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David Hazemali and Aleš Maver

Thematic Charting of Military Chaplaincy Scholarship (2014–2024): A Scopus and Web of Science Scoping Review

Tematsko kartiranje znanstvene in strokovne literature o vojaški duhovščini (2014–2024): sistematični pregled podatkovnih baz Scopus in Web of Science

Abstract: This scoping review maps peer-reviewed scholarship on military chaplaincy (2014–2024) indexed in Scopus and Web of Science. We asked how chaplains' roles, delivery models, collaborations, and methodological approaches relate to moral injury, suicide care, religious and ethnic plurality, and readiness. Searches (14 March 2025) yielded 217 records and after analysis 58 met our criteria analysis. We classified studies as outcomes (n=3), implementation/provider-facing (n=37), and conceptual/historical/policy/evidence syntheses (n=18). The literature depicts a maturing discipline, moving from traditional ad hoc pastoral responses towards structured, reproducible approaches. Military Chaplain collaboration with behavioural health and command is the most developed thematic area, supported by learning collaboratives and crisis protocols. Moral-injury interventions cluster into chaplain-only, co-facilitated, and protocolised narrative-ritual models, with promising but limited outcome signals. Evidence-informed practice is growing via screening, shared language, and brief interventions; comparative work highlights diverse measurement approaches, ethics, and governance across countries. Samples are heavily weighted toward Christian chaplains, male service members, and the U.S. VA/DoD contexts. Gaps include rigorous trials, non-U.S. and minority-faith contexts, mechanism testing, and economic evaluation.

Keywords: Military chaplaincy, Military chaplains, Moral injury, Suicide prevention, Integrated care, Spiritual readiness, Implementation science, Confidentiality, International comparison, Scoping review, Armed forces

Povzetek: Pričujoči shematični pregled mapira znanstveno in strokovno literaturo o vojaški duhovščini, indeksirano v podatkovnih bazah Scopus in Web of Science v obdobju 2014–2024. V prispevku odgovarjamo na vprašanje, kako so vloge vojaških kaplanov, modeli izvajanja, oblike sodelovanja in metodološki pri-

stopi povezani z moralno ranjenostjo, samomorilnostno oskrbo, verskim in etničnim pluralizmom ter stalno pripravljenostjo. Iskanje v bazah (14. marec 2025) je prineslo 217 zapisov, po presoji jih je našim merilom ustrezalo 58. Študije smo kategorizirali na troje vrst, in sicer: študije izidov (n = 3), izvedbene/na izvajalce usmerjene (n = 37) ter konceptualne/zgodovinske/politične/sintezne (n = 18). Raziskava je pokazala, da je sodelovanje vojaških kaplanov s psihološko službo in poveljstvom najbolj razvito področje, podpirajo pa ga mreža sodelujočih in krizni protokoli. Intervencije ob moralni ranjenosti se razvrščajo v tri tipe: intervencije, ki jih izvajajo kaplani, sovodene (kaplan in klinični strokovnjak) in protokolirani narativno-ritualni pristopi s sicer obetavnimi, a še omejenimi izidi. Dokazano podprta praksa se razvija prek preverjanj, skupnega jezika in kratkih intervencij; primerjalne študije poudarjajo raznolike merilne parametre, etične okvire in upravljanje po državah. V vzorcih so sicer izrazito zastopani krščanski duhovniki, moški pripadniki ter ameriški vojaški in veteranski konteksti. Vrzeli vključujejo pomanjkanje strožjega preskušanja učinkovitosti, raziskav zunaj ZDA in manjšinskih veroizpovedi, preizkušanja mehanizmov delovanja ter ekonomskega vrednotenja.

Ključne besede: vojaška duhovščina, vojaški kaplani, moralna rana, preprečevanje samomora, integrirana oskrba, duhovna pripravljenost, implementacijska znanost, zaupnost, mednarodna primerjava, sistematični pregled literature, oborožene sile

1. Introduction

Today, military chaplains are uniquely positioned at the intersection of embedded presence, ritual competence, ethics advising, community linkage, and, in many jurisdictions, privileged confidentiality (Primc 2025, 98; Kocjančič 2021a; Šimac 2020).[1] Their "ministry of presence" makes them accessible both in garrison and during deployment. Their remit includes facilitating religious support across faiths and for those of no faith, advising commanders on ethics and accommodation, and conducting rituals that help individuals and units process loss and restore belonging (Carey and Hodgson 2018; Boniface 2022; Koenig 2022). Importantly, chaplains are often perceived as low-stigma entry points for care and as early confidants for distress, frequently preceding contact with mental and/or behavioural health services (Ramchand et al. 2015a; Morgan et al. 2016). At the same time, contemporary military chaplaincy operates within religiously plural armed forces and diverse legal frameworks: mandates and confidentiality protections vary internationally, shaping what chaplains can do, document, and share (Rance and Snape 2021; Liuski and Ubani 2021; Kocjančič 2021b).

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Over the last decade, military chaplaincy practice has profoundly changed, moving from traditional, generally *ad hoc* pastoral responses towards structured, reproducible approaches for addressing complex challenges such as moral injury (MI)[2] and suicide risk (Ames et al. 2021; Carey et al. 2023; Drescher et al. 2018). This evolution is evidenced by the articulation of specialized, chaplain-led MI protocols that centre on narrative, forgiveness, repair, and ritual, such as the eight-stage Pastoral Narrative Disclosure (PND)[3], which integrates concepts of narrative, forgiveness, and ritual, and has been evaluated favourably by chaplains for use alongside other treatment regimens (Carey et al. 2023). Furthermore, chaplains are increasingly crucial partners in multidisciplinary care, engaging in initiatives like the Moral Injury Group (MIG)[4], often co-facilitated with clinicians, which incorporates communal healing ceremonies to address the isolation and despair associated with moral pain (Antal et al. 2022). To better coordinate these efforts, integration models involving defined referral pathways, co-located teams, and learning collaboratives have matured across military chaplaincy and behavioural health (BH) structures in the military and among veterans, aimed at reducing fragmentation and clarifying roles by building essential professional trust (Nieuwsma et al. 2014; Jones et al. 2022). Complementing these clinical and organizational advances, the profession is developing and adapting measurement approaches to workflow, including frameworks for Spiritual Fitness (SF)[5] (Gutierrez et al. 2021; Koenig 2022) and chaplain-usable screening tools like the Brief Interview Screen for Military Spiritual Distress (BISMiSD)[6] for use in spiritual assessments (SAs)[7] (Kopacz et al. 2022), facilitating early identification and interdisciplinary communication regarding MI. However, despite this rapid programmatic growth, the evidence base supporting these interventions remains limited, with only a small number of rigorous studies completed to date, highlighting the continuing need for comprehensive MI-specific outcome data (Jones et al. 2022).

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[2] Moral injury is a trauma-related state that arises when serious moral wrongs, through one's own actions or inactions, by witnessing them, or via betrayal by trusted authorities, collide with deeply held values, disrupting psychological, social, and spiritual well-being and sometimes physical health (Carey and Hodgson 2018; Carey et al. 2023).

[3] PND is a pastoral care, counselling, and guidance–based rehabilitation approach for Australian Defence Force chaplains (Navy, Army, and Air Force) that prioritizes moral injury (Carey et al. 2023).

[4] MIG (Moral Injury Group) is a chaplain- and psychologist-led group therapy protocol for veterans, run across twelve 90-minute sessions, that focuses on moral injury (not PTSD). It builds a safe communal language for morally injurious experiences, integrates moral/spiritual concepts, and culminates in a public Community Healing Ceremony to promote healing, moral engagement, and shared responsibility (Antal et al. 2022).

[5] Spiritual fitness is the capacity of an individual or a group of people to draw on one's beliefs, principles, and values to stay grounded and resilient under stress, hardship, or loss. It involves cultivating personal qualities, rooted in religious, philosophical, or humanistic values, that shape character, guide decisions, and sustain integrity (Gutierrez et al. 2021).

[6] The BISMiSD is a brief, interview-based spiritual assessment for chaplains that screens for moral injury in military contexts by eliciting experiences and rating four indicators (exposure, moral dilemma, trust difficulties, and disruption with ultimate values/Higher Power) on a 5-point scale to produce a 4–20 score indicating likelihood of clinically significant MI (Kopacz et al. 2022).

[7] A spiritual assessment is a routine, usually pencil-and-paper survey used by VA chaplains to document a patient's desire for spiritual care and gather planning-relevant information, with formats varying by chaplaincy department rather than being fully standardized across the VA (Kopacz et al. 2022).

Given the recent acceleration of structured interventions and collaborative models in military spiritual care, this review adopts a scoping approach to map the extent, range, and nature of peer-reviewed scholarship on military chaplaincy from 2014 onwards. Our aim is not to assess effectiveness but to describe what exists: the roles chaplains perform in relation to MI/suicide and unit readiness; how services are delivered (stand-alone, co-delivered, or embedded); how chaplains collaborate with behavioural health and command; what is being measured (and what is not); and which implementation facilitators and barriers recur across settings. We also consider international variation (mandates, Church–State arrangements, confidentiality, and non-coercion), workforce formation and well-being, and the use of rituals and ceremonies as community reintegration practices.

We position our scoping review against prior syntheses that established the baseline of the field. Liuski and Ubani (2020) offered a comprehensive multidisciplinary review of how military chaplaincy is portrayed in European journal articles (2000–2019) indexed in JSTOR and EBSCO. This review noted a lack of research on modern military chaplaincy in international literature, observing that most European scholarship in this period focused predominantly on historical perspectives, especially concerning times of war, thereby indicating a need for more contemporary engagement with the profession. Subsequent reviews further mapped the field, including the scoping review by Layson et al. (2022), which gathered evidence on chaplaincy utilisation from a wide range of disciplinary databases (ATLA, CINAHL, PsycINFO, PubMed, SOCindex, EBSCO, Google Scholar), and Jones et al. (2022), which scoped MI interventions across discipline in 11 databases. However, the landscape of military spiritual care continues to evolve rapidly. Crucially, all these foundational scoping studies pre-dated the full-scale Russian invasion of Ukraine (February 2022) and the subsequent period characterized by significant geopolitical conflict, particularly the renewal of the Middle Eastern crisis (2023–present) and humanitarian crises that followed, inflection points likely associated with changes in operational demands, policy attention, and publication volume (Ristevska 2024). By conducting systematic searches in Scopus and Web of Science (2014–2024) and applying explicit inclusion/exclusion criteria, we produced a focused, practice-oriented field-level map that identifies mature thematic areas and emergent lines of inquiry, intended to inform current practice, policy, and future research.

2. Method

2.1 Design and Protocol Language

We conducted a scoping review with the pragmatic aim of mapping the extent, range, and nature of recent peer-reviewed scholarship on military chaplaincy (2014–2024) using two reputable, curated citation indexes: Scopus and Web of Science Core Collection. Their complementary coverage helps mitigate disciplinary

blind spots: Scopus typically includes newer applied social-science and health-services research, whereas Web of Science emphasizes long-established journals in theology, religious history, ethics, and military studies. Building on prior reviews in this inherently interdisciplinary domain (spiritual care, mental health, sociology), we first assessed their search coverage. Layson et al. (2022) and Liuski and Ubani (2020) did not include Scopus or Web of Science, while Jones et al. (2022), although using both, focused on interventions for moral injury rather than producing a comprehensive bibliographic map of military chaplaincy. Because Scopus and Web of Science are widely recognized discovery infrastructures for bibliometrics and systematic reviews, owing to their breadth, stable metadata, and citation-tracking capabilities, we conducted systematic searches in both databases for 2014–2024, as the foundation for our field-level bibliographic map.

We followed Arksey and O'Malley's foundational framework for scoping studies: identifying the question, locating studies, selecting studies, charting the data, collating/summarizing results, and consultation (Arksey and O'Malley 2005). Reporting adheres to PRISMA-ScR (Tricco et al. 2018).

Because journals often do not deposit their metadata to the large abstracting services immediately, we closed the window on 31 December 2024 to reduce the risk that early-2025 articles would be unevenly indexed and thus distort retrieval.[8]

2.2 Research Question

Guided by the scoping purpose, our review was organized around the following primary research question: *What peer-reviewed scholarship published since 2014 describes the roles, practices, delivery models, and measurement approaches of military chaplaincy, including its interfaces with behavioural health and command, in ways that bear on moral injury, suicide care, pluralism, and readiness?*

To effectively structure the thematic area architecture, we set three additional supporting questions:

a) How are military chaplains' distinctive contributions (embedded presence; ritual/memorial work; ethical advising; confidentiality; community linkage) characterised across services and countries, and how do these functions intersect with low-stigma pathways into care?

b) What patterns of service delivery and collaboration are reported (chaplain-only, co-facilitated clinical–chaplain interventions, embedded/triadic models), and how have these matured over the last decade?

c) What methodological approaches and parameters are being targeted (e.g., spiritual fitness, help-seeking, MI screening, readiness-adjacent outcomes), with which instruments, and where are the principal evidence gaps?

2.3 Information Sources and Search Strings

[8] This boundary maximizes retrieval stability while acknowledging that early-2025 articles may not yet be fully indexed; we note this as a limitation.

We searched Scopus and Web of Science Core Collection on 14 March 2025. The Scopus search was conducted using the TITLE-ABS-KEY field, which targets terms in the article title, abstract, and author-supplied keywords. The search string was designed around distinct conceptual clusters. The foundational term was "*military chaplaincy*", encompassing the institutional role of religious personnel in armed forces. We began with the phrase "*military chaplain**" and expanded it to include commonly used variations such as "*armed forces chaplain**" and "*combat chaplain**" to ensure full coverage of terminological variation across national and disciplinary contexts. Recognizing that relevant literature may use broader or slightly different language, we included "*chaplain**" as a standalone term to capture articles that discuss chaplains in military contexts without explicitly using the term "military" in the title or abstract. Similarly, we added concepts such as "*pastoral care*", "*pastoral counseling*", "*spiritual care*", and "*spiritual support*" to reflect the diversity of expressions used to describe the chaplain's role in caregiving and counselling. To ensure relevance to military populations, we included contextual keywords such as "*soldier*", "*military*", "*armed forces*", and "*army*". We further added "*defense*", "*defence*" (to account for British spelling), "*service member*", and "*armed services*" – terms that appear in both U.S. and international military publications to describe personnel and organizations. Finally, to capture thematic diversity within chaplaincy literature, we incorporated keywords reflecting prevalent research themes: "*moral injury*", "*resilience*", "*confidentiality*", "*pluralism*", "*mental health*", "*ethical guidance*", "*spiritual fitness*", "*values*", and "*moral support*". These terms were chosen based on a preliminary scan of existing literature, prior reviews (e.g, Jones et al. 2022; Liuski and Ubani 2020; Layson et al., 2022) and known focal areas in military chaplaincy scholarship (e.g., mental health collaboration, interfaith ministry, and ethics).

We combined terms using the AND operator to require the intersection of chaplaincy, military context, and topic relevance. Within each concept group, synonymous or related terms were linked by OR to ensure inclusivity. The search was limited to the TITLE-ABS-KEY fields to retrieve studies where chaplaincy-related content is a central focus rather than incidental.

The search was limited to the years 2014 through 2024 (PUBYEAR > 2013 AND PUBYEAR < 2025) and filtered to peer-reviewed journal articles only, using LIMIT-TO(DOCTYPE, "ar") for document type and LIMIT-TO(SRCTYPE, "j") for source type.

This resulted in the following Scopus search string or query:

```
TITLE-ABS-KEY(
       ("military chaplain*" OR "chaplain*"
       OR "armed forces chaplain*" OR "combat chaplain*"
       OR "pastoral care" OR "pastoral counselling"
       OR "spiritual care" OR "spiritual support")
    AND
       ("soldier*" OR "military" OR "armed forces" OR "army"
       OR "defense" OR "defence" OR "service member*"
       OR "armed services")
    AND
      ("moral injury" OR "resilience" OR "confidentiality"
       OR "pluralism" OR "mental health" OR "ethical guidance"
       OR "spiritual fitness" OR "values" OR "moral support")
    )
AND PUBYEAR > 2013 AND PUBYEAR < 2025
AND LIMIT-TO(DOCTYPE, "ar")
AND LIMIT-TO(SRCTYPE, "j")
```

In the Web of Science Core Collection, we used the TS= field, which searches article titles, abstracts, author keywords, and the proprietary "Keywords Plus." Although functionally similar to Scopus's TITLE-ABS-KEY, the Web of Science TS= field employs a different indexing algorithm that may produce complementary results, especially in citation-rich fields such as theology, military ethics, and historical studies. To ensure consistency, we replicated the same keyword clusters and Boolean structure used in Scopus, applied equivalent filters for publication type and date range (from 1 January 2014 to 31 December 2024), and selected only records classified as journal articles (DT = Article). All editions of the Web of Science Core Collection were included to maximise coverage.

This resulted in the following Web of Science search string or query:

```
TS This = (
       ("military chaplain*" OR "chaplain*"
       OR "armed forces chaplain*" OR"combat chaplain*"
       OR "pastoral care" OR "pastoral counselling"
       OR "spiritual care" OR "spiritual support")
    AND
       ("soldier*" OR "military" OR "armed forces" OR "army"
       OR "defense" OR "defence" OR "service member*"
       OR "armed services")
    AND
       ("moral injury" OR "resilience" OR "confidentiality"
       OR "pluralism" OR "mental health" OR "ethical guidance"
       OR "spiritual fitness" OR "values" OR "moral support")
    )
AND DT=(Article)
```

The final Scopus pull returned 115 records, while the Web of Science search yielded 102. Records from both platforms were exported and prepared for deduplication prior to eligibility assessment.

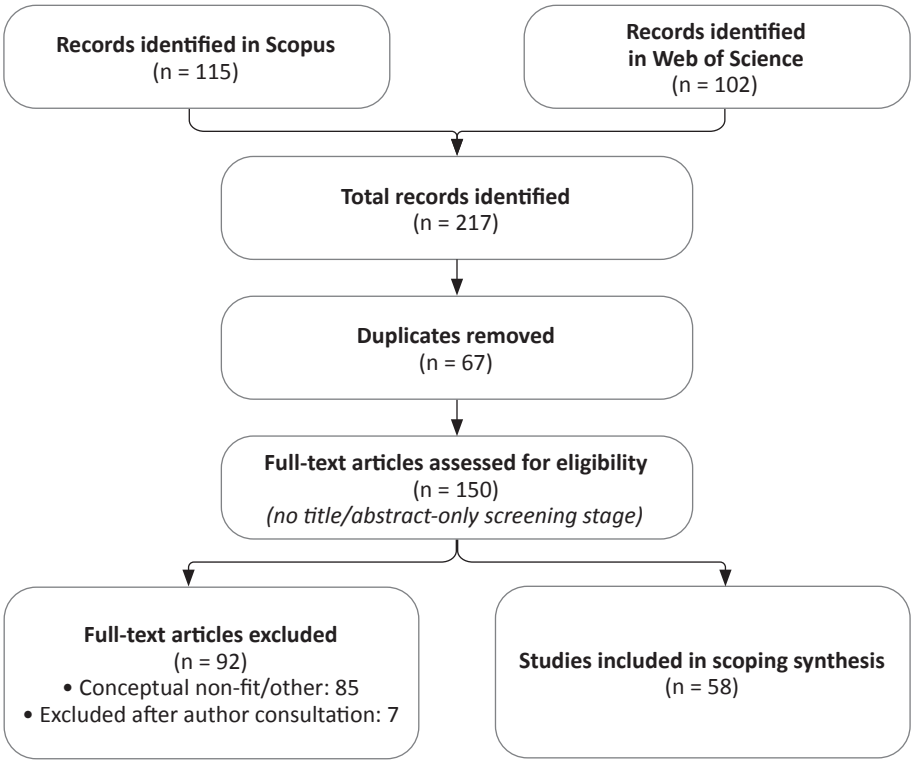

Figure 1: *PRISMA-ScR flow of information through the study selection process for military chaplaincy (2014–2024).*

2.3 Analysis Workflow and Eligibility Criteria

Database searches in Scopus (115) and Web of Science Core Collection (102) yielded 217 records. After exporting to CSV, we normalised titles (case and white-space), deduplicated by exact title match (removing 67), and verified uniqueness within and across databases. The resulting 150 records proceeded to full-text relevance analysis.

We defined inclusion in precise terms: the article must place military chaplains or military chaplaincy at the centre of analysis–whether the focus was role, practice, utilization, training, ethics, collaboration, intervention delivery, or system integration–and the setting must involve the armed forces (active, reserve, or guard) and/or veteran health systems. We retained studies from veterans' systems where chaplains are embedded or central to care delivery.[9] Disagreements were resolved by consensus.

[9] When U.S. programs are cited, we name the U.S. Department of Veterans Affairs (VA) and Department of Defense (DoD) explicitly.

We manually reviewed the 150 curated full texts and excluded 85 for the reasons noted above (e.g. non-military chaplaincy; studies of religion or spirituality without chaplains as a substantive focus; civilian clergy; purely legal or conceptual pieces with only tangential reference to military chaplains). Following further consultation with Slovenian military historian Miha Šimac (subject-matter expert), we excluded 7 additional studies. This resulted in a deduplicated, transparently analysed corpus of 58 unique studies suitable for scoping synthesis.

2.4 Data Charting and Synthesis

We developed and piloted a structured charting template (Excel) on a heterogeneous subset of papers, then applied it to the full corpus, following scoping review standards for transparent, reproducible data capture prior to synthesis (Arksey and O'Malley 2005; Tricco et al. 2018). For each included article, we recorded bibliographic metadata, country and service context, branch or unit (if specified), and setting (garrison, deployed/operational, training, medical treatment facility, or mixed). We then extracted concept variables covering: (a) chaplains' role emphases (embedded presence, ritual/ceremony, ethical advising, community linkage, confidentiality/privilege); (b) collaboration patterns with behavioural/mental health professionals and command; and (c) service delivery configuration (chaplain-only, co-facilitated chaplain–clinician, integrated/team-based).

The authors independently charted and cross-checked entries for completeness. Disagreements were resolved through discussion. Consistent with Arksey and O'Malley's optional consultation stage, we also sought iterative feedback from subject-matter expert Miha Šimac on boundary cases and thematic area definitions.

To guide synthesis, each record was assigned a study type according to a simple hierarchy:

a) Outcomes: any participant outcomes attributable to chaplain-involved care, whether chaplain-only or co-led;

b) Implementation/provider-facing: empirical data without participant outcomes, e.g., roles, workflows, feasibility, acceptability, integration, training uptake, utilisation patterns, psychometric feasibility, quality-improvement/process evaluation;

c) Conceptual/historical/policy/evidence synthesis: non-empirical theory, history, policy analysis, or narrative reviews; single-case expositions without measured outcomes.

Each paper was assigned one primary thematic area (best thematic fit) and, where appropriate, up to two secondary thematic areas. The pre-specified thematic area architecture comprised six areas, which were later used to organise the Discussion:

a) The evolving role and identity of the modern military chaplain;

b) Chaplains as gateways to care (access, stigma, suicide prevention);

c) Collaboration with behavioural health professionals and command;

d) Chaplain-involved interventions for moral injury;

e) Assessment, Measurement Approaches, and Evidence-Informed Practices;

f) International, ethical, and governance dimensions.

Synthesis proceeded narratively through an iterative inductive–deductive process, moving between article-level charted variables and the six thematic areas. We first summarised studies by setting and delivery configuration, then consolidated patterns, consistencies, and gaps within the thematic area framework.

2.5 Limitations

Several choices inherent to scoping reviews (and a few peculiars to this topic) temper the inferences that can be drawn from our analysis. First, despite harmonized strings across Scopus and Web of Science, terminology in this domain is unusually variegated across languages, services, and eras; studies that foreground "religious support teams," "unit ministry teams," "spiritual readiness/fitness," "moral resilience," "soul care," "field priest/padre," "religion adviser," or tradition-specific titles (e.g., *aumônier*, *Feldgeistlicher*/*Feldprediger*, *fältpräst*) may not surface when "chaplain*" is absent from the title or abstract. Second, we delimited coverage to peer-reviewed journal articles and excluded books, book chapters, theses, reports, and other grey literature also indexed in these databases which biases the corpus toward disciplines and outlets that publish journal articles and away from historically oriented or policy venues. Third, although our search window extends through 2024, Scopus and Web of Science often index on with a delay; late-year issues and backfilled records can appear months later, and we therefore acknowledge a non-trivial risk. Finally, we retained veteran-system studies in which chaplains are embedded or central to care to capture system-level variation (mandate, confidentiality), but this choice may bias findings towards settings with established chaplain–clinical integration.

3. Results: Analysis of Study Type, Temporal Trends, and Thematic Distribution

Of the 58 studies that met the inclusion criteria (see the abridged master charting table in the Appendix), 3 were outcomes studies (Ames 2021; Cafferky, Norton, and Travis 2016; Cenkner et al. 2021), 37 were implementation or provider-facing, and 18 were conceptual, historical, policy, or evidence-synthesis papers.[10]

Across the 58-study corpus, publications rose sharply in 2020–2022 (10, 10, and 9 papers, respectively), then tapered in 2023–2024 (6 and 4) (see Table 1).

[10] For clarity, we include in the Appendix an abridged master charting table that summarizes variables across the six thematic areas for the full sample. Given the corpus size and scope, the complete, granular charting table is available from the authors upon request.

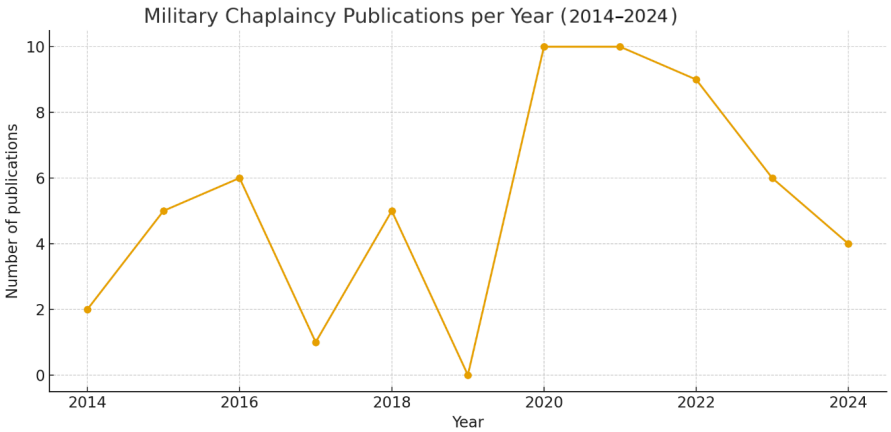

Chart 1: *Military Chaplaincy Publications per Year (2014–2024).*

Because the upswing begins before Russia's 2022 full-scale invasion of Ukraine, it likely reflects several converging drivers: COVID-era operational strain, the maturation of chaplain–behavioural-health collaboration around moral injury, and growing interest in "spiritual readiness." The post-2022 period did not reverse this trend; output remained high through 2022 and beyond, adding not only Jones et al.'s scoping review (2020) but also a wave of system-context analyses that focus on specific militaries and veteran forces: predominantly the U.S. (7 studies), as well as the Australian Defence Force and Australian veterans (Hodgson, Carey, and Koenig 2022; Carey et al. 2023; Layson, Carey, and Best 2023), France (Boniface 2022), the Slovenian Armed Forces (Muršič Klenar 2024), Sweden (Grimell 2024), South Korea (Feuer 2022; Lee 2022), the Netherlands (Schuhmann et al. 2023), and the Armed Forces of Ukraine (Makovskyi 2023; Sokolovskyi, Slyusar, and Hordiichuk 2024).

3.1 The Evolving Role and Identity of the Modern Military Chaplain

The reviewed literature presents military chaplaincy as a profession positioned at the intersection of pastoral care, institutional service, and public meaning-making. Foundational sociological studies describe chaplains as "doubly commissioned," accountable to both their faith communities and the military organisation, which creates productive, and at times acute, role tensions (Davie 2015). Contemporary theorists contend that many armed forces are experiencing processes of desecularisation, in which religious symbols, practices, and personnel re-enter organisational life in new forms. This reframes chaplaincy as part of broader institutional change rather than a static legacy function (Levy 2018). Conceptual analyses from Sweden further clarify how national contexts shape mandates: the Swedish model of "military soul care" positions chaplains as protectors of meaning, cohesion, and the will to defend, which contrasts with rights-based accommodation models in other Western forces (Grimell 2024).

Historical and policy perspectives highlight how public narratives and governance regimes contour shape practice. In pronouncedly secular France, centenary commemorations of First World War chaplains reveal how *laïcité* coexists with a symbolic public role for chaplaincy, even as direct religious authority is constrained (Boniface 2022). A South African World War I case study surfaces enduring role tensions between pastoral care and prophetic critique and even controversy over whether bearing arms is compatible with Holy Orders, foreshadowing later debates about complicity and resistance (Houston 2016). In Chile, debates about inclusive laicism and non-coercion surface highlight ethical risks in state-sponsored religion and the importance of safeguards for minority or non-religious personnel (Bellolio 2020). In the U.S. context, World War I chaplaincy also provided an early template for pluralistic practice: Protestant, Catholic, and Jewish chaplains frequently crossed confessional lines at bedsides and burials, operationalizing a "tri-faith" ideal (Mislin 2015). These cases underscore that chaplaincy identities are not monolithic; they are shaped by legal frameworks, civil-military relations, and national theologies of service.

Within units, embedded presence and trusted relationships remain defining features. Historical accounts of early Royal Air Force chaplaincy document the institutionalisation of an on-flightline, trusted-friend posture that continues to inform contemporary embedded ministry (Rance and Snape 2021). Recent qualitative work with chaplains describes the psychological costs of their role, including exposure to trauma and role strain, alongside sources of resilience such as collegial support and faith resources (Whitworth, O'Brien, and Stewart 2021). Practice-oriented essays suggest that ambiguity, when navigated reflexively, can serve as a pastoral resource, enabling chaplains to hold space for moral complexity in operational settings (Woodhouse 2021).

Finally, emerging readiness frameworks and ethical guidance indicate a shift towards evidence-informed, outcomes-focused identities. Proposals for "spiritual readiness" within total force models, and applied frameworks for operationalising spiritual fitness, invite collaboration across leadership, chaplaincy, and behavioural health, while raising important measurement questions (Koenig 2022; Gutierrez et al. 2021). At the same time, confidentiality and privileged communication remain central ethical pillars that enable chaplains to serve as low-stigma gateways to care and as moral advisors within command ecosystems (Prazak and Herbel 2020). Together, the conceptual and historical literature frames the modern military chaplain as an embedded practitioner who negotiates institutional and pastoral mandates to safeguard meaning, moral functioning, and access to care across plural contexts.

3.2 The Chaplain as a Gateway to Care: Access, Stigma, and Suicide Prevention

Across multiple samples, chaplains serve as a low-stigma, confidential entry point into the broader helping ecosystem. Post-deployment soldiers commonly report turning to chaplains and other non-provider sources when organisational barri-

ers or concerns about career impact make formal care less attractive (Kim et al. 2016). Large survey analyses show that those who seek chaplain care often face heavy stressor loads and mental health needs, underscoring chaplaincy's role as a front-door rather than a peripheral option (Morgan et al. 2016). Demand-side evidence further indicates that combat exposure increases utilisation of religious supports, including chaplain counselling, suggesting that operational stress elevates the salience of pastoral pathways to care (Cesur et al. 2020).

Within units, chaplains are often consulted first and then facilitate movement across the system. Studies of non-commissioned officers show that chaplains are a top referral choice for at-risk service members, with confidentiality cited as a key reason (Ramchand et al. 2015b). Help-avoidance syntheses recommend that chaplains leverage privileged communication, to normalise help-seeking, and enact structured handoffs to behavioural health when indicated (Prazak and Herbel 2020). At the population level, patterns from the DoD *Health Related Behaviours Survey* identify who is more likely to use chaplains and confirm that chaplain users commonly also engage other providers, positioning chaplains as both a gateway and a complement to clinical care (Kazman et al. 2020).

Qualitative research in deployed settings describes how chaplains' function within chaplain–behavioural health–command triads during acute suicide-related events, including advising leaders, managing boundaries around confidentiality, and coordinating postvention (Adler et al. 2018). Provider-facing surveys quantify the frequency with which chaplains encounter suicidality and simultaneously reveal gaps in preparedness that indicate a need for upskilling (Kopacz et al. 2016; Ramchand et al. 2015a). In response, programme evaluations show that targeted training in evidence-based practices can enhance chaplains' capability and collaborative confidence in suicide-relevant care (Wortmann et al. 2021). In high-stress communities of practice, such as special operations forces, chaplains' ongoing presence and relationship building underpin prevention and intervention, while communal rituals support postvention and unit healing (Lee-Tauler et al. 2024).

A consistent theme across utilisation and pathway studies is that confidentiality and embedded presence are primary facilitators of access. When perceived organisational barriers increase, reliance on chaplains and other non-providers also increases (Kim et al. 2016). Leadership preferences for referring to chaplains further institutionalise these pathways (Ramchand et al. 2015b). Implementation guidance highlights practical levers chaplains can use to reduce help avoidance, including clear explanations of privileged communication, stigma-reducing messaging, and coordinated warm handovers to behavioural health (Prazak and Herbel 2020). Complementary survey evidence suggests chaplains can also advance public health goals when equipped and authorised to do so, for example, through brief health behaviour interventions in routine encounters (Van Voorhees et al. 2014).

Population-level analyses identify demographic and experiential correlates of chaplain utilisation, including younger age, higher perceived stigma, and histories

of abuse, while also showing that most chaplain users are not isolated from the medical system (Kazman et al. 2020). Among active-duty soldiers, those who seek chaplain help exhibit higher rates of probable post-traumatic stress disorder (PTSD) and depression and are more likely to have experienced specific combat exposures, such as seeing dead bodies, which has implications for triage and risk assessment in pastoral contexts (Morgan et al. 2016).

In the field of access, stigma, and suicide prevention, the literature presents a coherent narrative. Chaplains are accessible and trusted, often serving as the first point of contact for individuals in distress, including those at risk of suicide, particularly when stigma or systemic barriers deter formal care (Kim et al. 2016; Ramchand et al. 2015b). They address significant clinical needs and frequently act as connectors to behavioural health services rather than as substitutes (Kazman et al. 2020; Morgan et al. 2016). Their effectiveness within the suicide care continuum relies on three key elements: a protected relational space grounded in confidentiality, structured collaboration with command and clinicians, and targeted training in evidence-based competencies (Adler et al. 2018; Prazak and Herbel 2020; Wortmann et al. 2021). Strengthening these pillars provides a practical roadmap for policy and programme design, with relevance for high-risk communities where an embedded pastoral presence serves as a crucial access lever (Lee-Tauler et al. 2024).

3.3 Chaplaincy Collaboration with Behavioural Health Professional and Command

Evidence across the Veteran and Defence systems shows that integration is not a single programme but a set of mutually reinforcing arrangements: co-location, shared protocols, and leadership endorsement. A large mixed-methods assessment identified familiarisation gaps and trust deficits between chaplains and clinicians, but also documented sites where team inclusion, routine case conferencing, and aligned referral pathways were already normal practice (Nieuwsma et al. 2014). Subsequent quality improvement work showed that structured collaboratives can shift everyday behaviours, with measurable gains in screening, referral clarity, and role understanding at participating facilities (Nieuwsma et al. 2017).

When chaplains are incorporated into broader health and public health initiatives, integration becomes routine rather than exceptional. National survey data on smoking cessation activities showed high chaplain willingness to perform brief interventions, illustrating how chaplaincy can serve as a "no wrong door" access point for health behaviour change within clinical pathways (Van Voorhees et al. 2014). Reviews mapping overlapping competencies recommend practical mechanisms to integrate workflows: warm handoffs in both directions, shared documentation conventions where appropriate, and deliberate cross-training to reduce misconceptions (Cooper et al. 2023).

During acute risk events, collaboration is operationalised through rapid coordination with commanders and clinicians. Qualitative analysis from deployed set-

tings details leader advisement, careful stewardship of privileged communication, and synchronised postvention activities following suicide-related incidents (Adler et al. 2018). Surveys of military chaplains and chaplain assistants highlight both the frequency of contact with suicidal individuals and uneven preparedness, reinforcing the need for agreed escalation thresholds and joint rehearsal of crisis protocols (Ramchand et al. 2015a; Kopacz et al. 2016).

Help-avoidance can be reduced when chaplains explicitly explain confidentiality, normalise help-seeking, and employ warm handoffs to behavioural health once risk or clinical need is established (Prazak and Herbel 2020). Preferences among non-commissioned officers to refer at-risk personnel to chaplains provide a leadership-level lever for standardising these pathways across units (Ramchand et al. 2015b). Ethical guidance for high-risk domestic scenarios, such as intimate partner violence, further specifies decision points for referral to statutory programmes while maintaining pastoral rapport and safety planning (Whiting et al. 2020).

Wortmann et al. (2020) found that training initiatives that equip chaplains with evidence-informed strategies strengthen joint working. Evaluation of the Mental Health Integration for Chaplain Services (MHICS)[11] training showed increased capability to use acceptance and commitment and problem-solving methods in pastoral encounters, along with reported gains in confidence when collaborating with clinicians (Wortmann et al. 2021). At the same time, provider well-being is an integration issue. Qualitative accounts of chaplain stressors and resilience recommend peer support, supervision, and institutional backing to sustain participation in multidisciplinary care (Whitworth et al. 2021).

In special operations communities and units, chaplain integration relies on persistent presence, insider networks, and autonomy-supportive interventions that interface smoothly with clinical and command elements. Communal rituals facilitate postvention at the team level (Lee-Tauler et al. 2024). Internationally, organisational models demonstrate similar logics. In Finland, chaplains serve as ethics trainers and lead psychosocial follow-ups after critical events within a doctrine that presumes close cooperation with other services (Liuski and Ubani 2021). In Ukraine, statutory role definitions assign chaplains responsibilities for psychoeducation, post-stress rehabilitation, and structured referral in partnership with psychologists, illustrating formalised collaboration during wartime (Makovskyi 2023). Conversely, Swedish accounts emphasise absolute confidentiality and the ministry of presence while advising command on ethics, which requires clear relational boundaries for credible cooperation with medical teams (Grimell 2020a; 2020b).

Successful integration appears to depend on clearly negotiated boundaries. The understudied area of cross-gender pastoral care presents distinctive safeguarding and referral considerations that must be aligned with clinical and command

[11] An intensive, specialty education in evidence-based psychosocial and collaborative approaches to mental health care (Wortmann et al. 2021).

policy to maintain trust for all parties (Roberts and Kovacich 2020). Provider-generated taxonomies of moral injury practice show where chaplains' narrative, cognitive, and ritual methods complement psychotherapy rather than compete with it, clarifying when co-treatment or sequential referral is preferable (Drescher et al. 2018).

Taken together, the literature presents integration as a design space with (at least) three actionable pillars. First, system scaffolding: leadership-backed collaboratives, consistent protocols, and participation in public-health workflows (Nieuwsma et al. 2014; 2017; Van Voorhees et al. 2014). Second, pathway choreography: use of confidentiality to lower thresholds for access, with scripted warm handoffs and joint crisis playbooks (Ramchand et al. 2015a; 2015b; Prazak and Herbel 2020; Adler et al. 2018). Third, workforce capability and sustainability: targeted cross-training, role clarity in sensitive cases, and supports that enable chaplains to collaborate effectively (Wortmann et al. 2021; Roberts and Kovacich 2020; Whitworth et al. 2021). Different theatres and national systems adapt these pillars to local mandates, but the core mechanisms remain consistent and are presumably replicable (Lee-Tauler et al. 2024; Liuski and Ubani 2021; Makovskyi 2023; Grimell 2020a; 2020b; Cooper et al. 2023; Drescher et al. 2018; Rance and Snape 2021).

3.4 Chaplain-Involved Interventions for Moral Injury

Emerging intervention models cluster into three typologies. First, chaplain-only protocols, such as the manualised Structured Chaplain Intervention, demonstrate feasibility and symptom change signals in case-level outcomes on the PCL-5[12] and the Moral Injury Symptoms Scale – Military Version (MISS-M)[13], while results from a larger comparative trial are pending (Ames et al., 2021). Second, co-led formats pair chaplains with clinicians: a 12-week Moral Injury Group reported pre-post improvements in depression and religious/spiritual struggles, as well as gains in psychological health, self-compassion, and post-traumatic growth. The companion practice paper details the public, ritualised Community Healing Ceremony as a core element (Cenkner et al., 2021; Antal et al., 2022). Third, structured chaplaincy protocols such as PND have been scaled at the provider level in the Australian Defence Force, showing strong acceptability and a clear multistage pathway from narrative disclosure to ritual and restoration, although participant outcomes have not yet been reported (Carey et al., 2023).

Across these models, core therapeutic ingredients recur guided narrative work, moral meaning-making, ritual, communal witnessing, and confidentiality-enabled trust. Provider surveys describe how chaplains already operationalise these elements in routine practice, while qualitative veteran accounts in Australia link cha-

[12] The PCL-5 is a 20-item self-rated scale that assesses symptoms across the four DSM-5 clusters: intrusions (Criterion B), avoidance of trauma reminders (Criterion C), negative alterations in cognitions and mood (NACM; Criterion D), and alterations in arousal and reactivity (Ames et al. 2021).

[13] The Moral Injury Symptom Scale – Military Version (MISS-M) specifically assesses MI symptoms (not events) and includes spiritual/religious indicators of MI (Ames et al. 2021).

plain roles to screening, counselling, and protocolised stages addressing betrayal and restoration (Drescher et al., 2018; Hodgson et al., 2021; Hodgson et al., 2022). Feasibility studies extend the toolkit by embedding moral injury screening into spiritual assessments and by piloting clinician–clergy collaborations supervised by a VA chaplain. These were judged as acceptable and set the stage for chaplain-delivered variants (Kopacz et al., 2022; Pyne et al., 2021). Complementing these pilots, a VA Dynamic Diffusion Network ("learning while doing") initiative distilled ten core components of co-facilitated chaplain–mental health MI groups. This implementation science lens clarifies how teams make MI care reproducible across sites and where chaplaincy distinctives sit within the shared model (Smigelsky et al. 2022).

Methodologically, the evidence base is promising but limited. Outcome studies are few, sample sizes are small, and most designs are uncontrolled, which restricts causal inference and dosage guidance. Nevertheless, convergence across typologies supports plausibility and informs training and implementation (Ames et al., 2021; Cenkner et al., 2021; Carey et al., 2023). Future priorities include head-to-head and comparative effectiveness trials, routine incorporation of MI-specific measures alongside readiness-adjacent outcomes, and attention to delivery contexts where chaplains serve as low-stigma gateways within integrated pathways (Cooper et al., 2023).

3.5 Tools of the Trade: Assessment, Measurement Approaches, and Evidence-Informed Practices

Across the corpus, chaplaincy is moving towards routine, evidence-informed practice that employs structured assessment and shared clinical language. Moral injury screening within chaplain encounters is feasible, demonstrates acceptable internal consistency, and aligns with convergent constructs when chaplains administer brief instruments, supporting workflow integration rather than parallel tracks (Kopacz et al. 2022). Existing chaplain-collected assessment data already inform risk triage, for example, mapping sources of guilt and their relationship to suicidal ideation in veterans who sought chaplaincy services (Kopacz et al. 2015). At the practice-architecture level, PND provides a staged, chaplain-led template aligned with the World Health Organization Spiritual Intervention Codings (WHO SPICs)[14], explicitly linking screening to narrative, ritual, and restoration; its feasibility and workforce uptake at a national scale were demonstrated in Australia (Carey and Hodgson 2018).

Capability building is the second pillar. A VA–DoD training programme in evidence-based practices, including Acceptance and Commitment Therapy (ACT)[15]

[14] The WHO-SPICs (World Health Organization Spiritual Intervention Codings) are the colloquial abbreviation for the five categories of "spiritual intervention" procedural codes that resulted from the revision of the WHO-ICD-10 "Pastoral Intervention Codings". These codings are employed by chaplains and other spiritual carers to formally notate the spiritual screening and treatment interventions they use to assist the health and well-being of their clients (Carey and Hodgson 2018).

[15] Acceptance and Commitment Therapy (ACT) is a transdiagnostic intervention proposed as a promising

and Problem-Solving Therapy (PST)[16], led to provider-level gains in confidence, skills, and collaboration relevant to suicide prevention and mental health support. This indicates that chaplains can learn and apply empirically supported techniques without losing pastoral distinctiveness (Wortmann et al. 2021). Quality improvement efforts at scale are also important. A national learning collaborative targeting chaplain–mental health integration reported measurable improvements in screening, referral workflows, and role clarity, which together create the infrastructure that enables assessment tools and brief interventions to be sustained in practice (Nieuwsma et al. 2017). The Bio-Psycho-Social-Spiritual (BPSS) model[17] advanced by Layson, Carey, and Best further situates evidence-informed chaplaincy as integrative, blending spiritual assessment/ritual with practical supports and coordinated referral, rather than as a parallel track to clinical care (2023).

Finally, several adjacent strands reinforce an evidence-informed approach. Public health-style initiatives demonstrate chaplains' readiness to contribute to standardised care processes such as the 5 A's (ask, advise, assess, assist, and arrange) for tobacco cessation, indicating the transferability of protocolised skills to other behaviour change targets (Van Voorhees et al. 2014). Provider surveys and qualitative syntheses show how chaplains already use therapeutic elements such as narrative work and ritual, providing targets for future mechanistic measurement and fidelity checks (Drescher et al. 2018). Observational outcomes research highlights plausible pathways through spirituality and resilience that can inform construct selection for chaplain-relevant metrics, while large surveys of help-seeking and utilisation identify populations where screening yield is likely to be highest and where collaborative handoffs should be prioritised (Cafferky et al. 2016; Kim et al. 2016; Kazman et al. 2020; Cooper et al. 2023). Together, these strands validate the core claim of a profession that is becoming more measurable, more comparable across settings, and better equipped to link pastoral distinctives with empirically grounded practices.

3.6 International, Ethical, and Governance Dimensions

A growing body of comparative research corrects a US-centric evidence base by revealing diverse mandates and delivery models. Qualitative and descriptive studies from Sweden illuminate a distinct "military soul care" paradigm grounded in confidentiality, ritual, and ethical advising within a national defence ethos (Grimell

approach for addressing moral injury (MI), aiming to foster psychological and behavioural flexibility by promoting acceptance of experiences and facilitating commitment to actions toward value-based behaviour, often utilizing mindfulness and values clarification (Jones et al. 2022).

[16] Problem-Solving Therapy (PST) is an evidence-based cognitive-behavioural treatment recommended for major depressive disorder that has been adapted into a brief, didactic group format (Problem-Solving Training) in the military to build real-life problem-solving skills for coping with stressful events and maintaining readiness (Wortmann et al. 2021).

[17] The Bio-Psycho-Social-Spiritual (BPSS) model further situates evidence-informed chaplaincy as integrative, advocating that chaplains blend spiritual assessment/ritual (e.g., through methods like Pastoral Narrative Disclosure, PND) with practical supports and coordinated referral to clinical care, thereby leveraging their role as a crucial resource rather than merely operating on a parallel track (Layson, Carey, and Best 2023).

2020a; Grimell 2020b; see also Grimell 2024). Australia provides a comprehensive case of national development and implementation of a chaplain-led moral injury framework, PND, with workforce training, uptake data, and veteran-facing implications (Carey et al. 2023; Hodgson et al. 2021; Hodgson et al. 2022; Carey and Hodgson 2018). The Netherlands offers process-focused accounts of how chaplains cultivate moral resilience and use ritual in care (Schuhmann et al. 2023), while Finland and Ukraine map contemporary organisational structures and practice roles, including psychosocial follow-up, ethical training functions, and chaplain–clinician collaboration in conflict settings (Liuski and Ubani 2021; Makovskyi 2023; Sokolovskyi, Slyusar, and Hordiichuk 2024). Additional perspectives from Slovenia and South Korea describe deployment prayer and ritual models, as well as religious-tradition-specific practice manuals that interface with humanitarian law (Muršič Klenar 2024; Lee 2022). Historical and policy analyses from secular and pluralistic states such as France and Chile raise governance and ethics questions related to non-coercion, equity, and Church–State boundaries, which are crucial for interpreting programme transferability and safeguarding inclusive care (Boniface 2022; Bellolio 2020; Levy 2018). Pastoral-theological work further casts chaplains as potential "organic intellectuals" who accompany veterans through trauma and mobilise counter-hegemonic solidarities, thus linking moral-injury care to civic ethics and public meaning rather than limiting it to intrapsychic repair (Morris 2020). Political-pastoral analyses extend these governance questions by interrogating how command–obedience dynamics and patriarchal structures can enlist care to problematic ends; they urge chaplains to sustain a prophetic stance that prioritises divine/ethical obligation over institutional pressures and situates some forms of moral injury within these structural conflicts (Tietje 2020). Korean Buddhist history cautions that state priorities can shape military chaplaincy ideology and practice, underscoring the need for explicit ethical guardrails when religious care is embedded in the military institution (Feuer 2022). Voices from minority faith perspectives further highlight the stakes of pluralism and institutional trust, especially where experiences of discrimination intersect with moral injury and access to care (Hosein 2018).

4. Discussion

The scoping review shows that scholarship on military chaplaincy is not evenly distributed across all identified areas of inquiry; instead, evidence indicates it is concentrated in several high-density clusters, while other areas are only beginning to emerge and some remain significantly under-researched.

4.1 Areas of High-Density Research

Three thematic areas stand out as the most researched and heavily populated within the last decade of scholarship: the integration of military chaplains with behavioural health professionals, their role in suicide prevention, and the development of interventions for moral injury.

Collaboration with behavioural health physicians and command is the most prominent and well-developed theme. Research in this area provides a rich, multi-level picture of integration efforts. At the system level, Nieuwsma et al. (2014) present a foundational mixed-methods assessment of collaboration across the American VA and DoD settings, identifying systemic barriers as well as areas of success. Related studies demonstrate military chaplaincy's integration into broader health initiatives, such as public health workflows like smoking cessation, indicating the feasibility of wider "no-wrong-door" pathways involving chaplains (Van Voorhees et al., 2014). At the implementation level, a national quality improvement learning collaborative evaluated by Nieuwsma et al. (2017) showed that structured initiatives can produce measurable gains in screening, referrals, and role clarity. At the practice level, Cooper et al. (2023) synthesise evidence to map the overlapping and complementary roles of chaplains and clinicians, advocating concrete collaborative pathways and warm handovers (Cooper et al., 2023; Nieuwsma et al., 2014). Qualitative work such as Adler et al. (2018) provides a detailed view of collaboration in practice, describing coordination dynamics among chaplains, behavioural health providers, and commanders during acute crises.

A second high-density area is suicide prevention, intervention, and postvention. The literature documents military chaplains' roles across the full continuum of suicide care. Large-scale surveys empirically establish chaplains and their religious support teams as key gatekeepers–often a preferred first point of contact for at-risk service members and a top referral choice for NCOs–frequently attributed to confidentiality protections (Ramchand et al. 2015b; Kim et al. 2016; Kazman et al. 2020; Adler et al. 2018; Lee-Tauler et al. 2024; Cesur et al. 2020). Studies have quantified how often chaplains engage with suicidality and identified corresponding training gaps, underscoring the need for targeted competency development (Kopacz et al. 2016; Ramchand et al. 2015a). In response, evaluations of chaplain training in evidence-based practices (e.g. ACT, PST) show gains in capability, confidence, and collaboration relevant to suicide care (Wortmann et al. 2021). Beyond prevention and intervention, qualitative accounts highlight chaplains' essential postvention roles–relational ministry and facilitation of communal grief rituals that contribute to unit healing and survivor care (Adler et al. 2018; Lee-Tauler et al. 2024; Liuski and Ubani 2021).

A critical mass of literature has now formed around intervention typologies for moral injury. Recognition of moral injury as a distinct form of suffering has driven significant innovation in chaplain-involved care. Research from this decade covers a range of intervention models: chaplain-only, manualised protocols such as the "Structured Chaplain Intervention", currently undergoing randomised clinical trial testing (Ames et al. 2021); co-led, interdisciplinary group models like the Moral Injury Group, with pilot outcomes (Cenkner et al. 2021) and operational specification (Antal et al. 2022); feasibility studies of protocols delivered by community clergy under VA-chaplain supervision (Pyne et al. 2021); and national framework implementation, with workforce training and adoption data from Australia's PND (Carey et al. 2023), with veteran-facing relevance and stage-spe-

cific chaplain actions further illustrated (Hodgson et al. 2021; 2022). Collectively, these studies demonstrate a sustained shift beyond conceptual discourse towards the development, testing, and implementation of specific, replicable, and spiritually integrated therapeutic approaches.

4.2 Emerging Research Fronts

Alongside well-established themes, two areas represent newer but rapidly developing fronts of inquiry: the development of validated assessment tools for military chaplaincy and the expansion of research into international and comparative models of spiritual care.

The field is moving beyond conceptual calls for measurement toward the empirical development and testing of tools tailored for the aforementioned chaplaincy practice. Feasibility studies within VA chaplaincy, for example, have examined the integration of moral injury screening directly into routine spiritual assessments, demonstrating both practical feasibility and preliminary psychometrics validity for chaplain-administered instruments (Kopacz et al. 2022). Related military chaplaincy assessment studies also show how routine data (e.g., guilt sources) can inform risk identification and care planning, further normalising evidence-based assessment within pastoral workflows (Kopacz et al. 2015).

Comparative international evidence broadens the perspective beyond the United States, demonstrating that military chaplaincy is not a single template but a family of context-shaped mandates. Taken together, the governance questions are not peripheral; they are central design constraints that determine whether confidentiality, presence, and ritual can be delivered as ethically legitimate public services within diverse armed forces worldwide. Moreover, comparative governance research urges systematic attention to chaplains and ritual at the unit level (cohesion, motivation) and to Church–State tensions at the institutional level (accommodation vs. establishment), reinforcing why transferability depends on legal–cultural fit (Hassner 2016).

4.3 Key Evidence Gaps and Future Research Priorities

To improve the field and equip policymakers with decision-grade evidence, several gaps require focused investment:

The corpus contains very few rigorous outcomes studies. Signals are promising in moral injury and resilience work, but most evidence is case-based, pilot, or implementation-focused rather than randomised or comparative effectiveness research (Ames 2021; Cenkner et al. 2021; Schuhmann et al. 2023). Previous evidence synthesis likewise concludes that chaplain-only models are under-tested and that outcome measurement often relies on proxies rather than head-to-head designs (Jones et al. 2022).

Beyond *does it work*, studies should identify *how* it works. Existing work points to plausible active ingredients, including guided narrative disclosure, communal ritual, relationship-based access, and structured collaboration, yet mechanisms

are rarely isolated or tested. Current sources describe candidate mechanisms and components that can be specified and mediated in trials: PND stages and military chaplain tasking, including restoration and ritual (Carey and Hodgson 2018; Carey et al. 2023; Hodgson et al. 2021; Hodgson et al. 2022), communal rituals within MI groups (Antal et al. 2022), chaplain presence and insider networks for suicide prevention (Adler et al. 2018; Lee-Tauler et al. 2024), and collaboration pathways with clinicians that may reduce stigma and improve referral capture (Cooper et al. 2023; Nieuwsma et al. 2014; Nieuwsma et al. 2017). Future studies should include theory-driven mediators and moderators, for example changes in moral meanings and ritual participation, alongside outcomes.

Samples and settings are heavily weighted toward Christian chaplains, male service members, and the American VA or DoD contexts. Important exceptions highlight why broader inclusion matters, including studies on Muslim service members and moral injury, Buddhist military chaplaincy guidance, Nordic and Australian models, and gendered care dynamics (Hosein 2018; Lee 2022; Feuer 2022; Grimell 2020a; Grimell 2020b; Liuski and Ubani 2021; Carey et al. 2023; Layson et al. 2023; Roberts and Kovacich 2020). Further research is needed to understand how military chaplaincy practice is adapted for, and experienced by, service members from different genders, faith traditions (including non-theists, humanists), service branches, and components (e.g., the Reserve), whose unique stressors and spiritual needs may not be captured by the current body of evidence.

Finally, to our awareness, none of the included studies evaluate the economic impact of military chaplaincy services. Although some work documents demand and utilization, these do not estimate costs or savings, nor effects on retention or readiness-linked productivity (Cesur et al. 2020; Van Voorhees et al. 2014). Future studies should incorporate health economic methods, such as cost–utility and budget impact analyses, and link chaplaincy inputs to downstream utilisation, readiness, and retention outcomes within integrated data systems.

5. Conclusion

The body of scholarship produced between 2014 and 2024, when considered as a whole, presents a compelling narrative of the professionalisation of military chaplaincy as an evidence-informed discipline. The emergence and development of specific research streams are not random but indicate a field in transition. Systematic evaluations of training programmes that equip chaplains with evidence-based clinical practices demonstrate a clear commitment to aligning spiritual care with established standards in behavioural health. The use of implementation science, including quality improvement collaboratives that enhance chaplain-clinician integration, reflects an awareness of the systems-level changes required to make care effective. The appearance of pilot trials, even if small and uncontrolled, demonstrates an ambition to subject chaplain-led interventions to the same standards of empirical validation expected of other health professions.

This scoping review documents the maturation of the discipline and highlights what is needed next. Our synthesis draws on literature indexed in Scopus and Web of Science, and thus reflects peer-reviewed journal outputs. We acknowledge that additional knowledge resides in other repositories and formats, including monographs, edited volumes, service reports, theses, program manuals, and grey literature, all of which warrant systematic mapping to complete the record. There is an increasing case for research literacy in military chaplaincy training, for chaplains who can participate in and lead studies, and for policy and funding that support chaplain-led research. On balance, recent conflicts appear to coincide with, but do not solely explain, the recent peak in scholarly output on military chaplains; they appear to sustain an already accelerating trajectory rather than initiate it. Taken together, the decade's scholarship depicts a field learning to account for its practices with clarity and rigour. The emerging narrative is one of steady consolidation toward an integrated model in which faith and evidence work in tandem to guide care.

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Appendix: Abridged Master Charting Table

Authors	Year	Country/System context	Study Type
Adler et al.	2018	U.S. Army	Implementation
Ames et al.	2021	U.S. Veterans	Outcomes
Antal et al.	2022	U.S. VA	Implementation
Bauer et al.	2023	U.S. Army (Medical Center)	Conceptual / Historical / Policy / Evidence Synthesis
Bellolio	2020	Chilean Armed Forces	Conceptual / Historical / Policy / Evidence Synthesis
Boniface	2022	France	Conceptual / Historical / Policy / Evidence Synthesis
Cafferky, Norton, and Travis	2016	U.S. Air Force	Outcomes
Carey and Hodgson	2018	Armed Forces/Veterans (General)	Conceptual / Historical / Policy / Evidence Synthesis
Carey et al.	2023	Australian Defence Force (ADF)	Implementation
Cenkner et al.	2021	U.S. VA	Outcomes
Cesur, Freidman, and Sabia	2020	U.S. Armed Forces	Implementation
Cooper et al.	2023	U.S. DoD	Implementation
Davie	2015	UK Armed Forces	Conceptual / Historical / Policy / Evidence Synthesis
Drescher et al.	2018	U.S. VA	Implementation
Feuer	2022	South Korean Military	Conceptual / Historical / Policy / Evidence Synthesis
Grimell	2020a	Swedish Armed Forces	Implementation
Grimell	2020b	Swedish Armed Forces	Implementation
Grimell	2024	Swedish Armed Forces	Conceptual / Historical / Policy / Evidence Synthesis
Gutierrez et al.	2021	U.S. DoD	Implementation
Hassner	2016	Primarily U.S.	Implementation
Hodgson, Carey, and Koenig	2021	Australian Veterans	Conceptual / Historical / Policy / Evidence Synthesis
Hodgson, Carey, and Koenig	2022	Australian Veterans	Implementation
Hosein	2018	U.S. Military	Conceptual / Historical / Policy / Evidence Synthesis
Houston	2016	South African Forces (WWI)	Conceptual / Historical / Policy / Evidence Synthesis
Jones et al.	2022	Military/Veterans (General)	Conceptual / Historical / Policy / Evidence Synthesis
Kazman et al.	2020	U.S. Military	Implementation
Kim et al.	2016	U.S. Army	Implementation
Koenig	2022	U.S. Military	Conceptual / Historical / Policy / Evidence Synthesis
Kopacz et al.	2022	U.S. VA	Implementation
Kopacz et al.	2015	U.S. VA	Implementation
Kopacz et al.	2016	U.S. VA/DoD	Implementation
Layson, Carey, and Best	2023	Australian Military (context)	Conceptual / Historical / Policy / Evidence Synthesis
Lee	2022	South Korean Military	Implementation
Lee-Tauler et al.	2024	U.S. Special Operations Forces (SOF)	Implementation
Levy	2018	U.S. & Israel	Conceptual / Historical / Policy / Evidence Synthesis
Liuski and Ubani	2021	Finnish Defence Forces	Implementation
Makovskyi	2023	Armed Forces of Ukraine (AFU)	Implementation

Authors	Year	Country/System context	Study Type
Mislin	2015	U.S. Military (WWI)	Conceptual / Historical / Policy / Evidence Synthesis
Morgan et al.	2016	U.S. Army	Implementation
Morris	2020	U.S. Veterans	Implementation
Muršič Klenar	2024	Slovenian Armed Forces	Implementation
Nieuwsma et al.	2014	U.S. VA/DoD	Implementation
Nieuwsma et al.	2017	U.S. VA/DoD	Implementation
Prazak and Herbel	2020	U.S. Military	Implementation
Pyne et al.	2021	U.S. VA	Implementation
Ramchand et al.	2015a	U.S. Army	Implementation
Ramchand et al.	2015b	U.S. Army & USMC	Implementation
Rance and Snape	2021	UK Royal Air Force (WWI)	Implementation
Roberts and Kovacich	2020	U.S. Army	Implementation
Schuhmann et al.	2023	Netherlands Armed Forces	Implementation
Smigelsky et al.	2022	U.S. VA	Conceptual / Historical / Policy / Evidence Synthesis
Sokolovskyi, Slyusar, and Hordiichuk	2024	Armed Forces of Ukraine (AFU)	Conceptual / Historical / Policy / Evidence Synthesis
Tietje	2020	U.S. Military	Conceptual / Historical / Policy / Evidence Synthesis
Van Voorhees et al.	2014	U.S. VA	Implementation
Whiting, Cardinet, and Merchant	2020	U.S. DoD	Implementation
Whitworth, O'Brien, and Stewart	2021	U.S. Military	Implementation
Woodhouse	2021	British Army	Implementation
Wortmann et al.	2021	U.S. VA/DoD	Implementation