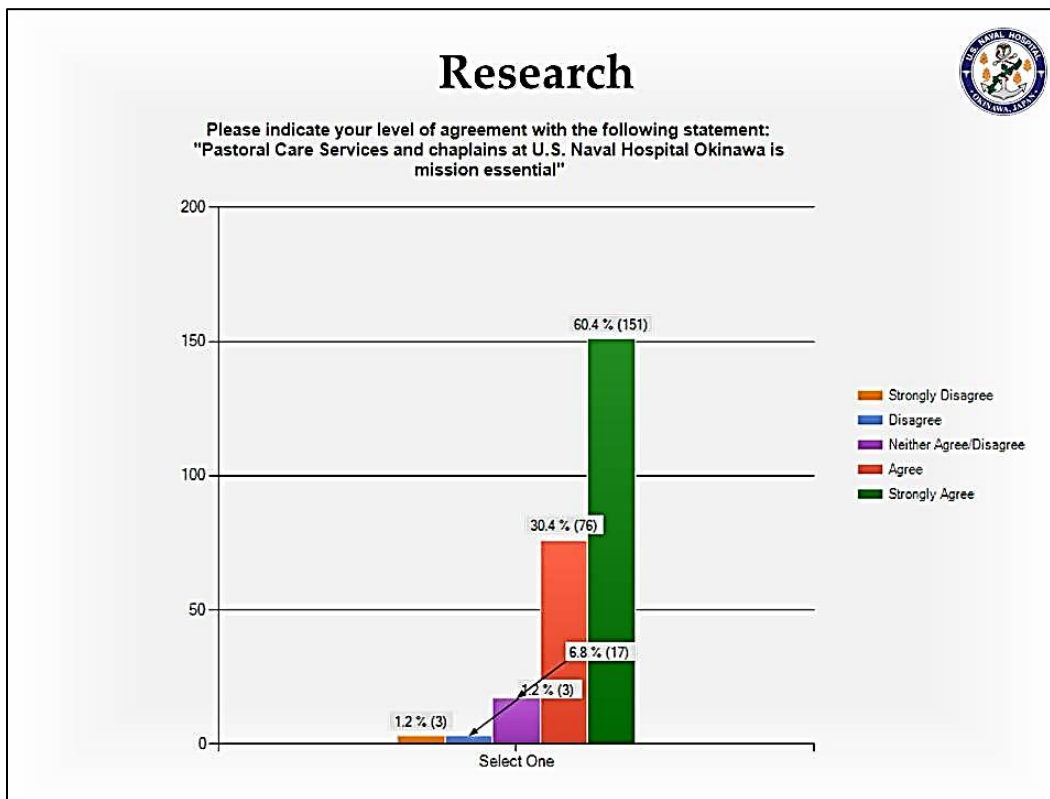
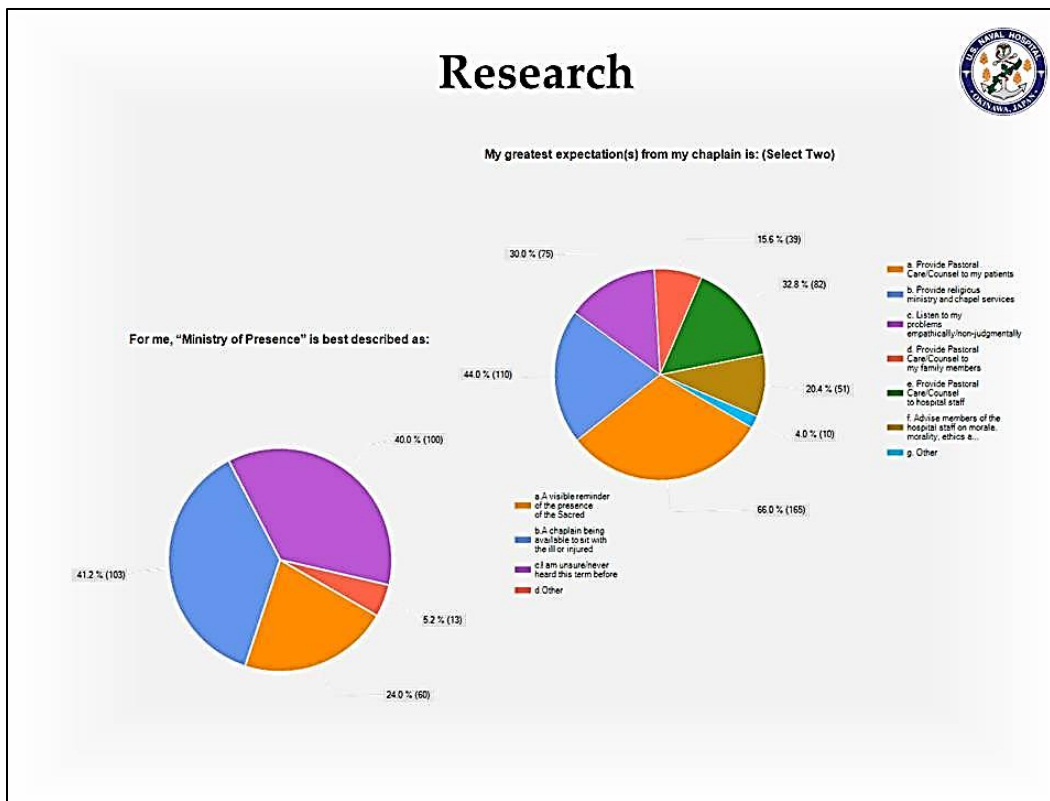
This project has been approved by and is under the joint direction of NMC San Diego, USNHOKi, and Liberty University.

All documentation requesting approval are available online via the Defense Medical Research Network (DMRN) on the Defense Knowledge Online website. This project has been designated by the NMCSD IRB as CIP #NHOK.2012.0118

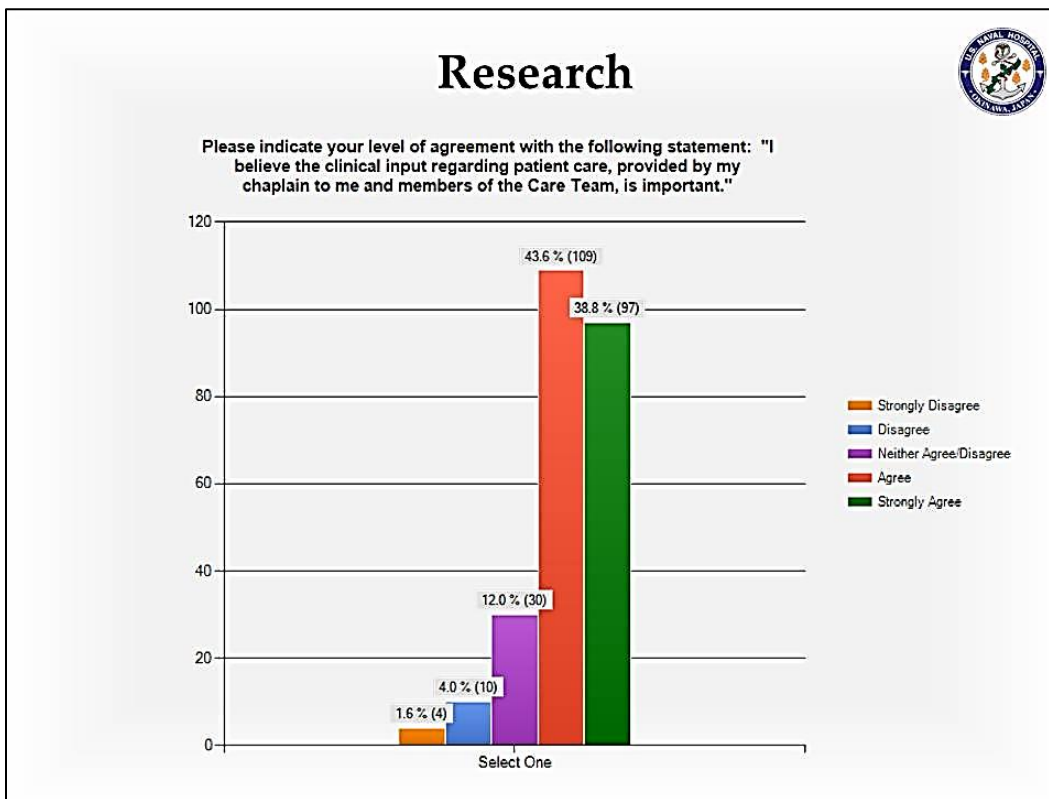
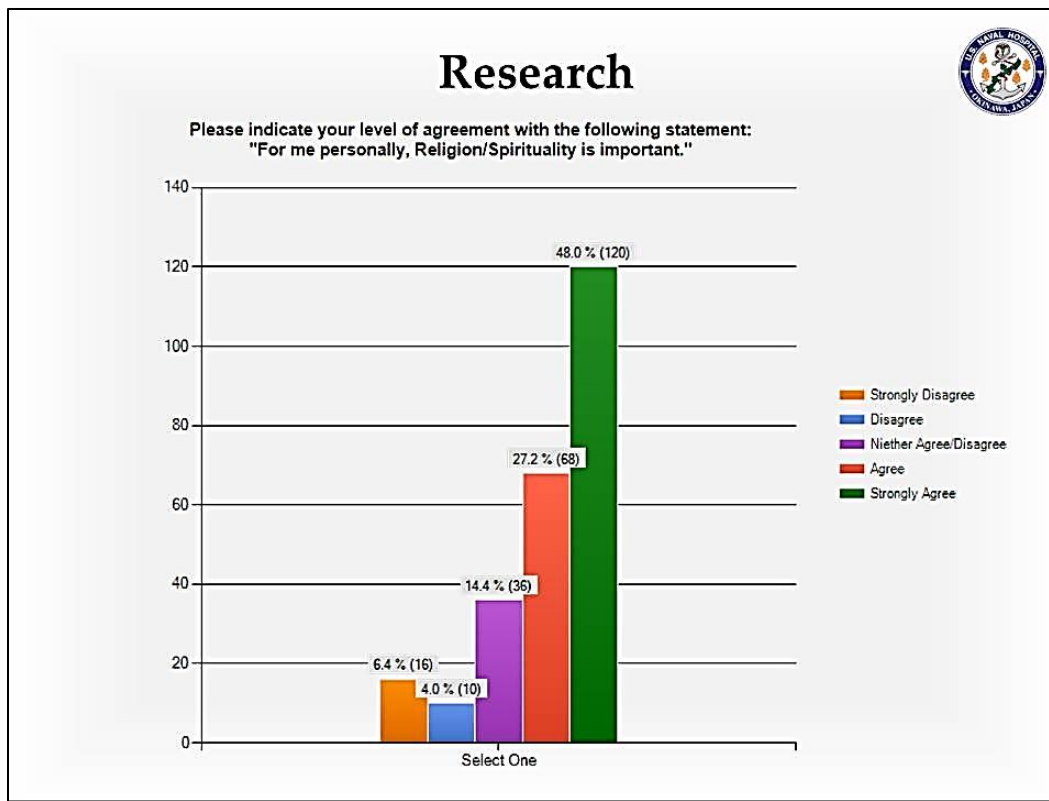
APPENDIX E Cont'd



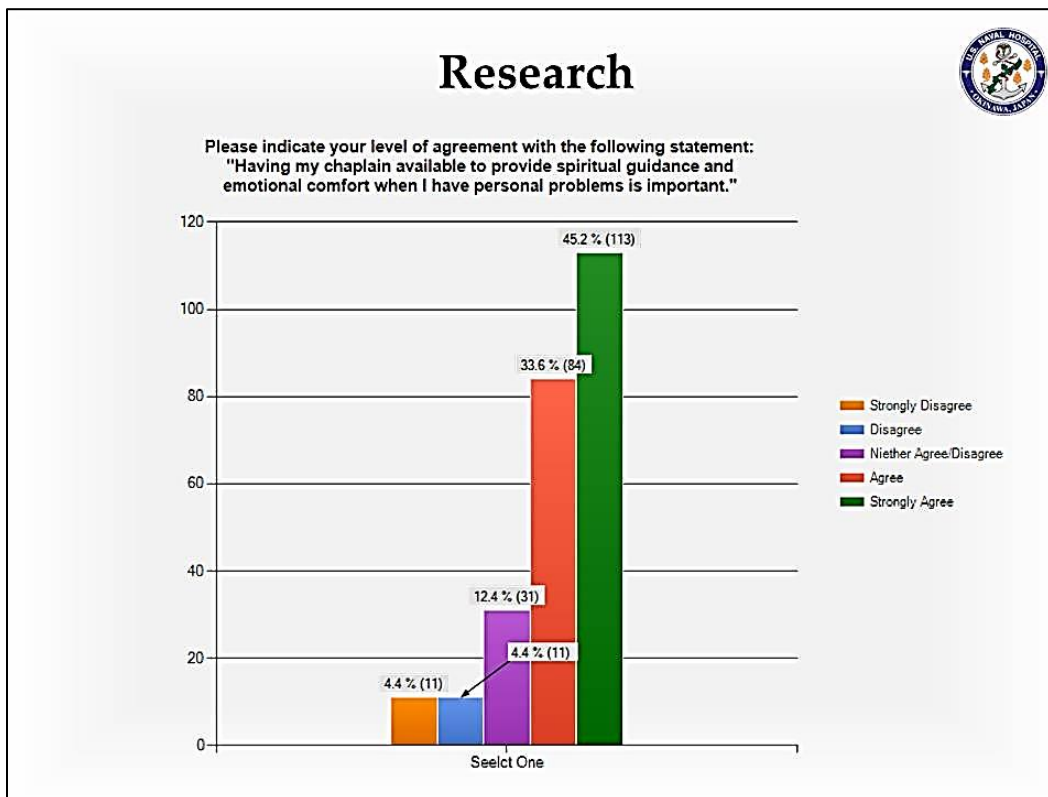
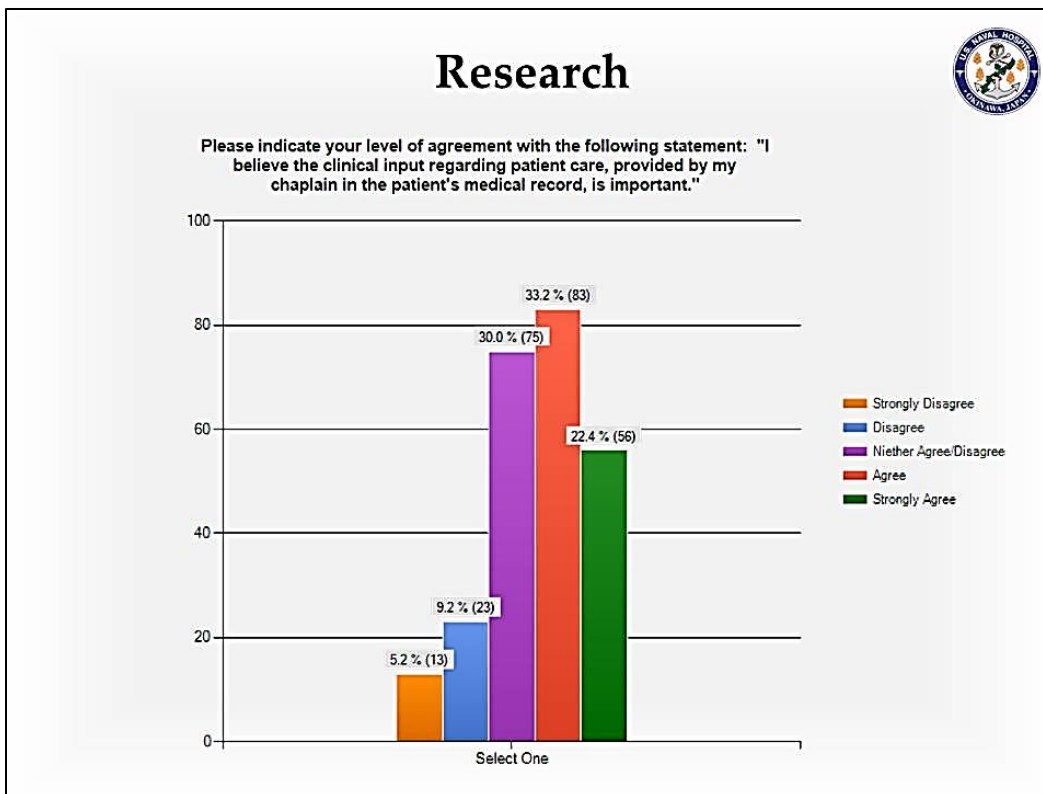
APPENDIX E Cont'd



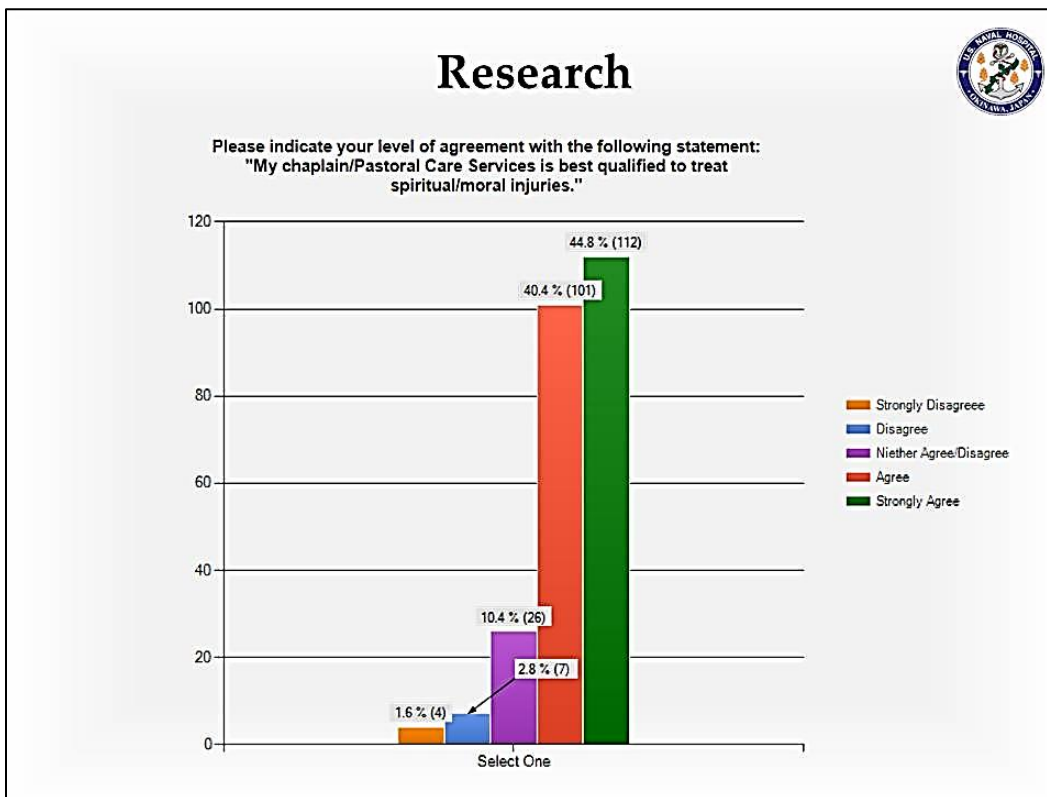
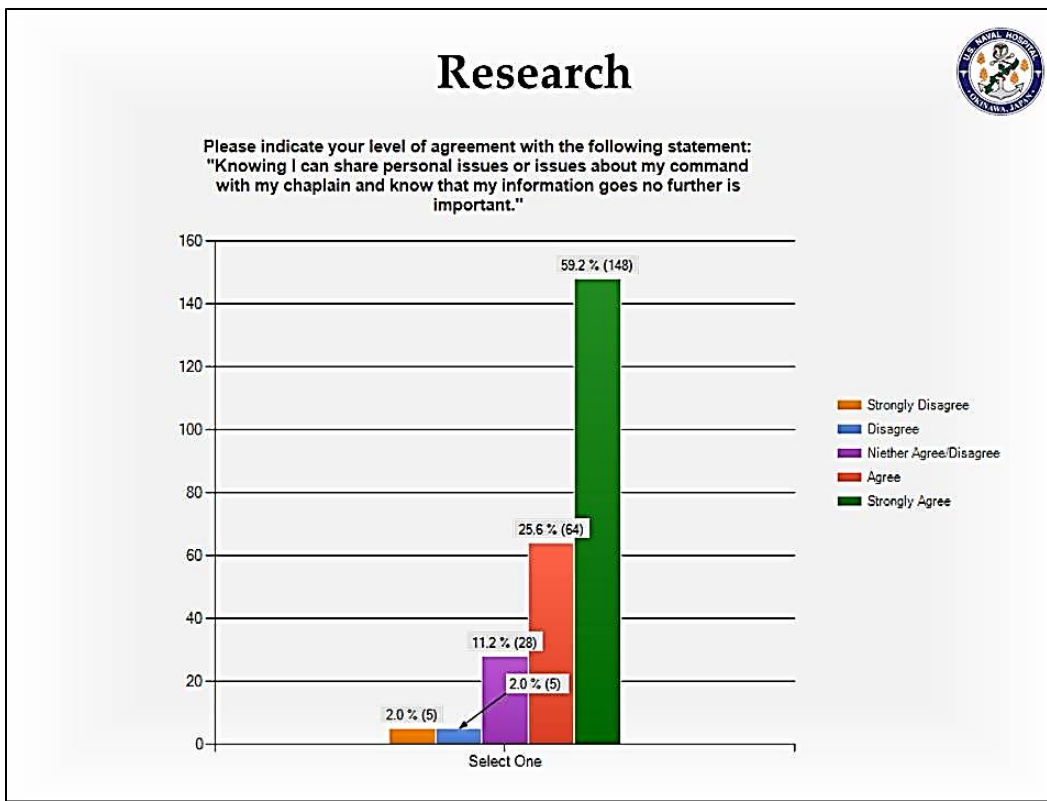
APPENDIX E Cont'd



APPENDIX E Cont'd



APPENDIX E Cont'd



## APPENDIX E Cont'd

## Introduction to Chaplaincy



### Historic Religion in the Military

- Abraham, 25<sup>th</sup> Century BCE, (Pre- Judaic/ Mesopotamia)
- Pharaoh Thutmose III, 15<sup>th</sup> Century BCE (Egypt)
- Sun Tzu, *Art of War*, 4<sup>th</sup> Century BCE (China)
- Kautilya, *The Arthashastra*, 4<sup>th</sup> Century BCE, (India)
- Shinto/Bushido, 8<sup>th</sup> Century CE (Japan)

## Introduction to Chaplaincy



### Historic Religion in Medicine

- Priests are those who practice healing, (Neolithic) 10,000 to 3000 BCE
- Shamans, 3000 BCE, use hypnotism to treat the sick in Asia
- Imhotep, 2650 BCE, Egypt's first and greatest physician/priest
- Buddha gives Pirit ritual as means to cure the sick
- Hippocrates, 500 BCE, Father of Modern medicine; Physician & Priest play different roles
- Knights Hospitallers, 1095 CE, monks/warriors operate first hospitals in Jerusalem
- Brotherhood of Cosmas and Damian, 1572 CE, first Medical Professional Society



## APPENDIX E Cont'd

## Introduction to Chaplaincy



### Beginnings- St. Martin of Tours

Early 20<sup>th</sup> Century- *Response to Sin*  
 Mid 20<sup>th</sup> Century- *Ministry of Presence*  
 Late 20<sup>th</sup> Century- *Outcome Oriented*



### U.S. Navy Today

-U.S. Constitution: *"Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof..."*

#### -Navy Chaplains

- +Primary advisor to the CO on matters of Morale, Morals, Ethics, and Religion
- +Facilitate, Provide, Care, Advise

## Religion/ Spirituality & Chaplaincy



### Modern Thought

Sigmund Freud: *"Talking Cure"*

*"Obsessional Neurosis"*

C.G. Jung:

*"Talking Cure"*

*"Collective Unconscious"*

*"Individuation"*

*"Analytical Psychology"*

Carl Rogers:

*"Empathic Listening"*

*"Ministry of Presence"*





## APPENDIX E Cont'd

## Introduction to Navy Chaplaincy



**Navy Chaplains go anywhere, anyplace to serve our Marines/Sailors**

## Outcome Oriented Chaplaincy



**BUMEDINST 1730.2A (March 2011)**

**“... religious ministry in the health care environment has evolved in the last 30 years into a clinical discipline supported by medical research, medical school curricula, professional journals, national bodies that certify clinical chaplain training and education programs, national bodies that accredit hospital pastoral care services, and national standards for the professional competencies and ethics of religious ministry professionals working in the health care environment.”**

## APPENDIX E Cont'd

## OOE Educational Requirements



BUMEDINST 1730.2A (March 2011)

**“To be fully qualified to provide clinical pastoral care to patients, chaplains must have... completed Four units of Clinical Pastoral Education (CPE) from an accredited, national certifying body (1,600 hours) and 2,000 hours of post-CPE supervised clinical care. These are the minimum requirements for board eligibility. Graduates of the Navy Medicine Pastoral Care Residencies meet the criteria in reference (b) and are considered board eligible by most national certifying bodies.”**

## Outcome Oriented Chaplaincy



***“Outcome Oriented Chaplaincy is a method of Chaplaincy care that emphasizes achieving, describing, measuring and improving outcomes that result from a chaplains work.”***

***Internationally recognized organizations by the DoD to board certify chaplains***

*Association of Professional Chaplains*  
*National Association of Catholic Chaplains*  
*National Association of Jewish Chaplains*  
*College of Psychotherapists and Pastoral Counseling*  
*Canadian Association for Spiritual Care*  
*Canadian Association for Pastoral Practice and Education*

## APPENDIX E Cont'd

## Standards of Practice



In 2010, the *Standards of Practice for Professional Chaplains in Acute Care Settings* was developed by the Association of Professional Chaplains and is the standard for Professional Naval Chaplaincy in BUMED.

### Six of the thirteen standards that strongly reiterate the principles of OOC:

**Standard 1, Assessment:** The chaplain gathers and evaluates relevant data pertinent to the patient's situation and/or bio-psycho-social-spiritual/religious health.

**Standard 2, Delivery of Care:** The chaplain develops and implements a plan of care to promote patient well-being and continuity of care.

**Standard 3, Documentation of Care:** The chaplain enters information into the patient's medical record that is relevant to the patient's medical, psycho-social, and spiritual/religious goals of care.

**Standard 4, Teamwork and Collaboration:** The chaplain collaborates with the organization's interdisciplinary care team.

**Standard 11, Continuous Quality Improvement:** The chaplain seeks and creates opportunities to enhance the quality of chaplaincy care practice.

**Standard 12, Research:** The chaplain practices evidence-based care including ongoing evaluation of new practices and, when appropriate, contributes to or conducts research.

## Common Standards for Professional Chaplaincy



In 2004 this document was approved by all six of the professional pastoral care organizations in North America and is the standard for Professional Naval Chaplaincy in BUMED.

The minimum required competencies for OCC/BUMED are:

~Formulate and utilize spiritual assessments in order to contribute to plans of care.

~Provide effective pastoral support that contributes to well-being of PTs, their families, and staff.

~Document one's contribution of care in the appropriate records.

~Establish/maintain professional and interdisciplinary relationships.



## APPENDIX E Cont'd

## Assessment, Interventions, Outcomes

Aside from the legal requirement to make notes in the medical record of patients, charting is a major means of communication between the chaplain and the rest of the health care team. Charting also enables staff to know:

1. The chaplain has seen the patient.
2. The issues with which the patient may be dealing.
3. Useful information to the team about the patient about which they may not be aware, e.g. a patient may share with the chaplain that his/her parent died recently but not have mentioned this significant life event to the medical staff, who may have been focusing on the patient's medical symptoms.
4. Establish a spiritual care plan.

## Assessment, Interventions, Outcomes



Starting with needs, hopes, and resources we acknowledge the Patient has needs. It also acknowledges they have hopes that provide energy, direction, impetus, and motivation for the future. Hopes draw the individual forward.


Resources that allow the individual to cope, heal, and thrive are the goal; patients typically possess a wide variety of spiritual resources that were helpful up to the present moment.

Chaplaincy care involves focusing on:

- ~What are the spiritual needs, hopes, and resources?
- ~What are the emotional needs, hopes, and resources?
- ~What are the relational needs, hopes, and resources?
- ~What are the biomedical needs, hopes, and resources?

APPENDIX E Cont'd

### Assessment, Interventions, Outcomes: Essentris®



Chaplain Assessment and Note \* TEST-8 Inpatient MH Admit 99-987-65-4321

Note: Edit View

---

Note Time: N/A Type: Chaplain Assessment and Note \* Topic: N/A  
 Last Store At: N/A Last Stored By: (Created) Mode: Edit

#### Chaplain Assessment and Notes

**Patient Information**

Diagnosis:  \*\*Imported from H&P\*\*

Religion:  \*\*Imported from CHCS\*\*

Religion:  \*\*Specify as Needed\*\*

#### Chaplain Assessment and Initial Care Plan

Reason:

Type of Pastoral Visit:

Pastoral Visit Requested By:

**Interventions:**

Patient:

Family: Facilitated mind-body-spirit techniques,  
 Made referral to:

Other: Prayed with Patient, Family Members, Staff,  
 Provided DNR counseling,  
 Comments: Provided Educational and spiritual care literature,  
 Provided information on Pastoral Services,  
 Provided organ donation counseling,  
 Provided pastoral care and counseling,

**Outcomes:**

Patient:


Family:

Other:

Comments:

Now in Choose APPEND Mode. Press [Insert] to Switch to REPLACE Mode.

### Assessment, Interventions, Outcomes: Essentris®



Chaplain Assessment and Note \* TEST-8 Inpatient MH Admit 99-987-65-4321

Note: Edit View

---

Note Time: N/A Type: Chaplain Assessment and Note \* Topic: N/A  
 Last Store At: N/A Last Stored By: (Created) Mode: Edit

**Assessment:**

Emotional Distress:

Spiritual Distress:

Source of Support:

Quality of Support:

Present Coping Level:

Active in faith community:

Active in cultural community:

Concern about death and dying issues:

Challenges:

Strengths:

Ongoing Pastoral/Spiritual Needs:

Comments:

**Plan:**

Desired Outcomes:

Chaplaincy Plan:

Comments:

Note By:

Co-signed:

Now in Choose APPEND Mode. Press [Insert] to Switch to REPLACE Mode.

APPENDIX E Cont'd

# SPIRITUAL FITNESS GUIDE

This is a self-assessment tool to help service members consider their spiritual condition.  
 Spirituality may be used in a general sense to refer to that which gives meaning and purpose in life, or the term may be used more specifically to refer to the practice of a philosophy, religion, or way of living.

FIT	STRESSED	DEPLETED	DRAINED
<b>Potential Indicators</b>	<b>Potential Indicators</b>	<b>Potential Indicators</b>	<b>Potential Indicators</b>
<ul style="list-style-type: none"> <li>➢ Engaged in life's meaning/purpose</li> <li>➢ Hopeful about life/future</li> <li>➢ Makes moral decisions</li> <li>➢ Able to forgive self and others</li> <li>➢ Respectful of people of other beliefs</li> <li>➢ Engaged in core values/beliefs</li> </ul>	<ul style="list-style-type: none"> <li>➢ Neglecting life's meaning/purpose</li> <li>➢ Less hopeful about life/future</li> <li>➢ Makes some poor moral decisions</li> <li>➢ Difficulty forgiving self or others</li> <li>➢ Less respectful of people of other beliefs</li> <li>➢ Neglects core values/beliefs</li> </ul>	<ul style="list-style-type: none"> <li>➢ Losing a sense of life's meaning/purpose</li> <li>➢ Holds very little hope about life/future</li> <li>➢ Makes poor moral decisions routinely</li> <li>➢ Unable to forgive self or others</li> <li>➢ Strong disrespect for people of other beliefs</li> <li>➢ Disregards core values/beliefs</li> </ul>	<ul style="list-style-type: none"> <li>➢ Claims life has no meaning/purpose</li> <li>➢ Holds no hope about life/future</li> <li>➢ Extreme immoral behavior</li> <li>➢ Forgiveness is not an option</li> <li>➢ Complete disrespect for people of all beliefs</li> <li>➢ Abandons core values/beliefs</li> </ul>

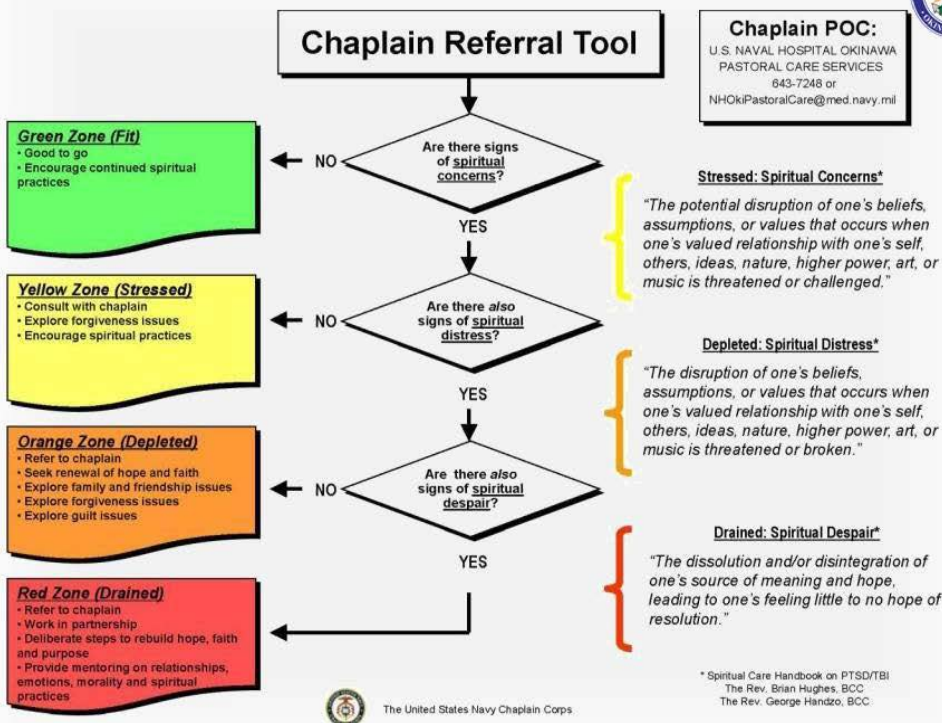
**Your chaplain cares about you and can help with your Spiritual Fitness.**

**Chaplain POC:**  
 U.S. NAVAL HOSPITAL, OKINAWA  
 PASTORAL CARE SERVICES 643-7248 or  
 NHOKiPastoralCare@med.navy.mil



The United States Navy Chaplain Corps

## Providers can/should refer to Pastoral Care when warranted



## BIBLIOGRAPHY

- Asquith, Glenn H., Jr. "Care of Souls," *The Concise Dictionary of Pastoral Care and Counseling*. Kindle Edition: Abingdon Press, 2010.
- Association of Professional Chaplains. "Common Standards for Professional Chaplaincy." <http://professionalchaplains.org/uploadedFiles/pdf/common-standardsprofessionalchaplains.pdf> (accessed April 1, 2012).
- \_\_\_\_\_. "Common Standards for Professional Chaplaincy in Acute Care Settings." [http://www.professionalchaplains.org/uploadedFiles/pdf/Standards%20of%20Practice%20Draft%20Document%20021109.pdf#Project\\_Update](http://www.professionalchaplains.org/uploadedFiles/pdf/Standards%20of%20Practice%20Draft%20Document%20021109.pdf#Project_Update) (accessed April 1, 2012).
- Austin, Larry J. "Spiritual Assessment: A Chaplain's Perspective." *Explore* 2 (2006): 540–542.
- Barnett, David Lee. "A Strategy for a Successful Doctor of Ministry Project." D. Min. diss., Liberty Baptist Theological Seminary, 1992.
- Bennett, George. *When They Ask for Bread: Or Pastoral Care and Counseling in Everyday Places*. Atlanta: John Knox Press, 1978.
- Beauchamp, Tom and James F. Childress. *Principles of Biomedical Ethics*, 6th ed. Oxford: Oxford University Press, 2009.
- Bonhoeffer, Dietrich. *Life Together: The Classic Exploration of Faith in Community*, Translated by John Doberstein. San Francisco: Harper, 1954.
- Bozarth, J.D., Zimring, F.M., R. Tausch. "Client-Centered Therapy: The Evolution of a Revolution," In *Humanistic Psychotherapies: Handbook of Research and Practice*, edited by D.J. Cain and J. Seeman in *Theory and Practice of Counseling and Psychotherapy*, 8th ed., edited by Gerald Corey. Belmont, CA: Brooks/Cole, 2009.
- Brister, C.W. *Pastoral Care in the Church*. San Francisco: Harper, 1992.
- Britannica.com. *Encyclopædia Britannica Online*, s. v. "Carl R. Rogers", <http://www.britannica.com/EBchecked/topic/506798/Carl-R-Rogers>, (accessed April 15, 2012).
- Burton, Laurel, ed. *Chaplaincy Services in Contemporary Health Care*. Schaumburg, IL: College of Chaplains, 1992.
- Cabot, Richard, and Russell Dicks, *The Art of Ministering to the Sick*. New York, NY: Macmillan Company, 1936.

- Cadge, W., PhD, J. Freese, PhD, & N.A. Christakis, PhD. "The Provision of Hospital Chaplaincy in the United States: A National Overview." *Southern Medical Journal* 101 (2006): 626–630.
- Calhoun, Lawrence G. and Richard Tedeschi. *Facilitating Posttraumatic Growth: A Clinician's Guide*. New York: Routledge Group, 1999.
- Carson, D.A. *The Gagging of God: Christianity Confronts Pluralism*. Grand Rapids: Zondervans, 2002.
- Carter, John A. "Navy Chaplains: Cooperation and Conflict," D. Min. diss., Covenant Theological Seminary, 2012.
- Clark, A., M. Drain, and M.P. Malone, "Addressing Patients' Emotional and Spiritual Needs," *Joint Commission Journal on Quality and Safety* 29 (2003): 659–70.
- Clebish, William A. and Charles R. Jaekle. *Pastoral Care in Historical Perspective: An Essay with Exhibits*. New York: Harper Torchbooks, 1967.
- Clinebell, Howard J., "The Emmanuel Movement: Religion Plus Psychotherapy," *Understanding and Counseling the Alcoholic* (1956).  
[http://silkworth.net/emmanuel\\_movement/01003.htm](http://silkworth.net/emmanuel_movement/01003.htm)
- Clinton, Tim and Joshua Straub. *God Attachment: Why You Believe, Act, and Feel the Way You Do about God*. New York: Howard Books, 2010.
- Corey, Gerald. *Theory and Practice of Counseling and Psychotherapy*, 8th ed. Belmont, CA: Brooks/Cole, 2009.
- Crabb, Larry. *Connecting: Healing for Ourselves and Our Relationships: A Radical New Vision*. Nashville: Word, 1997
- Crawford, Dan. *DiscipleShape: Twelve Weeks to Spiritual Fitness*. Peabody, MA: Hendrickson, 1998.
- Criswell, W.A. *Criswell's Guidebook for Pastors*. Nashville: Broadman Press, 1980.
- Crouterfield, Bruce W. "The Value of the Naval Chaplain in the Fleet U.S. Marine Force Environment," D. Min. diss., Liberty Baptist Theological Seminary, 2009.
- Davies, Richard. *Handbook for Doctor of Ministry Students: An Approach to Structured Observation of Ministry*. Lanham, MD, University Press of America, 1984.
- Department of the Defense. "DODINST 1300.17: Accommodation of Religious Practices within the Military Services" Dtd February 2009.  
<http://www.dtic.mil/whs/directives/corres/ins1.html> (accessed April 1, 2012).



- Department of the Navy. "OPNAVINST 1730.1D: Religious Ministry in the Navy" Dtd May 2003. <http://doni.daps.dla.mil/allinstructions.aspx> (accessed April 1, 2012).
- \_\_\_\_\_. "SECNAVINST 1730.7D: Religious Ministry Support within the Department of the Navy" Dtd August 2008. <http://doni.daps.dla.mil/allinstructions.aspx> (accessed April 1, 2012).
- \_\_\_\_\_. "SECNAVINST 1730.8B: Accommodation of Religious Practices" Dtd October 2008. <http://doni.daps.dla.mil/allinstructions.aspx> (accessed April 1, 2012).
- \_\_\_\_\_. "SECNAVINST 1730.10: Chaplain Advisement and Liaison" Dtd August 2009. <http://doni.daps.dla.mil/allinstructions.aspx> (accessed April 1, 2012).
- \_\_\_\_\_. "SECNAVINST 1738.1: Chaplains Religious Enrichment Operation" Dtd December 2011. <http://doni.daps.dla.mil/allinstructions.aspx> (accessed April 1, 2012).
- Desiring God: God Centered Resources from the Ministry of John Piper. "Brothers, We are not Professionals: A Plea to Pastors for Radical Ministry by John Piper." <http://www.desiringgod.org/resource-library/books/brothers-we-are-not-professionals> (accessed April 5, 2013).
- Dictionary.com. *Dictionary.com Unabridged*. Random House, Inc. <http://dictionary.reference.com/browse/> (accessed April 12, 2013).
- Doehring, Carrie. *The Practice of Pastoral Care: A Postmodern Approach*. Westminster: John Knox Press, 2006.
- Dourley, John P. *The Psyche as Sacrament: A Comparative Study of C.G. Jung and Paul Tillich*. Toronto: Inner City Books, 1981.
- Faber, Heije. *Pastoral Care in the Modern Hospital*. Philadelphia, PA: Westminster Press, 1977.
- Figley, Charles R. and William P. Nash, eds. *Combat Stress Injury: Theory, Research, and Management*. New York, NY: Routledge, Taylor & Francis Group, 2007.
- Fitchett, G. *Assessing Spiritual Need: A Guide for Caregivers*. Minneapolis, MN: Augsburg/Fortress Press, 1993.
- \_\_\_\_\_. *Assessing Spiritual Needs*. Lima, OH: Academic Renewal Press, 2002.
- \_\_\_\_\_. "Making Our Case(s)." *Journal of Health Care Chaplaincy*, 17 (2011): 3–18.
- Flannelly, Kevin J., K. Galek, H.P. Tannenbaum, & G.F. Handzo. "A preliminary proposal for a scale to measure the effectiveness of pastoral care with family members of hospitalized patients." *Journal of Pastoral Care and Counseling* 61 (2006): 19–29.

- Flannelly, K., G.F. Handzo, W. Smith, & A. Weaver. "A National Survey of Health Care Administrators' Views on the Importance of Various Chaplain Roles." *The Journal of Pastoral Care & Counseling* 59 (2005): 87–96.
- Flannelly, K., G.F. Handzo, K. Galek, A. Weaver, & J.A. Overvold. "A National Survey of Health Care Directors' Views on the Importance of Various Chaplain Roles: Differences among Disciplines and Types of Hospitals." *The Journal of Pastoral Care & Counseling* 60, no. 3 (2006): 1–23.
- Fortin, Auguste VI, M.D., MPH, and Katherine Gergen Barnett. "Medical School Curricula in Spirituality and Medicine." *Journal of the American Medical Association* 291, no. 23 (2004): 2883.
- Frampton, S., P. Charmel, & L. Gilpin. *Putting Patients First: Designing and Practicing Patient-Centered Care*. San Francisco: Jossey-Bass, 2003.
- Frankl, Viktor E. *Man's Search for Meaning*. Boston: Beacon Press, 2006.
- Georges, Robert and Michael Owens. *Folkloristics*. USA: Indiana University Press, 1995.
- Gleason, John J. "An Emerging Paradigm in Professional Chaplaincy." *Chaplaincy Today* 14, no. 2 (1998): 9–14.
- \_\_\_\_\_. "The Four Worlds of Spiritual Assessment and Care." *Journal of Religion and Health*, 38 (1999): 305–317.
- Gormely, Harold. "The History of Hospitals and Wards," *Healthcare Design* 10, no. 3 (2010), 50–55.
- Gorsuch, Richard L., & Miller, William R. "Assessing Spirituality" In *Integrating Spirituality into Treatment: Resources for Practitioners*, ed. W. R. Miller, 47–64. Washington, DC: American Psychological Association, 1999.
- Griffith, James L. *Religion that Heals, Religion that Harms: A Guide for Clinical Practice*. New York: The Guilford Press, 2010.
- Haggbloom, S.J. et al. "The 100 Most Eminent Psychologists of the 20th Century", *Review of General Psychology*, Vol. 6, No. 2, (2002), 139–152.
- Handzo, G., & H. Koenig. "Spiritual Care: Whose Job is it Anyway?" *Southern Medical Journal*, 97 (2001): 1242–1244.
- Handzo, G., et al. "What do Chaplains Really do? Visitation in the New York Chaplaincy Study." *Journal of Health Care Chaplaincy* 14 (2008): 20–38.

- \_\_\_\_\_. “What do Chaplains Really do? Interventions in the New York Chaplaincy Study.” *Journal of Health Care Chaplaincy* 14 (2008): 39–56.
- \_\_\_\_\_. “What do Chaplains Really do? Referrals in the New York Chaplaincy Study.” *Journal of Health Care Chaplaincy* 14 (2008): 57–73.
- Hannah, John “The Cure of Souls; or, Pastoral Counseling: The Insight of John Owen,” *Reformation and Revival: A Quarterly Journal for Church Leadership* Vol. 5, No. 3 (Summer 1996): 71-91.
- Hathaway, William L. “Clinically Significant Religious Impairment.” *Mental Health, Religion and Culture*, 6 (2003): 113- 129.
- Herman, Judith. *Trauma and Recovery: The Aftermath of Violence—From Domestic Abuse to Political Terror*. New York: Basic Books, 1997.
- Holifield, E. Brooks. *A History of Pastoral Care in America: From Salvation to Self-Realization*. Eugene, OR: Wipf & Stock Publishers, 2005.
- \_\_\_\_\_. *God’s Ambassadors: A History of the Christian Clergy in America*. Grand Rapids, MI: Eerdmans Publishing, 2007.
- Hodge, David R. “A Template for Spiritual Assessment: A Review of the JCAHO Requirements and Guidelines for Implementation.” *Social Work* 51 (2006): 317–326.
- Holst, Lawrence E., ed. *Hospital Ministry: The Role of the Chaplain Today*. New York: Crossroad Publishing, 1992.
- Hummel, Leonard, et al., “Defining Spiritual Care: An Exploratory Study.” *Journal of Health Care Chaplaincy* 17 (2008): 40–51.
- Hutcheson, Richard G., CAPT, CHC, USN (Ret), *The Churches and the Chaplaincy* (U.S. Government Printing Office, 1975)
- Jankowski, Katherine, George F. Handzo & Kevin J. Flannelly. “Testing the Efficacy of Chaplaincy Care,” *Journal of Health Care Chaplaincy* 17 (2011): 100–125.
- Jordan, Merle R. *Reclaiming Your Story: Family History and Spiritual Growth*. Louisville, KY: John Knox Press, 1998.
- Johnson, Albert R. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*, 7th ed. New York: McGraw-Hill Medical, 2010.
- Johnson, Robert. *Owning Your Own Shadow: Understanding the Dark Side of the Psyche*. New York: HarperOne Publishing, 1993.

- Jung, C.G. *Answer to Job*, reprint ed. New Jersey: Princeton University Press, 2010.
- \_\_\_\_\_. *The Undiscovered Self: The Dilemma of the Individual in Modern Society*. New York: New American Library, 2006.
- King, D.E. and B.J. Wells, "End of Life Issues and Spiritual Histories," *Southern Medical Journal* 96 (2003): 391-93.
- Knitter, Paul F. *Introducing Theologies of Religions*. Maryknoll, NY: Orbis Books, 2007.
- Koenig, Harold G. M.D. *Spirituality in Patient Care: Why, How, When, and What*. Kindle Edition: Templeton Foundation Press, 2009.
- \_\_\_\_\_. "Taking a Spiritual History." *Journal of the American Medical Association* 291, no. 23 (2004): 2881.
- Kraft, Heidi S. *Rule Number Two: Lessons I Learned in a Combat Hospital*. New York: Little, Brown and Co., 2007.
- Kubler-Ross, Elisabeth. *On Children and Death: How Children and Their Parents Can and Do Cope with Death*. New York: Touchstone, 1983.
- Leas, Robert David. *Anton Theophilus Boisen: His Life, Work, Impact, and Theological Legacy*. United States: Journal of Pastoral Care Publications, 2009.
- Ledbetter, Timothy J. "Screening for Pastoral Visitations using the Clinical + Coping Score." *The Journal of Pastoral Care and Counseling* 62 (2008): 367-373.
- Litz, Brett T., ed. *Early Intervention for Trauma and Traumatic Loss*. New York: Guilford Press, 2004.
- Lyall, David. "Clinical Pastoral Counselling in a Postmodern Context" *Counselling in Pastoral Settings*, Edited by Gordon Lynch. Kindle Edition: Routledge, 2011.
- Lynch, Gordon, ed. *Clinical Counsellings in Pastoral Settings*. London: Routledge, 1999.
- MacArthur, John and the Master's Seminary Faculty. *Rediscovering Pastoral Ministry*. Nashville: Word Publishing, 1995.
- McMinn, Mark. *Psychology, Theology and Spirituality in Christian Counseling*. Carol Stream, IL: Tyndale House, 1996.
- McNeill, J.T. *A History of the Cure of Souls*. New York, NY: Harper and Bros., 1951.
- Merton, Thomas. *Spiritual Direction and Meditation*. Collegeville, MN, Liturgical Press, 1987.

- Modjarrad, Kayvon. "Medicine and Spirituality." *Journal of the American Medical Association* 291, no. 23 (2004): 2880.
- Moore, Thomas. *Care of the Soul in Medicine: Healing Guidance for Patients, Families, and the People who Care for Them*. New York: Hay House, Inc., 2010.
- Mottram, Kenneth P. *Caring for Those in Crisis: Facing Ethical Dilemmas with Patients and Families*. Grand Rapids, MI: Brazos Press, 2007.
- Millspaugh, D. "Assessment and Response to Spiritual Pain: Part I." *Journal of Palliative Medicine*, 8 (2005), 919–923.
- Najavits, Lisa M. *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. New York: The Guilford Press, 2002.
- Newbigin, Lesslie. *The Gospel in a Pluralist Society*. Grand Rapids: Eerdmans Publishing, 1989.
- NLT Interlinear. "Mark 2: 1-28", <http://nltinterlinear.com/Mark.2.1-28/interlinear> (accessed May 15, 2012).
- Nouwen, Henri N.W. *The Wounded Healer*. New York: Doubleday, 1979.
- O'Connor, Thomas. "Is evidence-based spiritual care an oxymoron?" *Journal of Religion and Health* 41 no. 3 (2002): 253–62.
- Orton, Margaret J. "Transforming Chaplaincy: The Emergence of a Healthcare Pastoral Care for a Post-Modern World." *Journal of Health Care Chaplaincy* 15 (2008): 114–131.
- Patton, John. *Pastoral Care: An Essential Guide*. Nashville: Abingdon Press, 2005.
- Peteet, John R., M.D. and Michael N. D'Ambra, M.D. *The Soul of Medicine: Spiritual Perspectives and Clinical Practice*. Baltimore, MD: The Johns Hopkins University Press, 2011.
- Puchalski, C. "Spiritual Assessment in Clinical Practice." *Psychiatric Annals* 36 (2006), 150–155.
- Puchalski, C., Lunsford, B., Harris, M., & Miller, R. "Interdisciplinary Spiritual Care for Seriously Ill and Dying Patients: A Collaborative Model." *The Cancer Journal* 1295 (2006): 398–416.
- Puchalski, Christina M., MD and Betty Ferrell, RN, PhD. *Making Health Care Whole: Integrating Spirituality in Patient Care*. West Conshohocken, PA: Templeton Press, 2010.

- Reimer, Lawrence D. and James T. Wagner. *The Hospital Handbook: A Practical Guide to Hospital Visitation*, revised edit. Wilton, CT: Morehouse & Barrow, 1987.
- Retief, L. Cilliers., "The evolution of hospitals from antiquity to the Renaissance," *Acta Theologica*, Supplementum 7, Vol 26, No 2 (2006): 213-232.
- Richards, P. Scott, & Bergin, A. E. "Religious and Spiritual Assessment," In *A Spiritual Strategy for Counseling and Psychotherapy*, 2nd ed., edited by P. S. Richards & A. E. Bergin, 219–247. Washington, DC: American Psychological Association, 2003.
- Roberts, Stephen B., ed. *Professional Spiritual and Pastoral Care: A Practical Clergy and Chaplain's Handbook*. Woodstock, VT: Skylight Paths Publishing, 2012.
- Roberts, Stephen B., and Williard W.C. Ashley Sr., eds. *Disaster Spiritual Care: Practical Clergy Responses to Community, Regional, and National Tragedy*. Woodstock, VT: Skylight Paths Publishing, 2008.
- Robertson, Robin. *Beginners Guide to Jungian Psychology*. Lake Worth, FL: Nicholas-Hays, Inc., 1992.
- \_\_\_\_\_. *The Shadow's Gift: Find Out Who You Really Are*. Lake Worth, FL: Nicholas-Hayes, 2011.
- Sanford, John A. *The Kingdom Within: The Inner Meaning of Jesus' Sayings*. New York: Harper Collins, 1987.
- \_\_\_\_\_. *The Man Who Wrestled with God*. New York: Paulist Press, 1987.
- Shay, Jonathan. *Achilles in Vietnam: Combat Trauma and the Undoing of Character*. New York: Scribner, 2003.
- \_\_\_\_\_. *Odysseus in America: Combat Trauma and the Trials of Homecoming*. New York: Scribner, 2002.
- Stairs, Jean. *Listening for the Soul: Pastoral Care and Spiritual Direction*. Minneapolis, MN: Fortress Press, 2000.
- Stein, Murray. *Jung's Map of the Soul: An Introduction*. La Salle, IL: Open Court Publications, 2005.
- \_\_\_\_\_. *The Principle of Individuation: Toward the Development of Human Consciousness*. Willmette, IL: Chiron Publications, 2006.
- Stokoe, Rodney J.R. "Clinical Pastoral Education," *The Nova Scotia Medical Bulletin* 53, no. 1 (1974): 26–28.

- Sweet, Leonard. *Post Modern Pilgrims: First Century Passion for the 21st Century World*. Nashville: Broadman, 2000.
- \_\_\_\_\_. *SoulTsunami: Sink or Swim in a New Millennium Culture*. Grand Rapids: Zondervan Publishing House, 1999.
- Swinton, John and Richard Payne, eds. *Living Well and Dying Faithfully: Christian Practices for End-of-Life Care*. Grand Rapids, MI: Eerdmans Publishing, 2009.
- Tedeschi, Richard and Lawrence G. Calhoun. *Trauma and Transformation: Growing in the Aftermath of Suffering*. Thousand Oaks, CA: Sage Publications, 1995.
- Tucker, Dennis C. *Research Techniques for Scholars and Students in Religion and Theology*. Medford, NJ: Information Today, Inc., 2002.
- University of Iowa College of Nursing. "CNC—Overview: Nursing Outcomes Classification (NOC)." U.S. Naval Hospital Okinawa. <http://www.nursing.uiowa.edu/cncce/nursing-outcomes-classification-overview> (accessed May 28, 2012).
- U.S. Navy Bureau of Medicine and Surgery. "BUMEDINST 1730.2A: Navy Medicine Plan for Religious Ministries including Pastoral Care Services" Dtd March 2011. <http://www.med.Navy.mil/directives/Pages/BUMEDIInstructions.aspx> (accessed April 1, 2012).
- VandeCreek, L. *Professional Chaplaincy and Clinical Pastoral Education Should Become More Scientific: Yes and No*. Binghamton: Haworth Press, 2002.
- VandeCreek, L., & L. Burton "Professional Chaplaincy: Its Role and Importance in Healthcare." *Journal of Pastoral Care & Counseling* 55 (2001), 81–98.
- VandeCreek, Larry and Arthur M. Lucas, eds. *The Discipline for Pastoral Care Giving: Foundations for Outcome Oriented Chaplaincy*. New York: Haworth Press, 2007.
- VandeCreek, Larry, Hilary Bender, and Merle Jordan. *Research in Pastoral Care and Counseling: Quantitative and Qualitative Approaches*. Journal of Pastoral Care Publications, 1994.
- Vyhmeister, Nancy Jean. *Your Guide to Writing Quality Research Papers: For Students of Religion and Theology*. Grand Rapids: Zondervan, 2008.
- Webber, Robert, ed. *Listening to the Beliefs of Emerging Churches*. Grand Rapids: Zondervan, 2007.
- \_\_\_\_\_. *Who Gets to Narrate the World? Contending for the Christian Story in an Age of Rivals*. Downers Grove, IL: InterVarsity Press, 2008.

Willows, David and John Swinton, eds. *Spiritual Dimensions of Pastoral Care: Practical Theology in a Multidisciplinary Context*. London: Jessica Kingsley Publishers, 2000.

Zieger, Hans. "Why Does the U.S. Military Have Chaplains?" *Pepperdine Policy Review*: Vol. 2, (2009), Article 4.



## VITA

Russell A. Hale

## PERSONAL

Born: May 6, 1967

Married: Rebecca L. Hammons, February 24, 1989

Children: Joshua Taylor, December 9, 1992

Samantha Grace, June 12, 2003

## EDUCATIONAL

Associate of Arts, Tulsa Junior College, Tulsa, OK, 1990

Bachelor of General Studies, University of Mary Hardin-Baylor, Belton, TX, 1997

Master of Arts, (Cum Laude) Criswell College, Dallas, TX, 1999

Master of Divinity, Southwestern Baptist Theological Seminary, Fort Worth, TX, 2001

Clinical Pastoral Education (4 Units), Hampton Roads CPE Center, 2010-2011

Doctor of Ministry (Cand.), Liberty Theological Seminary, Lynchburg, VA, 2013

## MINISTERIAL CREDENTIALS

Ordained: Lakeview Baptist Church, Belton, TX, December, 1997

Holy Orders: Diocese of St. Cuthbert, Sparta, TN, December, 2007

## PROFESSIONAL CERTIFICATIONS

Endorsed Chaplain, North American Mission Board, 1998-2007

Endorsed Chaplain, Communion of Evangelical Episcopal Churches, 2007- Present

U.S. Navy Pastoral Care Residency- Pastoral Counselor, Naval Medical Center,  
Portsmouth, VA, 2010-2011

Board Certified Chaplain, Association of Professional Chaplains, 2012

## PROFESSIONAL ORGANIZATIONS

U.S. Navy, Lieutenant Commander, Chaplain Corps, 2002-Present

Executive Board, Order of the Companions of Christ, O.P. 2006-Present

Member, Military Chaplains Association, 2005-Present

Member, Association for Clinical Pastoral Education, 2010-Present

Member, Association of Professional Chaplains, 2010-Present

Member, Association of Christian Counselors, 2010-Present

Member, American Association of Pastoral Counselors, 2012-Present

Member, American Legion, 1992-Present

Member, Veterans of Foreign Wars, 2006-Present

## Interdisciplinary Review Board Research Approval

**LIBERTY**  
UNIVERSITY™

The Graduate School at Liberty University

November 2, 2012

LCDR Russell A. Hale, CHC, USN  
IRB Exemption 1437.110212: Professional Naval Chaplaincy: Navy Chaplaincy in a Bureau of  
Medicine and Surgery Hospital

Dear Russell,

The Liberty University Institutional Review Board has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and that no further IRB oversight is required.

Your study falls under exemption category 46.101 (b)(2), which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:

- (2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:
- (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and
  - (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Please note that this exemption only applies to your current research application, and that any changes to your protocol must be reported to the Liberty IRB for verification of continued exemption status. You may report these changes by submitting a change in protocol form or a new application to the IRB and referencing the above IRB Exemption number.

If you have any questions about this exemption, or need assistance in determining whether possible changes to your protocol would change your exemption status, please email us at [irb@liberty.edu](mailto:irb@liberty.edu).

Sincerely,

**Fernando Garzon, Psy.D.**  
*Professor, IRB Chair*  
**Counseling**

**(434) 592-4054**

**LIBERTY**  
UNIVERSITY.

*Liberty University | Training Champions for Christ since 1971*

## Interdisciplinary Review Board Research Approval



**Clinical Investigation Department**  
 Naval Medical Center, San Diego  
 34800 Bob Wilson Drive, Suite 5  
 San Diego, CA 92134-1005  
 Tel: 619-532-9927; FAX: 619-532-8137  
 Email: mary.massello@med.navy.mil

March 18, 2013

From: Head, Clinical Investigation Department (CID)  
 To: LCDR Russell Hale, M.A., M.Div.  
 Subj: **FINAL APPROVAL OF CLINICAL INVESTIGATION PROGRAM (CIP)  
 STUDY CIP #NHOK.2012.0118, "Professional Naval Chaplaincy: Navy Chaplaincy in a  
 Bureau of Medicine and Surgery Hospital"**  
 Ref: (a) NAVMEDCEN SDIEGOINST 6500.9A

1. Two members of the Institutional Review Board (IRB) have reviewed and recommended approval of your application and found that it meets the criteria specified in 63 CFR 60364-60367 category(ies) 7. Based on the board members findings and recommendation, and his review, the IRB Chairman concurred with the recommendation as specified and reported in the January 9, 2013 IRB meeting minutes. The IRB members and Chairman reviewed all documents attached to the original submission. Naval Medical Center San Diego holds Office of Human Research Protections Federal Wide Assurance number **FWA00002342** and **DOD Navy Assurance number 40005**.

2. **IRB APPROVAL DATE:** January 9, 2013  
 Type of Review: Expedited Review

3. **CLINICAL INVESTIGATION PROGRAM NUMBER (CIP#):** NHOK.2012.011. This number is the clinical investigation program number and is required to be included with all correspondence, consent forms, and research data files.

4. **ADVERSE EVENT (AE) REPORTING:** All problems that could possibly effect subject safety must be reported to the IRB within five days; serious AEs must be reported within 24 hours. All deaths, whether or not they are directly related to study procedures, must be reported.

5. **AMENDMENTS:** Prior IRB approval is required before implementing *any* changes to the protocol, including investigator additions or deletions, edits to consent documents or any other modifications to the documentation contained in the original submission package.

6. **EXPIRATION DATE:** Your protocol will expire on January 8, 2014. If the project is to continue, it must be renewed **prior to the expiration date**.

7. **COMMENT:** The Research Administration Office will send you a **Continuing Review Report (CRR) approximately 60 days prior to the expiration of the study**. The IRB wishes to remind you that, according to the Department of Health and Human Services (DHHS) and NMCSD policy, the renewal of exempt research projects is the **Investigator's** responsibility and a renewal application is required **at least** annually for all projects involving human subjects.

8. **ARTICLES/ABSTRACTS/POSTERS:** : If you wish to submit an item for publication or presentation, it must be submitted to the CID Medical Editor, Ms. Elisea Avalos. Ms. Avalos can be reached at (619)

## Interdisciplinary Review Board Research Approval

532-8134. She will assist in their preparation, will ensure proper acknowledgment of BUMED as sponsor, will obtain command approval and submit them to journals and publications.

9. The Principal Investigator is responsible for obtaining final authorization to begin implementation and recruitment at Naval Hospital Okinawa. The PI is directed to contact the NHOK Command Research Coordinator to facilitate final command approval.

10. **QUESTIONS:** Please contact the IRB Research Administration Division (RAD) if you have any questions:

Mary Massello at 619-532-9927

J.D. Malone, MD  
Head, Clinical Investigation Department