SPIRITUAL PSYCHOLOGY AND COUNSELING
spiritualpc.net / 2023 Volume: 8 Number: 3

Review Article

Guilt and Shame As a Result of Violating Beliefs: "Moral Injury"

Erhan Tunç[1]
Gaziantep University

Gülşah Candemir[2]
Ministry of Education

[1] Erhan Tunç, Assoc. Prof., Faculty of Education, Department of Guidance and Psychological Counseling, Gaziantep University, Gaziantep, Turkey. E-mail: erhantunc25@gmail.com
[2] Gülşah Candemir, PhD, Ministry of Education, Osmaniye, Turkey. E-mail: gulsah48895@gmail.com

Corresponding author:
Erhan Tunç
E-mail: erhantunc25@gmail.com

eISSN: 2458-9675

Received: 23.06.2023
Revision: 11.07.2023
Accepted: 22.07.2023

©Copyright 2023 by Author(s)

Abstract

This study on moral injury, which has a content as old as the history of humanity, is believed to contribute significantly to the relevant literature. Despite the limited number of sources in the literature on the subject, which are mostly related to veterans with war experience or limited to the field of religious psychology, this study is expected to fill the gap and provide valuable insights. The study attempted to clarify the distinction between moral injury, which involves a psychological injury caused by a dilemma, and post-traumatic stress disorder, which shares similar features with moral injury and arises after experiencing a traumatic event. As part of this study, psychotherapy approaches within the scope of interventions for the symptoms of moral injury were also included and the issue was tried to be addressed from a mental health perspective. In this context, "mindfulness-oriented meditation", "self-compassion", "spiritually-oriented counseling", and "work focused on forgiving oneself and others", whose effectiveness has been tested, are included. The issue of moral injury was addressed with psychology-spirituality dimensions; the scope of the study was further expanded with intervention-treatment titles. This study summarizes moral injury's conceptual framework and focuses on interventions and treatment approaches. As a result, the concept of moral injury was addressed holistically and contributed to the conceptual framework.

Keywords:
Moral injury • moral resilience • trauma • PTSD • belief

Citation: Tunç, E., & Candemir, G. (2023). Guilt and shame as a result of violating beliefs: "Moral injury". *Spiritual Psychology and Counseling, 8*(3), 387–404. http://doi.org/10.37898/spiritualpc.1319074

Introduction

Litz et al. (2009) define morality as *personal and shared familial, cultural, social and legal rules for social behavior, basic assumptions about how things should work and how one should behave*. Moral injury refers to the deterioration in an individual's understanding of morality and capacity to act fairly. Perceived immoral acts cause this injury, the inability to stop such actions or witnessing acts that are particularly inhumane, cruel, immoral or violent, causing pain, suffering or death to others (Drescher et al., 2011).

Various events that cause moral damage may occur in the form of the individual's inability to prevent situations in which the individual directly acts against others or in which others may be harmed or it may occur in the form of having to witness events in which others are harmed by others (Litz et al., 2009). Thus, as a result of these negative experiences, the fundamental beliefs that the world they share with others is reliable and reasonable are shaken, and thus they may experience temporary or permanent problems in terms of mental health.

The most common personal-based potentially morally injurious events (PMIE=potentially morally injurious events) are as follows (Yeterian et al., 2019):

(a) seeing immoral acts and doing nothing to stop them (96.2 percent);

(b) killing within the rules of engagement/agreement (84.6 percent) and

(c) making a mistake or failing in a task that harmed others (73.6 percent).

The most common personal-based potential moral injury incidents based on others are:

(a) seeing others suffer as a result of decisions made or not made by someone else (92.3 percent);

(b) seeing others treat the helpless with disrespect (88.5%), and

(c) harm to the patient or others / causing harm to the patient or others (88.5%).

Events that cause moral injury may have negative consequences for the mental health of an individual and may also trigger a pathology to which the individual is prone. Litz et al. (2009) state that the symptoms of moral injury include event-related avoidance and depersonalization/hypersensitivity components related to post-traumatic stress disorder (PTSD). In addition, it includes demoralization, self-sabotage and self-harming behaviors. In other words, violative actions and moral injury overlap with the mechanisms of moral injury such as guilt, shame, withdrawal, self-condemnation, etc., as well as with secondary consequences such as self-sabotage, demoralization,

self-harm, etc. Among the possible manifestations of moral injury described so far (Drescher et al., 2011; Litz et al., 2009; Vargas et al., 2013) are guilt and shame, social or relational problems, spiritual and existential problems (which may include loss of spirituality or weakened religious faith, negative attributions towards God or a higher power, lack of forgiveness, meaning crisis, etc.), substance abuse and attempts at self-sabotage, self-harming behaviors and suicide. The impact of events that have the potential for moral injury is mainly based on affect and cognitions such as shame, not on the fear it creates. That is, the emotional consequences of moral injuries such as shame and guilt, are realized when the individual confronts the event and/or the meaning of the event.

Changing beliefs about the self and the world due to moral injury can be deeper and more universal. For example, someone who experiences moral injury may begin to see themselves as immoral, irredeemable and irreparable or believe that they live in an immoral world. Litz et al. (2009) explain this with the signs of anguish, guilt and shame, or even a strong conscience, which they believe are inherent in moral injury. In other words, moral injury is only possible if individuals have a sound moral belief system. In this respect, moral injury involves the normal and expected reactions of the individual to morally violating actions. Moral emotions (e.g., anger, contempt, disgust, guilt, shame), both towards oneself and others, are part of the development after moral injury. Interestingly, these emotions also provide a strong social influence on the phenomenology of moral injury and recovery (Farnsworth et al., 2014)

Principles determining the process of moral injury

Feelings of anger, guilt and shame that emerge as a result of the personalization of emotions and thoughts arising from violations cause moral injury. These are the features that characterize the moral injury process. The framework of how the moral injury process, which occurs after events that have the potential to cause moral injury, works with the inclusion of some variables is explained in the light of 5 principles determined by Zalta & Held (2020):

Principle 1: *"Moral injury is characterized by high levels of shame and negative beliefs about the self.*"

Principle 2: *"Moral injury is characterized by unashamed guilt and few negative beliefs about the self.*"

Although the feelings of guilt and shame that arise in relation to moral injury are often both described as characteristic features of moral injury, there are also fundamental differences between these feelings. Guilt is an emotion with adaptive qualities towards positive behavior change. Shame, on the other hand, involves an

evaluation that results in negative beliefs about oneself (e.g., "*I am a bad person*" or "*I am a terrible person for not intervening*"). Although guilt and shame often co-occur, guilt without shame is likely to be adaptive, whereas shame is often associated with negative outcomes such as social isolation, maladaptive coping, depression and suicide (Tangney et al., 2007). Unlike guilt and shame, although it does not characterize moral injury on its own, if the emotion of anger is related to an event that has the potential for moral injury in the form of witnessing the violations of others, it can be personalized and the moral injury can be experienced as "*I am a terrible person for not intervening*" (Litz & Kerig, 2019). Therefore, the fact that the event with the potential for moral injury involves violations of others, despite the feeling of anger, the individual's lack of reaction (not intervening, not preventing/preventing, not talking about the event, etc.) may trigger feelings of shame and cause moral injury.

Principle 3: *Moral injury-induced rumination (initially in the form of internal explanations of the event) is a process of self-blame and guilt, followed by feelings of shame and negative beliefs about the self.*

Principle 4: *Individuals with high shame tendency are more likely to solve the rumination about the event with internal explanations than those with low shame tendency.*

A key factor in how to resolve rumination triggered by moral injury is the tendency to feel shame for perceived transgressions (Tangney et al., 2007). Individuals with high shame tend to be able to resolve rumination processes faster by finding internal explanations. Individuals with lower shame tend to distinguish between their actions and their identity (e.g., "*Even though I have done something wrong, I am not a bad person*") (Zalta & Held, 2020).

Principle 5: *Individuals with higher cognitive flexibility are more likely to resolve event-related rumination with external explanations than those with lower cognitive flexibility.*

Cognitive flexibility is a process that enables individuals to make more than one explanation about their roles and outcomes in events (Rende, 2000). In other words, individuals having higher cognitive flexibility may act as a buffer against maladaptive self-evaluations. Zalta & Held (2020) found that individuals with high cognitive flexibility, although they feel guilty about their behavior, conceptualize the reasons for their behavior in a situation-specific way (*"I did something terrible, but I was under stress and could not see anything else among the options at the time").* However, individuals with lower cognitive flexibility are likely to adhere to stricter rules (e.g., *black-and-white thinking*) and rely more on internal explanations.

Consequences of moral injury

Moral injury can have profound effects at the personal level as well as at the societal level. Theorists have suggested that the cognitive and emotional changes that occur after exposure to potentially morally wounding events (especially if the individual avoids direct confrontation and/or reparative interventions) can lead to a range of personal, social and spiritual consequences. According to Litz et al. (2009) and Wortmann et al. (2017), these consequences may include social withdrawal, alienation, self-sabotaging behaviors (e.g., substance use, criminal behavior), avoidance, demoralization, and spiritual distress.

1. Personal consequences

In a study conducted by Yeterian et al. (2019) with clinicians, it was observed that clinicians stated that their patients who experienced events with the potential for moral injury based on self and others showed significant changes in their attitudes and behaviors related to the event; in parallel with these, they expressed low self-esteem, high self-criticism, beliefs that they were bad, damaged, worthless and weak. It has been suggested that patients exposed to events with the potential for moral injury also engage in self-harming and/or high-risk behaviors (substance abuse and neglect of self-care). Clinicians reported that patients exposed to incidents with the potential for moral injury directly to the individual self viewed themselves as unlovable and unforgivable. Those exposed to incidents with the potential for moral injury to others reported feeling inadequate passive and having difficulty in persisting in goal-directed behaviors (low self-efficacy to stick to what they believe is right or to do the right thing at a critical moment; "nothing will ever *be good again*"), especially in responding effectively to subsequent exposures. Indeed, one clinician summarized the overall internal impact of any potentially morally injurious event as follows: "*It changes them at their core. They no longer have basic confidence in themselves, let alone the capacity to trust the world. They don't know how to get back to themselves.*"

Demoralization, one of the symptoms of moral injury, is the phenomenon of "not being able to cope" (Clarke & Kissane, 2002), feeling hopeless and helpless. Although it is often seen together with depression, in a study conducted with a large sample (Kuo et al., 2004), it was found to predict suicide more strongly than depression. In fact, it was stated that being exposed to an event with the potential for moral injury directed toward another person causes more demoralization than being directed toward oneself, for example, not being able to prevent the death of a relative in war, fighting or disasters. Bryan et al. (2013) stated that hopelessness as a component of demoralization is a risk variable for suicidality among veterans directly exposed to war. Bryan et al. (2010) and Selby et al. (2010) reported that suicidal individuals tend to have extremely negative self-perceptions and to be highly critical of perceived

flaws. In addition, it is stated that neuroticism (negative affect) is negatively related to self-forgiveness (Ross et al., 2007), which has a very strong positive relationship with self-condemnation (Ross et al., 2004).

2. Interpersonal consequences

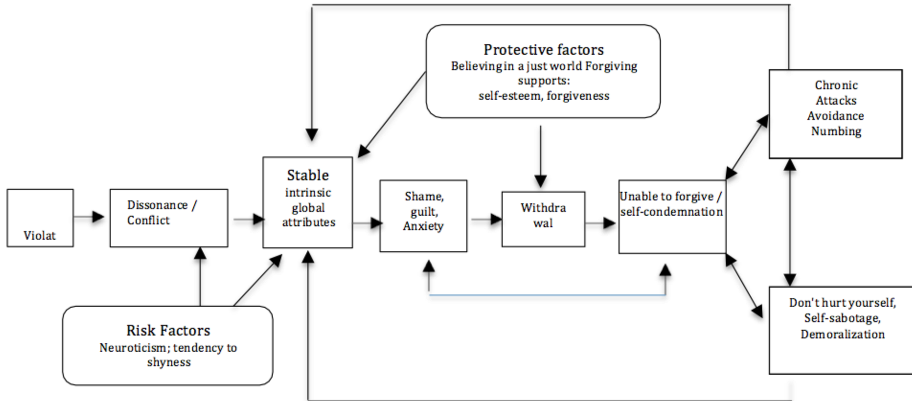
In the literature (Currier et al., 2015; Nash et al., 2013), individuals with moral injury are defined as individuals who experience social isolation and withdrawal in the form of difficulty in relating to, connecting with, or caring about others (e.g., in military service providers, especially towards civilians). In fact, Koenig et al. (2021) state that the concept of moral injury was initially discussed among military personnel as limited to the transgression of moral beliefs and values during combat but has now expanded beyond these boundaries to include similar feelings experienced by healthcare workers, first responders, and others who experience moral emotions arising from work performed during traumatic events or circumstances. It has also been reported that these individuals are disinterested in socializing with people who do not know how dangerous and/or corrupt the world really is. Scholars (Currier et al., 2015; Nash et al., 2013; Yeterian et al., 2019) have even reported that people with moral injury tend to behave in relationships in a way that they exposed to more traumatic situations (staying in unhealthy relationships, using aggression in relationships, etc.). Therefore, it can be said that individuals who experience moral injury have poorer social and relational adjustment.

Tangney et al. (2007) focused on how negative moral evaluations of self such as shame and guilt, affect interpersonal relationships. While guilt is an emotion arising from a “negative evaluation of a particular behavior”, shame is a “negative universal evaluation of the self” (Farnsworth et al., 2014). Shame is basically related to the negative evaluation that occurs as a result of the violation of what is expected by others who are valuable to the person. The shame caused by condemnation and rejection in traumatic conditions will also lead to withdrawal in a wide area. This withdrawal will inevitably lead to toxic interpersonal problems, such as anger and lack of empathy. In general, research has shown that shame is more damaging to emotional and mental health than guilt (Tangney et al., 2007).

Another aspect of moral injury, guilt, focuses on a specific behavior, while shame is a negative global evaluation of the self, accompanied by feelings of worthlessness, powerlessness, vulnerability and exposure (Tangney et al., 2007). In this respect, guilt stimulates greater empathy and socially restorative initiatives, whereas shame typically stimulates social isolation (Joireman, 2004). Furthermore, shame is strongly associated with substance misuse, anger and aggression (Tangney & Dearing, 2002), whereas guilt deters individuals from such problematic behaviors (Tangney et al., 1996).

Figure 1.

The ordinary/daily/temporary work framework for moral injury (Litz et al., 2009)



Existential and spiritual consequences

Regardless of the type of event with the potential for moral injury, individuals often complain of existential and spiritual conflicts, as well as changes in beliefs about morality and humanity. In studies on moral injury (Purcell et al., 2016; Vargas et al., 2013; Yeterian et al., 2019), clients who lost faith in the religious beliefs that individuals previously held and no longer believe that there is a just world or expect people to be good have been identified. It has been observed that after an event with any potential for moral injury, clients have more certain and established views about right and/or wrong. Their thoughts are exaggerated or more black and white, contrary to cognitive flexibility. It is also stated that they tend to be overly rigid, intolerant of their own harm or the harm of their relatives in terms of their moral expectations towards themselves or others and that many clients no longer have a meaning to life and have difficulty finding a worldview that makes sense to them (Yeterian et al., 2019). Therefore, it can be said that moral injury is related to spiritual or existential conflict or questioning. Witvliet et al. (2004) stated that moral injury is associated with intense post-traumatic symptoms of spiritual struggles within oneself (especially religious doubt), alienation from others (especially believers), and/or spiritual struggles with God or the divine (feeling abandoned or punished for one's sins).

As a result, the individual's revision of their beliefs about themselves, others and the world and their efforts to find meaning again after the events involving violations both by themselves and others they witnessed show that events with the potential for moral injury have existential and spiritual consequences.

Conceptualizing moral injury and post-traumatic stress disorder

Although moral injury is conceptualized in the literature with reactions that occur within the framework of guilt and shame, it should not be considered as very different from post-traumatic stress disorder (PTSD), trauma-related major depressive disorder or mental reactions that occur in parallel with the search for meaning after trauma. Although it is a newer concept in the literature compared to post-traumatic stress disorder, it overlaps at many points in the context of reactions that develop after trauma.

Moral injury should not be conceptualized as a distinct syndrome to replace PTSD or major depressive disorder. Currier et al. (2014) and Mantri et al. (2021) found that experiences of moral injury were significantly associated with mental health problems. Research (Farnsworth et al., 2014; Litz et al., 2009) suggests that the moral suffering that characterizes moral injury, as well as maladaptive attempts to avoid or control such suffering, clearly overlap with PTSD, major depressive disorder and other existing mental health disorders. Moral injury can be identified as a risk factor for such conditions, affecting recovery processes and/or further complicating the clinical picture. Bryan et al. (2018) stated that (a) moral injury and PTSD emerge as distinct constructs (e.g., fear in PTSD vs. guilt/shame in moral injury) and (b) PTSD accompanied by moral injury is associated with more severe suicidal ideation/attempt than when it occurs alone. Although moral injury has clear similarities with PTSD in terms of content, PTSD involves more negative thoughts that the world is not a safe place, while those with moral injury exhibit more prescriptive beliefs expressing moral values such as "the world should be a safe place."

It should be noted that moral injury cannot be mentioned for everyone with PTSD. Although feelings of guilt and shame related to moral injury have also been described as potential PTSD symptoms, they are not diagnostic criteria. Similarly, not everyone who experiences moral injury has PTSD. In particular, someone with moral injury does not necessarily have to have experienced the kind of trauma required for a diagnosis of PTSD. Diagnostic criteria for post-traumatic disorder and adapted scales developed for moral injury can be utilized. In a recent study, the Moral Injury Scale developed by Litz et al. (2022) was adapted into Turkish by Tunç et al. (2022).

Treatment

Litz et al. (2009) state that by the end of a successful therapy process, the client is now able to recognize that it is both possible and healing to express thoughts and feelings about painful situations, especially in the presence of others who show compassion. The following interventions for the treatment of moral injury are also shown to work on the concepts of anger, shame and guilt that are often characterized by moral injury. Especially at the beginning of the treatment, it is important to work on painful memories and to be able to share situations that are defined as both necessary

and important for a healthier life and even shameful without being condemned by another person.

Central to the therapy process is the client's values and efforts to change behavior. Mental health service providers are well aware that only part of moral repair is intrapsychic and that compassion and forgiveness, which are part of therapy, require the support of the community (Wortmann et al., 2017). Since being part of a whole and being accepted by a group will help create meaning and purpose beyond the self. Thus, being connected to supportive cultures and groups can be a functional tool in the process of moral repair. Therefore, in the therapy process, the client's participation in group activities and communities that have the potential to provide spiritual support is a channel of treatment (Drescher et al., 2007).

After moral injury, the counselor's attitude of increasing the flexibility of cognitive schemas and supporting socially oriented behaviors regarding potential stressors that may cause moral injury may help moral repair (Farnsworth et al., 2014). Leary et al. (2007) stated in their research that self-compassion acts as a buffer against negative emotions and taking responsibility for personal failures. Farnsworth et al. (2014) also suggested that self-compassion causes changes in self-understanding for moral repair and may even be an indicator that moral repair has taken place. Accepting the imperfect self that performs the action is not the same as accepting the action (Litz et al., 2009).

Adaptive Disclosure (AD)

Adaptive disclosure (AD), which is one of the interventions that treat self-forgiveness and compassion within the scope of post-moral injury interventions, was first applied in a 6-8-session study developed by Gray et al. (2012) for active duty military personnel. In the AD application, after the client first describes the violating event in a safe therapeutic environment, it is carried out in the form of participating in an imaginary dialogue supported by the therapist with a forgiving and compassionate moral authority about the violating event and the harm it caused (e.g., self-harm) (Frankfurt & Frazier, 2016).

AD is carried out through the application of imaginary exposure exercises to facilitate the processing of the psychological, behavioral and spiritual/existential consequences of traumatic military experiences. The therapist makes use of the "empty chair" exercise for a dialogue between the client and an imaginary compassionate moral authority. The aim of this exercise is to elicit a reappraisal of the event and to bring about the hoped-for behavioral change from self-blame to compassion and forgiveness. Results of an initial pilot study showed improvements in PTSD symptoms, depression, and reductions in negative post-traumatic cognitions (Gray et al., 2012).

Building Spiritual Strength (BSS)

BSS is a faith-based, 8-session group therapy model first developed for military personnel with mental distress(Harris et al., 2015). Forgiveness within religious and spiritual frameworks is considered as a vital repertoire in alleviating guilt, shame and demoralization. Witvliet et al. (2004), in a study with veterans, stated that veterans who did not forgive themselves and had punitive religious beliefs had worse mental health problems.

Spiritual care is thought to help to develop a sense of meaning and purpose, confront pain, to recognize forgiveness and gratitude, accept oneself, to better connect with others and to recognize the existence of a higher power, a benevolent deity or to re-establish a relationship with God (Kopacz et al., 2014). Spiritual care should not be seen as the imposition of values or beliefs or as a passive endeavor focusing only on "discovery". In simple terms, spiritual care involves expressing one's own sense of spirituality, using one's own words to determine that it gives the individual a sense of meaning and purpose (Kopacz et al., 2016).

Awareness Based Approaches

Mindfulness-Based Stress Reduction (MBSR) (Kabat-Zinn, 2003), Acceptance and Commitment Therapy (ACT) (Hayes, 2004) and Mindfulness-Based Cognitive Therapy (MBCT) (Morgan, 2003) are examples of mindfulness-based approaches with appropriate strategies for addressing dynamic grievances associated with moral injury. Mindfulness practices include interventions to improve attention regulation, body awareness and emotion regulation. Hölzel (2011) states that the reduction of complaints and psychological change is possible through the development of physical-physiological, emotional and cognitive awareness.

The 8-week, structured Mindfulness-Based Stress Reduction (MBSR) program, offered in group sessions of approximately 2.5 hours and one full-day retreat, includes quiet sitting meditation, body awareness and yoga positions, walking meditation and group support (Kabat-Zinn & Hanh, 2009). Fjorback et al. (2011), in their study in which they applied the MBSR program, stated that many symptoms, including depression and anxiety, decreased. In the MBSR studies conducted by Kearney et al. (2012) and Niles et al. (2012) with veterans, it was reported that there was a decrease in PTSD symptoms, but there was no significant effect on outcomes related to moral injury (However, conceptually, the effect of MBSR on moral injury symptoms may have been weak compared to the effect of decreasing depressive and anxious thoughts). Mindfulness skills preserve the power to connect with the here and now but also teach how to acknowledge painful thoughts and decide which thoughts are worthy of more attention. Each skill involves refocusing attention on the here and now, as well as recognizing dysfunctional thoughts. Raes & Williams (2010)

emphasized that MBSR is also useful in alleviating the distress caused by brooding on past experiences and negative thoughts about the future, which are common in moral injury.

Mindfulness-based strategies have been integrated into empirically supported therapies such as cognitive-behavioral therapy, which was more recently developed for depression and adapted for PTSD (King et al., 2013). In addition, Acceptance and Commitment Therapies also include interventions that use mindfulness specifically designed to help people cope with painful thoughts, feelings and memories (Orsillo & Batten, 2005).

Cognitive Processing Therapy (CPT)

CPT, developed as a unique form of Cognitive Behavioral Therapy, is a 12-session psychotherapy developed for the treatment of PTSD (Resick et al., 2002). After the traumatic experience, the development of maladaptive beliefs that negatively affect the individual's self-worth, reactions to safety and danger, and the capacity to trust themselves and others may cause the individual to be "stuck" in the natural healing process and prolong the acute process (Resick et al., 2008). These maladaptive beliefs include guilt, shame and self-harming behaviors. CPT develops the cognitive restructuring skills necessary for the individual to gain a new personal meaning related to the trauma (Resick et al., 2008). It can be said that CPT as a treatment method is highly effective in reducing the symptoms of PTSD, depression, guilt and suicidal ideation, all of which are also the main features of moral injury (Gradus et al., 2013; Resick et al., 2002).

Acceptance and Commitment Therapy (ACT)

ACT was developed in the tradition of cognitive behavioral therapy. Nieuwsma et al. (2015) state that ACT, which supports seeing human suffering as normal, predictable and potentially meaningful; forgiving in a way that accepts guilt; respecting current suffering and even engaging in morally harmful experiences, is also inclusive in moral injury.

Luoma et al. (2012), in a study on substance users, also reported the effectiveness of ACT in coping with the feeling of shame, which is one of the characteristic features of moral injury. In another study examining the effect of ACT (Zettle & Rains, 1989), it was stated that ACT not only reduces depression symptoms but also reduces unwanted thoughts, feelings and behaviors that the individual experiencing moral injury has difficulty with.

Although moral injury is not part of the typical human experience, it is considered normal to feel feelings of guilt, anger, shame, etc. when under the influence of moral

injury. In ACT, it is paradoxically hypothesized that an attempt to control/resolve negative memories, thoughts and feelings associated with moral injury, on the contrary, increases or prolongs them (Walser & Westrup, 2007). Many people suffering from moral injury try to control unwanted memories, thoughts, and emotions that they think restrict their lives. However, this control effort is often not functional. ACT supports reducing such managing efforts and liberating the individual to make choices rather than working on current emotional states and past events (Nieuwsma et al., 2015).

Individuals who connect to life in a more psychologically flexible way can also change their perspective by allowing different reactions to emerge under different and changing conditions. This increases the capacity to respond appropriately in a variety of situations, leading to adaptability and therefore to healthy living. But more importantly, the psychologically flexible person is able to maintain a balance between various life domains. Nieuwsma et al. (2015) consider this as a potential that needs to be developed in people suffering from moral injury, corresponding to the capacity to realize their future in a flexible, viable and purposeful way. In fact, the feeling of guilt that arises under moral injury is an emotion worth studying to understand how one can choose to live in the future.

As can be seen, ACT, as an alternative to therapies for the control of emotions, thoughts and behaviors, puts forward acceptance and willingness that develops with inner experiences. Reactions such as guilt, shame and regret arising from experiences of moral injury are also reactions to stop/control past experiences.

"Moral resilience" in the context of moral injury

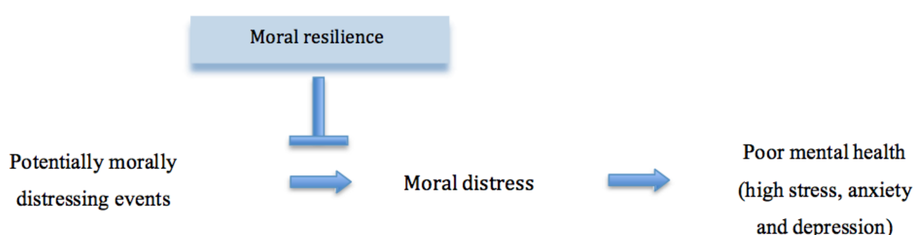
Rushton (2018) defines moral resilience as a buffer against moral injury and its negative consequences. Heinze et al., 2021; Holtz et al., 2018 also define moral resilience as "*an individual's capacity to maintain or restore integrity in response to moral challenges*". Moral resilience, which is developing as a new concept in the literature, is based on a sound understanding of personal, professional and relational integrity. Clinicians state that moral resilience includes the essential components of personal and relational integrity, vitality, self-regulation and awareness, moral efficacy and self-management (Holtz et al., 2018). Heinze et al. (2021) state that moral resilience consists of four sub-dimensions: (1) reactions to moral challenges, (2) personal integrity, (3) moral competence, and (4) relational integrity.

At the individual level, moral resilience includes skills such as knowing one's own values, the ability to self-regulate, being flexible in complex ethical situations, distinguishing the boundaries of integrity, acting decisively in morally charged situations, and seeking meaning in situations that threaten integrity (Rushton, 2018).

Moral resilience, related to the capacity to maintain or reconstruct one's integrity in response to moral distress (Rushton, 2018), is also a way to mitigate the harmful effects of moral distress (Rushton, 2016). The concept of moral resilience, relatively new in the literature, was conceptualized with an innovative model by Spilg et al. (2022). This model is associated with the idea that (1) moral resilience alleviates the degree of moral distress caused by potentially morally distressing events and (2) moral distress caused by these events reduces the degree of poor mental health burden (Figure 2).

Figure 2.

Theoretical model of moral resilience (Spilg et al., 2022)



Moral resilience is also associated with lower symptoms of stress, anxiety and depression. Spilg et al. (2022) state that being male, being older, not having a diagnosis of a mental disorder, getting more sleep, and receiving more support from employers and colleagues are factors that can be independently associated with stronger moral resilience. Moral recovery, as a concept also related to moral resilience, is more global than local according to Kant's approach and largely local rather than global to Hume's constructivist approach (Arruda, 2017). Moral improvement, whose effect can be explained at the global or local level in different approaches, can be a start for restructuring and making sense of life in human life.

Results

In this study, it was attempted to create an up-to-date source on the subject by reviewing the relevant literature. Although the concept of moral injury is related to many different disciplines, it was observed in the relevant literature that studies do not reflect this diversity. In this study, the differences between moral injury, in which moral values are under threat as a kind of dilemma, and post-traumatic stress disorder, which has common aspects, are characteristically revealed. The concept of moral injury, of interest to disciplines such as psychology, social psychology, guidance and counseling, psychology of religion and spiritual psychology as different approaches, is mentioned in this study through the use of contemporary sources. This study summarizes the conceptual framework of moral injury and focuses on interventions

and treatment approaches. In a similar study (Altınlı Macić, 2022), it was stated that theoretical and applied studies on moral injury in various contexts should bring new perspectives to the literature on the concept in different fields. As a result, in the present study, the concept of moral injury was addressed holistically to attract the attention of different disciplines and tried to contribute to the conceptual framework.

Acknowledgements. The authors would like to thank the editors and reviewers for their contributions to this study.

Ethical approval. This study is a review study and ethics committee approval was not obtained since it does not contain personal data.

Authors' contributions. The authors contributed equally to the preparation of this article.

Peer Review. Externally peer-reviewed.

Funding. No funding was provided for this study.

Disclosure statement. The authors declare that they have no conflict of interest.

References

Altınlı Macić, M. (2022). "Gizli yara: Ahlaki yaralanma". *Mizânü'l-Hak:* İslami İlimler *Dergisi, 15*, 519-554. https://doi.org/10.47502/mizan.1198478

Arruda, C. T. (2017). The varieties of moral improvement or why Metaethical constructivism must explain moral Progress. *Ethical Theory and Moral Practice*, *20*, 17-38. https://doi.org/10.1007/s10677-016-9738-1

Bryan, C. J., Morrow, C. E., Anestis, M. D., & Joiner, T. E. (2010). A preliminary test of the interpersonal-psychological theory of suicidal behavior in a military sample. *Personality and Individual Differences, 48*, 347–350. http://dx.doi.org/10.1016/j.paid.2009.10.023

Bryan, C. J., Ray-Sannerud, B., Morrow, C. E., & Etienne, N. (2013). Guilt is more strongly associated with suicidal ideation among military personnel with direct combat exposure. *Journal of Affective Disorders, 148*, 37– 41. http://dx.doi.org/10 .1016/j.jad.2012.11.044

Bryan, C. J., Bryan, A. O., Roberge, E., Leifker, F. R., & Rozek, D. C. (2018). Moral injury, posttraumatic stress disorder and suicidal behavior among National Guard personnel. *Psychological Trauma: Theory, Research, Practice, and Policy, 10*(1), 36–45. https://doi.org/10.1037/tra0000290

Clarke, D. M., & Kissane, D. W. (2002). Demoralization: Its phenomenology and importance. *Australian and New Zealand Journal of Psychiatry, 36*, 733–742. http://dx.doi.org/10.1046/j.1440- 1614.2002.01086.x

Currier, J. M., Holland, J. M. & Malott, J. (2014). "Moral injury, meaning-making, and mental health in returning veterans." *Journal of Clinical Psychology 71*(3), 229-240. https://doi.org/10.1002/jclp.22134

Currier, J. M., Holland, J. M., Drescher, K., & Foy, D. (2015). Initial psychometric evaluation of the Moral Injury Questionnaire-Military version. *Clinical Psychology & Psychotherapy, 22*(1), 54–63. https://doi.org/10.1002/cpp.1866

Drescher, K. D., Smith, M. W., & Foy, D. W. (2007). Spirituality and readjustment following war-zone experiences. In C. R. Figley & W.P. Nash (Eds.), *Combat stress injury: Theory, research, and management,* 295−310. Routledge/Taylor & Francis Group.

Drescher, K. D., Foy, D. W., Kelly, C., Leshner, A., Shutz, K., & Litz, B. T. (2011). An exploration of the viability and usefulness of the construct of moral injury in war veterans. *Traumatology, 17*, 8–13. http://doi.org/10.1177/1534765610395615

Farnsworth, J. K., Drescher, K. D., Nieuwsma, J. A., Walser, R. B., & Currier, J. M. (2014). The role of moral emotions in military trauma: Implications for the study and treatment of moral injury. *Review of General Psychology, 18*, 249–262. https://doi.org/10.1037/gpr0000018

Fjorback, L. O., Arendt, M., Ørnbøl, E., Fink, P., & Walach, H. (2011). Mindfulness-based stress reduction and Mindfulness-based cognitive therapy: A systematic review of randomized controlled trials. *Acta Psychiatrica Scandinavica, 124*(2), 102-119. https://doi.org/10.1111/j.1600-0447.2011.01704.x

Frankfurt, S., & Frazier, P. (2016). A review of research on moral injury in combat veterans. *Military Psychology, 28*(5), 318–330. https://doi.org/10.1037/mil0000132

Gradus, J. L., Suvak, M. K., Wisco, B. E., Marx, B. P. & Resick, P. A. (2013). Treatment of post-traumatic stress disorder reduces suicidal ideation. *Depress Anxiety. 30*(10), 1046-53. https://doi.org/10.1002/da.22117

Gray, M. J., Schorr, Y., Nash, W., Lebowitz, L., Amidon, A., Lansing, A., ... Litz, B. T. (2012). Adaptive disclosure: An open trial of a novel exposure-based intervention for service members with combat-related psychological stress injuries. *Behavior Therapy, 43*(2), 407-415. https://doi.org/10.1002/da.22117

Harris, J. I., Park, C. L., Currier, J. M., Usset, T. J., & Voecks, C. D. (2015). Moral injury and psycho-spiritual development: Considering the developmental context. *Spirituality in Clinical Practice, 2*, 256–266. http://dx.doi.org/10.1037/scp0000045

Hayes, S. C. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. *Behavior Therapy*, *35*(4), 639-665. https://doi.org/10.1016/S0005-7894(04)80013-3

Heinze, K., Hanson, G. C., Swoboda, S. M., & Rushton, C. H. (2021). Measuring healthcare interprofessionals' moral resilience: Validation of the Rushton Moral Resilience Scale. *Journal of Palliative Medicine*. https://doi.org/10.1089/jpm.2020.0328

Holtz, H., Heinze, K., & Rushton, C. (2018). Interprofessionals' definitions of moral resilience. *Journal of Clinical Nursing*, *27*(3-4), 488-494. https://doi.org/10.1111/jocn.13989

Hölzel, B. K., Lazar, S. W., Gard, T., Schuman-Olivier, Z., Vago, D. R., & Ott, U. (2011). How does mindfulness meditation work? Proposing mechanisms of action from a conceptual and neural perspective. *Perspectives on Psychological Science*, *6*(6), 537-559. https://doi.org/10.1177/1745691611419671

Joireman, J. (2004). Empathy and the self-absorption paradox II: Self-rumination and self-reflection as mediators between shame, guilt and empathy. *Self and Identity, 3*(3), 225–238. https://doi.org/10.1080/13576500444000038

Kabat-Zinn, J., & Hanh, T. N. (2009). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. Delta.

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clin Psychol-Sci Pr, 10*(2), 144–156. https://doi.org/10.1093/clipsy.bpg016

Kearney, D. J., McDermott, K., Malte, C., Martinez, M., & Simpson, T. L. (2012). Association of participation in a mindfulness program with measures of PTSD, depression and quality of life in a veteran sample. *Journal of Clinical Psychology*, *68*(1), 101-116. https://doi.org/10.1002/jclp.20853

King, A. P., Erickson, T. M., Giardino, N. D., Favorite, T., Rauch, S. A., Robinson, E., ... Liberzon, I. (2013). A pilot study of group mindfulness-based cognitive therapy (MBCT) for combat veterans with post-traumatic stress disorder (PTSD). *Depression and Anxiety*, *30*(7), 638-645. https://doi.org/10.1002/da.22104

Koenig, H. G., …, & Al Zaben, F. (2021). Moral injury: An increasingly recognized and widespread syndrome. *Journal of Religion and Health 60*(5), 2989-3011. https://doi.org/10.1007/s10943-021-01328-0.

Kopacz, M. S., Connery, A. L., Bishop, T. M., Bryan, C. J., Drescher, K. D., Currier, J. M., & Pigeon, W. R. (2016). Moral injury: A new challenge for complementary and alternative medicine. *Complementary Therapies in Medicine, 24*, 29-33. https://doi.org/10.1016/j.ctim.2015.11.003

Kopacz, M. S., O'Reilly, L. M., Van Inwagen, C. C., Bleck-Doran, T. L., Smith, W. D., & Cornell, N. (2014). Understanding the role of chaplains in veteran suicide prevention efforts: A discussion paper. *Sage Open*, *4*(4), 1-10. https://doi.org/10.1177/2158244014553589

Kuo, W. H., Gallo, J. J., & Eaton, W. W. (2004). Hopelessness, depression, substance disorder, and suicidality: A 13-year community-based study. *Social Psychiatry and Psychiatric Epidemiology, 39*, 497–501. https://doi.org/10.1007/s00127-004-0775-z

Leary, M. R., Tate, E. B., Adams, C. E., Batts Allen, A., & Hancock, J. (2007). Self-compassion and reactions to unpleasant self-relevant events: The implications of treating oneself kindly. *Journal of Personality and Social Psychology, 92*, 887–904. https://doi.org/10.1037/0022-3514.92.5.887

Litz B. T., & Kerig P. K. (2019). Introduction to the special issue on moral injury: Conceptual challenges, methodological issues, and clinical applications. *Journal of Traumatic Stress, 32*, 341–349. https://doi.org/10.1002/jts.22405

Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C., & Maguen, S. (2009). Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical Psychology Review, 29*(8), 695-706. https://doi.org/10.1016/j.cpr.2009.07.003

Luoma, J. B., Kohlenberg, B. S., Hayes, S. C., & Fletcher, L. (2012). Slow and steady wins the race: A randomized clinical trial of acceptance and commitment therapy targeting shame in substance use disorders. *Journal of Consulting and Clinical Psychology*, *80*(1), 43-53. https://doi.org/10.1037/a0026070

Mantri, S., Lawson, J. M., Wang, Z., & Koenig, H. G. (2021). Prevalence and predictors of moral injury symptoms in health care professionals. *The Journal of Nervous and Mental Disease, 209*(3) 174-180. https://doi.org/10.1097/NMD.0000000000001277

Morgan, D. (2003). Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse. *Psychother Res.,13*(1), 123–125. https://doi.org/10.1093/ptr/kpg004

Nash, W. P., Marino Carper, T. L., Mills, M. A., Au, T., Goldsmith, A., & Litz, B. T. (2013). Psychometric evaluation of the Moral Injury Events Scale. *Military Medicine, 178*, 646–652. https://doi.org/10.7205/MILMED-D-13-00017

Nieuwsma, J. A., D Walser, R., K Farnsworth, J., D Drescher, K., G Meador, K., & Nash, W. (2015). Possibilities within acceptance and commitment therapy for approaching moral injury. *Current Psychiatry Reviews, 11*(3), 193-206. https://doi.org/10.2174/1573400511666150629105234

Niles, B. L., Klunk-Gillis, J., Ryngala, D. J., Silberbogen, A. K., Paysnick, A., & Wolf, E. J. (2012). Comparing mindfulness and psychoeducation treatments for combat-related PTSD using a telehealth approach. *Psychological Trauma: Theory, Research, Practice and Policy, 4*(5), 538-547. https://doi.org/10.1037/a0026161

Orsillo, S. M., & Batten, S. V. (2005). Acceptance and commitment therapy in the treatment of post-traumatic stress disorder. *Behavior modification*, *29*(1), 95-129. https://doi.org/10.1177/0145445504270876

Purcell, N., Koenig, C. J., Bosch, J., & Maguen, S. (2016). Veterans' perspectives on the psychosocial impact of killing in war. *The Counseling Psychologist, 44*, 1062–1099. https://doi.org/10.1177/00110000166 66156

Raes, F., & Williams, J. M. G. (2010). The relationship between mindfulness and uncontrollability of ruminative thinking. *Mindfulness, 1*(4), 199-203. https://doi.org/10.1007/s12671-010-0021-6

Rende B (2000). Cognitive flexibility: Theory, assessment, and treatment. *Seminars in Speech and Language*, *21*, 121–133. https://doi.org/10.1055/s-2000-7560

Resick, P. A., Nishith, P., Weaver, T. L., Astin, M. C., & Feuer, C. A. (2002). A comparison of cognitive-processing therapy with prolonged exposure and a waiting condition for the treatment of chronic post-traumatic stress disorder in female rape victims. *Journal of Consulting and Clinical Psychology*, *70*(4), 867-879. https://doi.org/10.1037/0022-006X.70.4.867

Resick, P. A., Monson, C. M., & Chard, K. M. (2008). *Cognitive processing therapy: Veteran/military version.* Washington, DC: Department of Veterans' Affairs.

Ross, S. R., Hertenstein, M. J., & Wrobel, T. A. (2007). Maladaptive correlates of the failure to forgive self and others: Further evidence for a two-component model of forgiveness. *Journal of Personality Assessment, 88*, 158−167. https://doi.org/10.1080/00223890701267985

Ross, S. R., Kendall, A. C., Matters, K. G., Wrobel, T. A., & Rye, M. S. (2004). A personalogical examination of self- and other-forgiveness in the five-factor model. *Journal of Personality Assessment, 82*, 207−214. https://doi.org/10.1207/s15327752jpa8202_8

Rushton, C. H. (Ed.). (2018). *Moral resilience: Transforming moral suffering in healthcare*. Oxford University Press. Available from: https://oxfordmedicine.com/view/10.1093/med/9780190619268.001.0001/med- 9780190619268

Rushton, C. H. (2016). Moral resilience: A capacity for navigating moral distress in critical care. *AACN Advanced Critical Care*, *27*(1), 111-119. https://doi.org/10.4037/aacnacc2016275

Selby, E. A., Anestis, M. D., Bender, T. W., Ribeiro, J. D., Nock, M. K., Rudd, M. D., . . . Joiner, T. E. (2010). Overcoming the fear of lethal injury: Evaluating suicidal behavior in the military through the lens of the interpersonal–psychological theory of suicide. *Clinical Psychology Review, 30*, 298–307. https://doi.org/10.1016/j.cpr.2009.12.004

Spilg, E. G., Rushton, C. H., Phillips, J. L., Kendzerska, T., Saad, M., Gifford, W., ... Robillard, R. (2022). The new frontline: Exploring the links between moral distress, moral resilience and mental health in healthcare workers during the COVID-19 pandemic. *BMC Psychiatry*, *22*, 1-12. https://doi.org/10.1186/s12888-021-03637-w

Tangney, J. P., & Dearing, R. (2002). *Shame and Guilt*. Guilford Press.

Tangney, J. P., Miller, R. S., Flicker, L., & Barlow, D. H. (1996). Are shame, guilt, and embarrassment distinct emotions? *Journal of Personality and Social Psychology, 70*, 1256–1269. https://doi.org/10.1037/0022-3514.70.6.1256

Tangney, J. P., Stuewig, J., & Mashek, D. J. (2007). Moral emotions and moral behavior. *Annual Review of Psychology, 58*, 345–372. https://doi.org/10.1146/annurev.psych.56.091103.070145

Tunç, M. F., Özdemir, İ., & Ümmet, D. (2022). Adaptation of Moral Injury Scale into Turkish culture. *TRC Journal of Humanitarian Action, 1*(3), 109-116. https://doi.org/10.55280/trcjha.2022.1.3.0014

Vargas, A. F., Hanson, T., Kraus, D., Drescher, K., & Foy, D. (2013). Moral injury themes in combat veterans’ narrative responses from the National Vietnam Veterans’ Readjustment Study. *Traumatology, 19*, 243–250. https://doi.org/10.1177/1534765613476099

Walser, R. D., & Westrup, D. (2007). *Acceptance and commitment therapy for the treatment of post-traumatic stress disorder and trauma-related problems: A practitioner’s guide to using mindfulness and acceptance strategies*. New Harbinger Publications.

Witvliet, C. V., Phipps, K. A., Feldman, M. E., & Beckham, J. C. (2004). Post-traumatic mental and physical health correlates of forgiveness and religious coping in military veterans. *Journal of Traumatic Stress: Official Publication of the International Society for Traumatic Stress Studies*, *17*(3), 269-273. https://doi.org/10.1023/B:JOTS.0000029270.47848.e5

Wortmann, J. H., Eisen, E., Hundert, C., Jordan, A. H., Smith, M. W., Nash, W. P., & Litz, B. T. (2017). Spiritual features of the war-related moral injury: A primer for clinicians. *Spirituality In Clinical Practice, 4*, 249–261. https://doi.org/10.1037/scp0000140

Yeterian, J. D., Berke, D. S., Carney, J. R., McIntyre–Smith, A., St. Cyr, K., King, L., ... Moral Injury Outcomes Project Consortium. (2019). Defining and measuring moral injury: Rationale, design, and preliminary findings from the moral injury outcome scale consortium. *Journal of Traumatic Stress, 32*(3), 363-372. https://doi.org/10.1002/jts.22380

Zalta, A. K., & Held, P. (2020). Commentary on the special issue on moral injury: Leveraging existing constructs to test the heuristic model of moral injury. *Journal of Traumatic Stress, 33*(4), 598-599. https://doi.org/10.1002/jts.22516

Zettle, R. D., & Rains, J. C. (1989). Group cognitive and contextual therapies in treatment of depression. *Journal of Clinical Psychology*, *45*(3), 436-445. https://doi.org/10.1002/1097-4679