Moral injury

treatment innovation for traumatic horror, horror, injustice, embitterment and shame

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Ehlers and Clarks 2000 cognitive model

Fig. 1. A cognitive model of PTSD.
The nature of intrusive memories after trauma: the warning signal hypothesis

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The threat-fear-terror pathway to PTSD

**NORMAL FUNCTIONING**

- Stress response
- Fight/Flight/Freeze
- Activation of threat survival response
- Memory processes
- View of self & world

**TRAUMA:** Traumatising Elements

- Exposure to life threat - self or others
- Death, injury or near-miss
- Activation of fear-terror response
- Inability to control, eliminate or respond to threat
- Repeated exposure to events that involve threat to life

**THREAT-TERROR RESPONSE**

- Heightened awareness of sources of danger
- Threat pervades and pollutes everyday activities
- Unpredictability of future threat
- Inability (perceived or real) to eliminate sources of future threat
- Helplessness
- Disempowerment

**‘PTSD’:** Threat-Terror System Locked On

- Threat appraisal triggered by reminders and uncertainty
- High sensitivity to rule violations that could lead to threat
- Persistent sense that danger is ever present
- Hypervigilance and sensitivity to environmental noise that interferes with need to maintain vigilance
- Reliving events – introduce a constant reminder of ever present danger
Moral injury...is what happens when there is a high-stakes violation of what’s right” by someone holding legitimate authority in a high-stakes situation. The “what’s right” is in the realm of culture. Legitimation and authority are in the social structure (Shay, 2009).

Perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations. (Litz et al., 2009)

Disruption in an individual’s confidence and expectations about one’s own or others’ motivation or capacity to behave in a just and ethical manner, brought about by bearing witness to perceived immoral acts, failure to stop such actions, or perpetration of immoral acts, in particular acts that are inhumane, cruel, depraved, or violent, bringing about pain, suffering, or death of others. (Drescher et al., 2011)
The horror-shock-injustice pathway to PTSD

‘NORMAL’ FUNCTIONING

Stress response
Fight/Flight/Freeze
Activation of horror-disgust-anger response
Memory processes
View of self & world

TRAUMA:
Traumatising Elements

Injustice with impunity
Grotesque scenes
Betrayal, abandonment, blame
Moral pollution
Personal connection
Actions that violate personal moral codes

HORROR RESPONSE

Overwhelm, shock, outrage – too much to digest
Moral injury
Psychologically violated
Helplessness
Disempowerment
Assault on deeply held beliefs, assumptions & expectations

‘PTSD’:
Mortal Threat System Locked On

Shame & guilt cycle
Unresolved sense of injustice
High sensitivity to injustice
Loss of trust/faith in world
Feel tainted, contaminated, isolated
Replaying events – trying to change outcome: ‘what if,’ ‘if only,’ ‘should have.
Posttraumatic-embitterment’
**THREAT-FEAR-TERROR PATHWAY**

**THREAT TO PHYSICAL INTEGRITY**
- Physical threat (abuse, harm, death)
- Inability to control, eliminate or respond to threat
- Repeated exposure

**TERROR RESPONSE**
- Helplessness
- Intense fear & vulnerability
- Complete loss of control
- Fight/flight/freeze under extreme activation

**THREAT TO MORAL INTEGRITY**
- Moral Pollution: grotesque scenes & devastation, personal connection
- Moral Betrayal: Injustice, abandonment, blame
- Moral Compromise: Action or inaction that violates personal moral code

**HORROR-SHOCK RESPONSE**
- Shock, grief
- Disempowerment
- Outrage, disgust
- Psychologically violated
- Assault on deeply held beliefs, assumptions, expectations

**HORROR - SHOCK - INJUSTICE - GUILT PATHWAY**

**Biological, psychological and social functioning under normal circumstances**

**Traumatising elements**

**Activation of mortal threat system**

**BIOPSYCHOSOCIAL SELF**
- Fight, flight, freeze
- Memory Processes
- Stress response/training
- View of self & world
TERROR PATHWAY

TERROR RESPONSE
- Helplessness
- Intense fear & vulnerability
- Complete loss of control
- Fight/flight/freeze under extreme activation

HORROR-SHOCK RESPONSE
- Shock, grief
- Disempowerment
- Outrage, disgust
- Psychologically violated
- Assault on deeply held beliefs, assumptions, expectations

TRAUMATIC INJURY

Accumulation
- Ongoing Threat
- Overwhelm

THREAT-TERROR SYSTEM HYPERACTIVE
- Reliving traumatic events
- Threat appraisal triggered by reminders and uncertainty
- Persistent sense of danger / hypervigilance
- Sensitivity to environmental noise that interferes with need to maintain vigilance
- Intolerance for ignorance of threat / high sensitivity to rule violations

PTSD

MORAL-SYMBOLIC THREAT SYSTEM HYPERACTIVE
- Feel tainted, contaminated, isolated / shame & guilt cycle
- Replaying events – trying to change outcome: ‘what if,’ ‘if only,’ ‘should have.
- Unresolved sense of injustice / injustice sensitivity / anger attacks / posttraumatic-embitterment
- Alienation, loss of purpose / chronic detachment / loss of trust – faith in world

MORAL INJURY

GUILT PATHWAY

Personal Connection

Moral injury

Ongoing Symbolic Threat

*Both pathways involve threat to one’s personal integrity: one physically, the other symbolically.

Activation of mortal threat system

Mechanisms of traumatic injury

Biopsychosocial functioning after traumatic injury has occurred
The nature of predominant emotional responses in persistent PTSD depends on the particular appraisals

1. Appraisals concerning perceived danger lead to fear (e.g. "Nowhere is safe"),
2. Appraisals concerning others violating personal rules and unfairness lead to anger (e.g. "Others have not treated me fairly"),
3. Appraisals concerning one's responsibility for the traumatic event or its outcome lead to guilt (e.g. "It was my fault"),
4. Appraisals concerning one's violation of important internal standards lead to shame (e.g. "I did something despicable")
5. Appraisals concerning perceived loss lead to sadness (e.g. "My life will never be the same again").
A Scheme for Categorizing Traumatic Military Events

Nathan R. Stein¹, Mary Alice Mills¹, Kimberly Arditte¹, Crystal Mendoza³, Adam M. Borah⁴, Patricia A. Resick¹,², Brett T. Litz¹,² and the STRONG STAR Consortium

¹,²,³,⁴
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<th>Feeling/emotion</th>
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<th>2</th>
<th>3</th>
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<tr>
<td>Afraid</td>
<td>.82&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-.02</td>
<td>-.02</td>
<td>.02</td>
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<td>Terrified</td>
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<td>.00</td>
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<td>.19</td>
<td>.12</td>
<td>.15</td>
<td>-.08</td>
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<td>Shocked/surprised</td>
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<td>.01</td>
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<td>.21</td>
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<td>.11</td>
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<td>.01</td>
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<td>Humiliated</td>
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<td>.85&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.03</td>
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<tr>
<td>Embarrassed</td>
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<td>.81&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.04</td>
<td>-.06</td>
<td>.07</td>
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<tr>
<td>Sad</td>
<td>.17</td>
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<td>.79&lt;sup&gt;a&lt;/sup&gt;</td>
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<td>-.12</td>
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<tr>
<td>Guilty</td>
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<td>Rage</td>
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<tr>
<td>Angry</td>
<td>.00</td>
<td>-.10</td>
<td>.04</td>
<td>.78&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.05</td>
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<td>Numb</td>
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<td>.10</td>
<td>.04</td>
<td>.22</td>
<td>.51&lt;sup&gt;a&lt;/sup&gt;</td>
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<tr>
<td>Detached, as if in a dream</td>
<td>.32</td>
<td>.16</td>
<td>-.02</td>
<td>-.11</td>
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<tr>
<td>Grief/discrimination</td>
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<td>.81</td>
<td>.04</td>
<td>.40</td>
<td>.43&lt;sup&gt;a&lt;/sup&gt;</td>
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Posttraumatic Embitterment Disorder in Comparison to Other Mental Disorders

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Spectrum of Embitterment Manifestations

Michael Linden and Max Rotter
Charité University Medicine Berlin

Categorization of Embitterment

489 patients with embitterment

31% - no critical life event
9% - accumulated life adversity (complex PTED)
14% - Posttraumatic embitterment Disorder
45% - following diagnosis associated with a critical event (secondary embitterment)
Combat-related guilt and the mechanisms of exposure therapy

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\textbf{ABSTRACT}

Exposure therapy (EXP) is one of the most widely used and empirically supported treatments for PTSD; however, some researchers have questioned its efficacy with specific populations and in targeting specific symptoms. One such symptom, guilt, has garnered increased attention in the PTSD treatment literature, as it is associated with worse symptomatology and outcomes. The current study examined cognitive changes in guilt in response to Intensive (3-week) and Standard (17-week) Trauma Management Therapy (TMT), and the potential mechanisms underlying TMT treatment. TMT is an exposure based intervention that does not include an emotional processing component after the imaginal exposure session. A portion of the sample completed measures of guilt. As a result, sample size for these analyses ranged from 39 to 102 and varied by the domain and measure. Of the 102 individuals that completed the PTSD Checklist- Military Version, 42 completed the Trauma Related Guilt Inventory, and 39 completed the Clinician Administered PTSD Scale supplemental guilt items. Participants reported significant reductions in trauma-related guilt symptoms over the course of the TMT interventions. Greater reductions in avoidance and prior session general arousal predicted the reduction of guilt symptoms. Exposure therapy may be effective in reducing trauma-related guilt even in the absence of the emotional processing component of treatment.
Using Prolonged Exposure and Cognitive Processing Therapy to Treat Veterans With Moral Injury-Based PTSD: Two Case Examples

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Moral injury refers to acts of commission or omission that violate individuals’ moral or ethical standards. Morally injurious events are often synonymous with psychological trauma, especially in combat situations—thus, morally injurious events are often implicated in the development of posttraumatic stress disorder (PTSD) for military service members and veterans. Although prolonged exposure (PE) and cognitive processing therapy (CPT) have been well established as effective treatments for veterans who are struggling with PTSD, it has been suggested that these two evidence-based therapies may not be sufficient for treating veterans whose PTSD resulted from morally injurious events. The purpose of this paper is to detail how the underlying theories of PE and CPT can account for moral injury-based PTSD and to describe two case examples of veterans with PTSD stemming from morally injurious events who were successfully treated with PE and CPT. The paper concludes with a summary of challenges that clinicians may face when treating veterans with PTSD resulting from moral injury using either PE or CPT.
Resolution of trauma-related guilt following treatment of PTSD in female rape victims: A result of cognitive processing therapy targeting comorbid depression?

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Abstract

Background and methods—Although Resick et al. (2002) [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 posttraumatic stress disorder in female rape victims. J. Consult. Clin. Psychol. 70, 867–879.] reported comparable results for treating rape-related posttraumatic stress disorder (PTSD) using either cognitive-processing therapy (CPT) or prolonged exposure (PE), there was some suggestion that CPT resulted in better outcomes than PE for certain aspects of trauma-related guilt. The present study revisited these findings to examine whether this effect was a function of improvement in a subset of participants with both PTSD and major depressive disorder (MDD).
ADAPTIVE DISCLOSURE

A New Treatment for Military Trauma, Loss, and Moral Injury

Brett T. Litz,
Leslie Lebowitz, Matt J. Gray,
and William P. Nash