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Veterans, providers, moral injury, and the integration of spirituality in clinical care

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VETERANS, PROVIDERS, MORAL INJURY, AND THE INTEGRATION OF SPIRITUALITY IN CLINICAL CARE

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TABLE OF CONTENTS

Page

LIST OF TABLES

Page

LIST OF FIGURES

Page

DEDICATION

This dissertation is dedicated to my irreplaceable family (parents, siblings, and husband). Thank you for all your support, humor, and love. I could not have reached this milestone without each of you.

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ABSTRACT

Moral Injury (MI) is known to be prevalent among military populations, however, the integration of spirituality into the treatment of veterans with trauma/posttraumatic stress disorder (PTSD) is an understudied topic. This systematic review sought to explore how mental health clinicians and chaplains view the integration of spirituality in the course of clinical care with traumatized veterans who experience MI. Utilizing qualitative methodology, the existing knowledge base was studied to shed light on this topic and to also identify the similarities and differences between these types of providers. The meta-aggregation approach was applied to analysis of the available data and a total of 11 eligible articles were included. The results revealed that as a field, we know more about chaplain perspectives compared with mental health clinicians and that these disciplines seem to conceptualize and treat MI differently. Both provider types, however, appear to recognize that morality is a complex and relevant subject matter when treating this population. In addition, a thorough assessment of MI and its associated challenges is understood as a fundamental component of appropriate clinical care. Interdisciplinary collaboration and training opportunities between both disciplines were identified as areas of need. Another finding was that chaplains prioritize the integration of spirituality in their work with affected veterans, whereas mental health clinicians may or may not. Additionally, veterans' experience of meaning-meaning in the context of human suffering, and the concept of forgiveness were identified as pertinent outcomes of this study. It was clear that working with traumatized veterans affected by MI has the potential to have a significant impact on providers' own well-being. As such, this type of work calls for ethical and competent providers who are able to compassionately respond to the complexities of MI and the spiritual features potentially involved.

Keywords: moral injury, spirituality, PTSD, trauma, providers

Chapter 1: Background and Rationale

Statement of the Problem

Moral Injury (MI) has been defined many times in the literature since it was initially recognized by Shay in 1994, a military psychiatrist who identified a syndrome affecting veterans of the Vietnam war (Koenig & Al Zaben, 2021). Shay's (2014) original definition describes MI as, "A betrayal of what's right, by someone who holds legitimate authority, in a high stakes situation" (p. 183). Litz and colleagues in 2009 then later reported on MI in veterans of war and introduced a new definition of MI as, "the lasting psychological, biological, spiritual, behavioral, and social impact of perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" (p. 695). Since 2009, this subject has gained significant traction in both clinical and academic arenas (Koenig & Al Zaben, 2021). Interestingly, the topic has been explored among a broad range of disciplines including psychology, psychiatry, social work, philosophy, and the religious/spiritual professions (Griffin et al., 2019). Although the concept continues to garner significant attention in the area of trauma studies, no definitive agreement has been reached on what exactly MI entails (Griffin et al., 2019).

When people engage in war, they may be forced to engage in acts that violate personal moral beliefs in the course of following occupational responsibilities and orders from other military personnel in positions of authority and superior ranking. The types of acts that war involves, such as killing, would be considered immoral in other life contexts (Drescher et al., 2011; Litz et al., 2009; Maguen et al., 2011). Research indicates that other various stressors could be relevant in understanding MI. These stressors might include being exposed to severe human suffering that is characteristic of war, behaving in ways that are morally ambiguous in

response to quick decision-making, bearing witness to or personally acting in an excessively and unnecessarily violent manner, being involved in events that caused harm to civilians, being unable to stop others being harmed, or experiencing betrayal from people in trusted positions (Currier et al., 2015b; Drescher et al., 2011; Litz et al., 2009).

As a result of these complex stressors, cognitive dissonance may be experienced as one's actions were not consistent with personal moral beliefs (Drescher et al., 2011). If this dissonance continues without resolution, a variety of problems can ensue (Drescher et al., 2011; Litz et al., 2009; Nash & Litz, 2013a; Vargas et al., 2013). Research to date has shown that MI appears to have a broad impact on a person's life including in affective, cognitive, and behavioral domains (Drescher et al., 2011; Harris et al., 2015; Maguen & Litz, 2014; Nash et al., 2013a). In combat veterans who present with persistent mental health struggles, the research suggests that MI tends to be more prevalent in individuals who experience trauma-related events (Drescher et al., 2011; Harris et al., 2015). The specific types of issues that affect the individual include a range of difficulties with social and occupational functioning, problems trusting self, others, and institutions, and spiritual or existential concerns (Drescher et al., 2011; Farnsworth et al., 2017; Harris et al., 2015; Maguen & Litz, 2014; Nash et al., 2013a).

In general, the inclusion of the adverse impact of trauma on one's sense of morality has largely been excluded in conceptualizations of the aftermath of trauma. Nash (2019) critically highlights that since the 1940's the field of traumatology has seemingly neglected to address the moral facets of trauma in research and practice. He also asks why there has been a deliberate distancing in the field in struggling to understand the influence of morality in defining trauma as opposed to the existing narrow focus on the fear-based aspects after being confronted with the threat or experience of death (Nash, 2019).

Quite strikingly, in every set of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* diagnostic criteria for posttraumatic stress disorder (PTSD) between 1980 and 2013, the extreme moral dilemmas experienced in many traumatic experiences have not been mentioned as relevant to a person's exposure to traumatic events (Nash, 2019). Neither were any changes made in this regard in the most recent text revision published in 2022 (*DSM-5-TR*; American Psychiatric Association, 2022). Concerning the PTSD diagnostic criteria in the DSM-5, painful moral emotions are only considered a part of the clinical picture if this occurs in response to death that has taken place or been threatened, serious injury, or violence of a sexual nature. The impact of serious moral betrayal is otherwise blatantly ignored (Nash, 2019). Mental health clinicians and chaplains, however, are still confronted with the complicated reality of MI when veterans seek their services. Understanding how these disciplines approach this phenomenon in the course of their professional duties seems imperative to ensuring veterans receive appropriate care.

Overview of Current Research, Theory, and Practice

History of Military Traumatic Stress and Moral Injury

An important aspect of the discussion on MI involves its history in human experience. Although the MI construct has a relatively recent history in the field of psychology and psychiatry, such experiences can be presumed to have existed since ancient times (Drescher et al., 2011; Richardson & Lamson, 2021). Nevertheless, the formal recognition of MI in the fields of psychology and psychiatry was preceded by a more general understanding of psychological distress that could occur in the context of military trauma. Given that PTSD rates in the military population have been found as high as 38.2%, it seems especially important to understand the

history of military trauma and how MI can be traced up to the present time (Andrews et al., 2007; Drožđek et al., 2020).

The first recorded description of trauma symptoms in the military emerged during the Civil War (1861 and 1865) in the United States of America. The term “nostalgia” was used to describe and diagnose the soldiers who showed signs of despair, struggled to be away from their home, experienced sleep difficulties, and endorsed sad mood and symptoms of anxiety (Friedman, 2018; Richardson & Lamson, 2021).

World War I was the next point in history when psychological distress in the context of war was studied. The symptoms now defined as PTSD were referred to as “shell shock” as soldier reactions were viewed as being directly caused by the explosions they were exposed to during combat. This perspective later transitioned, however, when treating clinicians discovered that other soldiers presented with the same symptoms despite a lack of exposure to explosions (Friedman, 2018; Richardson & Lamson, 2021).

World War II was another episode in history that supported the need to examine the psychological impact of war. The terms used to describe PTSD-type symptoms included Combat Stress Reaction (CSR) and “battle fatigue,” as soldiers were viewed as having become exhausted from the long distances they needed to travel during the course of their duties (Friedman, 2018; Richardson & Lamson, 2021).

It was not until 1980 that the American Psychiatric Association (APA) defined PTSD as a clinical syndrome officially in the DSM system (*DSM-III*; Friedman, 2018; Richardson & Lamson, 2021). This diagnosis emerged from studying a wide variety of people affected by traumatic stress, which included veterans from the Vietnam War, Holocaust survivors, and

sexual assault survivors (Friedman, 2018; Richardson & Lamson, 2021). The PTSD diagnosis has since evolved with further research and updated versions of the *DSM*.

Outlining the history of how war-related trauma has been defined is relevant because of the more recent emergence of the MI construct, which itself has likely existed as long as the history of wars yet is only now gaining appreciation in the treatment of those who are affected by it. Importantly, however, inadequacies of the existing *DSM-5 PTSD* diagnosis in capturing the extent of the impact of military trauma must be noted given that MI represents experiences that go beyond mere psychiatric categorical symptoms. For this systematic review specifically, the influence of spirituality and its inclusion in the treatment of trauma/PTSD when veterans also present with more complex symptoms such as that of MI, is a central consideration.

Common Themes Across 12 Definitions of Moral Injury

Richardson et al. (2020) found the following common themes that have emerged from the 12 definitions of MI they studied from the existing literature:

- *Ethics:* are involved in terms of a person's struggle to comprehend issues of right and wrong.
- *Betrayal:* can be experienced on an intrapersonal and/or interpersonal level, sometimes also occurring at the same time.
- *Orientation:* refers to how the individual makes sense of their own beliefs surrounding morality and how this maps on to the morally injurious event(s).
- *Reconciliation:* involves the ways in which a person's belief system can be restored in the aftermath of morally injurious events.
- *High-stress environments:* tend to characterize the context in which morally injurious events take place.

- *Spiritual wound:* relates to how MI can be experienced by veterans as a spiritual matter.
- *Psycho-behavioral wound:* refers to the psychological symptoms that result from the morally injurious event(s).

Moral Injury and Key Life Domains Impacted

An integrative review that synthesized important studies of MI (Griffin et al., 2019), distinguished four broad categories that offer a framework for increasing clarity about this developing concept and how it impacts the individual. These categories include: (a) psychological and behavioral; (b) social; (c) religious/spiritual; and (d) biological.

Psychological and Behavioral Health Domains. It is proposed that individuals who experience MI are at a higher risk of developing a variety of mental health disorders and potentially life-threatening outcomes. While MI can be distinguished from PTSD as a clinical syndrome, it is also apparent that it can co-exist with it. Psychological symptoms specific to MI may include a range of PTSD symptoms, dysphoric mood, anxiety, anger, self-loathing, self-injurious and suicidal behaviors, other types of behavior that demonstrate a pronounced lack of self-care, and reports of demoralization (Drescher et al., 2011; Harris et al., 2015; Litz et al., 2009; Maguen et al., 2011; McEwen et al., 2021; Nash et al., 2013a; Sher, 2009).

Externalizing problems have also been linked to MI including aggression directed towards others as well as engagement in drug and alcohol use (Griffin et al., 2019). Other issues can include social withdrawal, aggressive behavior, conduct problems, misuse of substances, and sociopathy (Harris et al., 2015; Maguen & Litz, 2014; Nash et al., 2013a). The complications of MI can additionally result in sleep disturbances and issues with quality of life directly impacted by poor mental health (Hall et al., 2021).

Social Domain. In this category, persons with MI may perceive or actually experience rejection by family or friends. Veterans may develop a sense of resentment on returning to civilian life due to feeling their military experiences are not understood within the civilian population. Additionally, a loss of trust can occur in a pervasive way to include those in positions of authority within the military, romantic partners, the government as a whole system, and society more generally. Impaired social functioning may occur due to significant challenges experienced with community engagement and a decline in the quality of personal relationships (Griffin et al., 2019).

Religious/Spiritual Domain. Spiritual and existential concerns that are also connected to the experience of MI can include issues involving guilt, shame, forgiveness of oneself and/or others, spiritual or religious beliefs impacted in terms of change or rejection of such, questioning trust in oneself or others to behave in morally appropriate ways, losing sight of the meaning or purpose of life; developing a fatalistic attitude, religious fears, and problems forming or maintaining relationships with people connected to a faith community of personal significance (Drescher et al., 2011; Harris et al., 2015; Nash et al., 2013a; Ogden et al., 2011). Individuals may experience cynicism and doubt about their religious/spiritual beliefs, feeling that God is no longer present and has abandoned them.

Additionally, the affected individual may feel distressed that their actions represent a transgression of the ethics of their particular religious/spiritual belief system. Religious/spiritual coping may also be used in a maladaptive way and can complicate the person's ability to heal from the morally injurious experience(s). For example, a person might come to believe they are beyond forgiveness (Griffin et al., 2019). It would seem a reasonable assertion that such matters

are complex in nature and challenging for mental health clinicians and chaplains alike in the course of their work with veterans.

Biological Domain. There are limited studies available that illuminate relevant biological aspects of MI. One specific area of concern, however, involves how MI interacts with stress-related illness. An accepted view is that MI may influence the onset and/or progression of stress-related illness (Ferrajão, 2017). For instance, Ferrajão (2017) points out that war veterans appear to be afflicted by chronic physical conditions, such as high blood pressure, diabetes, and asthma, more commonly than is found in the general population. Some evidence seems to indicate that physical distress can be decreased by processing the person's experiences (Ferrajão, 2017; Yan, 2016).

Based on these domains of a person's life, it is clear that MI has broad implications for the veterans it affects. It is evident that religion and spirituality are no less important in terms of a person's holistic well-being. As such, this systematic review will focus on how mental health clinicians and chaplains approach the spiritual domain with veterans seeking support with MI in the aftermath of trauma.

Moral Injury, Posttraumatic Stress Disorder, and Diagnostic Considerations

The concept of MI has gained attention from clinicians and researchers alongside debates regarding the adequacy of the PTSD diagnosis in capturing the far-reaching implications of how humans experience and react to traumatic life events. It is imperative to highlight that the proposed criteria for a new diagnosis of complex PTSD (CPTSD) in the World Health Organization's (WHO) *International Classification System for Diseases (11th ed.; ICD-11*), has been accompanied by a concurrent interest in and expansion of the concept of MI (Currier et al., 2021). The goal of this approach has been to account for the greater complexity in symptom

profiles typically seen in the aftermath of traumas involving chronic or repeated experiences, particularly of an interpersonal nature (Currier et al., 2021).

Concerning veterans specifically, one study found that out of a sample of 177 veterans from the United Kingdom who sought mental health treatment, 70% met the diagnostic criteria for either PTSD or CPTSD. Out of these veterans, the authors discovered that the majority (56.7%) could be diagnosed with CPTSD as opposed to PTSD (14%) (Murphy et al., 2020). The results would therefore suggest that veterans may present with a broader range of trauma symptoms than can be captured with the current *DSM-5* PTSD diagnosis. Critically, MI-related presentations could be especially relevant in understanding the mental health experiences of veterans who report more complex emotional difficulties that may fit more appropriately with a CPTSD diagnosis (Currier et al., 2021).

One of the most urgent issues emerging from the literature on PTSD and MI thus far, concerns how these experiences are viewed as related, distinct, or overlapping. Researchers are in the process of investigating whether the existing *DSM-5* diagnostic criteria of PTSD already depict the essence of MI symptoms without having to define MI further. It has been argued that the current PTSD diagnostic criterion D (defined as negative changes in a person's thoughts and mood that started or worsened following the trauma; APA, 2022), already addresses the meaning-making processes that individuals with this disorder might experience. How a person makes sense of their trauma, for instance, has an impact on whether or not they engage in self-blame and may affect their view of themselves and the world around them (Neria & Pickover, 2019).

Other studies, however, have suggested there may be a distinct difference between moral injury-based traumas when compared with danger-based traumas. The proposed distinction is

that danger-based traumas are centered around threat to one's own and/or another person's life, whereas moral injury-based traumas are experienced as involving a sense of wrongdoing (Held et al., 2019; Stein et al., 2012). Given that military roles may involve the act of killing in the course of combat, this can be considered a different type of traumatic experience than a threat-based trauma (Farnsworth et al., 2017; Purcell et al., 2016).

Essentially, there is a growing understanding that acts of perpetration are likely to be fundamentally different experiences than those involving danger, fear, sustained stress, and witnessing the suffering and/or death of others (Farnsworth et al., 2017; Friedman et al., 2011). It is also remarkable to highlight that research has uncovered feelings of supremacy, physiologically aroused states, and experiences of transcendence in veterans who have killed during war. This is in stark contrast to those who instead experienced revulsion as well as enduring feelings of ambivalence about their acts of killing despite being permitted by military rules of engagement (Farnsworth et al., 2017).

Another way to view MI and its relationship with PTSD is to consider how different symptoms may function for the affected individual. For example, avoidance of others/public spaces may occur because of fear-based symptoms of PTSD and the need to feel safe, whereas such behavior in a person experiencing MI may be to avoid feeling shame or may stem from a fear of exposing others to the presence of evil (Farnsworth et al., 2017).

In adding to this perspective, the literature suggests there are other hallmark symptoms of PTSD that do not correlate clearly with MI. For instance, it is uncertain whether or not hyperarousal symptoms are related in their content or function (Farnsworth et al., 2017). This argument reinforces the view that MI has distinct features that differentiate it from the threat-based responses involved with PTSD. Mental health clinicians and chaplains, therefore, need to

be able to appropriately recognize the types of issues they are faced with when traumatized veterans seek their support.

An essential reason for exploring MI is to support mental health clinicians' and chaplains understanding of what it entails and what this means for the support provided to veterans. There are concerns that psychological treatments for PTSD may not be adequate in helping a person address their experience of MI. Current treatments by mental health clinicians place a heavy emphasis on correcting maladaptive cognitions and attempting to decrease a person's fear (Farnsworth et al., 2017). Unfortunately, while these types of treatments may prove helpful in reducing PTSD symptoms, those suffering the effects of MI specifically might continue to do so until they are able to access treatment approaches that can effectively address these profoundly distressing experiences. It is helpful to consider, therefore, the approaches of both mental health clinicians and chaplains, and how these disciplines interface when supporting veterans with MI.

It is important to note that focusing initially on PTSD symptom reduction may be an appropriate response for many treatment-seeking veterans given the interactions that are likely to occur between PTSD and MI-related concerns (Currier, 2014). Once PTSD symptoms are adequately managed, treatment may then need to explicitly shift direction to address the anguish being experienced by the veteran when MI appears to be the remaining feature of the presenting problem (Currier, 2014). The challenge for mental health clinicians is the extent to which they feel adequately prepared to respond to concerns of an MI nature, particularly those of spiritual significance. Chaplains, on the other hand, are already set up in their profession to approach spiritual matters as a natural aspect of their work.

Assessment of Moral Injury in Professional Practice

Though MI is still a developing concept, it is also an accepted reality in the veteran population among those who have been impacted by war experiences. As such, it is imperative that mental health clinicians and chaplains have access to appropriate tools that enhance their ability to identify this issue when a veteran presents for treatment. For the purposes of this systematic review specifically, assessment measures of MI are of particular interest in terms of understanding whether or not spiritual aspects of the syndrome are acknowledged and explicitly incorporated by relevant providers.

Psychiatrist William Nash and his colleagues were the first to develop a measure of MI, which is known as the Moral Injury Events Scale (MIES), from their work with active-duty United States (US) Marines (Koenig & Al Zaben, 2021; Nash et al., 2013b). This scale consists of 11 items, nine of which address a person's perception of moral beliefs having been violated or betrayal by the self or other people. The other two items focus on perceptions of trust (Nash et al., 2013b). The Moral Injury Questionnaire-Military version (MIQ-M) was developed out of studies conducted with US veterans (Currier et al., 2015b, 2015c; Koenig & Al Zaben, 2021). There are 20 items in this scale that assess (a) acts of betrayal (five items); (b) acts involving disproportionate violence perpetrated against others (five items); (c) civilian deaths and/or incidents of harm (four items); (d) within rank violence in the military (two items); (e) inability to prevent the suffering or death of others (two items); and (f) experiences involving moral conflicts/ethical dilemmas (four items).

These scales were then followed by the development of the Moral Injury Symptom Scale-Military Version-Long Form (MISS-M), which has 45 items that are separated into 10 subscales that measure, "guilt, shame, feelings of betrayal, moral concerns, religious struggles, loss of

religious faith/hope, loss of trust, loss of meaning/purpose, difficulty forgiving, and self-condemnation" (Koenig et al., 2018a, p. 253). The Moral Injury Symptom Scale-Military Version-Short Form (MISS-M-SF) is an abbreviated version of the MISS-M consisting of 10 items (Koenig & Al Zaben, 2021; Koenig et al., 2018b).

The Expressions of Moral Injury Scale-Military Version consists of 17 items (EMIS-M, also available in a four-item version) that assess beliefs, attitudes, emotions, and behaviors a veteran experiencing MI directs at themselves and others (Currier et al., 2018; Koenig & Al Zaben, 2021). MI symptoms considered as directed at the self (for example, guilt and shame) and other symptoms directed elsewhere (for example, anger and betrayal), are assessed with these scales.

As is apparent from the overview of these assessment measures, only the MISS-M-LF and the MISS-M-SF scales include items that address religious or spiritual matters (Koenig & Al Zaben, 2021). Essentially, as it stands, formal assessment measures do not consistently address spiritual and religious concerns in persons presenting with MI. As previously noted, however, spiritual and existential issues are commonly connected to MI. Thus, the absence of items/subscales routinely assessing this domain in currently available MI measures is problematic both from the standpoint of enabling providers to detect MI in the course of PTSD treatment, as well as addressing religious and spiritual concerns that may come to light and so that treatments can be further appropriately tailored. Mental health clinicians and chaplains alike appear to play a critical role in the assessment process for veterans with MI.

Treatments Available for Moral Injury

Currently, available first-line treatments for PTSD are known to produce only moderate improvement in approximately half of the individuals who are treated for this clinical syndrome

(Bradley et al., 2005; Neria & Pickover, 2019). Additionally, research demonstrates that these treatments are even less effective for military members diagnosed with PTSD (Neria & Pickover, 2019; Steenkamp et al., 2015). Given the developing evidence that MI symptoms likely exist alongside PTSD in at least some individuals with the disorder, it is critical to determine whether existing PTSD treatments are adequate in effectively helping those who present also with MI issues. If existing PTSD treatments are inadequate in effectively responding to MI, there appears to be an ethical duty to patients to develop other approaches that deliver more appropriate and specialized interventions for this population (Neria & Pickover, 2019). This is where an increased understanding of the inclusion of spirituality in the course of treatment of PTSD and MI may offer a critical missing piece of the treatment puzzle. It is important to provide an overview of the existing treatments offered to veterans who experience MI given that providers need to be able to support veterans to address both the psychiatric symptoms of PTSD as well as issues of MI.

Secular Approaches. In terms of predominantly secular treatments, there are a variety of options available for mental health clinicians to utilize. Cognitive Processing Therapy (CPT) is one of the most commonly applied evidence-based treatments provided in military settings. The treatment focuses on processing problematic thoughts and emotions associated with the veteran's trauma by identifying "stuck points" that interfere with the veteran's ability to integrate the experience and move forward in a more adaptive way in their lives. In the most recent version of CPT, clinicians are provided with tools to address MI symptoms. For example, matters of guilt, forgiveness of self and others, inappropriate or excessive self-blame, and religious struggles are all areas the treatment can tackle (Koenig & Al Zaben, 2021) Sessions typically last one hour and are usually delivered individually to veterans on a weekly basis.

Prolonged Exposure (PE) is the other treatment widely utilized in military contexts. It involves repeatedly exposing the individual to their trauma through the use of imaginal and in-vivo exposure techniques. The goal of the therapy is to promote habituation via the repetitive exposure method so that the person eventually no longer feels distressed by exposure to the traumatic material. MI issues can also reportedly be addressed with PE (Held et al., 2018; Koenig & Al Zaben, 2021; Paul et al., 2014). Treatment addressing MI more specifically is administered in a one-to-one format over nine, 45-minute weekly sessions using the same techniques as described. An example is the use of in-vivo exposure techniques to help the veteran reconnect with values important to them (Norman & Maguen, 2021). The PE manual (Foa et al., 2007, as cited in Evans et al., 2021), outlines three areas in a person's life that tend to be avoided in the context of MI and can be addressed via the use of in-vivo exposure. These include situations the individual views as unsafe, causes the person to remember the trauma(s), and loss of interest in activities that were formerly enjoyable (Evans et al., 2021). Values-based behavioral activation can be utilized to encourage a return to such experiences that were previously fulfilling for the veteran (Evans et al., 2021). There are few published case reports, however, that have shown evidence to support the effectiveness of PE in treating MI (Koenig & Al Zaben, 2021).

In Adaptive Disclosure Therapy (ADT), emotion-focused cognitive behavioral techniques are used to support veterans and those still on active military duty to integrate and find resolution to the moral injuries they are exposed to during war (Koenig & Al Zaben, 2021; Litz et al., 2017). Participants are asked to discuss and process their memories and experiences of war, while simultaneously challenging maladaptive cognitions concerning the traumatic memories and moral violations. Examples of such cognitions include, "I am an evil person," or

"I don't deserve to be happy after what I did." Treatment is delivered across a series of six, 90-minute individual treatment sessions (Koenig & Al Zaben, 2021).

Acceptance and Commitment Therapy (ACT) helps the individual adapt to their circumstances, enhance their quality of life, and can also focus on MI as part of the presenting issues. Mindfulness is emphasized as an integral aspect of treatment. Living according to one's values is another essential component of the approach. The clinician is tasked with encouraging the veteran to engage in increased flexibility in their thoughts and behaviors as opposed to rigidity, specifically in relation to concerns of a moral nature. For instance, veterans presenting distorted beliefs involving themes of guilt and shame about conduct in the course of deployment may be a focus. The six central tenets of the treatment include clarification, commitment to action, a focus on acceptance, the principle of defusion, attention to the present moment, and understanding self-as-context. Treatment can be administered in both individual and group therapy sessions (Koenig & Al Zaben, 2021).

Cognitive Behavioral Therapy (CBT) can include a variety of approaches in addressing MI experienced by veterans. An example is the Impact of Killing (IOK) in war approach that is delivered on a one-to-one basis with the veteran. The goal of this specific CBT-based treatment is to support the veteran to experience relief from the guilt and shame associated with this act in the context of war (Koenig & Al Zaben, 2021; Maguen & Burkman, 2013; Maguen et al., 2017; Purcell et al., 2018). Treatment focuses on helping veterans to forgive themselves and engage in repair actions where this is possible and appropriate. Cognitive restructuring is utilized to undermine dysfunctional beliefs that are at the root of the veteran blaming themselves for death that occurred during wartime. Themes of acceptance and grief are also addressed in this therapy approach (Koenig & Al Zaben, 2021).

Healing Through Forgiveness (HTF) incorporates strategies from both CPT and PE and involves both the veteran and their family members (most often the spouse). Treatment is delivered over 12 sessions on a once-weekly basis (Grimsley & Grimsley, 2017; Koenig & Al Zaben, 2021). HTF addresses PTSD symptoms as well as MI via structured sessions with a specific topic for each week including the person's trauma memories, how to deal with guilt and shame, the role of the subconscious, the role of forgiveness and fear, and their relationship to anger, and family topics (Koenig & Al Zaben, 2021).

Eye Movement Desensitization and Reprocessing (EMDR) therapy has also reportedly shown some success in terms of veterans who received the treatment to help them work through PTSD and MI issues (Hurley, 2018; Koenig & Al Zaben, 2021; Shapiro & Laliotis, 2015).

Secular and Religious/Spiritual Combined Approaches. Additionally, there are a variety of integrative treatments available to address MI, which involve combining secular treatment with religious/spiritual components. Building Spiritual Strengths (BSS) is a manualized group therapy treatment that is typically provided in faith community settings. It was developed to alleviate the distress associated with PTSD and MI. This treatment is flexible in the sense that either mental health professionals or chaplains/clergy who have received mental health training can provide this treatment (Koenig & Al Zaben, 2021).

Spiritually Integrated CPT (SICPT) is a manualized, structured, individual treatment intervention provided over approximately six to 12 weeks in sessions lasting 50 minutes (Koenig & Al Zaben, 2021; Koenig et al., 2017). A mental health professional delivers the treatment, which focuses on the integration of spiritual/religious matters to treat MI while also treating PTSD. The veteran's spiritual/religious beliefs are deliberately utilized to support the processing of the trauma and the associated maladaptive cognitions (Koenig & Al Zaben, 2021).

In Religiously Integrated CBT (RCBT), neither PTSD nor MI are specifically addressed. The treatment instead focuses on depression, which commonly co-exists alongside MI. Maladaptive thoughts and assumptions, as well as negative behaviors that frequently maintain depression, are the treatment targets (Koenig & Al Zaben, 2021). There are seven major tools utilized in RCBT. Patients are taught a technique called "Renewing of the Mind," which encourages a focus on the person's religious teachings to substitute negative, erroneous thoughts with uplifting principles from scripture (Pearce et al., 2015). Patients can also be asked to memorize a passage from scripture and taught how to meditate on these passages. Drawing on the patient's religious resources that "encourage forgiveness, gratitude, generosity, and altruism" is another aspect of the treatment (Pearce et al., 2015, p. 59). Other behavioral practices, for example, prayer and engaging with the spiritual concept of "walking by faith" rather than feelings, are incorporated (Pearce et al., 2015). Another intervention involves the use of various other religious/spiritual resources that might include, for example, "meditation…engaging in charity, and attending religious services or activities" (Pearce et al., 2015, p. 59). Last, the patient is encouraged to identify a person they can lean on for support within their religious community (Pearce et al., 2015).

Religious/Spiritual Approaches. Religious/spiritual interventions are additionally available to treat MI in military settings and are delivered by clergy and chaplains who have received training in mental health. These professionals are considered ideally placed to support veterans with issues of MI due to the moral component involved. One such approach is Pastoral Narrative Disclosure (PND), which allows for the sacrament of penance to be utilized as a way to support the emotional and moral healing of veterans experiencing MI (Carey & Hodgson, 2018; Koenig & Al Zaben, 2021). It reportedly provides a way for veterans to focus on

absolution, forgiveness, and cleansing. PND is therefore based on the confessional model found within religious faith traditions for veterans to utilize upon their return from war (Koenig & Al Zaben, 2021; Verkamp, 2006). The confessional terminology has reportedly been neutralized in order for it to be suitable for patients regardless of spiritual faith identification (Koenig & Al Zaben, 2021).

Moral Injury Reconciliation Therapy (MIRT) is delivered over a course of five sessions that focus on identification and awareness of the MI that has occurred; the role of confession; supporting the individual to engage in meaning-making; facilitation of repair, forgiveness, grief, and humanitarian considerations; and reconciliation through the development of spiritual habits (Koenig & Al Zaben, 2021; Lee, 2018). PTSD and the specific issues associated with sexual trauma are also accounted for in this approach (Koenig & Al Zaben, 2021).

Moral Injury Group (MIG) is provided over 12 weeks of 90-minute group sessions. Both a psychologist and chaplain deliver the treatment and they focus on the psychological, moral, and spiritual concerns related to MI that have occurred in a military context (Cenkner et al., 2020; Koenig & Al Zaben, 2021). Psychoeducation is provided about MI and a variety of topics are explored including "moral emotions, moral values, moral dilemmas in moral disengagement (including spiritual struggles)" (Koenig & Al Zaben, 2021, p. 3004). Participants are also provided the space to explore the role of their spirituality and how this interacts with their military experiences. A key focus of the treatment is to normalize moral pain that results from combat by supporting veterans to understand that the society the veteran has acted in defense of also shares in the burden of warfare. The treatment finishes with a chapel service at a VA and can be attended by loved ones as well as members of the public (Koenig & Al Zaben, 2021).

Structured Pastoral Care (SPC) is a manualized and structured approach delivered on a one-to-one basis by chaplains and has been developed to treat veterans struggling with MI and prominent PTSD symptoms (Ames et al., 2018; Koenig & Al Zaben, 2021). Twelve, 50-minute sessions are provided once or twice weekly across a period of six to 12 weeks. The intervention is religion-specific and is available in a variety of religious versions including Christian, Muslim, Jewish, Hindu, and Buddhist. Original scriptures are drawn upon from the relevant religious tradition to address the following ten manifestations of MI: "guilt, shame, moral concerns, feelings of betrayal, lack of trust, lack of meaning, difficulty forgiving, self-condemnation, religious struggles, and loss of religious faith" (Koenig & Al Zaben, 2021, p. 3005). The chaplain then starts with the least distressing aspect of the MI for the individual and focuses on eight treatment modules including: "conviction, lamentation, repentance, confession, forgiveness, reconciliation, atonement, recovery, and resilience" (Koenig & Al Zaben, 2021, p. 3005).

While there is a diversity of treatment options available, both secular and spiritual in nature, the extent to which both mental health clinicians and chaplains are able to integrate and competently engage with the issues involved with PTSD and MI remains unclear. Additionally, it is critical to understand how the integration of spirituality when addressing MI is viewed by mental health clinicians and chaplains who encounter it in the course of their professional duties.

Spiritual Considerations in Understanding Moral Injury

Critical to this systematic review, one of the most contested matters in conceptualizing MI concerns whether or not spiritual symptoms should be included as a fundamental aspect of it (Koenig & Al Zaben, 2021). Studies of a cross-sectional and longitudinal nature have demonstrated that individuals report a higher rate of PTSD symptoms when also experiencing

spiritual distress (Harris et al., 2008; 2012, 2015; Ogden et al., 2011). Additionally, mental health prognosis tends to be poorer for individuals who experience a loss of religious or spiritual faith after trauma has taken place (Ben-Ezra et al., 2010; Harris et al., 2015; ter Kuile & Ehring, 2014).

Not all veterans identify spirituality as an important part of their well-being and neither is it the case that MI will be experienced by all veterans. It is important to note, however, that over 90% of veterans as well as the general American population endorse believing in a higher power (Fontana & Rosenheck, 2004; Harris et al., 2015). Also, spirituality is known to play a vital role in military culture and may even be viewed as a more acceptable and desirable source of support when compared with conventional mental health services (Harris et al., 2015; Hoge et al., 2004). Attention must therefore be paid to the veterans whose moral perspectives are founded in spirituality when they present for treatment with spiritual distress (Harris et al., 2015).

There is a body of literature that points to the critical need for mental health clinicians to understand the extent to which a veteran's religious or spiritual belief system influences their experience of morality. This is because the transgressions that can occur within a military context can challenge a person's experience of morality and mental health clinicians must be able to identify and discuss whether the veteran's response to these issues is determined by their faith (Wortmann et al., 2017). Moreover, being able to competently support morally injured war veterans who are experiencing struggles with matters of religion and spirituality is considered an aspect of multicultural competence expected of psychologists (Wortmann et al., 2017). In essence, mental health clinicians are responsible for reflecting on their personal capacity to respond to matters involving spiritual distress, have an open and willing attitude to collaborate

with religious and spiritual providers, and be able to discern when a referral would be appropriate on behalf of the veteran concerned (Wortmann et al., 2017).

MI arguably provides a framework for understanding the type of spiritual wound that occurs in the aftermath of certain forms of traumatic experiences (Liebert, 2019). As morality can often involve some aspect of spirituality, mental health clinicians are challenged to acknowledge the potential role that spiritual matters may play in the treatment outcomes of military veterans who experience MI. Chaplains, in contrast, seem more likely to readily embrace the spiritual realm of service provision given the nature of their work. Both types of professionals, however, are confronted with the complexity of MI and how to best respond to the veterans affected by it.

The Relevance of a Specific Focus on Spirituality in Moral Injury

There is increasing support for the intentional inclusion of spirituality in addressing the issue of MI as a part of treatment and also as a way to support the needs of military personnel in terms of their spiritual health and range of personal values and beliefs (Brémault-Phillips et al., 2019). A critical finding from the research literature is that veterans who are spiritually and/or religiously oriented may choose to opt out of psychotherapy due to mental health clinicians not explicitly embracing their religious and spiritual beliefs as a source of positive coping (Koenig et al., 2017). In fact, increased use of religious and spiritual practices has been correlated with the experience of posttraumatic growth (PTG; Koenig et al., 2017). The positive role of spiritual beliefs for military veterans should therefore not be underestimated. Research shows this aspect of a veteran's life is commonly employed to cope with the stress that war causes and that recovery from PTSD tends to take place more quickly than without the use of this type of coping behavior (Currier et al., 2015a; Koenig et al., 2017). In comparison, untreated MI is associated

with a longer recovery trajectory and prolonged need for mental health service provision as a consequence of unresolved spiritual distress (Currier et al., 2015a; Fontana & Rosenheck, 2004; Koenig et al., 2017; Witvliet et al., 2004).

Another pivotal aspect on the topic of military veterans, PTSD, and inclusion of spirituality in treatment in response to MI necessitates addressing mental health clinician attitudes towards spirituality during the course of treatment more generally. In a national survey of psychiatrists, 56% stated they either never, rarely, or only sometimes asked patients about spiritual concerns, in a sample of people diagnosed with depression and anxiety (Curlin et al., 2007; Koenig et al., 2017). The clinician's own countertransference in response to religious matters as well as collusion with the patient's own avoidance of the topic, perhaps unconscious, have also been identified as other factors that interfere with MI being addressed in clinical practice (Koenig et al., 2017).

Given that MI can involve spiritual matters in addition to symptoms of PTSD, it is imperative that mental health clinicians can identify and address their own attitudes in this regard so that treatment outcomes for veterans are not negatively impacted. Unfortunately, the literature suggests that MI is an aspect of treatment frequently ignored by treating clinicians (Koenig & Al Zaben, 2021). The perspectives of chaplains in responding to MI is another area of significant interest due to the existing widespread utilization of this discipline in supporting veterans who seek care for their emotional/spiritual wounds. This systematic review will therefore seek to shed light on the views of both mental health clinicians and chaplains so that their perspectives on spirituality and its role in MI treatment can be better understood.

Rationale, Primary Aims, and Research Questions

This systematic review will focus on the role of mental health clinicians and chaplains in addressing spiritual matters in the course of service provision with veterans who present with MI. It is posited that whether or not military veterans possess a religious or spiritual faith, moral compromise occurs when fundamental assumptions about the self, others, and the world are damaged due to difficulty in finding contentment, meaning, and fulfillment in life after traumatic experiences (Wortmann et al., 2017).

The spiritual and existential issues associated with MI as yet have not been sufficiently investigated and this represents a significant gap in the available literature on this topic (Hodgson & Carey, 2017). Litz and Kerig (2019) note that mental health clinicians have been more recently challenged to appreciate the psychological impact of military veteran experiences of MI as critically relevant to psychological treatment if we are to find ways to help this population effectively. They further state there is a need for clinicians to understand the contribution of faith in understanding and addressing both the causes and outcomes from MI as inextricable to offering the resources needed by these individuals as they work towards their own repair (Litz & Kerig, 2019). It is hoped the results of this study will make a valuable contribution to understanding how mental health clinicians and spiritual providers might collaborate and support each other in their work with the complex phenomenon of MI. The goal of this is to help play a crucial role in the healing of those affected by this type of human suffering.

The objective of this review is to explore the perspectives of mental health clinicians and chaplains concerning the integration of spirituality in their care of veterans with MI in the aftermath of traumatic experiences in the military. There are two research questions this systematic review will address: (a) What do we know about the perspectives of providers (mental

health clinicians and chaplains) regarding the integration of spirituality in the clinical care of MI in veterans with trauma/PTSD?; and (b) Are there similarities and differences in mental health clinician and chaplain perspectives?

Chapter 2: Methodology

Systematic Review Approach

This systematic review utilized a qualitative methodology approach. Qualitative research seeks to illuminate the meaning associated with the lived experiences and perspectives of participants and providers involved in the research process (Lockwood et al., 2015). This systematic review focused on the perspectives of mental health clinicians and chaplains and the integration of spirituality in response to the psychological and spiritual suffering of traumatized military personnel with MI. A qualitative approach was used because this methodology allows for a depth of analysis considered important to understand support services for veterans experiencing MI and spiritual challenges.

The meta-aggregation approach to qualitative data analysis was utilized to extract and synthesize findings that addressed how providers view the topic of spirituality integration with veterans who present with MI. This type of review strives to ensure that study findings are not re-interpreted and in contrast accurately and reliably delivers the extracted information to reflect the original intentions of the authors (Florczak, 2018; Lockwood et al., 2015).

A variety of authoritative sources were consulted in the design of this systematic review, including the Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA-P), the Cochrane Collaborative, the Campbell Collaborative (Moher et al., 2009), and the Joanna Briggs Institute (Lockwood et al., 2015).

Eligibility Criteria

Source Eligibility Criteria

This review was limited to studies published in the English language. As the concept of MI was first formally introduced into the literature in 2009 by Litz and colleagues, this review focused on studies that were published from this date onwards.

Study Eligibility Criteria

Types of Research Variables. This review focused on mental health clinicians and chaplains who offered their views on the treatment of traumatized veterans experiencing MI, and how spirituality is addressed (or not) in the process. The term "*moral injury*" had to be used by the researchers in the relevant studies that were included in this systematic review. Only the following additional terms that identify MI in the literature were permitted for inclusion in this study: moral distress; moral pain; spiritual injury; and spiritual wound. Only literature that focused on the military population, trauma/PTSD, and MI were included.

Types of Participants. Subjects included either mental health clinicians, chaplains[1], or both in the study. All religious and faith orientations of the mental health clinicians and chaplains were included. There were no limits as to gender identity, race/ethnicity, sexuality, disability status, or any other sociodemographic factors for participants.

Types of Studies. Peer-reviewed journal articles that utilized a qualitative methodology provided the necessary material for this review. Qualitative findings from studies that applied a mixed-methods approach as relevant to this study's topic were also considered for inclusion.

Types of Settings. Studies from any international destination that focused on the military population and MI were included.

[1] Please note: the term *chaplain* encompasses faith leaders of diverse religious backgrounds.

Exclusion Criteria

Systematic reviews, scoping reviews, and meta-analyses were excluded from this study.

Search, Screening, and Selection Process

Information Sources

The following four electronic databases were searched via the EBSCOhost platform: PsycINFO, Military and Government Collection, Published International Literature on Traumatic Stress (PILOT), and Scopus (Appendix A).

Search Terms

Following a preliminary literature search, a set of primary terms (keywords) and synonyms/alternate forms were identified. Each primary term was also labeled with a search term identity number for organizational use (Appendix B). The search terms and syntax/alternate forms devised included the following:

- moral injury OR morally injurious OR moral distress OR moral pain OR spiritual wound OR spiritual injury
- moral injury OR morally injurious OR moral distress OR moral pain OR spiritual wound OR spiritual injury AND veteran OR military OR military personnel OR military combat OR combat OR service member OR war OR war-related OR deploy OR active duty
- moral injury OR morally injurious OR moral distress OR moral pain OR spiritual wound OR spiritual injury AND posttraumatic OR post-traumatic OR posttraumatic stress OR post-traumatic stress OR posttraumatic stress disorder OR post-traumatic stress disorder OR PTSD OR trauma OR traumatic OR traumatization OR trauma-exposed
- moral injury OR morally injurious OR moral distress OR moral pain OR spiritual wound OR spiritual injury AND spirituality OR spiritual coping OR religion OR religious OR

religious coping OR faith OR God OR existential OR clergy OR chaplain OR priest OR pastor OR minister OR spiritual leader OR religious leader OR forgive OR guilt OR shame

- moral injury OR morally injurious OR moral distress OR moral pain OR spiritual wound OR spiritual injury AND treatment OR psychotherapy OR therapy OR evidence OR evidence-based OR service OR support OR approach OR intervention OR recover

Screening and Selection of Studies

Next, the results of each search term screening were recorded on an Excel spreadsheet before moving on to the article selection phase. The search date, full search identification number, type of search, database/source, search term identification number, search syntax, fields searched, the search specifiers, and number of records obtained were noted on the screening form (Appendix C). Then, screening and selection of each article was conducted (Appendix D). In phase one (color-coded red), the author screened studies produced by the search terms by listing the author(s), year of publication, and abbreviated title of the article first. The database or source from which the article was obtained was noted along with columns that allowed the author to use keyword and abstract screening decision codes, including the associated date of these choices as relevant.

In the second phase (color-coded blue), a full-text review took place to determine eligibility for inclusion. To reach this conclusion, this author documented whether a full-text screening occurred, the study source that included all research variables, assurance that the data were taken from a qualitative aspect of the study, the exclusion criteria, and the date the decision was made to include the study or not.

Finally, in phase three (color-coded green) of the screening process, a definite decision was made as to whether or not the article was selected for inclusion in the systematic review. The categories included in this last phase reflected the decision of the primary reviewer (author) and secondary reviewer (Dissertation Chair) as needed. This author's final decision, the date of the decision, and any relevant notes were documented to assist with organization. A PRISMA flow chart was also utilized to provide a visual overview of the process conducted in selecting appropriate studies for the systematic review (Appendix E).

Data Collection and Extraction

Study Variables

A range of variables were utilized to facilitate data collection to address the two research questions outlined. In seeking to answer both research questions, variables included MI; military veterans; trauma/PTSD; spiritual issues; and an international provider role (either mental health clinicians, chaplains, or both). Exploration of whether or not spirituality was integrated during service provision was investigated as well as provider views on the usefulness of doing so in responding to traumatized veterans who experience MI.

Development of the Data Extraction Form

A data extraction form was used for all of the studies included in this systematic review (Appendix F). The form was adapted from a sample provided by the Cochrane Effective Practice and Organization of Care (EPOC), based in Norway. The data extraction form gives each study a document identification number, notes the author(s) and year, the full title, and the research variables studied. Once this information had been documented, the form included another eight sections that this author systematically utilized to extract relevant information from each of the studies. These sections included general information, the design characteristics and

methodological features of each study, assessment of the research variables, study participant characteristics and recruitment information, setting characteristics of the study, the type of qualitative analyses conducted, important themes that emerged from the study including any key perspectives, outcomes, and/or other type of results, and ended with conclusions and follow-up recommendations.

Data Extraction

Each study was read in its entirety. The Dissertation Chair was provided with a random sample of the source documents reviewed so that the utilization of the data extraction form was checked by another party. Collaborative engagement occurred between this author and the Dissertation Chair in addressing any discrepancies that might have occurred. One of the key reasons to follow this step is to reduce the likelihood of personal biases influencing the decisions as to the types of data extracted. The use of this form was critical to keeping the data organized and readily accessible for later evaluation given the often complex and extensive information collated in the process of qualitative research.

Quality Appraisal

All studies underwent a rigorous quality appraisal process to ensure their inclusion value. It is understood that assessing the quality of qualitative studies is not straightforward because of the less structured format of this type of research. A specific form titled the Individual Study Quality Assessment (ISQA; Appendix G) was developed by Dr. Shelly Harrell at Pepperdine University to support researchers in their endeavors to discern the degree of quality of any given qualitative study considered for inclusion in the research process. This document allows the researcher to note the specific design/inquiry approach used by the author(s) of each study. A Likert scale is then used to rate the perceived quality of the study's methodological framework

utilized. Authors can choose from *Strong* = 3, *Good/Adequate* = 2, *Weak* = 1, *Missing* = 0, or *Not Applicable*. The form then invites the researcher to consider the strength of the literature foundation included in the study and how well the authors defined the rationale for the study. Next, researchers are asked to evaluate how clear and specific the aims of the study are, and the quality of the methodological approach applied. Sample selection and characteristics are considered in addition to the data collection tools and processes used. The quality of the data analysis presented in the study is then reviewed, followed by discussion of study limitations and the helpfulness of this latter section to the reader. As should always be the case, researchers then consider how cultural and diversity factors have been addressed in the study.

Furthermore, the researcher is tasked with giving the study an overall rating on another Likert scale and can choose from either *Exemplary*, *Strong*, *Good/Adequate*, or *Weak*. As qualitative research frequently involves the perspectives of professionals, a subjective determination needed to be made as to the quality of each study that was included. In the context of this systematic review, an independent quality appraisal process was conducted concurrently during data extraction utilizing the form that has been described. A random selection of studies that were quality appraised with this document was provided to the Dissertation Chair to ensure the work completed is considered a competent assessment of included studies.

In addition to the routine quality appraisal process of individual studies, meta-aggregation involves assessment of the quality of the data extracted prior to deciding on using it. Levels of "plausibility" are assigned in this regard and are defined as:

> (1) Unequivocal (findings accompanied by an illustration that is beyond reasonable doubt and therefore not open to challenge); (2) Equivocal (findings accompanied by an

> illustration lacking clear association with it and therefore open to challenge); (3) Unsupported (findings are not supported by the data). (Lockwood et al., 2015, p. 183)

Only unequivocal and equivocal findings are extracted according to this approach to the systematic review process and no unsupported findings are taken into consideration. Both unequivocal and equivocal findings are recognized as sharing equal credibility in the data synthesis process (Lockwood et al., 2015). As such, only articles with supported findings were included in this study.

Data Management, Synthesis, and Analysis Plan

Data Management

Information from the Quality Appraisal forms and Data Extraction forms were transferred into a table titled Characteristics of Included Studies (Appendix H). This document recorded all of the relevant study characteristics collected from the included studies. Given the culmination of a vast amount of data in need of qualitative analysis, this procedural step is considered critical for organizational and ease-of-use purposes.

Data Analysis and Synthesis

The meta-aggregation approach selected for this systematic review is an integrative procedure that involves applying three steps in the process of thematic analysis. The procedure includes:

> (1) Extraction of all findings from all included studies with an accompanying illustration and allocated level of plausibility for each finding; (2) Developing categories for findings with at least two findings per category; and (3) Developing one or more synthesized findings of at least two categories. (Lockwood et al., 2015, p. 184)

The researcher was tasked with repeatedly analyzing the findings that were identified as relevant to the study and then this data were grouped into categories based on similarity in meaning. Each identified category consisted of a brief description of a particular key concept that emanated from the clustering of at least two alike findings. An explanatory statement was then provided that conveyed the overall meaning surmised from this grouping of similar results (Lockwood et al., 2015).

This systematic review focused on studying qualitative data in order to demonstrate the views of mental health clinicians and chaplains on the integration of spirituality in the clinical care of traumatized veterans who experience MI. Data were analyzed to address two research questions: (a) What do we know about the perspectives of providers (mental health clinicians and chaplains) regarding the integration of spirituality in the clinical care of MI in veterans with trauma/PTSD?; and (b) Are there similarities and differences in mental health clinician and chaplain perspectives?

Other relevant issues that emerged from the existing literature on MI in military populations concerning the role of spirituality in recovery were included as appropriate. It is important to highlight that the meta-aggregation approach seeks to ensure that the original meaning conveyed in qualitative studies is maintained and all expectable and reasonable efforts were made to carefully adhere to this stipulation during the systematic review process.

Reporting of the Results

To accomplish the goals of meta-aggregation in this systematic review, another table titled Categorized Themes is presented to convey an overview of the data extracted and synthesized (Figure 5 in the Results section). The author expected the synthesized statements to align with the following major themes of assessment, diagnosis, and conceptualization of MI in

the military population; spiritual issues in the context of military-related MI; identification of explicit inclusion and/or neglect of spirituality in the course of service provision; mental health clinician and chaplain attitudes towards and obstacles to addressing spiritual issues during treatment; and recommendations for addressing the spiritual needs of military personnel who experience MI in the aftermath of trauma/PTSD. A diagram is also provided as an example to visually demonstrate the aggregated findings from this systematic review (Appendix I).

Limitations and Potential Contributions

Limitations

It must be acknowledged that there are likely to be other articles published in the literature before 2009 that allude to themes related to the experience of MI in the military population. As the concept was not officially formulated until 2009, studies that do not formally identify MI as the focus of their research were not included in this study.

While spot checks were performed to ensure a high standard of research protocol is maintained at all times, it may be inevitable that some information was overlooked due to one person being primarily responsible for the research process. This author also wishes to acknowledge her personal interest in the topic of spirituality in the field of psychology in general, and so it is possible that unintentional bias could have occurred in investigating the importance of this dimension of a person's life, regardless of MI and military traumatic experiences.

As the concept of MI was first formally introduced into the research literature in 2009, there are already understood limitations in terms of the breadth of literature available on this topic. There is also a lack of consensus on an exact and universally accepted definition of MI, which had the potential to complicate this study. Another drawback is that much of the literature

on MI has been conducted in Western countries, meaning that the experiences of military personnel in other international contexts have been largely ignored despite the extremely valuable contributions such studies would likely offer. Last, as spirituality is a broadly used term, there may be others in the field who do not align with how this concept was approached in the current study.

Potential Contributions

Though potential limitations exist, it is hoped that this qualitative systematic review offers a much-needed contribution to the literature on MI and the role of spirituality specifically in a person's recovery from the psychological and spiritual wounds caused by traumatic life events. Not only does this topic apply to military personnel but it is highly likely that there is much to be learned from this type of study in supporting civilian populations also. Furthermore, this study aimed to address a significant gap in the clinical literature as to how the topic of spirituality in general is either incorporated or neglected by providers. As mental health clinicians, it is imperative to consider the totality of a person's life experiences, one aspect of which involves concerns of an existential nature. Perhaps it will be possible to develop richer psychotherapy approaches that skillfully draw on the wisdom and guidance of spiritual leaders who are well-equipped to enhance the well-being of the individuals served in the process of seeking mental health support.

Chapter 3: Results

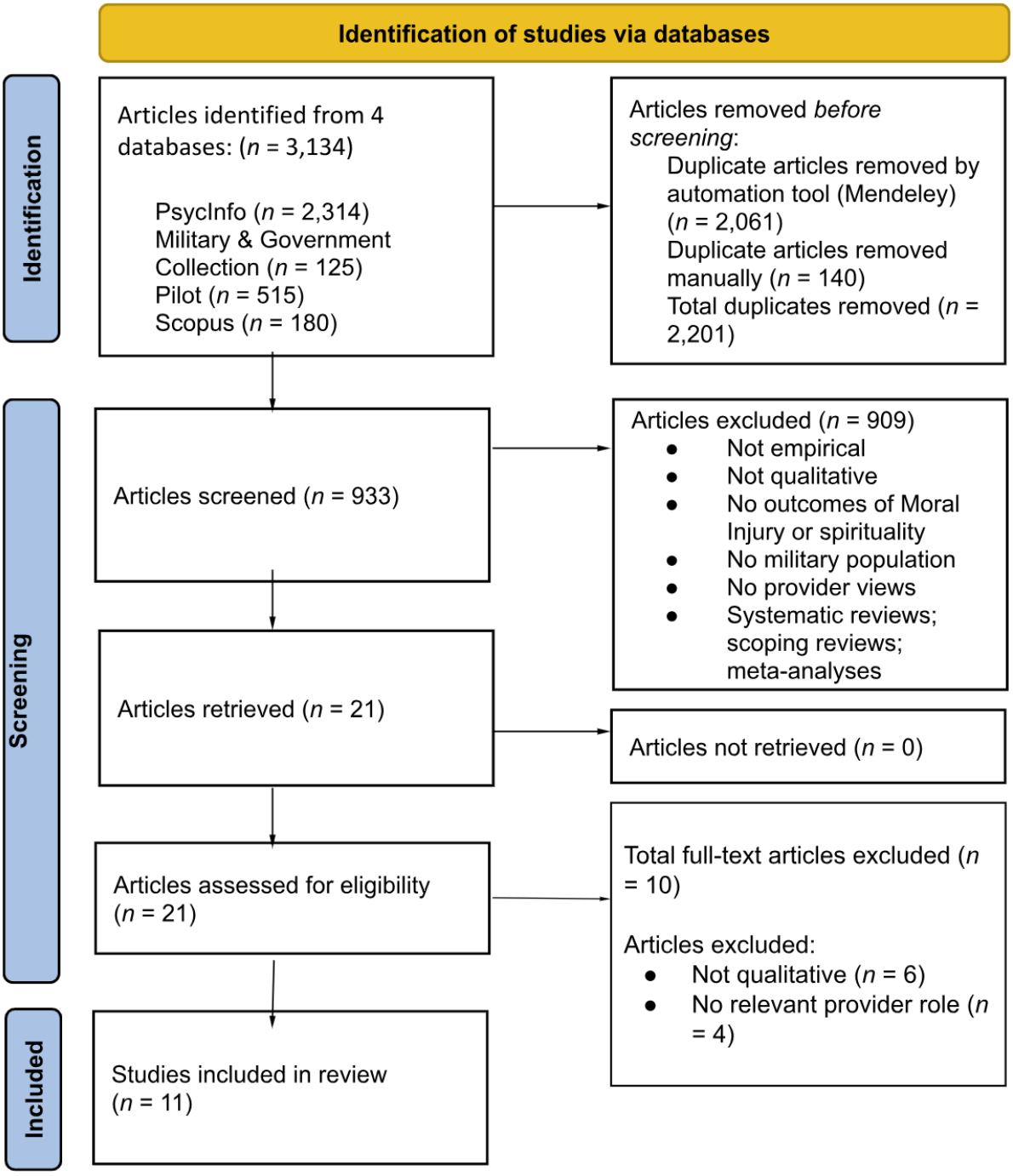
Overview

On review of Pepperdine University's Institutional Review Board (IRB) guidelines and in consultation with the Dissertation Chair of this systematic review, it was determined that IRB review and approval was not required for this study. No human subject participation was involved and neither did this study use data collected from any individual participants.

After combining all four electronic database search results, a total of 3,134 peer-reviewed articles were identified for the screening process to begin. Before proceeding with screening, 2,061 were removed by an automation tool (Mendeley). Additional manual duplicate removal was required and this was conducted using features in Microsoft Excel, which resulted in a further 140 articles being eliminated. This left a total of 933 articles for initial screening of title, keywords, and abstract. Through this process, 909 articles were identified as not appropriate for further screening according to the following exclusionary criteria: not an empirical study; qualitative methodology was not utilized; no outcomes of *moral injury* or spirituality were addressed; a military population was not studied; provider views were not a focus of the study; and/or the study was excluded because it was either a systematic review, a scoping review, or a meta-analysis. For retrieval of articles, 21 were obtained and then full-text screening took place to assess inclusion eligibility. Of these articles, 10 were excluded as six did not include a qualitative component and four did not address a relevant provider role. To ensure all pertinent articles were identified, the reference section of each included article was reviewed. No additional articles, however, were discovered during this process. The final number of articles selected for inclusion in this systematic review was 11. Please refer to Figure 1 to view the visual presentation of this information.

Figure 1

PRISMA Diagram



General Characteristics of Included Studies

An overview of the general characteristics of each article selected for this study is provided in the table titled, Characteristics of Included Studies (Appendix H). This table details the authors; year of publication; study title; methodology utilized; method of data collection; data analysis approach; overall rating of the quality appraisal measure implemented; phenomena of interest in each study; country the study was conducted in; the study setting; sample size; participant age, gender, race/ethnicity, highest level of education, and spiritual/religious beliefs of the providers.

Methodology, Method of Data Collection, and Data Analysis Approach

As this systematic review employed a qualitative methodology approach, a qualitative component needed to be a key element of the included studies' research. Of the 11 chosen studies, eight were qualitative only (Boska et al., 2021, 2023; Burkman et al., 2019; Drescher et al., 2018; Eikenaar, 2022; Van Denend et al., 2022; Williamson et al., 2019, 2021) and the remaining three used mixed-methods (Jin et al., 2022; McCormick et al., 2017; Wortmann et al., 2022). The manner in which data was collected involved online surveys (n = 3); focus groups (n = 2); in-depth and/or semi-structured interviews (n = 4); webinars and online conversations (n = 1); and case studies (n = 1). In terms of the data analysis process, inductive content analysis (n = 2), thematic analysis (n = 5), and exploratory approaches (n = 1) were used, and some studies did not state their approach (n = 3).

Phenomena of Interest and Settings

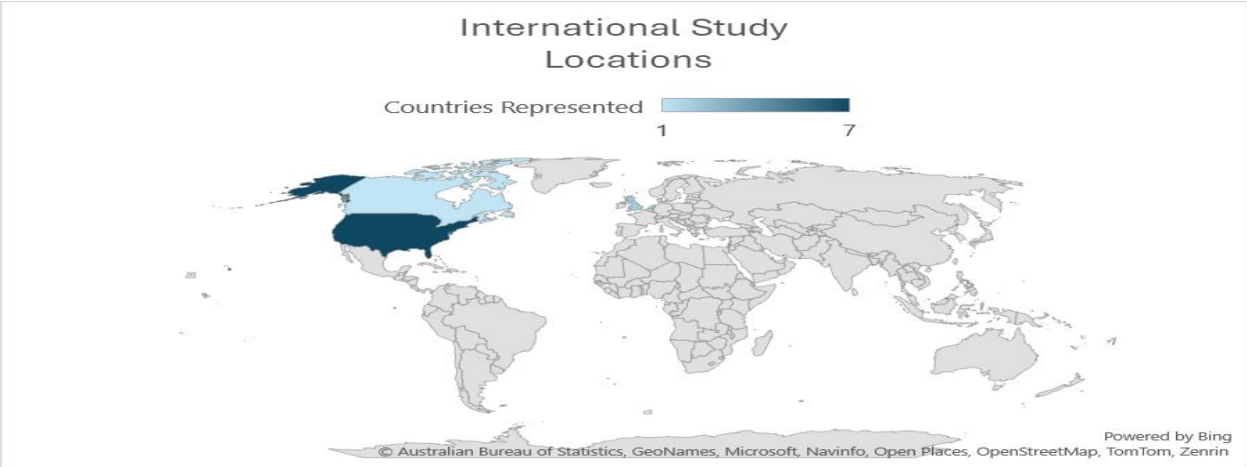
The studies analyzed addressed a range of phenomena of interest relevant to the research questions of this study. Broadly speaking, both chaplains and mental health clinicians offered

their perspectives on MI and themes that they have encountered in the course of their duties as related to spirituality and the therapeutic care of veterans.

This systematic review explored the identified research questions from an international perspective. Out of the 11 studies included, seven were carried out in the United States of America (USA; Boska et al., 2021, 2023; Burkman et al., 2019; Drescher et al., 2018; McCormick et al., 2017; Van Denend et al., 2022; Wortmann et al., 2022), two in the United Kingdom (UK; Williamson et al., 2019, 2021), one in The Netherlands (Eikenaar, 2022), and one study included data from both The Netherlands and Canada (Jin et al., 2022). All of the USA-based studies took place in a Veterans Administration (VA) setting. Within this context, the data was collected in a variety of mental health settings and chaplaincy-based services. The UK studies focused on recruitment within the National Health Service (NHS), Ministry of Defense (MoD), UK Armed Forces, and voluntary sector organizations. The remaining studies in The Netherlands and Canada implemented their research via online and video formats in both educational and employment settings. See the table below for a visual overview of the countries represented in this study.

Figure 2

International Study Locations



Characteristics of Study Participants

Sample Sizes and Provider Roles

The following table provides a visual overview of the sample sizes and provider roles included in each of the 11 studies:

Table 1

Overview of Sample Sizes and Provider Roles

TABLE											
Study #	1	2	3	4	5	6	7	8	9	10	11
Author(s) (Year)	Drescher et al. (2018)	Boska et al. (2023)	Wortmann et al. (2022)	Williamson et al. (2021)	Jin et al. (2022)	Williamson et al. (2019)	McCormick et al. (2017)	Burkman et al. (2019)	Eikenaar (2022)	Van Denend et al. (2022)	Boska et al. (2021)
Study Title	A Qualitative Examination of VA Chaplains' Understandings and Interventions Related to Moral Injury in Military Veterans.	Chaplains' perspectives on standardizing spiritual assessments.	Collaborative spiritual care for moral injury in the Veterans Affairs Healthcare System (VA): Results from a national survey of VA chaplains.	Delivering treatment for morally injured UK military personnel and Veterans: The clinician experience.	Moral Injury and Recovery in Uniformed Professionals: Lessons From Conversations Among International Students and Experts.	Moral injury in UK armed forces veterans: a qualitative study	Professional Quality of Life and Changes in Spirituality Among VHA Chaplains: A Mixed Methods Investigation	Provider perspectives on a novel moral injury treatment for veterans: Initial assessment of acceptability and feasibility of the Impact of Killing treatment materials.	Relating to moral injuries: Dutch mental health practitioners on moral injury among military and police workers.	The Body, the Mind, and the Spirit: Including the spiritual domain in mental health care.	Understanding moral injury morbidity: A qualitative study examining chaplain's perspectives.
Sample Size & Provider Roles	245 chaplains	7 chaplains	367 chaplains	15 clinicians (3 = psychiatrists; 5 = psychologists; 7 = mental health nurses)	94 total participants 9 participants (17.6%) = psychiatrists 7 participants (13.7%) = psychologists 1 participant (2.0%) = rehab medicine Other participants = not listed as their views were not taken into consideration for data extraction purposes.	4 clinicians (specific roles not reported)	267 full- or part-time VHA chaplains	10 clinicians (60% = psychology; 20% = social work; 20% = psychiatry)	30 practitioners Chaplains Confidential counsellors Social workers Psychologists Therapists (4 = military chaplains; 12 = military mental health clinicians; others = worked with the police)	1 relevant case study of the Veteran studied; Chaplain sample size not stated.	7 chaplains

Slightly over half of the articles exclusively focused on chaplain perspectives (n = 6), three articles honed in on mental health clinicians' views, and one article included both chaplains and mental health clinicians. Of note, the remaining study conflated the mental health clinicians' roles (psychiatrists and psychologists) with other non- or less-relevant participant types (Jin et al., 2022). A concerted effort was made to only extract information from this particular article that appeared to specifically reflect the views of mental health professionals.

Participant Ages

Participant age was not consistently reported across studies as only six out of the 11 studies explicitly addressed this. From the available data, the youngest participants were in the 25-44 age range with the oldest age represented as 65 years or older.

Gender

With regard to gender, two studies (18%) did not provide this information (Eikenaar, 2022; Van Denend et al., 2022). The other nine studies (82%) identified gender categories as split between either male or female.

Race/Ethnicity

Race/ethnicity was not reported in five out of the 11 studies (Eikenaar, 2022; Jin et al., 2022; Van Denend et al., 2022; Williamson et al., 2019, 2021). The racial/ethnic categories delineated in the other six studies included White, Black or African American, Spanish/Hispanic/Latino/a, Asian or Asian American, Native Hawaiian, and other (unspecified).

Highest Level of Education

In terms of the participant education levels, this included a starting point of possessing a high school diploma (chaplains specifically) through to a doctoral degree. Three studies did not indicate the level of education of the participants (Eikenaar, 2022; Van Denend et al., 2022; Williamson et al., 2019).

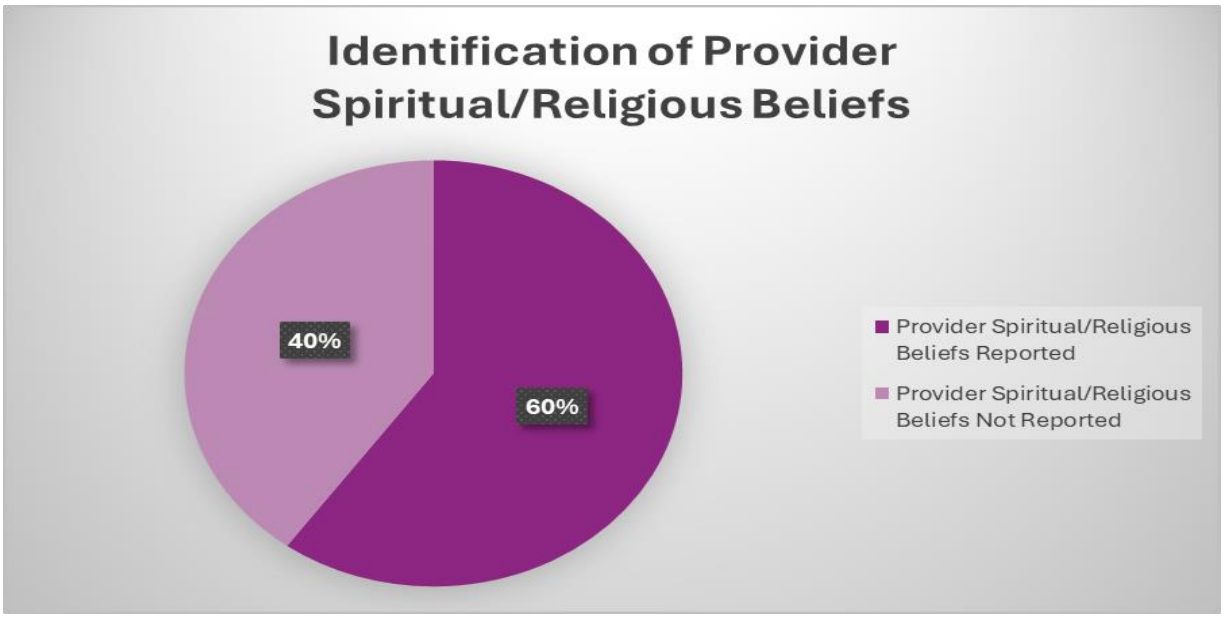
Spiritual/Religious Beliefs of Providers

The beliefs of individual providers were diverse as a wide range of Christian denominations were disclosed in addition to other monotheistic faiths including Judaism, Islam, Buddhism, and other belief systems not specified. Four studies did not report this information

(Burkman et al., 2019; Jin et al., 2022; Williamson et al., 2019, 2021). Remarkably, no data was reported on the spiritual/religious beliefs of the mental health clinicians.

Figure 3

Identification of Provider Spiritual/Religious Beliefs



Quality Appraisal

The articles studied in the process of this systematic review were rated as either *Good/Adequate* (*n* = 3), Strong (*n* = 5), or Exemplary (*n* = 3). Factors that impacted the quality appraisal rating included a lack of reference to the methodology and/or data collection methods utilized, neglecting to report the study sample size and various types of participant demographic factors as addressed earlier, the ways in which data were analyzed and presented, how well or not study limitations were discussed, and the overall attention paid toward culture and diversity. Per the guidelines outlined earlier in the methodology section on assigning credibility to each included study utilizing the meta-aggregation approach, no unsupported findings were discovered during the data extraction process.

Research Questions: Findings

The two research questions posed in this study are addressed in the information to follow. The first research question aimed to examine what the literature reveals about the perspectives of providers (mental health clinicians and chaplains) regarding the integration of spirituality in the clinical care of MI in veterans with trauma/PTSD. The second research question sought to explore the similarities and differences between mental health clinician and chaplain perspectives on this same subject matter.

To assist with categorizing the findings in line with the meta-aggregation approach to systematic reviews, a table was developed to present this information in a helpful manner (Table 2). Nine themes were developed from the data that emerged from the 11 included studies, as follows: (a) spiritual injury; (b) morality; (c) assessment; (d) therapeutic interventions utilized by providers; (e) the need for provider training; (f) forgiveness; and (g) suffering and meaning-making. This information was then organized into three groupings with a synthesized statement developed for each to address the research questions.

Table 2

Categorized Themes

TABLE: Categorized Themes												
Study #	1	2	3	4	5	6	7	8	9	10	11	
Author(s) (Year)	Drescher et al. (2018)	Boska et al. (2023)	Wortmann et al. (2022)	Williamson et al. (2021)	Jin et al. (2022)	Williamson et al. (2019)	McCormick et al. (2017)	Burkman et al. (2019)	Eikenaar (2022)	Van Denend et al. (2022)	Boska et al. (2021)	
Study Title	A Qualitative Examination of VA Chaplains' Understandings and Interventions Related to Moral Injury in Military Veterans.	Chaplains' perspectives on standardizing spiritual assessments.	Collaborative spiritual care for moral injury in the Veterans Affairs Healthcare System (VA): Results from a national survey of VA chaplains.	Delivering treatment for morally injured UK military personnel and Veterans: The clinician experience.	Moral Injury and Recovery in Uniformed Professionals: Lessons From Conversations Among International Students and Experts.	Moral injury in UK armed forces veterans: a qualitative study	Professional Quality of Life and Changes in Spirituality Among VHA Chaplains: A Mixed Methods Investigation	Provider perspectives on a novel moral injury treatment for veterans: Initial assessment of acceptability and feasibility of the Impact of Killing treatment materials.	Relating to moral injuries: Dutch mental health practitioners on moral injury among military and police workers.	The Body, the Mind, and the Spirit: Including the spiritual domain in mental health care.	Understanding moral injury morbidity: A qualitative study examining chaplain's perspectives.	TOTAL FINDINGS FOR EACH CATEGORY
SPIRITUAL INJURY (CATEGORY 1)	Y	Y	Y	N	N	N	Y	N	N	Y	Y	6
MORALITY / VALUES (CATEGORY 1)	Y	N	Y	Y	N	N	N	Y	Y	Y	N	6
ASSESSMENT (CATEGORY 2)	Y	Y	N	Y	Y	Y	N	Y	N	N	Y	7
THERAPEUTIC INTERVENTIONS (CATEGORY 2)	Y	Y	Y	Y	Y	Y	N	Y	N	N	Y	8
INTERDISCIPLINARY COLLABORATION (CATEGORY 2)	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	7
PROVIDER TRAINING (CATEGORY 2)	Y	N	Y	Y	N	N	N	Y	N	N	N	4
FORGIVENESS (CATEGORY 3)	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
SUFFERING / MEANING-MAKING (CATEGORY 3)	Y	N	Y	Y	Y	N	Y	Y	Y	Y	N	8

Synthesized Statement #1

The concept of MI has not yet reached a consensus among the providers treating the veterans affected by it, and the component of spirituality as either an aspect of MI or a distinct concept in its own right remains unresolved. Two categories provide support for this synthesized statement.

Category #1: Spiritual Injury Was Identified by Some Providers as a Distinct Phenomenon

The data revealed that six of the 11 studies referred to veterans being affected by spiritual injury specifically while discussing the topic of MI. One study that included chaplain participants only referred to "religious or spiritual injury" (Drescher et al., 2018, p. 2455) as a mechanism of MI. To highlight this finding, a chaplain, for instance, stated, "One receives moral and spiritual injury to one's humanity and is scarred: the joy of life is damaged" (Drescher et al., 2018, p. 2452). This study specifically stated that chaplains who described MI this way were focused on cases involving veterans identified as clearly having a difficult time with faith or spiritually-related matters. Boska et al. (2023) in their study of chaplains viewed spiritual injury as important from an assessment standpoint and explained how such a perspective helps the provider to gain insight into what type of issue the veteran is experiencing. In terms of percentage, in one study, describing MI as a type of spiritual injury arose in approximately 10% of the definitions raised by chaplains specifically (Wortmann et al., 2022). A quote from a chaplain in one study stated, "I have questioned many parts of faith, life, and spiritual beliefs as I explore these with veterans dealing with moral or spiritual injury" (McCormick et al., 2017, p. 121). While addressing the relevance of MI as applied to a case study and chaplain perspectives on its treatment with a veteran, the author referenced other research to support the point on the importance of not overlooking the spiritual injury that may be affecting the veteran (Brémault-

Phillips et al., 2019; Brock & Lettini, 2012, as cited in Van Denend et al., 2022). Though the exact term spiritual injury was not used in the final article to be able to report it in this section, the chaplains explained the presentation of MI as showing up as "'spiritual pain' and/or 'crises of faith'" (Boska et al., 2021, p. 3093).

Research Questions #1 and #2 Summary. Mental health clinicians did not seem to understand or describe MI as a type of spiritual injury. The information presented in Category #1 demonstrates that we know more about chaplain perspectives than we do about mental health clinicians regarding how MI is conceptualized in treating veterans with trauma/PTSD (Research Question #1). It is unclear if this represents a fundamental difference between mental health clinician and chaplain perspectives as literature is not available on whether or not the former would embrace the term spiritual injury as a way to conceptualize MI (Research Question #2).

Category #2: Morality and Personal Values Were Viewed as Relevant to Understanding and Treating Moral Injury

A seemingly more complex theme involving morality also emerged from the data while seeking an understanding of how providers perceive other relevant aspects of MI, its development, and treatment. This was referred to across the data in a variety of ways and was apparent in six of the 11 studies. Drescher et al. (2018) identified "values, beliefs, or moral conflict/change" as a factor involved in the etiology of MI and additionally considered "moral outrage" as a sign and/or symptom of MI in their chaplains only study (p. 2450). In this article, forcible violation of a veteran's core moral standards was referred to as deeply traumatic for the individual concerned. This same study also used the term "moral compass" as another way to depict MI (Drescher et al., 2018, p. 2452).

From an assessment perspective, identification of transgression or violation of the veteran's "morals or values" by either self or other was regarded as significant to the person's "conscience or spirit" (Wortmann et al., 2022, p. 521) and the phrase "moral compass" was also used (Wortmann et al., 2022, p. 514). The mental health clinicians in one of the UK studies referred to compromise of the veteran's "moral code" when discussing how a person's core beliefs can become challenged and the individual feels psychologically distressed as they try to reconcile their morally injurious experiences with beliefs about self, others, and/or the world (Williamson et al., 2021, p. 117). Other ways morality was conveyed as an important piece in the understanding of MI was as a "moral struggle" (per mental health clinicians) (Burkman et al., 2019, p. 89), as "moral issues" (Eikenaar, 2022, p. 6), involving "moral risks" (per mental health clinicians and chaplains; Eikenaar, 2022, p. 7), and "moral values" (per chaplains; Van Denend et al., 2022, p. 3580). As one chaplain described it:

> I perceive moral injury is the wounding of the soul, the spirit within each of us - injuries so deep yet invisible to the naked eye - but one who has been there can see these injuries without even asking. I have been there and can relate. (Drescher et al., 2018, p. 2452)

Research Questions #1 and #2 Summary. The literature revealed that both mental health clinicians and chaplains seem to recognize the complex role of morality when treating veterans with MI and trauma/PTSD (Research Question #1). It appears there may also be some degree of consensus between these provider roles in terms of willingness to understand MI as involving moral complications (Research Question #2).

Synthesized Statement #2

For effective collaboration to occur between chaplains and mental health clinicians treating MI, cross-discipline training is needed in methods of assessment and appropriate treatment interventions. Four categories provide support for this synthesized statement.

Category #1: Comprehensive Assessment of Moral Injury is Needed in the Routine Care of Veterans to Support Identification of the Role That Spirituality May Play in Their Distress and Subsequent Treatment

The importance of assessment of MI was highlighted as pivotal to understanding the nature of veterans' presenting concerns and noted in seven of the studies. Obtaining an in-depth history of the spiritual backgrounds of each affected veteran, including associated "spiritual/moral distress" was deemed significant (chaplain study; Drescher et al., 2018, p. 2454). This study stated, "less attention has focused on clarifying the emotional, social, behavioral, and spiritual sequelae that may help clinicians to identify whether a MI has occurred" and "over 20% highlighted the importance [*sic*] conducting a spiritual assessment" (Drescher et al., 2018, p. 2456).

In another study, chaplains emphasized aspects of spiritual assessment as including the veteran's spiritual history, existing faith practices, understanding the extent of the veteran's engagement in their faith community, and identifying whether a spiritual injury is present (chaplain study; Boska et al., 2023). Such spiritual assessments are considered beneficial to informing clinical care and providing support with reducing the distance between interdisciplinary teams and helping with planning treatment (Boska et al., 2023). Standardized assessment that allows for conversational engagement with veterans was identified as a need among chaplains in particular (Boska et al., 2023).

Failing to assess MI thoroughly was viewed by mental health clinicians as an issue that results in inadequate treatments offered and poorer patient outcomes (Williamson et al., 2021). Cross-cultural and holistic assessment (per mental health clinicians; Jin et al., 2022) and paying attention to both minority religious identifications and those with no religious identification (per chaplains; Boska et al., 2021) were mentioned in other included studies as part of an appropriate assessment. An underappreciation and lack of understanding of the experiences of veterans with MI as well as the need to improve this in clinical settings was highlighted as an issue elsewhere (mental health clinician study; Williamson et al., 2019).

Possessing the ability to recognize struggles of a moral nature was also outlined as important to more accurately assessing psychopathology and engaging in the psychiatric diagnostic process (mental health clinician study; Burkman et al., 2019). As one mental health clinician described it, “we’re spending an awful lot more time talking to soldiers about beliefs about themselves and judgements, am I good, am I bad, did I do wrong, was I wronged?” (Williamson et al., 2021, p. 117).

Research Questions #1 and #2 Summary. It is apparent that both mental health clinicians and chaplains value the role and importance of assessment during the course of clinical care when evaluating MI and treating veterans with trauma/PTSD (Research Question #1). Mental health clinicians and chaplains both seem in support of ensuring that a thorough assessment is offered to veterans with MI so that this can, in turn, appropriately inform their subsequent treatment process (Research Question #2).

Category #2: Therapeutic Interventions Among Chaplains and Mental Health Clinicians Both Overlap and Vary in Their Approach, and Spirituality is Not Consistently Recognized Nor Addressed by Mental Health Clinicians

Eight studies highlighted an overlap between spiritually-related interventions and therapeutic interventions. Specific pastoral care interventions were reported as "spiritual/religious counseling…prayer…religious rituals" and supporting veterans with fostering their accessing of internal and external resources such as, "Drawing upon existing spiritual resources and/or fostering spiritual growth or connection with God" (chaplain study; Drescher et al., 2018, p. 2455). This study posited that in responding to MI with veterans in the course of providing chaplaincy services, there is a tendency to make use of faith-tradition-informed approaches to providing spiritual care. Chaplains also reported their main priority is to address the spiritual needs of the veterans they serve and to place their focus on matters relevant to the spiritual domain (Boska et al., 2023). One particular chaplain stated, "the difference between the chaplaincy and other mental health providers is like our service, what we provide, is more relational. It's a pastoral relationship" (Boska et al., 2023, p. 36).

In an alternate study, chaplains identified the integration of evidence-based psychosocial practices alongside spiritual care in treating veterans with MI as a high priority. Acceptance and Commitment Therapy (ACT) was considered a particularly appropriate therapeutic treatment for this purpose (Wortmann et al., 2022). Of note, qualitative and quantitative results appeared to have been conflated in this particular study. Chaplains were asked to describe their own definitions of MI with open text space and were also asked a variety of closed-ended questions in the survey. Other relevant therapeutic treatment approaches identified included compassion-focused therapy and mindfulness (per mental health clinician studies; Gilbert, 2012, as cited in

Williamson et al., 2019, 2021). The importance of a holistic approach was noted by other studies also (per mental health clinicians and chaplains; Boska et al., 2021; Jin et al., 2022; Williamson et al., 2021). Jin et al. (2022) stated that "Inclusion of third wave behavioral and spirituality-integrated therapies is warranted" (p. 8).

An especially novel treatment was discovered during this systematic review process. It is also particularly important for this part of the results section and has been called Impact of Killing (IOK) (Burkman et al., 2019). All of the mental health clinicians interviewed in this study reported that this unique approach "served a clinical need not otherwise fulfilled by existing evidence-based treatments for PTSD" (Burkman et al., 2019, p. 84). Utilizing this treatment approach allows clinicians to address veterans' moral values, spirituality, and support their striving in working toward moral repair (Burkman et al., 2019). IOK is described as a six- to eight-session treatment model that uses a cognitive-behavioral framework and is both evidence-based and focused on trauma (Purcell et al., 2018). Typically, it is intended to follow a course of PE or CPT once PTSD-specific issues have been addressed and to ensure an MI component is a feature of the veteran's presentation. Purcell et al. (2018) explain that "IOK is unique in its focus on the act of killing and on the moral distress that veterans experience in the aftermath of combat" (p. 648). It provides veterans with an opportunity to start communicating the war experiences that have caused psychological pain and allows for cognitive processing and re-evaluation of a type of trauma that might otherwise remain unspoken. This treatment acknowledges that military acts can violate a person's own boundaries and can result in experiences of guilt, shame, and condemnation of oneself. Supporting veterans to face these challenging matters can increase their ability to re-integrate after returning from work, improve capacity for intimacy with others, and encourage a process of self-forgiveness and self-

acceptance (Purcell et al., 2018). Specific topics addressed in this treatment include (a) assessment of the problem(s), addressing barriers to engagement, coping skills; (b) the physiology, emotions, and cognitions associated with killing; (c) providing a CBT framework to discuss the meaning of killing and associated cognitions; (d) defining forgiveness and exploring barriers to self-forgiveness; and (e) a focus on making amends and maintaining gains from therapy (Purcell et al., 2018). The treatment has been designed for delivery by therapists (mental health clinicians) and willingness to openly engage with topics of a spiritual nature and with veterans from diverse faith traditions are considered important prerequisites for delivering this type of therapy (Purcell et al., 2018).

Research Questions #1 and #2 Summary. Findings suggest that chaplains prioritize a focus on spirituality in their work with veterans who present with MI and trauma/PTSD. Mental health clinicians, however, may opt for secular interventions in their treatment of veterans with this type of presentation. As is clear from the example of the IOK approach, mental health clinicians also have the option and are encouraged to explicitly integrate discussions about spirituality when treating veterans with MI (Research Question #1). It seems clear, therefore, that there are differences in the consistency of treatment approaches between chaplains and mental health clinicians. Chaplains appear to routinely address matters of spirituality whereas mental health clinicians may do so more sporadically (Research Question #2).

Category #3: Interdisciplinary Collaboration Among Chaplains and Mental Health Clinicians is an Important Aspect of Providing Effective Treatment to Veterans With Moral Injury

Collaboration was identified as a prominent theme in the data and supported by seven studies. As Drescher et al. (2018) stated, “MI sits at the nexus of psychological and spiritual health. As such, both mental health professionals and chaplains will continue to have a keen

interest in this topic; and both will care for veterans suffering from MI" (p. 2457). Following on from this, integration of mental health and chaplaincy provision has been deemed crucial. Providers are described as needing to promote understanding of the other profession, possess the competence to screen and make referrals for patients to the other profession, reach an understanding of the shared treatment objectives for veterans with MI, and be welcoming of the best practices that emerge in the literature based on evidence (per chaplain study; Drescher et al., 2018).

Another study specifically stated that, "Collaboration between chaplaincy and behavioral health is crucial for optimally treating spiritual injuries, such as moral injury" (chaplain study) (Boska et al., 2023, p. 38), and that spiritual assessments, as well as therapy (both individual and group), would be feasible means to help facilitate this collaboration (per chaplain studies; Boska et al., 2021; Griffin et al., 2015, as cited in Boska et al., 2023).

Interdisciplinary collaboration was supported by other studies that recognize the value of integrative work (chaplain study; Van Denend et al., 2022) and the inherent need for both pastoral care and clinical support to address issues such as depression, PTSD, and/or suicidality (chaplain study; Boska et al., 2021). In the study that discussed the IOK treatment, the authors reported their encouragement of collaboration between mental health clinicians and chaplaincy, particularly if spiritual counseling was indicated in any veteran's care (mental health clinician study; Burkman et al., 2019). As one chaplain in another study stated, "I think it's important that in the interdisciplinary team, that we're all working toward the same goal for the Veteran, even with holistic health" (Boska et al., 2023, p. 34).

While data suggest that collaboration is important between chaplains and mental health clinicians, chaplains reportedly are less actively involved in this approach to care (mental health

clinician study; Wortmann et al., 2022). In contrast with studies that highlighted a consensus around interdisciplinary collaboration, one specific study documented a difference in opinion about collaboration by suggesting that MI should not be a focus of clinical practice at all (mental health clinician and chaplain combined study; Eikenaar, 2022). This viewpoint was expressed by some providers who were described as chaplains and who conveyed their concern about "clinical appropriation" regarding the treatment of MI by mental health clinicians (Eikenaar, 2022, p. 5).

Furthermore, contention was uncovered in this study pertaining to difficulties between disciplines with cooperating and coordinating care (Eikenaar, 2022). Psychologists and psychiatrists were described as "'highly dominant disciplines' that obliterate what is valuable, but hard to fit into protocols" (Eikenaar, 2022, p. 5). These providers were criticized for either ignoring a phenomenon when *DSM* classification or a protocol cannot accommodate it neatly or making it fit into a protocol regardless (Eikenaar, 2022). Furthermore, individual therapy by itself is considered an inadequate intervention for MI (Eikenaar, 2022). Rather, it is suggested that veterans should be supported to make return trips to places where they carried out missions to allow these individuals to "clean their consciousness, look for reconciliation and (self) forgiveness" (Eikenaar, 2022, p. 6).

Research Questions #1 and #2 Summary. Overall, it seems evident that mental clinicians and chaplains alike value interdisciplinary collaboration and consider this an important aspect of effective treatment for veterans with MI (Research Question #1). A poignant difference, however, was discovered pertaining mainly to chaplains, some of whom expressed explicit disagreement with the approach mental health clinicians may take in treating veterans with MI (Research Question #2).

Category #4: Training is an Identified Need of the Providers Who Support Veterans With Moral Injury, Particularly for Mental Health Clinicians Who Are Not Confident in Assessing and/or Incorporating Spirituality into this Process

Though not extensively addressed across the studies, there were four that identified the need to train providers to respond to the complex needs of veterans with MI. Interdisciplinary training opportunities were described as a way to help develop trust and supportive relationships between providers when integration takes place (chaplain study; Drescher et al., 2018). Access to training that is evidence-based and collaborative in nature was also considered a way to provide integrated psychosocial-spiritual care to veterans with MI (chaplain study; Wortmann et al., 2022). Additionally, mental health clinicians in particular reported that they would value increased access to training and resources that would allow them to identify and treat MI-related psychiatric disorders (Williamson et al., 2021). Improved mental health clinician confidence was noted as another important reason to focus on provider training needs in working with veterans affected by MI (Williamson et al., 2021).

In the study of the specialized IOK treatment, mental health clinicians expressed a desire for more preparation and training due to the stigmatized topics addressed in this approach. Such topics included military training as it relates to killing, reactions that veterans commonly experience in response to killing, and learning about the spiritual traditions of the veterans they treat (Burkman et al., 2019). As an example, one mental health clinician stated:

> I don’t feel I need to know all the distinctions between Baptist and Lutheran, but it helps me to know that Catholics do confession and Protestants don’t and just to have a little bit…about Buddhism…I think it will strengthen the ability of a provider who doesn’t

> have to turn to their patient for every single part of educating them about their faith tradition. (Burkman et al., 2019, p. 89)

Research Questions #1 and #2 Summary. Mental health clinicians and chaplains both relayed the importance of training opportunities to help develop trust between these different disciplines (Research Question #1). Additionally, a specific difference found was that mental health clinicians identified interdisciplinary training as a way to increase their knowledge and confidence in addressing spiritual matters during the course of their work with veterans experiencing MI (Research Question #2).

Synthesized Statement #3

Specific spiritual themes indicated in the treatment of veterans affected by MI include issues of forgiveness and existential matters involving human suffering and meaning-making.

Category #1: Forgiveness is a Frequently Encountered Spiritually-related Issue by Providers When Responding to Veterans With Moral Injury

Forgiveness and struggles around this spiritually-related concept were identified in almost all of the included studies (10 out of 11). Lack of forgiveness was named as a sign and/or symptom of MI, particularly as related to the veterans forgiving themselves (chaplain study) (Drescher et al., 2018). Self-forgiveness was reported by 25% of the respondents in one particular study as relevant to the treatment of veterans with MI (Drescher et al., 2018) and identified as a general theme that surfaced during treatment in other studies of both mental health clinicians and chaplains (Burkman et al., 2019; Eikenaar, 2019; Jin et al., 2022; Van Denend et al., 2022; Williamson et al., 2019, 2021; Wortmann et al., 2022).

Of note, self-forgiveness is a specific component of the IOK treatment for veterans presenting with MI (Burkman et al., 2019). The profound struggle involved with self-forgiveness as related to killing is evident in the following mental health clinician quote:

> Well there's certainly [patients] … who had to shoot a child. One who was laden and strapped with explosives, approaching the gates of Bastion and … the issue was being high-fived by his colleagues for taking the shot … for this particular chap [his] wife wants to have a child and … he couldn't consider that as [he thought] 'how could I possibly be a father to a child, I'm a murderer.' (Williamson et al., 2019, p. 4)

Forgiveness of others (mental health clinician study; Williamson et al., 2019) receiving God's forgiveness (chaplain study; McCormick et al., 2017), and the relevance of forgiveness in helping to address social withdrawal and separation from others (chaplain study; Boska et al., 2021) were additional aspects of this spiritually-related concept mentioned in the data. It is important to highlight that one particular study respondent explained that "for many persons around the world, forgiveness is intricately tied with spiritual beliefs, practices, and relationships" (Jin et al., 2022, p. 7).

Research Questions #1 and #2 Summary. The existing literature is clear that both mental health clinicians and chaplains recognize and embrace the critical issue of forgiveness of self and/or others when treating veterans with MI and trauma/PTSD (Research Question #1). Two specific differences between the disciplines, however, revealed that chaplains identified the importance of God's forgiveness and the role of forgiveness as a way to help veterans reconnect socially (Research Question #2).

Category #2: Learning to Find Meaning in Suffering is a Common Existential Concern Among Veterans Who Experience Moral Injury

Another finding that emerged from the data involves the existential theme of suffering and how veterans strive to make sense of their experiences in the aftermath of impactful events. The relevance of a veteran's "meaning systems…shaped by a religious or spiritual tradition" was mentioned in the Drescher et al. (2018; chaplain study) article and how this can present as a major part of the effects of MI on the individual. In response, encouragement of activities intended to enhance the veteran's sense of meaning and purpose in life has been identified as an important consideration in treatment (Drescher et al., 2018).

For effective recovery to take place, willingness to move in a forward direction despite painful memories and the experience of suffering was another finding (chaplain study) (Wortmann et al., 2022). In this same study, chaplains described the significance of supporting veterans to reach a place of appropriate acceptance of suffering that occurs in the world on both an intellectual and spiritual level in their treatment (Wortmann et al., 2022).

Similarly, Williamson et al. (2021; mental health clinician study) addressed this type of suffering from the perspective of negative appraisals and veterans developing a view of the world as a terrible place. MI was described by mental health clinicians in another study as suffering "from existential and spiritual conflicts as well as changes in beliefs about morality and humanity" (Jin et al., 2022, p. 8). Providers are therefore tasked with developing treatments that are culturally appropriate, personalized, and need to "promote resilience, meaning, purpose, hope, and social connection" (Drescher & Farnsworth, 2021, as cited in Jin et al., 2022, p. 8; Litz & Kerig, 2019; Toombs et al., 2021).

One study highlighted how chaplains themselves are challenged with making sense of the narratives they hear from veterans. A participant in this study stated:

> Attempting to hold a person suffering from moral injury is like trying to hold the pieces of a valuable porcelain vase which has shattered with one hand and trying to apply glue with the other. It is never the same again. (McCormick et al., 2017, p. 122)

The experience of veterans with MI was described in this study as "spiritual and emotional burdens" (McCormick et al., 2017, p. 126).

Another study reported the importance of a provider's "ability to tolerate intense feelings of guilt, remorse, disillusionment, and despair that do not stem from distortions of reality, but rather recognition of our human capacity for destruction and cruelty" (mental health clinician study; Burkman et al., 2019, p. 91). Eikenaar (2022; mental health clinician and chaplain combined study) concurs with this perspective on providers engaging in sense-making in the context of confronting the realities of inhuman situations. In their findings, Van Denend et al. (2022; chaplain study) concluded that the presence of religion and spirituality has remained a constant aspect of life over time and that these sources of support offer a way to find meaning and comfort in the midst of suffering (Park et al., 2013, as cited in Van Denend et al., 2022).

Research Questions #1 and #2 Summary. As these findings highlight, mental health clinicians and chaplains alike commented on the far-reaching impact of suffering that veterans with MI and trauma/PTSD experience. In addition, each of these disciplines recognized the importance of meaning-making in the aftermath of exposure to such life events when treating veterans with these concerns (Research Question #1). Differences were found among these disciplines in their approach to these issues. The role of a veteran's faith tradition and the ability of the individual to accept the existence of suffering were components of clinical care

emphasized by chaplains. Mental health clinicians, on the other hand, highlighted that treatment might focus on the negative evaluation of the trauma(s) and the issue of human suffering as a way to help the veteran in their recovery from MI. Both disciplines recognized the importance of the provider's own capacity to manage the complex and distressing nature of this type of work when providing clinical care to the affected veterans.

Chapter 4: Discussion

Overview

This dissertation utilized the systematic review approach to methodology to explore the views of both chaplains and mental health clinicians on the integration of spirituality in the care of veterans with MI and histories of trauma/PTSD. Two research questions were addressed, which included: (a) What do we know about the perspectives of providers (mental health clinicians and chaplains) regarding the integration of spirituality in the clinical care of MI in veterans with trauma/PTSD?; and (b) Are there similarities and differences in mental health clinician and chaplain perspectives? The qualitative data revealed consistency between chaplains about recognizing and actively addressing spirituality in their work with veterans. Mental health clinicians, however, demonstrated variability in their perspectives on the integration of spirituality in their treatment of veterans. The studies in their totality showed that matters of spirituality may be a relevant feature of a veteran's struggles when they seek services, whether or not providers feel adequately prepared to respond when MI is a presenting concern.

Conceptualization of Moral Injury

It is clear from the available literature that the subject of MI is a growing field of study. As Sullivan and Starnino (2019) report, "A majority of scholarship on this topic remains theoretically based, while almost all existing studies are of a qualitative nature" (p. 28). This is further highlighted by this study given that a total of 11 studies containing qualitative data were eligible for inclusion. In addition, though a larger proportion of included studies in this project elicited the views of chaplains, a scoping review in 2016 stated at that juncture, little empirical research on chaplains and MI was in existence (Carey et al., 2016). This point is again supported

by the fact that a wide pool of qualitative studies is not yet accessible to the field. Despite these considerations, the current literature supports each of the themes that surfaced in this study.

The scoping review conducted by Carey et al. (2016) lists various terms to describe the phenomenon of MI, which includes spiritual injury that chaplains mentioned in this study. These authors note that while MI is a more recent categorization of these types of veteran struggles, chaplains have been attending to such *soul wounds* for a vast amount of time (Carey et al., 2016). It is noted, however, that despite an increase in the study of MI over the past decade, a consensus has still not been reached as to the precise definition of this concept (Sullivan & Starnino, 2019). In the present study, some chaplains pointed out their perspective of viewing MI as a distinct concept from the spiritual distress experienced by veterans with trauma/PTSD (Research Question #1). This study highlights that there are clear differences in how mental health clinicians and chaplains conceptualize MI, however, more is known about chaplain viewpoints overall at this time (Research Question #2). The results in their entirety demonstrate that MI "remains an indeterminate and elusive notion, falling between multiple disciplines" (Eikenaar, 2022, p. 7).

Integration of Spirituality

Spirituality has also been related to the beliefs, values, and code of morality by which veterans align (Litz et al., 2009; Doehring, 2015, as cited in Brémault-Phillips, 2019). In addition, support for integrating spirituality as an aspect of treatment for MI is growing and considered a way to address the values and spiritual concerns of the military members that providers treat (Blinka & Wilson Harris, 2016; Carey et al., 2016; Doehring, 2015; Drescher et al., 2011; Hufford et al., 2010; Keenan et al., 2014; Kopacz et al., 2014; Kopacz et al., 2016; Litz

et al., 2009; Purcell et al., 2016; Pearce et al., 2018; Rennick, 2013; Worthington & Lanberg, 2012, as cited in Brémault-Phillips et al., 2019).

The findings of this study are consistent with opinions outlined in the literature regarding the importance of assessing spiritual matters when veterans seek care. The chaplains in this study already understood the significance of gathering this type of information from veterans when responding to MI (Research Question #1). On exploration of the literature, the issue of assessment is discussed in direct reference to the role of mental health clinicians. For instance, spiritual assessment is described as a professional responsibility of mental health clinicians (Sullivan & Starnino, 2019). Another author explains how the optimal assessment and subsequent interventions used to help traumatized veterans necessitate "an understanding of the idioms and perspectives of various spiritual (religious and philosophical) traditions on transgression and their recommendations for forgiveness and healing" (Wortmann et al., 2017, p. 249). Spiritual struggles may then be elicited by mental health clinicians when veterans seek psychotherapy (Buhagar, 2021).

The results of this study also further confirmed the lack of consistency demonstrated by mental health clinicians in both identifying and intervening with MI when this is present with the veterans they treat (Research Question #2). It is an obvious statement that chaplains focus their intervention efforts on the provision of spiritual care when serving veterans, as also verified in this study (Research Question #1). With mental health clinicians, on the other hand, much more variability is observed in how they manage such matters in the course of clinical care (Research Question #1). Nieuwsma et al. (2013) is cited in a scoping review as stating, "there is a gap in how consistently issues of religion and spirituality are addressed by mental health…providers.

These providers often do not integrate religious and spiritual issues into the care of patients" (as cited in Carey et al., 2016, p. 1236).

Interestingly, however, spirituality is considered the purview of other professionals and not just the responsibility of those associated with religious practices (Bryan et al., 2015, as cited in Kopacz, 2015). *The Diagnostic and Statistical Manual-5 (DSM-5)* is also mentioned as part of the assessment process with traumatized veterans. One study notes that the inclusion of "guilt" in the definition of PTSD represents a legitimate recognition of spiritual distress as an aspect of PTSD (Harris et al., 2018). Indeed, mental health clinicians are challenged to prepare for and perhaps even encourage veterans to reflect on their experience of spirituality in seeking to enhance and/or at least maintain their quality of life as they attempt to push ahead in the aftermath of military traumas (Currier et al., 2016). Failing to do so, may result in a lack of understanding as to the veteran's prognosis over the long term, neglect "a source of solace and possible motivation for therapeutic change" (Currier et al., 2015a, p. 58), and inadvertently dismiss the significance of this life domain in the process of the veteran's recovery (Currier et al., 2015a).

Johnson (2014) bolsters this perspective by recommending that mental health clinicians evaluate veteran trauma in spiritual terms. This can reportedly take place by identifying the significance of the spiritual aspects of their symptoms and possibly supporting the veteran to strengthen their thoughts, emotions, and behaviors as related specifically to spirituality/religion while undergoing psychotherapy (Johnson, 2014). Caution is provided to mental health clinicians about the delicate nature of this process and that how such interventions are handled is likely to be affected by the clinician's own therapeutic skills. Mental health clinicians are tasked with ensuring that the veteran is not deprived of access to their own spiritual/religious rituals through

modification of their cognitions and give the example of "the confession of sin as an avenue to grace" (Johnson, 2014, p. 16).

Collaboration

Collaboration between mental health clinicians and chaplains was found in the present study and is a finding supported by the literature. In this study, both chaplains and mental health clinicians commented on the important role that collaboration may play in supporting traumatized veterans (Research Question #1), perhaps with the exception of the smaller number of chaplains who expressed discontent about the involvement of mental health clinicians in treating MI (Research Question #2). One particular study in the literature raises the issue of mental health clinicians lacking a clear understanding as to when it would be most prudent to consult with spiritual/religious providers (Vieten et al., 2016). The authors of this study provide information to mental health clinicians about situations that may indicate collaboration with religious providers, such as chaplains or clergy, and could assist in intervening with certain aspects of the veteran's MI (Wortmann et al., 2017). Possessing the skills to seek such consultation is regarded as likely to positively impact the care provided to traumatized veterans (Wortmann et al., 2017). Furthermore, mental health clinicians need to ensure they recognize the highly valuable role that chaplains play in assisting veterans. As Layson et al. (2022) stated, "chaplaincy is shown to be an important contributor to the wellbeing of personnel because…it provides holistic pastoral/spiritual care and is a trusted point of entry into mental health programmes should it be required" (p. 1172).

Training of Providers

Both chaplains and mental health clinicians highlighted the need for increased access to training when responding to the needs of veterans who have MI (Research Question #1). The

literature also supports this finding, though it seems to emphasize a greater need among mental health clinicians as opposed to chaplains (Research Question #2). Mental health clinicians appear to lack the knowledge, awareness, and training to understand the significance of the role that religion and spirituality may play in supporting a person's well-being (Carey et al., 2016). Training is viewed as important in helping to reduce the stigmatization of spiritual struggles (Currier et al., 2015a). Unfortunately, however, one study states that "Whether working with trauma survivors or otherwise, clinicians seldom receive formal training for addressing spirituality in their work" (Shafranske & Cummings, 2013, as cited in Currier et al., 2015a, p. 58). This is an interesting issue given that the ability to assist traumatized veterans to address religious and spiritual struggles is considered a necessary component of multicultural competence for mental health clinicians (Sullivan & Starnino, 2019).

Competency and Ethical Considerations

Another author points out that integrating religion and spirituality into clinical practice requires a sophisticated approach by mental health clinicians (Johnson, 2014). Ethical boundaries are mentioned as an aspect of this process and the American Psychological Association's (APA) Ethics Code is referenced to explain the ethical duties of psychologists in these types of professional circumstances (Johnson, 2014). Standard two of this code "reminds psychologists to secure the training, supervision, and/or consultation necessary to work competently with clients" (Johnson, 2014, p. 16) and is furthermore considered an essential competence in working with the spiritual health of traumatized veterans (Johnson, 2014). Wortmann et al. (2017) specifically state that responding to spiritual/religious concerns when treating veterans is not only a type of multicultural competence but actually fits within a mental health clinician's scope of practice.

One particular area that mental health clinicians appear to encounter difficulty with is not possessing sufficient familiarity with the diverse range of spiritual and religious belief systems of those they treat (Vieten et al., 2016, as cited in Wortmann et al., 2017). Furthermore, there is a lack of confidence among mental health clinicians in recognizing the need for spiritual consultation on this matter (Vieten et al., 2016, as cited in Wortmann et al., 2017).

The Role of Forgiveness

An especially prominent theme that recurred in the present study is the matter of forgiveness (Research Question #1). This particular finding is supported extensively across the literature on veterans and MI and seems to be a critical aspect of responding appropriately to the needs of this population (Worthington & Langberg, 2012, as cited in Currier et al., 2016). Numerous studies highlight that the utilization of forgiveness-focused interventions of the self and others may be a more effective way to address MI in veterans (Litz et al., 2009; Maguen et al., 2017; Steinmetz & Gray, 2015, as cited in Jones et al., 2022). As veterans are faced with bearing witness to trauma and/or may also be perpetrators of it, a host of challenging reactions may occur in response, including "unforgiveness toward self (e.g., guilt and shame) and others (e.g., resentment/hostility, sense of betrayal)" which can result in significantly reduced quality of life (Currier et al., 2016).

It is acknowledged that incorporating spiritual interventions and the concept of forgiveness in the course of psychotherapy tends to be a source of controversy yet a research interest that is receiving more attention (West, 2001). This author further adds that "The therapeutic use of forgiveness holds great promise to aid the effective healing of many clients and therapists need to inform themselves of how best to use it within their clinical practice" (West, 2001, p. 421). Rye (2005) makes it clear that forgiveness interventions typically share

overlapping content whether religiously-based or secular. The sheer importance of attending to issues of forgiveness in the care of veterans is emphasized by Johnson (2014), who points out that problems in this area of spiritual health have been found to predict the severity of PTSD. Furthermore, another study explains that the capacity to forgive oneself and/or others can be accomplished by veterans who follow a faith tradition and those military personnel who do not (Wortmann et al., 2017). The present study specifically highlighted the role of God's forgiveness as a distinct consideration of chaplains who work with veterans affected by MI (Research Question #2).

Human Suffering and Existential Matters

The remaining theme that was detected in this current study pertains to the problem of human suffering and issues of an existential nature as experienced by traumatized veterans. Whether explicitly stated or not, it was evident that each of the included studies, regardless of discipline, conveyed an appreciation for these types of struggles that veterans face (Research Questions #1 and #2). Yeterian et al. (2019), include the role of spiritual/existential beliefs in their conceptualization of MI (as cited in Jones et al., 2022).

In consideration of the role that spirituality plays in supporting mental health, existential meaning is viewed as a possible mechanism in this process (de Carvalho & Moreira-Almeida, 2023). Berg (2011) states that "existential issues of life and death are all central to spirituality" (p. 1, as cited in Sullivan & Starnino, 2019, p. 28). Moral injuries are referred to elsewhere as a form of "existential wounds" and in need of a shared approach that is not simply medical in focus (Hodgson & Carey, 2017, as cited in Sullivan & Starnino, 2019, p. 37). These authors continue that "moral repair may require far more than health care professionals can provide" and that military personnel may instead seek help from chaplains, which can be viewed as a more

socially acceptable form of care (Sullivan & Starnino, 2019). Based on the results of the present study and in view of this information, it seems that both mental health clinicians and chaplains are well-placed to support veterans with such concerns and may need to lean on each other during the process. Of note, however, both mental health clinicians and chaplains pointed to the need for providers to possess the ability to navigate the often-disturbing content presented by veterans who experience MI and seek clinical care in response to such distress (Research Question #2).

Strengths and Limitations

In terms of this writer's confidence in the included data and its quality, overall this appeared to be sufficient in adequately answering the research questions. There was, however, some conflation of the results in two particular studies (Eikenaar, 2022; Jin et al., 2022). Some of the studies had large sample sizes while others had relatively small sample sizes, yet all still appeared to produce quality findings. The smallest sample size was found in the Van Denend et al. (2022) study, though the findings of the case study that was analyzed still demonstrated congruence of the themes found among the other studies.

The Eikenaar (2022) study indicated an inconsistency with other study findings pertaining to the helpfulness of interdisciplinary collaboration. Overall, however, the data clearly detected that mental health clinicians and chaplains alike are personally and professionally challenged by the complexity of treating MI. Forgiveness was the most consistent theme across all of the studies, particularly self-forgiveness. The studies conducted in the UK contained the least explicit focus on spirituality in treatment and it is unclear why this is the case in comparison with the other international studies.

This study indicates that as a field, we seem to know more about chaplain perspectives on the inclusion of spirituality in the care of traumatized veterans than mental health clinicians and that this represents a gap in the literature. It is apparent that chaplains are much more comfortable with the topic of spirituality in the course of clinical care. Mental health clinicians may not even raise the subject or know how to approach it. In one study, tension between chaplains and mental health clinicians was reported due to disagreement about which discipline is best positioned to address MI (Eikenaar, 2022). Most agreement discovered was between chaplains on how to integrate spirituality into clinical care. It should be noted that the broad definition of spirituality utilized in this systematic review may also represent another limitation of this study as this complex concept can be understood in so many different ways.

The included studies typically reported on the religious/spiritual beliefs of chaplains but not the mental health clinicians. This finding appears to be consistent with the assertion by Shafrankse and Cummings (2013) that as a group of professionals, psychologists tend to identify as religious much less frequently than their patients (as cited in Vieten et al., 2016). This consideration seems to be highly significant as willingness to discuss this aspect of a veteran's life and indeed that of patients more generally is likely a neglected area of practice. As highlighted in a study published by the American Psychological Association (APA), only 30% of psychologists endorsed engaging in discussion about religion and spirituality with their patients, and less than 50% asked about this topic in their assessment and treatment planning (Hathaway et al., 2004, as cited in Vieten et al., 2016).

Additionally, there was insufficient international representation from other countries and the spiritual backgrounds of the chaplains. It is not possible to comment on this aspect of the mental health clinicians' representation as this information was not addressed. In a similar vein,

there appears to be a potential lack of cultural diversity among providers across all providers regardless of discipline, which seems likely to impact veteran experience of service provision.

Concerning the review process itself, the developing nature of this study's topic contributes to the existing literature base given the applicability to not only veterans but also in addressing the issue of the integration of spirituality into clinical care more generally in the field. Due to this study's narrow focus, familiarity with the available literature on the topic was accomplished and it appears that all relevant studies from the databases were likely identified.

The quality of studies was thoroughly assessed via the Quality Appraisal tool and the credibility process that is built into the meta-aggregation approach. One drawback to this study, however, is that this writer did not utilize a secondary reviewer to replicate the exact screening process to determine article inclusion. Additionally, the 11 studies included in this systematic review can be considered a small sample size. It is the perspective of this author, however, that the findings of this study are generalizable given the overall consistency of themes elicited and the inclusion of a number of studies that extracted their data from objectively large sample sizes (Drescher et al., 2018; McCormick et al., 2017; Wortmann et al., 2022). In addition, the findings seem to be generalizable to the veteran population and potentially other types of trauma survivors.

Future Research Directions and Practice Implications

This study may open the door to exploring how MI impacts other populations which might include other professions where exposure to extreme trauma occurs (for example, journalism; medicine; and governmental protective services). The forensic/correctional populations could possibly benefit from the exploration of how MI affects individuals involved in the criminal legal system. As this study addressed matters of an existential nature, contribution

to the research of suicidality might also be relevant in terms of gaining further insight into the etiology behind veteran suicide as well as that of other traumatized people. Additionally, it seems reasonable to highlight how MI may affect veterinarians and people affected by exposure to the suffering of animals.

There are other implications of this systematic review. Mental health clinicians need to be supported to increase their comfort level with broaching the topic and treatment of spirituality in the course of treatment. Chaplains in particular have knowledge to share with mental health clinicians in educating other disciplines on the positive coping resources that spirituality can offer.

The results of this study suggest that some country settings may be more open to exploring spirituality, and the UK stood out as less focused on this topic in comparison to other international locations. Further understanding the gaps between chaplains and mental health clinicians seems likely to help with improving collaboration among providers in providing effective care to traumatized veterans. Researchers should strive to better understand the barriers that exist with effective communication and collaboration between chaplains and mental health clinicians.

Further research is needed to explore a broader range of faith backgrounds and spiritual beliefs and practices of the providers who support traumatized veterans with MI. It seems important for future research to explore the impact of working with MI on providers' own spiritual experiences and the type of support that may be indicated, regardless of professional discipline. This particular finding has wider applicability to other types of providers also when dealing with severe forms of human suffering and its long-lasting aftermath.

Moving forward, it seems important for the field to find ways to support the destigmatization of the subject of spirituality and with building in ways to make this a more routine part of assessment and treatment. This may help veterans feel more supported in knowing that this life domain can be included as an aspect of their care at the earliest opportunity. This is also a relevant consideration in supporting other patient populations.

Concluding Comments

In essence, spirituality as an integral domain of life remains poorly understood among mental health clinicians. Neither do mental health clinicians demonstrate sufficient comfort nor competency with how to integrate spirituality into patient care. These providers also need formal training on the subject of spirituality to ensure that veterans and other patient needs are not overlooked. Further clarity seems needed regarding the differences in the roles of chaplains and mental health clinicians in treating MI and indeed whether the idea of spiritual injury is a distinct issue or a facet of MI for some veterans. This may help to inform treatment approaches and interdisciplinary collaboration.

Spirituality is clearly an inadequately addressed topic among mental health clinicians who treat MI, and this is likely to be reflective of the field more generally. This is despite the importance placed on multicultural competence among mental health clinicians. Current psychological treatments are not likely acceptably robust in helping veterans to effectively recover from MI, particularly those who have spiritual concerns. It also seems important to continue exploring the issue of whether mental health clinicians and chaplains can reach a consensus on the meaning and treatment of MI. It is, however, possible this tension may not be easily resolved.

In providing final comments, this author has found it beneficial to ponder the potential utility of five spiritually-based tools that mental health clinicians might consider using in the course of clinical practice. Plante (2022) outlines such interventions as follows, "(a) underscoring the sacredness of all; (b) learning to accept others, even with faults, (c) focusing on spirituality modeling, (d) encouraging virtues of forgiveness, kindness, gratitude, and compassion, and (e) incorporating ethics in daily decision-making" (p. 275). It would seem that regardless of one's professional background, these spiritually relevant strategies could prove meaningful and effective in supporting veterans with their journey of recovering from severe trauma that reaches the individual at their innermost core.

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APPENDIX A

Comprehensive Search Plan

COMPREHENSIVE SEARCH PLAN

* Includes electronic databases

Search Type	Databases or Sources	Search Term ID(s)	Search Syntax or Instructions	Fields to Search	Specifiers	Plan Notes
Electronic Database	PsycINFO	01, 02	"moral injury," OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "military," OR "veteran," OR "military personnel," OR "military combat," OR "combat," OR "service member," OR "war," OR "war-related," OR "deploy," OR "active duty"	Title, Keywords, Abstract	*Years: 2009-2023 *Type: Peer-reviewed articles only	
Electronic Database	PsycINFO	01, 03	"moral injury," OR, "morally injurious", OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "trauma," OR "posttraumatic," OR "post-traumatic," OR "posttraumatic stress," OR "post-traumatic stress," OR "posttraumatic stress disorder," OR "post-traumatic stress disorder," OR "PTSD," OR "traumatic," OR "traumatization," OR "trauma-exposed"	Title, Keywords, Abstract	*Years: 2009-2023 *Type: Peer-reviewed articles only	
Electronic Database	PsycINFO	01, 04	"moral injury," OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "spirituality," OR "spiritual coping," OR "religion," OR "religious coping," OR "faith," OR "God," OR "existential," OR "clergy," OR "chaplain," OR "priest," OR "pastor," OR "minister," OR "spiritual leader," OR "religious leader," OR "forgive," OR "guilt," OR "shame"	Title, Keywords, Abstract	*Years: 2009-2023 *Type: Peer-reviewed articles only	
Electronic Database	PsycINFO	01, 05	"moral injury," OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "treatment," OR "psychotherapy," OR "therapy," OR "evidence," OR "evidence-based," OR "service," OR "support," OR "approach," OR "intervention," OR "recover"	Title, Keywords, Abstract	*Years: 2009-2023 *Type: Peer-reviewed articles only	
Electronic Database	Military and Government Collection	01, 02	moral injury, OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "military," OR "veteran," OR "military personnel," OR "military combat," OR "combat," OR "service member," OR "war," OR "war-related," OR "deploy," OR "active duty"	Title, Keywords, Abstract	*Years: 2009-2023 *Type: Peer-reviewed articles only	
Electronic Database	Military and Government Collection	01, 03	"moral injury," OR, "morally injurious", OR "moral distress," OR "moral pain," OR "spiritual wound" OR "spiritual injury" AND "trauma," OR "posttraumatic," OR "post-traumatic," OR "posttraumatic stress," OR "post-traumatic stress," OR "posttraumatic stress disorder," OR "post-traumatic stress disorder," OR "PTSD," OR "traumatic," OR "traumatization," OR "trauma-exposed"	Title, Keywords, Abstract	*Years: 2009-2023 *Type: Peer-reviewed articles only	
Electronic Database	Military and Government Collection	01, 04	moral injury, OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "spirituality," OR "spiritual coping," OR "religion," OR "religious coping," OR "faith," OR "God," OR "existential," OR "clergy," OR "chaplain," OR "priest," OR "pastor," OR "minister," OR "spiritual leader," OR "religious leader," OR "forgive," OR "guilt," OR "shame"	Title, Keywords, Abstract	*Years: 2009-2023 *Type: Peer-reviewed articles only	
Electronic Database	Military and Government Collection	01, 05	moral injury, OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "treatment," OR "psychotherapy," OR "therapy," OR "evidence," OR "evidence-based," OR "service," OR "support," OR "approach," OR "intervention," OR "recover"	Title, Keywords, Abstract	*Years: 2009-2023 *Type: Peer-reviewed articles only	
Electronic Database	PILOT (Published International Literature on Traumatic Stress)	01, 02	moral injury, OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "military," OR "veteran," OR "military personnel," OR "military combat," OR "combat," OR "service member," OR "war," OR "war-related," OR "deploy," OR "active duty"	Title, Keywords, Abstract	*Years: 2009-2023 *Type: Peer-reviewed articles only	
Electronic Database	PILOT (Published International Literature on Traumatic Stress)	01, 03	moral injury, OR, "morally injurious", OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "trauma," OR "posttraumatic," OR "post-traumatic," OR "posttraumatic stress," OR "post-traumatic stress," OR "posttraumatic stress disorder," OR "post-traumatic stress disorder," OR "PTSD," OR "traumatic," OR "traumatization," OR "trauma-exposed"	Title, Keywords, Abstract	*Years: 2009-2023 *Type: Peer-reviewed articles only	
Electronic Database	PILOT (Published International Literature on Traumatic Stress)	01, 04	moral injury, OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "spirituality," OR "spiritual coping," OR "religion," OR "religious coping," OR "faith," OR "God," OR "existential," OR "clergy," OR "chaplain," OR "priest," OR "pastor," OR "minister," OR "spiritual leader," OR "religious leader," OR "forgive," OR "guilt," OR "shame"	Title, Keywords, Abstract	*Years: 2009-2023 *Type: Peer-reviewed articles only	
Electronic Database	PILOT (Published International Literature on Traumatic Stress)	01, 05	moral injury, OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "treatment," OR "psychotherapy," OR "therapy," OR "evidence," OR "evidence-based," OR "service," OR "support," OR "approach," OR "intervention," OR "recover"	Title, Keywords, Abstract	*Years: 2009-2023 *Type: Peer-reviewed articles only	
Electronic Database	Scopus	01, 02	moral injury, OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "military," OR "veteran," OR "military personnel," OR "military combat," OR "combat," OR "service member," OR "war," OR "war-related," OR "deploy," OR "active duty"	Title, Keywords, Abstract	*Years: 2009-2023 *Type: Peer-reviewed articles only	
Electronic Database	Scopus	01, 03	moral injury, OR, "morally injurious", OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "trauma," OR "posttraumatic," OR "post-traumatic," OR "posttraumatic stress," OR "post-traumatic stress," OR "posttraumatic stress disorder," OR "post-traumatic stress disorder," OR "PTSD," OR "traumatic," OR "traumatization," OR "trauma-exposed"	Title, Keywords, Abstract	*Years: 2009-2023 *Type: Peer-reviewed articles only	
Electronic Database	Scopus	01, 04	moral injury, OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "spirituality," OR "spiritual coping," OR "religion," OR "religious coping," OR "faith," OR "God," OR "existential," OR "clergy," OR "chaplain," OR "priest," OR "pastor," OR "minister," OR "spiritual leader," OR "religious leader," OR "forgive," OR "guilt," OR "shame"	Title, Keywords, Abstract	*Years: 2009-2023 *Type: Peer-reviewed articles only	
Electronic Database	Scopus	01, 05	moral injury, OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "treatment," OR "psychotherapy," OR "therapy," OR "evidence," OR "evidence-based," OR "service," OR "support," OR "approach," OR "intervention," OR "recover"	Title, Keywords, Abstract	*Years: 2009-2023 *Type: Peer-reviewed articles only	

APPENDIX B

List of Search Terms

LIST OF SEARCH TERMS

*Each Primary Search Term should have synonyms or alternate forms to use with the "OR" operator in your searches

Search Term ID#	Primary Term	Synonyms/Alternate Forms	Notes
01	Moral Injury	"morally injurious," "moral distress," "moral pain," "spiritual wound," "spiritual injury"	
02	Military	"veteran," "military personnel," "military combat," "combat," "service member," "war," "war-related," "deploy," "active duty"	
03	Trauma	"posttraumatic," "post-traumatic," "posttraumatic stress," "post-traumatic stress," "posttraumatic stress disorder," "post-traumatic stress disorder," "PTSD," "traumatic," "traumatization," "trauma-exposed"	
04	Spirituality	"spiritual," "spiritual coping," "religion," "religious coping," "faith," "God," "existential," "clergy," "chaplain," "priest," "pastor," "minister," "spiritual leader," "religious leader," "forgive," "guilt," "shame"	
05	Treatment	"psychotherapy," "therapy," "evidence," "evidence-based," "service," "support," "approach," "intervention," "recover"	

APPENDIX C

Search Documentation Record

SEARCH DOCUMENTATION RECORD

Search Date	FULL SEARCH ID#	TYPE OF SEARCH	DATABASE/SOURCE	SEARCH TERM IDRs	SEARCH SYNTAX OR OTHER GUIDELINES FOR THE SEARCH	FIELDS SEARCHED	SEARCH SPECIFIER: Years	SEARCH SPECIFIER: Publication Type	(Columns for Other Specifiers as Needed)	# of Records	NOTES
1/30/2023	101	Electronic Database	PsycINFO	01, 02	"moral injury," OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "military," OR "veteran," OR "military personnel," OR "military combat," OR "combat," OR "service member," OR "war," OR "war-related," OR "deploy," OR "active duty"	Title, Keywords, Abstract	2009-2023	Peer reviewed journals only	N/A	576	
1/30/2023	102	Electronic Database	PsycINFO	01, 03	"moral injury," OR, "morally injurious", OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "trauma," OR "posttraumatic," OR "post-traumatic," OR "posttraumatic stress," OR "post-traumatic stress," OR "posttraumatic stress disorder," OR "post-traumatic stress disorder," OR "PTSD," OR "traumatic," OR "traumatization," OR "trauma-exposed"	Title, Keywords, Abstract	2009-2023	Peer reviewed journals only	N/A	599	
1/30/2023	103	Electronic Database	PsycINFO	01, 04	"moral injury," OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "spirituality," OR "spiritual coping," OR "religion," OR "religious coping," OR "faith," OR "God," OR "existential," OR "clergy," OR "chaplain," OR "priest," OR "pastor," OR "minister," OR "spiritual leader," OR "religious leader," OR "forgive," OR "guilt," OR "shame"	Title, Keywords, Abstract	2009-2023	Peer reviewed journals only	N/A	353	
1/30/2023	104	Electronic Database	PsycINFO	01, 05	"moral injury," OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "treatment," OR "psychotherapy," OR "therapy," OR "evidence," OR "evidence-based," OR "service," OR "support," OR "approach," OR "intervention," OR "recover"	Title, Keywords, Abstract	2009-2023	Peer reviewed journals only	N/A	786	
									TOTAL	2,314	
1/30/2023	105	Electronic Database	Military and Government Collection	01, 02	"moral injury," OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "military," OR "veteran," OR "military personnel," OR "military combat," OR "combat," OR "service member," OR "war," OR "war-related," OR "deploy," OR "active duty"	Title, Keywords, Abstract	2009-2023	Peer reviewed journals only	N/A	51	
1/30/2023	106	Electronic Database	Military and Government Collection	01, 03	"moral injury," OR, "morally injurious", OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "trauma," OR "posttraumatic," OR "post-traumatic," OR "posttraumatic stress," OR "post-traumatic stress," OR "posttraumatic stress disorder," OR "post-traumatic stress disorder," OR "PTSD," OR "traumatic," OR "traumatization," OR "trauma-exposed"	Title, Keywords, Abstract	2009-2023	Peer reviewed journals only	N/A	29	
01/30/23	107	Electronic Database	Military and Government Collection	01, 04	"moral injury," OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "spirituality," OR "spiritual coping," OR "religion," OR "religious coping," OR "faith," OR "God," OR "existential," OR "clergy," OR "chaplain," OR "priest," OR "pastor," OR "minister," OR "spiritual leader," OR "religious leader," OR "forgive," OR "guilt," OR "shame"	Title, Keywords, Abstract	2009-2023	Peer reviewed journals only	N/A	16	
01/30/23	108	Electronic Database	Military and Government Collection	01, 05	"moral injury," OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "treatment," OR "psychotherapy," OR "therapy," OR "evidence," OR "evidence-based," OR "service," OR "support," OR "approach," OR "intervention," OR "recover"	Title, Keywords, Abstract	2009-2023	Peer reviewed journals only	N/A	29	
									TOTAL	125	
01/30/23	109	Electronic Database	PILOT	01, 02	"moral injury," OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "military," OR "veteran," OR "military personnel," OR "military combat," OR "combat," OR "service member," OR "war," OR "war-related," OR "deploy," OR "active duty"	Title, Keywords, Abstract	2009-2023	Peer reviewed journals only	N/A	164	
01/30/23	110	Electronic Database	PILOT	01, 03	"moral injury," OR, "morally injurious", OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "trauma," OR "posttraumatic," OR "post-traumatic," OR "posttraumatic stress," OR "post-traumatic stress," OR "posttraumatic stress disorder," OR "post-traumatic stress disorder," OR "PTSD," OR "traumatic," OR "traumatization," OR "trauma-exposed"	Title, Keywords, Abstract	2009-2023	Peer reviewed journals only	N/A	168	
01/30/23	111	Electronic Database	PILOT	01, 04	"moral injury," OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "spirituality," OR "spiritual coping," OR "religion," OR "religious coping," OR "faith," OR "God," OR "existential," OR "clergy," OR "chaplain," OR "priest," OR "pastor," OR "minister," OR "spiritual leader," OR "religious leader," OR "forgive," OR "guilt," OR "shame"	Title, Keywords, Abstract	2009-2023	Peer reviewed journals only	N/A	65	
01/30/23	112	Electronic Database	PILOT	01, 05	"moral injury," OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "treatment," OR "psychotherapy," OR "therapy," OR "evidence," OR "evidence-based," OR "service," OR "support," OR "approach," OR "intervention," OR "recover"	Title, Keywords, Abstract	2009-2023	Peer reviewed journals only	N/A	120	
									TOTAL	515	
01/30/23	113	Electronic Database	SCOPUS	01, 02	"moral injury," OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "military," OR "veteran," OR "military personnel," OR "military combat," OR "combat," OR "service member," OR "war," OR "war-related," OR "deploy," OR "active duty"	Title, Keywords, Abstract	2009-2023	Peer reviewed journals only	N/A	2	
01/30/23	114	Electronic Database	SCOPUS	01, 03	"moral injury," OR, "morally injurious", OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "trauma," OR "posttraumatic," OR "post-traumatic," OR "posttraumatic stress," OR "post-traumatic stress," OR "posttraumatic stress disorder," OR "post-traumatic stress disorder," OR "PTSD," OR "traumatic," OR "traumatization," OR "trauma-exposed"	Title, Keywords, Abstract	2009-2023	Peer reviewed journals only	N/A	47	
01/30/23	115	Electronic Database	SCOPUS	01, 04	"moral injury," OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "spirituality," OR "spiritual coping," OR "religion," OR "religious coping," OR "faith," OR "God," OR "existential," OR "clergy," OR "chaplain," OR "priest," OR "pastor," OR "minister," OR "spiritual leader," OR "religious leader," OR "forgive," OR "guilt," OR "shame"	Title, Keywords, Abstract	2009-2023	Peer reviewed journals only	N/A	8	
01/30/23	116	Electronic Database	SCOPUS	01, 05	"moral injury," OR "morally injurious," OR "moral distress," OR "moral pain," OR "spiritual wound," OR "spiritual injury" AND "treatment," OR "psychotherapy," OR "therapy," OR "evidence," OR "evidence-based," OR "service," OR "support," OR "approach," OR "intervention," OR "recover"	Title, Keywords, Abstract	2009-2023	Peer reviewed journals only	N/A	123	
									TOTAL	180	
									GRAND TOTAL:	3,114	

APPENDIX D

Screening and Selection Record: Sample

SCREENING AND SELECTION RECORD

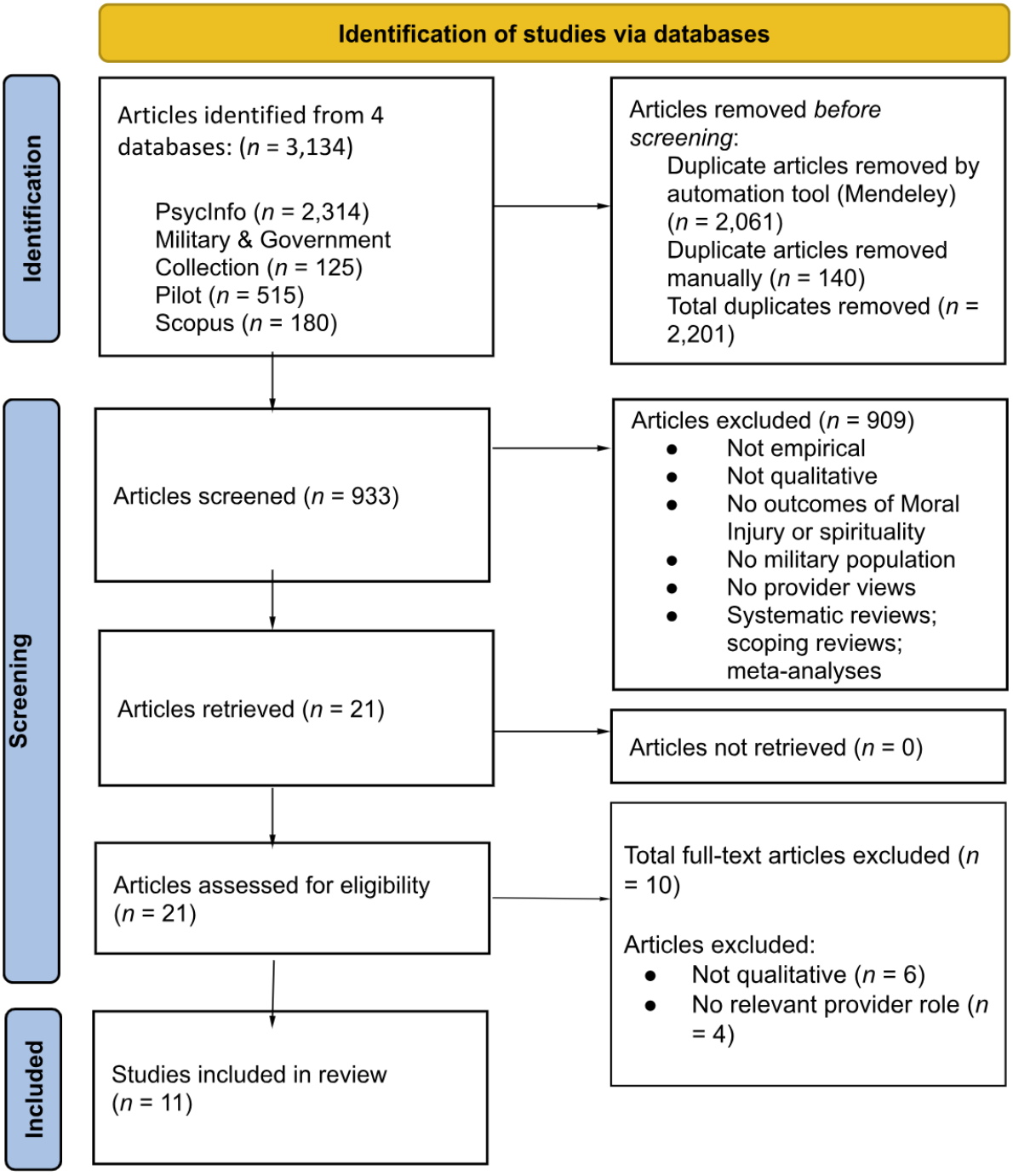
PHASE 1: Title/Keywords/Abstract (Screening) PHASE 2: Full Text Review (Eligibility) PHASE 3: Final Decision (Selection)

DECISION CODES: INCLUDE/CONTINUE TO ABSTRACT/CONTINUE TO FULL TEXT/UNDECIDED/EXCLUDE (IN/CAB/CFT/UN/EX)
CRITERIA CODES: (IS THE CRITERIA MET?): YES/UNCLEAR/NO (Y/UC/N)

AUTHOR(S)	YEAR	ABBREVIATED TITLE	DATABASE/ SOURCES	TITLE AND/OR KEYWORD SCREEN: DECISION DATE	ABSTRACT SCREEN: DECISION DATE	FULL-TEXT SCREEN?	INC (SO): Peer reviewed Published Study/Article from 2009-2023	INC (M): Qualitative (inc. from mixed methods)	INC (RV): Moral Injury	INC (PAR): Military Veterans	INC (RV): PTSD	INC (RV): Spiritual Issues	INC (RV): International Provider Role in Treatment (Chaplain and/or Clinician)	EXCL:	REVIEWER DECISION DATE	DECISION NOTES	SECONDARY CONFIRMATORY DECISION	FINAL DECISION	FINAL DECISION DATE	DECISION NOTES
Quintner et al.	2011	Maldynia as a moral judgment?	PsycINFO	CAB 09/25/23	EX 09/25/23	N								*						
Riegler	2013	Public distress as a moral consideration in afterbirth abortion	PsycINFO	EX 09/25/23	NA	N								*						
Anderson	2013	Take action to diminish moral distress in critical care nurses	PsycINFO	EX 09/25/23	NA	N								*						
Nomie	2009	Review of clinical errors, nursing shortage and moral distress: The situation in Jordan	PsycINFO	EX 09/25/23	NA	N								*						
Ulrich and Grady	2012	Perceptions of appropriateness of care in the intensive care unit	PsycINFO	EX 09/25/23	NA	N								*						
Woods	2011	Case commentary: Baby John	PsycINFO	EX 09/25/23	NA	N								*						
Rover et al.	2013	Nursing facing the loss of the right to universal health access in Spain	PsycINFO	EX 09/25/23	NA	N								*						
Karlsson et al.	2009	A difficult mission to work as a nurse in a residential care home	PsycINFO	EX 09/25/23	NA	N								*						
Klein	2009	Moral distress in pediatric palliative care: a case study	PsycINFO	EX 09/25/23	NA	N								*						
Goethals et al.	2010	Nurses ethical reasoning and behavior: A literature review	PsycINFO	EX 09/25/23	NA	N								*						
Goldberg	2009	Exilic effects of illness and pain in Solzhenitsyn's cancer ward	PsycINFO	EX 09/25/23	NA	N								*						
Schiavone	2009	The effects of exposure to community violence on aspects of adolescent identity development	PsycINFO	EX 09/25/23	NA	N								*						
Shay	2009	The trials of homecoming: Odysseus returns from Iraq/Afghanistan	PsycINFO	CAB 09/25/23	EX 09/25/23	N								*						
Mrayyan and Hamdeleh	2009	Clinical errors, nursing shortage and moral distress: The situation in Jordan	PsycINFO	EX 09/25/23	NA	N								*						
Mendenhall	2009	Chaplains in mental health: Healing the spiritual wounds of war	PsycINFO	CAB 09/25/23	CFT 09/25/23	N								*						
Blondal and Halldorsdottir	2009	The challenge of caring for patients in pain: From the nurse's perspective	PsycINFO	EX 09/25/23	NA	N								*						
Iglesias et al.	2010	Moral distress related to ethical dilemmas among Spanish podiatrists	PsycINFO	EX 09/25/23	NA	N								*						
Hortiana et al.	2011	Experiences of relocation in dementia care from the perspective of six care workers	PsycINFO	EX 09/25/23	NA	N								*						
Cole and Morgan	2011	Veganphobia: Derogatory discourses of veganism and the reproduction of speciesism in UK national newspapers	PsycINFO	EX 09/25/23	NA	N								*						
Rashotte et al.	2011	Nurses' moral experience of administering PRN antisecure medications in pediatric palliative care	PsycINFO	EX 09/25/23	NA	N								*						
Ratanawongsa	2016	Capsule commentary on Zoreg et al, Moral distress amongst American physician trainees regarding futile treatments at the end of	PsycINFO	EX 09/25/23	NA	N								*						
Priya	2012	Social constructionist approach to suffering and healing: Juxtaposing Cassell, Gergen and Kleinman	PsycINFO	CAB 09/25/23	EX 09/25/23	N								*						
Han et al.	2012	Do frontal eyes activate empathy related brain regions in individuals with callous traits?	PsycINFO	EX 09/25/23	NA	N								*						
Silen et al.	2011	Moral distress and ethical climate in a Swedish nursing context: Perceptions and instrument usability	PsycINFO	EX 09/25/23	NA	N								*						
Sheyard	2010	Moral distress: A consequence of caring	PsycINFO	EX 09/25/23	NA	N								*						
Penney and You	2011	Preparing occupational therapy students to make moral decisions	PsycINFO	EX 09/25/23	NA	N								*						
Pololi et al.	2013	Experiencing the culture of academic medicine: Gender matters, a national study	PsycINFO	EX 09/25/23	NA	N								*						
Peter	2015	Guest editorial: Three recommendations for the future of moral distress scholarship	PsycINFO	EX 09/25/23	NA	N								*						
Ojhile et al.	2012	The experience of surviving life threatening injury: A qualitative synthesis	PsycINFO	CAB 09/25/23	EX 09/25/23	N								*						
Pavlish et al.	2011	Early indicators and risk factors for ethical issues in clinical practice	PsycINFO	EX 09/25/23	NA	N								*						
McGraw et al.	2012	From the commercial to the communal: Reframing taboo tradeoffs in religious and pharmaceutical marketing	PsycINFO	EX 09/25/23	NA	N								*						
Deady	2012	Studying multidisciplinary teams in the Irish Republic: The conceptual wrangle	PsycINFO	EX 09/25/23	NA	N								*						
Pololi et al.	2012	Why are a quarter of faculty considering leaving academic medicine?	PsycINFO	EX 09/25/23	NA	N								*						
Austin et al.	2009	An overview of moral distress and the paediatric intensive care team	PsycINFO	EX 09/25/23	NA	N								*						

APPENDIX E

Study Selection Flow Diagram



APPENDIX F

Data Collection and Extraction Form

Modified from: *Effective Practice and Organisation of Care (EPOC). Data collection form. EPOC Resources for review authors. Oslo: Norwegian Knowledge Centre for the Health Services; 2013. Available at: http://epoc.cochrane.org/epoc-specific-resources-review-authors*

APPENDIX E: Data Collection and Extraction Form

Document ID#

Authors and Year *(last names of authors and year of publication, e.g., Johnson, Jones, and Jackson 2011)*

Full Document Title

Research Variables

Notes:

1. General Information

Date form completed *(dd/mm/yyyy)*	
Initials/ID of person extracting data	
Source/Publication Type *(journal, book, conference, report, dissertation, abstract, etc.)*	
Source Name *(Title of Journal, Book, Organization, etc.)*	
Other	
Notes:	

2. Design Characteristics and Methodological Features

	Descriptions as stated in report/paper	**Location in text** *(pg & ¶/fig/table)*
Aim(s) of study		
General Method (Qual, Mixed)		
Design or Specific Research Approach		
Other		

Notes:

3. Assessment of Research Variables

RESEARCH VARIABLES RELATED TO MORAL INJURY IN THE MILITARY POPULATION AND PROVIDER PERSPECTIVES	How Assessed *(Definition, Measure, Observation, Interview Question, Archival, etc.)*	Definition/Conceptualization/ Model/Theory/Perspective/ Professional Opinions	Location in text *(pg & ¶/fig/table)*
1. Moral Injury			
2. Military Veterans			
3. Trauma/PTSD			
4. Spirituality			
5. International Provider Role in Treatment (Chaplain and/or Clinician)			
Notes:			

4. Study Participant Characteristics and Recruitment

	Description as stated in report/paper	Location in text *(pg & ¶/fig/table)*
Population of Interest (Chaplains and/or Clinicians)		
Recruitment Methods		
Sample Size		

	Description as stated in report/paper	Location in text *(pg & ¶/fig/table)*
Age		
Gender		
Race/Ethnicity		
Highest Level of Education		
Spiritual/Religious Beliefs of Provider		
Other		
Notes:		

5. Setting Characteristics

	Descriptions as stated in report/paper	Location in text *(pg & ¶/fig/table)*
Study Location (Country)		
Data Collection Setting(s)		
Other		
Notes:		

6. Analyses Conducted

	Description as stated in report/paper	Location in text (pg & ¶/fig/table)
Qualitative Analyses conducted (e.g., Framework Synthesis; Grounded Theory for Synthesis; Meta-Ethnography; Meta-Study; Meta-Aggregation; Meta-Narrative; Meta-Summary; Textual Narrative Synthesis; Thematic Synthesis)		
How were themes coded?		
How was the data reviewed?		
How were discrepancies and biases handled?		
Other		
Notes:		

7. Important Themes: Key Perspectives/Outcomes/Results

	Description as stated in report/paper	Location in text *(pg & ¶/fig/table)*
Definitions of Moral Injury Used		
Assessment Considerations		
Diagnostic Considerations		
Psychological Treatment		
Integration of Spirituality into Treatment		
Views of Mental Health Clinicians		
Views of Religious/Spiritual Leaders/Providers		
Other		

	Description as stated in report/paper	Location in text *(pg & ¶/fig/table)*
Notes:		

8. Conclusions and Follow-up Recommendations

	Description as stated in report/paper	Location in text *(pg & ¶/fig/table)*
Key conclusions of study authors		
Study Author's Recommendations for Future Research		
Does the study directly address your review question? ***(any issues of partial or indirect applicability)***		
Your Take-Aways: General		
Your Take-Aways: Implications for Practice		
Salient Study Limitations (to inform Quality Appraisal)		
References to other relevant Studies		
Other publications from this dataset		
Further study information needed? *(from whom, what, and when, contact info)*		
Correspondence received		

(from whom, what, and when)	
Notes:	

APPENDIX G

Quality Appraisal Form

APPENDIX G: INDIVIDUAL STUDY QUALITY APPRAISAL FORM FOR SYSTEMATIC REVIEWS

Developed by Shelly P. Harrell, Ph.D., Pepperdine University

Author(s) and Year: **Study ID#:**

Title:

1. **Methodology:** Qualitative
2. **Specific Design/Inquiry Approach**:

RATING SCALE: Strong=3 Good/Adequate=2 Weak=1 Missing=0 N/A

3. **Strength of Literature Foundation and Rationale for Study:** _____
   (POSSIBLE CONSIDERATIONS: current and relevant references, background literature sufficiently comprehensive, need/rationale for study clearly stated, etc.)
4. **Clarity and specificity of Research Aims/Objectives/Questions/Hypotheses:** _____
5. **Quality of research design or methodological approach:** _____
   GENERAL CONSIDERATIONS: provides rationale for design chosen, appropriateness for research questions, clear description of design and methodological approach, strength of design characteristics utilized
   QUALITATIVE CONSIDERATIONS: consistent with specific practices relevant to the inquiry strategy (e.g., phenomenological study, case study, grounded theory, etc.), triangulation, audit trail
6. **Sample Selection and Characteristics:** _____
   GENERAL CONSIDERATIONS: detailed description of sample characteristics, adequacy of sample characteristics in the context of research aims, detailed description of recruitment and selection of participants; rationale provided for sample size; inclusion and exclusion criteria indicated as relevant
   QUALITATIVE CONSIDERATIONS: sample size appropriate for inquiry strategy; rationale for purposeful sample characteristics
7. **Data Collection Tools (Scales, Observation, Interviews, etc.):** _____
   GENERAL CONSIDERATIONS: rationale for selection, appropriateness for assessing variables, development of study-specific tool or process clearly described, piloting, pretesting;
   QUALITATIVE CONSIDERATIONS: appropriateness for inquiry strategy and purpose; interview or other data collection process described clearly and comprehensively
8. **Data Collection Processes:** _____
   (POSSIBLE CONSIDERATIONS: data collection procedures clearly described in sufficient detail, intervention strategies and implementation described in detail, quality of data collected, design-specific considerations such as saturation in grounded theory, etc.)
9. **Analysis and Presentation of Data:** _____
   GENERAL CONSIDERATIONS: appropriateness of analysis for research questions and type of data; results presented clearly and comprehensively; usefulness and clarity of any tables, graphs, and charts
   QUALITATIVE CONSIDERATIONS: textual data and/or direct quotes reported and used effectively; transparent description of the development of themes from raw data

10. **Discussion of Study Limitations:** _____
    GENERAL CONSIDERATIONS: identifies and discusses limitations in the context of design/strategy utilized
    QUALITATIVE CONSIDERATIONS: transferability, credibility, transparency

11. **Consideration of culture and diversity:** _____
    (POSSIBLE CONSIDERATIONS: attention to diversity within sample, includes culturally appropriate methods and tools, avoids biased language, uses appropriate terminology, etc.)

12. **OVERALL RATING:**	**EXEMPLARY** (e.g., all "3"s)	**STRONG** (e.g., mostly "3"s)	**GOOD/ADEQUATE** (e.g., mostly "2"s)	**WEAK** (e.g., mostly "1"s)

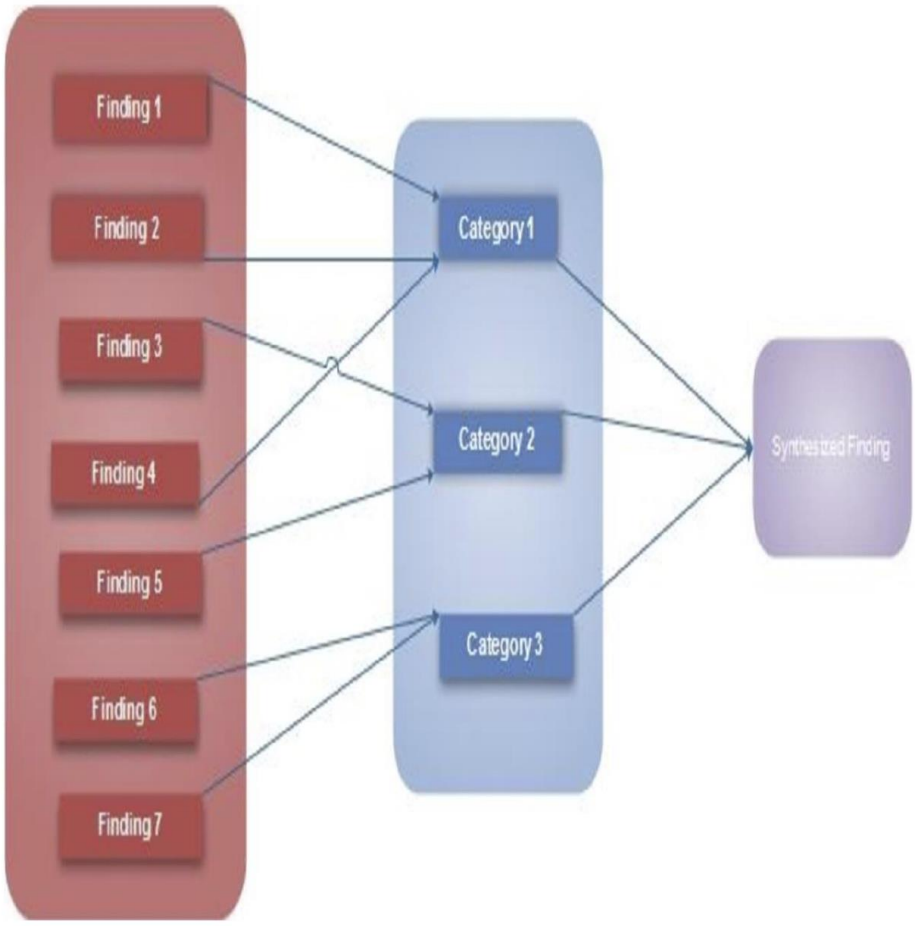
APPENDIX H

Table of Characteristics of Included Studies

TABLE											
Characteristics of included studies.											
Study #	1	2	3	4	5	6	7	8	9	10	11
Author(s) (Year)	Drescher et al. (2018)	Boska et al. (2023)	Wortmann et al. (2022)	Williamson et al. (2021)	Jin et al. (2022)	Williamson et al. (2019)	McCormack et al. (2017)	Burkman et al. (2019)	Eikenaar (2022)	Van Dinnend et al. (2022)	Boska et al. (2021)
Study Title	A Qualitative Examination of VA Chaplains' Understandings and Interventions Related to Moral Injury in Military Veterans	Chaplains' perspectives on standardizing spiritual assessments	Collaborative spiritual care for moral injury in the Veterans Affairs Healthcare System (VA): Results from a national survey of VA chaplains	Delivering treatment for morally injured UK military personnel and Veterans: The clinician experience	Moral Injury and Recovery in Uniformed Professionals: Lessons From Conversations Among International Students and Experts	Moral injury in UK armed forces veterans: a qualitative study	Professional Quality of Life and Changes in Spirituality Among VHA Chaplains: A Mixed Methods Investigation	Provider perspectives on a novel moral injury treatment for veterans. Initial assessment of acceptability and feasibility of the Impact of Killing treatment materials	Relating to moral injuries: Dutch mental health practitioners on moral injury among military and police workers	The Body, the Mind, and the Spirit, Including the spiritual domain in mental health care.	Understanding moral injury morbidity: A qualitative study examining chaplain's perspectives.
Methodology	Qualitative; exploratory	Qualitative	Mixed-methods (qualitative and quantitative)	Qualitative	Mixed methods (qualitative and quantitative)	Qualitative; exploratory pilot study	Mixed methods (qualitative and quantitative)	Qualitative	Qualitative; grounded theoretical approach.	Qualitative	Qualitative
Method of Data Collection	Web-based survey	Focus groups	National survey (online)	In-depth qualitative interviews	Webinars and conversations of 75-90 minutes duration	Semi-structured qualitative interviews	Online survey	Semi-structured interview	Interview	Case study	Focus groups
Data Analysis	Inductive content analytic approach	Thematic analysis	Not reported	Thematic analysis	Thematic analysis (inductive and deductive)	Thematic analysis (inductive analytical approach)	Inductive content analytic approach	Thematic analysis	Explorative	Not reported	Not reported
Quality Measure Overall Rating	Strong	Exemplary	Exemplary	Strong	Strong	Good/Adequate	Strong	Exemplary	Good/adequate	Good/adequate	Strong
Phenomenon of Interest	"This study examines Veterans Administration (VA) chaplains' understandings of moral injury (MI) and preferred intervention strategies." (P. 2444)	"The goal of this study was to learn chaplains' perspectives on if integrating standardized assessment into spiritual assessments would be acceptable to chaplains, appropriate for chaplaincy practice, and consistent with organizational culture." (P. 31)	"The present project aims to further advance our understanding of how chaplains in the VA Healthcare System conceptualize moral injury as well as their attitudes and behaviors with respect to intervention and collaboration, using qualitative and quantitative survey data." (P. 511)	"This study explored the experiences and challenges faced by clinicians in providing treatment in cases of moral injury-related mental health problems to inform potential improvements to the provision of psychological care." (P. 116)	"We aimed to (1) better understand MI and moral dilemmas, and (2) identify key insights that could inform prevention of and recovery from MI." (P. 1)	"The aim of this study was to examine UK AF veterans experiences of moral injury, and the perceptions and challenges faced by clinicians in treating moral injury-related mental health difficulties." (P. 1)	"... this study (1) examined the types of changes in chaplains' spirituality and emotional well-being due to their work with veterans who are struggling with moral injury and other combat-related concerns and (2) explored how these changes were associated with adaptive and maladaptive aspects of PmQOL." (P. 117)	"The purpose of this study was to identify whether trauma clinicians within VHA find materials for IOK treatment acceptable, feasible, and potentially beneficial for veterans who are diagnosed with PTSD and endorse distress related to killing in war." (P. 82)	"This paper ...explores bottom-up how various practitioners locate and qualify moral injury in their practices. I do so by discussing their responses to two main questions: what is a moral injury and how should it be approached?" (P. 2)	"This paper examines the clinical consequences of incomplete or underdeveloped attention to the spiritual domain in mental health. It offers five depersonalized and composite case studies, each of which synthesizes the lived experience of its authors (all chaplains working in mental health), with emerging evidence related to the incorporation of specialized spiritual care in mental health treatment. Each of the case studies, then shows what utilizing the spiritual domain offers, and, correspondingly, what is missed when it is not engaged." (P. 3572)	"The current study examined qualitative data regarding how moral injury is viewed through the lens of Chaplain Services within the Veterans Health Administration (VA). Specifically, chaplains were asked to describe how moral injury presents, what kinds of complaints veterans voice with regard to moral injury, and how moral injury impacts social functioning. Chaplains highlighted how moral injury is a pervasive issue affecting veterans across multiple domains." (P. 3090)
Country	United States of America (USA)	USA	USA	United Kingdom (UK)	Canada and the Netherlands	UK	USA	USA	The Netherlands	USA	USA
Setting	Military / VA	VA in a south-eastern facility	VA Healthcare System	National Health Service (NHS); Ministry of Defense (MoD); and voluntary sector organizations	Online conversations facilitated by Leiden University, the University of Alberta and the Dallaire Institute for Children, Peace and Security Between General Dallaire, world experts, and graduate students.	"Combat Stress (CS), a national charity which provides psychological interventions for UK AF [armed forces] veterans, including treatment for PTSD." (P. 2)	"...VHA-sponsored educational initiative on moral injury conducted by the National Center for PTSD in Menlo Park, California (Training and Dissemination Division)." (P. 117)	Large VA medical center	Video conferencing and a few at the work place of the participants	Different mental health settings at the VA	Chaplain services within the VA
Sample Size	245 chaplains	7 chaplains	367 chaplains	15 clinicians	94 total participants 9 participants (17.8%) = psychiatrists 7 participants (13.7%) = psychologists 1 participant (2.0%) = rehab medicine Other participants = not listed as their views were not taken into consideration for data extraction purposes.	4 clinicians	267 full- or part-time VHA chaplains	10 clinicians	30 practitioners Chaplains Confidential counsellors Social workers Psychologists Therapists	1 relevant case study of the Veteran studied, chaplain sample size not stated.	7 chaplains
Participant Ages	25-44 = 6.5% 45-54 = 17.1% 55-64 = 49% 65 years or older = 27.3%	Mean age = 46.10	25-34 = 2.5% 35-44 = 9.4% 45-54 = 18% 55-64 = 41.8% 65 and older = 26.9% Did not respond = 1.6%	Mean age of clinicians = 47.1 years	Not reported	Not reported	Over the age of 55 = 75.4%	Not reported	Not reported	Not reported	Not reported
Gender	Male = 85.3% Female = 14.7%	Male = 57.14% Female = 28.57%	Male = 78.1% Female = 19.4% Did not respond = 2.5%	10 out of 15 were male	Female = 48 participants Male = 46 participants	3 = male 1 = female	Male = 84.9%	Female = 70% Male = 30%	Not reported	Not reported	Female = 3 Male = 4
Race/Ethnicity	White = 76.3% African American = 13.1% Latino/a = 3.3% Asian American = 2.9% Other = 4.5%	White = 28.57% African American = 71.42%	White = 71.5% Black or African American = 17.7% Asian = 3.9% Native Hawaiian = 0.6% Other = 4.7% Ethnicity Spanish/Hispanic/Latino = 4.4%	Not reported	Not reported	Not reported	White = 78.2%	White = 90% Asian American = 10%	Not reported	Not reported	African American = 5 White = 2
Highest Level of Education	Doctoral degree = 28.2% Masters degree = 68.6% Undergraduate degree = 2.9% High school diploma = 0.3%	All chaplains who participated in the focus groups had masters of divinity degrees and two had doctor of ministry degrees	Master's degree = 66.8% Doctoral degree = 26.9% Board-certified = 45.7% More than 3 units of CPE = 81.5% Completed or completing Mental Health Integration for Chaplain Services (MHICS) = 14.4%	3 = psychiatrists 5 = psychologists 7 = mental health nurses	Highest level = doctoral	Not reported	Master's degree = 69.7% Doctoral degree = 27.5%	Discipline Psychology (doctoral): 60% Social Work (masters): 20% Psychiatry (doctoral): 20%	Not reported	Not reported	Masters = 5 Doctorate = 2
Spiritual/Religious Beliefs of Provider	Nearly all of the participants were affiliated with Judeo-Christian denominations (98.2%) Specific Breakdown: Mainline Protestant = 10% Evangelical Protestant = 34.7% Roman Catholic = 18.4% Black Protestant = 5.3% Jewish = 2.0% Other = 2.0%	Faith identification: African Methodist Episcopal = 14.29% American Baptist = 14.29% Independent Evangelical = 14.29% Pentecostal = 14.29% Presbyterian = 14.29% Southern Baptist = 14.29%	Evangelical Protestant = 33.5% Mainline Protestant = 33.5% Historically Black Protestant = 7.5% Catholic = 14.1% Orthodox = 2.2% Other Christian traditions - 6.5% Jewish = 2.2% Muslim = 0.3% Buddhist = 0.3% Other faith - 7.2%	Not reported	Not reported	Not reported	Evangelical Protestant = 35.7% Mainline Protestant = 35.3% Roman Catholic = 20% Other religious affiliation = 9%	Not reported	Chaplains: "Traditionally this form of support had a religious background, and concerned support of soldiers struggling with serious moral and existential issues." (P. 3)	Jewish and Christian faith traditions	Faiths represented: African Methodist Episcopal American Baptist Independent Evangelical Pentecostal Presbyterian Southern Baptist United Church of Christ

APPENDIX I

Visual Representation of the Meta-Aggregation Process



Visual representation of meta-aggregation process showing the move from findings to categories and finally to synthesized findings

Reference: Theoretical foundations of meta-aggregation: insights from Husserlian phenomenology and American pragmatism (Tufanaru, C., 2016)