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Emerging Interventions for Moral Injury: Expanding Pathways to Moral Healing

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Abstract

Purpose of Review Over the past decade, empirical efforts have deepened and broadened to develop, evaluate, and refine effective interventions for moral injury. Much of the early work primarily made use of individual therapy in cognitive-behavioral models that had demonstrated effectiveness in the treatment of trauma. However, treatment development

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has moved beyond adaptations of trauma treatments to specifically target responses to moral pain and facilitate moral healing. In this paper, we present four distinct interventions while highlighting similarities across the approaches that point to potential shared qualities and processes of moral healing.

Recent Findings The four interventions described are acceptance and commitment therapy (ACT), a relational dynamic group therapy, a meaning-oriented collaborative care model (Reclaiming Experiences and Loss [REAL]), and a communal intervention model (Moral Engagement Group [MEG]). These interventions are at various stages of development, but early evidence demonstrates their potential for moral healing. Notably, all four interventions utilize a group format, and two are co-facilitated by a mental health provider and a chaplain.

Summary In introducing these promising approaches to a wider audience, the goal is to stimulate discussion and inspire further study and innovation. Broad clinical implications, implications for collaborative care, and recommendations for future research are included to help guide these efforts.

Introduction

Moral injury is psychosocial-spiritual suffering stemming from events that involve deep violations of moral values through acts of commission, omission, or betrayal [1]. The upsurge of attention, discourse, and research on moral injury since 2009 has yielded several potential interventions. Treatments for posttraumatic stress disorder (PTSD) like Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT) have been shown to be feasible and suggested to be flexible enough to facilitate moral healing while treating PTSD [2–4]. However, authors [5] have also called for further development and evaluation of psychotherapies for moral injury. The need for more potent pathways to moral healing is echoed widely through the broad, multidisciplinary literature on moral injury [5–11].

Recently, clinical researchers have developed several interventions for moral injury including Adaptive Disclosure (AD) [12, 13], Impact of Killing (IOK) [14, 15], and Trauma-Informed Guilt Reduction Therapy (TrIGR) [16, 17]. Among other adaptations, these interventions augment the traditional scope of cognitive behavioral, trauma-focused therapies to emphasize military cultural considerations, event-specific trauma processing, and procedures for facilitating meaning-making. However, like PE and CPT, these interventions are typically delivered in an individual format and still utilize traditional cognitive-behavioral models as the basis of the intervention. Another existing model, Building Spiritual Strength (BSS) [18] uses a chaplain-led, group-based intervention to address religious and spiritual concerns, specifically distress in the relationship with one's Higher Power. This approach highlights the possibilities of expanding beyond traditional mental health treatment paradigms. Other interventions developed for moral injury focus on specific processes often overlooked in traditional CBT-based approaches including self-forgiveness [19] and moral elevation [20].

Even as these interventions are expanding and enhancing the tools available to providers working with moral injury, patient-centered care is improved by providing multiple, effective interventions that offer diverse pathways to healing, restored vitality, and meaningful (re)connection with the world. Herein, specific authors (see author contribution statement) describe four emerging interventions for moral injury, each of which leverages group dynamics and advancements in conceptualization of moral injury to strengthen intervention outcomes: Acceptance and Commitment Therapy for moral injury; a process-focused relational dynamic moral injury group therapy; the Reclaiming Experience and Loss (REAL) group; and the Moral Engagement Group (MEG). Independently, these

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four models expand moral injury conceptualization and care considerations. Collectively, these distinct approaches converge on qualities and change processes that are likely central to moral healing and may point the field toward fruitful avenues for intervention and research.

Acceptance and Commitment Therapy (ACT) for Moral Injury

Acceptance and Commitment Therapy (ACT) has over 1000 randomized controlled trials (RCTs) demonstrating its effectiveness in ameliorating suffering, enhancing functioning, and increasing wellbeing among a wide range of clinical and non-clinical populations. While some mixed findings on the results ACT for posttraumatic stress disorder (PTSD) have been published [21, 22], ACT is a broadly applicable, evidence-based intervention. ACT for moral injury (ACT-MI) [23, 24] is a relatively recent adaptation of the model, which was developed, in part, in response to early attempts to define a moral injury "syndrome" and develop treatments targeting "symptoms" of moral injury [25]. Like all ACT interventions, ACT-MI is rooted in functional contextualism and, in lieu of characterizing the thoughts, feelings, and sensations associated with exposure to morally injurious events as pathological, seeks to understand and, as needed, transform the function of these experiences in survivors' lives. A functional contextual definition of moral injury [25] explicitly distinguishes moral pain from moral injury and emphasizes that moral pain (i.e., aversive moral emotions and thoughts) is not only natural but also adaptive as a crucial component of successful societies [23–27]. Moral injury is, from this perspective, the enduring biopsychosocial-spiritual suffering that arises from unworkable and costly attempts to avoid that pain [25].

The primary target of ACT is cultivating psychological flexibility. To do so, six core processes are engaged: acceptance, cognitive defusion, present moment contact, self-as-context, values clarification, and commitment action. Through ACT, awareness of the often unworkable and costly nature of experiential avoidance is fostered through "creative hopelessness," which creates space for an alternative approach to internal experiences characterized by willingness or acceptance. This then allows for the reallocation of attention and energy toward values-aligned action. Three qualities permeate ACT when implemented in the service of moral healing. First, the functional definitions of moral pain and injury integral to ACT mean the intervention is not predicated on the assumption that distorted thoughts, exaggerated emotions, or invalid behaviors require correction. Rather, the moral pain is explicitly identified as an indicator of an intact moral compass, an awareness that enables an essential shift in one's relationships with themself, others, and the world.

Second, the central target of (re)alignment of behavior to values is facilitated, in part, by forgiveness. Forgiveness from the ACT lens is the action of *giving* what came *before* the harm [28]. In this sense, "giving" is an action. Forgiveness, whether of self or other(s), becomes the catalyst for healing and vitalizing (re)engagement with personally chosen values, often including those that were transgressed [23]. Last, moral values are understood as social in nature and, thus, transgression of these values often frays the social fabric.

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ACT-MI, therefore, emphasizes the social components for healing through the group format, mapping moral communities exercises, and giving and receiving compassion [23].

ACT for moral injury is preferably implemented in a group format. Farnsworth and colleagues [25] describe a six- and eight-session group intervention. An in-progress randomized controlled trial of group-based ACT-MI includes 12 sessions. Alternatively, ACT-MI may be implemented individually in person or via telehealth [29]. A course of ACT for moral injury is likely to include engagement of each of the core processes foundational to the ACT model. Commonly, ACT protocols begin with making experiential contact with the unworkability and costliness of avoidance-based control strategies followed by values clarification and the remaining psychological flexibility processes. The order and amount of time allocated to each process may vary and should be determined by the functional formulation of the individual's or group's experience of moral injury.

Outcomes from two ACT for moral injury groups support the feasibility and acceptability of the intervention as well as improvements in psychological flexibility, values-aligned living, and symptom severity of cooccurring psychological diagnoses (e.g., PTSD, depression) [13]. A RCT of ACT-MI utilizing Present Centered Therapy as a control is currently underway (Co-PIs Borges & Barnes, NCT03760731). Finally, it is worth noting that numerous care providers unaffiliated with the research efforts described above are implementing moral injury groups from an ACT perspective. Thus, there is not a singular ACT-MI intervention but rather numerous interventions that rely on ACT principles to address moral injury. Importantly, one in particular is co-facilitated by a chaplain and integrates a spiritual care paradigm with ACT processes [30]. Further empirical evaluation of these interventions and models is warranted, underway, and encouraged.

Process-focused Relational Dynamic Group Therapy

Despite a historic connection between group psychotherapy, traumatized war veterans [31], and the VA [32, 33], there are currently few process-focused, manualized group therapies in VA mental health clinics. The developers are addressing this gap by developing a moral injury group therapy treatment manual for combat veterans, drawing on relational dynamic therapy [34], best practices in group therapy [35, 36], and stated needs and preferences reported by veterans and VA clinicians [37].

Moral injury undermines connections with others, disrupts a core sense of self and identity, alters expectations for security, trust, meaning and purpose, and fragments affective experiences such as anger, guilt, disgust, and shame [38, 39]. A process-focused relational dynamic group therapy supports exploration, meaning-making, and reintegration by creating and maintaining a psychologically safe enough social context. When it is possible to speak honestly about old experiences, new experiences, and experiences happening in the moment, group members have an opportunity to bear the burden

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of painful affect together—reducing isolation, increasing relatedness, and increasing opportunities for new ways of being.

Relational dynamic therapy emphasizes the role of relationships with others, real and imagined, in constructing mental life, including mental disorders and distress [40]. Broadly speaking, dynamic therapies effectively target psychosocial and interpersonal functioning, including depression, grief, and anxiety [41]. The goal of relational dynamic trauma therapy is to help participants identify connections among their current functioning and their experiences in combat, current life stressors and relationships, and the developmental factors that carry person-specific meaning to their combat experiences [34].

Whereas group formats in psychotherapy are often valued for their economy (e.g., the "therapeutic classroom" model with individual psychotherapy happening in parallel), group therapy presents many other therapeutic opportunities, such as experiences of universality, diversity, a social context for change, and peer learning [42]. Analogous to the treatment alliance in individual psychotherapy, group cohesion has the most robust relationship with positive outcomes in group psychotherapy [43] and this relationship is even stronger in therapy groups where the therapist fosters cohesion [44]. By attending to present context in a manner which promotes psychological safety, the process-focused group therapy approach has potential to allow participants to explore and process the impact of moral injury because the group offers an interpersonal context that can hold, contain and co-regulate the powerful affect that these painful experiences can evoke [45].

This process-focused relational dynamic group therapy targets functioning and quality of life, two transdiagnostic outcomes. The proposed therapeutic action is threefold: (1) to feel validated, accepted, and understood by their peers; (2) to enable the veterans to develop an organized narrative about what is troubling them and understand the central meaning and implication of these events over time; and (3) to learn that any ensuing emotions and challenges can be accepted and managed. Symptom reduction occurs through increasing the capacity to consciously reflect on experiences and develop an integrated self-awareness of the various factors that affect their mental states [46]. Group psychotherapy provides opportunities for deep and shared affective engagement, a social context for increased understanding and change, and a potential for multiple paths to healing. The result is greater reflective functioning, less avoidance, and greater adaptive incorporation of life experiences and their aftermath and meanings into one's inner world.

Sessions are co-led by two therapists meeting weekly with 7–9 veterans. Sessions last 90 min over a period of approximately six months. Group enrollment is closed after the first session. Practice-based evidence (e.g., session-by-session process measures) monitor group functioning and individual coping [42, 47]; these measures are important because silence and reluctance to share is expected throughout the group albeit particularly during group formation.

Broadly, the group has four main tasks: (1) Facilitation of group cohesion and psychological safety, focusing on experiential here-and-now processing; (2) Explicit preparation to speak on, and listen to others speak on, their haunting military experiences, developing a shared language to communicate when breaks are needed or the group becomes overwhelmed; (3) Speaking on and bearing witness to others' moral injury events together as a group

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and sharing the emotional load, then retelling their stories in light of their group experiences; (4) Termination, including group mourning, and saying goodbye.

The process-focused relational dynamic moral injury group therapy manual is in development, with funding for SF from the Department of Veterans Affairs (see NCT05020587 [37]). Treatment development is proceeding in three stages: (1) Assess treatment needs, treatment preferences, engagement-barriers, and engagement-facilitators through interviews with moral injury-impacted veterans and VA trauma clinicians; (2) design a treatment manual and refine it using feedback from veterans, trauma clinicians, and an expert clinical advisory board; (3) Conduct two open trials with morally injured veterans ($N = \sim 12$). The manual will be iteratively revised based on feedback from veteran participants, treating clinicians, and clinical expert panel feedback. Employing user-centered design methods for treatment development allow for continuous gathering of user experiences to enhance effectiveness and usability because the development is closely guided by its intended consumers and users [48].

Reclaiming Experiences and Loss (REAL)

Reclaiming Experiences and Loss (REAL) is a moral injury group therapy that is co-facilitated by a mental health professional and a chaplain. It was developed to address a gap in trauma-focused care for veterans, specifically difficulty making meaning of traumatic experiences [49, 50]. REAL is theoretically integrative, drawing from the humanistic, constructivist, narrative, cognitive-behavioral, and acceptance-based traditions of psychotherapy in addition to honoring and integrating an individual's spirituality and/or religious commitments. In REAL, moral injury is conceptualized as the fracturing of one's meaning-making system, resulting from an inability to name and grieve losses of one's sense of self, relationships, and whatever one believes to be sacred [51] (see Smigelsky et al., 2022 for a fuller description of the intervention). To *intervene in meaning* [52] requires regarding the quest for meaning as an essential part of the human experience [53] and willingness to confront and reorient toward the meaning of one's life [54]. In REAL, facilitators encourage this by adopting a posture of *companioning* [55], or honoring and witnessing another person's story and very existence. The goal of REAL is not to reconstruct a prior meaning-making system that has been irreparably damaged by a morally injurious event. Rather, the goal is to help people get "unstuck" in their quest for meaning.

Getting "unstuck" may sound like an unambitious goal. It does not require crossing a diagnostic threshold or entering a state of symptomatic remission. Yet it does require the demanding work of transforming "unbearable pain into livable disappointment" (K. Meador, personal communication, May 7, 2021). Likewise, livable disappointment does not seem like much of a prize unless it is measured against pain that has become unbearable. Any hint of *joie de vivre* in those suffering from moral injury

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is deflated by a commanding belief that they are not worthy of envisioning a life of possibility and potential. The ability to imagine a good and meaningful life anew is the beginning of transformation.

Transformation is a process, and psychotherapy specifically is a linguistic process. REAL relies on deconstruction of language to unveil deeper meanings and challenge beliefs about worthiness. Language (both verbal and embodied) allows for communication of meaning, yet *interpretations* of language can distort the speaker's intention and place people into boxes. Common boxes in moral injury care include the type of morally injurious event experienced (i.e., betrayal vs. perpetration), the context in which the morally injurious event occurred (e.g., combat) and the desired outcome of intervention (e.g., acceptance, forgiveness, compassion). These boxes, while not inherently bad, pre-determine something about a person's experience or journey, including who might be appropriate for the intervention. With REAL, facilitators strive to hold all boxes, labels, and interpretations loosely, creating space for deconstruction of language, with the intention that language neither distorts nor destroys meaning but rather helps define it for each individual. REAL is appropriate for moral injury stemming from military-related events (whether combat-related or non-combat related) as well as adverse childhood experiences and events in adulthood (e.g., causing the death of another in a car accident while driving under the influence).

The therapeutic container in which language is unpacked and deconstructed is characterized by tolerance for ambiguity and vulnerability. Skilled co-facilitators are responsible for creating this container. The chaplain/mental health dyad is optimally equipped to allow group members to explore both the psychological and spiritual dimensions of their quest for meaning. This exploratory stance evokes what individuals need to forge their own pathway of transformation. Empirical research suggests that *clinically wise practice* requires the ability to endure ambiguity and vulnerability [56]. Mental health clinicians may be accustomed to manualized approaches that remove uncertainty, which is appropriate for many conditions but is insufficient to allow one to intervene in meaning. Co-facilitation with a chaplain checks the impulse to go down a pre-determined path.

REAL unfolds over 12–13 sessions, though facilitators are encouraged to spend more time as needed. The curriculum comprises three phases that are modeled after Herman's (1992) trauma recovery model [57]. Phase 1 ensures that each group member makes an autonomous decision regarding undertaking moral injury work, and the group commits to journeying together for the remaining sessions. Phase 2 explores the experience of moral injury through the lens of grief and loss and culminates in communal sharing and lamentation. Phase 3 marks a transition as group members begin to *move forward with* moral injury, using the metaphor of *kintsugi* [58] – which is a Japanese art form that involves mending broken pottery with precious metals – to convey that brokenness creates beauty and value.

Preliminary evidence suggests that REAL may help reduce symptoms of PTSD and depression, specifically suicidality [51]. Through an ongoing VA quality improvement project, feedback has been obtained from veterans who participated in REAL groups at VA facilities across the country. When asked about the impact of this group, their responses included the following:

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- I can love again, and I can be loved.
- I do my best not to hurt people anymore.
- I'm as angry as I was, but I manage it better now.
- The people in my life tell me they see me differently.
- I was asked where my hope comes from, and that question made me realize I don't have hope in anything… so that became my starting place.
- I'm not at war with myself like I had been.

The Moral Engagement Group (MEG)

The Moral Engagement Group (MEG) at the Corporal Michael J. Crescenz VA Medical Center in Philadelphia uses a chaplain and psychologist co-facilitation model, as the model couches moral injury at the intersection of psychology, spirituality, and ethics [59]. The model includes a theory of shared responsibility [60, 61] and community complicity because "we are accountable individually for what we do together" [62], and military action always involves collective action. Veterans' moral pain stems in part from a moral responsibility unfairly acquired and not appropriately shared by the public. In the MEG, moral pain associated with military service and combat is accepted as normative, not pathologized as disordered. Receipt of treatment in hospitals can reinforce a veteran's identity as victims and as "patients," such that they assume themselves to be broken, weak, disabled, sick, or damaged. In the MEG, veterans are not patients but rather are *prophets* in the sense of being bearers of uncomfortable truths, needed by the public for their wisdom and insight about the moral complexity and human costs of military service. Moral injury is the consequence of unfair distribution of appropriate moral pain, so recovery from moral injury requires that moral burdens be shared with society [59]. "The causes of moral injury lie not only at the individual level but also in contextual factors" [63]. The MEG group developers posit that veterans and the public must examine this wider context, including "the range of social, cultural, and political factors that may contribute to the occurrence of" moral injury [5]. Widespread "moral disengagement" [64], the unexamined structural and cultural violence that undergirds "U.S. war-culture" [65] and "moral exploitation" [66] are among the contextual factors exacerbating moral injury examined in the MEG.

The MEG emphasizes four key mechanisms of change or core therapeutic processes. First, veteran participants gain insight and become empowered through building a vocabulary of terms and concepts related to moral injury. Second, veteran participants are able to better integrate and be less burdened by their experiences of moral injury by articulating them to other group members and to the general public. Third, when veteran participants learn about the social contract existing between the citizenry, the military, and the government, they can recontextualize their moral pain, and see the rationale for the more equitable distribution of moral responsibility. As citizens accept their fair share of responsibility, the weight of moral responsibility on the veterans is lessened. Finally, the veteran participants model moral engagement and

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use their prophetic voice to awaken and challenge the community to accept greater responsibility, thus facilitating moral repair and spiritual development for the community [59].

The MEG is comprised of 12 weekly, 90-min group meetings. The first six meetings emphasize building vocabulary and exploring concepts related to moral injury. These include moral values, moral emotions, moral dilemmas, moral disengagement, and reengagement. The focus in the second half of the model then shifts toward understanding the social contract and considering the rationale for a public ceremony. Throughout the 12 weeks, there is an ongoing integrative process of sharing experiences of moral injury with each other as preparation for the culminating ceremony. The MEG features a public community healing ceremony in the tenth week, in which veterans articulate the complex moral realities of military service and warfare, and the audience is invited to share the moral responsibility of military service and warfare with veterans.

A pilot study of 40 participants showed recruitment feasibility and high retention. Veterans were measured for depression (PHQ-9), psychological health (SOS-10), self-compassion (SCS-SF), post-traumatic growth (PTGI-SF), and religious and spiritual struggles (RSSS). Outcome data revealed reductions in depressive symptoms and spiritual struggles as well as improvements in psychological functioning, self-compassion, and personal growth. Please see the published pilot study for details on measures and outcomes [67].

Discussion

Neither moral injury nor moral healing are new phenomena. However, only relatively recently have these experiences begun receiving earnest empirical attention from clinical researchers in the social and behavioral sciences. Pragmatism guided initial examination of the applicability of existing evidence-based, trauma-focused therapies for their potential impact on moral injury. Clinical expertise and lived experience, cultural considerations, and interdisciplinary collaboration are guiding the development and adaptation of novel, targeted models of moral healing.

The four interventions described herein have distinct histories, philosophies, and theoretical underpinnings. These range from psychodynamic (process-focused relational dynamic group therapy) to contextual behavioral (i.e., ACT), and from grief-focused existential (REAL) to the elements of testimony, ceremony, and prophetic witness found in many religious traditions (MEG). Each intervention also takes a recognizable but unique perspective on moral injury – disrupting core relatedness (process-focused relational dynamic group), unworkable responding to moral pain (ACT), fractured meaning-making and unmourned grief (REAL), or unfair distribution of appropriate moral pain (MEG).

Despite these distinctions, all four interventions unfold in a group setting to scaffold shared experiences, promote interpersonal affective processing, and facilitate meaning-making. There are other similarities as well. For example, both REAL and MEG are co-facilitated by a mental health professional

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and a chaplain (ACT-MI can also be co-facilitated [30]). In these groups, spiritual and existential concerns are integrated with psychosocial ones. The relational dynamic group therapy and REAL both make use of the group as a containing and holding environment, so that each individual need not work through the pain of moral injury alone [68]. In addition, with varied scopes and specific procedures, each intervention orients participants toward (re)engagement with moral values. For example, ACT-MI advocates committed action on the moral values that were previously transgressed and MEG encourages modeling of moral engagement and even challenging the community at large to accept greater responsibility. Finally, fundamental to each intervention is connecting to a sense of common humanity. The ACT group focuses on common humanity via through group experiential exercises and behavioral realignment to moral (i.e., social) values. The relational dynamic group therapy creates a context to contain and co-regulate, to hold and heal. The REAL group does this through a shared commitment to journey together and by bearing witness to one another's stories of loss. The MEG group does this by creating a sacred space to bear witness to and share societal moral injuries.

Finally, rather than position the experience of moral pain as an intervention target, each of these groups seeks to transform the relationship participants have with their morally injurious experiences. ACT-MI, REAL, and MEG share a commitment to language that explicitly normalizes moral pain, and all four interventions support meaning-making and decreasing avoidant coping processes that arise from struggle with moral pain. One way this unfolds in each of the models—with varied salience—is by cultivating a vocabulary and an approach to language that disinhibits meaning making and liberates individuals from life-limiting interpretations, labels, and judgements.

Clinical Implications

As the evidence base grows for these—and other—interventions for moral injury, guideposts for care providers walking with those in the healing process are needed. Three conscious considerations are recommended here. First, select interventions that include evidence-based processes of change for the target experience. For PTSD related to fear-provoking, life-threatening experiences, exposure, and cognitive restructuring are robust treatments [2]. For guilt, contempt, disillusionment, or anguish related to moral violations or transgressed values, other processes—including acceptance, meaning making, and revitalization of social relationships—have been shown to be effective [2, 12, 14, 16, 18–20]. Second, practicing within the bounds of one's competence as a care provider is essential. Therefore, consider further training in new evidence-based interventions so as to expand one's scope of practice. Consider that competent care may be facilitated by collaboration with spiritual care providers (see next paragraph). Last, it is recommended that care providers engage persons served in shared decision making about whether and how to proceed with moral injury care. Shared decision-making is generally best

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practice and, when beginning the journey of moral healing, this collaboration may actually be the first step in becoming unstuck and re-engaging a thwarted meaning-making process.

Collaborative Care

The nature of moral injury beckons beyond the bounds of traditional mental health care and invites consideration of spiritual and existential dimensions of suffering and healing. REAL and MEG are just two examples of collaborative moral injury group (MIG) approaches that have been developed by frontline VA mental health providers and chaplains. These providers were motivated to respond in innovative ways to the problem of moral injury because they experienced firsthand the limitations of existing care approaches and saw the need for veterans to engage spiritual and psychosocial concerns simultaneously. In 2017, building on nearly a decade of work integrating and training chaplains and mental health providers [69, 70], VA's Integrative Mental Health (IMH) program began identifying many of those who were engaged in this work and created a network for shared learning and accountability [7]. Interventions that were part of this Dynamic Diffusion Network ($N = 6$) were analyzed to identify core components of collaborative moral injury care being offered under real-world conditions [71]. The interventions that are part of the DDN are not an exhaustive representation of all collaborative care approaches but rather represent those that are part of ongoing efforts by IMH and other VA research and operational partners (e.g., QUERI, HSR&D, Innovation Ecosystem). Importantly, other clinicians and researchers are engaged in similar important innovations in integrative care (e.g., [18, 72]). The DDN efforts specifically focus on systematic measurement of these approaches, iterative refinement of group curricula, and structured training opportunities to promote collaborative moral injury group implementation at new care sites. These groups, as well as the Process-focused Relational Dynamic Group Therapy described above, are being developed and refined in an iterative manner that deliberately incorporates participant and clinician feedback to promote more rapid improvements in care. These efforts are intended to foster diverse approaches to moral injury care while promoting scientific accountability during a crucial time in which interest in moral injury is expanding rapidly.

Future Directions

The four interventions described herein are currently at different levels of development. Research, in some cases RCTs, and quality improvement efforts in the VA context are underway to examine intervention effectiveness and promote refinement. Rigorous evaluation of effectiveness and safety is essential to the field and those served before broad dissemination of new

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interventions can be recommended. Results of the aforementioned studies are forthcoming.

Importantly, the real potential of these interventions is dependent on educating care providers about moral injury. Incorporating moral injury screening into mental health and spiritual care settings would help identify individuals who may be suffering from moral pain, which may be in addition to mental health problems and/or religious/spiritual struggles. Provider education should include an expanded conceptualization of trauma that extends beyond fear and anxiety to include guilt, shame, grief, and disillusionment. In addition to general provider education about moral injury, it will be essential to support training efforts to equip mental and spiritual care providers to offer competent care for moral injury.

Conclusion

Myriad histories, cultures, and communities yield unique humans and moral values. Researchers and clinicians would do well to consider the full range of potential pathways to moral healing, and to that end this introduction to emerging interventions for moral injury can enrich the field. Overreliance on existing approaches to trauma recovery may mean missing the shortcomings of interventions that pathologize pain and seek to "resolve" the adaptive hurt that comes from bearing witness to horror. Unifying around some of the central tenets of these emerging interventions—acceptance, meaning making, reclamation of values, and communal involvement—may enhance the healing experience for all, even along different pathways.

As theory and conceptualization of moral injury continue to evolve, so too must interventions. The four interventions described here have been developed with evidence-based modalities and cohesive theories at their foundations, and these underlying theories and interventions are well supported in the literature. Healthcare professionals are called to use evidence-based interventions when they are available. It is, simultaneously, vital to the field and those served to build on and improve the understanding of and response to moral injury, particularly as we now see moral pain and injury increasing among healthcare workers, first responders, schoolteachers, and others.

Authors' Contributions

All authors contributed substantively to the manuscript. WRE, MAS, SBF, and SBM contributed to the abstract, introduction, and discussion. WRE contributed the section on ACT. SBF and SBM contributed the section on relational dynamic group therapy. MAS and CC contributed the section on REAL. CJA and PDY contributed the section on MEG. All authors reviewed the complete manuscript. All authors read and approved the final manucscript.

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Declarations

Conflict of Interest
The authors have no conflicts of interests to disclose.

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.

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