Occasional Essay

Moral Wounds and Moral Repair: The Dilemmas of Spirituality and Culturally Sensitive Practice

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Abstract
As our understanding of trauma is expanding, greater consideration is being given to factors such as moral injury and spirituality. Moral injury appears to be especially pertinent in the case of war-related trauma, as one may not only be the victim of, or witness to, troubling events but also be the perpetrator of acts that run counter to personal values. For some, moral beliefs and values and key elements of the assumptive world are intertwined with spiritual and religious matters. This article discusses moral injury and repair in the context of spiritually and culturally sensitive practice. Strategies for addressing issues such as moral anguish, loss of meaning, identity disturbance, guilt and shame, forgiveness, and spiritual struggle are discussed.

Keywords
moral injury, moral repair, spirituality, religion, trauma, veterans, military

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The process whereby discrete life events become elevated to the status of a social problem has been analyzed from multiple perspectives (see Chambers & Wedel, 2009; Loseke, 1999; Spector & Kitsue, 1987). Objective factors that abet the process include the sheer number of people impacted by a condition, the direct and indirect costs associated with the defined malady, and the potential impact an issue has on individuals, families, and society as a whole. From a social constructionist point of view, one cannot ignore the power of those who claim a problem is at hand, the degree to which conditions violate widely held morals and norms, as well as the social status of those afflicted. Together, these diverse set of forces and factors ultimately decide if a given situation is deemed worthy of widespread attention and the degree to which social resources will be brought to bear to address this now identified concern. This process of identification and labeling of conditions as problematic is ever changing. Even the basic definition of conditions evolve over time, and with increased scrutiny, important subtleties and nuances of an identified problem emerge. Because most social problems are complex, they generally defy simple models of causation and amelioration.

War and Trauma’s Impact
In many ways, the evolution of how we conceptualize trauma, including posttraumatic stress disorder (PTSD), follows the same overall pattern described above. This article

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explores the concepts of *moral injury* and *spirituality*, specifically as these apply to war-related trauma. Both concepts are relatively recent additions to the trauma-informed care lexicon and therefore deserve attention. As Ray (2008) notes, the concept of trauma emerged from a Greek term that meant to pierce or wound. Thus, the origin of the term trauma was rooted in the physical realm. However, by World War I, it was clear that many suffered emotional and psychological pain as a result of combat experiences, and by World War II, the use of terms like *shell shock* and *fright neurosis* were used freely (Brill, 1943). It became evident that the negative impact of war did not end with exit from battle or discharge from service. If anything, the struggle to return to civilian life only underscored how deep the damage was and often exacerbated it (McCormack & Ell, 2017; Sreenivasan, Smee, & Weinberger, 2014). By 1980, the term PTSD was added to the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; *DSM-III*), and it was noted that stressors that led to this diagnosis were caused by an array of events outside the normal realm of human experience, including participation in combat, torture and exploitation, natural disasters, and being a victim of physical and/or sexual assault. In recent times, we have witnessed great interest in the pervasive effect of trauma, ranging from the biophysical realm to the impact on interpersonal relationships and social functioning, as well as personal and psychological development. As our understanding of trauma is expanding, the appreciation of the types of conditions that can lead to PTSD has broadened as well.

Sometimes it is a fruitful exercise to go back to where it all started. So much contemporary interest in war trauma, and PTSD, was fueled by the aftershock of Vietnam. It is from this era forward that guerilla-type warfare has become the norm, and discerning friend from foe, or combatant from noncombatant, has become increasingly difficult. This puts soldiers constantly on edge and forces them to make snap judgements, often with life and death consequences. Vargas, Hanson, Kraus, Drescher, and Foy (2013) observe that in such an environment, soldiers are more likely to deviate from customary and traditional rules of engagement. As a result, from Vietnam forward, more soldiers report being aware of shooting a gun in battle and having killed another (Jinkerson, 2016; Purcell, Koenig, Bosch, & Maguen, 2016). Increasingly, this includes women and children. Clearly many veterans are able to view their battlefield behavior as a function of doing their job. Candidly, some will also admit a sense of satisfaction from combat and further that while in the throes of battle there was a rush-like and nearly addictive quality to killing (Brinn & Auerbach, 2015; Purcell et al., 2016). It is in the aftermath, however, that some suffer and acknowledge thinking about their targets for the rest of their lives and grapple with the fact that they have taken a life (Purcell et al., 2016). For these reasons, veterans from the modern war era may have increased difficulty reintegrating into civilian life (Nieuwsma et al., 2014).

The discussion above underscores the unique features of traumatic experiences that come from war. Here, one may not only be the victim of, or witness to, troubling events but also be the perpetrator of acts that run counter to personal values. Such events can challenge deeply held beliefs about the self, the world, and even life itself—referred to as the assumptive world (Frank, 1974; Janoff-Bulman, 1992; Tedeschi & Calhoun, 2004). Janoff-Bulman (1992) notes that three common assumptions that undergird our lives are that the world is benevolent, the world is meaningful, and the self is worthy. Traumatic events, including battle, can be so unnerving they have the potential to shatter a person’s assumptive world, resulting in harm to the psyche. Litz et al. (2009) posit that if left untreated, this deep sense of shattering can intensify as the years go by, as “service members will be convinced and confident that not only their actions, but they are unforgiveable” (p. 700).

Just as it is understood that particular types of child abuse (e.g., physical, emotional, and sexual abuse; neglect; exploitation) require unique responses, so it is true in the area of war trauma. It is for this reason that the damage caused to a person’s assumptive world is captured under the term *moral injury* (Hodgson & Carey, 2017; Kopacz & Connery, 2015;
Litz et al., 2009; Shay, 2014; Sreenivasan et al., 2014; Vargas et al., 2013). Litz et al. (2009) describe moral injury as “an act of transgression that creates dissonance and conflict because it violates assumptions and beliefs about right and wrong and personal goodness” (p. 638). Hodgson and Carey (2017) view moral injury as a wound that is truly an “injury to the soul,” one that threatens a person’s basic integrity and spiritual well-being (p. 1213). Shay (2014), in an observation particularly relevant to military service, where following orders and commands is essential, underscores that moral injury also results from the sense of having been betrayed by those in authority. At hand is the loss of trust, and “when social trust is destroyed, it is replaced by the settled expectancy of harm, exploitation, and humiliation from others” (Shay, 2014, p. 186).

Moral injury, however, is not properly captured by current PTSD diagnostic categories (American Psychiatric Association, 2013; Currier, Holland, & Malott, 2015; Jinkerson, 2016; Litz et al., 2009; McCormack & Ell, 2017; Shay, 2014; Vargas et al., 2013). Antal and Winings (2015) assert that a key difference between moral injury and current understandings of PTSD is that the latter is conceptualized as stemming from a foundational physiological reaction—the presence of specific stimuli serve as triggers for flight or fight responses by the afflicted. The roots of moral injury, meanwhile, are guilt and shame. Jinkerson (2016) elaborates further:

Although moral injury and PTSD likely often co-occur, moral injury does not develop through an experience of physiological distress. Instead it develops through a moral conflict in which one’s actions, or the actions of one’s peers or leaders, are demonstrably inconsistent with one’s moral code. (p. 125)

To this end, Southwick, Gilmartin, McDonough, and Morrissey (2006) note that while standard treatments may have a positive impact on key symptoms of the condition, “many veterans with PTSD, who have experienced the darkest side of human nature, are left with profound existential questions related to the loss of meaning in life” (p. 162). The result, according to these same authors, is that clients remain tormented and feel hopeless. Treatments, such as cognitive behavioral therapy and exposure therapy, that try to disrupt the stimulus response connection and medications that deal with depression and anxiety may be helpful, but if not geared to deal with moral anguish, loss of meaning, identity disturbances, and spiritual struggle, the professional response will be inadequate. Failure to address these concerns will serve to hinder the process of recovery. In fact, the rebuilding or repair of the assumptive world may prove to be the most important factor in the process of post-traumatic growth (Tedeschi & Calhoun, 2004; Triplett, Tedeschi, Cann, Calhoun, & Reeve, 2012; Updegraff & Taylor, 2000). It is the spiritual dimensions of moral wounds and the treatment of such wounds that we turn to next.

**Spiritual Beliefs and Moral Wounds**

For some, moral beliefs and values and key elements of the assumptive world are intertwined with religious and spiritual matters. These frameworks can provide an overall sense of coherence and can serve as effective coping mechanisms during, and in the aftermath, of traumatic events (Bryant-Davis & Wong, 2013; Draucker et al., 2011; Knapik, Martsolf, & Draucker, 2008; Pargament, Murray-Swank, & Tarakeshwar, 2005). In the case of military personnel, many rely on spirituality and religion to find meaning, achieve acceptance, develop a support network, and engage in self-growth (Pargament & Sweeney, 2011).

Life struggles, however, including the most traumatic, can be interpreted through negative spiritual and religious lenses (Antonovsky, 1980; Fallot, 2007; Fallot & Heckman, 2005; Peres, Moreira-Almeida, Nasello, & Koenig, 2007; Shaw, Joseph, & Linley, 2005). For some, spirituality and religion can be sources of stress (Kopacz & Connery, 2015; Stauner, Exline, & Pargament,
Wortmann et al. (2011) observe that spiritual struggle “represents negative religious cognitions about the self, God, and the world” (p. 442). The stress and strain are particularly acute when one appraises negative life events as the result of punishment for misdeeds or a function of God abandoning them. Abandonment issues are also associated with a sense of betrayal, a feeling that often arises in the course of warfare (Bunkers, 2018; Currier, McCormick, & Drescher, 2015; Shay, 2014; Wortmann et al., 2017). Closely held beliefs and values can be questioned, including beliefs in a benevolent God or the very existence of a higher power (Worthington & Langberg, 2012). If spiritual/religious beliefs have historically been central to one’s assumptive world and such principles are shattered, a personal crisis is at hand. Loss of belief, which can be an offshoot of the war experience, has been associated with depression, anxiety, and suicide, as well as an increase in PTSD symptoms (Fallot & Heckman, 2005; Fontana & Rosenheck, 2004; Nieuwsma et al., 2013; Shaw et al., 2005; Sherman, Harris, & Erbes, 2015; Stauner et al., 2016).

Stauner et al. (2016) note those who have very strong religious or spiritual beliefs may subscribe to stringent moral rules and codes of conduct, and as a result, perceived failure to live up to embodied standards can be a strong source of guilt and shame. Litz et al. (2009) argue that guilt “is tied to certain acts of transgression of a personal or shared moral code of expectation” (p. 699), while shame, which may lead to greater life difficulties, involves the global negative evaluation of the self. Not surprisingly, descriptions of moral injury are rife with veterans’ reports of feeling guilt and shame (Gaudet, Sowers, Nugent, & Boriskin, 2016; Purcell et al., 2016; Schok, Kleber, Elands, & Weerts, 2008; Singer, 2004).

It is also important to acknowledge that meaning systems are shaped by social support and context, including involvement in spiritual communities (Brinn & Auerbach, 2015). When such support is strong and readily available, feelings of guilt and shame may be mitigated. When such support is absent or, worse, when the veteran feels rejected, or cast aside (as was commonly reported in post-Vietnam America), guilt and shame can be intensified, leading to the urge to withdraw from others and/or producing intense anger.

**Case Example**

Below, we provide an example of a type of combat experience that can lead to moral injury, consequently challenging a person’s spiritual life. Later, practice strategies for addressing these very issues are discussed.

By the time Private Brad Stevenson was deployed during Operation Enduring Freedom, he had been married for 3 years and had one child. He had met his wife during his senior year in high school, and she had found steady work in an accounting firm after earning an Associate of Arts degree. Brad grew up in a religious household, and both of his parents were active in the Catholic Church. Before his deployment, Brad and his wife Sara were also active in a local church and, in fact, participated in religious education courses. In one of his first days of active duty in Afghanistan, Brad’s patrol was ambushed by a group of insurgents, who appeared to be ordinary citizens. While Brad escaped unscathed, his best friend from boot camp was riddled by gunfire while standing next to him. The following day, Brad’s unit was asked to return to the village, with a mission to root out the insurgents. As his squad cautiously entered the village, a family, frightened by their presence, tried to run for cover. Startled by the sudden movement, Brad opened fire. He watched as an adult male fell mortally wounded. Experiencing fear and rage that boiled over from the day before, Brad suddenly began firing round after round indiscriminately. One of his comrades soon after grabbed his arm firmly and told him to stand down. Taking one more glance, he saw a distraught mother hovering over a child, as a superior turned him aside, and told him to keep moving.

When Brad tried to process what had happened in the days that followed, his superior officers, and even a pastoral counselor in the
field, largely suggested it was best to put the memories to the side and do what he could to forget it. He couldn’t. He struggled with a range of intense, almost uncontrollable emotions, and upon discharge, the feelings did not abate. He struggled with the purpose for conflict and was angry at the officers that asked him to return to the field where they had just lost colleagues. At night, he was haunted by visions of his friend who had been caught in the crossfire. Also late at night, unable to sleep, he would ruminate about the fate of the young boy and the adult male he had surely killed. More than anything, he felt intense shame and guilt. In his mind, he had sinned. He had broken one of the Ten Commandments. Furthermore, there were times when he felt angry at God, wondering why God would allow war to occur and why God had seemingly abandoned him at the field of battle. To his complete surprise, he became aware that he was even questioning the existence of God. Life, at the moment, had no meaning.

He unsuccessfully tried to suppress the memories of war when he returned to civilian life. Before long, he became uncommunicative and reclusive. He stopped all involvement with the church and, additionally, began to drink heavily and abuse prescription medications. Finally, following 2 difficult years after returning home, his marriage fell apart. While he wanted to maintain his relationship with his son, his sense of failure was so pervasive, he chose to stay away. After receiving a second DUI, he started receiving services at a nearby VA hospital.

As Brad enters into services and begins to unravel the various aspects of his story, it should become clear to his providers that he is experiencing more than simply PTSD symptoms—he is simultaneously dealing with moral anguish and spiritual challenges.

**Strategies for Facilitating Meaning Making and Moral Repair**

Wortmann et al. (2011) feel that “until trauma-related information is reconciled with prior beliefs, symptoms of PTSD persist while the trauma remains in active memory” (p. 442). Schok et al. (2008), in very straightforward language, suggest the task at hand as, “Firstly, one has to make sense of the event by answering the questions: What happened, how, and why? Secondly, one has to find personal significance in the event or gain from the experience for one’s present life” (p. 358). It is important to note that often people cannot draw meaning from a traumatic event, and Park (2010) even suggests that some who avoid the attempt to do so are in the end better off. Nonetheless, the task before clinicians is to help individuals move past the impress of traumatic events and, in the best case scenario, begin the process of posttraumatic growth.

So how can a behavioral health professional help clients sift through the moral anguish they feel, find meaning from horror, and try to move forward in their life? There is a natural tendency in professional helpers, and reflected in society as a whole, to rush to alleviate suffering. Yet it is best to first consider the overall goal of our interventions. If PTSD is understood as a fear response to horrific events, medication, cognitive-behavioral interventions, emotional processing, and a host of other like interventions are logical responses. In terms of the appraisal of traumatic events, cognitive therapies and group process can be beneficial in challenging crippling thoughts and beliefs about previous combat experience. For example, veterans can come to see that their self-persecutory thoughts are far too harsh, and they may come to understand that they had made the best decisions among a host of bad alternatives or fate simply dealt them an unfavorable hand. With the help of others, including fellow veterans, group interventions can serve a similar purpose and provide a needed supportive space among those who share a common bond (Bormann, Thorp, Wetherell, & Golshan, 2008; Cox, Owen, & Ogrodniczuk, 2017). These interventions should be considered, including for individuals who identify as spiritual or religiously oriented.

However, where moral wounds are present, this is not where the assessment, or
possible interventions, should end. In the case example offered above, this warrior is aware that he has killed and, more, may have killed a civilian and a child. Even when contextual factors have been accounted for and notions of one’s duty to fellow soldiers, and country, are acknowledged, some veterans will still undoubtedly wrestle with the notion of violating sacred moral codes. From this point forward is where a host of thorny dilemmas arise. It is important to acknowledge that we are at the nascent stage in the development of effective treatment programs for moral injury. Clearly, some of the basic practice principles that guide trauma-informed care are useful. First and foremost in this process is the need to help veterans feel safe and affirmed as people worthy of attention and care. From here, distinct situations demand different types of interventions.

In our case example, a professional helper may want to start with a formal assessment process, and it is here that a tool like the Moral Injury Symptom Scale—Military Version (Koenig et al., 2018) may be useful. This assessment instrument is comprised of subscales that capture many of the signature elements of moral injury, including guilt, shame, betrayal, violation of moral values, loss of meaning, difficulty forgiving, self-condemnation, spiritual/religious stress, and loss of religious faith/hope. When one analyzes the case example offered above, it is easy to suggest that nearly every dimension of moral injury is present. Like all good practice, as the relationship develops, the client can be expected to become more comfortable sharing further details about some of the areas captured in this assessment instrument. Certain experiences would suggest the utility for a specific array of interventions. Considering treatments for moral injury are still being developed, it is impossible to discuss all possible interventions that flow from each dimension of moral injury. For the purpose of this article, we focus primarily on principles and strategies for addressing issues involving the shattering of one’s assumptive world, loss of meaning, spiritual crisis/loss of faith, along with struggles related to forgiveness.

According to Maguen and Burkman (2013), there is no way to sanitize killing, as it does occur in battle and in the execution of orders. Litz et al. (2009) suggest that when veterans feel anguish, guilt, and shame, these “are signs of an intact conscience and self-and other-expectations about goodness, humanity, and justice” (p. 701). Accordingly, Antal and Winings (2015) observe that, at hand, “is not a personality disorder but rather a wound suffered by a self-reflective and conscientious moral agent” (p. 384). The basic human response to such accounts by many members of the lay public, and professionals, is tempered by respect for the sacrifices service members have made. Thus, there is a rush to quickly reassure and offer whatever level of forgiveness is in their power. After all, there is a recognition that these veterans were often confronted with impossible situations, and self-aware individuals consider how they might have responded under duress. Paradoxically, those in the decades well after the Vietnam era have come home to a country and community more willing to commend them for their time and sacrifice, but for some, the public valorization of service can bring more pain than joy (Kinghorn, 2012; Purcell et al., 2016). Thus, while the public cheers and thanks them for their service, some veterans are painfully trying to come to terms with actions and behaviors that they cannot, at the moment, reconcile with their personal values and code of conduct. In the end, the only real arbiter of the need for forgiveness is the individual who is suffering. Because of this, Litz and associates (2009) instruct:

It is important to appreciate that holding onto the idea of a moral self or a moral code may require that a bad act be judged as such. In other words, maintaining a sense of morality is likely to preclude an easy forgiveness of a bad act and this is not something to be contested. Rather, the goal is to help the service member or veteran to move toward an appreciation of context and the acceptance of an imperfect self. (p. 703)

Singer (2004) posits that if the individual is going to move past trauma and moral
wounds, in the end, forgiveness must come from within the person, with additional help, where needed, coming from professionals and other members of their support system. Kinghorn (2012) notes that due to a medicalized view of PTSD, too often trauma therapies become tools that serve the narrow goal of reducing the symptoms of suffering. However, when moral injury is at hand, symptom relief is not the ultimate goal. In fact, suffering can be an important aspect of self-forgiveness—and self-forgiveness may be an important first step toward posttraumatic growth.

Cornish and Wade (2015) underscore the importance of self-forgiveness in overall mental health and quality of life, and this is a particularly salient issue in the face of this dimension of moral injury. They suggest that self-forgiveness can be characterized by four R’s: responsibility, remorse, restoration, and renewal. Taking responsibility may begin with a look back at a specific event with a particular focus on circumstances and context. As will be explored below, cognitive-behavioral therapy techniques may be important here, and the veteran may reappraise the situation. However, there may be times when the client attempts to engage in a level of denial, or to shift blame, requiring the helper to sensitively push the individual to accept at least some responsibility. Allowed to go unchallenged, shame and guilt may linger, and a range of self-destructive behaviors may follow.

When veterans grapple with incidents that produce guilt and shame, feelings of remorse are often intense. As Cornish and Wade (2015) argue, the task for the therapist is to help the client separate an undesirable behavior from a global assessment of self. It is here that the helper must remain person-centered, empathic, and nonjudgmental. From here, restoration may take many forms. Making of reparations for misdeeds may be important, but for veterans of world conflicts, there is often little opportunity to do so directly. It is here that well-used therapeutic techniques such as having individuals write a letter to a victim that they will share with others in an individual session or group, empty chair techniques, or other forms of expressive methods such as art therapy or psychodrama may be useful. In the case of the deeply religious and/or spiritual person, this may require a request for forgiveness via prayer, confession, or penance. In the case example above, Brad has been brought up in the Catholic tradition, and thus, these types of reparations are not uncommon to him. The fourth R in Cornish and Wade’s schemata, renewal, is akin to the concept of posttraumatic growth. This may involve the acceptance of one as a flawed being but one who is, in balance, a good citizen. Also important in this phase is a recommitment to one’s personal guiding values and beliefs, a crucial step in rebuilding the assumptive world. In practice, for some veterans this may underscore the importance of reconnecting with a supportive spiritual community or reinvigorating one’s religious/spiritual principles.

Wade (2016) offers a range of practice principles that align with but may differ slightly from the positions offered above. In particular, it is argued that those in therapeutic roles should not push for forgiveness but instead first work with clients to reintegrate into the surrounding world and reconnect with significant people in their life. Then, as healing begins, the client may search for a way to atone for past deeds. A method Southwick et al. (2006) use to help veterans in their quest for forgiveness is community service activities. In a creative way, the authors note how such service can be linked to traumatic events in the veteran’s life. Thus, if a client is haunted by the killing of a mother, it may be useful to work directly with orphaned children or children separated from their parents. Southwick et al. (2006) believe that meaning making should be at the heart of services to veterans battered by combat and that meaning can be found in service to others. This approach is particularly useful in cases in which guilt and shame produce a drive for forgiveness, and a veteran would like to atone for matters that involved people and places that are separated by years and miles, and even life and death.
Not all veterans face the moral struggle that follows taking the life of another; however, the range of events in the theater of war that are trauma-producing and provoke religious and spiritual struggles are vast. In a more direct manner, efforts have been extended to develop and implement cognitive and group interventions, as well as models of individual psychotherapy, informed by spiritual and/or religious principles and practices (see Bormann et al., 2008; Cox et al., 2017; Currier, Pearce, Carroll, & Koenig, 2018; Harris et al., 2011; Koenig et al., 2017; Wade, 2016). These innovative approaches are especially relevant for veterans and military personnel whose spiritual and religious values are at play. In discussing Spiritually Oriented Cognitive Processing Therapy, Koenig et al. (2017) explain:

Spiritual concepts such as mercy, repentance, forgiveness, spiritual surrender, prayer/contemplation, divine justice, hope, and divine affirmations are discussed as means to engage shame, guilt, anger, humiliation, spiritual struggles, and loss of faith. These techniques are supplemented by powerful rituals involving confession, penance, and faith community involvement, depending on what is most appropriate given the participant’s spiritual beliefs and tradition. (p. 150)

In addition to the above, Bormann et al. (2008) utilize an approach centered around mantra practice, while Harris et al. (2011) present a model that includes prayer and meditation.

Unquestionably, many professional helpers are uncomfortable with the idea of incorporating some of the practices mentioned directly above (not to mention a lack of training), but it would be inaccurate to suggest that therapy is completely divorced from such activities. Interestingly, the call for the use of such practices points to the nature and style of work that may be most useful to help people suffering from moral injury. To wit, Kinghorn (2015) argues, “If ‘moral injury’ is a reality, moral consideration and judgment are not superfluous or incidental to combat-related PTSD but rather essential for understanding certain forms of its manifestation” (pp. 30-31). Writing a script, using behavioral techniques, and even the language of evidence-based treatment, presents helping as a science, and the good helper is, by extension, technically proficient. But here we are discussing entering the client’s moral space and engaging in an honest conversation about moral issues, in particular the sense of having engaged in moral transgressions and issues of guilt, shame, and forgiveness. To be effective, as uncomfortable as it may be at first, professionals may need to roll up their sleeves and be prepared to have these conversations in individual or group settings. Kinghorn (2015) agrees that continued efforts to refine the science of helping are important. Using the field of psychiatry as an example, he posits that the discipline is also a practice of moral engagement, a deeply human activity in which psychiatrist and patient together, each constituted in particular ways by biology, culture, and language, work to discern what the shape of a good life looks like for the patient. Any belief, judgment, or practice that specifies the kind of life that is worth living, the kind of life conducive with flourishing, is on my account “moral.” Humans are moral beings, on this account, not simply because we adhere to social rules or norms but because we constantly weigh and discern the sorts of norms that are worth pursuing; as such, “morality” names the sphere of belief, judgment, and practice by which humans discern their good and thereby display agency. (p. 28)

It isn’t easy work, and Kinghorn (2015) outlines three standards that are required that seem applicable to all professional helping traditions. First, there is a need for training to go beyond basic clinical and scientific matters. The helping professions, particularly the area of mental health, promote the idea of person-centered care. There is also a great emphasis on cultural competence and humility, yet far too often, this does not include an appreciation of the impress of religion and spirituality in the lives of clients. Second, rather than striving to avoid
moral entanglements, professionals need to understand that such issues may be central to the client’s presenting problem. For Kinghorn (2015), the question at hand is, “Given that I must engage in discernment with patients about the sorts of ends that are worth pursuing, how do I do so responsibly, in a way that serves the patient’s good and that recognizes the way that my own moral commitments are affecting the sort of counsel and direction that I provide” (p. 36). The third dictum may appear to be the most simple but is easily the most critical. It requires helpers to be competent but also morally grounded, as “the space of moral engagement and discernment is a vulnerable and dangerous space: patients who allow clinicians into this space can easily be exploited” (p. 36).

Perhaps as much as anything, moving into a discussion of moral and spiritual matters with clients may feel like a boundary violation or, at the very least, an area beyond the expertise of practitioners. There is no question that it can be vitally important to build helpful connections with spiritual communities, especially leaders (Nieuwsma et al., 2014). There are times when a morally injured veteran is searching to be healed in a spiritual sense, not simply free of symptoms. In some cases, restoration of spiritual beliefs and participation in what may be considered sacred rituals and practices may be key to healing. As Kinghorn (2012) suggests, such activities “place the healing of combat trauma within a richly contextual context that clinical psychology cannot” (p. 67). If bridges can be established between the clinic and places of worship, practitioners can help set the stage to ensure that the right supports are in place to help veterans who wrestle with a high degree of ambivalence about re-engaging in the world of faith. In Brad’s case above, church attendance had always been a central part of his life, and it can be a potential source of sustenance in his current life with the proper supports. Additionally, spiritual leaders, particularly when clients come from spiritual traditions that are outside the norm, can be vital consultants when discerning the nature of spiritual struggle.

There also may be ways to incorporate healing rituals (mantra, meditation, prayer, etc.) in clinical settings, as is already happening with some of the spiritually integrated interventions mentioned above (e.g., Borrmann et al., 2008; Harris et al., 2011; Koenig et al., 2017). However, we are still at the nascent stage of understanding how best to intervene with clients who face moral injury, and further research is certainly needed in this area. Even said, simply dismissing new ideas (or old ones) because they force us to reconsider our professional roles is unacceptable.

**Conclusion**

Undoubtedly, this entire conversation may lead to feelings of discomfort by many. First, mental health professionals tend to be less spiritual and religious than their clients (Dein, 2018). In addition, in the course of a career, professionals will treat individuals who have been abused by members of the clergy, were damaged by participation willingly and unwillingly by cult like groups, or have been shunned by spiritual communities due to things like race, sexual orientation, and narrow definitions of acceptable behavior. However, we cannot proclaim to engage in culturally competent care if we ignore a client’s spiritual, religious, or moral life. This becomes especially important when working with those who present with trauma-related moral injuries. The ultimate goal of care should not be the remission of symptoms alone. The goal should be greater overall well-being for veterans, with the hope that individuals can repair their assumptive world, find meaning in past experiences or at least in life at the present, and move towards posttraumatic growth. For those veterans who identify as religious and/or spiritual, direct attention to these concerns is a necessity.

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