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Spiritually Integrated Cognitive Processing Therapy: A New Treatment for Post-traumatic Stress Disorder That Targets Moral Injury

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Abstract

Background: Post-traumatic stress disorder (PTSD) is a debilitating disorder, and current treatments leave the majority of patients with unresolved symptoms. Moral injury (MI) may be one of the barriers that interfere with recovery from PTSD, particularly among current or former military service members.

Objective: Given the psychological and spiritual aspects of MI, an intervention that addresses MI using spiritual resources in addition to psychological resources may be particularly effective in treating PTSD. To date, there are no existing empirically based individual treatments for PTSD and MI that make explicit use of a patient's spiritual resources, despite the evidence that spiritual beliefs/activities predict faster recovery from PTSD.

Method: To address this gap, we adapted Cognitive Processing Therapy (CPT), an empirically validated treatment for PTSD, to integrate clients' spiritual beliefs, practices, values, and motivations. We call this treatment Spiritually Integrated CPT (SICPT).

Results: This article describes this novel manualized therapeutic approach for treating MI in the setting of PTSD for spiritual/religious clients. We provide a description of SICPT and a brief summary of the 12 sessions. Then, we describe a case study in which the therapist helps a client use his spiritual resources to resolve MI and assist in the recovery from PTSD.

Conclusion: SICPT may be a helpful way to reduce PTSD by targeting MI, addressing spiritual distress, and using a client's spiritual resources. In addition to the spiritual version (applicable for those of any religion and those who do not identify as religious), we have also developed 5 religion-specific manuals (Christianity, Judaism, Islam, Buddhism, and Hinduism) for clients who desire a more religion-specific approach.

Keywords

post-traumatic stress disorder, moral injury, religion, spirituality, psychotherapy

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Post-traumatic stress disorder (PTSD) is one of the most debilitating disorders affecting military service members and is a precipitating factor for suicide.[1] Of those that seek treatment from PTSD, only 20% to 30% fully recover,[2] making the development of more effective interventions a research and public health priority. One of the factors that seems to impede the effectiveness of current PTSD treatments is moral injury. Moral injury (MI) has been defined as "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs,"[3] and experiencing

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"a deep sense of transgression including feelings of shame, grief, meaninglessness, and remorse from having violated core moral beliefs,"[4] and "betrayal of what's right, by someone who holds legitimate authority, in a high-stakes situation."[5] Notably, MI can result in psychological symptoms (eg, shame, guilt, rage) and spiritual symptoms (eg, spiritual struggles, moral concerns, loss of meaning, self-condemnation, difficulty forgiving, loss of faith, loss of hope).[6] MI appears to be a barrier to recovery from PTSD[5] and is positively correlated with PTSD among Veterans.[7–10] In a recent study with 427 Veterans, 90% had at least 1 symptom of moral injury that was rated 9 or 10 on a scale from 1 to 10, and 50% had 5 or more symptoms at this level.[11]

Spirituality is an important and complex phenomenon that needs to be considered in the conceptualization and treatment of PTSD. Spirituality has the potential to be a positive and protective resource or an exacerbating factor for PTSD or both. Active duty soldiers and Veterans report high rates of spirituality/religiosity (S/R),[12,13] and many reports relying on their faith to cope.[14] Service members who reported higher S/R also reported less substance use, risky behaviors, and better affect.[12] On the other hand, individuals with spiritual struggles report lower recovery rates from PTSD and a greater need for VA (Veterans Affairs)-approved mental health services.[15,16] Given that MI and spiritual struggles are common among those with combat-related PTSD,[9,17,18] a PTSD intervention that specifically addresses a patient's spirituality and MI may be particularly effective in reducing PTSD symptoms.[6,19]

Over the last decade, several interventions have been developed to address MI in the context of PTSD, including Adaptive Disclosure,[3] Trauma Informed Guilt Reduction Therapy,[20] and ACT for moral injury.[21] These treatments are advances in the treatment of PTSD and have shown promising results; however, none of these MI interventions have specifically included spiritual resources or targeted spiritual distress, which as discussed are important components of MI. In contrast, a few interventions have used spiritual resources and these have shown promise for reducing PTSD, including Mantra Meditation,[22] Mindfulness Meditation,[23] and Building Spiritual Strengths.[24,25] Although these interventions included spiritual resources, they did not target or measure MI. In addition, Building Spiritual Strengths is a group intervention delivered by chaplains. Notably, Resick et al. recently found that 1-on-1 Cognitive Processing Therapy (CPT) for PTSD was more effective than group CPT.[26]

In summary, although moral injury is intimately connected with spiritual beliefs and values, these are typically not addressed in secular approaches, not to mention spiritual struggles and loss of religious faith due to trauma, which are typically not addressed at all. Instead, secular approaches focus on thinking errors, dysfunctional cognitions, erroneous underlying assumptions, and rational justifications, not on spiritual resources, spiritual struggles, and the spiritual ramifications of trauma and their interconnection with symptoms of PTSD. In addition, among the approaches that do address spirituality in the treatment of PTSD, moral injury is typically not addressed, particularly for individual treatment. Therefore, there is a need for empirically based individual treatments for PTSD that target MI that make explicit use of a patient's spiritual resources, particularly given the evidence that such resources predict faster resolution of PTSD.[9,27]

Spiritually Integrated Cognitive Processing Therapy

To address this gap, we (a clinical psychologist, an active duty military psychologist, a psychiatrist, and a VA chaplain, all with expertise in developing and/or researching spiritually integrated treatments) have developed Spiritually Integrated Cognitive Processing Therapy (SICPT). This novel treatment is an adaptation of CPT,[28] one of the primary empirically validated treatments for PTSD and one of the three treatments used by the VA for Veterans with PTSD.[29] In addition to CPT's large evidence based for reducing PTSD, we chose to adapt CPT because of the overlap between MI and PSTD and the fact that many aspects of MI can be addressed by the same approach used for PTSD.

CPT is designed to target inaccurate or maladaptive beliefs—called stuck points—that result in guilt, shame, and self-blame, rendering individuals stuck in their trauma recovery. 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. Similar to CPT, SICPT is designed for individuals experiencing PTSD across the spectrum of severity, from mild to severe symptom presentations.

SICPT differs from CPT in 5 major ways. First, SCIPT specifically targets MI as a major barrier to achieving recovery from PTSD, whereas CPT directly targets PTSD. Second, SICPT targets MI by challenging erroneous interpretations of trauma by focusing on cognitive restructuring using clients' spiritual/religious resources (ie, spiritual beliefs, practices, sacred writings, values, and motivations) to challenge maladaptive thinking patterns. Third, given that MI does not always reflect erroneous interpretations—accurate and legitimate self-blame and guilt can result from intentional perpetration or an intentional lack of action—cognitive restructuring may not be sufficient for the resolution of MI.[30]

To address the need for moral repair, SICPT employs spiritual tools to help resolve moral injury and its damaging sequelae, such as shame, guilt, rage, demoralization, and self-handicapping behaviors. Specifically, SICPT uses the spiritual concepts and rituals of compassion, grace, spiritual guided imagery, repentance, confession, forgiveness, atonement, blessing, restitution, and making amends.

Fourth, SICPT also encourages patients to access support from or emersion in a faith community, which can help with recovery and reintegration. Finally, in addition to identifying spiritual resources to aid in recovery, spiritual struggles, which are part of MI, are specifically normalized and addressed in treatment. Spiritual struggles might include feeling angry at God for allowing this to happen, feeling punished by God, questioning God's love and one's religious faith, feeling abandoned by God or one's faith community, or a complete loss of faith as a result of severely traumatic experiences. (''God'' is used here to represent the person's understanding of a transcendent power or higher being, which may widely vary.)

Given that SICPT makes explicit use of a patient's spiritual/religious beliefs, this intervention is only appropriate for individuals who identify as spiritual or religious. In a recent multisite study, nearly three-quarters of 427 Veterans indicated that religion was important or very important in their lives, over 80% indicated this for spirituality, and more than two-thirds indicated that they would definitely engage in or be open to engaging in a spiritually integrated treatment such as SICPT.[11] Thus, at least among U.S. Veterans, the vast majority finds religion/spirituality important and would be receptive to and eligible for such a treatment.

Session Content

Similar to CPT, SICPT is delivered in 12 sessions over 6 to 12 weeks.[31] Each session is 50 to 60 min in length and follows a similar format.

Session 1: Moral Injury and Rationale for SICPT focuses on rapport building, education on PTSD and MI, and the rationale for spiritually integrated cognitive processing treatment that targets MI to reduce PTSD. The patients' most traumatic event to be targeted in treatment is defined. For homework, patients write a statement describing the impact of the trauma on their beliefs about God, self, others, and the world; their spiritual belief, practices, and well-being; and how the trauma may have violated their conscience or created moral distress.

Session 2: Meaning of the Event and Spirituality begins with patients reading their impact statement and discussing its meaning, particularly that of the MI and the trauma's impact on their spiritual beliefs and practices. ''Stuck points'' (ie, erroneous or unhelpful beliefs driving the experience of negative emotions) are then added to the stuck point log. Patients state how they define and practice their spirituality and what spiritual resources they have available to them. The relationship between thoughts, feelings, and behavior are introduced using the A–B–C (Antecedent, Belief, and Consequence) worksheet. For homework, patients complete A–B–C worksheets and the My Spiritual Resources worksheet, which includes identifying someone in their spiritual community that might provide support during SICPT.

Session 3: Spiritual Resources and Moral Injury begins with a review of the worksheets completed for homework. Stuck points are discussed, particularly as they relate to MI, self-blame, and spiritual struggles. Patients are encouraged to make use of their spiritual resources and have regular contact with their support person. The spiritual values of cultivating kind attention and compassion are introduced as a lens through which to view the trauma and MI, in order to combat self-blame and condemnation. For homework, patients complete A–B–C worksheets on MI stuck points and read a short story on compassion.

Session 4: Kind Attention and Compassion begins by reviewing the A–B–C worksheets on MI stuck points and by discussing story on compassion. The impact that trauma and MI can have on one's spiritual well-being is explained and spiritual distress is normalized. Lament is introduced as a formal expression of sorrow and spiritual grief. The Spiritually Integrated Challenging Questions worksheet is introduced to help patients challenge stuck points using their spiritual beliefs and values. For homework, patients complete the Spiritually Integrated Challenging Questions worksheets, read the Spiritual Reactions to Trauma and MI worksheet, and write a lament.

Session 5: Challenging Questions and Spiritual Distress begins by reviewing the Spiritually Integrated Challenging Questions worksheet, discussing identified spiritual distress, and reading aloud and processing the patient's lament. The spiritual ritual of confession/acknowledgement is introduced as a tool for dealing with guilt resulting from violating one's moral code (eg, self-induced MI or rage/revenge for other-induced MI); if applicable, a confession ritual is chosen by the patient (eg, acknowledging in prayer the moral violation to a moral authority or confession to a priest, depending on client's faith tradition). The Patterns of Problematic Thinking worksheet is introduced, which is completed for homework, along with a daily confession ritual.

Session 6: Confession Ritual and Problematic Thinking begins by reviewing the Patterns of Problematic Thinking worksheet and the impact of emotions and thoughts that resulted from the spiritual ritual of confession. The spiritual tool of forgiveness is introduced as a tool for healing MI. Discussion includes the stages of the

REACH model of forgiveness (Recall, Empathize, Altruism, Committing, and Holding on)[32] and possible targets of forgiveness (ie, self, others, God). Patients identify someone they want to forgive for the MI. The Spiritually Integrated Challenging Beliefs worksheet is introduced, and the first 2 steps of forgiveness are assigned for homework. Patients also read a short story on forgiveness.

Session 7: Forgiveness I and Challenging Beliefs begins with reviewing the Spiritually Integrated Challenging Beliefs worksheet and patients' success with and impact of the first 2 steps of forgiveness. The last 3 steps in the REACH forgiveness model are introduced. The theme of trust for self, others, and God are discussed, including how their ability to trust may have changed as a result of the trauma and MI. For homework, patients read a module on trust and complete the REACH forgiveness worksheet. They also complete Spiritually Integrated Challenging Beliefs worksheets, particularly targeting stuck points related to forgiveness.

Session 8: Forgiveness II and Trust begins with a review of the REACH forgiveness worksheets and the Spiritually Integrated Challenging Beliefs worksheets, focusing on stuck points related to trust and forgiveness. Making amends (or restitution) is introduced as a spiritual tool for dealing with MI. If this is applicable, patients choose one action to complete over the next week to help another person, with the goal of neutralizing feelings of shame and guilt. The spiritual tool of verbally blessing others is introduced, and patients are asked to choose someone to bless. The theme of esteem for self, others, and God/divine being is also presented. For homework, patients read a module on esteem and complete Spiritually Integrated Challenging Belief worksheets on esteem-related stuck points, engage in the making amends action, and create and daily say a verbal blessing for someone.

Session 9: Making Amends and Esteem begins with a review of the completion and impact of the making amends and verbal blessing exercises, as well as the esteem-related Spiritually Integrated Challenging Beliefs worksheets. The theme of power/control related to self, others, and God/divine being is introduced next. Spiritual discrepancies related to power and control (ie, how one's lived experiences may differ from one's spiritual beliefs) are discussed and the emotions and stuck points that may have risen from these discrepancies. For homework, patients read a module on power/control and complete Spiritually Integrated Challenging Beliefs worksheets on this theme, particularly those related to spiritual discrepancies.

Session 10: Power, Control, and Spiritual Discrepancies begins with a review of the Spiritually Integrated Challenging Beliefs worksheets related to power/control. Spiritual discrepancies and spiritual issues related to power, such as anger at God, the limited nature of human perspective, free will, and active surrender, are discussed. The theme of intimacy related to self, others, and God is introduced. Spiritual partnerships are discussed, both in terms of how trauma and MI can impact these relationships and how deepening or reengaging in spiritual partnerships/community can help with the healing process. For homework, patients choose one way to develop greater intimacy with God or someone in their spiritual community. They also read a module on intimacy and complete Spiritually Integrated Challenging Beliefs worksheets on stuck points related to intimacy.

Session 11: Spiritual Partnerships and Intimacy begins with a review of the Spiritually Integrated Challenging Beliefs worksheets on intimacy and the completion and impact of the action to deepen intimacy. The theme of safety related to self, others, and God/divine being is introduced. The session concludes with the concept of post-traumatic growth (PTG; experiencing growth and benefits as a result of going through challenges and trauma) and how patients might be able to experience this, if they have not already. For homework, patients read a module on safety and complete Spiritually Integrated Challenging Beliefs worksheets on safety-related stuck points. They also write another trauma impact statement, state their current level of moral distress, and describe possible PTG they may have experienced or could imagine experiencing in the future.

Session 12: Post-Traumatic Growth and Safety begins by reviewing the Spiritually Integrated Challenging Beliefs worksheets on safety. Patients read the new impact statement and compare it to the original impact statement. Changes and growth are discussed, particularly as they relate to MI, spiritual well-being, and PTG. The rest of the session is spent reviewing the course of treatment and the major concepts and skills they learned, including their spiritual tools and resources (eg, compassion, kind attention, lament, confession/acknowledgment, forgiveness, making amends, verbal blessing, spiritual partnerships). Any remaining issues that need attention are identified, and future goals are set. Finally, patients are asked to "pay it forward" to other people, including those with similar issues, family members, their spiritual community, and those in need.

Religion-specific SICPT Supplements

The manual-based sessions described above were designed to be applicable for patients with spiritual and religious beliefs, with particular care given to make the therapy appropriate for patients who identify as spiritual, but not necessarily religious. We have also developed brief religion-specific SICPT supplements that cover each of the 12 sessions. These supplements are

available for 5 major world religions: Christianity, Judaism, Islam, Hinduism, and Buddhism. For each session, the supplements describe specific religious concepts, teachings, principles, and stories about religious figures that might inform treatment. Sacred scriptures, prayers, and rituals that relate to the content of each session are also provided. These religion-specific supplements are designed to aid therapists in deepening the work with their religious clients and providing background information about the various faith traditions that might be helpful in addressing trauma and MI.

Note that given space limitations, we are limited in how much detail we can provide on the content of the sessions in this article. For those who would like more detail, we would be happy to provide the full treatment manual and religions-specific supplements that are currently being refined through field testing and a future randomized controlled trial.

SICPT Case Study

This case is a compilation of several patients to protect confidentiality.

James is a 39-year-old Hispanic man and Iraq War Veteran who was diagnosed with PTSD. He presented at the VA for treatment, and upon evaluation, he scored 57 on the PTSD Checklist—DSM-5—Military Version (PCL-5) and described various war-related traumatic experiences on the Life Events Checklist-DSM-5. He reported experiencing flashbacks and nightmares, among other symptoms, since returning to the United States 1 year ago. The traumatic experience he named as most troublesome for him was "doing something bad" on a convoy he commanded. James also shared that his Christian faith was important to him, although he found it hard to practice as actively as before his deployment. Upon learning of the option of engaging in SICPT, James chose this treatment approach.

In session 1 of SICPT, James became teary-eyed when learning about the concept of moral injury and agreed to write about the convoy memory that plagued him for his impact statement that week. In session 2, James read his impact statement. He described the power inherent in his position as Convoy Commander and the presence, on that day, of a visiting dignitary, an attractive female who was assigned to travel in his vehicle. He stated that a civilian vehicle was repeatedly attempting to pass his convoy. At his orders, the vehicle was temporarily deterred by other military vehicles, but the civilian driver did not give up. Finally, as the vehicle approached James' vehicle, he ordered his driver to force it off the road. Right before the vehicle crashed, he saw a man and a woman in the front seat, with 2 small children in the back seat. He expressed much anger at the civilian driver for not standing down. He described the far-reaching implications of that experience, including losing trust in himself, others, and God, and feeling distant in his relationships. Regarding moral distress, he wrote, "Some actions are too bad to be forgiven."

In session 3, during the introduction of the spiritual values of kind attention and compassion for self, James again became teary-eyed. He remarked that he did not have a supportive community, and that he knew his church would reject him if they knew what he had done. He chose his uncle as his support person. In session 4, he reported a great deal of spiritual distress, which he wrote about in his lament that week.

During the review of ABC worksheets in session 5, the therapist remarked on James' tendency to be self-condemning. James began to open up about why the convoy experience bothered him so much. He said,

> There is that moment of decision when you must act and do what is right for the safety of all. But there is also that little voice inside that knows the truth. One small part of me forced that vehicle off the road into the overpass embankment—not to ensure our safety—but to show off for my VIP. What kind of person does that? I wasn't raised that way. I know God doesn't approve of that. What if those people all died in that car?

The therapist sought to convey understanding, but did not offer any quick answers. Instead, after a few minutes, the therapist introduced the spiritual ritual of confession/acknowledgment, a tool for resolving justified guilt. After discussion, James indicated he would be open to talking with a clergy person. Instead of his pastor, he opted for a referral to a mental health chaplain at his VA.

In session 6, James said he had not yet met with the chaplain, but had confessed his action to God in prayer. He was still struggling with guilt and shame from the event and said he wanted to work on forgiving himself. In sessions 7 and 8, they worked through the REACH forgiveness steps and he was able to forgive himself for his action motivated by wanting to impress the VIP. During this time, he also described a "great" visit with the chaplain, who told him that no act is beyond the reach of God's grace and forgiveness.

In session 9, for his making amends activity, James chose to volunteer with a local nonprofit that provides clothes and furniture to impoverished families. He wanted to dedicate his work there to the memory of the family in Iraq that was involved in the car accident. In session 10, he discussed his fear of returning to church, but also his longing to have those kinds of relationships in his life again. He e-mailed the therapist on Monday morning to say that he had gone to the Sunday morning worship service and was pleasantly surprised that people did not stare at him. He said that he even

had a nice conversation with a parishioner and that he intended to return next Sunday. In session 11, they went through the concept of PTG, and after the session, he noted that maybe his deepening intimacy with his wife was the start of this kind of growth.

In his second impact statement, which he read aloud in session 12, James said he had learned a valuable lesson from the convoy command on that day of the accident. He quoted the adage of "absolute power corrupting absolutely," and decided that he, along with the rest of the human community, was susceptible to temptation. He was also able to describe the sadness he felt for the family, but seemed to have made peace with the guilt. His PCL score registered at 31, indicating comparably reduced symptoms from his initial 57 score, and which fell under the cutoff of 35 for a probable diagnosis of PTSD. He also told the therapist that he hoped to help other Veterans like himself who were stuck in guilt and shame and that using the resources of his Christian faith would help him in finding healing from this traumatic event.

Conclusion

The recognition and treatment of PTSD has come a long way over the last few decades. We believe one of the next important steps for improving PTSD treatment effectiveness is to address specific barriers to recovery. One of these barriers is moral injury. Given that moral injury is composed of both psychological and spiritual symptoms, it follows that the most effective treatments for MI in the context of PTSD will be those that address both types of symptoms. As such, a spiritually integrated treatment that targets moral injury may reduce one of the barriers to full recovery from PTSD and may provide much needed relief for those who are suffering, particularly those who serve our country and protect our freedom. We offer SICPT as one such intervention that has the potential to fill this treatment gap. Research is needed to determine the empirical effectiveness of this approach for individuals who desire a spiritually or religiously integrated treatment for trauma.

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