**Chapter 4: Interpersonal Competencies in Spiritual Care**

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**Abstract**

 Chaplains and community religious leaders may be first responders when people struggle with four kinds of suffering: suicide and despair, addictions, trauma, and moral injury. How can they offer immediate and ongoing evidence-based spiritual care? What interpersonal competencies do they need to build trust when people struggle with suicide, addictions, post-traumatic symptoms, and moral injury? In this chapter, we use the Helping Styles Inventory[[1]](#endnote-1) along with an extended case study to illustrate how chaplains integrate research-based knowledge with interpersonal competencies in response to these forms of suffering.

**Competencies for Building Interpersonal Spiritual Trust**

Interpersonal competencies consist of three elements.[[2]](#endnote-2) First, there is knowledge and research for assessing and treating spiritual suffering, such as suicide, addictions, trauma, and moral injury. Second are the interpersonal skills a care seeker needs and to utilize the relevant research. Third are the sound clinical judgments or the wisdom of chaplains, which include their capacities for spiritual and social empathy and self-reflexivity. Those receiving care also bring their wisdom in dealing with these issues and discerning the trustworthiness of those offering spiritual care.[[3]](#endnote-3) Knowledge can be learned in academic courses, workshops, clinical education in CPE units, and through reading. Skills are usually learned through observation and practice, participating in role plays and doing clinical work under supervision. Skills in listening and responding are crucial to interpersonal competencies.[[4]](#endnote-4) Clinical judgment and wisdom are the ability to make wise responses and choices using empathy and self-reflexivity for understanding the unique ways others experience suffering and hope. This reflexivity utilizes feedback from supervisors, peers, and others.[[5]](#endnote-5) Knowledge of intersectionality and systemic racism highlight the need for assessing the ways that systemic racism and enduring colonialism compound suffering.[[6]](#endnote-6) Chaplains and community religious leaders need interpersonal competencies to build the relational foundation of spiritual trust described in chapter 3. In an evidence-based approach to spiritual care, clinical wisdom and judgment draw upon knowledge of the relevant research to understand the distinctive needs of the spiritual care receiver.[[7]](#endnote-7)

As a chaplain or spiritual care provider approaches a patient or care receiver for the first time, a basic competency is understanding and utilizing a model to guide their care. One example of a model is the Helping Styles Inventory, developed by Peter VanKatwyk. This model describes four areas of interpersonal competency that a beginning chaplain needs for working with spiritual care receivers.[[8]](#endnote-8) The tool consists of four quadrants: celebrant, consultant, manager, and guide. Each role describes a different style of helping role and interpersonal competencies that spiritual care givers can utilize to help spiritual care seekers.[[9]](#endnote-9) (See Appendix 1 for the HSI)

In conjunction with a universal assessment model, a spiritual care giver also needs skills for addressing the forms of suffering they are likely to encounter in the clinical environment or community they serve. In this chapter, we will explore four aspects of suffering through a composite case study of a chaplain resident “Joe” providing care to a military veteran “Alex” in a VA (Veteran’s Affairs) medical center.[[10]](#endnote-10) The purpose of the case study is to demonstrate how the chaplain approaches the aspects of suffering in a single case, as it develops over time. The authors recognize that chaplains in many settings may only have one opportunity to visit a patient, while some spiritual caregivers may develop short to long-term relationships with those they serve. This case study is meant to be illustrative rather than prescriptive.

**Case Study: Military Veteran Alex, Chaplain Joe, and Spiritual Care of Suicide Risk**

We introduce our case with the basic information Joe presented to his peers for his first consultation on this case:

Chaplain: Joe Veteran: “Alex”[[11]](#endnote-11) Visit #1 Age: 42 Faith Tradition: Catholic

Location: Acute Psychiatric Unit Branch: Army Ethnicity: Latino

Diagnosis/Pertinent Medical History: 72-hour suicidal ideation hold, acute alcoholism

Reason for visit: Sunday spirituality group Topic: Guided Imagery Meditation using Psalm 23

Background/Observations: After group, Veteran requested a Bible. Pt stated that he was not active in his faith. He was looking down, as if ashamed. He had been quiet during group.

Plan: Bring veteran a Bible, establish rapport with patient, and if possible, explore shame. Explore faith practices that may help him cope with hospitalization.

Chaplain residents serving in hospitals with acute psychiatric or behavioral health units often lead spirituality groups, requiring them to have a basic understanding of group facilitation.[[12]](#endnote-12) Most chaplain residents enter CPE with worship and small group leadership experience, such as leading Bible studies or youth groups. Leading a spirituality group in a secular institution such as the VA requires chaplains to facilitate engagement with patients of many faiths and no faith. It also requires a basic knowledge of mental health.[[13]](#endnote-13)

Knowing that Alex was receiving treatment for suicidal risk, Joe was ready to pick up on any cues that Alex’s struggles with despair and suicidal thoughts were intensifying. All chaplains should be familiar with a suicidal risk assessment, such as the Columbia-Suicide Severity Rating Scale protocol for asking questions about suicide.[[14]](#endnote-14) When Joe returned with the Bible, he planned to follow-up on Alex’s statement that he was no longer active in his faith. Drawing on the HSI, he approached Alex with “facilitative” skills. Alex thanked Joe for the Bible saying, “I need to get back to my faith” while looking down at the floor. Hearing that Alex was ready to connect, Joe invited Alex to say more. Alex replied, “My family is very religious. I need to go to treatment. I wasn’t ready before. I wanted to run around and party. I thought I was too young to be sober, but I’m over 40 now. It’s time for me to grow up. It was stupid of me to take all those pills, I know. I was just so mad when my sister said I couldn’t sleep on her couch anymore. Everyone in my family is sick of me.” Embodying the celebrant, Joe responded, “I’m glad you’re here getting help. Tell me how having this Bible might help in the next couple of days.” Joe found himself wondering how the Bible was going to help Alex. He feared that if Alex read passages portraying a judgmental God, it might cause him more distress.

Alex looked down as his hands tightened around the Bible. He did not initially respond. Then he said in a low voice, “I’m not sure. What you said in group about God being the good shepherd made me feel safe. I thought maybe I should read the Bible, but I have no idea where to start.”

 Knowing that his time with Alex was brief and there was a clear risk of Alex experiencing religious struggles with God that could intensify his shame, Joe decided to risk shifting into a guiding style by asking for permission to help Alex use the Bible and Psalm 23 in a calming, breath-centered practice.[[15]](#endnote-15) “Alex, would you be okay with trying a way to feel like God is the Good Shepherd right now?” Alex said, “You mean, like saying a prayer?” Joe responded, “It’s sort of like praying. Do you want to try that spiritual practice I talked about in chapel today? [Alex nods]. We get a sense of our feet touching the ground [Joe gently bounced his feet on the floor] and we sit up straight, with our backs feeling supported the chair. [Joe adjusted his posture and Alex followed suit]. Next, we are going to take some slow, deep breaths together. We are going to breath in slowly counting to four [Joe models this and Alex follows his guide.] Now we are going to hold to the count of four. [Joe paused to do this.] Now we breathe out slowly through our mouths.” Joe guided Alex in taking another slow, deep breath, noticing that Alex looked down while he did this. Joe guided him in several slow deep breaths, inviting Alex to feel the weight and warmth of the bible in his hands.

A few moments of silence followed. Joe saw that Alex’s shoulders had relaxed and his hands around the bible were no longer clenched. When Alex looked up, the muscles around his eyes had relaxed. Alex sighed, saying, “That was good.” Joe suggested that Alex might try taking some slow deep breaths while holding the Bible over the next couple of days. Then, if he wanted to, he could open it to Psalm 23, where Joe had put a card with his name. Alex could try reading the Psalm and pausing to take some slow deep breaths, especially when he felt pulled back into troubling memories.[[16]](#endnote-16) Alex said he’d like to try this. Joe arranged to check back with him in a few days.

**Suicide and Despair**

This initial visit reflects a myriad of skills and competencies demonstrated by Joe. For the purposes of this chapter, the immediate presenting issues are suicide and despair. Suicide and despair are closely linked to depression, hopelessness and psychache. [[17]](#endnote-17) Psychache is “intense, unrelenting psychological pain” that can lead to suicide.[[18]](#endnote-18) Suicide is present in most cultures. In 2019 the United States recorded 47,000 suicides;[[19]](#endnote-19) in Canada there were 4000 deaths by suicide.[[20]](#endnote-20) High rates of suicide and suicidal ideation in the US military and veterans are well documented.[[21]](#endnote-21)

 Research demonstrates that spirituality is a mediating force in protecting against suicide attempts.[[22]](#endnote-22) Linda MacKay argues that “perfect listening” on the part of the chaplain is the most healing tool in dealing with the despair of attempted suicide.[[23]](#endnote-23) This visit also demonstrates the use of a mindfulness strategy, which has well documented evidence in the literature. Despair can lead to suicide, when a person who regards every attempt at living a meaningful and productive life as futile. Paul Tillich asserted that such meaninglessness is one of the fundamental anxieties of human experience.[[24]](#endnote-24) This branch of philosophy known as existentialism became contextually meaningful in the 20th century in response to genocides such as the holocaust. Existentialism asks: Is there any meaning to life or is life just the survival of the fittest? Where was the divine in all these atrocities? Feminist theologian Susan Nelson describes how moral and redemptive ways of finding meaning are often inadequate for those in despair, who often need, instead, a “paradigm of radical suffering [that] stands in this place of suffering and incoherence, recognizes everything such evil threatens, realizes that this evil cannot be justified but must be resisted, and asks in the face of such evil, ‘Where is God?’ or ‘What kind of God... ?’ or ‘Is there a God at all?’”[[25]](#endnote-25) Nelson describes how, for those in despair, hope may be experienced in the present and not just the future, in practices of care: “Prisoners at Auschwitz practiced acts of resistance to the evil of that place.…Others resisted evil by practicing simple acts of justice and kindness that bore witness to a world order far beyond the terror and cruelty imposed by the Nazi's.”[[26]](#endnote-26)

Spiritual care helps those in despair experience their interconnectedness within lifegiving webs often experienced as transcendent or sacred. This sense of spiritual trust enables them to search for meanings without being overwhelmed by despair. In the aftermath of trauma, even the horrors of genocide, survivors grounded in a sense of interconnectedness with the inherent goodness of humanity may be able to look back on their suffering and search for life giving meanings. Viktor Frankl, a Jewish psychiatrist who was imprisoned in a concentration camp in World War II, developed a form of therapy that describes how, once a therapeutic alliance is established, people can enter into a process of searching for meanings in the aftermath of profound suffering.[[27]](#endnote-27)

Returning to our case study, we can see how Alex is seeking the chaplain for guidance in finding meaning in his life, through his request for a Bible. . Often a spiritual guide, what John O’Donohue calls a “soul friend,” who journeys with the person in the darkness can be helpful.[[28]](#endnote-28) Helping a person identify a source of hope is an important element for those who survive a suicide event. Pam McCarroll and Helen Cheung did an extensive review of the literature on hope using health care, theological, and pastoral literature.[[29]](#endnote-29) The despair and hopelessness that sometimes gives rise to suicide is exacerbated by substance use. A clinical question for the chaplain is: How does Joe foster hope within Alex who has attempted suicide and struggles with addiction? Returning to the HSI, Joe serves as a Consultant, by helping Alex identify sources of hope that can motivate him to address his addiction which exacerbates suicide ideation and despair. The chaplain can carry the hope for the spiritual care receiver for a time, through belief in the systems that can offer help.[[30]](#endnote-30)

A significant interpersonal competency needed for chaplains is the ability to assess despair, suicidal thoughts, and impulses. Chaplains need to be able to draw upon knowledge about suicide risk and use interpersonal and communication skills to go through a suicide assessment. The consultant role in the HSI allows the chaplain to ask questions in a non-judgemental way, conveying support and empathy. Chaplains need skills to manage their anxiety about suicide and not let it get in the way of their assessment and care plan.

**Continued Spiritual Care of** **Alex**

As promised, Joe followed up with Alex in a few days. By this time, he was admitted to the hospital’s 28-day Substance Abuse Recovery Program (SARP). Joe made the following note about his second visit:

Veteran: “Alex” Faith Tradition: Raised Catholic Reason for visit: Spiritual Intake

Observations: Veteran shared story of military discharge due to excessive drinking/drug use, which spiraled recently as a way of coping with an injury at work. He linked his excessive drinking and drug abuse to a history of failed romantic relationships, and broken family relationships. Veteran connected this story to childhood sexual abuse and military sexual trauma. Veteran denies reporting abuse and stated: “I didn’t want people thinking I was gay.”

Assessment: Veteran self-rated low (1-2) in 12/15 items on Moral Injury Symptom Scale.[[31]](#endnote-31) He acknowledges his part in broken relationships and seems eager engage in the work of recovery.[[32]](#endnote-32) Veteran is motivated to reconcile with his family and conflates his faith/relationship with Higher Power with his relationship to family.

Interventions: Empathetic listening, reviewed intake assessment, and explored faith, family resources.

Outcome: Veteran requested ongoing support from chaplain. Reported using Psalm 23 and “breath prayer” to stay grounded.

 This second visit again demonstrates several competencies, including the use of an evidence-based assessment tool. In addition, Joe drew on a theory that Post Traumatic Stress Disorder (PTSD) is a form of complicated grief.[[33]](#endnote-33) This theory is not meant to reduce PTSD to grief, but rather to identify grief work as part of the healing process for PTSD. Wolfelt’s theory was transformative for Joe because he felt comfortable with facilitating grief as a chaplain. Approaching Alex’s PTSD as a form of grief helped him focus on the ways that spiritual care is different from therapy. In addition, Joe developed a more thorough understanding of the role of guilt, shame, and anger—the primary emotions woven through Alex’s story.[[34]](#endnote-34)

One competency described in the previous chapter is knowing when to seek supervision. Joe came to supervision, after this visit, with a sense of anxiety and urgency. Over the next couple of weeks, while Alex completed SARP, Joe ‘unpacked’ his conversations with Alex in supervision. While he knew that providing spiritual care to persons of diverse backgrounds, including diverse sexual orientations and gender identities, was a competency needed by spiritual care givers, Joe had never previously faced a care receiver questioning his sexual orientation. Joe initially found it hard to reconcile a psychological understanding of sexuality and mental illness with his fundamentalist theological heritage, which attributed both to the devil and sin. Due to the significance of sexuality in most people’s lives, it is vital that chaplains develop skills in approaching patient’s intimate feelings about the subject. In supervision, Joe disclosed unresolved guilt about previously espousing fundamentalist beliefs against Lesbian, Gay, Bisexual and Transgender (LGBT) people, as well as his ignorance about sexuality outside of heterosexual marriage. He also voiced a fear of judgment from his lesbian-identified educator. In these disclosures, Joe demonstrated the vulnerability which helped him courageously consult about sexuality with his peers and supervisor.

In parallel to his spiritually integrative learning, Joe’s relationship with Alex continued to deepen, through spirituality groups and individual meetings. Like Joe, Alex had struggled with a God he perceived to be punishing. Since he was molested as a child, Alex believed he was “damned” from a young age and began drinking at a young age as a way to cope. His abuser, an uncle, had died when Alex was on a deployment many years ago. Alex felt a mixture of relief and guilt for never confronting his uncle. He buried these complex feelings in alcohol and recreational drugs. His experience of military sexual trauma (MST) began with getting special privileges from a senior officer, which led to the assault. Alex again buried the experience in drugs and alcohol. Alex said, “I saw a lot of stuff over there, but none of that bothers me.” Joe understood this to mean that while Alex had combat-related triggers for PTSD, his experience of military sexual trauma was what haunted him the most.[[35]](#endnote-35)

At times, Joe felt overwhelmed by Alex’s story. However, he took solace in knowing he was part of Alex’s treatment team. Through serving in SARP, Joe developed a working understanding of the 12-step addiction program and helped Alex articulate what he believed about God.[[36]](#endnote-36) Alex participated in weekly spirituality groups, focused on topics of moral njury, including forgiveness, betrayal/trust, guilt, and shame. The concept of military moral injury emerged from therapy with veterans whose posttraumatic stress included lasting moral conflicts about harm caused by themselves, fellow service members, or those in authority. Alex worked in therapy to understand how he carries a profound sense of betrayal from his experience of assault. His story helped Joe understand moral injury and recognize a degree of moral injury in himself.[[37]](#endnote-37) To heal his feelings of moral injury, Joe processed feelings of guilt for perpetuating harm against LGBT and mentally ill people, at the behest of former church leaders. As Joe worked on reconciling his moral injury, he helped Alex grieve his past, acknowledge his loss of innocence, and develop trust in using the AA program.[[38]](#endnote-38) Alex had unresolved grief about leaving the army, and even missing his uncle’s funeral. When he finished the SARP program, Alex acknowledged that he was not yet ready to forgive his abusers but was working on forgiving himself for the part he played in compounding his trauma. He left the VA for a transitional care home and expressed his commitment to rebuilding the relationship with his family. Alex’s involvement in the 28-day addiction program began to address his addiction to alcohol and drugs. However, Alex was not ”fixed” in 28 days; he will be on a lifelong healing journey. This program brought out his underlying experience of trauma, post-traumatic stress, and moral injury which fueled his addictions. A spiritual care provider needs a basic, working understanding of these spiritual struggles in order to journey with those in their care. What follows is an attempt to introduce the reader to these areas of study, to encourage further exploration.

**Spiritual Care and Addiction**

Treatment for addiction has different approaches. Michelle Cleary and Sandra Thomas in a review of the literature summarize six: 1) spiritual means, 2) medical interventions, 3) individual therapy, 4) group therapy, 5) 12-step programs, and 6) family therapy.[[39]](#endnote-39) These different aspects of treatment follow two major pathways. One is abstinence from alcohol, drugs, and addictive behaviours; the other is harm reduction of the drug and/or behaviour. The abstinence approach is usually associated with the 12-step program of Alcoholics Anonymous (AA) for alcohol and Narcotics Anonymous (NA) for addictive drugs. Both programs emphasize a desire for complete abstinence from the drug and behaviour of choice even if this takes some time to achieve. Daily, weekly, monthly peer-led meetings are widely available online and in person. In these groups, persons with addictions tell their stories and struggles with the addictive substance and receive support and wisdom from other persons in recovery from addiction.[[40]](#endnote-40) Individuals are expected to engage in an intensive process of self-reflection, with the help of an active sober member called a “sponsor” using the 12 steps:[[41]](#endnote-41)

1. We admitted we were powerless over alcohol-that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn over our will and our lives over to the care of God *as we understood Him*.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we have harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God *as we understood Him,* praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

The 12 steps are highly spiritual, having originally arisen from Protestant Christianity. However, one can be an atheist or agnostic and live the AA Program. The Higher Power can be anything that person envisions as greater than self and offers help, such as faith in the treatment team, their 12-step group, or a belief in Love. Chaplains can support people in 12-step based programs by helping them articulate their understanding of their higher power and develop their practices of prayer and meditation. Spiritual care providers can also help by supporting patients’ journey with the 12 steps, for example, in celebrating milestones of recovery.[[42]](#endnote-42) Other evidence-based interventions include self-forgiveness and forgiveness of others, noted in step nine. Harm reduction refers to the reduction in use of the drug or behavior of choice. Harm reduction became more known as an evidence-based approach when the World Health Organization (WHO, 1999), the United States National Association for Public Health Policy (NAPHP, 1999) and the Canadian Drug Strategy (CCSA, 1998) “endorsed the principles of harm reduction in key documents.”[[43]](#endnote-43) Harm reduction may be helpful for behaviors patients feel unable or unwilling to cease entirely. Again, the chaplain may support people in harm reduction programs, through celebrating victories and bolstering their commitment to healthy behaviors. All chaplains need the competency to support patient’s values, rather than impose their own upon patients. Thus, while a chaplain is not expected to support behavior that they find immoral, they are expected to support the *values* of a person, such as a reduction in their dependence on an addictive behavior.

How else does spiritual care help persons with addictions such as Alex? Mate maintains that compassion, empathy, and listening are important to those struggling with intractable addictions.[[44]](#endnote-44) Like suicide and despair, a spiritual care relationship built on positive regard, empathy, and congruence can be healing for Alex. He needs to work with Chaplain Joe as an integral part of the whole treatment team.

Besides the spiritual care relationship, other spiritual care practices can be beneficial. Mindfulness and meditation are often used to help slow the impulsivity and compulsion that lead to addiction. Joe used the guiding style earlier, when he showed Alex how to use the phrase, “The Lord is my Shepherd” from Psalm 23. A spiritual care provider may also suggest passages from a sacred text or 12 step literature, rituals/practices for practicing forgiveness for self and others. These practices may augment work being done in therapy and recovery, such as the process of making amends in the “Ninth step.” Chaplains need to use their skills of assessment to determine when the manager and guiding styles (from HSI) are most helpful, and offer or teach skills, when care seekers are interested.

Returning to our case study, Joe developed trust with Alex as he journeyed with him through the 28-day program. Fortunately, Joe quickly realized that he was out of his depth with Alex’s story and brought those conversations to his supervisor to discuss. This led him on his own journey of healing and discovery, apart from his work with Alex. In CPE, Joe unpacked his initial reactions to Alex’s comment associating sexual abuse with being gay. In consultation with his supervisor, he realized that he had moved past his childhood church’s stance on homosexuality, and that he needed to develop his own theology of sexuality. Another competency of a skilled practitioner is identifying ongoing learning goals. Joe identified ongoing learning goals about understanding human sexuality, trauma, and moral injury.

**Trauma and Post-Traumatic Stress Disorder (PTSD)**

Trauma is an area of suffering that spiritual care providers face in their work. Alex experienced trauma in childhood sexual abuse and adult sexual assault in his military career. For Alex, both events were by authority figures whom he trusted: an uncle and a military officer. These traumas were factors in Alex’s addiction and attempted suicide.[[45]](#endnote-45) What knowledge, skills and clinical judgment does Joe need as Alex discloses his experiences of trauma?

 Trauma has many definitions. Patricia Berendsen defines trauma “as an experience of being so overwhelmed that one’s capacity to cope is compromised.”[[46]](#endnote-46) Trauma is a threat to one’s physical, emotional, and spiritual health.[[47]](#endnote-47) The result of trauma can be post-traumatic stress syndrome (PTSD) which affects the body, mind, emotions, and spirit of the person.[[48]](#endnote-48) Trauma is stored in the body and psyche.[[49]](#endnote-49) Flashbacks and dreams can replay the trauma in the person who has experienced PTSD. Somatic therapy and spiritual practices focusing on the emotional, mental, and physical aspects of trauma can be helpful.[[50]](#endnote-50)

For a spiritual care provider, Carl Rogers’ core aspects of spiritual care are crucial to help a person with PTSD: unconditional positive regard and empathy.[[51]](#endnote-51) Compassion for the traumatized person is key to healing.[[52]](#endnote-52) The chaplain should be able to listen, summarize, and work from the celebrant and consultant approaches of the Helping Styles Inventory. They need to be a non-anxious presence, especially if the traumatized person describes the traumatic event.[[53]](#endnote-53) Patricia Berendsen says that it is essential to create a safe place for the spiritual care seeker.[[54]](#endnote-54) The victim did not feel safe in the experience of the trauma. One must move slowly, be supportive and let the spiritual care seeker set the agenda and pace. The spiritual care provider needs to be careful around probing questions especially when the person shows resistance. One does not want to re-traumatize the victim.[[55]](#endnote-55) The key is to do no harm.[[56]](#endnote-56) In listening to the trauma event, a caregiver begins by asking what strengths the person has to survive the event.[[57]](#endnote-57) These strengths need to be affirmed especially in the person who felt powerless in the experience. The fact that the survivor physically got through the event indicates strength.

Research indicates that trauma victims do best with a spiritual care provider who is trauma informed, i.e., the spiritual care provider has had some experience of working with trauma victims under supervision and has some knowledge and skill in the area.[[58]](#endnote-58) This means having the basic skills to assess PTSD and knowing when and where to refer to someone more trained. Usually, a beginning chaplain needs to work under a trauma informed supervisor to know how to be helpful to the victim. A spiritual care provider can experience vicarious trauma by listening to the story of trauma from a spiritual care seeker. Supervision and possibly therapy for the spiritual care provider are highly recommended in vicarious trauma.

**Moral Injury**

In our case study, Joe recognized that Alex avoided the pain and shame of his traumatic experiences through the compulsive use of alcohol and drugs. Addiction then became a source of moral failure, which further complicated his life. Once Alex began to abstain from drugs and alcohol, he began to address his underlying attachment issues – namely the sexual abuse he suffered as a child, which led him to abusive, unhealthy relationships as an adult.

What should a clinical chaplain know about moral injury and what interpersonal competencies do they need to address this issue in spiritual care seekers? First, it is important to have a working definition. Defined in the literature, moral injury is about breaking one’s own ethical code,[[59]](#endnote-59) which leads to moral stress. Carrie Doehring sees moral injury as the extreme end of a continuum on moral stress.[[60]](#endnote-60) Moral injury and moral stress occur when a person experiences danger, life threat, and suffering that compromises core values that give purpose to their lives, vocations, and roles. Doehring argues “that moral stress is inherently spiritual and religious requiring both psychological and theological approaches to care.” [[61]](#endnote-61)

Most people have an ethical code that guides their behavior. Situations may occur where a person breaks their own moral code. These could also be called acts of commission. In the military and law enforcement, people are trained to use lethal force. In retrospect, they might realize that an action, such as taking a life, broke their own code. There are also moments when the code is broken by omission, such as seeing a wrongdoing and doing nothing about it. Moral injury may also result from being part of an organization or system in which people feel betrayed by those in authority. All forms of moral injury can result in guilt and shame. Sometimes moral injury includes a situation where the victim feels responsible for the transgression of another. Victims of sexual assault often report unresolved guilt and shame, often due to engaging in substance use and being assaulted while under the influence. Military sexual trauma can be exacerbated by the explicit moral codes to protect each other, at all cost. Since military units can function for service members as a replacement family, the implicit sense of betrayal is more akin to sexual abuse by a parent – a person duty-bound to protect them. The guilt and shame resulting from traumatic events such as these, compounded by addiction and other comorbidities, may lead to a downward spiral of despair, resulting in attempted suicide. For Alex, moral injury was exacerbated by a view of the Divine that was harsh, judgmental, unforgiving, and punishing. Having an unprocessed adverse childhood trauma is also a risk factor.

 According to Doehring, chaplains can help the spiritual care seeker in three areas:

1. Connect with God/a sense of transcendent goodness/benevolence through compassion based spiritual care.
2. Identify embedded beliefs and values shaped by family and culture that cause moral stress and injury.
3. Co-create life-giving beliefs and values with trusted others that are flexible, integrated, capable of complex meanings and support life-giving relationships.[[62]](#endnote-62)

Resolving moral injury and moral stress requires a commitment of both the spiritual caregiver and care seeker.

**Conclusion**

We have examined the interpersonal competencies needed by spiritual care providers helping a person who has attempted suicide and experienced addiction, trauma, and moral injury. We have illustrated these competencies through the case study of a veteran, Alex seeking care from Chaplain Joe, and what he learns from the case in supervision. The Helping Styles Inventory has served as a guide, showing the diversity of approaches, skills, and interpersonal competencies needed by spiritual care providers. But the HSI is only one map/tool to guide these interpersonal competencies. We have also drawn on relevant theory and research in an evidence-based approach.

**Questions for Discussion**

* 1. Carl Rogers stresses the interpersonal competencies and skills of unconditional positive regard, congruence, and empathy as crucial in spiritual care. In the case scenario, how would you rate Joe on these interpersonal competencies on a scale of 1-10 with 10 being high and one being low? How would you rate yourself in your clinical work? Are there any clients where you would rate yourself low? Why?
	2. The research indicates that spirituality is a factor in healing shame and guilt that arises from attempted suicide and addiction. Do you see that in your spiritual care work?
	3. What are your personal and professional barriers in discussing suicide ideation with a spiritual care seeker? What strengths do you bring to this conversation?
	4. After reading the sections on trauma and moral injury, do you feel you have enough knowledge, skill, and clinical experience with these issues to deal with them? What was helpful to Joe in working with Alex’s trauma and moral injury?
	5. Peter VanKatwyk describes four styles in the Helping Styles Inventory (HSI): celebrant, consultant, manager, and guide. Which of these styles do you use the most in your spiritual care practice? For which ones do you need more training?

**Recommended Readings**

O’Connor, Thomas, Kristine Lund, and Patricia Berendsen, eds. *Psychotherapy: Cure of the Soul*, (Waterloo: Waterloo Lutheran Seminary, 2014)

Ramsay, Nancy, and Carrie Doehring, eds. *Military Moral Injury and Spiritual Care:* *Resources for Religious and professional Leaders* (Nashville: Chalice Press, 2019).

VanKatwyk, Peter. *Spiritual Care and Therapy: Integrative Perspectives* (Waterloo: WLU Press, 2003).

Wolfelt, Alan D. *Reframing PTSD as Traumatic Grief: How Caregivers Can Companion Traumatized Grievers through Catch-Up Mourning* (Fort Collins: Companion Press, 2014).

Waters, Sonia.  *Addiction and Pastoral Care* (Grand Rapids: Eerdmans, 2019).

Appendix 1: Helping Styles Inventory Map



From Peter VanKatwyk *Spiritual Care and Therapy*…177

1. **ENDNOTES**

 Peter VanKatwyk, *Spiritual Care and Therapy: Integrative*

*Perspectives* (Waterloo, Ont.: WLU Press, 2003). [↑](#endnote-ref-1)
2. College of Registered Psychotherapists of Ontario (CRPO) *CRPO Competency Profile*.

(Toronto, Ont.: CRPO, 2015); For more on a definition of competency in spiritual care especially

the role of interpersonal skills, see Thomas St. James O’Connor and Sylvia Davis, “Roll of the

Dice and Running the Gauntlet: Critical Examination of the Praxis of the CAPPE National

Certification Appearance,” *Pastoral Sciences,* Fall (1999,): 91-10. [↑](#endnote-ref-2)
3. *CRPO Competency Profile*; Also see Erin Snyder, Ayse Erenay, Thomas St. James O’Connor,

Ruth Smith, Stephanie Hong, Lisa Dolson, L. and Michael Folger, “Evidence Based Spiritual

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