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ORIGINAL PAPER

Moral Injury, Spiritual Care and the Role of Chaplains: An Exploratory Scoping Review of Literature and Resources

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Abstract This scoping review considered the role of chaplains with regard to 'moral injury'. Moral injury is gaining increasing notoriety. This is due to greater recognition that trauma (in its various forms) can cause much deeper inflictions and afflictions than just physiological or psychological harm, for there may also be wounds affecting the 'soul' that are far more difficult to heal—if at all. As part of a larger research program exploring moral injury, a scoping review of literature and other resources was implemented utilising Arksey and O'Malley's scoping method (Int J Soc Res Methodol 8(1):19–32, 2005) to focus upon moral injury, spirituality (including religion) and chaplaincy. Of the total number of articles and/or resources noting the term 'moral injury' in relation to spiritual/religious issues ($n = 482$), the results revealed 60 resources that specifically noted moral injury and chaplains (or other similar bestowed title). The majority of these resources were clearly positive about the role (or the potential role) of chaplains with regard to mental health issues and/or moral injury. The World Health Organization International Classification of Diseases: Australian Modification of Health Interventions to the International Statistical Classification of Diseases and related Health problems (10th revision, vol 3—WHO ICD-10-AM, Geneva, 2002), was utilised as a coding framework to classify and identify distinct chaplaincy roles and interventions with regard to assisting people with moral injury. Several recommendations are made concerning moral injury and chaplaincy, most particularly the need for greater research to be conducted.

Keywords Chaplain · Moral injury · Pastoral care · Religion · Spirituality · Spiritual care

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Introduction

While some would argue that since time immemorial humans have, in one way or another, suffered various types of 'moral injury' (Verkamp 2006, p. xiii), nevertheless the term moral injury is a relatively new term—some authors admitting that they 'had never heard the phrase or at least paid any attention to it' (e.g., Weinrich 2013, p. 4). Some would argue that it is simply a new term for an old condition (e.g., 'battle fatigue' and 'shell shock'; Sutherland 2015). Others are adamant that moral injury has *not* been sufficiently defined or empirically tested to merit a distinct diagnosis and should, until proven otherwise, be confined under post-traumatic stress disorder (Phelps et al. 2015).

Yet others would argue that there is sufficient tacit knowledge based on contextual and experiential practice to indicate that moral injury is a dynamic phenomenon, that is distinct from post-traumatic stress disorder, and which can substantially affect the lives of individuals who have experienced (in one way or another) considerable trauma that was (and may continue to be) morally challenging (Schreiber 2015; Drescher et al. 2011; Antal and Winings 2015).

What is certain is that medical and allied health professionals (including chaplains), plus philosophers, ethicists, theologians and other social scientists, are still trying to understand the calibre and significance of moral injury—if any. The purpose of this research was to present the results of a scoping review exploring moral injury and the perspective, experiences and current role of chaplains. It sought to address the question: 'What role/s, if any, have and can chaplains fulfil with regard to moral injury (or similar nomenclature) as part of their spiritual care to military personnel and/or to those within the wider community?'

Background

The terms moral injury, spiritual care and chaplaincy each have a level of ambiguity. It is *not*, however, the purpose of this review to argue absolute definitions—as all three areas of study are somewhat interpretatively fluid depending on the context and substantive utilisation of each term. Nevertheless, for the purposes of this review, basic definitions will be proposed to enable an exploration of the literature that intersects all three domains.

What is Moral Injury?

The term 'moral injury' (also abbreviated 'MI') was first coined by Shay and colleagues based upon numerous narratives presented by veteran patients given their perception of injustice as a result of leadership malpractice (Shay and Munroe 1998). Shay's definition of MI had three components: 'Moral injury is present when (1) there has been a betrayal of what is morally right (in the local culture), (2) by someone who holds legitimate authority (according to the social system) and (3) in a high-stakes situation (Shay and Munroe 1998; Shay 2012a, b).

Others, however, developed an equally narrow definition of MI that does not criticise 'legitimate authority' but focused instead upon the individual and feelings of self-betrayal. Litz believed that MI occurs when an individual is involved in '… perpetuating, failing to prevent or bearing witness to acts that transgress deeply held moral beliefs and expectations' (Litz et al. 2009). Others preferred to avoid the harsh impact term of 'injury' that generally refers to physiological damage and instead prefer alternate terms (e.g., 'moral

affront', Neilson 2015; 'moral distress', Musto et al. 2015, Corley et al. 2001; 'moral conflict', Hale 2013; 'moral pain', Verkamp 2006; and 'moral trauma', 'moral wounds', 'moral disruption', Drescher et al. 2011). Drescher et al's (2011) research found that not only did some want to alter the word 'injury' but others wanted to substitute the word 'moral' suggesting 'emotional injury', 'personal values injury', 'life values injury' and 'spiritual injury' (Drescher et al. 2011, p. 11).

Irrespective of all the alternatives, what seems certain, as Phelp's et al. note, is that as yet (and unfortunately), there is '*no* agreed definition of *moral injury*' (Phelps et al. 2015, p. 152). Indeed for some, 'moral injury remains a relatively abstract concept—one that is still in its empirical infancy, with as yet undetermined applicability in clinical, public health, or research settings' (Kopacz et al. 2014a, b, pp. 7–8). While the focus of this paper is not upon differentiating between PTSD and 'moral injury', nevertheless it is important to acknowledge that some argue MI should *not* be considered unique from post-traumatic distress disorder (PTSD), while others adamantly disagree or simply accept that while related to PTSD, nevertheless MI is either not fully encompassed under PTSD or sufficiently tangent from PTSD (e.g., Frame 2015a, b, 2016; Puniewska 2015; Shay 2014; Dombo et al. 2013; Brock and Lettini 2012; Drescher et al. 2011).

No doubt similar to the necessity of having a consensus conference to define the vague term 'spirituality' (e.g., Puchalski et al. 2009), it has been suggested that there will also need to be a conference to achieve a consensus definition about 'moral injury' (Carey et al. 2016, p. 2)—one can only imagine that this would be a very rigorous forum and may still *not* resolve a definitive solution! Alternatively, one could argue of course that it is possible to simply amalgamate the two foci to include both the personal moral violation and the sense of corporate ethical betrayal into one extended definition. We offer the following collation:

> Moral injury originates (1) at an individual level when a person perpetuates, fails to prevent or bears witness to a serious act that transgresses deeply held moral beliefs and expectations which leads to inner conflict because the experience is at odds with their personal core ethical and moral beliefs, and/or (2) at an organisational level, when serious acts of transgression have been caused by or resulted in a betrayal of what is culturally held to be morally right in a 'high-stakes' situation by those who hold legitimate authority.

While there is some empirical descriptive research that identifies both individual and corporate factors as causes of MI (Drescher et al. 2011; Nash et al. 2013), it is still yet to be determined whether a consolidated definition encompassing both individual transgression and corporate betrayal will be considered or accepted by the various professional disciplines. No doubt some organisations, in order to avoid an emphasis upon corporate responsibility, will prefer to use Litz et al's (2009) definition that emphasises a focus upon the individual, while others may prefer Shay and Munroe's (1998) definition that acknowledges corporate culpability. Shay (2014), the originator of the term 'moral injury', acknowledged that both types of 'violator' '…are important: both can coexist; and one can lead to the other in any order' (p. 185). Indeed, it seems obvious that *neither* the individual nor organisational violators are mutually exclusive—conceptually these should be seen as ethically intertwined—but what may be more important is to shift from definition-semantics to consider MI more pragmatically; that is, to consider the actual consequences of MI. As summarised by one military chaplain:

> … the precondition for moral injury is an act of transgression which shatters moral and ethical expectations rooted in religious or spiritual beliefs, or grounded in

> culture-based, organisational and group-based rules, about things like fairness and the value of life. The transgressions … in certain circumstances, leads to guilt or shame which can lead to withdrawal and a failure to forgive (Sutherland 2015, p. 198).

Likewise Frame (2016) also noted the impact of MI which he argued resulted from an 'existential dissonance', given an inner conflict or disagreement between what a person believes to be morally right and what they, or others, have witnessed, experienced or in which they have been involved:

> While operational service might impose an inordinate number of physical and mental demands and be the cause of intense stress, moral injury arises from existential dissonance associated with comparing idealised conceptions to concrete realities. In other words, there is a sharp disagreement about how things should be and how they actually are. So, in reflecting upon a morally challenging experience, a morally injured person realises they were not the individual they had previously believed themselves to be or hoped they were. This realisation, 'I am not the person I thought I was', causes discomfort and even despair (Frame 2016).

Spirituality and Spiritual Injury

Spirituality has been a vague term that has largely defied a credible definition for many years. For the purposes of this paper, a modification to the consensus definition of spirituality initiated by the palliative care community will be adopted. Namely, '…spirituality is that aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to God, to self, to others, to nature, and to the significant or sacred' (modified from Puchalski et al. 2009).

Similar to the definition of spirituality (noted above) and very close to the concept of MI is 'spiritual injury' first coined in 1992—*prior* to the term 'moral injury'. Spiritual injury was defined as '…our response to an event caused by self, or an event beyond our control, that damages our relationship with God, self and others, and alienates us from that which gives meaning to our lives' (Berg 1992, 1994, 2016). Such a definition notes a focus upon the individual but also that beyond the individual (e.g., social, organisational, environmental). With more specific reference to theological issues, Fuson (2013) defined spiritual injury:

> …as the condition where one's spiritual identity is in question. The individual suffering from spiritual injury has difficulty understanding how his or her view of faith, spirituality, relationship with God, and God's involvement in one's life can be true given the horrific experiences observed. A person suffering from spiritual injury doesn't have answers to the questions related to the trauma he or she has experienced, is unsure how to resolve this tension and find the answers, and/or may be doubting that God is trustworthy (Fuson 2013, p. vi).

Other terms have also been used that relate closely to spiritual injury such as 'spiritual distress', 'spiritual wound' or even 'soul injury'. Berg (2016) noted that 'spiritual injury, similar to how physical injury tears at or destroys bodily tissue, so too spiritual injury destroys or weakens spiritual tissue'. For Berg, the concept of spiritual injury indicated a personal, interpersonal, moral and sacred dimension which is largely missing from the bio-psycho-social model of human behaviour—a model, therefore, that is not truly holistic. Concern about partial care that omits spirituality has previously been noted:

> …so often there is agreement that a "holistic multi-disciplinary" model is mandatory within any contemporary health care program, so as to ensure total person-centred care for clients/patients. In actual fact however modern health care is usually ***not*** holistic but simply operates within a limited "bio-psycho-social model". Fundamentally this is usually because some from a medical, psychological and social work background have a personal and/or professional lack of respect for metaphysical dynamics (Carey et al. 2016, pp. 5–6).

According to Salmasy (2012), the incorporation of religious, pastoral and spiritual issues helps to ensure that a truly holistic 'bio-psycho-social-*spiritual*' model is utilised. While some are still resistant about being fully holistic in the application of their care, it is important to note that the deliberate inclusion of religious belief and spirituality with regard to patient-centred health care has long been ratified by the WHO over a considerable number of years ago and formalised as interventions within the WHO International Classification of Diseases and Health Related Interventions—WHO-ICD-10 (WHO 2002) and the International Classification of Function and Disabilities—WHO-ICF (WHO 2001).

Chaplaincy

The term 'chaplain' originates from the Latin *'cappa'*—meaning a hooded cloak or cape—which was extended to '*capallanis*' (chaplains), meaning 'keepers of the cloak' to attribute the role of clergy caring for people and important items or relics of sacred status maintained within a '*capella*' (chapel). Though an historic title, the genesis and meaning of the term 'chaplain' still has particular relevance to the Twenty-first century as the term originates due to the legendary kindness of a fourth-century Roman centurion (Martin de Tour, b. 316–397 AD) who was renowned to have used his military cape to aid homeless beggars suffering as casualties of war. Following his conversion to Christianity, ordination and appointment as Bishop of Tour (France), Martin established places of refuge, worship and education that provided counselling and support to those whose life was in a state of transition such as pilgrims and the homeless (Attwater and John 1995, p. 242).

Chaplains (or those with other such bestowed title) have voluntarily ministered alongside or have been professionally employed within community organisations or state military forces for over a millennia, with a particular focus upon caring for those suffering during and after the brutality of war—long before other contemporary allied health professions were even conceived let alone formalised (Verkamp 2006). Indeed, it can be argued that chaplains have the longest institutional memory related to MI issues and have been dealing with the associated psychological morbidity since the beginning of armed warfare—thus historically evolving the chaplaincy profession to uniquely provide specialist support to those dealing with MI.

Time and space restrictions limit a comprehensive presentation of chaplaincy functions; however, the utility of chaplaincy has been previously noted within the literature to be quite considerable (refer Table 1). Today (whether in the military, hospitals or prisons, etc.) various literature and resources indicates that chaplains still fulfil the role of retaining that which is considered sacred (e.g., values, beliefs, ethical principles and morality), and continue to provide support, counselling and education plus various rituals and rites of passage in order to ensure the holistic care of those within their ministerial bounds. Given the long history of chaplaincy and the breadth of their work, it would not be surprising if chaplains viewed 'moral injury' as somewhat of a 'novelty' term and that contemporary medicine has been somewhat slow to recognise that MI may be associated with a number of inherent mental health issues.

Table 1 Utility of spiritual carers/chaplains

Utility	Summary
Public service	Clergy have provided a public service for over three millennia (since Judaic Kohanim priesthood, 1000BC); specialist chaplaincy developed post-fourth-century AD (e.g., military, health, prisons, welfare and schools/universities) offering pastoral counselling, support, education, sacraments, ritual and worship ceremonies—for all personnel (patients, military personnel/veterans, families, staff and community)
Communication facilitator	Spiritual carers/chaplains encourage multi-logue consultation (patients, military/veterans, families and staff), plus input into ethics committees, local community services, faith groups, government, universities, etc.
Protection and advocacy	Provide support to all personnel (patients, military/veterans, families and staff) to ensure fundamental religious/spiritual/ethical/bioethical principles and confidentiality are upheld
Multi-purpose and multi-competent[a]	Undertake/provide pastoral/religious/spiritual assessments, support, counselling, education, ritual and worship interventions suitable to a variety of contexts (religious, interfaith or secular) which are appropriate/respectful of cultural/social norms, practices and ideology that utilise religious/spiritual products and technology to enhance/reinforce organisational services, systems and policies that encourage meaningful religious/spiritual activities and community participation/interaction
Economic benefit	Chaplains/spiritual carers assist with ethical and behavioural outcomes avoiding additional costs by facilitating inter-personnel communication, providing support, counselling, ritual/worship interventions and improving relationships/rapport which minimises frustration, alleviates conflict, helps to avoid ethical breaches and expensive litigation plus improves workplace well-being by helping to reduce stress, accidents and absenteeism

Developed from Carey (2012) 'Utility and commissioning of spiritual carers' Cobb et al. Oxford Textbook of Spirituality and Healthcare

[a] Based on the WHO-ICD-10AM (2002) 'Pastoral intervention codings' and the WHO-ICF (2001) 'International classification of functioning, disability and health'

A considerable amount of literature indicates that the role of chaplains involved in mental health care has been substantial and likely to continue—as highlighted by Hughes and Handzo (2014) *Spiritual Care Handbook on PTSD and TBI*, plus Koenig et al's (2012) *Handbook of Religion and Health*—but there is too much to discuss in detail within this article, other than to list examples of the key foci and related literature about chaplaincy ministry in mental health contexts (refer Table 2). It is notable, however, that the various clinical interventions of chaplaincy personnel implementing spiritual care within the clinical healthcare context have been designated by the WHO (2002) as being pastoral—(1) assessment, (2) ministry support, (3) counselling, (4) education and (5) ritual and worship (Carey and Del Medico 2013; refer Table 2). As will be noted later, each of these roles/interventions are useful categories for considering the literature regarding chaplaincy and moral injury.

Methods

To specifically consider chaplaincy and MI, Arksey and O'Malley's (2005) method of undertaking a scoping review of literature and other resources was completed. The primary purpose of utilising a scoping review approach, as opposed to other styles of literature

Table 2 Examples of literature identifying chaplaincy roles within mental health care

Source	Roles
Morrow and Matthews (1966)	Provision of Standard or Core Ministerial activities (e.g., provide religious, spiritual, pastoral counselling, lead ritual/worship activities) Involvement in clinical activities (e.g., diagnostic, treatment and therapy activities)
Perske (1966, 2003)	Establishing pastoral relationships Leader of the worship of God Provider of religious education programs Member of the inter-professional clinical team Theologian regarding the mentally disabled
Slaughter (1978)	Generalist: Assist staff–patient treatment, share administration tasks/committee work Specialist: Assist patients, co-therapist with staff, resource staff, consultant to staff, provide in-service training
Stephens (1994)	Supportive friend to patients and staff Resource person Liaison with faith communities Availability—'being there' Provision of religious/seasonal services Advocate
Rattray (2002)	Chaplains provide religious/spiritual expert for both patients and staff Chaplaincy provision ensures holistic teamwork for the 'whole' person Chaplaincy involvement in discussions and debates about physical, spiritual and mental health, issues, provides an example of a healthy team relationship genuinely trying to care for patients
Macritchie (2004)	Praxis theologian—developing theological praxis in mental health utilising psychological and theological/religious paradigms Suffering interventionist—developing an understanding of mental suffering and appropriate interventions that might require a pastoral and prophetic/advocate role to support patients and/or call into question certain institutional circumstances Religious/spiritual interventionist/therapist—recognising/critiquing negative and positive religious experience and using these as a potential avenue for healing and wholeness, forgiveness and absolution, love and acceptance
Swinton (2001)	Chaplains provide religious and spiritual knowledge/expertise Chaplains provide extended pastoral counselling time to engage/understand an individual's spiritual state Chaplains provide accurate discernment of individual spiritual experiences Provision of assessment/information for multidisciplinary teamwork Provide vital conduit into individual's religious/spiritual communities Access to and understanding of religious community belief structures and potentially problematic cultish belief systems
Carey and Del Medico (2013)/WHO (2002)	Pastoral assessment—narrative listening/developing rapport/undertaking religious/spiritual screening and assessments Pastoral ministry/support—facilitating/advocating/providing support for patients, their families and staff Pastoral counselling and education—providing personal religious/spiritual counselling and education; conducting education sessions/seminars for peers, staff and the wider community Pastoral ritual and worship—personal, unit or public ritual and worship activities/ceremonies (e.g., baptisms, weddings, last rites, memorials, funerals and cultural events)

reviews (e.g., systematic, meta-analyses), is to identify and resolve gaps in existing literature where little to no previous research has been previously conducted (Arksey and O'Malley 2005). Whereas other types of reviews (e.g., systematic reviews) often prioritise

Table 3 Electronic databases (in alphabetical order), keywords, search terms and synonyms utilised for systematic scoping review of chaplaincy and moral injury

Electronic databases	Ageline, AMED, CareSearch, CINAHL (Ebsco), Cochrane Library, ERIC, ETG Complete, EMBASE, Google, Google Scholar, Informit Health, Medline (OVID), ProQuest Central, PsycARTICLES, PsycINFO, ResearchGate, SCOPUS, Web of Science (ISI)		
Keywords and synonyms	Moral Injur* Moral Wound* Spiritual Injur* Soul Injur* Moral Distress Spiritual Distress	Clergy Pastoral Carer Spiritual Carer	Chaplain* Imam* Minister* Monk* Pastor* Priest* Rabbi*
Additional search terms	P (Population)	I (Interventions)	C (Comparison) and O (Outcomes)
	Military Veteran* Community	Pastoral Spiritual Religious	Administration Assessment Counselling Education Ministry Ritual Support Worship

* Asterisk = Truncated search term—e.g., Chaplain* = Chaplain/Chaplains/Chaplaincy; Injur* = Injury/Injuries; Priest* = Priest/Priests/Priesthood

specific types of empirical data sets (e.g., randomised clinical trials and cohort studies) as part of their primary inclusion/exclusion criteria, scoping reviews on the other hand collate a wide range of information from many sources (rather than from just one type of data set) and hence are more reliable in gathering and presenting a breadth of alternative material and opinions which can assist future research.

Inclusion and Exclusion Criteria

In accordance with a full scoping review, articles and/or resources (of any kind and or source; e.g., peer-reviewed literature, newspaper/magazine articles, video/audio clips, podcasts and web pages) were included in this review—but only if these sources contained within the title, abstract or content the term/s (1) ‘moral injury’, (2) plus the bestowed designation of either (a) chaplain, (b) clergy, (c) pastoral carer, (d) spiritual carer or other associated nomenclature (refer Table 3). These terms were additionally cross-referenced with other search terms (e.g., military, veteran* and community) to ensure that a thorough search of articles and other resources were excluded from the scoping review if they did not specifically cite MI in conjunction with any of the designated keywords or synonyms (refer Table 3).

Search Procedures

An initial search strategy was implemented identifying published literature that met the selection criteria (Carey et al. 2015a). Additional electronic searches were then conducted using specified keywords and synonyms to further extend the research in order to ensure a multifaceted unbiased evidence base that included all types of resources (refer Table 3). Full text and/or audio versions of all resources were examined and detail-checked for

compliance with the inclusion/exclusion criteria. All resources were entered and categorised according to the various search fields using EndNoteX7 (Thompson-Reuters 2015). The reference list of all obtained resources was also considered for any additional relevant articles or resources. Where researchers/authors, journals or organisations were identified as having a particular interest in chaplaincy and MI, names of these authors, journals and/or research groups/organisations were used in a Google and Google Scholar search to identify any additional resources.

Results

Of the available literature and other resources identified, nearly 500 resources ($n = 482$) were initially verified as being relevant to the topic of ‘moral injury’ in conjunction with at least one of the key terms and/or synonyms (refer Table 3). A cross-search of ‘moral injury’ with ‘chaplaincy’ (including alternative bestowed nomenclature such as minister or priest) was subsequently undertaken utilising the EndNote search category—‘any field’—so as to include those resource with a publication ‘title’, ‘abstract’, ‘keywords’ or any other notes referring to moral injury and chaplaincy. Approximately 10 % of resources made direct reference (in one way or another) to MI and chaplaincy ($n = 60/482$: 12.4 %). The majority of these were ‘journal articles’ and online ‘multimedia’ resources (refer Table 4). It is important to note that given the expanding interest in MI, additional resources were frequently being published/released—particularly online multimedia resources—the researchers were cognisant of the constantly changing number of resources and literature increasingly available with regard to moral injury.

Each of the obtained literature/resources were then considered in light of the established World Health Organization pastoral intervention codings (WHO 2002) and supplementary modifications (Carey and Cohen 2015), which provided a framework to further consider the relevance of each resource with regard to chaplaincy. The major codings utilised were:

Table 4 Nomenclature of identified resources relating to ‘chaplaincy’ and ‘moral injury’

Nomenclature	Identified[a]	Chaplaincy[b]	Percentage %[c]
Journal articles[d]	189	32	16.9
Online multimedia[e]	147	15	10.2
Theses	72	3	5.6
Book/book section	60	7	4.1
Conference paper[f]	10	2	20.0
Reports	4	1	25.0
Total	482	60	12.4

[a] All identified resources derived from keyword search of databases (refer Table 2)

[b] Resources specifically relating to chaplaincy or related bestowed titles and moral injury

[c] Percentage: n = Identified resources/chaplaincy (keyword) = %

[d] Includes both refereed and non-refereed journal articles

[e] Includes online web pages, online newspaper/press releases and magazine articles, podcasts, video and radio clips

[f] Conference: Unpublished conference papers

- Assessment
- Support
- Counselling
- Education
- Ritual and worship
- Administration

Due to space and time restrictions, not all the resources identified could be included in this review—only key examples will be presented which verified or indicated the potential role and tasks of chaplains with regard to moral injury.

Assessment

Generally speaking, religious, pastoral and spiritual assessments are noted within the identified literature as being done at (1) the informal screening level and/or (2) the formal evaluation level. However, while informal (and sometimes idiosyncratic) 'screenings' of sorts have commonly been used (one way or another) by chaplains, nurses and other health practitioners for a number of years, the undertaking of more formal religious, pastoral and spiritual assessments has been a challenging task for *some* chaplaincy practitioners who have been opposed to utilising a more scientific approach to professional chaplaincy and reticent about measuring pastoral care outcomes (refer VandeCreek 2003). Nevertheless, it has become increasingly recognised (at least within the mental health arena) that 'assessment and screening instruments have the capacity to help identify persons in need of chaplaincy services, plus contribute to creating a plan of care, allow for clinical changes to be tracked over time, and assist in the triaging of care between professionals' (Nieuwsma et al. 2013a, p. 124; Kopacz et al. 2015b).

Even the most basic literature review indicates that there are a number of spiritual screening and assessment instruments available for chaplains to utilise (refer Appendix 1: Table 8). With regard to mental health issues in particular, Kopacz et al. (2014a, p. 2) argued that improving the ability of chaplains to utilise more formal spiritual assessment scales (e.g., 'Spiritual Distress Scale') may help chaplains to identify those who are 'at risk' (e.g., suicide) and thus 'allow chaplains to be more responsive' to the spiritual and pastoral needs of those for whom they are required to provide care (p. 2). Unfortunately, there is, as yet, no comprehensive cross culturally validated screening or assessment tool for assessing both MI and spirituality (Nieuwsma et al. 2013a, b).

One informal assessment that could readily be undertaken as noted by Chang et al. (2014) was simply exploring with clients any hidden spiritual distress issues by asking about their client's military experience and/or any spiritual, religious or moral concerns with which they may be struggling (e.g., Chang et al. 2014). Encouraging clients to tell their story and listening to their narrative with theological sensitivity was argued to be important, which, given the assurance of absolute confidentiality, helped to build trust and would permit a chaplain to eventually undertake a more comprehensive assessment if required. Using informal and basic guides such as 'F.I.C.A.' or 'H.O.P.E.' or 'S.P.I.R.I.T.' assists the process of an informal screening. Other more formal assessment instruments that could be utilised by chaplains included such items as the 'Spiritual Injury Scale', 'Spiritual Distress Scale' and the 'Spiritual Needs Assessment Inventory' (refer Appendix 1: Table 8).

Support

Some of the identified literature highlighted the various roles of general 'support' provided by chaplains. Religious, pastoral and/or spiritual support mostly involved 'being there' and 'reflectively listening' with clients as they explore various pastoral, religious and spiritual issues. A variety of literature noted that such support is often regarded by chaplains as being a very practical and valued intervention that is beneficial for client, their family and staff—particularly with regard to assisting client rehabilitation.

Kopacz et al. (2016) noted that 'those affected by MI may benefit from more than just conventional mental health services', positing that complementary and alternative medicines (CAM) such as spiritual care and, more particularly, pastoral care as a modality have some distinct advantages in that—for example: (1) pastoral care may help to resolve some of the dynamic issues underpinning MI (such as forgiveness and guilt), (2) that military and veteran personnel who have embraced a religious/spiritual identity (though this may not be always apparent), may utilise/spiritual/religious resources for coping/resilience, (3) and that personnel within the military are familiar (via the role of the chaplain) with pastoral care services/support (as are other organisations that employ chaplains) and thus are accustomed to a supportive role which (4) does *not* encompass an imposition of values or beliefs but is sensitive to the individuals own spirituality and sense of meaning and purpose (Kopacz et al. 2016, p. 31).

Handzo (2013), utilising the work of Herman (1997), noted a number of 'stages of recovery from post-traumatic experiences' and acknowledged the benefits that chaplains can provide via their spiritual/pastoral care to help support clients along the recovery process—namely by assisting with anxiety reduction, dealing with grief, forgiveness, and reconnecting with the community (refer Table 5).

While empirical research in the area of pastoral support by chaplains is limited, some descriptive research has been undertaken. A study by Hale (2013) exploring the professional services of chaplains within a Navy Bureau of Medicine and Surgery Hospital (Okiniwa, Japan) considered the level of trust by US military personnel with regard to chaplains providing appropriate spiritual support. From among the local population of 1200 navy employed personnel (navy officers, enlisted and government employed civilians) approximately 20 % ($n = 250/1200$: 20.83 %) responded to a question about whether they believed that their 'chaplain/pastoral care service' were best qualified to treat spiritual/moral injuries. The majority either 'strongly agreed' ($n = 112/250$: 44.9 %) or 'agreed' ($n = 101/250$: 40 %) with only a minority disagreeing or strongly disagreeing

Table 5 Spiritual care and moral injury in military service members

Role of Chaplains	Basic description
1. Anxiety reduction	Interventions involving for example spiritual chanting/mantram repetition, prayer, breathing exercises, music
2. Grief work	Assisting with a member's grieving given effects of trauma and loss of who he or she use to be and will never be again
3. Forgiveness	Assistance with acceptance of guilt, sin, confession, forgiveness and self-forgiveness, absolution, blessing
4. Reconnection	Reconnection and reframing of meaning in life with God, with individuals and/or previously associated communities (e.g., religious community)

Developed form Handzo (2013) based on Herman's (1997) 'Stages of Recovery' from traumatic experiences

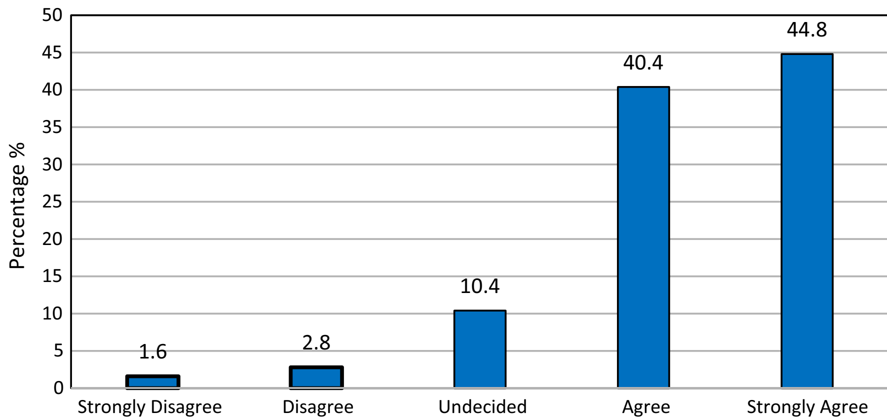

Fig. 1 Chaplaincy services treating spiritual/moral injuries. *Source*: Developed from Hale (2013). My chaplain/pastoral care services is best qualified to treat spiritual/moral injuries ($n = 250$)

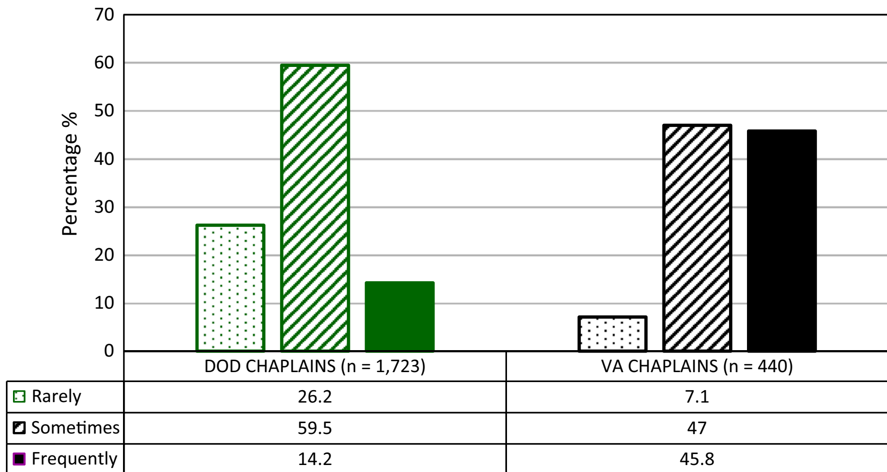

Fig. 2 Frequency of US DOD and VA chaplaincy involved in Moral Injury. *Source*: Developed from Nieuwsma et al (2013a). The Intersection of Chaplaincy and Mental Health Care in VA and DoD (Appendix II, p. 132). *DoD* Department of Defense (Army, Navy and Air Force), *VA* Department of Veteran Affairs

($n = 11/250$: 4.4 %) (refer Fig. 1). While the research (unfortunately) did not evaluate the level of respect for other professional groups (e.g., psychologists and social workers), the results nevertheless were considerably affirming for the role of chaplains.

A larger and more comprehensive study by Nieuwsma et al. (2013a, b; 2014), researching both Veteran Affairs' chaplains (VA: $n = 440$) and Department of Defense chaplains (DoD: $n = 1723$) involved in caring for retired veterans and military personnel with mental health problems, indicated that approximately 14 % of DoD chaplains and significantly more VA chaplains (approx. 45 %) *'frequently'* provided support to personnel suffering from MI (refer Fig. 2).

While it could be argued that frequency (i.e., 'frequently', 'sometimes' and 'rarely') and the type of interaction were not clearly research defined, nevertheless this result revealed a considerable workload for VA chaplains with regard to MI. Interestingly however, a

majority of DoD chaplains (59.5 %) acknowledged being involved 'sometimes' with military personnel suffering MI, which suggests a clear majority of military chaplains were connecting (even if only 'sometimes') with personnel whom chaplains believed were showing signs of MI (refer Fig. 2). Other results from this same study also indicated that the majority of both DoD (62 %) and VA chaplains (66.4 %) believed that their chaplaincy training made them 'very prepared' to provide pastoral support for those experiencing MI (Nieuwsma et al. 2013a, p. 132).

Counselling

In overall terms, a number of sources identified the role of chaplains and/or spiritual, religious interventions with regard to MI and (what could be referred to) as religious, spiritual or pastoral counselling. Such counselling in relation to MI would seem to be warranted given the evidence of Drescher et al's (2011) qualitative research involving a selected sample of health care and chaplaincy participants, a number of whom ($n = 11/23$: 48 %) identified spiritual/existential issues as indicating signs or symptoms of MI, namely 'giving up or questioning morality, spiritual conflict, profound sorrow, fatalism, loss of meaning, loss of caring, anguish, and feeling haunted' (Drescher et al. 2011, p. 11). Likewise, researchers such as Forbes et al. when summarising psychological and inter-disciplinary therapies (e.g., cognitive behaviour therapy, cognitive processing therapy and adaptive disclosure) identified the potential role of chaplains (along with others) with respect to 'spiritual, religious and social treatments' that 'aim to deal with social- and self-condemnation which are often accompanied by emotions of guilt, shame, remorse, regret and self-blame, experienced due to moral failures' (Forbes et al. 2015, pp. 14–15).

More specifically, Townsend (2015a, b), as a result of a number of interviews with various experts, noted that chaplains were usually considered to be at the 'front line' with regard to MI counselling. One reason for this is the advantage that personnel have when consulting with chaplains, as there is no appointment officially recorded (unless the counselee requests it) that would otherwise show up on medical documents or other records as would usually happen if they met with a physician or psychologist—thus chaplains, with no official record being collected, can ensure absolute confidentiality, which is considered a fundamental principle for chaplaincy (Carey et al. 2015b). Another aspect which Townsend noted was that MI counselling by chaplains is an expected role (particularly within the military), given that MI is essentially a spiritual existential crisis for which chaplains (given their studies in ontology, moral theology and ethics) are well trained and tasked to assist people—thus able to assist individuals to cope with issues such as guilt, shame, meaningfulness and forgiveness for themselves, of others and/or, of/or from God.

Previous research also indicated that military personnel and combat veterans are more likely to seek counsel from chaplains than traditional mental health providers because of the stigma associated with attending conventional mental health services and the high level of confidentiality provided by chaplaincy (CMI 2013; Carey et al. 2015b, pp. 687–688). Nieuwsma et al. (2013a, b) noted in their research about chaplaincy and mental health care (within US VA and DoD) that there were a number of frequently encountered problems for which personnel specifically sought assistance from chaplains (refer Table 6).

According to Schreiber, the cure for MI requires a different set of counselling skills from that which is provided by mental health professionals. Schreiber argued that the chaplain, as an extension of the church in the community, offers words 'of healing, comfort and absolution from all the bloodletting slaughter of war, to penetrate, cleanse and restore the conscience of the warrior from the battlefield' (Schreiber 2015, p. 22). Shay also noted

Table 6 Overview of problems encountered by Veteran and/or Military Chaplains

Relationship/family stress	Depression
Anxiety	Guilt
Work stress	Spiritual struggle
Physical health problems	Anger
Alcohol abuse	PTSD

Table based on Nieuwsma et al. (2013b)

that 'religious and cultural therapies are not only possible but may well be superior to what conventional mental health professions conventionally offer (Shay 2002, p. 152). Brock and Lettini (2012) argued that even veterans themselves were very much aware of the difference in perspective between a psychological approach and that relating to spirituality:

> Veterans with moral injury have souls in anguish, not a psychological disorder. Feelings of guilt, shame, and contrition were once considered the feelings of a normal ethical person. However, secular approaches tend to view them as psychological neurosis or disorders that inhibit individual self-actualization and interfere with "authentic" feelings and urges. Yet many veterans do not believe their moral struggles are psychological illnesses needing treatment. Instead, they experience their feelings, as a profound spiritual crisis that has changed them, perhaps beyond repair' (Brock and Lettini 2012, p. 51).

Education

Gladwin (2013a, b) points out in his Australian history text titled, 'Captains of the soul', that chaplains have historically and regularly been involved in the education and character training of military personnel (during peace and war campaigns), by teaching topics such as culture, ideology, religion, health, ethics, life skills and morality—'helping to calibrate the moral compass of soldiers, who have been authorised to use lethal force in increasingly complex situations' (p. 32). Through their educative role, chaplains can argue that historically and contemporarily, they have provided and continue to provide spiritual and moral leadership for the benefit of military personnel, for the improvement of military force organisations, and for the assistance of the wider community in which the majority of military and retired veterans reside—unfortunately it would seem that much of their chaplaincy educational work has received belated recognition (Reynaud 2014, p. 61).

Brock and Keizer (2015) acknowledged the potential educative tasks of modern day chaplains and clergy (i.e., religious leaders and seminarians) by recognising the important role that civilian religious communities can play to assist the development of 'moral pathways' that facilitate the 'soul repair' process for military and veteran personnel—from a state of 'lamentation towards reconstruction' of core values and self-worth. Puniewska (2015, p. 8) also provided an example of chaplains contributing to interdisciplinary community programs through events such as 'academic panels, exhibits and literary readings'. Other community education seminars (many of which were media recorded) involved local churches, theological colleges (Brock 2014a, b; Brock and Keizer 2015; Keizer 2010a, b) or alternatively chaplains speaking at community venues such as local golf clubs (Breitbarth and Entrekin 2013) or other 'non-stigmatising community setting' (Harris et al. 2015).

A particular contribution of chaplains revealed in the literature was that of educational retreats and extended seminars. McRae and Saunders (2014), for example, developed a

Table 7 Examples of educational moral injury rehabilitation programs

Author/s	Key program components	Spiritual practice
Verkamp (2006)	Examination of conscience Contrition Purpose of amendment Confession Absolution Penance	Ritual practice Conscience reflection Confession Absolution Penance
Brock et al. (2012)	Review of moral injury Getting into personal stories How does moral injury happen? The aftermath I will live with moral injury Soul Repair	Confession Forgiveness Absolution Penance
Dyer (2012)	Truth-telling Justice-Seeking Grace-giving Peace-making	Acknowledging spiritual authority Moral reflection and moral judgement Confession and confidentiality Forgiveness by moral authority Truth/restorative justice Rites of reconciliation Connection with God
Fuson (2013)	Building relationships Engaging cognitive and theological components of suffering Introducing grace Personal empowerment	Generating hope Considering pain, evil and abandonment Sin, acceptance and forgiveness
McRae and Saunders (2014)	What is moral injury and how is it different from PTSD Moral injury and spirituality Identity and belonging World views Military identity Moral injury and character Understanding beliefs and values Moral repair	Spiritual psycho-social-educational retreat Giving love Forgiving Listening Community
Bennett (2014)	Recovery versus deterioration Reflection versus depression Reconnection versus disconnection Reaffirmation versus depreciation Restoration versus destruction	Meaning reconstruction Moral injury repair
Hughes and Handzo (2014)[a]	Building relationship/safety Anxiety reduction Forgiveness Grief work Reconnection	Prayer Chanting Confession Forgiveness Reconnecting to God community

[a] Hughes and Handzo (2013) Spiritual care handbook on PTSD/TBI—Stages of recovery based on Herman (1997)

'moral injury and moral repair' eight lesson program for army personnel to help give soldiers an 'insight' as to 'what is going on in their heart and head' and to help them develop the language needed to articulate their struggles and feelings (refer Table 7). An independent evaluation of the program indicated that while there were some administrative

and facility issues, the majority of participants rated the program as ‘good’ and ‘relevant’, some noting that the program gave them the opportunity to talk to other people facing similar issues and ‘praised’ the opportunity to ‘spend time with the padres’ (Darragh 2014).

Likewise Fuson (2013) proposed a pastoral counselling seminar to be used by chaplains involved in the rehabilitating of post-combat soldiers who had experienced spiritual/moral injury[1] (refer Table 7). While the program also had rudimentary evaluations, Fuson concluded that those who participated believed that the topics covered assisted the felt needs of military personnel (Fuson 2013, p. 226). The need for a more comprehensive program evaluation was obvious, nevertheless of importance from this study and others similar to it, was that chaplains had devised and were involved in developing specialist intervention rehabilitation programs in an attempt to address spiritual/moral injury.

It is important to note of course that chaplains themselves can also suffer MI and need similar support. As noted by Schreiber (2015), ‘All chaplains are non-combatants. They do not (usually) carry a weapon. They do not kick in doors. They do not search and destroy and they do not shoot the ‘bad’ guys. Chaplains do not inflict violence, but they may suffer violence due to their proximity to the war zone and field of fire’ (p. 23). This is affirmed by Swinbourn (2015), an Australian Army Chaplain, who provided a powerfully honest account of his costly ‘compassion fatigue’ that self-accumulated after multiple deployments and which eventually led to an ‘erosion of moral conviction…sense of hopelessness…inability to fix things and a loss of trust in leadership’ (Swinbourn 2015, p. 93).

Other literature indicated that some chaplains (particularly those less experienced) were most likely to suffer compassion fatigue or burn out themselves from assisting clients suffering post-traumatic issues (e.g., MI), through the sheer exhaustion of providing intensely demanding services, plus not being accepted or fully integrated into mental health services, and thus experiencing a lack of appreciation for their contribution (Yan and Beder 2013).

The contribution of chaplains with regard to educational retreats has also been noted specifically *for* chaplains run *by* chaplains. Bennett (2014) noted in his research titled, ‘a post-conventional combat chaplain care model’, that ‘…combat trauma can shatter a chaplain’s traditional sense of spirituality’. He argued that ‘Deployed individuals in general, and chaplains in particular, can not only question the meaning and purpose behind the enormous scale of pain, suffering, and loss of life, but also bring their personal beliefs into question’ (Bennett 2014, p. 338). Given the effect of traumatic war-zone impact causing moral and spiritual injury to chaplains, Bennet proposed a week-long chaplain’s re-education retreat comprising a number of ‘stations’—each stage incorporating spiritual/religious considerations so as to ‘reconstruct meaning and moral injury repair’ (refer Table 7). Bennet’s argument was essentially:

> … all wounds both visible and invisible have an underlying spiritual connection that requires a spiritual solution …the root cause of trauma injury, like compassion fatigue and PTSD, affects the entire person, but is primarily spiritual in nature … if the problem is spiritual then the solution must at least include remedial processes that are spiritual in nature… (Bennett 2014, pp. 302–303).

[1] Fuson (2013) while noting ‘moral injury’ preferred the term ‘spiritual injury’ given the view that traumatic combat causes a fundamental violation of person’s religious/spiritual beliefs and values (e.g., thou shalt not kill/murder).

Ritual and Worship

Perhaps the most recurrent chaplaincy intervention, noted within the majority of identified resources, could be categorised as 'ritual and worship'. While for some the ritual and worship activity of a chaplain may be considered somewhat trite or an exercise in hubris, others would argue that, when it comes to moral injury, '*Chaplains are vital because they are acquainted with confession and contrition, with forgiveness and absolution, both at a corporate and an individual level*' (Coleman 2015, p. 212). Frame (2015b) argued that:

> The morally injured person can be debilitated by their injuries in a number of ways. He or she could abandon notions of right and wrong, good and bad, as they inhabit a world in which only legality defines morality. So a morally injured person could become completely hostile to all forms of authority and suspicious of every institution exercising any kind of power. The morally injured could be paralysed by unremitting guilt and unrelieved shame with no creative or constructive forms of confession and absolution, forgiveness and reconciliation (Frame 2015b, p. 60).

Brock (2014a, b) and Sippola et al. (2016) noted the particular importance of ritual and worship activities with respect to MI addressing guilt and shame, plus the role of clergy and religious communities assisting with the rehabilitation of those believed to be suffering MI. Brock argued that there were multiple overlapping losses that occurred for those suffering PTSD and/or MI (e.g., loss of closest friends, loss of role/purpose, loss of family/intimacy and loss of self). Some losses had direct spiritual relevance (e.g., loss of innocence or sense of goodness from a sinfulness and brokenness, loss of faith and loss/isolation from a meaningful religious/spiritual community).

To address these losses, Brock identified five main ways that clergy and religious communities could assist with renewal and/or transformation of individuals through ritual and worship: (1) helping people to be involved in the rhythms of the liturgical year which encourages renewal (helping to develop new neural pathways), (2) which can also lead to transformation via constant repetition of renewal, (3) the inclusion of sacramental structure for one's life (e.g., penance and absolution), (4) dramatic re-enactment and imagination of past sacred stories of redemption that correlate/relevant for the here and now, and (5) the power of art (in its many forms) to touch the heart and assist inner healing (Brock 2014a, b).

Mol (1976, 1983) argued that ritual and worship activities (whether these be corporate organisational rites/ceremonies or individual praxis) constituted an important 'sacralisation of identity mechanism' that is fundamental and common to all religious/spiritual beliefs and which help to provide a meaningful appreciation of and for life—irrespective of the particular culture, philosophy or theology—indeed some organisations adopt the inclusive creed of 'all faiths and none' (AFAN 2016). For chaplaincy, ritual activities have long been recognised as an important inclusion for the pastoral/spiritual care paradigm irrespective of faith or creed (Davoren, Carey and Cohen 2009).

Numerous authors noted the important role that ritual and worship activities have with regard to moral injury. Chang et al. (2014, p. 3) noted that ritual and worship activities such as reading religious scripts, helping people to confess their sins and responding to questions about religion, are all important methods that can be used to help military veterans (both active and retired) resolve spiritual issues. Chang et al. also noted a familiar role for chaplains that involved helping patients and families accept death and the process of organising funeral rituals (Chang et al. 2012, p. 275). Other authors also noted the

important place of prayer, confessions, contrition, penance, reconciliation, cleansing and healing rituals, forgiveness and grace, absolution and blessings (refer 'Ritual and Worship', Appendix 2: Table 9).

Administration

Perhaps a role and task gaining the least recognition within the literature was those relating to administration. Nevertheless, in order to achieve a considerable change in the lives of those suffering from MI, the administrative tasks of chaplains can assist the connection/neo-connection of individuals via referrals to 'new' or different support personnel, plus new communities (e.g., veteran associations, religious organisations)—which could be considered vital so as to assist with their adaptation, acceptance and ongoing support. Litz et al. (2009) and others (e.g., Drescher et al. 2007) affirmed the importance for those recovering from MI, to actual establish community connections and to be involved in group activities and/or spiritual communities in order to help people reconstruct their meaning and purpose.

Discussion

This research sought to explore the role/s, if any, that chaplains fulfilled with regard to MI as part of their spiritual care to military personnel and/or the wider community. In the process of seeking to achieve this objective, it was notable, as indicated by Stallinga (2013), that there is 'very little published research in the mental health literature on the role of clergy in response to persons suffering traumatic stress' (p. 27)—and as an extension, it would be fair to add that there is minimal empirical research with regard to chaplains and MI in particular.

However, the limited literature and resources identifiable from this scoping review confirmed that chaplains have, for many years, been addressing 'soul wounds', 'spiritual injury', 'spiritual distress', 'moral pain' (or other such nomenclature) suffered by military and veteran personnel—and now more recently the categorisation of 'moral injury'—something which looks to continue given the increasing interest in this field. Even given the limited amount of literature and resources obtained from this scoping review, the various chaplaincy roles identified seem, collectively, to fall within one or more of the expected WHO (2002) pastoral interventions codings—though few resources seemed individually to address all intervention categories. A summary overview of the literature results utilising the WHO pastoral care interventions with regard to MI is presented at Appendix 2 (Table 9).

It is important to note that only one reference could be found clearly opposed to chaplains being involved in MI. A representative from a minor Australian political party which acknowledged the importance of recognising MI—particularly with regard to the 'psychological, cultural and spiritual disconnect' that veterans experience—yet, ironically did not believe that MI was related to faith issues but rather was 'predominantly clinical'. Whish-Wilson argued: 'It should be made clear that while moral injury has been associated with chaplains, it is not inherently a matter of faith, and that the emerging study of moral injury is predominately clinical' (Whish-Wilson 2016).

While it is obvious that this argument is incongruent—namely that if MI is related to a 'spiritual disconnect', then it is intrinsically related to issues of faith; secondly, even if MI is pathologised as being 'predominantly clinical', it is therefore admitting that it is *not* exclusively clinical and thus any 'disconnect' of cultural, social and spiritual factors should

be encompassed as part of a holistic approach to rehabilitation, including those who are qualified to contribute (e.g., chaplains)—plus thirdly, it would also seem that holding such a position is in strong contrast to those who are suffering MI and to those actually responsible for providing care to military personnel and retired veterans suffering MI. As noted by one veteran association:

> The current paradigm of relying primarily on pharmaceutical medication and counselling is treating illness, but not addressing the "soul issues" of hope, identity and future purpose. The Chaplain or peer pastoral carer is able to assure the veteran of confidential treatment of their insecurities, their need to address guilt and reconciliation if needed, as well as help them to imagine new possibilities of life beyond their distress, or how to confront death with dignity (FADTCR 2016, p. 68).

Another dynamic arising from this scoping review was in relation to chaplains working with other healthcare professionals. Jacob (2013) states that 'the treatment of moral injury is a spiritual/emotional procedure' that should be appropriately dealt with by chaplains. Others such as Chang et al. (2014) in their qualitative research on spiritual distress of military veterans at the end of life note that 'Because spiritual distress usually manifests itself in such psychological symptoms as PTSD, it is often overlooked by mental health professionals'. Likewise Nieuwsma et al. (2013a) state:

> Additionally, there is a gap in how consistently issues of religion and spirituality are addressed by mental health and primary care providers. These providers often do not integrate religious and spiritual issues into the care of patients due to a lack of knowledge, awareness, and formal training in the importance of religious and spiritual issues for health. As such, there is a need for education among mental health and primary care providers regarding collaboration with chaplaincy services and with established community religious leaders (Nieuwsma et al. 2013a, p. 100).

Given the historical and the current extent of chaplaincy roles, plus the experience and tacit knowledge of chaplains indicated by this review, it would seem apt for other health professionals to work closely alongside chaplains to help military personnel and veterans who may be experiencing MI.

Research Limitations

For this exploratory review, a methodical literature and resource search was conducted of all the publically available electronic databases. Obviously however, private databases or secured government databases could not be accessed, given that some of the information would be considered too sensitive—and possibly leading to societal transparency, community reaction to the findings, damage to the reputation of a military force and/or possible costly government or insurance compensation—all of which fundamentally limits research being conducted and thus also limits the findings of this and other research. As previously acknowledged, the authors also recognise that an increasing amount of material regarding MI was being released and therefore additional material—both old and new—was and is constantly surfacing.

Further the goal of this scoping review was not to identify generalisable findings per se, but rather to explore the literature and resources relating to the utility and professional practice of chaplains with regard to moral injury. Most certainly additional research needs to be done to further this initial scoping review, plus additional support and funding needs to be applied to assist research that contributes to empirical findings with regard to MI and

the role of chaplains. As argued by Stallinga, 'the absence of research contributes to the isolation of chaplains from existing care teams in which they could play a crucial role' (Stallinga 2013, p. 27). It is the intent of the lead authors of this article to continue undertaking research into MI given that there are additional areas within and beyond the 'battlefield' to yet further explore (Devenish-Meares 2015; Dombo et al. 2013).

Epilogue

Fontana and Rosenheck (2004) based on the results of their PTSD research, suspected and concluded that '…one of the reasons that veterans continue[d] to seek mental health services [was] to obtain answers to existential questions concerning the meaning and purpose to their traumatic combat experiences and their subsequent lives—[and thus] mental health services should consider addressing spiritual losses as an integral part of treatment' (p. 583). Given the advent of moral injury potentially being accepted as a contributor to mental health issues, it would seem advantageous to proactively acknowledge (as did Fontana and Rosenheck over a decade ago) the particular expertise of pastoral counsellors/chaplains, '…because challenges to peoples' beliefs concerning the meaning and purpose of life are common sequelae of exposure to trauma, and these beliefs are rooted inherently in existential issues that are at the centre of religion and spirituality' (Fontana and Rosenheck 2004, p. 583).

Most certainly one could argue, given veterans who commit suicide post-deployment, that standard psychological/psychiatric services and treatment may not be as effective as most healthcare professionals would desire—and that perhaps spiritual and pastoral care services as implemented by chaplaincy departments should no longer be marginalised. Rather moral injury—no matter how it is defined—will more than likely take a combined effort of all professionals to properly assist those suffering its effects. Undoubtedly, as Nieuwsma suggests, this will require '…the creation and implementation of integrated models of care that will more optimally address the interrelations of spirituality with mental and physical health (Nieuwsma et al. 2013a, p. 100).

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Compliance with Ethical Standards

Conflict of interest The lead author regularly contributes to chaplaincy services and research within Australia and New Zealand.

Ethical Approval Ethics approval was granted by the University of Queensland Human Research Ethics Committee.

Human Subjects and Consent This research did not directly involve any human or other animal participants as research subjects.

Appendix 1

See Table 8.

Table 8 Examples of religious/spiritual screening and assessment tools available to military, veteran, health and community chaplains

Instrument	Key focus	Speciality
Guidelines for Spiritual Assessment (Stoll 1979)	Concept of God or Deity Sources of Hope or Strength Religious Practices Relationship—beliefs and health	Acute Nursing Chronic
Spiritual Injury Scale/Index (Berg 1992)	Guilt Anger or resentment Grief or sadness Lack of meaning or purpose Despair or hopelessness Feeling that God/life has been Religious doubt or disbelief Fear of death	Mental Health Spirit Injury Moral Injury
Spiritual Needs Assessment (Fitchett 1993)	Belief and Meaning Vocation and Obligations Experience and Emotions Doubt (Courage) and Growth Ritual and Practice Community Authority and Guidance	Clinical General
Maugens' Spiritual Screening (Maugans 1996)	S = Spiritual belief system P = Personal belief system I = Integration (with community) R = Ritualised (practices) I = Implications (for medical care) T = Terminal events planning	Clinical Chronic Illness Palliative Care
Spiritual Relationship Model (Larty 1997)	Spatial = with places and things Intra-personal = with self Inter-personal = with others Corporate = with organisations/among people Transcendence = with 'God'/'ultimate realm'	Multi-faith/cross-cultural Aged Care Palliative Care
Measure of Religious Coping (RCOPE) (Pargament, Koenig and Perez 2000)	Religious methods of coping to: Fine Meaning Gain control Gain comfort and closeness to God Intimacy with others and closeness to God	Mental Health Religious Coping
Spiritual History (Puchalski and Romer 2000)	F = Faith and Belief I = Importance C = Community Involvement A = Address care and action	Clinical
Spiritual Assessment Questions (Anandarajah and Hight 2001)	H = Hope—Sources of strength, meaning, love? O = Organised—Role of organised religion? P = Personal—Personal spirituality and practices? E = Effects—Effects of spirituality/beliefs?	Cancer Disability Chronic

Table 8 continued

Instrument	Key focus	Speciality
Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being Scale (Facit-SP) Peterman et al. (2002)	Themes: Sense of Peace/Peace of mind Meaning/Reason/Purpose Productivity Self-Comfort/Self-Harmony Comfort/Strength in faith/spiritual beliefs Illness strengthened faith/spiritual beliefs	Cancer Chronic Illness
Spiritual Needs Assessment Inventory for Patients (SNAP) Sharma et al. (2012)	Psychosocial Needs Spiritual Needs Religious Needs	Cancer Multi-faith
Spiritual Distress Scale Kopacz et al. (2015a) Kopacz et al. (2014a, b)[a]	Guilt Sadness/Grief Anger/Resentment; Despair/Hopelessness	Mental Health Veterans Moral Injury Suicide
Quality of Spiritual Care Scale (QSC) (Daaleman, et al. 2014)	Themes: Relationship with God/Loved ones Hope/Control/Coping Meaning/Peace Satisfaction/Value of Spiritual Care	Aged Care Palliative Caregivers

[a] Kopacz et al. (2014a, b) developed from Berg (1992) Spiritual Injury Scale

Appendix 2

See Table 9.

Table 9 Examples of literature and resources noting the religious, pastoral and spiritual interventions of Chaplains/Spiritual carers addressing moral injury

Chaplaincy interventions[a]	Authors/researchers[b]
Assessment	
Screening and Assessments Scales	Refer to Appendix 1
Support	
Establishing rapport/trust	Chang et al. (2014)
Narrative listening	Chang et al. (2014)
Advocacy	Ramsay (2015)
Spiritual resilience	Ramsay (2015)
Community	Ramsay (2015) and Brock (2011, 2014a, b)
Counselling	
Sorrow/grief/suffering/anxiety	Handzo (2013), Fuson (2013) and Drescher et al. (2011)
Shame and guilt	Gibson (2015) Puniewska (2015), Handzo (2013), and Forbes et al. (2015)
Alienation/isolation/ abandonment/relationships	Brock and Keizer (2015), Brock (2014a, b) and Fuson (2013)
Religious/spiritual issues	Fuson (2013), Schreiber (2015), Stallinga (2013), Brock (2011), Drescher et al. (2011) and Townsend (2015a, b)

Table 9 continued

Chaplaincy interventions[a]	Authors/researchers[b]
Confidentiality[c]	Townsend (2015a, b) and Carey et al. (2015b)
Personal Empowerment	Fuson (2013)
Education	
Personnel training/education	Gladwin (2013a, b) and Hodgson (2015)
Retreat/workshop/seminar	Denton-Borhaug (2015), Breitbarth and Entrekin (2013), Bennett (2014), Harris et al. (2015), Fuson (2013) and McRae and Saunders (2014)
Post-traumatic growth/education	Mendenhall (2010) and Breitbarth and Entrekin (2013)
Public and community education	Brock and Keizer (2015) and Brock (2011, 2014a, b)
Ritual and Worship	
Prayer/anxiety reduction	Stallinga (2013), Handzo (2013), Hughes and Handzo (2014) and Chang et al. (2012)
Confession/contrition	Handzo (2013), Coleman (2015), Chang et al. (2014), Verkamp (2006) and Antal and Winings (2015)
Penance/reconciliation/	Kinghorn (2012) and Verkamp(2006)
Cleansing and healing rituals	Puniewska (2015) and Sippola et al. (2016)
Reading sacred texts/scripts	Chang et al. (2014)
Forgiveness/grace	Handzo (2013), Coleman (2015), Townsend (2015a, b), Fuson (2013), Antal and Winings (2015) and Kopacz et al. (2016)
Absolution/blessing	Coleman (2015) and Schreiber (2015)
Remembrance and mourning	Stallinga (2013)
Spiritual/religious reconnection	Handzo (2013) and Chang et al. (2012);
Funeral preparation and rites	Chang et al. (2012)
Administration	
Connection/reconnection referral/neo-connections[d]	Handzo (2013), Hughes and Handzo (2014) and Carey et al. (2016)

[a] Chaplaincy interventions based on the major headings of the WHO-ICD-10 (2002) pastoral care codings and submission amendments (refer Carey and Cohen 2015)

[b] Authors/researchers: Some authors/researchers work covered multiple intervention codings

[c,d] Confidentiality and referral/neo-connections acknowledge the new and/or additional support required to assist an individual's life transformation following traumatic experience/moral injury

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