Ethical Implications of Religious Support in LSCO

by Hank Mauterer

Counterinsurgency (COIN) operations are the oldest form of warfare, predating the rise of conventional armies that began around 3000 BC in ancient Mesopotamia,[1] and has been the United States Army' wartime strategy since Islamic terrorist attacked the U.S. on September 11, 2001. After 20 years of focusing exclusively on COIN operations, the War on Terror came to an end in 2021 as Islamic terrorism ceased to be a significant concern. Now, with the emergence of regional threats like North Korea, Russia, and China, as the Army has changed its focus from COIN operations to large-scale combat operations (LSCO),[2] it finds itself lacking among its ranks military leaders trained in LSCO. As the Army scrambles to develop a superior LSCO strategy and a trained warfighting force, the Chaplain Corps is similarly working to develop its religious support doctrine and strategy. The purpose of this paper is to consider the ethical implications of religious support in LSCO. In addition, this paper with discuss a preemptive religious support measure that addresses the Army's mental, emotional, and spiritual resiliency (MESR) crisis that is the fundamental factor hampering individual Soldier readiness and combat effectiveness (ISR/CE).

The Ethics of a Profession

The Army Chaplain Corps, like the Medical Corps and Judge Advocate General Corps, is unique in that it is a profession nested within another profession: the U.S. Army. As stated in *Army Doctrine Reference Publication (ADRP) 1*,[3] the Army definition for profession, having been sourced directly from D. M. Snider's following passage, defines profession as:

> [A] relatively high-status occupation whose members develop and apply expert knowledge as human expertise to solve problems in a particular field of endeavor … there are five aspects of a profession that are inferred in this definition: (1) professions provide a unique and vital service to the society served, one it cannot provide itself, (2) they do so by the application of expert knowledge and practice; (3) because of their effective and ethical application of their expertise they earn the trust of the society; (4) they self-regulate; they police the practices of their members to ensure it is effective and applied only by following the profession's ethic. This includes the responsibility to educate and certify professionals, ensuring only the most proficient members actually apply their expertise on behalf of the client, and (5) they are therefore granted significant autonomy in their practice on behalf of the society.[4]

As such, the definition for "ethics" utilized throughout this discussion will be taken from professional ethics, which refers to the rules and standards (e.g., codes of conduct in workplaces, religious principles) provided by an external source (i.e., institutions, groups, or culture) to which an individual belongs.[5] All lawyers, for instance, must follow an ethical code laid down by their profession, regardless of their own feelings or preferences. Hence, ethics, in this discussion, will refer to *what someone ought to do*.[6]

Characteristics of Large-Scale Combat Operations

Now, in our effort to consider the potential ethical ramifications/conclusions of religious support (religious support) in large-scale combat operations (LSCO), it is likewise important to understand those specific characteristics of LSCO that can be expected to have a degrading effect on the Chaplain Corps' ability to effectively and ethically provide religious support in such an environment. According to *Field Manual (FM)*

3-0, large-scale combat will not only introduce levels of complexity, lethality, ambiguity, and speed to military activities that are uncommon in other operations,[7] it is also expected to result in devastating violence on a vast scale.[8] Differing greatly from small-scale combat, the LSCO environment will include "the predominance of indirect fires from both sides, as well as contested airspace without the guarantee of friendly air dominance … [while fluid] conditions on the battlefield dictate the need for rapid transitions between offense and hasty defenses … where leaders may not have time to fully develop engagement areas."[9]

Since the Army has transitioned from counterinsurgency (COIN) to multidomain operations and LSCO, the Army's current military leaders and chaplains generally lack any operational knowledge and experience of LSCO with only a handful of senior leaders who served in the 1990s and are still familiar perhaps with AirLand Battle, NATO's European warfighting doctrine and precursor to LSCO. Unlike AirLand Battle, which included the land, maritime, and air domains, in LSCO the operational environment for Army forces includes portions of the land, maritime, air, space, and cyberspace domains understood through three dimensions (human, physical, and information).[10] Whereas the land, maritime, air, and space domains are defined by their physical characteristics, the emergence of the cyberspace domain, a manmade network of networks that transits and connects all of the domains, multiplies the complexity and uncertainty of LSCO.

Therefore, this discussion will consider the ways in which LSCO can be expected to ethically impact the Chaplain Corps' ability to provide religious support in meeting its mission "to bring Soldiers to God and God to Soldiers."[11] Of particular concern are the LSCO characteristics as speed of movement, rapid transitions between offense and defense (transient fighting postures), broad areas of operation, the coordinated maneuver of large troop formations, complexity, ambiguity, and resulting high casualty counts.

Definition of Religious Support

Finally, this discussion also requires an agreeable definition for "religious support" which this author believes is sufficiently captured in the three core competencies of the U.S. Army chaplain (i.e., to nurture the living, care for the wounded, and honor the fallen).[12] At every echelon of the force, the chaplaincy is the Army's primary agency for facilitating the right to free exercise of religion for servicemembers[13] by "providing essential elements of religion to include worship, religious rites, sacraments and ordinances, holy days and observances, pastoral care and counseling, and religious education."[14] The chaplain's religious support responsibilities, as such, includes the following (the bolded responsibilities do not apply to LSCO):

> Military chaplains are responsible for tending to the spiritual and moral well-being of service members **and their families**. Their responsibilities include performing religious rites, conducting worship services and providing confidential counseling … The team's obligations to service members **and their families** include: Conducting worship and administering sacraments … Performing other religious ceremonies and services … **Developing religious education programs and religious youth activities** … **Conducting seminars and retreats** … Accompanying service members into combat … Providing combat stress support … Advising commanders on religious and moral matters … Counseling service members **and their families**.[15]

In accordance with the aforementioned definitions, the following discussion will address the potential ethical implications of the Chaplain Corps' abilities (what ought to be done) to provide religious support (in accordance with the Chaplain's core competencies) in the contested and hasty LSCO environment.

Nurture The Living

Although chaplains continue to nurture the living by providing religious services, pastoral care, and counseling to Soldiers,[16] they will be unable to do so either routinely or predictably due to speed of movement and rapid transitions between offense and defense, characteristic of LSCO. By necessity, chaplains must be prepared to conduct multiple, hasty, and opportunistic services (religious, pastoral, and counseling) given short notice, in harsh and contested environments and under considerable time constraints. Additionally, because Army chaplains

represent five distinct faith groups (i.e., Christianity, Judaism, Islam, Buddhism, and Hinduism) with each battalion chaplain representing one faith group, battalion chaplains in LSCO can only provide religious worship to those Soldiers who generally possess the same faith as them, but for their Soldiers who possess other faiths, they will be hard pressed in their ability to secure qualified chaplains from their area of operations to perform their religious worship requirements.

Care for the Wounded

As is commonly depicted in war movies, chaplains that remain with their battalions in LSCO have ready access and opportunity to care for the wounded and dying 'up close and personal' either by circulating throughout the battlefield or positioning themselves alongside their combat medics to assist them in their duties. For those Soldiers whose sectarian faiths require only sectarian chaplains for the performance of specialized rites (death rites, for instance), they are far less likely to receive this specialized care in time because they will encounter the same difficulties in their ability to secure a qualified chaplain from the area of operations. If these Soldiers, on the other hand, can accept the performance of these specialized rites from any battalion chaplain regardless of their endorsing faith group, then this no longer remains an ethical issue of concern.

Prior to the Korean War when the U.S. Army was far less religiously diverse, Army regiments included a Catholic chaplain, a Protestant chaplain, and a Jewish chaplain. Hence, the likelihood that most dying Soldiers could receive sectarian care from an expressly sectarian chaplain was considerably more likely,[17] even if they were willing to receiving the same care from any chaplain. Since our force structure has become highly religiously diverse and each battalion is assigned one chaplain that represents a single faith group, it is highly unlikely that most sectarian Soldiers will receive sectarian care.

Besides being with the battalion, battalion chaplains in LSCO can also be collocated with Role 2 medical support (whether by choice or by command direction). At Role 2 the medics provide:

> [A]dvanced trauma management and emergency medical treatment including continuation of resuscitation started in Role 1 … [to include] a greater capability to resuscitate trauma patients … additional emergency measures … [that] do not go beyond the measures dictated by immediate necessities … [and it] has the capability to provide packed blood products, limited x-ray, laboratory, dental support, combat and operational stress control, PVTMED, and Role 2 veterinary medical and resuscitative surgical support … having a limited hold capability (i.e., no bed capacity).[18]

At Role 2, chaplains generally position themselves among the triaged Soldiers categorized as black or 'expectant'. The medics have diagnosed these Soldiers as having "injuries so severe that survival is unlikely even with medical intervention, or they are already deceased."[19] Now, even though chaplains at Role 2 are separated from their assigned units and unable to provide them with nurture-the-living religious support , at Role 2 they are capable of providing nurture-the-living religious support to the recovering wounded, visiting servicemembers, and the medical team personnel, as well as care-for-the-wounded religious support to all military personnel, civilians, and enemy combatants brought through the Role 2 for life-saving care.

Honor the Fallen

As is the case with nurture-the-living religious support in LSCO, battlefield dynamics are expected to inhibit and even prohibit battalion chaplains from executing what would be normally expected of a military standard memorial ceremony or even memorial service (at least in a reasonable and timely manner). Although this may be fully possible once hostilities subside or cease or when the unit has been removed from the battlefield, but otherwise chaplains in their effort to meet their Soldiers' honor-the-fallen religious support needs should be prepared to conduct multiple, hasty, and opportunistic "memorials" given short notice, in harsh and contested environments and under considerable time constraints. Consequently, the Chaplain Corps may need to develop a standardized and abbreviated form of the memorial ceremony adapted for LSCO and disseminated as a combat template to all chaplains.

A Bigger Issue

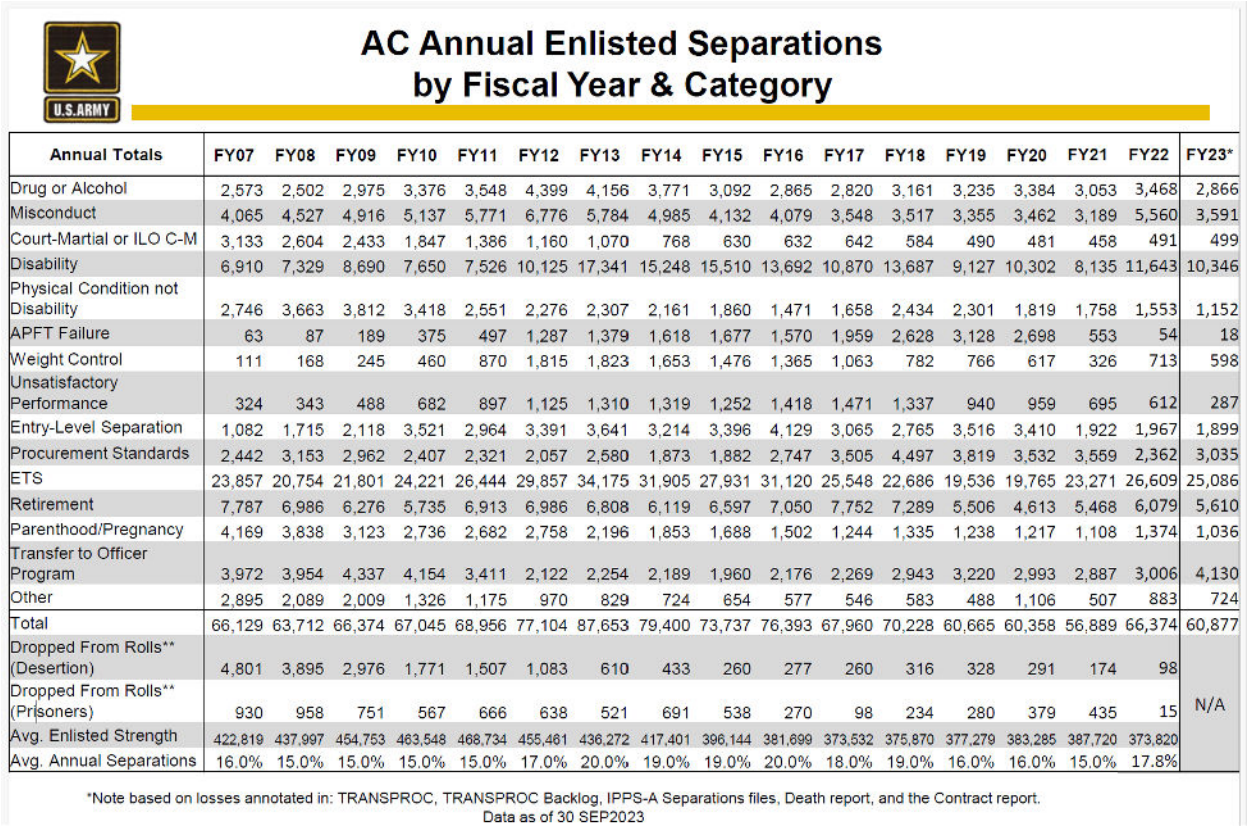
It is the opinion of this author that there is a more pressing ethical need that needs addressing which pertains to the current crisis in our Soldier mental, emotional, and spiritual resiliency (MESR) which, without action, will hamper chaplains' effectiveness in providing religious support in LSCO. Although this is not the forum to fully present this, the following is an abbreviated summary.

Military professionalism can be subdivided into two distinct categories: performance professionalism and personal professionalism. Performance professionalism entails the myriads of public and observable behaviors that comprise what most Army leaders regard as military professionalism: formations, drill and ceremony, wear of uniform, etiquette, conduct, customs, courtesies, bearing, ceremonies, official correspondence, etc. Personal professionalism entails the private and unobservable behaviors that comprise Soldiers' personal conduct in financial, inter-personal, legal, marital, medical, and political matters. Although Soldiers are generally proficient at maintaining the standards of the former, that is not the case with the latter where misconduct, being often criminal in nature, is routinely met with judicial punishment, criminal charges, and incarceration which can include general, other-than-honorable, and dishonorable discharges, forfeiture of pay and allowances, criminal charges, and confinement.[20] Because unprofessional behavior (i.e., extramarital affairs, drug use, theft, conduct unbecoming an officer) has the potential to bring discredit upon the armed forces and negatively impact good order and discipline, it is punishable under the Uniform Code of Military Justice (UCMJ).[21] And the wide-reaching consequences from breaches in Soldiers' personal professionalism effectively 1) degrades military readiness and force strength, 2) exacerbates Army recruiting efforts and shortfalls,[22] 3) consumes noncommissioned officer and commander energy by drawing them away from unit-level readiness training, and 4) leads to long-term broken lives. Critics cannot deny that for decades the greatest continued threat to individual Soldier readiness and combat effectiveness (ISR/CE) as well as the predominant cause for military separations and suicides has arguably been harmful and destructive behaviors that result from poor Soldier mental, emotional, and spiritual resiliency (MESR).

Few people set out to have extramarital affairs, go AWOL, steal property, engage in physical or sexual abuse, become addicted to drugs or alcohol, or commit rape or homicide. Although Soldiers realize the threat of prosecution and separation for such breaches, they may find themselves falling into unprofessional behaviors without really understanding how to avoid them. Such behaviors tend to emerge as Soldiers encounter problems in their social, emotional, moral, and spiritual wellbeing. They may 'fall' into breaches of personal professionalism because they are struggling and don't know how to stop themselves; or, they may know how stop themselves in principle but fail to receive critical reinforcement and encouragement in those resiliency behaviors and practices that are very effective at mitigating addiction. Negative military reinforcers do little to actually prevent Soldiers from entering the negative spirals that lead to these problems that may also, at times, be occasioned by the extreme stresses of military service.

Sadly, each year MESR-related situations account for an alarming number of Soldier separations, incarcerations, medical discharges, and deaths. These include drug and alcohol-related incidents (use, abuse, altercation, assault, dealing, underage, DUI, etc.), sex-related incidents [extramarital affairs, underage sex, rape, sexting, Sexual Harassment / Assault Response and Prevention (SHARP) violations, etc.), misconduct (abandoning post, AWOL, receiving stolen property, theft, larceny, hazing, bullying, etc.), psychiatric and mental-health issues (depression, personality disorder, PTSD, etc.), and death (homicide, suicide, hazardous / foolish behavior, etc.).[23] In 2023, the U.S. Army separated 7,243 enlisted Soldiers for issues related to drugs, alcohol, misconduct, court-martial, and unsatisfactory performance.[24] (Figure 1, pg. 54). Although this accounts for only 12 percent of all separations, this number is actually staggering when you consider that none of the remaining 53,634 separations [disability, physical conditions, Army Combat Fitness Test (ACFT) failure*, weight control*, Entry-Level Separation, procurement standards*, Expiration Term of Service (ETS), retirement, pregnancy, and transfer to officer program] resulted from misconduct.[5] Additionally, the ramifications from MESR-related military separations have a long-term effect on veterans following their discharge:

Research suggests that these types of challenges make it more likely that veterans will become involved with the justice system. According to 2021 census data, veterans make up about 6.5% of the U.S. population, yet 31% of veterans have been arrested at some point in their lives compared with 18% of nonveterans. Data also shows that veterans account for nearly 8% of individuals incarcerated in state prisons and more than 5% of those in federal prisons.[25]



AC Annual Enlisted Separations by Fiscal Year & Category

Annual Totals	FY07	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY23*
Drug or Alcohol	2,573	2,502	2,975	3,376	3,548	4,399	4,156	3,771	3,092	2,865	2,820	3,161	3,235	3,384	3,053	3,468	2,866
Misconduct	4,065	4,527	4,916	5,137	5,771	6,776	5,784	4,985	4,132	4,079	3,548	3,517	3,355	3,462	3,189	5,560	3,591
Court-Martial or ILO C-M	3,133	2,604	2,433	1,847	1,386	1,160	1,070	768	630	632	642	584	490	481	458	491	499
Disability	6,910	7,329	8,690	7,650	7,526	10,125	17,341	15,248	15,510	13,692	10,870	13,687	9,127	10,302	8,135	11,643	10,346
Physical Condition not Disability	2,746	3,663	3,812	3,418	2,551	2,276	2,307	2,161	1,860	1,471	1,658	2,434	2,301	1,819	1,758	1,553	1,152
APFT Failure	63	87	189	375	497	1,287	1,379	1,618	1,677	1,570	1,959	2,628	3,128	2,698	553	54	18
Weight Control	111	168	245	460	870	1,815	1,823	1,653	1,476	1,365	1,063	782	766	617	326	713	598
Unsatisfactory Performance	324	343	488	682	897	1,125	1,310	1,319	1,252	1,418	1,471	1,337	940	959	695	612	287
Entry-Level Separation	1,082	1,715	2,118	3,521	2,964	3,391	3,641	3,214	3,396	4,129	3,065	2,765	3,516	3,410	1,922	1,967	1,899
Procurement Standards	2,442	3,153	2,962	2,407	2,321	2,057	2,580	1,873	1,882	2,747	3,505	4,497	3,819	3,532	3,559	2,362	3,035
ETS	23,857	20,754	21,801	24,221	26,444	29,857	34,175	31,905	27,931	31,120	25,548	22,686	19,536	19,765	23,271	26,609	25,086
Retirement	7,787	6,986	6,276	5,735	6,913	6,986	6,808	6,119	6,597	7,050	7,752	7,289	5,506	4,613	5,468	6,079	5,610
Parenthood/Pregnancy	4,169	3,838	3,123	2,736	2,682	2,758	2,196	1,853	1,688	1,502	1,244	1,335	1,238	1,217	1,108	1,374	1,036
Transfer to Officer Program	3,972	3,954	4,337	4,154	3,411	2,122	2,254	2,189	1,960	2,176	2,269	2,943	3,220	2,993	2,887	3,006	4,130
Other	2,895	2,089	2,009	1,326	1,175	970	829	724	654	577	546	583	488	1,106	507	883	724
Total	66,129	63,712	66,374	67,045	68,956	77,104	87,653	79,400	73,737	76,393	67,960	70,228	60,665	60,358	56,889	66,374	60,877
Dropped From Rolls** (Desertion)	4,801	3,895	2,976	1,771	1,507	1,083	610	433	260	277	260	316	328	291	174	98	
Dropped From Rolls** (Prisoners)	930	958	751	567	666	638	521	691	538	270	98	234	280	379	435	15	N/A
Avg. Enlisted Strength	422,819	437,997	454,753	463,548	468,734	455,461	436,272	417,401	396,144	381,699	373,532	375,870	377,279	383,285	387,720	373,820	
Avg. Annual Separations	16.0%	15.0%	15.0%	15.0%	15.0%	17.0%	20.0%	19.0%	19.0%	20.0%	18.0%	19.0%	16.0%	16.0%	15.0%	17.8%	

*Note based on losses annotated in: TRANSPROC, TRANSPROC Backlog, IPPS-A Separations files, Death report, and the Contract report.
Data as of 30 SEP2023

Figure 1.

When also considering military suicide rates, Pentagon statistics reveal a rising trend over the past decade. In the first quarter of 2023, the Pentagon reported 94 Army active-duty suicides – a twenty five percent increase from 2022.[26] Since the total number of Army active-duty suicides for 2022 was 135, these first quarter 2023 numbers are quite staggering since they already account for seventy percent of the previous year's total number.[27]

In recognizing that poor Soldier MESR is the fundamental cause for the Army's ISR/CE crisis, the Army announced its Army People First Strategy:

> The Army is taking on issues and harmful behaviors that tear at the fabric of our force, including sexual assault, sexual harassment, suicide, discrimination and extremism. We are developing strategies and implementing programs to build diverse, adaptive and cohesive teams that sustain readiness … The Army People Strategy focuses on how we take care of our people and manage their unique talents.[28]

Addressing this crisis through Army policy, programs, and routine messaging, the Army in the recent *FM 7-22*-derived extract titled "Holistic Health and Fitness Operating Concept" stated:

In order to win on the battlefield, Soldiers must first deploy to the battlefield. The H2F [Holistic Health and Fitness] system focuses on improving health- and fitness-related knowledge, attitudes, and behaviors to increase deployable rates currently degraded by obesity, injury, and poor lifestyle choices. By addressing and optimizing

mental wellness and acuity, this system builds agile, adaptable, and fit Soldiers … The H2F System encompasses both the physical **and non-physical domains (mental readiness, sleep readiness, nutritional readiness, and spiritual readiness) required for optimal performance and improved readiness** [emphasis added].[29]

Hence, the question remains: 1) if poor Soldier MESR is indeed the predominant cause for the degradation of ISR/CE, and 2) if the Army acknowledges this to be the case, and 3) if the Army is actively taking steps to address its poor MESR crisis to overcome this warfighter / force weakness, then why has the Army not implemented a MESR-focused, prescriptive training and testing program as it has done with its other ISR/CE priorities?

The Army has taken several steps to address this crisis, although the crux of its enduring MESR strategies is marked by indistinct guidance, minimal requirements, non-preventative measures, and the transference of its MESR responsibility to the individual Soldier. For the U.S. Army to begin transitioning from its historically discretionary and ineffective MESR strategy to a more proactive, comprehensive, and prescriptive MESR training program, certain questions need to be answered to warrant such a significant paradigmatic shift: What benefits do mental and spiritual readiness training provide? How effective is mental and spiritual readiness training for building strong Soldier MESR? If the Army were to mandate such a prescriptive MESR program, what obstacles would it face? Because the spiritual H2F component is a preeminent factor in building strong MESR, this paper will limit its scope to the protective factor of Religious Faith and Spirituality (RFS).

Koenig's Meta-Study

Although religion, medicine, and healthcare have been interrelated to varying degrees in all population groups since the beginning of recorded history, it has only been in recent times that these systems of healing have been separated, mostly occurring among highly developed nations.[30] This separation has led to religion and psychiatry parting paths and, following the publication of several influential works by Sigmund Freud and Jean Charcot, resulted in the creation of a true schism between religion and mental health care that continues to this day.[31] As researcher Harold G. Koenig demonstrates, this animosity has manifested throughout the clinical work of many mental health professionals who generally ignore the religious resources of their patients or view them as pathological.[32] In fact, a national survey of U.S. psychiatrists published in 2007 that specifically addressed religious faith and spirituality (RFS) in clinical practice reveals that 56% of psychiatrists stated they never, rarely, or only sometimes inquire about RFS in patients with depression or anxiety despite powerful evidence of the positive association between spirituality and mental health.[33] With a growing body of evidence revealing a beneficial relationship between RFS and psychiatry, is there sufficient ground to maintain this schism? Koenig, in fact, revealed through his RFS meta-study how a majority of the groundbreaking research and clinical work regarding the role that RFS plays in mental health care has actually originated from outside the field of psychiatry:

> Despite the negative views and opinions held by many mental health professionals, research examining religion, spirituality, and health has been rapidly expanding—and most of it is occurring outside the field of psychiatry. This research is being published in journals … including those in medicine, nursing, physical and occupational therapy, social work, public health, sociology, psychology, religion, spirituality, pastoral care, chaplain, population studies, and even in economics and law journals … The result is a massive research literature that is scattered throughout the medical, social, and behavioral sciences.[34]

Despite the reluctance of mental health professionals to embrace psychedelic, spiritual, religious, and mystical (PSRM) interventions because of their perceived tension with science, Dr. Anthony Jack confirms that "recent decades have witnessed the accumulation of such a large body of empirical evidence that [it] establishes beyond any reasonable doubt that [PSRM] experiences can provide significant benefits to physical and psychological health."[35] The data provided by the 454 clinical, experimental, and peer-reviewed studies and randomized clinical trials analyzed by Koenig overwhelmingly reveal that people strong in their RFS have strong MESR, providing them positive gains in the 38 categories of mental health, healthy behavior, and physical health tested – many at a trend level (Figure 2).[36] Additionally, most of the categorical gains analyzed have direct application to the

Army's enduring MESR-crisis, reporting strong gains in, for example, coping with adversity (90%), resisting depression (67%), suicide (80%), substance abuse (alcohol 90%; drugs 86%), delinquency and crime (82%), cigarette smoking (90%), and risky sexual behavior (84%), as well as improving marital stability (92%), exercise (76%), diet (70%), and multiple aspects to physical health.[37] Among the lengthy benefits that accompany strong RFS, the most surprising was how it impacts physical longevity. As Koenig explains:

> There is both qualitative and quantitative research suggesting that [RFS] helps people to deal better with adversity, either external adversity (difficult environmental circumstances) or internal adversity (genetic predisposition or vulnerability to mental disorders) … The most impressive research on the relationship between [RFS] and physical health is in the area of mortality … Of those studies, 82 (68%) found that greater [RFS] predicted significantly greater longevity (three at a trend level) … The effects have been particularly strong for frequency of attendance at religious services … [where] [s]urvival among frequent attendees was increased on average by 37% … 37% is highly significant.[38]

#	FACTOR RESEARCHED	STUDIES	ADVANTAGE / GAIN	LOSS
1	Coping with Adversity (medical illness, chronic pain, kidney disease, diabetes, pulmonary disease, cancer, blood disorders, heart/cardiovascular diseases, dental or vision problems, neurological disorders, HIV/AIDS, systemic lupus erythematosus, irritable bowel syndrome, musculoskeletal disease, caregiver burden, psychiatric illness, bereavement, end-of-life issues, overall stress, natural disasters, war or acts of terrorism, and miscellaneous adverse life situations)	454	>90%*	0%
POSITIVE MENTAL HEALTH				
2	Well-Being & Happiness	326/120	79%/82%*^	<1%
3	Hope	40/6	73%/50%*	0%
4	Optimism	32/11	81%/73%*	0%
5	Meaning and Purpose	45/10	93%/100%*	0%
6	Self-Esteem	69/25	61%/68%	3%/8%
7	Sense of Control (Personal Control in Challenging Life Circumstances)	21/9	61%/44%	33%
8	Positive Character Traits (Altruism/Frequency of Volunteering, Forgiveness, Gratefulness, Kindness/Compassion)	47/20/40/5/3	70%/75%/85%/100%/100%*	11%/10%/0%
NEGATIVE MENTAL HEALTH				
9	Depression	444/178	61%/67%*^	6%/7%
10	Suicide Attempt, Completed Suicide, Attitudes Toward Suicide	141/49	75%/80%*	3%/4%
11	Anxiety	299/67/19/9/32	49%/55%/47%/78%/69%*^	11%/10%/5%/0%/3%
12	Psychotic Disorders and Schizophrenia	43	33%*^	23%
13	Personality Traits [Psychoticism (Risk Taking/Lack of Responsibility), Neuroticism, Extraversion, Conscientiousness, Agreeableness, and Openness to Experience]	19/54/50/30/30/26	84%/24%/38%/63%/87%/42%*	0%/9%/6%/3%/0%/12%
14	Substance Abuse: Alcohol	278/145	86%/90%*	1%/<1%
15	Substance Abuse: Drus	185/112	84%/86%*	1%/<1%
SOCIAL ISSUES				
16	Delinquency and Crime	104/60	79%/82%*^	3%/<1%
17	School Grades and Performance (Among Adolescence-College Age)	10	100%*	No inverse
18	Marital Instability	79/38	86%/92%*	0%
19	Social Support	74/29	82%/93%*	0%/0%
20	Social Capital (Community Participation, Volunteerism, Trust, Reciprocity, and Membership in Community-Based, Civic, Political, or Social Justice Organizations)	14/13	79%/77%*	0%
HEALTH BEHAVIORS				
21	Cigarette Smoking	137/83	90%/90%*^	0%
22	Exercise	37/21	68%/76%*^	16%/10%
23	Diet	21/10	62%/70%*^	<1%
24	Blood Cholesterol	23/9	53%/56%*	13%/<1%
25	Weight	36/25	-39%/-44% heavier	19%/20%
26	Risky Sexual Behavior (Outside Marriage, Multiple Partners)	95/50	86%/84%*^	1%/0%
PHYSICAL HEALTH				
27	Coronary Heart Disease (CHD) & Cardiovascular Reactivity, Heart Rate Variability, Outcomes Following Cardiac Surgery, and Other Cardiovascular Functions)	19/13/16	63%/69%/69%*	<1%/<1%/0%
28	Hypertension (Relationship w/Stress or Tension, and High Blood Pressure Linked to Greater Psychosocial Stress)	63/39	57%/62%^	11%/13%
29	Cerebrovascular Disease (Hypertension and Other Cardiovascular Diseases or Disease Risk Factors Ought to Translate Into a Lower Risk of Stroke)	9	44% lower	11%
30	Alzheimer's Disease and Dementia	21/14	48%/57%	14%/21%
31	Immune Function (White Blood Cell Count, Total Lymphocyte Count, Total T Cells, and Cytotoxic T Cell Aactivity)	27/14	56%/71%*	4%/0%
32	Susceptibility to infection/viral load in those with HIV	10-Dec	67%/70%*^	0%/0%
33	Endocrine Function (Cortisol, Epinephrine, and Norepinephrine) on Immune System	31/13	74%/69%*	0%/0%
34	Cancer (Onset and Outcome of Cancer and Cancer Mortality)	29/20	55%/60%	7%/0%
35	Physical Functioning (Performing Basic and Instrumental Activities of Daily Life)	61/33	36%/39%^	23%/18%
36	Self-Rated Health (Objective Health, Future Health, Health Services Use, and Mortality)	50/37	58%/57%	10%/8%
37	Pain and Somatic Symptoms	56/18	39%/50%	25%/20%
38	Mortality	121/63	68%/75%^	5%/5%

** Only/Near Only Significant Position Association*

^ Trend Level

Figure 2.

Cognitive Network Neuroscience

A number of studies from the emerging field of Cognitive Network Neuroscience (CNN) have begun to quantify network characteristics in a variety of cognitive processes and provide a context for understanding cognition from a network perspective.[39] Combining brain mapping with methods that reveal the network architecture of the brain, CNN offers for the first time a direct and data-driven method for charting the architecture of cognition.[40] In regard to mediating moral judgment, which has significant importance to the U.S. Army, CNN has shown that there is a specific network in the brain comprised of three regions that play a central role in the emotional processes that influence personal moral decision-making (i.e., right and left sides to medial prefrontal cortex, posterior cingulate, and temporo-parietal junction).[41] This empirical research has shown that human decision-making involves two competing neural networks – the empathic network and the analytic network – that suppress one another in a seesaw-like relationship. Healthy and mentally resilient individuals continuously cycle back and forth[42] between analytical thinking (e.g., scientific, logical, mathematical reasoning)[43] and empathetic thinking (e.g., ethical reasoning, social narratives, self-related processing, understanding other's perspective, RFS).[44] As Jack reports, the brains of healthy individuals "not only seesaw but also work to maintain balance between the networks."[45] Since healthy brains require this action, Shannon French and Jacob Sandstrom explain the importance of this process and its impact to Soldier MESR and ethical decision-making:

> Because one network suppresses the other, 'good' decision-making requires the agility to cycle between the networks effectively. Since we ask our soldiers to be both highly empathic and highly analytic, a neuro-intervention aimed at studying and encouraging this agility would be immensely beneficial, as it would increase 'good' decision-making as a byproduct. Additionally, improved agility would help individuals resist getting 'stuck' in one or the other neural network. This matters, because the psychological effects of the brain over-engaging either one of the networks include symptoms of depression and other negative impacts on mental health.[46]

> [L]eaders [need] to actively work on achieving a dynamic balance between the perspectives offered by two opposing networks in the human brain. When this balancing act is accomplished, true ethical leadership is given an opportunity to emerge. However, when an individual privileges one perspective over the other, shows poor judgment in deploying these different perspectives, or attempts to blend the two perspectives in a way that breaches neurobiological constraints, then ethical failure become inevitable with time …[I]n the dynamic domains of modern warfare, soldiers often have to be intensely analytic one moment and empathetic the next. If the ability to cycle between networks has atrophied or is blocked, this may not be possible. As Anthony I. Jack and other researchers have shown, there is also direct harm that can result from staying too long in one of the two opposed neural networks, such as depression, dissociation, and psychiatric disorders.[47]

Considering such positive empirical evidence, the U.S. Army should incorporate the forms of training that assist Soldiers to routinely cycle between analytical and empathetic modes of reasoning with the explicit purpose of building healthy, balanced minds that can mediate good and ethical decision-making. Because analytic reasoning and empathetic reasoning are incommensurable, relying completely on fundamentally different working assumptions to bring their subject matter into focus, the two networks "reveal different aspects of reality, the natural and the spiritual."[48] Being that the Army naturally provides an environment rife for analytic network reasoning [e.g., tactical decision making, operations orders, weapons qualification, the military decision-making process, vehicle repair, radio operation, PRT, etc.), to achieve that dynamic balance between the perspectives offered by two opposing networks in the human brain, the Army must provide an environment with a near-equal amount of empathetic network reasoning, which RFS provides as Jack and other CNN researchers' clinical work reveal:

> The division in the brain between analytic and empathetic modes of thought helps to explain several otherwise puzzling features of PSRM [RFS] thinking. The most obvious of these is their links with health, motivation, and a sense of meaning and purpose in life. These links are all

consistent with the notion that spiritual thinking helps to engage and fine tune the working of the empathic network. These are all functions that numerous brain mapping studies have identified with the empathetic network.[49]

Clinical evidence from CNN confirms the preeminence of RFS as a factor for building strong MESR, especially in regard to mental health care, ethical and moral decision-making, and contributing to healthy cycling between the analytic and empathetic cognitive networks. Empirical evidence from both Koenig's meta-study and CNN research clearly reveals the preponderant advantages that strong RFS provide to an individual's mental health, healthy behavior, and physical health.

Without threat of violating Soldiers' religious liberties commanders could incorporate into their unit training calendars a mandatory two-hour, bi-weekly block of structured MESR training that all Soldiers would be required to attend. Commanders would not direct their Soldiers to participate in any specific form of MESR training, practice, modality, or methodology except, perhaps, in those few situations where that is necessary (i.e., young Soldier with poor money management skills desperately requires financial readiness training). Soldiers would then select their preferred MESR training and register for that course. Being the Soldier's place of duty, subject matter experts would maintain attendance throughout the duration of that course, regularly providing commanders and first sergeants class attendance data for accountability purposes. Training would not necessarily need to be in person but could include video-conferencing options (i.e., Zoom, MS Teams) to accommodate specialized MESR training and provide RFS support to low-density faith groups and esoteric religious, interfaith, and humanist groups that lack representation. By creating post-wide and community-wide Zoom groups for such low-density groups and specialized training, the Army would concurrently develop communities of connection that provide natural and healthy support, especially important since the Department of Defense reports having 221 various religious and denominational preferences among its ranks.[50] MESR courses could include training from a broad variety of disciplines to include RFS, behavioral health, complementary and alternative methodologies / medicine (CAMS), positive psychology, community service groups, counseling services, personal skills training, and support groups. The Army could make the following available to its commanders with many already be available through garrison subject matter experts, Distinguished Religious Group Leaders (DRGLs), and community service resources:

- RFS training for all faith and denominational groups provided by chaplains, clergy, and DRGLs, done in person and/or by Zoom
  - Scripture studies, memorization, catechisms & creeds, mentorship, accountability, worship, administration of sacraments and ordinances, faith history, fellowship, meditation, book studies
- Behavioral health and CAMS
  - Mindfulness meditation (broad)
  - Deep breathing exercises
  - Progressive muscle relaxation
  - Guided imagery
  - Biofeedback
  - Meditation
  - Yoga
  - Tai chi
  - Acupuncture

- Garrison Services
  - Financial management & planning
  - Nutritional training / healthy eating / food preparation
  - Marriage training
  - Parenting training
- Other
  - Non-theist spiritualists, naturalists, and atheists
  - MESR book studies
  - MFLAC / FOCUS counseling
  - Building interpersonal relationships (community)
  - Interpersonal connections (healthy relationships)
  - Equine therapy
  - Art therapy
  - Journaling
  - Hospitality

Additionally, commanders could include an inter-faith ecumenical course open to all Soldiers that would discuss the transcendent issues specifically relevant to Soldiers' lives, to include fear of death in combat or routine training, what it means to be a good combatant / Soldier, how to deal with great moral risks particularly that which is associated with modern asymmetric warfare, how to transition between military and civilian roles and aspects of life, etc.). Implemented well, such training would foster unit cohesion and develop respect for those values and insights that come from different faith traditions. This training would similarly belay any Army concerns that the emphasis of RFS practice might result in fracturing of units. Consequently, since commanders would not compel Soldiers to complete any specific MESR course, allowing Soldier to select whichever course they desire from a breadth of disciplines, mandatory MESR training would not infringe on their civil liberties. This would require units to incorporate routine behavioral health, religious faith and spirituality (RFS), positive psychology, and CAM training which develops those effective protective factors that build strong MESR, foster ethical and moral decision-making, and provide decisive advantages to mental health, healthy behavior, and physical health. Hence, the Army's aversion to applying prescriptive training and testing measures to spiritual readiness because of the potential of violating religious rights does not appear to be an obstacle. On the contrary, it may be a residual reaction to previous threats of litigation by civil rights and anti-religious groups.[51]

Recent decades have witnessed the accumulation of such a large body of empirical evidence through CNN and clinical research studies that establishes beyond any reasonable doubt that RFS is the preeminent factor for building strong MESR, particularly in regard to mental health care, ethical and moral decision-making, and contributing to healthy cycling between the analytic and empathetic cognitive networks, while simultaneously providing preponderant advantages to mental health, healthy behavior, and physical health and a solid ethical framework. Despite the Army clearly acknowledging that poor Soldier MESR is the fundamental cause for its ISR/CE crisis, implementing policies, regulations, programs, and strategies to combat the crisis, the Army continues to implement ineffective discretionary MESR strategies marked by indistinct guidance, minimal requirements, non-preventative measures, and the transference of MESR responsibility to individual Soldiers. Although this may be due to such perceived obstacles as the fear of violating Soldiers' religious rights, being poorly perceived by the public, or negatively affecting military professionalism, this is not the case. Without violating Soldiers' civil religious liberties, the Army could implement a prescriptive MESR training program that offers Soldiers a variety of RFS, BH, CAMS, community service, counseling, personal skills, and support group

courses from which to pick, and would attend bi-weekly training until course completion before selecting another MESR course. The result would combat the Army's poor MESR crisis, the degradation to ISR/CE, and the number of Army non-judicial and judicial actions, and the result would be a considerably stronger warfighting force. Hence, the U.S. Army should mandate a MESR-focused, prescriptive training program as it has effectively done with its top three priorities for sustaining ISR/CE; it has an ethical obligation and duty of care to the health and welfare of its workforce and must work to build Soldier MESR to overcome its MESR crisis, to prevail against the pressures of military life, and to foster ethical decision-making when situations of moral risk arise.

Endnotes

1 https://www.moore.army.mil/mssp/Counterinsurgency/

2 https://mwi.westpoint.edu/armys-return-large-scale-operations-means-intelligence-warfighting-function/

3 https://www.moore.army.mil/mssp/Profession%20of%20Arms/

4 D.M. Snider, "Dissent, Resignation, and the Moral Agency of Senior Military Professionals" (Armed Forces & Society, p.8, 2017).

5 https://www.diffen.com/difference/Ethics_vs_Morals

6 https://learn.ligonier.org/articles/difference-between-ethics-and-morality

7 *Field Manual 3-0, Operations*, Paragraph 6-3.

8 https://lieber.westpoint.edu/large-scale-combat-operations-symposium-introduction/

9 https://www.lineofdeparture.army.mil/Journals/Armor/Fall-2023-Edition/Training-LSCO/

10 *Field Manual 3-07, Stability*, Paragraph 1-78.

11 Army Chaplain Recruitment Brochure (2025), https://usarlatraining.army.mil/Key-Resources-Home/Every-Chaplain-Corps-Member-A-Recruiter-ECAR

12 *Field Manual 1-05, Religious Support*, Paragraph 1-16.

13 Ibid, 1-4.

14 *Army Regulation 165-1, Army Chaplain Corps Activities*, Paragraph 2-4a.

15 https://www.militaryonesource.mil/benefits/unit-chaplain-roles-and-responsibilities/

16 https://www.usar.army.mil/News/News-Display/Article/3306894/chaplain-corps-meeting-soldiers-needs-far-from-home/

17 https://www.cambridge.org/core/journals/church-history/article/one-nation-three-faiths-world-war-i-and-the-shaping-of-protestantcatholicjewish-america/D594CFEF51CA67CCE6EB1D9258BA41DB

18 https://medcoeckapwstorprd01.blob.core.usgovcloudapi.net/pfw-images/dbimages/Ch%202.pdf

19 https://www.uscpronline.com/first-aid/triage

20 Attorneys, M. J. (2019, September 30). Understanding Article 134, UCMJ – Extramarital Sexual Conduct. Retrieved from Military Justice Attorneys: https://www.militaryjusticeattorneys.com/blog/article-134-umcj-extramarital-sexual-conduct/

21 Attorneys, Ibid.

22 Vergun, D. (2023, December 13). OD Addresses Recruiting Shortfall Challenges. Retrieved from U.S. Department of Defense: https://www.defense.gov/News/News-Stories/Article/Article/3616786/dod-addresses-recruiting-shortfall-challenges/

23 Tully, M. (2016, April 8). 10 Most Common Ways Troops Get Thrown Out of the Military. Retrieved from Military.com: https://www.military.com/undertheradar/2016/04/10-most-common-ways-troops-get-thrown-out-of-the-military

24 Corson, W. (2023, September 30). AC Annual Enlisted Separations by Fiscal Year & Category. TRANSPROC, TRANSPROC Backlog, IPPS-A Separations files, Death report, and the Contract report. DAPE-Preligious support.

25 Corr, A. (2023, November 9). Veterans Who Have Been Arrested or Incarcerated Are at Heightened Risk for Suicide. Retrieved from The Pew Charitable Trusts.: https://www.pewtrusts.org/en/research-and-analysis/articles/2023/11/08/veterans-who-have-been-arrested-or-incarcerated-are-at-heightened-risk-for-suicide

26 Perez, Z. (2023, July 3). Military suicide stats released, Army saw highest increase of deaths. Retrieved from Military Times: https://www.militarytimes.com/news/your-military/2023/07/03/military-suicide-stats-released-army-saw-highest-increase-of-deaths/

27 Baldor, L. C. (2023, October 26). The number of military suicides dipped in 2022 as the Pentagon works on new prevention programs. Retrieved from The Associated Press: https://apnews.com/article/military-suicides-trends-gun-safety-f134b78df0a682c0f450c2c61b496201

28 Army, U. (n.d.). Army People First: Prioritizing Our Most Valuable Asset. Retrieved from U.S. Army: https://www.army.mil/peoplefirst/

29 DPRR. (2020, October 1). The U.S. Army Holistic Health and Fitness Operating Concept. Retrieved from U.S. Army: Directorate of Prevention, Resilience and Readiness: https://www.armyresilience.army.mil/abcp/pdf/h2f_operating_concept.pdf

30 Koenig, H. G., VanderWeele, T., & Peteet, J. R. (2023). *Handbook of Religion and Health* (3rd ed). New York: Oxford Academic.

31 Koenig, H. G. (2012, December 16). Religion, Spirituality, and Health: The Research and Clinical Implications. doi:10.5402/2012/278730.

32 Koenig, H. G., 2012, Ibid.

33 Curlin, F. A., Lawrence, R. E., Odell, S., Chin, M. H., Lantos, J. D., Koenig, H. G., & Meador, K. G. (2007, December 12). Religion, Spirituality, and Medicine: Psychiatrists' and Other Physicians' Differing Observations, Interpretations, and Clinical Approaches. Retrieved from Psychiatry Online: https://psychiatryonline.org/doi/pdf/10.1176/appi.ajp.2007.06122088

34 Koenig, H. G., 2012, Ibid.

35 Jack, A. I. (2024, May 22). The Brain Divides Between "Material" and "Spiritual" Forms of Understanding (In Revision). (D. Yaden, & M. Van Elk, Eds.) The Oxford Handbook of Psychedelic, Religious, Spiritual, and Mystical Experiences, 27. Retrieved from https://doi.org/10.1093/oxfordhb/9780192844064.001.0001

36 Koenig, H. G., 2012, Ibid.

37 Ibid.

38 Ibid.

39 Medaglia, J. D., Lynall , M.-E., & Bassett , D. S. (2015, August 27). Cognitive Network Neuroscience. Retrieved from ResearchGate: https://www.researchgate.net/publication/274087989_Cognitive_Network_Neuroscience

40 Jack, The Brain Divides, p.2.

41 Landau, E. (2014, March 14). How your brain makes moral judgments. Retrieved from Cable News Network: https://www.cnn.com/2014/03/26/health/brain-moral-judgments/index.html

42 French, S. E., & Sandstrom, J. A. (2019, August 28). Military Neuro-Interventions: Solving the Right Problems for Ethical Outcomes. Retrieved from The Arthur D. Simons Center for Ethical Leadership and Interagency Cooperation: https://thesimonscenter.org/featured-articles/featured-article-military-neuro-interventions/

43 Jack, The Brain Divides, p.3.

44 Jack, The Brain Divides, p.5.

45 Jack, The Brain Divides, p.6.

46 French, Military Neuro-Interventions, p9.

47 French, Military Neuro-Interventions, p10.

48 Jack, The Brain Divides., p.13.

49 Jack, The Brain Divides., p.16.

50 King, D. (2017, May 14). Department of Defense expands list of military-recognized religions. Retrieved from The Daily Jeff: https://www.daily-jeff.com/story/news/2017/05/14/department-defense-expands-list-military/18934813007/

51 Rempfer, K. (2020, May 15). Stop the 'knee-jerk' reactions to 'anti-religion activists,' 20 congressmen tell senior DoD leaders. Retrieved from Army Times: https://www.armytimes.com/news/your-army/2020/05/15/stop-the-knee-jerk-reactions-to-anti-religion-activists-some-congressmen-tell-senior-dod-leaders/