Chapter 7
Understanding Moral Injury in Individuals: Current Models, Concepts, and Treatments

Joseph M. Currier, Steven L. Isaak, and Paola Fernandez

> For I do not understand my own actions. For I do not do what I want, but I do the very thing I hate. Now if I do what I do not want, I agree with the law, that it is good. So now it is no longer I who do it, but sin that dwells within me. For I know that nothing good dwells in me, that is, in my flesh. For I have the desire to do what is right, but not the ability to carry it out. —Romans 7:14–18

Introduction

The notion that people can be physically, emotionally, and spiritually wounded by their own transgressive behaviors and can suffer as a result of others' transgressions has been affirmed throughout human history in all major religions. Christianity in particular acknowledges the sinfulness of humanity in terms of *who we are* and *what we do*. However, because of Christ's incarnation, death, and resurrection, Christians typically believe they can be pardoned from sin and participate in transformative relationships with a loving God and fellow humans. From a psychological standpoint, Paul's words above capture the inner turmoil that most Christians experience at times in their spiritual journeys. No matter how far we progress in a quest toward virtue, maturity, or sanctification, most Christians will act (or fail to act) in ways that are truly incomprehensible in light of their views about the nature of reality, truth, and God. Rather than always honoring deeply held moral beliefs and values, every Christian will somehow make decisions and act in ways that violate his or her sacred core (i.e., closeness with God). In such moments, we may feel a desire to do what is right but experience an absence of ability, strength, or resolve to do so.

J. M. Currier (✉) · S. L. Isaak · P. Fernandez
Psychology Department, Clinical and Counseling Psychology Doctoral Program, University of South Alabama, Mobile, AL, USA
e-mail: jcurrier@southalabama.edu

J. R. Peteet et al. (eds.), *Christianity and Psychiatry*,
https://doi.org/10.1007/978-3-030-80854-9_7

Thankfully, like Flannery O'Connor's reflections on her own spiritual journey [1], most people contend with a "garden variety" of sins that do not lead to imminent death or serious harm to others (e.g., pride, gluttony, sloth, envy).

Nonetheless, particularly in certain circumstances or professions, peoples' transgressive acts and betrayals of trust may cause a multifaceted condition that psychiatrists, psychologists, and other mental health professionals are calling "moral injury." Although these disciplines have historically minimized moral aspects of trauma and violence, the Old and New Testaments are fraught with examples of moral injury. For example, Deuteronomy 20 highlights the potential inner turmoil of soldiers entering and returning from battle. Psalms also repeatedly affirms the debilitating shame/guilt that may emerge from moral violations which lead to the death or serious harm of another individual (e.g., Psalm 51) or the profound sense of anger/betrayal from being victimized by another's morally transgressive behavior (e.g., Psalm 22). In fact, one might argue that the denouement of salvation history in Christianity, when the many strands of God's redemptive story for humanity were ultimately woven together, began with Christ's morally injurious death on the cross. Drawing upon a case example of moral injury that combines elements from several patients with whom we have worked recently, we aim in this chapter to: (1) define moral injury as a clinical construct, (2) discuss spiritual features of moral injury with special relevance for Christian patients, and (3) summarize emerging treatments for moral injury.

Case Example

"Bob" was a 21-year-old African American man who was referred for individual therapy by his partner due to apparent posttraumatic stress disorder (PTSD) and depressive symptoms following a motor vehicle accident (MVA) that resulted in serious bodily injury to himself and death of his best friend, "Danny." The MVA had occurred nearly 1 year earlier while Bob and Danny were cutting class from a local community college. Bob asked one of his peers, "James," to give him a ride to a convenience store to get something to drink. James obliged, and both Bob and Danny got into the car. James was eager to show off his driving skills and new car; he drove erratically out of the parking lot, sped up quickly, and began to illegally pass cars on the busy city streets. Soon thereafter, James lost control, and Bob's last memory entailed seeing another vehicle collide with his side of the car. When Bob awoke in an intensive care unit after being unconscious for several hours, he felt an excruciating pain in his lower back and heard Danny crying out in a neighboring bed due to severe abdominal injuries. At the time, Bob reported that all he wanted to do was alleviate his friend's distress, but he surprisingly could not move. Bob suffered from internal bleeding, head trauma, and a spinal cord injury that resulted in temporary paralysis. Over the coming months, Bob recovered from his physical injuries and gradually regained his ability to walk. He also reported invisible injuries that would lead to profound emotional and spiritual suffering. He stated in the

intake interview: "It was my fault. It would have never happened if I hadn't suggested to go get something to drink during school hours."

Following a 6-month period with multiple surgeries and other medical interventions, Danny died from injuries sustained in the MVA. Upon returning to college shortly thereafter, Bob reported an intensification of intrusive recollections and nightmares about the MVA as well as shame/guilt about his role in the event, anger/betrayal at James for driving dangerously, as well as hypervigilance and other indications of chronic hyperarousal that limited his ability to meet academic and social demands (e.g., insomnia, concentration issues). Rumors also circulated in the school that Bob was responsible for Danny's death, which resulted in accusations and death threats that were confusing and scary for him. Combined with a strong desire to avoid any circumstances, relationships, and activities that were somehow reminiscent of the MVA, Bob became increasingly isolated and turned to daily drinking and marijuana use as a way to sooth his inner pain. Soon, he dropped out of school and relied on his partner for provision of basic needs in a manner that worsened his sense of thwarted belongingness and being a burden on others. He agreed to seek treatment at the behest of his partner after voicing a plan to attempt suicide. However, Bob also reported a painful absence of meaning and motivation for pursuing recovery, ultimately stating in the intake interview: "I was the one who deserved to die. I did an unforgiveable thing and do not deserve to be happy or successful. Because of Danny's death, I need to suffer and let God punish me for my selfishness."

Defining and Conceptualizing Moral Injury

This case illustrates many of the consensus features of moral injury that might warrant focused clinical attention. At present, psychiatry and other mental health professions lack a unifying definition or framework for conceptualizing moral injury. Applying insights from Homer's tragedies (e.g., Achilles in the *Iliad*) to make sense of Vietnam veterans' suffering who were seeking his care as a psychiatrist, Shay [2] first introduced this concept in the mental health literature nearly three decades ago. However, due to a flood of post-9/11 veterans who pursued treatment in the Veterans Healthcare System (VHA) in the mid- to late 2000s, moral injury did not become a target of serious scientific and clinical attention until the publication of Litz and colleagues' [3] seminal article. Since then, moral injury has garnered increasing interest from mental health professionals as well as theologians, philosophers, journalists, and a diversity of other stakeholders. However, even in a single field such as psychiatry, a lack of definitional specificity has created challenges with reliability and communication among clinicians and researchers. Namely, consistent with understanding posttraumatic reactions in general, distinctions should be made between different aspects of this emerging clinical construct (i.e., exposure, appraisal, or outcomes). In an effort to disentangle and define these varying components, Fig. 7.1 presents a preliminary model of the general process by which a moral injury might develop in a patient such as Bob. We will now offer definitions of key

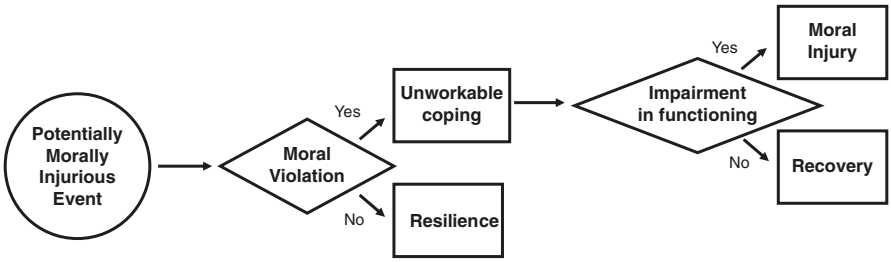

Fig. 7.1 Model of moral injury development

facets of moral injury development based on contemporary empirical, theoretical, and clinical sources.

Potentially morally injurious events Moral injury is thought to emerge after exposure to severely morally troubling events that fit into two categories according to perceived moral responsibility: transgressive/perpetration-based events and betrayal-based events. First, in keeping with Bob's experience of not being able to compel James to slow down, potentially morally injurious events (PMIEs) may entail actions or decisions in which someone transgresses a moral belief/value by what they did or failed to do. Litz et al. [3] defined these *transgressive acts* and *perpetration-based events* as "perpetrating, failing to prevent, or bearing witness to acts that threaten to transgress deeply held moral beliefs and expectations" (p. 700). As Bob's case also highlights, people might find themselves in the role of a witness or victim of others' moral wrongdoing as well. Shay [2] captured this second category of PMIEs in a three-part definition: (a) betrayal of "what's right," (b) by someone who holds legitimate authority, and (c) in a high-stakes situation. Building on Shay's focus on leadership malpractice and institutional aspects of moral injury, others have expanded these *betrayal-based events* to include other relationships or sources as well (e.g., trusted peers or partners) [4]. When compared to other types of events (e.g., life-threatening events), a growing research base has affirmed that exposures to PMIEs are often linked with greater conditional risk for common mental health conditions after trauma exposure (e.g., PTSD, MDD, suicide ideation or attempts) [3, 4] and greater complexity in distress symptom presentations [5].

Moral violation Notwithstanding the morally challenging nature of PMIEs, we should refrain from pathologizing the occurrence of such stressors in themselves. In the same way that most people who encounter potentially traumatic events in general do not develop chronic PTSD [6], research suggests individuals who experience PMIEs often do not become morally injured (e.g., marines returning from heavy combat operations) [7]. Instead, whether beginning in the aftermath of the event or later in the meaning making process, it is assumed that moral injury only develops when someone has appraised the event as being morally wrong or in violation of deeply held beliefs/values. Furthermore, a person may perceive a sense of personal

agency about the occurrence of PMIEs and/or feel an urge or strong desire to see others' moral violations punished or rectified. For example, Bob believed the MVA had occurred because of his selfishness to grab a soft drink and moral failure in succumbing to peer pressure by not urging James to drive more carefully. In this way, development of moral injury assumes that an individual possesses an intact set of moral beliefs that might be violated in the first place. To date, research has supported the crucial role of appraising PMIEs as being morally wrong in the development of moral injury [8]. However, in itself, the presence of moral violation should not be mistaken for moral injury.

Unworkable coping When PMIEs lead to moral violation, patients will experience painful moral emotions (e.g., shame, guilt, anger) and cognitions (e.g., moral culpability or responsibility, self- or other-condemnation) that can cause significant intrapsychic tension and conflict [9, 10]. Like Bob's response to Danny's untimely and painful death, such emotional-cognitive reactions are usually expected, natural, and non-pathological responses to horrific events. In the same way that people who display indications of distress (e.g., sadness and crying, cognitive confusion, social withdrawal) after losing an attachment figure to bereavement (e.g., child, spouse) often do not display chronic trajectories of PTSD, depression, or other loss-related conditions [6], the presence of moral pain might be an indicator of resilience rather than risk for long-term dysfunction. Namely, moral pain can be essential for maintaining shared moral beliefs/values with others that promote and safeguard the cohesion of human communities [9, 10]. Furthermore, when PMIEs are viewed as morally wrong, these appraisals can prompt behaviors that facilitate healing and repair ties to one's larger social group (e.g., shared acknowledgment of tragedy) as well as re-establish access to culturally and faith-sanctioned pathways to transcendence and belonging in life (e.g., religion, family). Therefore, moral pain may provide adaptive functions for the larger social group, but sometimes at the expense of a given individual such as Bob for varying lengths of time [9, 10]. This pattern can be seen in the ritual of the scapegoat assuming responsibility for the wrongdoing of the larger community in the Old Testament (Exodus 30, Leviticus 16). However, like Bob's extreme isolation and substance abuse, it is primarily when an individual engages in unworkable coping strategies that a moral injury might develop.

Moral injury In many cases, individuals who experience moral violation in response to PMIEs might not cope with painful moral emotions and cognitions in a manner that supports meaning making and social connectedness. Like Bob, they may display a trajectory of chronic emotional and spiritual suffering characterized by impairments in psychosocial functioning, self- or other-condemnation, and a range of self-destructive behaviors. Litz et al. [5] defined moral injury as "disruption in an individual's confidence and expecations about one's own or others' motivation to behave in a just and ethical manner … brought about by perpetrating, failing to prevent, bearing witness to, or learning about acts that trangress deeply held moral beliefs and expectations" (p. 700). Drawing on an acceptance and commitment therapy (ACT) model, Farnsworth et al. [10] defined moral injury as

"expanded and additional psychological, social, and spiritual suffering stemming from costly dysfunctional and/or unworkable attempts to manage, control, or cope with the experience of moral pain" [10]. Although there is a lack of consensus about the specific symptoms or outcomes that may signify this state of being morally injured, perpetration-based moral injury appears to be characterized at least partly by feelings of pervasive shame/guilt; beliefs/attitudes about being unlovable, unforgivable, and incapable of moral decision-making; and self-handicapping behaviors. In cases of betrayal-based events, outcomes of a moral injury likely include feelings of anger and moral disgust, beliefs/attitudes related to mistrust of others, and revenge fantasies for the responsible person(s) [11]. In Bob's case, he presented warning signs of both forms of moral injury. Whereas Bob could not alter the occurrence of the MVA, treatment is needed to address the modifiable ways in which he was carrying the morally injurious event.

Importantly, the model outlined in Fig. 7.1 does not negate the reality of other moral stressors with differing levels of magnitude and impact. Drawing upon a model from Litz and Kerig [12], we see that human beings can encounter *moral challenges* that might cause a sense of frustration but do not affect them directly or lead to much distress or impairment in functioning (e.g., other people's children dying from malnutrition). In more extreme cases, people might contend with *moral stressors* that are more personal but occur less frequently in day-to-day life (e.g., infidelity or deception from spouse). Per Litz and Kerig, these stressors can precipitate moral distress that causes impairment in psychosocial functioning (e.g., rumination, disrupted sleep, depressed mood). However, moral stressors should not be equated with PMIEs in that they are less likely to involve clear threats to personal integrity or loss of life. In these ways, moral stressors are less likely to cause severely painful moral thoughts/emotions that could lead to injurious and scarring experiences. Returning to Bob's case as an example, many college students cut class at times, and a smaller subset might engage in reckless driving. Even in rarer cases when teenagers or young adults get into a non-fatal MVA, they might experience moral frustration or distress based on their own rule-breaking or irresponsible behavior that might prompt introspection, amends-making, and behavior change. However, these situations usually do not end in the type of morally injurious event that Bob experienced [12]. Namely, only a small minority of college students who cut class and/or drive recklessly would truly be able to identify with Bob's experience and profound suffering.

Christianity and Recovery from Moral Injury

Christianity offers a multitude of behavioral, relational, and psychological dimensions that might inform treatment of moral injury. Since the birth of Christianity over 2000 years ago, a diversity of approaches to prayer and meditation have been passed along from generation to generation (e.g., petitionary, adoration, lament,

centering prayer). In keeping with the theistic relational nature of the Christian faith, engaging in these relationship-maintaining practices can support a sense of closeness with God and provide opportunities to transcend distress, experience positive emotions (peace, joy), and cultivate a fuller awareness of God's loving presence in one's life. As a lifelong Christian, Bob regularly talked with God about his problems, fears, and needs before the MVA. Christian traditions also proscribe unhealthy behaviors that perpetuate and/or worsen suffering in the aftermath of traumatic events. For instance, as highlighted in Bob's case, morally injured persons might turn to substance abuse as a way of anesthetizing moral pain and restoring a fleeting sense of inner equilibrium. Notwithstanding theological diversity within Christianity, Christians have historically refuted dualistic views that downgrade the sacredness of the physical body (e.g., Gnosticism). Like Paul's metaphor of the physical body as a temple of the Holy Spirit (I Corinthians 6:19) or Christ's resurrection as a first fruit of humans' possible bodily restoration after death (I Corinthians 15:20), morally injured persons may imbue healthy lifestyle practices with sacredness in a manner that also facilitates healing and natural recovery processes (e.g., daily exercise, healthy eating).

Christianity can also offer pathways to cultivating horizontal and vertical connections with others that support recovery. From a horizontal view, churches can promote relationships with people from diverse backgrounds who share similar understandings of God, morality, and perceived spiritual realities in the present and future. In such contexts, morally injured persons may receive acceptance, compassion, and support from fellow believers as well as solidarity in pursuing a shared mission together that aligns with the sacred values of the larger group. For example, the valued directions for such a journey could entail pursuing justice and equity in the broader community or being a loving parent or spouse, faithful in work or education, and diligent in practicing spiritual disciplines, as well as valuing other qualities and goals. In turn, horizontal bonds might lessen the probability of loneliness and existential alienation that often forms the core of moral injury. Further, whether via distributing meals, cleaning the facilities, or offering transportation to persons in need, faith communities can also encourage morally injured persons to serve in practical ways that pivot attention away from self and allow them to feel purposeful and productive. In Bob's case, he was born and raised in a Black Protestant church wherein an uncle served as lead pastor and his nuclear and extended family attended regularly. Prior to the MVA, he reportedly "lived in the church" and benefitted deeply from a commitment to serving his faith community in practical ways and receiving support from fellow believers.

Beyond cultivating these horizontal bonds, Christianity also commonly emphasizes the importance of pursuing a vertical connection with God. Relative to adherents of some other religions who are more likely to believe God is an impersonal force [14], Christians traditionally view God as a personal being who desires to establish a close relationship with humans. Dating back to Christ's summary of the Jewish Social-Religious Law (e.g., "You shall love the Lord your God with all your heart and with all your soul and with all your mind," Matthew 22:37) to early theologians (e.g., "To fall in love with God is the greatest romance; to seek Him, the

greatest adventure; to find Him, the greatest human achievement," St. Augustine of Hippo), cultivating both doctrinal and experiential knowledge of God's love can define patients' faith systems. In turn, Christian traditions and communities can offer cultural symbols (e.g., cross) and rituals (e.g., communion) as well as encourage private (e.g., prayer) and communal (e.g., worship service) behaviors that may establish or maintain closeness to God. In keeping with an attachment framework, research on religious coping suggests Christians often turn to God as a safe haven in ways that promote comfort and mitigate risks for unworkable coping strategies [13]. Furthermore, as patients progress in their healing journeys, having a secure attachment to God may provide a robust foundation for exploring the world and pursuing new opportunities and relationships. For example, although school had always been difficult for him and many of his peers had dropped out, Bob's relationship with God fueled a sense of hope to pursue a college degree and career as an FBI agent.

In all of these ways, Christianity offers interpretive frameworks for making meaning of morally injurious events in emotionally and intellectually satisfying ways [14]. Notwithstanding theological and cultural diversity across traditions, Christianity has historically offered robust explanations for trauma that facilitate a sense of coherence, identity, and relative predictability post-trauma (i.e., theodicies). Like Paul's example at the start of the chapter, Christians might then be primed to humbly accept their finitude as fallen or imperfect persons, seek forgiveness and reconciliation, and experience God's solidarity with them in their suffering. In such cases, these transcendent modes of meaning making can reduce shame and limit the counterfactual reasoning and other unhelpful forms of rumination that interfere with recovery from trauma-related disorders. These theodicies can address existential concerns across the mind and heart. For example, Christians have long appealed to Augustine's free will argument in intellectually reconciling the existence of a loving and powerful God with the distressing realities of evil and suffering (i.e., because choosing to love God freely is the highest possible good in life, humans by necessity have freedom to engage in PMIEs). Furthermore, as summarized in the book of Hebrews in particular, Christians often believe that God has cultivated experiential knowledge of evil and suffering via the incarnation, suffering, and death of Christ. In turn, morally injured persons may experience healing from belief in a deity who is intimately familiar with the transgressive acts and betrayals of trust that humans tragically perpetrate against one another.

Notwithstanding these resources for healing, Christianity might also serve as a source of suffering for patients such as Bob. Exline [15] defined spiritual struggles as tensions, strains, and conflicts about matters of ultimate concern that "imply that something in a person's current belief, practice, or experience is causing or perpetuating distress" (p. 459). Per Exline, these struggles might fall into three groups: supernatural, interpersonal, or intrapersonal. First, spiritual struggles may entail distress related to supernatural beings such as emotional tension or disconnection with God or distress related to assigning responsibility to demonic or evil beings. Second, patients could struggle in their relationships with religious adherents or leaders. For instance, morally injured persons might feel judged in their family or

community because of spiritual concerns or struggle with perceived injustice or betrayal at a more macro-level. Third, intrapersonal struggles could emerge from doubting one's beliefs, doctrines, or teachings, or moral distress from not living congruently with perceived standards of perfection, or feeling guilty for violating other sacred beliefs or values that have a basis in one's tradition. In other cases, intrapersonal struggles could be characterized by questions of ultimate meaning about the deeper purpose of human existence or whether there is any order in the universe at all. Overall, research has documented these struggles often co-occur with moral injury [16] and can interfere with recovery from PTSD and other trauma-related conditions in significant ways over time [17].

At the start of treatment, Bob was experiencing several of these spiritual struggles in a manner that added to the severity of his moral injury. Notwithstanding a long-standing routine of attending church and engaging in prayer and spiritual reading, Bob's religious commitment weakened after the MVA, and he felt disconnected from practices that had previously supported healthy coping and well-being. In turn, he received stigmatizing feedback from his family and fellow church members that worsened his shame and sense of moral failure. Like Job's friends, he was accused of "not having enough faith," "losing his way," "being selfish," and "not believing that God was in charge." In addition to feeling betrayed and hurt by fellow believers, Danny's death caused Bob to feel angry and abandoned by God. For the first time in his life, Bob found himself feeling punished by God and questioning God's character and ability to order the universe in a just and loving manner. As a result, Bob felt increasingly distant and ambivalent about his relationship with God and doubted whether the biblical picture of God was truly accurate. Rather than causing others to experience these same struggles, Bob withdrew from his church and family out of a sense of loyalty about not damaging the cohesion of their connections with one another. In so doing, he felt more alone, overwhelmed, and stuck in his moral pain.

Emerging Psychosocial Treatments for Moral Injury

Currier, Nieuwsma, and Drescher [18] recently developed a book for clinicians that provides guidance for conceptualizing moral injury, addressing clinical issues in assessing and treating moral injury, and describing promising treatments for moral injury. In the absence of a consensus definition and framework for moral injury, patients such as Bob who are struggling to work through painful moral emotions and cognitions associated with morally injurious events need effective treatment. Just as physicians and other healthcare professionals recently needed to implement treatments for COVID-19 in the absence of a vaccine and clinical guidelines that have been subjected to scientific scrutiny and replication, persons who seek psychotherapy should not be delayed care that might promote recovery from moral injury. Returning to Bob's case, failure to address his difficulties in working through shame/guilt and anger/betrayal related to Danny's death would have limited the effectiveness of treatment and likely eventuated in his dropping out. In turn, Bob's

substance abuse, isolation, and functional impairments could have worsened such that suicide became an increasingly viable solution for alleviating his suffering. In many such cases, addressing moral injury in clinical practice can be a life-or-death matter.

When presented with a possible moral injury, clinicians may currently pursue one of the two strategies for planning and selecting treatment. First, just as medical professionals saved lives of COVID-19 patients by applying treatments for related conditions (e.g., malaria), clinicians might implement empirically supported treatments (ESTs) for PTSD in working with patients such as Bob. Namely, many subject experts believe that, unless definitive evidence emerges that these ESTs are inferior to novel approaches that have not been rigorously evaluated, clinicians should rely on treatments with proven safety and efficacy. These approaches are largely based in a cognitive behavioral therapy model, and each has been endorsed by major organizations (e.g., the Institute of Medicine, VHA). For example, cognitive processing therapy (CPT) [19] utilizes cognitive therapy techniques to encourage expression of natural emotions (e.g., sadness), reduce emotions based on unhelpful cognitions (e.g., "I am solely to blame for this event"), and promote a more balanced set of beliefs about self, others, world, and possibly God. In addition, Foa et al.'s prolonged exposure (PE) [20] is another highly supported treatment that utilizes behavioral strategies to emotionally process the traumatic memory and revisit people, places, and activities that are reminiscent of the morally injurious event. Although ACT for PTSD has received less empirical scrutiny to date, this "third-wave" CBT-based intervention has also been applied to moral injury [9]. As opposed to CPT and PE, ACT's goal is not to "feel better" via changing the content of unwanted emotions and thoughts, but rather to increase willingness to experience moral pain for the sake of reconnecting with violated values and responding to life's inevitable stressors in a more psychologically flexible manner.

Other clinical researchers have developed and evaluated novel treatments for morally injured patients. Like Solomon's realization in older adulthood that there is "nothing new under the sun" (Ecclesiastes 1:9), the evolution of psychotherapies over the past century seemingly makes it impossible to create an entirely new approach. Instead, these newer treatments bolster ESTs for PTSD with existing components from other theoretical models (e.g., experiential strategies in emotion-focused therapy [EFT]) [21]. For example, adaptive disclosure (AD) [22] integrates CBT and EFT in a patient-centered manner. In cases of moral injury in which someone is struggling to come to terms with perpetration-based events, AD might begin with imaginal revisiting exercises from PE and shift to imaginal dialogues that specifically address forgiveness issues and moral conflicts. Impact of killing (IOK) [23] also begins with CBT strategies and incorporates elements of EFT and existential and relational psychotherapies. In addition to using exposure and cognitive therapy, IOK integrates experiential and narrative assignments to foster healing and resolution of moral conflicts. Lastly, as highlighted in Bob's case, Building Spiritual Strength (BSS) [24] is designed to foster resolution of spiritual struggles commonly reported among morally injured patients. Developed with an ecumenical and inclusive focus, the goal of BSS is to support patients from diverse faith backgrounds to

resolve spiritual struggles and make more effective use of spiritual resources for restoring a sense of meaning in life and possibly healing a damaged relationship with God.

Following a period of assessment, safety planning, and stabilization, Bob agreed to engage in a treatment approach based largely on AD [22]. Initially, Bob completed sessions in which imaginal exposure was utilized to promote emotional processing of the MVA in the context of a supportive relationship with the clinician. These exercises were recorded, and Bob listened to them between sessions. At points, Bob became emotionally overwhelmed, and the clinician utilized grounding to re-orient him into his body in the present moment. In keeping with a common trajectory in exposure-based treatments, his irritability and intrusive symptoms were worsened at first, and increased anger outbursts outside of sessions created conflicts with his partner. However, Bob maintained open and honest communication with his clinician, and the two of them partnered in adapting the treatment as needed. In the second month of treatment, the clinician utilized in vivo exposure to help Bob become more behaviorally active and connected with his sacred values. Specifically, Bob recognized a deep desire to honor Danny via pursuing hope and faithfulness in the education domain. Rather than continuing to avoid his moral pain, a series of exercises were planned in which Bob reconnected with Danny via visiting the college campus to varying degrees. Initially, he walked around the campus with his partner during non-school hours, and the two of them shared memories of Danny. In turn, Bob gradually moved onto revisiting the campus alone during school hours and worked up to a spiritual ritual of cleaning up the MVA site and planting a cross to affirm his restored confidence in God's atonement, eternal love, and care for his friend. In this process, Bob was able to gradually receive divine forgiveness and repent of substance abuse and other behaviors that were not aligned with his Christian faith system.

In keeping with Greenberg's EFT [21], Bob also engaged in a series of unfinished business imaginal dialogues that deepened his emotional processing of moral pain and ability to grieve Danny's death. For example, roughly halfway into the final imaginal exposure exercise, Bob stopped abruptly and stated: "I don't want to do this anymore." After the clinician inquired what was driving this statement, Bob tearfully stated: "It's my fault." In turn, Bob was coached to invite Danny into the session so that he might share his shame and sense of moral failure. Bob instantly began to sob and started the conversation by saying: "I'm so sorry." This led to Bob voicing his profound remorse for initiating the plan to leave campus, not forcefully insisting on James to slow down, and not being able to reduce his friend's suffering after the MVA. Upon shifting to Danny's chair, Bob recognized his best friend did not blame him for the MVA and experienced Danny's sadness and compassion for him. In turn, Bob gradually began to let go of shame and reconnect with sacred values to honor his friend by engaging more fully in his own life. Next, Bob participated in a dialogue with James. He explained the horrific consequences of his driving and how he felt as a survivor. He expressed feelings of betrayal and anger toward James along with a sense of empathy for how James might be feeling and an accompanying desire to forgive. Lastly, given that Bob voiced indicators of a divine

struggle throughout the treatment, the clinician facilitated a one-chair dialogue with God in which Bob disclosed his sadness, anger, and confusion toward God about Danny's death. After repeatedly switching chairs between himself and his conception of God, Bob began to transform his internalized representation of God from a distant and cruel deity to a co-sufferer who still wanted to forgive and bless him.

Conclusion

In this chapter, we provided a preliminary model by which a moral injury might develop in individual patients such as Bob, described the double-edged nature of Christianity in aiding and hindering recovery from moral injury, and outlined several of the promising treatments that subject experts have recommended for moral injury. To date, much of the clinical literature on moral injury has focused on military personnel and veterans for the purpose of operationalizing, assessing, and treating this multifaceted construct. As highlighted in Bob's case, moral injury can also provide a helpful framework for conceptualizing the unworkable suffering that sometimes emerges from civilian traumas. For example, as the ongoing COVID-19 pandemic has taught us, we rely heavily on specific professions, such as healthcare workers and first responders, to make decisions and act in ways that sometimes contradict their ideals or sacred beliefs and values. Although findings are limited, there is increasing consensus that moral injury provides a helpful framework for understanding burnout and other occupational hazards of working in healthcare and first responder professions. Looking ahead, there is also a need to equip psychiatrists and other mental health clinicians to address spiritual aspects of moral injury. Notwithstanding progress in introducing medical students and psychiatry residents to the role of spirituality in health [25, 26], trainees in mental health graduate and post-graduate programs generally do not receive any systematic or formalized training in this domain. As such, most mental health clinicians are not equipped to offer the highest quality of care for patients such as Bob. Clinicians certainly should avoid simplistic notions that all Christians will struggle with and/or draw strength from faith and/or spirituality. However, as Bob taught us during the treatment process, culturally responsive care for moral injury requires an acquisition of basic attitudes, knowledge, and skills to plan and facilitate treatment in ways that truly honor the sacred beliefs, values, practices, relationships, and communities of our patients.

References

1. O'Connor F. Letters of Flannery O'Conner: the habit of being. New York: Farrar, Straus, & Giroux; 1980.
2. Shay J. Achilles in Vietnam: combat trauma and the undoing of American character. New York: Simon and Schuster; 1994.

3. Litz BT, Stein N, Delaney E, Lebowitz L, Nash WP, Silva C, Maguen S. Moral injury and moral repair in war veterans: a preliminary model and intervention strategy. Clin Psychol Rev. 2009;29:695–706.
4. Griffin BJ, Purcell N, Burkman K, Litz BT, Bryan CJ, Schmitz M, Villierme C, Walsh J, Maguen S. Moral injury: an integrative review. J Trauma Stress. 2019;32:350–62.
5. Litz BT, Contractor AA, Rhodes C, Dondanville KA, Jordan AH, Resick PA, Foa EB, Young-McCaughan S, Mintz J, Yarvis JS, Peterson AL. Distinct trauma types in military service members seeking treatment for posttraumatic stress disorder. J Trauma Stress. 2018;31:286–95.
6. Galatzer-Levy IR, Huang SH, Bonanno GA. Trajectories or resilience and dysfunction following potential trauma: a review and statistical evaluation. Clin Psychol Rev. 2018;63:41–55.
7. Jordan AH, Eisen E, Bolton E, Nash WP, Litz BT. Distinguishing war-related PTSD resulting from perpetration-and betrayal-based morally injurious events. Psychol Trauma Theory Res Pract Policy. 2017;9:627–34.
8. Lancaster SL, Erbes CR. Importance of moral appraisals in military veterans. Traumatology. 2017;23:317–22.
9. Farnsworth JK, Drescher KD, Nieuwsma JA, Walser RB, Currier JM. The role of moral emotions in military trauma: implications for the study and treatment of moral injury. Rev Gen Psychol. 2014;18:249–62.
10. Farnsworth JK, Drescher KD, Wyatt Evans W, Walser R. A functional approach to understanding and treating military-related moral injury. J Contextual Behav Sci. 2017;6:391–7.
11. Currier JM, Farnsworth JK, Drescher KD, Sims BM, Albright DL. Development and evaluation of the expressions of moral injury scale – military version. Clin Psychol Psychother. 2018;25:474–88.
12. Litz BT, Kerig PK. Introduction to the special issue: conceptual challenges, methodological issues, and clinical applications. J Trauma Stress. 2019;32:341–9.
13. Pargament KI, Falb MD, Ano GG, Wachholtz AB. The religious dimension of coping: advances in theory, research, and practice. In: Paloutzian RF, Park CL, editors. Handbook of the psychology of religion and spirituality. New York: Guilford Press; 2013. p. 560–79.
14. Park CL, Currier JM, Harris JI, Slattery J. Trauma, meaning, and spirituality: translating research into clinical practice. Washington, DC: American Psychological Association; 2016.
15. Exline JJ. Religious and spiritual struggles. In: Pargament KI, editor. APA handbook of psychology, religion, and spirituality: context, theory, and research. Washington, DC: American Psychological Association; 2013. p. 459–75.
16. Currier JM, Foster JD, Isaak SL. Moral injury and spiritual struggles in military veterans: a latent profile analysis. J Trauma Stress. 2019;32:393–404.
17. Bockrath M F, Pargament KI, Wong S, Harriot VA, Pomerleau JM, Homolka SJ, Chaudhary ZB, Exline JJ. Religious and spiritual struggles and their links to psychological adjustment: a meta-analysis of longitudinal studies. Psychol Relig Spiritual. In press. 2021.
18. Currier JM, Drescher KD, Nieuwsma JA, editors. Addressing moral injury in clinical practice. Washington, DC: American Psychological Association; 2020. https://doi.org/10.1037/0000204-015.
19. Resick PA, Monson CM, Chard KM. Cognitive processing therapy for PTSD: a comprehensive manual. New York: Guilford Publications; 2016.
20. Foa EB, Hembree EA, Rothbaum BO. Prolonged exposure therapy for PTSD: emotional processing of traumatic experiences, therapist guide. New York: Oxford University Press; 2007. https://doi.org/10.1093/med:psych/9780195308501.001.0001.
21. Greenberg LS. Emotion-focused therapy: coaching clients to work through their feelings. Washington, DC: American Psychological Association; 2015.
22. Litz BT, Lebowitz L, Gray MJ, Nash WP. Adaptive disclosure: a new treatment for military trauma, loss, and moral injury. New York: Guilford Press; 2016.
23. Maguen S, Burkman K, Madden E, Dinh J, Bosch J, Keyser J, Schmitz M, Neylan TC. Impact of killing in war: a randomized, controlled pilot trial. J Clin Psychol. 2017;73:997–1012.

24. Harris JI, Usset T, Voecks C, Thuras P, Currier J, Erbes C. Spiritually integrated care for PTSD: a randomized controlled trial of "Building Spiritual Strength". Psychiatry Res. 2018;267:420–8.
25. Puchalski CM, Larson DB, Lu FG. Spirituality in psychiatry residency training programs. Int Rev Psychiatry. 2001:131–8.
26. Puchalski CM, Larson B. Developing curricula in spirituality and medicine. Acad Med. 1998;73:970–4.