An Intercultural Approach to Spiritually Oriented Therapy of Military Moral Injury

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The concept of military moral injury (MMI) emerged from therapy with veterans whose posttraumatic stress included lasting moral conflicts about harm caused by themselves, fellow service members, or those in authority. After defining MMI and spiritually oriented therapies, we describe evidence-based treatment approaches that respect the unique values and beliefs of veterans, and their intrinsically meaningful ways of experiencing goodness and recovery. We highlight the importance of identifying our beliefs and values about suffering arising from trauma, military service, and combat. Body-aware practices that alleviate stress, widely used with clients in many trauma therapies, are also helpful for clinicians. We describe how such practices connect us with hope and help us search for life-giving beliefs about suffering using an intercultural approach that builds trust by listening for and respecting what is unique in the ways persons search for meaning and experience transcendence.

Spiritual care in religiously diverse community, medical, military, educational, and prison contexts needs to be intercultural, evidence based, and grounded in psychological research focused on how aspects of religion and spirituality may help or harm people seeking whole selves. The spiritual struggles of moral injury often shake people to the core of their being, making the need for wholeness more compelling and complex (Kusner & Pargament, 2012). An extensive case study with a Vietnam veteran illustrates the use of spiritually oriented cognitive processing therapy (CPT) and acceptance and commitment therapy (ACT). As clinicians and chaplains step into the story of this veteran, they might consider what spiritual practices help them feel hopeful and grounded. They could contemplate how this particular veteran’s emotional pain prompts them to search for meaning in the face of terrible suffering, while also clarifying the values that ground their vocations of care.

**What Is Military Moral Injury?**

In the 1990s psychiatrist Jonathan Shay (2014) realized that his Vietnam veteran patients diagnosed with posttraumatic stress disorder (PTSD) struggled with what he called *moral injury*—“a betrayal of what’s right by someone who holds legitimate authority (e.g., in the military—a leader) in a high stakes’ situation” (p. 183). Shay used the Greek warriors Achilles and Odysseus in Homer’s ancient Greek epic poems *Iliad* and *Odyssey* to understand how lament over moral culpability in combat is as old as Greek tragedies (Shay, 1992, 2002). Shay initially describes betrayal-based moral distress. Since then, research has expanded to explore differences between betrayal-based and perpetration-based MMI. Feeling responsible for lethal use of force in ambiguous situations is often a liability in “nontraditional forms of combat, such as guerilla war in urban environments” (Litz et al., 2009, p. 696), that require quick decisions about use of lethal force that may generate moral anguish, and “emotional, spiritual, and psychological wounds” (Drescher et al., 2011, p. 8). Military training focuses on the mission of one’s unit, often compelling military personnel to set aside their own needs until trauma and moral injury cause overwhelming stress (Nash, 2019).

Who is responsible for harm—oneself or another—generates different emotional responses (Schorr et al., 2018, p. 2207)? Perpetration-based MMI is associated with (a) guilt, shame, and sadness; (b) reexperiencing symptoms and numbness (Stein et al., 2012); (c) beliefs about being unlovable, unforgivable, or incapable of moral decision-making; and (d) self-sabotaging and acting out behavior. Betrayal-based MMI, which may include witnessing morally distressing events, is associated with anger, outrage, and frustration (Stein et al., 2012), as well as moral disgust, mistrust of others, and revenge fantasies for the responsible person(s) (Currier et al., 2017). For many clients, these moral and psychological dynamics related to MMI arise from spiritual struggles, which we consider below.

**Spiritually Integrated Therapy of MMI**

Psychologist of religion Ken Pargament (2007) elaborated a model of spiritually integrated psychotherapy based on extensive research on how aspects of religion and spirituality may promote spiritual wholeness and/or transitional/chronic brokenness. His model may be integrated into MMI treatment models in two ways. First, therapists need to be familiar with research on spiritual struggles and the role of meaning making and spiritual practices in supporting or undermining health and spiritual wholeness. Second, therapists use an intercultural approach to spirituality and religion that respects the complex, distinctive ways that values, beliefs, coping, and spiritual practices are shaped by interacting cultural systems, especially military training and culture. A central concept in research on psychology of religion, and in Pargament’s approach, is understanding the role of moral orienting systems. An orienting system

consists of habits, values, relationships, belief and personality. . . [and] contains both helpful and unhelpful attributes, resources, and burdens. . . . Spirituality is one aspect of the general orienting system [that] contributes to the individual’s framework for understanding and dealing with the world. (Pargament et al., 2006, p. 130)

The values, beliefs, practices, emotions, and relationships of orienting systems shape how and whether spiritual and moral struggles/injury lead to wholeness or brokenness (Pargament et al., 2016, p. 379).

Orienting systems include both *global* beliefs and values about suffering, hope, and the purpose of one’s life and *situational meanings* about, for example, potential/actual moral stressors like harm caused in combat. Orienting systems are multilayered, with formative values, beliefs, and coping practices from childhood, family, peer, and cultural systems forming a bedrock orienting system that is often reenergized emotionally under acute/traumatic stress (Doehring, 2015a, 2015b), either by emotions like love and compassion that connect people with goodness in their bodies and relational systems or by shame and guilt that make people feel judged (particularly by God) and/or potentially shunned.

Spiritually integrated psychotherapy uses somatic practices like mindfulness meditation not simply as calming practices but also as part of a search for meanings. Intrinsically meaningful practices that help veterans experience goodness will likely reveal new values and beliefs about suffering and hope that can be incorporated into a veteran’s search for meanings. This interrelationship between intrinsically meaningful spiritual practices and searching for meanings is described by Sandage and colleagues (Shults & Sandage, 2006) as an “unfolding through dialectical processes of spiritual dwelling and seeking” (Tomlinson et al., 2016, p. 64).

**Stages of Trauma Treatment**

The case study reviewed in this chapter, naturally aligned with Judith Herman’s three phases of trauma treatment, focuses on the following stages in a sequential order (while also recognizing that individuals do not always move through these stages in a linear fashion): safety and stabilization, mourning and processing, and community reintegration (Herman, 1992). When clinically indicated, I (Barrs) often follow the structure of this sequentially staged treatment model when the client is presenting with a history of repeated interpersonal and/or combat traumas that lead to long-term changes in self-esteem, identity, emotion regulation, distress tolerance, physiological regulation, spirituality, and sense of safety and trust.

Herman’s model indicates that safety and stabilization is the first stage of trauma treatment for those who have experienced complex trauma. This stage of treatment entails treating acute and debilitating symptoms that are interfering with functioning, while also learning stress management, distress tolerance, body regulation, and emotion regulation skills. The client learns about the effects of trauma, how to ask for support, and how to manage and prevent crises. After the individual has developed the skills that will assist them in effectively coping with the next phase of treatment, they move into the remembrance and mourning stage where they process the trauma memories, engage in exposure-based work, and experience the grief and loss associated with what they have survived. In the final stage, reconnection, the individual is learning to live a life where trauma takes up less space, their identity as a survivor versus victim is strengthened, they engage in more meaningful activity, and they practice acceptance. During this phase, the individual works to develop a stronger support system while fostering deeper connection to the community and oftentimes a higher power. Herman’s model seemed to be especially relevant to the case study presented in this chapter and is directly in line with the veteran’s experience, therapeutic goals, and recovery.

It is important to note that some evidence-based trauma treatments tend to naturally align with the stages of Herman’s model. For example, stress inoculation (Meichenbaum, 2019), dialectical behavior therapy (Linehan, 2014), and seeking safety (Najavits, 2002) are often referred to as Stage 1 trauma treatments as they focus on developing a sense of safety, setting healthy boundaries, learning to calm the central nervous system, asking for help, emotion regulation, interpersonal effectiveness, and distress tolerance. The development and bolstering of these skills often assists individuals in moving to the next stage of trauma treatment where they directly address, confront, process, and reframe their trauma memories, thoughts, emotions, and meaning-making narratives. Stage 2 trauma treatments include such treatments as prolonged exposure therapy (Foa et al., 2019), CPT (Resick et al., 2017), and eye-movement desensitization and reprocessing therapy (Shapiro, 2017). In work with the veteran in this chapter’s case study, I (Barrs) used ACT in Stage 3 of trauma treatment, focusing on mindfulness, acceptance, self-forgiveness, identifying values, and engaging in committed action to live in direct accordance with values.

**Treatment Models Used in the Case Study**

*CTP With MMI*

CPT is a manualized, evidence-based treatment for PTSD (Resick et al., 2017; Resick & Schnicke, 1992) often used with military-affiliated populations. Pearce et al. (2018) elaborated on the mechanisms of this form of cognitive-behavioral therapy, stating,

CPT uses cognitive restructuring and behavioral exercises to help individuals change the way they think about the trauma. These cognitive changes allow individuals to better process their emotions, contextualize the event, and integrate the experience in a more positive or adaptive way into their lives. (p. 1)

The identification and challenging of stuckpoints is a primary component of CPT. *Stuckpoints* are defined as automatic thoughts or thinking patterns that interfere with the natural recovery from trauma, leading to symptoms of PTSD and psychological distress (Resick et al., 2017; Resick & Schnicke, 1992). Nieuwsma et al. (2015) elaborated on this concept when they stated, “Beliefs around guilt, shame, responsibility, and culpability are key targets for cognitive processing therapy, as these are the domains in which cognitive errors or beliefs may proliferate” (p. 195).

CPT also uses Socratic dialogue to assist clients in the self-identified realization of certain insight or knowledge through guided but gentle questioning by the therapist (Resick et al., 2017; Rutter & Friedberg, 1999; Rutter et al., 1999). Although the therapist initiates and facilitates the discussion, the conversation is conducted in a balanced and mutual manner where the therapist is not experienced as the expert or the holder of specific knowledge that he or she is imparting to the client. For example, in the case study described below, I (Barrs) gently assist the client in understanding that he killed in combat due to a wide variety of reasons, including sleep deprivation, fatigue, grief/loss, trauma, and disillusionment with the government. I did so by asking him clarifying questions regarding his mental and physical state at the time of combat, the types of experiences he had in Vietnam, and his experience of the U.S. government as having abandoned him and his comrades.

An additional and optional component of CPT includes the writing and reading of the impact trauma or the traumatic event that is leading to the most amount of distress, difficulty functioning, and/or suffering. The CPT-plus account intervention (CPT+A) was used in the case study that is presented in this chapter. Through the writing of the trauma account, clients recall all memories, emotions, thoughts, bodily sensations, and sensory details (sights, sounds, smells, and physical sensations), along with a chronological account of the actual details and content of the traumatic event. They then read it daily in between sessions and also read it out loud to the therapist in session several times. The CPT theory behind this intervention is that by reading the impact trauma account, individuals feel the natural emotions associated with the event, the distressing emotions will decrease over time, and they will be able to move forward. When describing this intervention, the authors of the CPT manual state, “As emotions decrease, individuals become more receptive to other points of view and acceptance of the traumatic event” (Resick et al., 2017, p. 88).

Although some researchers have supported the use of spiritually integrated CPT with MMI (Pearce et al., 2018), others have indicated that this evidence-based therapy can only go so far in terms of causing lasting change and decrease in MMI-related symptoms (Farnsworth, 2019; Gray et al., 2012). One criticism of the use of CPT with MMI suggests that this particular treatment model focuses on decreasing generalized fear and uses a learning model that does not adequately or thoroughly treat the moral and spiritual injuries that occur in the context of war (Gray et al., 2012; Maguen et al., 2010; Nash, 2007).

*ACT With MMI*

In the presented case study, I (Barrs) used both CPT and ACT to address several types of symptoms, facets of moral distress, and phases of trauma treatment. The use of ACT, which is a type of psychotherapy grounded in behaviorism theory (Hayes et al., 1999, 2012), seems to be particularly useful when treating spiritually or religiously related psychological or emotional struggles, such as moral injury (Santiago & Gall, 2016). ACT has also been shown to be an effective treatment for PTSD as it focuses on decreasing experiential avoidance, living according to values, acceptance, and mindfulness (Walser & Westrup, 2007). Although literature regarding the use of ACT is relatively new, there seems to be growing consensus in the field that this evidence-based therapy is well suited to the treatment of MMI (Farnsworth, 2019; Nieuwsma et al., 2015). Santiago and Gall (2016) state,

ACT is a value-driven therapy that involves facilitating transcendence of physical, mental, and emotional experience to alleviate human suffering; as such, ACT shares common ground with the domain of spirituality. Approached as a spiritually integrated therapy, ACT can help clients to access spiritual resources and create life meaning as well as aid in the resolution or transformation of spiritual struggles. (p. 239)

Symptom reduction and the challenging and restructuring of thoughts are not the primary therapeutic outcomes on which the ACT therapist focuses. Instead, ACT interventions target the increase of psychological flexibility, identification of values, decrease of avoidance-based behaviors, and engagement in values-based living. ACT also focuses on present-centered living and incorporates the use of mindfulness and acceptance into the treatment of a variety of types of psychological and medical ailments (Hayes et al., 2012). A key tenet of ACT suggests that the struggle to control and avoid inner experiences (i.e., experiential avoidance), such as those associated with trauma and moral injury, further perpetuates and sustains such symptoms (Walser & Westrup, 2007). Nieuwsma et al. (2015) commented:

Positive change is not measured by feeling better but by engagement in personal values and a renewed sense of vitality, by being able to flexibly respond to the current environment in a healthy way. This change goes hand-in-hand with a willingness to experience emotions and thoughts, including sadness, guilt, shame, and other apparently life limited events, as well as life-enhancing internal events such as joy and love. (p. 195)

ACT explores clients’ values as a motivation for change. This orientation to values makes ACT compatible with spiritually oriented approaches to therapy, which also explore spiritual practices for alleviating trauma symptoms and grieving loss, as well as values that motivate life-giving changes.

**Moral and Spiritual Orienting Systems of Those Providing Veteran Care**

Intercultural care of veterans raises questions for clinicians about suffering arising from military service and combat. In order to not be overwhelmed by the stress of stepping into a veteran’s trauma and moral injury, clinicians may need to find and use their own body-aware spiritual practices. Spiritual self-care, such as mindfulness meditation, personal and communal prayer, exercise, and experiences immersed in nature and beauty, fosters hope when clinicians experience goodness in their bodies, relational webs, humanity, and nature. When clinicians regularly practice spiritual self-care, they can use momentary practices when they step into the suffering of a veteran’s story. A mindful breath, phrase from a prayer, positive affirmation, or memory of beauty may help them experience hope and clarity in the face of a veteran’s trauma. An intercultural approach to spiritual self-care helps clinicians identify their spiritual practices, and their beliefs and values about care of veterans, in order to self-differentiate their own religious, spiritual, and moral struggles from the effects of their clients’ military service and combat. Spiritual self-differentiation helps clinicians resist the subtle, sometimes-unconscious temptation to convince clients that spiritual practices, beliefs, and values that help clinicians find hope will “heal” or “save” a veteran. Spiritual self-differentiation is the foundation for intercultural spiritual care that truly respects the particular ways a veteran finds hope, meaning, and value.

For example, I (Doehring) use personal practices of listening to sacred choral music and communal practices of attending Episcopal worship to connect with goodness and beauty. Similarly, I (Barrs) rely on a consistent yoga practice, social interaction, and walks in nature to remain grounded and connected to the world. While these practices have helped us trust others in searching for meanings about suffering, we would not assume that others would find these particular practices meaningful or soothing. Even offering such practices as examples might generate spiritual struggles in clients who feel guilty that traditional religious or spiritual practices are not helpful for them.

We draw upon moral foundations theory and research by moral psychologist Jonathan Haidt (2002, 2008) to identify our foundational values about care of veterans. Clinicians and chaplains might begin to identify values that shape their vocations and therapeutic interventions by identifying more everyday values, such as responsibility/concern for others, compassion, belonging to networks/professions of care, and evidence-based approaches to health and change. Many such values are also identified in professional codes of ethics. In our practice, we find it helpful to describe our foundational values in terms of those common across cultures and studied using moral foundations theory and research (Haidt, 2012). The moral foundation of *caring* *and* *doing no harm* is one we embrace, even as it provokes in us a deep sense of lament for the suffering veterans experience and the harm they may cause in following military orders or experiences. We lament the sometimes-chronic moral, spiritual, and religious struggles that may plague veterans for many years after their military service. Vietnam veterans may feel particularly conflicted about seeking help, given antiwar sentiments so prevalent when they returned from military service. Along with lament, our value of caring provokes our own moral struggles as citizens of a country responsible for fighting in the Vietnam War and for not adequately caring for its veterans in its immediate aftermath. Using body-aware practices deepens our compassion for self and others, makes us aware of our own struggles and pain, and clarifies why and how the value of caring for veterans is at the heart of our vocations.

Another foundational value for us is the value of *loyalty* to veterans, who deserve the best evidence-based spiritually oriented care available. A value of *authority* makes us lament experiences of veterans feeling/being betrayed by those in authority—either military or religious authorities—that increase their isolation and fears of being shunned. In addition, psychological struggles often stigmatize veterans, reinforcing societal prejudice that all veterans struggle in this way. Another foundational value of *fairness* makes us question whether those drafted or signing up for military service at the age of 18 can make mindful and informed choices about military service, and whether the responsibilities of military service are equally shared across all social, gender, and racial differences. The value of *fairness* also makes us grieve for the veterans who did not get the support they needed or deserved from systems or society after they experienced psychological and moral harm during and after their military service. We also feel a sense of moral responsibility for the harm done to veterans, as well as harm caused by complex dynamics during and after military service. Our value of the *sanctity of life* makes us part of a web of caring relationships that seeks to protect life, lament suffering, support recovery, and experience hope together.

Beliefs about the suffering of MMI and possibilities for hope, another part of moral orienting systems, tend to be specific to religious or philosophical orienting systems. Our beliefs and indeed our values about suffering of MMI arise out of personal and communal practices that ground each of us in a sense of goodness—personal, relational, familial, communal, creative, and transcendent goodness. This sense of goodness helps us compassionately understand our stress-based responses to the suffering and resiliency of veterans. Practices grounding us in goodness affirm the life-giving values identified above and evoke the following beliefs about the suffering of MMI.

When we work with service members and veterans, we resist the temptation to valorize individual service members as heroes or diagnose veterans as inevitably wounded and perhaps even condemn them as morally warped. We listen for the ways their stories of combat and war may be tragedies of irreparable human loss that may include posttraumatic growth reverberating across historical, national, family, and personal narratives. Understanding MMI as tragic offers us realistic hope that can be experienced in the here and now, especially through practices—personal and communal—that connect us with goodness.

Tragedy humiliatingly exposes the limits of our powers, but in thus objectifying our finitude makes us aware of an unfathomable freedom within ourselves. By being newly aware of the boundaries of our being, we sense an eternity of power beyond them. (Eagleton, 2003, p. 122)

We appreciate the tangled ways that agential and receptive moral injury are often intertwined. Indeed, a 21st-century view of creation often uses process philosophies of interconnected power as both agential and receptive. Those searching for a way beyond traditional beliefs about God’s omnipotence as wholly agential are often drawn to process theologies of s “the creativity of the universe that makes change and transformation possible. . . . All of reality, including divine and human, are thus part of an interdependent process” (Graham, 2017, p. 51). Process philosophies and theologies of suffering generate a collective rather than individualistic sense of moral responsibility that requires all persons, communities, and nations to work together in caring for those wounded by war.

The following case study illustrates how I (Barrs) put these beliefs and values into practice. Although specific evidence-based CPT and ACT interventions clearly prompted change for the veteran, the relationship of compassion and nonjudgment this veteran had with me (Barrs) and spiritual healers fostered a sharing of receptive and agential power that changed all of them, with change rippling out through their relational webs.

**CASE EXAMPLE: MORAL INJURY—CARL**

Carl, a 68-year-old Catholic, cisgender, heterosexual male, is a combat veteran who self-identified as biracial (African American and Caucasian). Carl first decided to pursue individual therapy more than 40 long years after serving two tours of duty in the jungles of Vietnam. He enlisted in the army at the age of 17 after having grown up in a family where his siblings, uncles, and father served in the U.S. military. Much of his family’s identity was formed around values of service, patriotism, and sacrifice for the common good. He spoke with pride about a wall of portraits in his mother and father’s home where all his male family members who had served were displayed in their uniforms next to an American flag and an ornate painting of the Virgin Mary. When Carl signed on the dotted line, he truly and deeply believed he was going to fight for freedom and democracy along with life, liberty, and the pursuit of happiness. He also talked about being proud of going “to do God’s work” and identified deeply with having grown up in a Catholic family.

More than 40 years later, when he initially called in for therapy, Carl reported that he was experiencing overwhelming pressure in his chest, anxiety, self-loathing, and sadness as his daughter refused to allow him to meet his one and only newborn grandchild due to his many years of isolation and avoidance. Carl had spent so many years separating himself from others, physically and emotionally, that his daughter felt chronically abandoned by him and did not want her child to experience the same sense of loss. During his initial call for services, he choked on his tears and expressed deep shame, stating he had avoided calling in for help for many decades but could no longer deal with the chronic sleepless nights, self-hatred, loneliness, and anger he had experienced “since going to that hellhole.” He also mentioned several times that he could barely look at himself in the mirror and hated the man he had become.

During his first therapy appointment, Carl spent most of the session trying to catch his breath as he sobbed through pressured speech and clear feelings of tangible shame. He arrived at the clinic a few minutes early and stumbled down the long hallway outside the clinic door to the building bathroom. The hallway was lined with many luscious and tall potted plants leading down the hall to a sterile white bathroom. When I (Barrs) initially walked out to get him from the clinic waiting room, he was clearly disoriented and immediately began stammering, stating repeatedly that he felt as if he was transported back to the jungle in Vietnam while walking down the clinic hallway. He was sweating and commented a few times that he smelled the jungle air, the vegetation, and the rainwater he had become so familiar with during his time in the country. It was only when he stumbled into the sterile white bathroom at the end of the hallway that he realized he was back at the clinic in the present day.

After he calmed down and I brought him back to my office, Carl spoke openly about the years he had isolated himself and struggled with the grief and loss surrounding the death of his wife, whom he always referred to as the love of his life. He spent many decades isolating himself in his wood shop in the garage, working on elaborate and beautifully crafted woodworking projects that he noted helped him to “zone out from the world” and remain separate from the stressors of civilian life. His successful woodworking business clearly brought him great pride and satisfaction, periodically leaving him with a feeling of mastery and purpose.

Carl was raised Catholic and attended Mass periodically throughout his adult life, returning in a much more active manner to his faith community in his later years after the tragic death of his wife from a very aggressive form of heart disease. During the first few years of returning to Mass, Carl often fled the church midservice sweating and in a panic; he often stated that he felt the other members of the congregation knew he was a “murderer.” He felt the congregation could see the evil and sin within him, which led to a sense of heightened panic and shame. He deeply desired a connection with God and his church but could hardly stand to sit in “God’s house” due to the deep guilt associated with the many lives that he took while in combat.

Even more distressing than actually taking the lives of these enemy soldiers was that Carl remembered enjoying and reveling in the adrenaline he experienced when “killing as many Gooks as possible.” He talked about the spiritual, emotional, and physiological effects of taking another human’s life, and although killing was initially very distressing for him, over time he became numb and detached from the actual experience and meaning of the act and began to find some solace and a sense of control in killing as he felt he was honoring his best friend, who had died in his arms in Vietnam. Carl talked about the day his best friend was killed as a turning point in him “where something changed inside and the monster was born.” The feeling of adrenaline and the rush of killing felt safer than connecting with the grief, loss, helplessness, and sadness he experienced under the surface of the rage.

In therapy, Carl identified deeply with symbolic images that assisted him in conveying the conflict he felt internally between being a kind man who loved his family and God, and feeling he was a “monster or murderer.” Carl believed that God no longer loved him and that he was irredeemable. For many years, he refused to look in the mirror in his home and avoided gazing upward when brushing his teeth or shaving as he felt a sense of shame and disgust when looking at himself in the eyes. He often arrived at therapy wearing shirts displaying images of sharks, wolves, and other fiercely predatory animals, commenting that he identified with these animals as he also saw himself as a vicious hunter.

When positive aspects of his identity were highlighted or identified, such as father, grandfather, friend, beloved partner, community member, child of God, and soldier, he immediately dismissed these images of himself and stated that he did not deserve to be associated with these roles. He often commented that if people really knew what a “monster” he was, they would immediately cast him aside and ostracize him. Carl almost seemed to experience some comfort and understanding in his daughter’s emotional distance from him as she “must have really seen [him] for what [he] was.” Her refusal to allow him to meet his grandchild seemed to serve as the validation he was looking for that he was in fact unworthy of love and connection.

During a more intense period of therapy, he was shopping at a local grocery store when a young teenage cashier welcomed him to the store and proudly stated, “Thank you for your service.” Carl ran from the store, cried in his car, and experienced a brief period of reemergence of his severe panic disorder symptoms and nightmares. Although he appreciated the sentiment of this young boy who was clearly attempting to be respectful, this interaction only further illuminated Carl’s deep and entrenched moral injury and the heavy weight of his guilt. He was adamant that he did not need to be thanked for “being a murderer.”

Over time through therapy, Carl made significant progress in learning to view himself through a more compassionate and balanced lens. He began to see himself as a more integrated and spiritual human being who had engaged in many behaviors that were strongly against his moral code, religious beliefs, and personal values but who was also a caring partner, family member, and group member.

Sadly, approximately 3 years into therapy, Carl was diagnosed with terminal Stage 4 cancer and died within months of receiving the news. Understandably, this diagnosis dredged up strong feelings of spiritual angst and existential fear in him that increased some of his inner turmoil and reignited the negative feelings and beliefs he had about himself. At the same time, however, he experienced some comfort in knowing he had mostly repaired his relationship with his family, had a relationship with his grandson, felt realigned with God, and had connected with his treatment team and fellow group members. He began experiencing grueling nightmares where Viet Cong soldiers were waiting on the other side to punish him and hold him accountable for their deaths. He spent hours and hours wondering whether he would be sent to hell and sentenced to an eternity of pain and suffering for taking the lives of many “enemy” veterans, whom he had actually begun to see as equal human beings who were simply fighting for their morals and values, just as he was initially when he enlisted.

I continued to meet with Carl every week until he died. He called a few days before his death to thank me for my support and to let me know I had helped him to work toward “feeling whole again.” Toward this end, I talked with him several times about possibly allowing his priest to visit him and help him to receive last rites—a Catholic ceremony for the dying that begins with confession, remembrance of baptismal promises, Holy Communion, and a blessing and prayers that include an anointing with oil. Carl refused to ask a priest for this rite due to the shame and fear he felt. Even after having done so much work on self-acceptance and forgiveness, he felt at the end as if he deserved to be held fully accountable for taking the lives of Viet Cong soldiers. He died partially believing his cancer was a physical manifestation of his sin and his punishment for what he had done in Vietnam. Even though his moral and spiritual injuries were still alive and well at the end of his life, Carl died having developed more of a sense of self-compassion and understanding for his behaviors during combat, along with a stronger connection with his family, community, nature, and God.

**Summary of Overall Process of Treatment**

The overall process of therapy with Carl aligned with Judith Herman’s (1992) three phases of trauma treatment, focusing on the following factors in a sequential order: safety and stabilization, mourning and processing of trauma, and community reintegration. Carl sequentially worked on the following goals and processes in therapy: stabilization of acute trauma-related and panic symptoms, telling his trauma story, changing the narrative regarding his impact trauma and combat-related behaviors, challenging unhelpful and paralyzing automatic thoughts regarding his trauma and moral injury, identifying values and living more consistently with these values, practicing acceptance and mindfulness, working toward self-forgiveness, reintegration with the community, and reconnecting with God and his spiritual identity.

*Stage 1 of Treatment: Safety and Stabilization*

The initial year of treatment with Carl focused primarily on helping him to establish emotional and physical safety in his life. I worked with him to understand the role and effects that trauma played on his life, his identity, his relationships, his spiritual/religious life, and his body. Therapy targeted acute symptoms of PTSD, panic disorder, insomnia, avoidance, and depression. He learned and practiced specific skills, such as progressive muscle relaxation, sleep hygiene, deep breathing, mindfulness, grounding techniques, positive affirmations, and anger management. He also built prayer and reflection into his daily life, which initially caused more distress because his shame and guilt—so clearly palpable to him at the time—were part of his religious and spiritual struggles with what was likely an experience of God’s judgment, a central feature of religious struggles (Exline et al., 2014). Though many aspects of therapy helped him find and use personally meaningful spiritual and religious practices, some practices, like last rites, were irrevocably associated with his sense of spiritual unworthiness.

Carl also agreed to join a support group for Vietnam veterans. He initially dropped out, stating that if the group members knew who he really was, they would not want him there; however, after months of challenging his thoughts about this, he decided to go back, expressed his fears to his fellow veterans, and was accepted back into the group with open arms. With much practice and commitment to his therapy, he clearly internalized the skills he learned and generalized the use of these calming and self-regulating methods to a variety of environments. At the time, however, he reported that he was still not ready to go back to Mass.

*Stage 2 of Treatment: Mourning and Processing of Trauma*

After Carl’s acute PTSD and panic symptoms subsided, a deep sense of depression and sadness seemed to arise from beneath his more palpable symptoms of anxiety and agitation. It seemed his chronic and acute symptoms of PTSD and anxiety had been masking the underlying moral injury and wounds to his identity that he had been struggling with for 40 years. He began to speak openly about the loss of his best friend in combat and how this particular event transformed him from “from good to beast.” He discussed feeling extreme guilt, shame, and anxiety about being unable to save his best friend the day that he died in combat.

He became preoccupied with his identity as a “monster” and “murderer” and seemed to want me to confirm that he was indeed a damaged and dangerous human being who was unworthy of love from himself and others. These thoughts were clearly interfering with his willingness and ability to get close to his family and experience any sense of joy in his life. Carl reported that his moral injury was keeping him away from going back to Mass or speaking with a priest as he was too ashamed and afraid to do so—a clear indication of chronic religious struggles with God and religious authorities that are correlated with many negative health and emotional health outcomes (Abu-Raiya et al., 2015). He attempted several times to go back to Mass, but during each service he was flooded with intrusive thoughts about being unable to save his best friend, along with the memories of the many Viet Cong he had killed.

At this point in his treatment, Carl agreed to complete CPT in order to help him make sense of his behaviors in combat, challenge the unhelpful and damaging automatic thoughts that were keeping him stuck in his recovery, experience the natural emotions he had been avoiding for many decades, and decrease self-blame regarding his friend’s death.

One of the initial interventions associated with CPT is completing the impact statement, which occurs after Session 1. According to Resick et al. (2017),

One objective of the Impact Statement is to elicit the client’s appraisals about the cause of the traumatic event and to have the client examine the effects the event has had on his or her life in several different areas (i.e., safety, trust, power/control, esteem, intimacy). (p. 102)

When Carl completed his initial impact statement, he identified his primary impact trauma as losing his best friend in combat. He also indicated that he believed the death of his friend was his fault and he should have been able to save him, although it was clear this was not actually the case once he explained the circumstances surrounding the event. Through this exercise and Socratic questioning, Carl was easily able to identify how this loss, along with his experiences of killing, had affected his views of self, others, the world, and God.

As has been found, “moral injury can result in psychological symptoms (e.g., shame, guilt, rage) and spiritual symptoms (e.g., spiritual struggles, moral concerns, loss of meaning, self-condemnation, difficulty forgiving, loss of faith, loss of hope” (Pearce et al., 2018, p. 2), all of which have proven to be significant barriers to recovery from trauma and improvement of suffering (Shay, 2014). Research on MMI and spiritual struggles demonstrates that when veterans and service members experience ongoing guilt, anger, shame, and disgust about traumatic events that caused harm, they are likely to experience God and those in religious authority as judging them (Evans et al., 2018). Spiritual and religious practices that are used to connect veterans with God and a sense of their own goodness now induce shame and guilt, as Doehring (2019) illustrates in an MMI spiritual care case study. This was clearly the case for Carl, and he began to realize and sit with the profound effect that Vietnam had on his life and spiritual identity.

After writing and reading the trauma account associated with his primary impact trauma, Carl began to allow himself to connect more and more with the natural emotions of grief and loss he felt after the death of his friend. He also began to identify the stuck points associated with his PTSD and depression symptoms: “I didn’t do enough to save my friend,” “I should have done more that day,” “I am a murderer,” “I am a monster,” “I am a disgusting human being,” “I don’t deserve happiness,” “I cannot get better,” “I should not be allowed to hold my grandson,” and “I cannot find any joy.” As he learned to challenge his automatic thinking and create more balanced and realistic thoughts, Carl began to report less of a sense of moral injury, and a decrease in feelings of hopelessness, guilt, shame, and self-disgust. This decrease in moral injury related to thoughts, behaviors, and feelings led to subsequent decreases in symptoms of depression and PTSD, while also increasing his behavioral engagement with his family and community.

Through CPT, Carl and I also worked to help him reframe the circumstances that prohibited him from being able to save his best friend’s life in combat. He had been telling himself for 40 years that he was “not a good enough soldier” and that he “didn’t do enough”; however, through Socratic dialogue and gentle challenging of his perceptions of the events that day, he was able to see that many factors that were outside of his control had influenced the resulting death of his battle buddy (e.g., spiritual disillusionment, fatigue, malnourishment, chronic insomnia, experiencing an ambush, grief and trauma, and the unpredictable nature of combat). Carl also began to work on challenging and reframing his stuck points and automatic thoughts regarding killing. He began to understand more deeply the context of these aggressive behaviors and was able to practice more self-compassion and self-forgiveness. Through therapy, he realized that he “acted as a consequence of the trauma context and not as a premeditated act or with instrumental intent to victimize” (Smith et al., 2013, p. 461).

It is important to note that, after much discussion, Carl finally agreed to meet with a local VA chaplain to discuss some of his spiritual/religious-related stuck points, such as “God does not love me,” “I am unforgivable,” I should not be allowed at Mass,” “I will go straight to hell,” and “I will be forever punished for what I did.” The combination of being able to challenge his stuck points with both a secular therapist and a chaplain seemed to help him reframe not only the objectively challengeable thoughts but also those that were more spiritual and values based in nature. Speaking to the chaplain also allowed him the opportunity to seek religious guidance about how to use prayer, meditation, and confession as tools to reduce the emotional and psychological impact of his religiously oriented stuck points. Carl’s final CPT impact statement demonstrated the significant growth he made toward reduction of symptoms, understanding the context of his combat-related behaviors, practicing compassion of self, tolerating natural emotions, reconnecting with God, and thinking in a more balanced and nuanced manner about his trauma.

*Stage 3 of Treatment: Community Reintegration and Committed Action*

After the completion of CPT, I began taking more of an ACT-based approach with Carl as this particular evidence-based treatment focuses more on the identification of personal values, acceptance, mindfulness, cognitive defusion, and living life in the present according to one’s values, which is wholly consistent with the treatment of moral injury (Nieuwsma et al., 2015). I also employed a spiritual-oriented approach focused on Carl’s particular values, beliefs, and religious practices.

Carl began this phase of therapy by identifying his primary core values, including accountability, calmness, compassion, community, contentment, faith, growth, honor, patriotism, and gratitude. He noted with significant insight that his current values were significantly different than the values he held so tightly when he first initiated therapy; these prior values included accuracy, carefulness, predictability, order, and self-control. So much of his life had been filled with experiential avoidance and compulsive attempts to control his inner experience (i.e., thoughts, memories, bodily sensations, and feelings related to the trauma), which paradoxically assisted in the maintenance and reinforcement of his symptoms.

For Carl, experiential avoidance in the context of trauma and moral injury included the avoidance of the following: religious practice, spending time with family, emotional intimacy, and social interaction. In addition, he had a long history of working more than 15 hours per day. Over time, Carl began to understand that during combat the act of killing also served as a form of experiential avoidance for him as this behavior temporarily served to distance him from the grief, disillusionment, rage, helplessness, and sense of meaninglessness he experienced in Vietnam.

Not only did Carl become more aware of his values and more accepting of his internal experiences, but also he began to live his life more engaged in mindful and intentional committed action. ACT defines committed action as a “values-based action that occurs at a particular moment in time and that is deliberately linked to creating a pattern of action that serves the value” (Hayes et al. 2012, p. 328). For Carl, attending therapy, spending time in nature, repairing his relationships, getting to know his grandson, praying, attending Mass, and giving back to his community demonstrated his strong dedication to committed action.

Carl benefited tremendously from learning and practicing mindfulness, which for most of his adult life he had avoided, other than in the context of his carpentry, during which he could intently focus for hours on end. A core component of ACT therapy is a focus on present-centered living instead of a focus on rumination about the past or worry about the future, which this veteran worked on diligently before his death. Over the last year of his life, he formed a strong connection with nature and animals and spent hours walking in the woods, studying plants, smelling flowers, and marveling over insects. He often brought in pictures he had taken of beautiful leaves or interesting bugs to share with me and would talk about the way in which mindfully petting and walking his dog soothed his soul.

He also began to practice mindfulness and intentionality during prayer and while in Mass, which led to him being less carried away by intrusive memories, along with feelings of guilt and shame. Carl became more and more comfortable sitting in Mass, and one Veterans Day he even spoke to the congregation about his experience as a combat veteran and how God and therapy had helped him to work toward forgiveness and self-acceptance. He developed a strong relationship with his daughter and grandson, who began attending therapy and church with him.

Although he worked on decreasing guilt, shame, and self-hatred for much of his therapy, it was clear that Carl continued to experience much distress, as killing was still directly in conflict with his core values of compassion, community, and faith. It is essential to note that the goal of ACT therapy in the context of moral injury is not to fully take away an appropriate sense of guilt for having engaged in a behavior that is considered morally or spiritually in conflict with one’s values, morals, and/or religious beliefs. Nieuwsma et al. (2015) addressed this by stating,

Whatever may be the true state of human beings’ agency, there is some danger in adopting a therapeutic stance that entirely precludes the very possibility of culpability. If a wrong (perceived or actual) has been committed, there may be need for a process of forgiveness (of self and/or others). (p. 20)

Carl began to focus on self-compassion and self-forgiveness, which he came to understand to be a nonlinear, spiritual, and ongoing process. As he began to practice forgiveness of self, he realized that giving back to the community and his church would allow him to begin to experience some sense of restitution. He began to do some volunteer work at church, which seemed to provide him with a sense of meaning and purpose. He began to see himself as a more integrated and spiritual human being who had engaged in many behaviors that were strongly against his moral code, religious beliefs, and personal values but who was also a caring partner, family member, and community member. He became more and more comfortable looking at himself in the mirror for sustained periods of time, and even as a symbolic gesture toward acceptance and forgiveness of self, he allowed a photographer to take a picture of his face, which he enlarged and hung up as a way to practice his commitment to self-compassion and his personal journey of change and recovery.

In one session after learning of his cancer diagnosis, I shared “The Veteran’s Prayer” by Hugh Scanlen with him. He had been working on acceptance, mindfulness, committed action, present-centered living, cognitive defusion, self-forgiveness, and compassion, all processes that seemed to be highlighted in petitions of this prayer:

<poem>May I accept who I am now. . . .

Help me to remember and to dim—  
not forget—the tragic past. . . .

Give me the strength to face the time I have left here  
to reconnect with humanity. (Tick, 2014, p. 235)

He was also working to reconnect with God and to let go of some of the religious and spiritual struggles he had held onto for 4 decades. When he read this prayer aloud for the first time in therapy, he immediately began weeping, looked up at the therapist, and simply and adamantly stated, “This is me.” Carl kept this prayer by his bed and read it nightly; he reported that it gave him deep comfort and that he felt it was written just for him.

During the last few months of his life, Carl was clearly living in a manner that was more consistent with his values, and he was actively engaged in more intentional committed action in his life. He worked toward practicing acceptance that he could not change his past or his future, but he could change the quality of the moments he had left with his family, himself, God, and nature. Although he was terrified of what would happen after he “crossed over” and faced God, he also experienced some comfort in knowing he could only focus on living life according to his values in the present moment. This provided him with a sense of freedom and release that most likely helped him live more fully, mindfully, and intentionally in his final moments.

**Conclusion**

An intercultural approach to spiritually oriented psychotherapy helps clinicians identify the layers in their own religious, spiritual, or moral orienting systems that shape the care they want for veterans like Carl. Our spiritual practices grounded us in goodness and hope as we entered Carl’s story of suffering. Our values of *care and doing no harm* provoked a deep sense of lament for not only the suffering Carl experienced and the harm he caused at such a young age but also his chronic moral, spiritual, and religious struggles over 40 years. We lamented the terrible suffering arising from combat done in the horrendous conditions Carl experienced. Spiritually oriented care is not just about caring for persons; it’s about social justice that challenges life-limiting and destructive systems that exacerbate suffering (Graham, 2017). We are grateful that Carl was able to accept a referral to a chaplain who did represent a caring religious authority, even though Carl could not permit himself to receive last rites. We see this as a tragic outcome of his deep sense of being unworthy, which we might describe as an irreparable soul wound or sense of desecration of humanity—of Carl, his buddy who died, and those he killed—that comes when the foundational value of *sanctity of life* is trespassed.

We experienced hope in the ways that Carl’s therapy brought about such radical transformation and posttraumatic growth, enabling him to connect with goodness through this therapeutic relationship and with his departed wife (“the love of his life”), his daughter and grandchild, his religious rituals and prayers, and his joy in nature. The goodness he experienced was, we believe, a sign of the goodness he entered into upon death and the goodness that lives on, among those who read and ponder this case study and the ways it evokes values, beliefs, and practices of caring for veterans like Carl.

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