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# Professionals' perspectives on relevant approaches to psychological care in moral injury: A qualitative study

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## Abstract

**Objectives**: Despite the increasing consensus that moral injury (MI) is a unique type of psychological stressor, there is an ongoing debate about best practices for psychological care. This qualitative study explored the perceptions of UK and US professionals in the field of MI investigating advances and challenges in treatment or support delivery and issues relating to treatment/support feasibility and acceptability.

**Methods**: 15 professionals were recruited. Semi-structured, telephone/online interviews were carried out, and transcripts were analyzed using thematic analysis.

**Results**: Two interconnected themes emerged: perceived barriers to appropriate care for MI cases and recommendations for providing effective care to MI patients. Professionals highlighted the challenges that occur due to the lack of empirical experience with MI, the negligence of patients' unique individual needs and the inflexibility in existing manualised treatments.

**Conclusions**: These findings illustrate the need to evaluate the effectiveness of current approaches and explore alternative pathways, which will effectively support MI patients in the long-term. Key recommendations include the use of therapeutic techniques which lead to a personalised and flexible support

plan to meet patients' needs, increase self-compassion and encourage patients to reconnect with their social networks. Interdisciplinary collaborations (e.g., religious/spiritual figures), could be a valuable addition following patients' agreement.

**KEYWORDS**
mental health, moral injury, psychological treatments, qualitative methods

## 1 | INTRODUCTION

The term 'moral injury' (MI) was first discussed by the psychiatrist Jonathan Shay in 1994 based on his clinical observations of Vietnam-era US military veterans (Shay, 1994, 2014). MI is defined as the profound psychological distress that may occur following exposure to potentially morally injurious events (PMIEs), which range widely from failing to prevent, perpetrating or bearing witness to acts that ultimately transgress one's deeply held moral beliefs and values (Litz et al., 2009). Other definitions emphasize the disruption in the individual's confidence and sense of identity (Drescher et al., 2011), decreased capacity to trust others (Jinkerson, 2016) or include spiritual symptoms as a core dimension of MI (Carey et al., 2016; Drescher et al., 2011; Frankfurt & Frazier, 2016).

MI is not currently considered a mental disorder, yet it is associated with a number of mental health difficulties, most strongly with post-traumatic stress disorder (PTSD), depression and suicidal ideation (Litz et al., 2009; Williamson et al., 2018; Williamson et al., 2021b). Core features of MI can overlap with common features of PTSD and includes symptoms such as functional impairment, negative changes in cognitions, and rumination (Litz et al., 2009; NICE, 2018; WHO, 2018). However, unlike "classically" traumatic or frightening events as detailed in the DSM-5 criterion A for PTSD (American Psychiatric Association, 2013; Ehlers & Clark, 2000), PMIEs do not necessarily involve a threat to life (Bonson et al., 2023; Jones, 2020). Following exposure to PMIEs, it is possible for individuals to develop MI and not meet criteria for PTSD (Resick et al., 2002). Notably, distress following PMIEs has been found to lead to different symptom profiles than distress from traumatic events that elicit a fear-based reaction (Hall et al., 2022; Smigelsky et al., 2019). More specifically, the effects of MI can include interpersonal difficulties or self-destructive behaviors (Litz et al., 2009; Shay, 2014), functional impairments (Farnsworth et al., 2017), or spiritual/existential conflict (Antal & Winings, 2015). Additional exposure to PMIEs can lead to alterations in cognitions and beliefs about the self and others (e.g., "I am a dreadful person") as well as maladaptive coping responses, such as substance abuse, social withdrawal, or self-destructive behavior (Griffin et al., 2019; Williamson et al., 2020; Williamson et al., 2021a). Research suggests that particular types of PMIEs (e.g., perpetration vs. being betrayed/witnessing betrayal) may provoke distinct responses. For example, perpetration-based PMIEs (i.e., perpetrating an act outside of one's values) have been found to be associated with greater levels of guilt and self-blame compared to life-threat traumas (Resick et al., 2016), whereas anger is a particularly pernicious symptom that can be experienced especially in cases of betrayal-based PMIEs (Litz et al., 2009). Moreover, recent evidence suggests MI can also follow "mixed" events that combine ethically challenging and more traditional, "threatening" traumatic events (Williamson et al., 2021b; Williamson, Murphy & Stevelink et al., 2020). "Mixed" events involve threatened or actual death, serious injury or sexual assault, which are otherwise consistent with the revised PTSD symptoms cluster in DSM-5 (Jones, 2020). In cases where MI and PTSD are combined, then greater PTSD, depression symptom severity and suicidal intent have been reported (Bryan et al., 2018; Koenig et al., 2018).

The concept of MI and its impact on wellbeing, was initially developed and studied in the context of combat with (ex-) military populations (Bryan et al., 2016; Currier et al., 2015; Williamson et al., 2019; Williamson, Murphy, Stevelink, et al., 2020). Although the experience and impact of exposure to PMIEs on civilians remains less clear,

recent evidence indicates that MI is not limited by context or profession. In particular, a wide range of civilian occupational groups, such as healthcare workers (Billings et al., 2021; Lamb et al., 2021; Stovall et al., 2020; Williamson, Murphy, Greenberg, 2020), law enforcement professionals (Blumberg et al., 2020; Lentz et al., 2021; Papazoglou & Chopko, 2017; Papazoglou et al., 2020), essential workers employed in a range of sectors (e.g., transportation, energy, manufacturing, and food) (Gaitens et al., 2021), firefighters (Lentz et al., 2021) and journalists (Feinstein et al., 2018) may also be at risk of exposure to PMIEs and MI. Recent evidence also suggests MI can be experienced outside of an occupational context, and in particular by refugees whose mental health and quality of life have been significantly affected by transgressive acts (Nickerson et al., 2015).

Despite the increasing consensus that MI is a unique type of psychological stressor, there is an ongoing debate about best practices for treatment (Griffin et al., 2019). Although, it is argued that evidence-based PTSD treatments could be sufficient (Held et al., 2018), some disagree (Litz et al., 2016; Phelps et al., 2022). For example, previous research suggested that prolonged exposure (PE) could potentially be harmful in cases of MI and exacerbate patient reactions of shame, disgust and guilt (Maguen & Burkman, 2013), however, in a recent systematic review cognitive-based treatments were found to effectively reduce symptoms of guilt and anger, while exposure-based treatments appeared effective for symptoms of guilt, shame and anger (Serfioti et al., 2022). Nonetheless, for example, in the United Kingdom (UK), clinicians have reported using a combination of several validated treatment approaches, such as compassion-focused therapy, elements of schema therapy or trauma-focused cognitive behavioral therapy, to treat patients with MI (Williamson et al., 2019; Williamson, Greenberg, Murphy, 2020; Williamson et al., 2021a). New PMIE-focused therapies include Adaptive Disclosure (AD) and Impact of Killing (IOK). AD is one of the treatments that has been developed with the military culture in mind to flexibly treat varied principal harms, including traumatic loss and MI (Gray et al., 2021). Evidence indicates that AD (Litz et al., 2017) may be effective for those who suffer from MI-related difficulties, but this treatment was developed for, and currently has only been delivered to small numbers of US military populations (Gray et al., 2012). IOK treatment is also considered a unique approach to address MI resulting from killing in war (Burkman et al., 2021). Although studies targeted US combat ex-military populations, results suggest that IOK can be beneficial by helping ex-military personnel to acknowledge their distress, shame or grief and increase the sense of acceptance, reconciliation, and forgiveness (Maguen et al., 2017; Purcell et al., 2018). In particular, IOK was valued for its focus on MI and its attention to the spiritual dimensions (Purcell et al., 2018).

With MI being considered by some as more closely related to an existential wound (Atuel et al., 2021) it has been argued that clinicians may not be able to adequately address MI while chaplains/clergy may be ideally positioned to address it (Antal & Winings, 2015). The need for a holistic and a multidisciplinary definition and treatment approach, which includes social, spiritual and religious interventions (Forbes et al., 2015; Jones et al., 2022; Nieuwsma et al., 2021) and encourages the combination of science and faith/spirituality (Carey & Hodgson, 2018b; Fritts, 2013) has been highlighted. It has been suggested that religious figures could be more suitable for helping individuals to explore their existential beliefs, sense of purpose and meaning in life post-PMIE (Hodgson & Carey, 2017). Recent studies (Ames et al., 2021; Pyne et al., 2021) which explored the benefits of chaplain-delivered interventions to (ex-) military personnel (e.g., *Structured Chaplain Intervention*, *Mental Health Clinician Community Chaplain Collaboration*), focused on forgiveness of a higher power, of others and of self and the processing of the trauma using a spiritual lens aiming to increase community reintegration (e.g., community connection/service) to make amends. Although, these interventions were perceived as beneficial, there was little evidence of significant symptom improvement for the sample.

Research on how clinicians treat MI-related mental health problems has often been focused on clinicians who provide psychological treatment to (ex-) military populations, and thus the impact of exposure to PMIEs on civilians, including certain occupational groups and other vulnerable populations, along with potential barriers to effective care remain less clear. In addition, the support and psychological care offered to patients is not solely delivered by clinicians and the role of other professionals, such as chaplains (Carey & Hodgson, 2018a), warrants further investigation. The investigation of different perspectives of a wide range of professionals could lead to a more

holistic understanding of MI and effective ways of offering psychological treatment or support. This could inform potential improvements to the provision of psychological care and ensure that appropriate and flexible treatment and support are available to patients with MI-related psychological problems, including (ex-) military and civilian populations. This qualitative study therefore aimed to explore the perceptions of professionals working in the field of MI, investigate perceived advances in management of MI, the MI-related symptoms which can be targeted therapeutically, the challenges in care delivery, and issues relating to MI care feasibility and acceptability.

## 2 | METHODS

### 2.1 | Study design

This was a qualitative study using in-depth, semistructured interviews. The qualitative approach utilized allowed for the exploration of professionals' experiences and perceptions of MI and treatments associated with it. The study was nested within a larger program of research aiming to develop, design and evaluate the feasibility of a module for treatment of MI-related mental health problems in UK AF veterans (Williamson et al., 2022).

### 2.2 | Participants

In total, 15 interviews were conducted with UK and US professionals working in the field of MI (Table 1). To participate in the interviews, participants had to be professionals who had experience of either providing clinical

**TABLE 1** Participants' demographic information.

| Participants | Country | Gender | Profession | Veteran/Civilian patients | Years of experience |
|---|---|---|---|---|---|
| P1 | US | M | Clinical Psychologist | Veterans | 30 |
| P2 | UK | M | Army Chaplain | Veterans | 25 |
| P3 | UK | M | Psychiatrist | Civilians | 30 |
| P4 | US | M | Clinical Psychologist/ Researcher | Veterans | 37 |
| P5 | US | M | Clinical Psychologist | Veteran/Civilian | 25 |
| P6 | US | M | Clinical Psychologist | Veterans | 20 |
| P7 | US | M | Psychiatrist/Researcher | Veterans | 20 |
| P8 | US | M | Psychiatrist | Veterans | 43 |
| P9 | UK | M | Psychiatrist | Veterans | 31 |
| P10 | UK | M | Clinical Psychologist | Veteran/Civilian | 25 |
| P11 | UK | M | Chaplain | Veterans | 15 |
| P12 | US | M | Clinical Psychologist | Veterans | 15 |
| P13 | US | M | Clinical Psychologist | Veterans | 30 |
| P14 | US | F | Clinical Psychologist | Veterans | 20 |
| P15 | UK | F | Clinical Psychologist | Veterans/Civilians | 25 |

Abbreviations: M, Male; F, Female.

treatment, other forms of support (e.g., chaplaincy support), or have experience of carrying out evidence-based MI research to provide insight into the latest developments in MI. Participants had to be aged 18 years or above, English speaking and willing to provide informed consent. There were no limitations on eligibility according to demographic characteristics (e.g., gender, age, and geographic location) or professional grade, rank or qualification.

## 2.3 | Qualitative interview schedule

The interview schedule was developed based on the research questions, the relevant academic literature relating to MI (e.g., Griffin et al., 2019; Williamson et al., 2019; Williamson et al., 2021a) and the experiential knowledge of the research team. The semi-structured interview questions focused on participants' experiences of working with individuals who have experienced MI. In particular, topics included their experience of supporting individuals with MI, the core psychosocial difficulties experienced by individuals with MI, the approaches they used to support individuals with MI, whether existing approaches are feasible to deliver and well tolerated, perceived advancements in MI care, perceptions of existing barriers to care.

## 2.4 | Procedure

A snowball sampling methodology was employed. Professionals were recruited via circulation of study advertisements via mailing lists, on social media, within organizations that provide mental health treatment/psychological care to military/exmilitary populations, and in veteran-affiliated newsletters. Participating professionals were also be asked to share the study with potentially eligible colleagues.

Interviews were conducted by a researcher who had training and experience in qualitative methods (VW). All interviews were carried out by telephone or online via Microsoft Teams. All participants gave audio-recorded verbal informed consent for their participation. Before the interview, basic demographic information was collected from each participant. Interviews lasted for 56.3 min on average (22.5–79.2 range). All interviews were audio-recorded and transcribed verbatim with personally identifying information removed.

## 2.5 | Data analysis

Data were analyzed using thematic analysis (Braun & Clarke, 2006). Thematic analysis was utilized as it is an analytical strategy used to identify patterns of meaning across a data set as a whole, in line with the study's aims of exploring professionals' perceptions regarding the presentations of MI, current care approaches and potential barriers to care. Data collection and analysis took place simultaneously to allow emerging topics of interest to be explored further in later interviews and to determine whether thematic saturation had been reached (Hennink et al., 2017). For clarity, we refer to all individuals who participating professionals described treating or supporting as "patients."

The following steps were utilized as described by Braun and Clarke (2006): reading and rereading the interview transcripts, producing codes, searching for and developing early themes, and revising and classifying themes. NVivo V.12 software was used to facilitate analysis (QSR International, 2021). An inductive analytical approach was used, with initial codes and themes proposed by DS. To ensure rigour, the coding frame was scrutinized by VW, with any disagreements resolved by a thorough re-examination of the data. A reflexive journal was kept throughout data collection (VW) and analysis (DS) in an effort to recognize the potential influence of the researchers' prior experiences and assumptions and prevent premature and/or biased interpretations of the data (Morse, 2015).

Peer debriefing was conducted and feedback regarding data interpretation and analysis was regularly sought from coauthors N. G. and D. M.

## 3 | RESULTS

As shown in Table 2, two overarching themes and seven subthemes emerged from the data, reflecting professionals' perceptions and experiences of providing care to (ex-) serving military and civilian patients following exposure to PMIEs. Anonymous participant comments are provided to illustrate our findings and all participants have been assigned a pseudonym.

### 3.1 | Perceived barriers to effective care for MI cases

#### 3.1.1 | Lack of diagnostic and clinical certainty

The lack of consensus regarding the definition of MI and the similarities observed in symptoms following a fear-based event and a PMIE (e.g., omission, commission, and betrayal) were considered a major challenge to identify, disentangle and treat patients. It was noted by many professionals that due to the clear and structured process of identification and treatment of PTSD, the concept of MI can be neglected in clinical treatment. Notably, clinicians argued that identifying MI-related psychological problems can be a complicated process for those who are not familiar with MI and are thus less experienced in asking effective questions, identifying and working with such complicated and potentially indistinct set of symptoms.

> *Clinicians are focusing on PTSD, that's the big one. They are focusing on a lot of times the consequences of MI, one of which is PTSD but also they're focusing on depression and suicide, and these are big things that clinicians have to address. The MI part, that's kind of optional, so they don't ask about it, they don't treat, they don't make attempts really to not knowing that it maybe driving these comorbid symptoms including substance abuse, relationship problems, unemployment…*—PM7 (Psychiatrist, male, US)

**TABLE 2** Themes and subthemes following thematic analysis.

| Themes and subthemes |
|---|
| Perceived barriers to effective care for MI cases |
| Lack of diagnostic and clinical certainty |
| Existing materials and approaches: Lack of flexibility to target the complexities of MI |
| Recommendations for providing effective care to MI patients |
| An in-depth understanding of the patient |
| The importance of being non-judgmental when offering psychological care |
| The need for flexibility in psychological care for MI |
| Reconnection |
| (i) Fostering self-compassion in psychological care |
| (ii) Reconnection with social networks |
| The role of nonclinicians in psychological care for MI |

### 3.1.2 | Existing materials and approaches: Lack of flexibility to target the complexities of MI

Clinicians reported that patients often struggled to define or express their distress following PMIEs. This was thought to be potentially due to a lack of vocabulary or difficulties in making sense of a situation and expressing it in words, which in some cases was a result of a poorer educational background or lower literacy level. In many cases, clinicians described that existing psychoeducation materials (e.g., therapy handouts) are written for targeting fear-based symptoms and are not tailored to include a wide range of symptoms related to MI (e.g., guilt and shame). This can result in missed opportunities for patients to make disclosures, and for clinicians to explore in-depth the patient's understanding and interpretation of the events. This lack of a flexible and patient-centered approach was reported to be a challenge in the development of an effective MI care plan.

> *Probably the emotion that people hide the most and is least easily disclosed is shame and so you need to have your clinical chops about you to be looking out for that. People don't just say, 'oh I'm ashamed' […] psychoeducation stuff around PTSD should include some information on shame. Even if people aren't disclosing there's a route in and one of the things that typically I would do is give people physical written information, and then ask them to highlight which are the bits that are most relevant for them…*—P10 (Clinical Psychologist, male, UK)

Professionals who work with (ex-) military personnel or civilian patients (that have been tortured, trafficked or abused in a domestic setting), argued that religion or spirituality in general could help to disentangle underlying MI causes. These professionals highlighted that central to MI is ethical or moral beliefs which stem from one's cultural or religious experiences. Nevertheless, they described that patients' belief systems are not often explored in clinical settings, due to the lack of clinician awareness and inadequate training on how to broach such topics. Clinicians highlighted that not prioritizing patients' worldviews, culture, and self-perception could hinder the development of a thorough and effective clinical treatment or care plan.

> *…Most of our clinicians seem to be antireligion; not just not religious but against religion. A lot of them are uncomfortable… I say this is why you need to understand all religions, you are going to have Jewish clients, Christian clients, Hindu clients, you'll have atheists. You need to understand where they are all coming from so as a clinician you can help them the best, particularly the MI area where it's all about ethics and right and wrong…*—P1 (Clinical Psychologist, male, US)

Existing evidence-based treatments for PTSD (e.g., PE or Cognitive Processing Therapy) were often considered by professionals as unable to effectively target the range of distress that patients with MI presented with, leading to poorer patient outcomes. More specifically, profound moral suffering was perceived to increase the complexity of a patient's case and contribute towards a disordered relationship with the self, others and the world. For example, although intense emotions, such as shame, guilt, worthlessness, or anger were thought to be common responses after fear-based traumatic events, in cases of PMIEs, professionals argued that such emotions are based on moral judgment and triggered by the violation of one's moral beliefs and ethical standards. Professionals reported that the lack of flexibility or clinician ability to effectively adjust standard psychological treatments to the unique patients' needs could be a key barrier to recovery for cases of MI.

> *…There are a lot of therapists who are treating this in a more scientific tradition, and they're not freed up and authentic to be compassionate and to be caring… The work is only going to be effective if you start to really get somebody and care for them…*—P4 (Clinical Psychologist, male, US)

## 3.2 | Recommendations for providing effective care to MI patients

### 3.2.1 | An in-depth understanding of the patient

With these hurdles in identifying and treating MI in mind, it was argued that to identify and effectively work with MI-related psychological problems, a personalised and holistic approach needed to be followed. Professionals, who worked with diverse populations (e.g., refugees, (ex-) military personnel, victims of human trafficking/abuse) stated that more time needed to be allocated at the beginning of the treatment/support process to develop a personalized care plan and gain a deeper understanding of the patient's personal meanings, belief systems (including spirituality and culture), past experiences, trauma history and current life situation (e.g., relationships, employment). This, in turn, could facilitate rapport building and ensure the use of the most appropriate therapeutic techniques. It was reported that by allocating more time, patients may also have the opportunity to feel more comfortable with the professional, which could reduce unhelpful beliefs regarding treatment/psychological care (e.g., the fear of being judged, concerns about confidentiality) and facilitate the disclosure of profound moral suffering.

> *…With MI you have to tailor so much more… with PTSD, we think we'll go in and give them this evidence-based psychotherapy and you tailor it to some extent but in many ways you are sticking to the core and that's just not the case with MI […] I think you have to set the stage, there is a lot of secrecy and shame and withdrawal, it has to be a process where they feel comfortable and they're asked the right questions and they feel comfortable answering.*—P14 (Clinical Psychologist, female, US)

> *…I'd start at the very human level, 'tell me what's going on, what you are thinking or feeling about what's going on … just throw it out there'. From there, in that hopefully intimate safe space, we can start to unpack and put together, repack, shape things and helping people to see for themselves that kind of Rogerian 'it's not for me to tell you what you need to think but let's work through this together until you find something that works for you to put this in its place'…*—P11 (Chaplain, male, UK)

### 3.2.2 | The importance of being non-judgmental when offering psychological care

Employing a non-judgmental approach was considered a key fundamental part of clinical treatment or psychological care when working with MI and in particular in cases of perpetration-based events or PMIEs which could include disclosure of horrific events (e.g., carrying out torture and death). The importance of a nonjudgement approach was acknowledged by both professionals who work with (ex-) military and civilian populations. It was argued that one of the first steps of the care should be to explore the patient's memories and events that occurred before and after the PMIEs to increase the understanding of what happened and help patients to contextualize the PMIEs in a way that would make sense to them. Some examples include having discussions about the uncertainty of specific situations (e.g., combat theaters) and introducing the idea that the PMIE may be something that other people could have also experienced. In addition, during this process of normalization, professionals reported that patients should be encouraged to accept their responsibility for what happened in a constructive way, to help them move forward.

> *…The main way of trying to find out if it's happened is to listen actively and non-judgmentally and to be curious […] Then if you are not shocked by that you may say 'well these are some of the things that I've seen in other people', and if you are non-judgmental, if you make it clear that you are not going to show them out of the room, then they will feel a little bit less unable to tell you…*—P3 (Psychiatrist, male, UK)

*…Once you've contextualized events, actually, there can be a better understanding about how it came to that point that that event occurred. That's not to absolve the person of responsibility they may hold for certain elements of it but that it's happened in a context […] someone has done something bad, and they're worried about it, and they feel guilty about it that's probably a good sign in itself as a starting point. So, normalizing that.*—P10 (Clinical Psychologist, male, UK)

### 3.2.3 | The need for flexibility in psychological care for MI

Professionals perceived therapeutic approaches which included concepts of acceptance, compassion and forgiveness as helpful in promoting patient wellbeing holistically. It was reported that such approaches would allow patients to develop adaptive coping mechanisms and resolve or come to terms with their MI-related symptoms (e.g., guilt or shame). In particular, it was reported that using approaches that are flexible and include a wide range of therapeutic approaches was the best way to introduce and promote such concepts, tailored to patients' values and self-concept. Some examples of treatments that clinician professionals recommended include AD, Compassioned-Focused Therapy (CFT), Acceptance & Commitment Therapy (ACT), IOK or adapted versions of these. Overall, professionals argued that patients often feel like they are carrying a burden following the PMIE, and this feeling was considered by professionals as a barrier for patients to make sense of who they have become and re-build meaningful lives. Accepting what has happened through a compassionate approach was thought by professionals to have the potential to help patients to accept events and forgive themselves or others. This process of forgiveness was reported to have the potential to enhance the healing process leading to long-term results.

*…AD is more multifarious, more personalized, there are a lot of different routes to behavior change in the world and service of healing and repairing and we've incorporated loving kindness mediation as a vehicle to push to the needle on either self-compassion or other compassion or both…*—P4 (Clinical Psychologist, male, US)

*I think the psychotherapeutic notion that comes closest is CFT… it does seem to me to be a way of addressing precisely that notion of feeling worthless and ashamed which among other things makes one more vulnerable to further injury or exploitation.*—P3 (Psychiatrist, male, UK)

The need for alternative resources tailored to the needs of the patients was also highlighted as fundamental part of a personalized MI care. Although many clinician professionals reported that providing tailored psychoeducation materials could facilitate patients to express themselves, chaplain professionals recommended the inclusion of literature, poems, or allegories, which could provide different ways for patients to make sense of the PMIEs and help to normalize their experience and emotions.

*…You are not yourself because of moral injury and there's something inside which is not right. Things that people often say and they can't put their finger on it, can't name it […] we have to give more than a voice, maybe we actually have to give vocabulary. It's very allegorical as well. I think poetry is going to help with this rather than just description and narrative, making some sort of meaning of it will be really helpful…*—P2 (Chaplain, male, UK)

Alternatives in treatment or support delivery was also discussed by professionals. For example, the increased use of delivering therapy online or via telephone due to COVID-19 was thought to be effective when the process included careful organization and clear guidelines. In addition, although individual clinical treatment or psychological care is what professionals usually see in practice for MI-related psychological problems, the potential benefits of a

carefully designed group therapy were also reported. A group setting with like-minded patients who may share a common understanding, similar PMIE experiences or values, such as (ex-) military veterans or victims of human trafficking, was reported to have the potential to facilitate disclosure and reduce feelings of shame. A combination of individual and group work was also recommended.

> *I think that there's a good therapeutic rationale though for doing it as group work. MI can be an extremely isolating experience… one of the things is withdrawing from other people so doing this work in a group… I think it's one of the more restorative experiences and it's one of the challenges with individual psychotherapy…*—P12 (Clinical Psychologist, male, US)

### 3.2.4 | Reconnection

*Treatment approaches to foster self-compassion in psychological care*

Professionals reported that understanding patients' perceptions of spirituality, including religious beliefs, could make clinical treatment or psychological care more beneficial. In a clinical context, ACT and IOK were described by some professionals as some of the treatment approaches which address the concept of spirituality in MI psychological care. However, professionals reported that a meaningful definition for spirituality needs to be agreed with the patient early on in treatment process. Professionals described that a patient's definition of spirituality did not need to necessarily include a specific religion or include a higher power. Patients could also benefit from incorporating a non-religion specific benevolent moral authority or a person the patient trusts, respects and admires (e.g., a family member, a friend, a respected figure). Clinical treatment or psychological care that allowed space and time for the patient to think what this benevolent person would say to them, or what they would advise this person if they were facing similar struggles, was viewed as beneficial by professionals. This type of technique was described as being used in AD and it was thought to help patients become more compassionate and increase acceptance of human pain, emotions and experiences. Although this specific technique may not be useful for all patients, professionals described that similar benefits could be achieved through other alternative techniques including engagements in social activities and amends making, which could be tailored to patients' customs and traditions.

> *…The animistic belief is very widely true across communities particularly in Nigeria, which goes alongside with both their religious beliefs and their extensive Western education… I see in some victims of trafficking that the effect of the witchcraft rituals can be incredibly powerful as a form of control…—P3 (Psychiatrist, male, UK)*

> *Once you have the person describe who this benevolent moral authority figure is and what's so great and wonderful about them then all of a sudden you put them in a position of saying now what would they say back to you… it's harder for them to put those words in that person's mouth. It's easy for them to beat themselves up […] there's other things that can be helpful and that might be more focused on symbolic and actual amend making, to begin to chip away at the rigidity and toxicity of self as evil conceptualisation…*—P5 (Clinical Psychologist, male, US)

*Reconnection with social networks*

Another potential beneficial aspect of a personalized MI psychological care plan was working with patients to target their social functioning to help them move towards the person they want to become. Professionals stated that the aim of this aspect of treatment/care would be to reduce feelings of isolation and encourage patients to accept that

they cannot change the event but must move forward, re-build interpersonal relationships, re-engage effectively in work and conduct everyday activities independently. Professionals reported that patients should be encouraged to make amends, including activities which the patient considers healing and restorative (e.g., writing an apology letter, volunteering, dedicating time to their family). However, this amends making was thought by professionals as something that needed to be carefully managed. They stated that making amends should not be presented in treatment/care as a reminder of the patient's perceived mistakes (which could exacerbate feelings of shame or guilt); but presented rather as a way to restore the disordered relationship with themselves and others in a compassionate and meaningful way.

> *It's really based on how they feel like they can best heal. So again, it's very personalized for each person and so they are able to really focus on what's in their best interests and how we can move forward with that. Then we encourage them to follow through with that plan because for each person again those amends are going to look really different…*—P14 (Clinical Psychologist, female, US)

### 3.2.5 | The role of non-clinicians in psychological care for MI

The impact that MI could have on spirituality was perceived as an important consideration by both clinician and nonclinician professionals. Professionals described that chaplains had the potential to be effective nonjudgmental figures who can listen to a patient's story and potentially make a unique contribution to their recovery. This perception of the potential role of chaplains was largely reported by professionals who work with (ex-) military personnel, as militaries often include chaplains to support personnel. Nonetheless, professionals who work with refugees or victims of torture who are religious also highlighted the importance of involving spiritual figures during clinical treatment/psychological care. Collaborative work between clinicians and chaplains, recognizing that both disciplines can contribute towards a patient's recovery, was acknowledged as having the potential to be very beneficial for patients with religious backgrounds not only during treatment but in the longer-term.

> *…One of the things within our mental health and chaplaincy program that we really try to do is bring to the table approaches that extend beyond what we typically see in evidence-based psychotherapy protocols […] if that chaplain can be a benevolent, accepting, moral authority … just the person of a chaplain being there with an open accepting posture can go a long way towards starting to maybe restore, maybe rebuild in some new kind of way a moral or spiritual foundation for a lot of people*.—P12 (Clinical Psychologist, male, US)

> *Some of these people are able to move on because of the spiritual restructuring that the particular priest in question who is quite experienced in this sort of thing seems to be able to facilitate. You work with what you have and in some of these people their religious belief is one of their remaining strengths and so trying to encourage cultivate that remaining strength…*—P3 (Psychiatrist, male, UK)

## 4 | DISCUSSION

This qualitative study provides insights into what clinical and nonclinical professionals experience when supporting individuals affected by MI. The key themes identified were (i) the perceived barriers to effective care that occur due to the lack of empirical experience with MI, the neglect of patients' unique individual needs and lack of flexibility of existing manualised treatments; and (ii) recommendations for providing effective care to MI patients, emphasizing the need for a highly personalized and flexible approaches that are open to interdisciplinary collaborations.

The current findings are in line with previous research indicating that MI is perceived as a highly complex construct caused by events that transgres an individual's moral code and ethics (Griffin et al., 2019; Williamson et al., 2019; Williamson et al., 2021a). For both clinical and nonclinical professionals, the key to understanding and addressing MI appeared to be targeting each patient's unique appraisal process and interpretations not only of the PMIE but the context in which it occurred, as well as pre- and post-event experiences. This is thought to be what determines whether the PMIE will increase dissonance with the patient's worldview and belief system and lead to MI development (Koenig & Al Zaben, 2021). In particular, our results suggested that patient's understanding and experiences of the PMIE is often only covered at a surface level at the beginning of the care process and was considered by participating professionals as one of the main issues that can later challenge the delivery of effective psychological care.

Currently, a common response to patients' disclosure to trauma is the use of formal questionnaires and further evaluations to screen and determine whether they meet the DSM-5 diagnostic criteria for PTSD, and if they do, they are likely to be referred for an evidence-based, manualized treatment (Kinghorn, 2020). As research into MI has expanded, it is now clearer that MI appears to be a separate and distinct aspect of trauma exposure, although it is frequently associated with PTSD (Barnes et al., 2019). These somewhat rigid processes following patient disclosures of trauma, combined with a lack of experience of some clinicians to identify and treat MI, were considered by participating professionals in the present study as a major barrier to effective care. As both MI and PTSD can stem from similar events (DSM-5 Criterion A for PTSD), both clinical and nonclinical professionals highlighted the need to clearly distinguish between MI and PTSD during clinical treatment/psychological care. A recommendation from professionals was to allocate more time at the beginning of the process to gain an in-depth understanding of the patient, beyond a comprehensive trauma history, consistent with previous studies (Williamson et al., 2021a). This time should include collecting information about patients' developmental experiences, their belief systems, culture, spirituality or religion to shed light on how they interpret the world and understand themselves. Notably, most of these aspects are understudied and poorly understood in the context of MI (Koenig & Al Zaben, 2021). A recent article suggested that one of the limitations in the conceptualization of MI in Western literature is the focus on the individuo-centric perspective in a clinic-based environment which often excludes the social-cultural aspect (Nwoye, 2021). The article discussed MI drawing from an Afri-centric perspective to indicate the lack of emphasis on the problem of violation of Indigenous cultural mores (i.e., offenses/experiences that are perceived to be against the acceptable cultural mores and traditions of the community) in Euro-centric approaches to psychological care.

In addition to culture, spirituality and religion are two aspects that were reported to be often overlooked at the beginning of the care process, leading to a less tailored care plan. Only more recently has spirituality and religion gained more systematic attention in the MI literature (e.g., Griffin et al., 2019; Nwoye, 2021). Although spiritual aspects will not necessarily be crucial for all MI patients, it will be useful for clinicians to bear this in mind with cases of MI so they can adjust the care plan according to patients' beliefs and needs. Research indicates that individuals raised in religious environments may be particularly vulnerable to moral conflicts (Worthington & Langberg, 2012), while moral compromise can create spiritual dissonance in those with or without religious faith by damaging foundational assumptions about self and the world (Wortmann et al., 2017). One recommendation drawn from the present study was to actively encourage interdisciplinary collaborations among clinicians and religious figures who have a good understanding of mental health (e.g., undertaken mental health training). These findings are in line with existing research which recognizes spiritual symptoms as a core dimension of MI (Frankfurt & Frazier, 2016; Hodgson & Carey, 2017), suggesting that religious figures could potentially be ideally positioned to address some of these concerns because of their role and authority with regard to carrying out the “sacrament of reconciliation” (i.e., confession, forgiveness for offenses committed against God) (Ames et al., 2021; Cenkner et al., 2021; Koenig & Al Zaben, 2021). For example, a recent article has discussed the possible value of rituals as a resource for healing and reconnection for US ex-military personnel and their families affected by MI (Ramsay, 2019). It was suggested that rituals, and overall spiritual care, could help MI affected individuals reclaim the transformative power of hope, reduce the isolation of shame and guilt, recognize the need for confession, and strengthen familial and communal

support. Additional research is needed to explore how such collaborative work between clinicians and religious figures should be structured to maximize potential benefits to individuals struggling with MI.

Finally, patients' educational background, was also viewed as an underlying barrier to clinical treatment/psychological care. In general, poorer educational attainment has been found to contribute to higher levels of mental stress later in life (Compton & Shim, 2015; ONS, 2017). There are cases when some patients' find it challenging to understand complex concepts or find the right words to describe their feelings and thoughts during clinical treatment/psychological care. It is the clinicians' responsibility to build a good rapport with patients and ensure they have the necessary tools, such as accessible psychoeducation materials, to help facilitate PMIE disclosure and cocreate a more accurate narrative of their experiences. The importance of psychoeducation in clinical treatment/psychological care is well established (Alizioti & Lyrakos, 2021; Phoenix, 2007) and the present study suggests that tailored MI psychoeducation, especially regarding complex emotions such as guilt and shame, could help facilitate PMIE disclosure and normalize distress. An additional recommendation from participating chaplains was the use of alternative psychoeducation materials (e.g., poems, literature)—which may not be typically drawn on in manualised therapy—to increase the understanding and normalisation of the event(s) and facilitate therapeutic interaction. Further research is needed to better understand how less 'traditional' psychoeducation materials in the form of poems, literature and other sources may contribute towards recovery for those struggling following PMIEs. The benefits of exploring these aspects in depth at the beginning of the process were thought to lead to a beneficial treatment or psychological care "cycle." In many cases PMIEs include "unspeakable" events (e.g., death, suffering, abuse, and torture) in often volatile contexts, such as war, police work, or natural disasters (Griffin et al., 2019). Disclosure of such events can be challenging for patients, who may think that they will be judged or misunderstood by professionals who may lack similar life experiences and occupational backgrounds (NHS, 2016). Results indicated that a less rigid screening assessment process could help professionals gain a holistic understanding of the patient and thus adopt a nonjudgmental approach which is clear to the patient. This, in turn, could enhance rapport building and increase the patient's sense of security.

In line with previous research (Griffin et al., 2019; Koenig & Al Zaben, 2021), MI in this study was considered to have a profound impact on an emotional, mental and social level (e.g., emotional numbing, inability to enjoy life/trust others, self-harm/suicide, demoralization, social isolation). For this reason, professionals highlighted the need for flexible approaches to clinical treatment/psychological care, which do not only target appraisals of the PMIE(s) but also provide guidance and support so that patients' regain confidence and take charge of their lives. The most effective approach to clinical treatment/psychological care for MI remains unclear, mainly because most research is targeting PTSD symptom reduction (Barnes et al., 2019). Results from other studies indicate the need to modify existing manualised treatments or combine alternative therapeutic tools/techniques to better address symptoms of MI. More specifically, recent studies and reviews also suggest that alternative approaches, such as AD, ACT, CFT, pastoral care interventions or spiritual/religious treatments may be beneficial by covering many aspects of patients' lives (Barnes et al., 2019; Koenig & Al Zaben, 2021; Serfioti et al., 2022; Williamson et al., 2021a). Notably, what was believed to be the key for effective clinical treatment or psychological care with long-term benefits in the present study was the effort made by the professional to adjust therapeutic techniques to the patient's unique needs and way of life. This was thought to be achievable through discussion and acknowledgment of the past moral violations, self-acceptance, emotional flexibility, self-forgiveness and making amends. These themes are broadly consistent with the previous literature in regard to secular and non-secular approaches and interventions (Griffin et al., 2019; Purcell et al., 2018).

## 5 | STRENGTHS AND LIMITATIONS

A strength of this study is the diverse nature of the sample, which included clinical and nonclinical professionals who have experience working with a range of (ex-) military personnel and civilian victims of abuse, torture or human trafficking. Additionally, professionals were recruited from a number of UK and US mental health services offering

an opportunity to observe similarities or differences in the perceptions of MI and clinical and chaplain-delivered support approaches. This study adds to the literature by suggesting potential therapeutic aspects that professionals could focus on at the beginning of the treatment/support to help them develop a care plan by incorporating individually specific factors such as spiritual background, culture, community, and educational background. However, as with most studies on MI, the professional participants in the present study were recruited from a Western context, were primarily male, with more experience of working with (ex-) military personnel. A larger-scale investigation, involving non-western countries and diverse civilian samples, would be useful to determine how the perspectives of professionals compare across settings internationally. Further systematic research is also necessary to investigate the potential short- and long-term benefits of pastoral care and the consideration of spirituality/religion and culture in psychological support (e.g., RCTs comparing secular and non-secular care) (Koenig & Al Zaben, 2021; Nwoye, 2021).

## 6 | CONCLUSIONS

This research expands on earlier qualitative studies (Drescher et al., 2011; Williamson et al., 2019; Williamson et al., 2021a) and provides further insight into the experiences of clinical and nonclinical professionals who provide care to MI patients, including civilian and (ex-) military populations. These findings highlight the range of difficulties faced by such professionals including the inflexibility in existing manualised treatments and the limited incorporation of patients' unique individual needs. Recommendations on the development of clear guidance on best practice for treating MI include: incorporating additional time to develop an in-depth understanding of the patients' personal, cultural and spiritual background and current needs, the importance of taking a nonjudgmental approach, and encouraging the patients to foster self-compassion and (re)connect with social networks. Finally, spirituality and religion are two aspects that could be explored, ideally early in the care process, which could lead to a more tailored approach that includes interdisciplinary collaborations between clinicians and trained religious or spiritual figures.

### AUTHOR CONTRIBUTIONS

*Conceptualization*: Victoria Williamson, Dominic Murphy, and Neil Greenberg. *Data curation*: Victoria Williamson, Danai Serfioti, Dominic Murphy, and Neil Greenberg. *Formal analysis*: Danai Serfioti, Victoria Williamson. Funding acquisition: Victoria Williamson, Dominic Murphy, and Neil Greenberg. *Methodology*: Victoria Williamson, Dominic Murphy, and Neil Greenberg. *Project administration*: Victoria Williamson, Dominic Murphy, and Neil Greenberg. *Resources*: Victoria Williamson, and Danai Serfioti. *Supervision*: Victoria Williamson, Dominic Murphy, and Neil Greenberg. *Validation*: Victoria Williamson, Danai Serfioti, Dominic Murphy, and Neil Greenberg. *Writing*: Danai Serfioti. *Writing*: Danai Serfioti, Victoria Williamson, Dominic Murphy, and Neil Greenberg.

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## DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author (V. W.), upon reasonable request. The data are not publicly available due to privacy and ethical restrictions (i.e., containing information that could compromise the privacy of research participants).

## ETHICS STATEMENT

This study was approved by King's College London Research Ethics Committee HR-20/21-20850

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## PEER REVIEW

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## REFERENCES

Alizioti, A. & Lyrakos, G. (2021). Measuring the effectiveness of psychoeducation on adherence, depression, anxiety and stress among patients with diagnosis of schizophrenia. a control trial. *Current Psychology*, *40*(8), 3639–3650. https://doi.org/10.1007/s12144-019-00255-4

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5 ed.). American Psychiatric Association.

Ames, D., Erickson, Z., Geise, C., Tiwari, S., Sakhno, S., Sones, A. C., Tyrrell, C. G., Mackay, C. R. B., Steele, C. W., Van Hoof, T., Weinreich, H., & Koenig, H. G. (2021). Treatment of moral injury in US veterans with PTSD using a structured chaplain intervention. *Journal of Religion and Health*, *60*(5), 3052–3060.

Antal, C. J. & Winings, K. (2015). Moral injury, soul repair, and creating a place for grace. *Religious Education*, *110*(4), 382–394. https://doi.org/10.1080/00344087.2015.1063962

Atuel, H. R., Barr, N., Jones, E., Greenberg, N., Williamson, V., Schumacher, M. R., Vermetten, E., Jetly, R., & Castro, C. A. (2021). Understanding moral injury from a character domain perspective. *Journal of Theoretical and Philosophical Psychology*, *41*, 155–173.

Barnes, H. A., Hurley, R. A., & Taber, K. H. (2019). Moral injury and PTSD: Often co-occurring yet mechanistically different. *The Journal of Neuropsychiatry and Clinical Neurosciences*, *31*(2), A4–103.

Billings, J., Biggs, C., Ching, B. C. F., Gkofa, V., Singleton, D., Bloomfield, M., & Greene, T. (2021). Experiences of mental health professionals supporting front-line health and social care workers during COVID-19: Qualitative study. *BJPsych Open*, *7*(2), e70. https://doi.org/10.1192/bjo.2021.29

Blumberg, D. M., Papazoglou, K., & Schlosser, M. D. (2020). Organizational solutions to the moral risks of policing. *International Journal of Environmental Research and Public Health*, *17*(20), 7461.

Bonson, A., Murphy, D., Aldridge, V., Greenberg, N., & Williamson, V. (2023). Conceptualization of moral injury: A socio-cognitive perspective. *Journal of Military, Veteran and Family Health*, *9*(2), 75–81.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Bryan, C. J., Bryan, A. O., Anestis, M. D., Anestis, J. C., Green, B. A., Etienne, N., Morrow, C. E., & Ray-Sannerud, B. (2016). Measuring moral injury: Psychometric properties of the moral injury events scale in two military samples. *Assessment*, *23*(5), 557–570. https://doi.org/10.1177/1073191115590855

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

Burkman, K., Maguen, S., & Purcell, N. (2021). Impact of killing: A treatment program for military veterans with moral injury. In *Addressing moral injury in clinical practice* (pp. 203–221). American Psychological Association.

Carey, L. B., & Hodgson, T. J. (2018a). Chaplaincy, spiritual care and moral injury: Considerations regarding screening and treatment. *Frontiers in Psychiatry*, *9*, 619. https://doi.org/10.3389/fpsyt.2018.00619

Carey, L. B., & Hodgson, T. J. (2018b). Chaplaincy, spiritual care and moral injury: Considerations regarding screening and treatment. *Frontiers in Psychiatry*, *9*, 619. https://doi.org/10.3389/fpsyt.2018.00619

Carey, L. B., Hodgson, T. J., Krikheli, L., Soh, R. Y., Armour, A.-R., Singh, T. K., & Impiombato, C. G. (2016). Moral injury, spiritual care and the role of chaplains: An exploratory scoping review of literature and resources. *Journal of Religion and Health*, *55*(4), 1218–1245.

Cenkner, D. P., Yeomans, P. D., Antal, C. J., & Scott, J. C. (2021). A pilot study of a moral injury group intervention co-facilitated by a chaplain and psychologist. *Journal of Traumatic Stress*, *34*(2), 367–374.

Compton, M. T. & Shim, R. S. (2015). The social determinants of mental health. *Focus*, *13*(4), 419–425.

Currier, J. M., Holland, J. M., & Malott, J. (2015). 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

Drescher, K. D., Foy, D. W., Kelly, C., Leshner, A., Schutz, K., & Litz, B. (2011). An exploration of the viability and usefulness of the construct of moral injury in war veterans. *Traumatology*, *17*(1), 8–13.

Ehlers, A. & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, *38*(4), 319–345. https://doi.org/10.1016/s0005-7967(99)00123-0

Farnsworth, J. K., Drescher, K. D., Evans, W., & Walser, R. D. (2017). A functional approach to understanding and treating military-related moral injury. *Journal of Contextual Behavioral Science*, *6*(4), 391–397. https://doi.org/10.1016/j.jcbs.2017.07.003

Feinstein, A., Pavisian, B., & Storm, H. (2018). Journalists covering the refugee and migration crisis are affected by moral injury not PTSD. *JRSM Open*, *9*(3), 205427041875901.

Forbes, D., Kartal, D., Lau, W., Phelps, A., & O'Donnell, M. (2015). What are effective interventions for veterans who have experienced moral injury. *A rapid evidence assessment. Report Prepared for the Australian Government Department of Veterans' Affairs. Carlton, Melbourne: Phoenix Australia-Centre for Posttraumatic Mental Health*. https://www.dva.gov.au/sites/default/files/files/publications/research-and-studies/question_9_moral_injury_technical_report_november_2016.pdf

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

Fritts, P. D. (2013). Adaptive disclosure: Critique of a descriptive intervention modified for the normative problem of moral injury in combat veterans. *ProQuest Dissertations & Theses Global database*.

Gaitens, J., Condon, M., Fernandes, E., & McDiarmid, M. (2021). COVID-19 and essential workers: A narrative review of health outcomes and moral injury. *International Journal of Environmental Research and Public Health*, *18*(4), 1446. https://doi.org/10.3390/ijerph18041446

Gray, M. J., Binion, K., Amaya, S., & Litz, B. T. (2021). Adaptive disclosure: A novel evidence-based treatment for moral injury. In *Addressing moral injury in clinical practice* (pp. 183–201). American Psychological Association.

Gray, M. J., Schorr, Y., Nash, W., Lebowitz, L., Amidon, A., Lansing, A., Maglione, M., Lang, A. J., & 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/10.1016/j.beth.2011.09.001

Griffin, B. J., Purcell, N., Burkman, K., Litz, B. T., Bryan, C. J., Schmitz, M., Villierme, C., Walsh, J., & Maguen, S. (2019). Moral injury: An integrative review. *Journal of Traumatic Stress*, *32*(3), 350–362.

Hall, N. A., Everson, A. T., Billingsley, M. R., & Miller, M. B. (2022). Moral injury, mental health and behavioural health outcomes: A systematic review of the literature. *Clinical Psychology & Psychotherapy*, *29*(1), 92–110.

Held, P., Klassen, B. J., Brennan, M. B., & Zalta, A. K. (2018). Using prolonged exposure and cognitive processing therapy to treat veterans with moral Injury-Based PTSD: Two case examples. *Cognitive and Behavioral Practice*, *25*(3), 377–390. https://doi.org/10.1016/j.cbpra.2017.09.003

Hennink, M. M., Kaiser, B. N., & Marconi, V. C. (2017). Code saturation versus meaning saturation: How many interviews are enough? *Qualitative Health Research*, *27*(4), 591–608.

Hodgson, T. J., & Carey, L. B. (2017). Moral injury and definitional clarity: Betrayal, spirituality and the role of chaplains. *Journal of Religion and Health*, *56*(4), 1212–1228. https://www.jstor.org/stable/26749116

Jinkerson, J. D. (2016). Defining and assessing moral injury: A syndrome perspective. *Traumatology*, *22*(2), 122–130. https://doi.org/10.1037/trm0000069

Jones, E. (2020). Moral injury in a context of trauma. *The British Journal of Psychiatry*, *216*(3), 127–128. https://doi.org/10.1192/bjp.2020.46

Jones, K. A., Freijah, I., Carey, L., Carleton, R. N., Devenish-Meares, P., Dell, L., Rodrigues, S., Madden, K., Johnson, L., Hosseiny, F., & Phelps, A. J. (2022). Moral injury, chaplaincy and mental health provider approaches to treatment: A scoping review. *Journal of Religion and Health*, *61*(2), 1051–1094.

Kinghorn, W. (2020). Challenging the hegemony of the symptom: Reclaiming context in PTSD and moral injury. *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine*, *45*(6), 644–662. https://doi.org/10.1093/jmp/jhaa023

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

Koenig, H. G., Ames, D., Youssef, N. A., Oliver, J. P., Volk, F., Teng, E. J., Haynes, K., Erickson, Z. D., Arnold, I., O'Garo, K., & Pearce, M. (2018). Screening for moral injury: The moral injury symptom scale - military version short form. *Military Medicine*, *183*(11–12), e659–e665.

Lamb, D., Gnanapragasam, S., Greenberg, N., Bhundia, R., Carr, E., Hotopf, M., & Docherty, M. (2021). The psychosocial impact of COVID-19 pandemic on 4,378 UK healthcare workers and ancillary staff: Initial baseline data from a cohort study collected during the first wave of the pandemic. *medRxiv Preprint Server*, *78*(11), 801–8.

Lentz, L. M., Smith-MacDonald, L., Malloy, D., Carleton, R. N., & Brémault-Phillips, S. (2021). Compromised conscience: A scoping review of moral injury among firefighters, paramedics, and police officers. *Frontiers in Psychology*, *12*(681), 639781. https://doi.org/10.3389/fpsyg.2021.639781

Litz, B. T., Lebowitz, L., Gray, M. J., & Nash, W. P. (2016). *Adaptive disclosure: A new treatment for military trauma, loss, and moral injury*. Guilford Press.

Litz, B. T., Lebowitz, L., Gray, M. J., & Nash, W. P. (2017). *Adaptive disclosure: A new treatment for military trauma, loss, and moral injury*. Guilford Publications.

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.

Maguen, S. & Burkman, K. (2013). Combat-related killing: Expanding evidence-based treatments for PTSD. *Cognitive and Behavioral Practice*, *20*(4), 476–479.

Maguen, S., Burkman, K., Madden, E., Dinh, J., Bosch, J., Keyser, J., Schmitz, M., & Neylan, T. C. (2017). Impact of killing in war: A randomized, controlled pilot trial. *Journal of Clinical Psychology*, *73*(9), 997–1012. https://doi.org/10.1002/jclp.22471

Morse, J. M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research*, *25*(9), 1212–1222.

NHS. (2016). *Developing mental health services for veterans in England engagement report*. https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/09/veterans-mh-services-engagement-rep.pdf

NICE. (2018). Post-traumatic stress disorder - NICE guidelines. https://www.nice.org.uk/guidance/ng116/chapter/recommendations

Nickerson, A., Schnyder, U., Bryant, R. A., Schick, M., Mueller, J., & Morina, N. (2015). Moral injury in traumatized refugees. *Psychotherapy and Psychosomatics*, *84*(2), 122–123. https://doi.org/10.1159/000369353

Nieuwsma, J., Smigelsky, M. A., Wortmann, J. H., Haynes, K., & Meador, K. G. (2021). *Collaboration with chaplaincy and ministry professionals in addressing moral injury*.

Nwoye, A. (2021). Decolonizing moral injury studies and treatment approaches: An africentric perspective. *Theory & Psychology*, *31*(6), 912–931. https://doi.org/10.1177/09593543211027228

ONS. (2017). *An overview of lifestyles and wider characteristics linked to Healthy Life Expectancy in England: June 2017 (Office for National Statistics)*. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/articles/healthrelatedlifestylesandwidercharacteristicsofpeoplelivinginareaswiththehighestorlowesthealthylife/june2017

Papazoglou, K., Blumberg, D. M., Chiongbian, V. B., Tuttle, B. M., Kamkar, K., Chopko, B., Milliard, B., Aukhojee, P., & Koskelainen, M. (2020). The role of moral injury in PTSD among law enforcement officers: A brief report. *Frontiers in Psychology*, *11*(310), 310. https://doi.org/10.3389/fpsyg.2020.00310

Papazoglou, K., & Chopko, B. (2017). The role of moral suffering (moral distress and moral injury) in police compassion fatigue and PTSD: An unexplored topic. *Frontiers in Psychology*, *8*, 1999.

Phelps, A. J., Adler, A. B., Belanger, S. A. H., Bennett, C., Cramm, H., Dell, L., Fikretoglu, D., Forbes, D., Heber, A., Hosseiny, F., Morganstein, J. C., Murphy, D., Nazarov, A., Pedlar, D., Richardson, J. D., Sadler, N., Williamson, V., Greenberg, N., & Jetly, R. (2022). Addressing moral injury in the military. *BMJ Military Health*, e002128. https://militaryhealth.bmj.com/content/early/2022/06/14/bmjmilitary-2022-002128.abstrac

Phoenix, B. J. (2007). Psychoeducation for survivors of trauma. *Perspectives in Psychiatric Care*, *43*(3), 123–131.

Purcell, N., Burkman, K., Keyser, J., Fucella, P., & Maguen, S. (2018). Healing from moral injury: A qualitative evaluation of the impact of killing treatment for combat veterans. *Journal of Aggression, Maltreatment & Trauma*, *27*(6), 645–673. https://doi.org/10.1080/10926771.2018.1463582

Pyne, J. M., Sullivan, S., Abraham, T. H., Rabalais, A., Jaques, M., & Griffin, B. (2021). Mental health clinician community clergy collaboration to address moral injury symptoms: A feasibility study. *Journal of Religion and Health*, *60*(5), 3034–3051. https://doi.org/10.1007/s10943-021-01257-y

QSR International. (2021). *NVivo V.12*. https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home/

Ramsay, N. J. (2019). Moral injury as loss and grief with attention to ritual resources for care. *Pastoral Psychology*, *68*(1), 107–125. https://doi.org/10.1007/s11089-018-0854-9

Resick, P. A., Monson, C. M., & Chard, K. M. (2016). *Cognitive processing therapy for PTSD: A comprehensive manual*. Guilford Publications.

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. *Journal of Consulting and Clinical Psychology*, *70*(4), 867–879. https://doi.org/10.1037//0022-006x.70.4.867

Serfioti, D., Murphy, D., Greenberg, N., & Williamson, V. (2022). The effectiveness of treatments for symptoms of post–trauma related guilt, shame and anger in military and civilian populations: A systematic review. *BMJ Military Health*, e002155. https://doi.org/10.1136/military-2022-002155

Shay, J. (1994). *Achilles in Vietnam: Combat trauma and th undoing of character*. Simon & Schuster.

Shay, J. (2014). Moral injury. *Psychoanalytic psychology*, *31*(2), 182–191.

Smigelsky, M. A., Malott, J. D., Veazey Morris, K., Berlin, K. S., & Neimeyer, R. A. (2019). Latent profile analysis exploring potential moral injury and posttraumatic stress disorder among military veterans. *Journal of Clinical Psychology*, *75*(3), 499–519.

Stovall, M., Hansen, L., & Ryn, M. (2020). A critical review: Moral injury in nurses in the aftermath of a patient safety incident. *Journal of Nursing Scholarship*, *52*(3), 320–328. https://doi.org/10.1111/jnu.12551

WHO. (2018). *International classification of diseases for mortality and morbidity statistics (11th Revision)*. https://icd.who.int/browse11/l-m/en

Williamson, V., Greenberg, N., & Murphy, D. (2019). Moral injury in UK armed forces veterans: A qualitative study. *European Journal of Psychotraumatology*, *10*(1), 1562842.

Williamson, V., Greenberg, N., & Murphy, D. (2020). Impact of moral injury on the lives of UK military veterans: A pilot study. *BMJ Military Health*, *166*(5), 302–306. https://doi.org/10.1136/jramc-2019-001243

Williamson, V., Murphy, D., Aldridge, V., Bonson, A., Seforti, D., & Greenberg, N. (2022). Development of an intervention for moral injury-related mental health difficulties in UK military veterans: A feasibility pilot study protocol. *European Journal of Psychotraumatology*, *13*(2), 2138059.

Williamson, V., Murphy, D., & Greenberg, N. (2020). COVID-19 and experiences of moral injury in front-line key workers. *Occupational Medicine*, *70*(5), 317–319. https://doi.org/10.1093/occmed/kqaa052

Williamson, V., Murphy, D., Stevelink, S. A. M., Allen, S., Jones, E., & Greenberg, N. (2020). The impact of trauma exposure and moral injury on UK military veterans: A qualitative study. *European Journal of Psychotraumatology*, *11*(1), 1704554.

Williamson, V., Murphy, D., Stevelink, S. A. M., Allen, S., Jones, E., & Greenberg, N. (2021a). Delivering treatment to morally injured UK military personnel and veterans: The clinician experience. *Military Psychology*, *33*(2), 115–123. https://doi.org/10.1080/08995605.2021.1897495

Williamson, V., Murphy, D., Stevelink, S. A. M., Allen, S., Jones, E., & Greenberg, N. (2021b). The impact of moral injury on the wellbeing of UK military veterans. *BMC Psychology*, *9*(1), 73. https://doi.org/10.1186/s40359-021-00578-7

Williamson, V., Stevelink, S. A. M., & Greenberg, N. (2018). Occupational moral injury and mental health: Systematic review and meta-analysis. *The British Journal of Psychiatry*, *212*(6), 339–346.

Worthington, E. L. & Langberg, D. (2012). Religious considerations and self-forgiveness in treating complex trauma and moral injury in present and former soldiers. *Journal of Psychology and Theology*, *40*(4), 274–288.

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

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