Building Spiritual Strength: 
a Spiritually Integrated Approach 
to Treating Moral Injury

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Abstract

Purpose of Review This article reviews a spiritually integrated group therapy, Building Spiritual Strength (BSS), designed to treat moral injury and associated syndromes (e.g., PTSD, burnout) with Gestalt and cognitive techniques and psychoeducation about spiritual coping. BSS was designed for active duty and military veterans but has since been adapted and expanded for other groups experiencing moral injury.

Recent Findings Two RCTs have demonstrated BSS led to a decrease in PTSD symptoms in military members. Though BSS did not outperform a person-centered group therapy control in one RCT, the BSS group reported a decrease in spiritual struggle compared to the control. While no studies have yet been published on the expansion of BSS to new populations, emergent qualitative evidence on BSS for volunteers working with refugees indicates effectiveness in increasing positive spiritual coping. This expansion also revealed an opportunity for BSS to increase cultural humility in group members, in addition to reducing moral injury and other symptoms of distress.

Summary BSS is an effective, spiritually integrated means of reducing distress and improving spiritual coping. There are numerous opportunities for expansion of BSS to new populations and to test a variety of outcomes, including moral injury, spiritual flourishing, and cultural humility.
Moral injury (MI) can occur after an individual violates their moral beliefs, engages in unethical acts, or witnesses atrocities (e.g., violent acts such as killing) [1, 2]. MI symptoms include shame, guilt, and a lack of trust in others. It also includes an existential component, wherein people experience spiritual or existential struggles, as the event precipitating MI often forces an individual to redefine how they see the world [1]. Known consequences of moral injury include depression, PTSD, anxiety, and substance abuse [3•, 4]. Suicidal ideations are also among known consequences [5]. Moral injury has also resulted in poor self-image, burnout, sleep disturbances, and emotional pain [3•, 4]. Much of the existing research on MI has focused on military veterans and active duty members [3•, 5, 6].

Though implications and prevalence rates have largely been based on the military community, MI has impacted healthcare workers at a rapid rate over the last few years [4]. Often mislabeled as burnout, healthcare professionals can experience potentially morally injurious events (pMIEs) that threaten their emotions and self-image [7]. Likewise, physicians are another group of healthcare workers that experiences pMIEs at a higher rate. Since most physicians feel strongly about helping people, pMIEs may have a greater effect on their well-being [7]. Experiencing pMIEs can lead to moral injury symptoms such as guilt and shame [1]. Other healthcare workers such as nurses experience symptoms of moral injury. As a result, this makes healthcare professionals more vulnerable to moral injury and associated negative health outcomes.

Distinguishing Moral Injury From Other Presenting Problems

The distinction between burnout and MI is often blurred, though the two are distinct constructs. Burnout has been described as pervasive stress, fatigue, and loss of empathy and self-efficacy [8]. It is known that healthcare professionals experience burnout. However, newer research suggests that mislabeling MI as burnout may have greater implications (e.g., worse health outcomes) [8]. In addition, the distinction between moral distress and MI has also been made. Moral distress can result from regret, suffering, and guilt [9]. Over time, moral distress can lead to MI, if not recognized and mediated by known protective factors (e.g., social support) [9].

Posttraumatic stress disorder and MI can result from the same experiences, and PTSD and MI can co-occur. While PTSD is a recognized psychiatric disorder in the DSM-5 with specific criteria regarding emotion, cognitive, and behavioral functioning, MI is primarily defined by its emotional functioning (shame, guilt) and existential questioning [4]. The combination of these has been shown to increase suicidal thoughts and attempts [5]. PTSD has also been considered among the secondary symptoms of moral injury [1]. More research is needed to understand the relationship between these constructs and differentiate between them.

Religious and spiritual struggles share some overlap with MI. Spiritual distress encompasses guilt, shame, struggles with forgiving oneself or others, and a distancing of self from a higher power after a distressing event [10]. Like MI, spiritual distress is also associated with higher rates of suicidal ideation [10].
When confronted with events causing MI and associated presenting problems, individuals are motivated to explain what has happened. For many, these explanations involve a spiritual dimension. Harris and others have suggested that psychospiritual developmental theories provide a strong framework for clinical conceptualization—clinicians can track where their clients suffering from MI are in their spiritual development, and how their level of (and change or stagnation in level of) spiritual development may affect how they explain the events causing MI [11–13]. Fowler’s theory of psychospiritual development has the most empirical support of established developmental theories and was used to develop the Building Spiritual Strength program [11–13]. There is an excellent case study using Fowler’s theory to conceptualize moral injury which readers may find useful [13].

Fowler’s theory includes six stages of development. The first two stages, Intuitive-Projective and Mythic-Literal, represent spiritual cognitions experienced in childhood. These stages involve magical thinking and literal interpretations of faith texts and ideas; they tend to align with Piaget’s preoperational and concrete operations stages. By adolescence, many people enter stage three, Synthetic-Conventional, which involves deferring to their religious institutions’ authority figures when attempting to explain personal events. Here, people interpret events as “good” or “bad.” Many people remain at stage three for most of their lives. During emerging adulthood, most people have an opportunity to progress to stage four, Individuative-Reflective, where people can hold multiple religious ideas and practices and can interpret events as not “good” or “bad” but as a complex combination. If a person progresses to stages five or six, it happens later in life and involves flexibility in religious thinking (stage five, Conjunctive) and recognizing all persons as part of a community (stage six, Universalizing). Few people progress to stage six [11–13].

The leap from stage three to stage four is most relevant when conceptualizing moral injury and recovery from moral injury. This leap requires people to move from seeing events or persons as all-good or all-bad to recognizing layers and spectra of complexity, or multiple moral contexts. People at higher stages (i.e., stage four or beyond) may be able to take ambiguous or complex situations and interpret them in several ways, thereby avoiding the trap of interpreting an event, a person, or even God, as all-bad. Usset and colleagues review this stage progression and its implication for moral injury alongside empirical evidence that readers may find helpful [14•].
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development [11, 12]. Given that MI results from individuals being exposed to distressing events that gravely conflict with their worldview, being able to hold multiple perspectives and think abstractly (i.e., higher stages of Fowler’s theory) about meaning would be protective.

BSS in its original form was intended as complementary treatment to traditional individual or group psychotherapy treatments [15•, 16]. BSS participants meet once per week for eight sessions, each session lasts an average of 90 min. Sessions may be led by 1 or 2 trained facilitators. Participants are asked to complete homework in a treatment manual between sessions. Given the overt integration of spiritual functioning into the program, both chaplains with mental health specialties and psychologists can deliver BSS programming. This also allows BSS to be delivered in a variety of settings, from traditional mental health facilities to community centers and places of worship. The spiritual content in BSS is interfaith and the language used in BSS is meant to be inclusive. Participants in BSS programming have come from Christian, Jewish, Hindu, agnostic, and spiritual-but-not-religious backgrounds. This is consistent with the definitions of MI being tied to spiritual struggle and faith development, regardless of one’s religious identification [13].

BSS uses Gestalt, cognitive, mindfulness, psychoeducation, and spiritual resourcing techniques to reduce PTSD and moral injury symptoms [13, 15•]. One major component is the ongoing use of an empty chair exercise, where participants are invited to speak their struggles to a higher power (in the empty chair). As it is a group context, other participants are then invited to share their reactions and suggest responses (either from a higher power or from themselves). Participants also receive psychoeducation on the most effective ways of spiritual coping based on empirical evidence [17] and build insight around how they make meaning of evil in the world.

Empirical Evidence

The efficacy of BSS with veterans has been tested with two randomized controlled trials (RCTs), though moral injury was not the primary outcome measure for these studies [18, 19]. No other peer-reviewed studies of BSS effectiveness to treat moral injury or other commonly associated outcomes (e.g., spiritual struggle, PTSD) have been conducted.

The first RCT (N = 54) compared BSS (n = 26) to a waitlist condition (n = 29). The sample was mostly male (88%), white (74%), and Protestant (61%). Results indicated that the BSS condition experienced a statistically and clinically significant reduction in PTSD symptoms (d = −0.67) and fared better than the waitlist condition [18]. However, the RCT did not measure participants' level of moral injury during the study.

The second RCT (N = 138) compared BSS (n = 71) to a person-centered group therapy program (n = 67) [18]. The sample was male (76%) and white (83%), with just over half of participants identifying as Protestant (54%). Both BSS and person-centered group therapy led to decreases in PTSD symptoms (d = −1.06; −0.92, respectively); there were no differences between the
conditions in PTSD symptom reduction. While moral injury was not explicitly assessed in the study, participants’ religious and spiritual struggles were assessed, and it was found that the BSS group experienced a significant reduction in distress in relationships to a higher power \( (d = -1.43) \) while the person-centered group therapy participants experienced an increase in spiritual distress [19].

There are three primary opportunities to expand the research on BSS’ efficacy. First, while BSS seems effective in reducing PTSD symptoms, additional RCTs focusing on moral injury as an outcome are needed. Based on the second RCT, it may be that BSS is as effective as other treatments when it comes to PTSD (e.g., person-centered therapy) but outperforms other treatments on more spiritually defined presenting problems (e.g., moral injury, spiritual struggles). Second, while the first study used psychologists as group facilitators, the second study used chaplains with mental health specialties [18, 19]. It is likely that, despite training on the BSS manual, these leaders may have approached treatment from slightly different perspectives in training and case conceptualization. Further work is needed to unpack who can successfully deliver BSS—and how differences among professionals may manifest in client outcomes. Third, BSS has since been adapted for the treatment of moral injury with volunteers working with refugees, healthcare workers during the COVID pandemic, and individuals in recovery from addiction. Follow-up research is needed on these adaptations to determine their effectiveness.

**Dismantling Studies—Unpacking the Mechanisms of Change**

Once the above research has been conducted, researchers will want to consider dismantling studies in order to determine what the mechanisms of change in BSS are. Determining the effective mechanisms of change will allow researchers and clinicians to continue adapting BSS to new populations suffering from moral injury, including front-line workers and nurses [1, 8]. Specifically, researchers should focus on the effectiveness of the empty chair technique as used in BSS. Other specific mechanisms to explore include the use of psychospiritual education and meaning making/reframing of difficult concepts, such as evil in the world. There are also group-level mechanisms to consider, including how established group therapy curative factors (e.g., Yalom’s factors for group psychotherapy) may be amplified by the addition of psychospiritual content and processes, such as spiritual intimacy that may develop among group members [20, 21].

**Expanding BSS—Reflections and Recommendations**

Recently, I (SWB) adapted BSS to reduce moral injury, compassion fatigue, and burnout in volunteers working with refugees. While the pilot \( (N = 36) \) was too small to warrant quantitative analysis, my co-investigator and I noted four themes during the process of adaptation and implementation. First, as noted in other studies, levels of distress in the program participants were not clinically significant [18, 19]. However, participants did report experiencing benefits from
the program, especially regarding spirituality. BSS was designed as an adjunctive therapy, and therefore in addition to tracking participants’ change in PTSD and other clinical symptoms, researchers and clinicians should consider tracking change in spiritual flourishing and other well-being constructs. Second, many volunteers who were invited to participate in the BSS group expressed interest but cited burnout and being overcommitted to other activities (including volunteering). The current BSS structure of eight 90-min sessions may be too much for people to commit to, given the overlap between burnout and MI [8]. Further work is needed to determine whether BSS can be condensed into shorter or less frequent sessions to make the program more accessible and feasible. The dismantling study approach described above may facilitate this process, whereby the strongest change mechanisms are retained into an abridged program.

Third, the volunteers who participated in this study took a broader definition of MI and suggested that BSS be implemented within faith congregations for the purpose of community healing (community wounds included changes in church leadership, handling of COVID-19 mitigation policies, political polarization, treatment of traditionally disenfranchised groups within religious traditions, such as LGBTQ persons, and revelations of nationwide clergy abuse). The participants expressed optimism at using BSS as a facilitator for community healing, though this level of adaptation requires significant re-writing of the BSS program. From an ethical perspective, group therapy requires confidentiality of all members’ experiences and stories. The dual relationships that would arise out of this broad adaptation require careful consideration and additional, explicit guidance with participants about the boundaries of the group. This also raises questions about the goal of BSS in such a context—to heal individual group members or to promote community healing.

Preliminary qualitative analyses of BSS—adapted for volunteers working with refugees—suggest another outcome in addition to reducing PTSD, MI, and compassion fatigue. Many volunteers described themselves and the refugees they worked with in various relationships. Some were vertical, where the volunteer was implied to have more power and overall ability. Others were horizontal, where the volunteers described themselves and the refugees as equals. Many times, the positionality changed depending on the situation being discussed. This theme of Refugee Positionality has been reported in other scholarship on U.S. volunteers and workers assisting refugees: the volunteers or workers often must grapple with diverse cultural expectations, rules, and morals. It is common for volunteers to struggle with remaining culturally humble and centering the refugee culture in their work, particularly if the volunteers and refugees come from different faith traditions. To hold one’s own worldview alongside another disparate worldview requires high levels of faith development as defined by Fowler. In this way, BSS’s development around Fowler’s faith development model may predispose it to be an excellent tool for developing higher levels of cultural humility. It is worth noting that all volunteers in the adapted BSS program identified as Christian, and therefore the group itself did not pose opportunities for many significant interpersonal learning or corrective experiences in the moment when it came to cultural and religious differences. Interfaith BSS groups may facilitate cultural humility growth more. This is another critical area of scholarship to explore.
Summary

BSS provides an exciting opportunity to push the field of spiritually integrated treatments further. It has demonstrated effectiveness within military populations for PTSD and has been adapted into other groups. With additional RCTs, BSS is also poised to become one of the first official empirically supported treatments, per APA guidelines, that integrates spirituality. There are many research opportunities to unpack, including identifying specific change mechanisms and testing various outcome variables, including moral injury. The fact that BSS can be facilitated by chaplains and mental health professionals also reinforces a growing movement, whereby spiritual and clinical professionals can work together to promote a more holistic well-being among their clients.

Author Contribution

Both authors contributed to the review. SWB conceptualized and organized the piece and wrote most of the manuscript; KK conducted a comprehensive literature review and wrote the introduction.

Declarations

Conflict of Interest
The authors declare no competing interests.

Human and Animal Rights and Informed Consent
This article does not contain any studies with human or animal subjects performed by any of the authors.

References and Recommended Reading

Papers of particular interest, published recently, have been highlighted as:
• Of importance

1. Jinkerson JD. Defining and assessing moral injury: a syndrome perspective. Traumatology. 2016;22(2):122–30. https://doi.org/10.1037/trm0000069.
2. Litz BT, Stein N, Delaney E, Lebowitz L, Nash WP, Silva C, et al. Moral injury and moral repair in war veterans: a preliminary model and intervention strategy. Clin Psy Rev. 2009;29(8):695–706. https://doi.org/10.1016/j.cpr.2009.07.003.
3. Hall NA, Everson AT, Billingsley MR, Miller MB. Moral injury, mental health and behavioural health outcomes: a systematic review of the literature. Clin
Good, recent resource on moral injury across populations and in relation to mental health outcomes.

4. Williamson V, Murphy D, Greenberg N. COVID-19 and experiences of moral injury in front-line key workers. Occ Med. 2020;70(5):317–9. https://doi.org/10.1093/occmed/kqaa052.

5. Bryan CK, Bryan AO, Roberge E, Leifker FR, Rozek DC. Moral injury, posttraumatic stress disorder, and suicidal behavior among National Guard personnel. Psychological Trauma: Theory, Research, Practice, and Policy. 2018;10(1):36–46. https://doi.org/10.1037/tra0000290.

6. Flipse Vargas A, Hanson T, Kraus D, Drescher K, Foy D. Moral injury themes in combat veterans’ narrative responses from the National Vietnam Veterans’ Readjustment Study. Traumatology. 2013;19(3):243–50. https://doi.org/10.1177/1534765613476099.

7. Dean W, Talbot S, Dean A. Reframing clinician distress: moral injury not burnout. Fed Pract. 2019 Sep;36(9): 400–402. Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6752815/.

8. Hooper C, Craig J, Janvrin DR, Wetsel MA, Reimels E. Compassion satisfaction, burnout, and compassion fatigue among emergency nurses compared with nurses in other selected inpatient specialties. J Emerg Nurs. 2010;36(5):420–7. https://doi.org/10.1016/j.jen.2009.11.027.

9. Cartolovni A, Stolt M, Scott PA, Suhonen R. Moral injury in healthcare professionals: a scoping review and discussion. Nurs Ethics. 2021;28(5):590–602. https://doi.org/10.1177/0969733020966776.

10. Harris JI, Erbes CR, Engdahl BE, Ogden H, Olson RH, Winkskowski AM, et al. Religious distress and coping with stressful life events: a longitudinal study. J Clin Psych. 2012;68(12):1276–86. https://doi.org/10.1002/jclp.21900.

11. Fowler J. Toward a developmental perspective on faith. Rel Educ. 1974;69(2);207–19.

12. Parker S. Research in Fowler’s faith development theory: a review article. Rev Rel Research. 2010;51(3): 233–252. Available from https://www.jstor.org/stable/20697343.

13. Harris J, Park CL, Currier JM, Usset TJ, Voecks CD. Moral injury and psycho-spiritual development: considering the context. Spiritual Clin Prac. 2015;2(4):256–66. https://doi.org/10.1037/scp0000045.

14. Usset, TJ, Gray E, Griffin BJ, Currier JM, Kopacz MS, Wilhelm JH, Harris JI. Psychospiritual developmental risk factors for moral injury. Religions. 2020;11(10):484–495. https://doi.org/10.3390/rel11100484.

This provides an excellent description of Fowler’s stages of development and how they relate to implications for moral injury onset and recovery.

15. Harris JI, Chamberlin ES, Engdahl B, Ayre A, Usset T, Mendez D. Spiritually integrated interventions for PTSD and moral injury: a review. Curr Treat Options Psych. 2021;8:196–212. https://doi.org/10.1007/s40501-021-00248-w.

16. Harris JI, Chamberlin ES, Engdahl B, Ayre A, Usset T, Mendez D. Spiritually integrated interventions for PTSD and moral injury: a review. Curr Treat Options Psych. 2021;8:196–212. https://doi.org/10.1007/s40501-021-00248-w.

17. Harrison MO, Koenig HG, Hays JC, Eme-Akwar A, Pargament K. The epidemiology of religious coping: a review of recent literature. Int Rev Psych. 2001;13(2):86–93. https://doi.org/10.1080/09540260124356.

18. Harris JI, Erbes CR, Engdahl BE, Thuras P, Murray-Swank N, Grace D, et al. The effectiveness of a trauma focused spiritually integrated intervention for veterans exposed to trauma. J Clin Psych. 2011;67(4):425–38. https://doi.org/10.1002/jclp.20777.

19. Harris JI, Usset T, Voecks C, Thuras P, Currier J, Erbes C. Spiritually integrated care for PTSD: a randomized controlled trial of “Building Spiritual Strength”. Psychiatry Research. 2018;267:420–428. https://doi.org/10.1016/j.psychres.2018.06.045.

20. Yalom ID. The theory and practice of group psychotherapy. 4th ed. New York: Basic Books; 1954.

21. Kusner KG, Mahoney A, Pargament KI, DeMaris A. Sanctification of marriage and spiritual intimacy predicting observed marital interactions across the transition to parenthood. J Fam Psychol. 2014;28(3):604–14. https://doi.org/10.1037/a0036989.

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