



Brief Eclectic Psychotherapy for Moral Trauma (BEP-MT): treatment protocol description and a case study

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ABSTRACT

Background: Traumatic events can be related to severe transgressions or violations of moral boundaries. Moral injury (MI) has been described as 'the lasting psychological, biological, spiritual, behavioral and social impact of perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations.' These events can provoke emotions such as remorse, guilt and shame, and affects someone's self-image and identity.

Objective: The aim of the study is to evaluate a treatment protocol that addresses the specific characteristics of moral trauma in treatment of PTSD, next to anxiety.

Method: Brief Eclectic Psychotherapy for Moral Trauma (BEP-MT) is an adaptation of the evidence-based Brief Eclectic Psychotherapy for PTSD (BEPP). BEP-MT integrates components of cognitive-behavioural, psychodynamic, constructivist, and systemic psychotherapy. In the current study treatment progress of a refugee Dusan was monitored. Prior to and after treatment the Clinical-Administered PTSD Scale for DSM-5, the PTSD Checklist (PCL-5), the Brief Symptom Inventory (BSI) and the Moral Injury Appraisal Scale (MIAS) were administered. Every session moral emotions were assessed on a Likert scale.

Results: Whereas PTSD complaints and strong feelings of guilt and shame were manifest prior to treatment, during BEP MT a gradual decline in the intensity of the moral emotions was found. After BEP-MT Dusan no longer met criteria for PTSD and his psychological complaints diminished.

Conclusion: The case of Dusan has shown it is worthwhile to address moral trauma and BEP-MT is a promising treatment protocol for patients suffering from PTSD after moral trauma. Further research is needed to examine the effectiveness of BEP-MT.

Psicoterapia ecléctica breve para el trauma moral (BEP-MT): Descripción del protocolo de tratamiento y un estudio de caso

Antecedentes: Los eventos traumáticos pueden estar relacionados con transgresiones graves o violaciones de los límites morales. El daño moral (DM) se ha descrito como 'el impacto duradero psicológico, biológico, espiritual, conductual y social de perpetrar, fallar en prevenir o testificar actos que transgreden creencias y expectativas morales profundamente sostenidas'. Estos eventos pueden provocar emociones como remordimiento, culpa y vergüenza, y afectan la autoimagen y la identidad de una persona.

Objetivo: El objetivo del estudio es evaluar un protocolo de tratamiento que aborde las características específicas del trauma moral en el tratamiento del TEPT, junto a la ansiedad.

Método: La psicoterapia ecléctica breve para el trauma moral (BEP-MT) es una adaptación de la psicoterapia ecléctica breve basada en la evidencia para el TEPT (BEPP). La BEP-MT integra componentes de psicoterapia cognitivo-conductual, psicodinámica, constructivista y sistémica. En el estudio actual, se monitoreó el progreso del tratamiento de un refugiado, Dusan. Antes y después del tratamiento, se aplicó la Escala de TEPT para el DSM-5 administrada por clínicos, la Lista de chequeo de TEPT (PCL-5, por su sigla en inglés), el Inventario breve de síntomas (BSI, por su sigla en inglés) y la Escala de evaluación de lesiones morales (MIAS, por su sigla en inglés). En cada sesión, las emociones morales se evaluaron en una escala Likert.

Resultados: Mientras que las quejas de TEPT y los fuertes sentimientos de culpa y vergüenza se manifestaron antes del tratamiento, durante BEP-MT se encontró una disminución gradual en la intensidad de las emociones morales. Después de BEP-MT, Dusan dejó de cumplir los criterios para el trastorno de estrés postraumático y sus quejas psicológicas disminuyeron.

Conclusiones: El Caso de Dusan ha demostrado que vale la pena abordar el trauma moral y BEP-MT es un protocolo prometedor para los pacientes que sufren de trastorno de estrés postraumático después de un trauma moral. Se necesitan más investigaciones para examinar la eficacia de BEP-MT.

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关键词

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HIGHLIGHTS

- BEP-MT is a promising treatment protocol that addresses moral injury, which encompasses emotions such as remorse, guilt and shame, and negative self-image, after traumatic events that include transgressions or violations of moral boundaries.

道德创伤的简单折衷心理疗法 (BEP-MT): 治疗方案说明和案例研究

背景: 创伤事件可能与严重违法或违反道德界限有关。道德伤害 (MI) 被描述为“犯下、未能预防或见证违背深层道德观念和期望行为的持久心理、生物、精神、行为和社会影响。”这些事件会激起诸如悔恨、内疚和羞耻的情绪, 并影响某人的自我形象和身份。

目的: 研究的旨在评估一种治疗方案, 该方案致力于PTSD治疗中有别于焦虑的特定道德创伤性创伤特征。

方法: 道德创伤的简明折衷心理疗法 (BEP-MT) 是针对PTSD询证简明折衷心理疗法的改编 (BEP, Gersons et al, 2000; Gersons & Olf, 2005; Gersons & Schnyder, 2013)。BEP-MT整合了认知行为、心理动力、建构主义和系统性心理治疗的组成部分。在本研究中, 监测了难民杜尚的治疗进度。在治疗前后, 都要使用DSM-5临床用PTSD量表、PTSD清单 (PCL-5)、简要症状量表 (BSI) 和道德损伤评估量表 (MIAS)。每次治疗的道德情感都用李克特量表进行评估。

结果: 尽管在治疗前出现了 PTSD 抱怨以及强烈的内疚和羞耻感, 在 BEP MT 期间发现道德情感的强度逐渐下降。在 BEP-MT 之后, 杜尚不再符合 PTSD 的标准后, 他的心理抱怨也减少了。

结论: 杜尚的案例表明, 解决道德创伤是值得的, 而 BEPMT 是一个对于道德创伤后 PTSD 患者有前景的治疗方案。需要进一步研究来考查 BEP-MT 的有效性。

1. Introduction

Traumatic events can be related to severe transgressions or violations of moral boundaries. A growing number of studies focus on moral injury (MI) as a construct to describe the impact of such events. The most common definition of MI is the definition of Litz et al. (2009). They describe MI as ‘the lasting psychological, biological, spiritual, behavioral and social impact of perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations.’

The events that are considered a Potentially Morally Injurious Event (PMIE) diverge. Litz and Kerig (2019) propose a heuristic model to differentiate moral challenges and moral stress from PMIE. They define experiences that have no immediate self-relevance as ‘moral challenges’, such as concerns about societal issues. These experiences may result in moral frustration. When an event is self-referential, namely when someone has to act or to refrain from acting or when someone is affected by someone else’s transgressive behaviours, e.g. bullying, the event can be considered ‘moral stress’, with moral distress as a response. They define a PMIE as more serious than moral stress, with ‘moral injury’ as a more serious response. A PMIE encompasses grave threats to personal integrity or loss of life. PMIEs are generally categorized into two types of events: moral transgressions in which someone acts or fails to act and events in which someone is exposed to someone else’s transgressions. MI in response to such an event is different from moral stress as the severity of moral emotions, i.e. shame and guilt is stronger and the event affects someone’s self-image and identity (Litz & Kerig, 2019).

Litz et al. (2009) describe that remorse about morally wrong behaviour can provoke feelings of guilt, while blaming oneself because of a perceived personal inadequacy, shame, and anger challenge beliefs about self and others, with demoralization, self-harm, avoidance or sometimes (self)destructive behaviour as a result. In

military populations, MI is associated with aggressive behaviours (Begić & Jokić-Begić, 2001), poor self-care (Schnurr & Spiro, 1999), self-harm (Bras et al., 2007), alcohol and drug abuse, severe recklessness, self-handicapping behaviours and demoralization (Litz et al., 2009). An immoral act can also provoke compensatory behaviours in response, which was found to be less likely in individuals that engaged in symbolic action, such as physical cleansing to restore the moral self (Zhong & Liljenquist, 2006).

However, most research on MI focus on the military, other populations are also at risk for MI. For instance, Feinstein, Pavisian, and Storm (2018) observed symptoms of MI in journalists covering the migration crisis in Europe and closely witnessed painful events, but often were not able to provide aid. Also, amongst law enforcement officers MI is observed and was an important predictor of PTSD symptoms (Papazoglou et al., 2020). The current COVID-19 pandemic has posed serious moral dilemmas to health care professionals and studies refer to mental health consequences, but also to MI (Kopacz, Ames, & Koenig, 2019; Lu et al., 2020; Lu, Wang, Lin, & Li, 2020; Wang et al., 2021). A population at high risk for MI are refugees. Refugees are often exposed to multiple trauma in their country of origin and on their flight to seek refuge, and can be exposed to PMIEs as a civilian during war time, as torture survivor, but also in the military. Studies have found a major impact of PMIEs on mental health and beliefs about self and others (Hoffman, Liddell, Bryant, & Nickerson, 2018; Nickerson et al., 2015).

A PMIE can be defined as a moral trauma if it meets the DSM-5 definition of trauma (criterion A), when the event is related to perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations (American Psychiatric Association [APA], 2013; Litz et al., 2009). The cognitive, emotional and behavioural consequences may then be

consistent with a diagnosis of Posttraumatic Stress Disorder (PTSD). Treatment of PTSD generally focuses on imaginary exposure of anxiety related to a life-threatening trauma. As MI is characterized by emotions of remorse, guilt and shame, part of criterion D of PTSD, and related to a moral trauma, next to anxiety, it would be valuable to address the specific characteristics of moral trauma in treatment of PTSD (Litz et al., 2009).

In the current paper the aim is to describe a treatment protocol that was designed for PTSD, but adapted for moral trauma to focus not merely on anxiety, but also on the specific characteristics of MI, in particular the moral emotions: the Brief Eclectic Psychotherapy for Moral Trauma (BEP-MT). The treatment of moral trauma is illustrated by a case study of a refugee who served in the military in his country of origin during the war.

2. Method

2.1. Procedure

ARQ Centrum '45 is a Dutch mental health institute specialized in treatment of psychopathology associated with trauma and (multiple) loss due to war or organized violence and work-related trauma, with national referrals for patients that cannot be treated elsewhere.

At the department for refugees, patients that are eligible for treatment enrol in either outpatient treatment at our polyclinical or day-treatment programme after intake (de la Rie et al., 2020). Assessment is carried out prior to the start of trauma focused treatment and after finishing treatment. When psychological complaints have not decreased, follow-up treatment is recommended. In a case of persisting symptoms related to a moral trauma, it was decided to offer BEP-MT as a pilot study of the protocol. Assessment is carried out prior to the start of BEP-MT and after finishing treatment. Treatment progress is assessed by weekly assessment of changes in emotions.

2.2. Measurements

2.2.1. PTSD: Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)

The Dutch version of the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5; Boeschoten et al., 2018; Weathers et al., 2018) is a clinician rated interview to assess diagnostic criteria for PTSD of the DSM and the severity of PTSD complaints. Psychometric properties of this version were described as good (Boeschoten et al., 2018; Weathers et al., 2018). PTSD symptom severity score is calculated by summing the scores of the 20 DSM-5 PTSD symptoms (range 0–80) (Weathers et al., 2018).

2.2.2. PTSD Checklist (PCL-5)

The PTSD Checklist (PCL-5) is used to measure PTSD symptoms. This 20-item questionnaire measures PTSD

symptoms according to the DSM-5 (Wortmann et al., 2016). Psychometric properties are adequate (Blevins, Weathers, Davis, Witte, & Domino, 2015; Krüger-Gottschalk et al., 2017).

2.2.3. General psychopathology: Brief Symptom Inventory (BSI)

The Brief Symptom Inventory is a 53-item self-report questionnaire (BSI; De Beurs & Zitman, 2006) that measures symptoms of psychological stress on nine subscales: depressive mood, interpersonal sensitivity, hostility, somatization, psychoticism, suspicion, phobic fear, cognitive problems and anxiety. Answers are scored on a 5-point Likert scale (0 = 'totally disagree' to 4 'totally agree'). Internal consistency is high (Cronbach's $\alpha = .87$) (Abu Ruz et al., 2010).

2.2.4. Moral injury: Moral Injury Appraisals Scale (MIAS)

Moral injury is assessed with the Moral Injury Appraisals Scale (MIAS; Hoffman et al., 2018). The MIAS is a modified version of the Moral Injury Events Scale (Nash et al., 2013) and the Moral Injury Scale of Nickerson et al. (2015). This 9-item questionnaire consists of five appraisals of MI in respect to the self (MI-Self) and four appraisals with respect to others (MI-Other). Each question is rated on a 4-point Likert scale (1 = not at all, 4 = very much). In the study of Nickerson et al. (2015) a two-factor structure of the MIAS was confirmed. This suggests that there are two distinct subtypes of MI appraisals that are salient for refugees, namely MI-Other and MI-Self. This is in line with studies on MI in military samples that describe separate factors relating to one's own and others' actions (Bryan et al., 2016; Currier et al., 2015; Nash et al., 2013).

2.2.5. Anxiety, sadness and moral emotions: emotion self rating scales

Anxiety, sadness, and moral emotions, namely shame and guilt, are assessed weekly using four Likert scales. The Likert-scales ranged from '0 = no feeling of emotion' to '10 = maximum intensity of feeling of emotion'.

3. Treatment of moral trauma: Brief Eclectic Psychotherapy for Moral Trauma

The Brief Eclectic Psychotherapy for Moral Trauma (BEP-MT) is an adaptation of the Brief Eclectic Psychotherapy for PTSD (BEPP; Gersons et al., 2000; Gersons & Olf, 2005; Gersons & Schnyder, 2013). BEPP has been found effective in PTSD and is recommended in the guidelines of the American Psychological Association (American Psychological Association, Guideline Development Panel for the Treatment of PTSD in Adults, 2017). An adaption of the BEPP protocol for traumatic grief (BEP-TG) has been found relevant to

Table 1. BEP-MT protocol.

Number of Session	Phases of treatment	Components of the different phases
Session 1	Information and Motivation	Explanation of the treatment: the framework of the treatment protocol and explanation of the gradual imaginary exposure to the Moral Trauma and dealing with the thoughts and emotions that are provoked by the trauma, including feelings of guilt and shame
Session 2–7	Imaginary Exposure on Moral Trauma	Imaginary exposure on Moral Trauma: the traumatic event is explored repeatedly in a slow pace with detailed questions in the present tense, in particularly in the 'hotspot'. If necessary: stimulus exposure and exposure with response prevention on dysfunctional coping strategies
Session 3–6 Session 7–16	Mementos and Writing Tasks Finding Meaning and Activation	Bringing mementos to the sessions alongside exposure and writing letters at home Getting to terms with a shattered world view and self image. Addressing moral emotions like feelings of remorse, and in particularly guilt and shame: 'wrong-doing' and 'wrong- being' A new perspective on the future: new social, recreational, and, if relevant, work-related goals.
Session 13–16	Farewell or Closure Ritual	Repent and remember, a symbolic farewell and transition to a new phase of life at the end of treatment.

patients with traumatic loss (Smid et al., 2015) and has been applied for the treatment of refugees (de Heus et al., 2017).

BEP-MT integrates components of cognitive-behavioural, psychodynamic, constructivist, and systemic psychotherapy. The integration of different treatment components within the phases of one protocol differentiate BEP-MT from traditional CBT treatment protocols. It consists of five components that also comprise BEPP and BEP-TG and that are specifically adapted to meet the needs of moral trauma survivors. BEP-MT can be used in moral trauma in general populations, but can accommodate cultural aspects of moral trauma. It incorporates interventions of cognitive behavioural therapy of PTSD for MI in veterans such as Adaptive Disclosure (Litz, Lebowitz, Gray, & Nash, 2017). In comparison to Adaptive Disclosure, which is an effective short treatment protocol for PTSD in the military, the current protocol is longer, more explicitly focusses on moral emotions during the phase of exposure as well as during the phase of finding meaning with a variety of interventions. BEP-MT has several experiential components, like making use of mementos, writing letters, the imagery conversation and the use of rituals. These elements contribute to a less cognitive approach in BEP-MT.

It is adapted for anyone that is exposed to moral trauma. Table 1 shows the structure of the protocol.

The different components of BEP-MT are as follows:

3.1. Information and motivation

The first session is to inform and motivate the patient. The patient is asked to bring along a partner or close friend. First of all the view on his or her symptoms and how these symptoms are related to his or her moral trauma are discussed. It is explained that the first sessions will focus on the gradual imaginary exposure to the Moral Trauma and dealing with the thoughts and emotions that are provoked by this trauma and that expression of

emotions is encouraged. The aim of the treatment is explained: learning to deal with the moral trauma and relieving symptoms related to moral trauma, the moral emotions, posttraumatic stress and depression. The further course of treatment is briefly explained.

3.2. Imaginary exposure

The second to the sixth sessions will focus on imaginary exposure on the moral trauma. First the therapist explains that people with moral trauma can avoid their pain and feelings related to the moral traumatic event, in particular when emotions of shame and guilt increase the anxiety to speak about it. The aim of exposure is explained, i.e. how exposure can enable the patient overcome their anxiety for their emotions and to realize that he can manage the painful and shameful reality of the moral trauma and the feelings and thoughts associated with it. Imaginary exposure of BEP-MT is different from prolonged exposure or Narrative Exposure Therapy (NET). In imaginary exposure of moral trauma, the therapist encourages the patient to reflect on the moral trauma, asking about what happened, his or her role in the event and the circumstances surrounding the moral trauma, noticing (nonverbal) emotional reactions of the patient. After short Jacobson exercises the patient keeps his eyes closed. The imaginary exposure will last 20 minutes. Only a part of the traumatic event will be explored, the pace is very slow. The therapist encourages the patient to express what he sees, hears, smells, thinks, feels and which physical sensations are experienced in the present tense. The therapist will ask frequently to express what the patient think and feels emotionally and physically right now, while sitting in the therapist room. There is intensive attention for the most distressing moments of the moral trauma ('hot-spots'). Hotspots will be frequently addressed. At the start of the next session the imaginary exposure will restart at the first hotspot. During 5–6 sessions of imaginary exposure the complete traumatic event and all its details will be explored. The therapist encourages the

patient to express what he sees, hears, smells, thinks, feels and which physical sensations are experienced in the present tense. When a patient avoids particular memories of specific events related to the moral trauma, the therapist continues with exposure until recollections of the moral trauma arouse less intense emotions and are no longer avoided. Essential in the BEP-MT protocol is that the imaginary exposure focuses on the feelings of deep sorrow. At a certain point patients are crying, thus releasing the feelings. This encompasses the start of self-compassion.

When the flashbacks or nightmares about the event are accompanied by dysfunctional coping strategies such as avoidance, stimulus exposure and exposure with response prevention can be introduced. Stimulus exposure to different cues or reminders of the event that are avoided can be introduced. Response prevention to e.g. compulsive washing ('moral cleansing') will facilitate to feel and express the emotions that are avoided, that enables experiencing that anxious expectations will not come true (e.g. 'going mad')

3.3. Mementos and writing assignments

The third to sixth sessions mementos and writing assignment accompany the exposure. During this phase of treatment and alongside the imaginary exposure, bringing mementos to the sessions and writing letters are useful interventions for expression of feelings of sadness, anger and guilt associated with the moral trauma.

3.3.1. Mementos

Mementos are objects that symbolize the bond with the event of the moral trauma, such as pictures or objects that are (symbolically) linked to the traumatic event. Bringing along and talking about these objects enhances exposure. The thoughts and feelings regarding the object are discussed. When there are no mementos, the therapist can use drawings of the patients or images/pictures on internet.

3.3.2. Writing assignments

Writing assignments are a useful tool to enable patients to overcome avoidance of emotions and to bring about cognitive change (Wagner, Knaevelsrud, & Maercker, 2006). There are several writing assignments, which can all facilitate expressing feelings of remorse, sadness, anger and anxiety related to the moral trauma. The form of the writing assignment is related to the characteristics of the moral trauma and the personal characteristics. It could be an 'angry letter' to perpetrators, a 'farewell letter' to deceased victims, or a 'remorse letter' expressing feelings of remorse towards other victims in which the patient can express feelings of shame and regret.

3.4. Finding meaning and activation

After the phase of imaginary exposure, the next phase of BEP-MT focuses on finding meaning and activation. A moral trauma confronts people with cruelty and often harsh parts of human behaviour. It affects their world view and self-image. The moral trauma as well as intervening stressors are associated with loss of safety, trust, morality, self-esteem, and power. The patient needs to confront all aspects of the moral trauma, to facilitate self-forgiveness and openness to speak with others, learning to trust others and himself again, to adjust his negative world view. Whereas it may be that some events are cruel, and seemingly meaningless, finding meaning refers to helping a patient to reflect on what the event means for his or her view on him/herself, the world and others, as meaning is attributed to events regardless of its nature. This phase aims to enable understanding of and dealing with the emotions provoked by moral trauma and to formulate a future perspective.

3.4.1. Finding meaning

The therapist needs to acknowledge the impact of the moral trauma and show empathy with the thoughts and feelings related to it as well as challenge negative beliefs. Exploring the appraisal of the event, and discussing different viewpoints may contribute to a nuanced meaning to an event, other than for example 'all good, all bad'. The therapist may use an imaginary conversation with a moral authority, in which the patient decides who he regards as moral authority, for example, a higher power (God, etc.), a tribunal or judge, or a leader of the community (Litz et al., 2017).

3.4.2. Interventions focused on shame and guilt

Moral emotions such as guilt and shame are considered 'self-conscious' emotions (Farnsworth, Drescher, Nieuwsma, Walser, & Currier, 2014). Whereas feelings of guilt are related to the perception of 'wrong-doing,' feelings of shame are more often perceived as feelings of 'wrong-being' (Farnsworth et al., 2014; Tangney, Stuewig, & Mashek, 2007). Strong feelings of guilt can be addressed using experiential and cognitive techniques that may help discriminate between real and perceived (exaggerated) guilt. An example of a cognitive intervention could be to discuss a 'responsibility pie' (Greenberger & Padesky, 1995), in which the contribution of the self and others to the moral trauma can be visualized. In case of 'real' guilt, (symbolic) compensation can be discussed. Strong feelings of shame affect self-worth. It is often associated with withdrawal or hiding from others as they are expected to condemn oneself. However, it may also provoke intense anger to compensate humiliation (Farnsworth et al., 2014; Tangney et al., 2007). A non-judgemental therapeutic alliance and fostering positive moral emotions, such as (self-)compassion may alleviate the feelings of guilt and shame.

3.4.3. *Activation*

After exposure and finding meaning, inactivity can be addressed. It is important that the patient finds his way to let go of the past and to see to what extent the worldview in which people are bad, aggressive and dangerous can be adjusted. It will be possible to look ahead to the future. The therapist explores what kind of activities a patient used to like and which activities the patient would like to start again. The therapist encourages the patient to think of new goals.

3.5. *Farewell ritual*

At the end of therapy, the therapist can address if the patient regards what could be a way to repent or do something to remember the victims in a culturally sensitive manner. In the last sessions of treatment the patient thinks of an appropriate farewell ritual suitable for his or her situation. A farewell ritual completes treatment. Patients are encouraged to fully express, the sorrow they still feel, for one last time, and then to celebrate leaving it all behind and regaining control over their life (Gersons & Olf, 2005). This farewell ritual can symbolize an irreversible transition, justifying emotions, facing the reality of an ending, learning from experience, and experiencing support and comfort (Van der Hart & Boelen, 2003). Examples of a farewell ritual include: visiting the place where the moral trauma took place; visiting a memorial to commemorate the event; creating a lieu of remembrance; performing a culturally appropriate ritual; making a donation or doing community service or volunteer work for a related charity; renouncing objects related to the traumatic circumstances of the moral trauma; burning the angry letter(s).

The ritual marks the end of treatment, a farewell of the therapist who encourages the patient to share the ritual with loved ones.

4. *The case of Dusan*

This first case study with BEP-MT is that of a refugee, who has been in the military in his country of origin. The described case has been disguised, in particular regarding personal information, to protect the privacy. Permission to use this case illustration was granted by the client and is on file.

Dusan was born in what is now called Bosnia-Herzegovina, former Yugoslavia, and was raised in a small village with his parents and two sisters. When Dusan turned 18 years old he had to serve in the Yugoslavian army as part of obligatory military service and he was sent to a rural area. During the war he defected like many other Bosnian men and picked up arms to defend the Bosnians. After some time fighting on the frontline, he fled to the Netherlands. He lived and worked in the Netherlands for many

years and developed PTSD symptoms after major life events. These became so severe and impaired his everyday functioning to the extent that he was referred to ARQ Centrum⁴⁵ for specialized treatment.

At intake Dusan was clinically diagnosed with PTSD, and depressive disorder. At the intake assessment he scored in sum 31 out of 80 on the CAPS, which is considered moderate PTSD (Weathers et al., 2018), he scored 56 out of 80 on the PCL-5 (Wortmann et al., 2016) and 2.4 on the BSI (De Beurs & Zitman, 2006). He enrolled in the yearlong outpatient day treatment for refugees with PTSD (de la Rie et al., 2020). During the day treatment he completed Narrative Exposure Therapy in which his most severe traumatic events were treated with NET (Schauer, Neuner, & Elbert, 2011). Although the NET enabled him to deal with several traumas, one specific trauma was still haunting him after completion of the therapy and PTSD complaints diminished, but not below threshold. This situation, which is described in the next paragraph, was linked to flashbacks he suffered. It provoked an extreme sense of shame and guilt, which had prevented him to share this trauma with anybody. As he built trust and felt ready to discuss this moral trauma with his therapist, he agreed to start with BEP-MT.

Before treatment with BEP-MT, several instruments were administered to assess symptoms. On the CAPS 5 Dusan scored 25 out of 80, which is considered mild PTSD (Weathers et al., 2018). On the PCL-5 as measured at the start of the BEP-MT he scored 49 out of 80 (Wortmann et al., 2016). On the BSI as measured at the start of the BEP-MT he scored 2.08 (total is 4), (De Beurs & Zitman, 2006). The MIAS was used to get an indication on the nature and level of the moral trauma that Dusan suffered from (Hoffman et al., 2018). Dusan scored 31 at start of the BEP-MT (range 4 to 36). During the treatment trajectory Emotion Self-rating scales were used to monitor the patients' feelings of fear, sadness, shame and guilt at the start of every session. At the first session he scored 'anxious = 9, sadness = 9, shame = 10, guilt = 10'.

5. *Results*

5.1. *Brief eclectic psychotherapy for moral trauma in the case of Dusan*

The case study illustrates how different common aspects of moral trauma can be addressed during BEP-MT at different phases of the treatment.

5.1.1. *Information and motivation*

Dusan was informed about his treatment at his last treatment evaluation, when finalizing the day-treatment program. He was asked to bring along his wife when starting the BEP-MT to explain this particular treatment in more detail.

The first session of the BEP-MT Dusan arrived without his wife. Although Dusan's wife was informed about his treatment, she had no information on the traumatic events Dusan has been exposed to. He was unwilling to share this painful event with her and hesitated to enter treatment that would focus on his moral trauma. His nightmares had disappeared after NET, but he continued to have daily flashbacks which were solely about his moral trauma. After the psycho-education Dusan understood the need to process feelings of guilt and shame, but he felt reluctant to do so emotionally. The therapist validated his feelings. He was encouraged to keep on expressing his feelings and hesitations and to give the treatment a chance. After this, the aim of the treatment was explained: learning to speak about the event, confronting emotions connected with it and relieving symptoms related to post-traumatic stress and moral trauma. A treatment plan for the sessions was finalized together with the patient.

5.1.2. Exposure: imaginary exposure on witnessing a mass execution of innocent civilians during the war

The next sessions of BEP-MT focused on imaginary exposure of the moral trauma. In the case of Dusan his moral trauma was explored step by step and in great detail throughout the sessions. No other forms of exposure were necessary.

Dusan hardly slept prior to the first exposure sessions. His level of anxiety and sadness increased, and he withdrew himself more from family life. His urge to avoid was validated and the function was explained. He then was encouraged to speak about his moral trauma. He told about witnessing a mass execution of innocent civilians during the war.

During his time as a soldier in the Yugoslavian army he and his unit had to strike a village in a rural area, a place unknown to him. They were told they were under attack and that they had to clear the area. Dusan and his unit ran towards the nearest town and he and some other soldiers took an elderly couple from their house. They gathered all the captives in an open location just outside the village. It gradually became clear that they hadn't been under attack at all and that the people they captured were just ordinary older civilians. When the military captain, who was Serbian, walked towards the captives, he started shouting and beating them. Dusan saw this happening from a distance and didn't know what to do. He was shocked, afraid and angry. But he didn't dare to intervene because he knew he would be taken prisoner or be killed. After a minute the military captain drew his gun and killed an older man. At that time all the other captives were killed by a few soldiers. After this, Dusan and his unit moved on. Nobody spoke about what happened ever again. The images of fear in the eyes of these innocent people and the killed lifeless bodies

were coming back to Dusan every day in flashbacks and recurrent nightmares. He felt responsible for the killing, because he was part of the army unit in this operation and the two people he took from their house, were later killed. He felt ashamed and guilty of not having stood up to the authority of the Serbian army captain and the other soldiers that performed the killing. In later parts of his life he had tried to make right what he felt was done wrong in this incident by actively engaging in activities to protect others in need. Also, his worldview was changed and his trust in other people was lost due to this situation. He felt ashamed and scared to talk about it, having to confront what he didn't do and his feelings connected to it. He was easily angered when he felt something was unjust.

During the imaginary exposure Dusan experienced strong feelings of fear and tension in his body. Towards the end of the imaginary exposure he felt strong feelings of sadness, being confronted with the death of innocent people. He felt more calm after being able to express his emotions.

5.1.3. Mementos and writing assignments: a bracelet and letters of anger and sorrow

In the sessions 3–6 mementos and writing assignments were introduced to Dusan. His memento was a bracelet he received from a friend. This provided support, strength and confidence in difficult situations. He wore this bracelet also during the moral trauma and it reminded him of the time he spent fighting in the war. It was used to support the exposure.

Dusan started writing letters at the 7th and 8th session, which facilitated the transition from the phase of exposure to the phase of finding meaning. The first letter was an angry letter to the perpetrators, and more specific the Serbian commander. He called this letter 'Why?'. He expressed his anger in the letter, but only to a certain limit in order not to be like the perpetrators. The second letter was to ask forgiveness to the victims. He experienced sadness, fear, guilt and shame writing this letter. Both letters he wrote in his native language to be able to express himself more freely. In the session he read them to the therapist first in his own language and then he translated them to the language spoken in the therapy. This both provoked similar feelings.

5.1.4. Finding meaning and activation

5.1.4.1. Finding meaning: imaginal conversation with a moral authority. In the treatment of Dusan, an intervention was used in which he engaged in an imaginal conversation with a higher authority by means of an empty chair technique (Litz et al., 2017). At first Dusan was sceptical. He chose to design a courtroom or tribunal by placing five chairs in the room, two on either side, and one in the middle from where Dusan discussed his case with the different

entities. The moral authorities, a Dutch civilian and a German judge, were asked to 'look at his case.' The audience consisted of the family of the victims in one chair and the deceased victims in another chair. In the imaginal conversation, he discussed his case and took the viewpoints of all four other parties in the room. All moral aspects of the event were expressed and weighed. Especially the imaginary conversations with the family of the victims and the victims he found confrontational, emotional, painful and insightful. He was able to make a sincere apology. He also experienced his own feelings of grief and loss of family and friends in the Bosnian war.

5.1.4.2. Interventions focused on shame and guilt: a weight off Dusan's shoulders. At this moment in therapy Dusan was more able to explore his feelings of guilt and shame, having gained trust within the therapeutic alliance. His feelings of guilt and shame were challenged by discussing an analysis of the advantages and disadvantages of these feelings, to better understand why it was important for him to hold on to the moral trauma and the difficulties to accept what happened.

His feelings of shame prevented him to share this trauma with his wife, who descends of a similar ethnic background as the villagers. After being able to open up about his trauma within the context of a nonjudgmental therapeutic alliance, he decided to open up and told his wife what kept him awake at night. Sharing with her was extremely difficult for him, but eventually helped him to feel less shame about what happened because of her understanding reaction. A weight was lifted off his shoulders and it decreased his feelings of shame and fear, his physical pain problems, his concentration issues and flashbacks of the moral trauma. In the final part of the therapy a theme was 'daring to let go of the moral trauma'. Dusan had lived with this memory for many years and this had severely limited his daily functioning. To rebuild his life and start normal daily activities shifted the focus from his past to the here and now and his future.

5.1.4.3. Activation: a cautious change in Dusan's world view. Dusan distrusted people and he carried a secret with him for years. After creating more openness and the love and support he felt in return, his view of the world and humanity also seemed to become less negative. He also restarted some of the activities he used to do.

5.1.5. Farewell ritual of Dusan

During the last treatment sessions, Dusan thought of a way to repent and remember the victims. He decided to do volunteer work for an international NGO and to annually light a candle in his home for the people that were killed that day.

Dusan explored what would be an appropriate farewell ritual in his case. Burning of the angry letter was not yet an option for him. At the end of the therapy Dusan took a stone home with him to throw in a nearby lake as a way to mark ending his treatment of the moral trauma. This stone was a symbol to mark the moral trauma and his role in it.

The last session his wife joined Dusan. She then realized the impact of the moral trauma on his life, their relationship and his functioning as a father. It encouraged them to reconnect and to share their feelings and needs.

5.1.6. Treatment evaluation

In Dusan's case PTSD-symptoms and feelings of shame and guilt related to the moral trauma decreased. On the CAPS-5 the score was reduced to 19, which is considered asymptomatic/few symptoms on PTSD. Overall a decrease of more than 15 points on the CAPS is considered clinically significant (Weathers et al., 2018). On the PCL-5 he scored 36, showing a decrease in PTSD-symptoms. On the BSI his scores went down to 1.06, showing a significant decrease in symptoms. The score on the MIAS was 28 at finishing treatment. He felt slightly less troubled by morally wrong things done by others and things he has done. On the Emotion Rating Scales he scored 'anxious = 4, sadness = 3, shame = 5, guilt = 5' at the last session. During the BEP-MT the patient reported a gradual decline on the felt intensity on these four emotions. The scores are summarized in Table 2.

In an evaluation of his treatment process, Dusan admitted he had sincere doubts to start the therapy, but he was happy to have completed the sessions, and where it had taken him. It had helped him to work on his core problems. He felt strong to be more active and less avoidant, his global functioning had improved substantially. He was able to have a more nuanced perspective on his responsibility during the moral trauma. He mentioned that especially the intervention in which he engaged in an 'imaginal conversation with a moral authority' was of great value. Furthermore, he had dared to open up to his wife, which decreased his feelings of shame. He then felt more connected with his own feelings and as a result of this also his loved ones. He again felt joy to continue his life again.

6. Discussion

This paper describes the application of BEP-MT on moral trauma, PTSD and general psychological symptoms in a single-case treatment.

Whereas Dusan's symptom severity due to multiple traumas decreased after NET, his moral trauma kept haunting him and prevented him to fully benefit from regular PTSD treatment. Psychological complaints persisted, resulting in impaired functioning. Witnessing

Table 2. Change in symptoms before and after treatment.

Instrument	Before NET at TDV	Before BEP-MT	After BEP-MT
CAPS-5	31	25	19
BSI	2.4	2.08	1.06
PCL-5	56	49	36
MIAS	n.a.	31	28
ERS anxiety	n.a.	9	4
ERS sadness	n.a.	9	3
ERS shame	n.a.	10	5
ERS guilt	n.a.	10	5

TDV = Daytreatment Program; NET = Narrative Exposure Therapy; BEP-MT = Brief Eclectic Psychotherapy for Moral Trauma. CAPS-5 = Clinician Administered PTSD Scale for DSM 5; BSI = Brief Symptom Inventory; PCL-5 = PTSD Checklist for DSM 5; MIAS = Moral Injury Appraisals Scale; ERS = Emotion Rating Scale; n.a. = not applicable.

a moral transgression of murder, committed by others, in which he did not act to prevent it provoked guilt, shame and remorse, alongside anxiety. The trauma evolved to a central event in the way he perceived himself as a person, as 'wrong-being' provoking intense feelings which he tried to avoid and ruminated about. It changed his view on others and ruminated about the cruelty of mankind. He could only discuss this trauma and the invalidating emotions, after gaining trust in the therapist.

The event took place during Dusan's service as a military, but he has been exposed to multiple trauma, like most refugees, resulting in a high trauma load. In general, the type of traumas refugees are faced with may encompass life threatening situations, (sexual) abuse, moral transgressions, but also traumatic loss and post migrations stress, eliciting a wide range of emotions in response. Nickerson et al. (2015) described that the extent to which someone is affected by moral transgressions contributes significantly to mental health outcomes and quality of life in refugees, even after controlling for dosage of trauma exposure and postmigration stressors. Whereas NET is recommended as an evidence based treatment in refugees (Nosè et al., 2017), and addresses most debilitating traumas, the need to address specific emotions, such as grief after traumatic loss of loved ones or moral emotions after moral trauma is warranted when psychological complaints persist. The current protocol may then facilitate further decrease of symptoms.

The protocol was not specifically adapted for refugees. Whereas refugees are at risk, moral trauma can also affect, among others, law enforcement personnel or journalists (Feinstein et al., 2018; Papazoglou et al., 2020). In the recent COVID-19 pandemic moral trauma can also affect health care professionals (Wang et al., 2021; Kopacz et al., 2019; Lu et al., 2020). As the distress and moral emotions that are provoked by such a trauma may be comparable for people from different backgrounds, it could be worthwhile to examine if the current protocol could be similarly helpful for others who have been exposed to moral trauma, but currently this is not known.

The merits of the BEP-MT protocol could be that this modified evidence-based treatment protocol (BEP)

for PTSD enables to focus on specific aspects of a moral trauma, the slow pace fosters a corrective experience within the therapeutic alliance that alleviates shame and it encompasses more tools to address the different emotional aspects of the moral trauma through experiential techniques (memento's, writing assignments, ritual and imaginary conversation with moral authority/victims, next to the CBT-interventions), than is the case with a focused CBT-protocol, which focusses more on exposure and cognitive interventions.

The current paper has limitations. It describes an adapted treatment protocol in a single-case study, which obviously warrants for cautious conclusions. So far no research on the effectiveness of the protocol has been carried out, and currently several cases are monitored that may lead up to a multiple baseline study to examine the effectiveness of the treatment protocol. Furthermore, it is unclear what specific or unique elements of the current protocol are most relevant. Further research is needed to examine the effectiveness of the protocol with different patients in an RCT that will compare this treatment protocol with other forms of treatment that address moral trauma. No recommendations can be drawn from this study yet. Nevertheless, we conclude that the case of Dusan has shown it is worthwhile to address moral trauma and BEP-MT is a promising treatment protocol for moral trauma.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Data availability statement

Data are not available for privacy reasons. We report the results of one case (not of a set of data). The scores on the administered questionnaires and interview are reported in the manuscript and can be checked if necessary. The paper describes the protocol and a first treatment. The use of the protocol was not a research project, but part of a clinical decision to offer the adapted protocol as treatment to patients with moral trauma.

Ethical approval

No approval of the ethical committee has been asked for. There was no review board. Since the first experiences in using the protocol are promising this may indeed lead up to a research project to examine the effectiveness of the protocol. When that is the case, we will write a proposal for a review board.

Patient consent

The patient gave a written informed consent to publication of the manuscript on his treatment progress.

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