Feature Article: **JAF2362**

MORAL DAMAGE AND SPIRITUAL REPAIR
IN POSTTRAUMATIC STRESS DISORDER

by A. A. Howsepian

SYNOPSIS

Posttraumatic Stress Disorder (PTSD) can be precipitated by a wide variety of traumatic experiences, some of which involve acts that result in injury to the *moral* dimensions of the sufferer. PTSD caused by this underappreciated form of traumatic injury is less well understood and, thereby, less well treated in clinical contexts than are other varieties of PTSD. Part of what appears to explain this relative deficit in understanding and clinical intervention is that the recognition and treatment of such *moral injury* involves an expertise that many mental health practitioners either do not possess or are uncomfortable employing in clinical contexts. Some worry, for example, that the exploration of ethical and religious issues in clinical situations is outside of their scope of practice, or that religious and ethical beliefs are private matters whose entanglement in therapeutic contexts is perilous. There is, on the other hand, a growing awareness that neglecting these aspects of human experience does PTSD patients a great disservice, often relegating them to needless, lifelong suffering. Raising awareness of this issue, both inside and outside of the therapeutic arena, is one important way in which Christians can contribute both to the health of PTSD sufferers and to the well-being of the mental health profession itself.

You narrowly survive a terrorist attack. You witness a rape or murder. You are told that your child was killed in a car accident. These events—one of which you have undergone, one of which you have witnessed, and one of which you were made aware—count as *traumatic events* (in the technical, psychiatric use of that term) if you respond to those events with emotions of intense fear, helplessness, or horror. Posttraumatic Stress Disorder (PTSD) is one of several psychiatric disorders that can be precipitated by traumatic events. PTSD requires not only having experienced a traumatic event, but it also requires certain psychological symptoms that last for more than one month and that result in significant functional impairment in social,

occupational, or other important life contexts. The psychological symptom requirement consists in a specified number of symptoms from three distinct core symptom clusters, namely *re-experiencing* symptoms (including nightmares, flashbacks, and intrusive thoughts of the trauma), *avoidance* symptoms (e.g., avoiding reminders of the traumatic event), and *hyperarousal* symptoms (including insomnia, hypervigilance, and an exaggerated startle response).

The lifetime prevalence of PTSD in the United States is approximately 8 percent and PTSD is approximately twice as likely to occur in women exposed to trauma as it is in men. Rape appears to be the single traumatic event with the highest risk of precipitating PTSD. Although highly prevalent in combat situations, combat-related PTSD comprises, overall, only a minority (15 percent) of PTSD cases in this country; hence, in 85 percent of cases, one suffers from PTSD in virtue of being a victim, witness, or recipient of information involving a motor vehicle accident, a civilian assault, a natural disaster, a work-related accident, the diagnosis of a terminal illness,[1] an acute myocardial infarction,[2] or, less commonly, due to identifying charred dental remains[3] or due to having been accidentally stuck by a needle believed to be contaminated with the Human Immunodeficiency Virus (HIV).[4] In fact, PTSD has also been reported to develop in *therapists* who *treat* persons who suffer from PTSD, by way of "vicarious traumatization," in virtue of therapists' being exposed to sometimes horrific narrative accounts of patients' traumata that subsequently traumatize those who themselves are treating PTSD sufferers.[5] A similar pattern of transmitting PTSD contagion has been reported in those exposed to narratives of trauma by those who suffer from PTSD within *family* networks, for example, in the households of Holocaust survivors.[6] Importantly, PTSD symptoms might not surface until sometimes months, or even years, after having been exposed to traumatic events.

Not all PTSD is lifelong, even *without* treatment; but a significant minority is, even *with* treatment. PTSD due to combat trauma appears to be more resistant to treatment, hence more chronic than PTSD due to trauma suffered in civilian contexts. Similarly, PTSD due to a single traumatic event appears less resistant to treatment than PTSD that is due to multiple traumatic experiences.[7]

PTSD TREATMENT

Treatments for PTSD can, and often do, involve the use of psychiatric medications (e.g., sertraline [Zoloft]), psychotherapeutic techniques, psychosocial interventions, and appropriate spiritual discernment, direction, and practice. Psychotherapeutic interventions that have been studied in the greatest detail and that appear to have the best evidence for their effectiveness are based on Cognitive-Behavioral Therapy (CBT) approaches that focus on the current ways in which PTSD adversely affects one's perceptions and generates emotional symptoms by way of distorted patterns of thinking about oneself and one's life circumstances. These therapies are optimally carried out while the PTSD sufferer is exposed to recollections of their traumatic experiences, at which times problematic patterns of thinking are identified and corrected.

CBT's historical antecedents are sometimes traced to Socrates, who routinely challenged the distorted thinking of his interlocutors, and to the author of Proverbs, who stated that as one thinks within oneself, so one is (23:7).

In addition, marital and family therapy interventions are often profitably employed in the treatment of PTSD in virtue of the emotional havoc that is often wrought in one's relationships as a result of PTSD symptoms. These include irritability, angry outbursts, profound sleep disturbances, intense anxiety, emotional numbing, and avoidance of multiple social activities, all of which can interfere with interpersonal relations and stifle emotional and spiritual growth.

Appropriate psychosocial interventions in PTSD might involve assistance with employment, housing, the legal system, personal finance, medical care and social service linkage, and help negotiating complex compensation systems (as found, e.g., in the Veterans Administration healthcare system). Unlike multiple physical disabilities that are readily visible to others, the hiddenness of PTSD to others and the stigma associated with mental illness in general introduce further complications to PTSD's recognition and optimal management.

The Benefit of Faith

Spiritually based interventions are perhaps the most neglected, and potentially some of the most important, ways both to facilitate the well-being of persons suffering with PTSD (and, correlatively, their loved ones) and to prevent the onset of PTSD (by, e.g., increasing one's "resiliency," "self- efficacy," or "hardiness."[8]) Undergoing traumatic experiences resulting in PTSD typically changes the way in which PTSD sufferers experience the world in an often quite pervasive way, and religious faith can help one adapt to or reverse this change.

For example, one who undergoes an assault or an accident subsequently will tend to view the world as a very dangerous and unpredictable place. This shift in one's sense of security—in the direction of profound insecurity, danger, mistrust of others, and unpredictability—can be crippling, causing one to isolate oneself from others, or from other potentially retraumatizing life circumstances, in a manner that can profoundly impair occupational, academic, interpersonal, religious, and general social functioning.

Alan Fontana and Robert Rosenheck have stated, "One of the most pervasive effects of traumatic exposure is the challenge that people experience to their existential beliefs concerning the meaning and purpose of life. Particularly at risk is the strength of their *religious faith* and the comfort they derive from it."[9] In fact, Fontana and Rosenheck conclude, specifically with respect to veterans, that their "pursuit of mental health services appears to be driven *more* by their *guilt* and the *weakening of their religious faith* than by the severity of their PTSD symptoms or their deficits in social functioning," adding that "a primary motivation of veterans' continuing pursuit of treatment may be their *search for a meaning and purpose to their traumatic experiences*."[10] They go on, wisely, to recommend that "mental health services should consider addressing spiritual losses as an integral part of treatment."[11]

Focusing on one's trust in God, being joyful no matter what one's circumstances (James 1:2), "fearing not" (one of the most prevalent commands in the Holy Scriptures), "being anxious for nothing" (Phil. 4:6), forgiving those who might have harmed you, and realizing, as even Socrates understood, that one cannot really harm a good man[12] can be pivotal vehicles for re-engaging the world by attenuating fear and anxiety both concerning others and concerning life's precarious circumstances.

MORAL INJURY

Another important focus for spiritual intervention in PTSD involves the aforementioned notion of "moral injury."[13] There has been a groundswell of recent interest in psychiatry in what are termed the *moral emotions* (e.g., guilt, shame, regret, and remorse).[14] It is, in this context, critically important to realize that PTSD is not always accompanied by feelings of passivity, unpredictability, and "innocence" with respect to the traumas experienced. In many cases it is rather accompanied by feelings of shame and guilt for one's perceived role in the genesis of one's traumatic experiences.

There are myriad examples of such feelings of moral damage in clinical contexts. For example, combat veterans often feel guilt (termed *survivor guilt*) for having survived a firefight while others of their comrades in arms died or were badly injured. There is often, in such cases, a sense that, had they acted more courageously, or had they volunteered for a given assignment for which they did not volunteer, or had they been less concerned about their own well-being or more concerned about the well-being of their fellow warriors, their friends might not have died or been seriously wounded. There is, in these cases, often a feeling that one has been selfish, or reckless, or cowardly that often eventuates in one's wishing that one were killed or injured rather than those who were in fact killed or injured. This is followed by a lifetime of acting in ways consistent with the conviction that one does not deserve to live a good and happy life, since one would be living such a life at the expense of others, at the expense of those who died or were maimed and who no longer have this opportunity. Similarly, if one witnesses an assault in civilian life, but does not intervene, one might feel guilt, or a sense of shame for cowardice, over one's nonintervention.

There is an additional, more direct manner in which guilt and shame are often precipitated as a result of traumatic experiences, namely, by exposure to violent traumatic events that the PTSD sufferer *himself precipitates*. In addition to my work as a psychiatrist at the Veterans Hospital in Fresno, California, I have a private consultation practice in which I primarily undertake forensic psychiatric evaluations (i.e., evaluations for attorneys concerning criminal or civil legal matters involving psychiatric elements). In this latter context, I have evaluated persons accused of murder who, seemingly counterintuitively, report having been traumatized by the very killings for which they have been charged. More commonly, in my work with veterans, I routinely encounter cases involving PTSD that have resulted from a combat veteran's having killed the enemy in the context of war.

Tragically, suicidal behavior and ideation are not uncommon in PTSD.[15] Guilt about one's own perceived morally damaging combat actions is a significant *additional* risk factor for suicide in war veterans.[16]

Violating One's Own Moral Code

The reason that PTSD symptoms are often associated with suicidal thinking or behavior, even if these symptoms are the result of one's killing others in the context of war, is not difficult to discern when noncombatants (e.g., unarmed women and children) are killed, or when bodies of fallen enemy combatants are mutilated or otherwise treated disrespectfully. It might be more difficult to understand, however, how it is that one might come to suffer from PTSD when enemy combatants are killed in time of war. Many soldiers have grown up in Christian homes and attempt to adhere, as best they can, to the admonition to love one's neighbors and even one's enemies. To embrace this attitude toward human life and then to be placed in a position in which the killing of others is not only permitted, but sanctioned and commanded, can result in profound internal conflict, emotional disequilibrium, and *moral injury*[17] in virtue of one's coming to believe that, in killing others, even in times of war, one is violating a core moral commitment. In order to mitigate the extent of this moral damage, rules of engagement have been developed in military contexts historically that shield warriors as much as possible from the character-eroding effects of killing enemy combatants. These rules of war are meant to *constrain* the action of warriors, to limit the character-disintegrating effects of combat trauma that might result from killing others in times of war, by sharply delineating the difference between the kind of killing that occurs in enemy combat and the kind of killing that occurs in criminal contexts.

The warrior's code aims to inculcate a deep respect for one's enemies, and to prosecute war in such a manner that one's actions are honorable and enemies are viewed not as dehumanized and evil, but as honorable and worthy opponents. In this way, a difficult task is required of those charged to train military personnel for war. Because prospective soldiers often endorse a strict moral code that prohibits the killing of humans, typically training is needed to loosen this moral constraint—one that edges close to *dehumanizing* one's enemies, thus seemingly making the killings of other humans more palatable. However, if this process of loosening pre-existing constraints on killing is reckless, the trauma that one might experience as a result of engaging in the killings of humans that appear to be *less than honorable* amplifies both one's risk for PTSD and the degree to which one's PTSD is resistant to treatment. If one grossly oversteps the boundaries of honorable warfare by killing enemy *non*-combatants, or by killing enemy combatants with relish or pleasure, the risk of PTSD as a result of perpetrating such killings is further increased.

TREATING MORAL INJURY

The treatment for this form of moral injury often focuses on *rehumanizing* one's former enemies, *letting go of hatred* for those who one has killed or attempted to kill, *forgiving*

former enemies for any perceived hatred or violence on their part toward oneself or one's friends and, instead, fostering love, care, and honor for former enemies.

Jesus' eminently difficult, but profoundly wise teaching to love one's enemies (Matt. 5:44) is deeply healing. The Vietnam Veterans of America, among other organizations, has attempted to be a vehicle for this healing by sponsoring return trips ("Tours of Peace") to Vietnam for Vietnam veterans in which arrangements are made for them to engage in humanitarian projects (including providing food, medicine, clothing, school supplies, tools, and livestock to villages, schools, orphanages, hospitals, and homes) in order to help the Vietnamese people rebuild their lives in the aftermath of the Vietnam War. In the process, veterans encounter the humanity of their former enemies and engage in activities that foster their own humanity by extending compassion and by directing love toward those whom they formerly hated and wished to kill.

An Eternal Perspective of Morality

The concept of moral injury is not restricted to combat situations, but commonly extends into other domains of human experience that are, for most of us, closer to the life context in which we find ourselves. I mentioned earlier that Socrates taught that one could not hurt a good man. What did he mean by that? Plato reports, in his *Apology*, that after being sentenced to death on trumped up charges, Socrates said, of himself, a "good man can't be harmed in life or in death."[18] Socrates' idea—one that resonates deeply with Christian teaching (cf. Matt. 10:28, where Jesus tells His followers to "not fear those who kill the body, but are unable to kill the soul")—is that no matter what anyone does to us (even to the extent of torturing and killing us), such external assaults and the suffering or death that might result, cannot corrupt our characters or disintegrate our souls.

As Christians we further believe that such assaults cannot deprive us of our life with God through Christ our Lord. Jesus asked, in one of the most sobering of all Scriptures, what it profits a man if he gains the whole world but forfeits his soul (Mark 8:36). Correlatively, it is a foundational, albeit difficult, Christian teaching that losing one's life is clearly preferable to losing one's soul (as Jesus taught, for example, in Mark 9). The only way to lose or otherwise corrupt our souls is by free actions that *we* perform (in word, thought, or deed), not by actions *others* take against us. Moral injury, therefore, is *always an inside job*. Such injury, therefore, can occur in multiple contexts independent of combat situations.[19]

Consider, for example, occupational contexts in which one is pressured by administrators to act in ways that violate one's conscience. Suppose, for instance, that one works in the healthcare field and is pressured to prescribe or dispense abortifacients, or birth control pills, or erectile enhancers for patients who are not married, or to perform abortions or commit euthanasia, or to assist in suicide. Further suppose that these activities are *known* to be *intrinsically* evil. In that case, not only would you expect to do violence to *your own* conscience were you to participate in those activities, but it also seems that engaging in such acts would *be expected* also to cause

moral damage to you were you to *refer* those patients for *others* to perform those known intrinsically evil acts that you could not bring yourself to perform. In that case, it seems, the *act of referring* would *itself* be evil.[20] The emotional and spiritual trauma in these contexts is precipitated in the referring agent by way of one's violating one's own moral standards and thereby doing violence to one's conscience, injuring one's moral self, and thereby damaging one's soul. Unfortunately, in this fallen world, pressures to compromise morally and, thereby to dim the light of faith with which we have been graced, are commonly encountered. In this manner, "posttraumatic" experiences resulting in moral injury are not far from any of us, nor, thankfully, is the forgiveness and spiritual repair that comes from God by grace through faith in our Lord and Savior, Jesus Christ.

A. A. Howsepian, M.D., Ph.D., is an assistant professor of psychiatry in the University of California, San Francisco-Fresno, Medical Education Program, whose many articles can be found in philosophy, bioethics, psychiatry, and neurology journals. His Ph.D. is in philosophy from the University of Notre Dame.

NOTES

1 Lindsay N. French-Rosas, Jennifer Moye, and Aanand D. Naik, "Improving the Recognition and Treatment of Cancer-Related Posttraumatic Stress Disorder," *Journal of Psychiatric Practice* 17, 4 (July 2011): 270–76.

2 Ralph Burton DeVaul, Jr., *Posttraumatic Stress Disorder in Vietnam-Era Veterans Following an Acute Myocardial Infarction* [doctoral dissertation], Walden University, Publication Number 9941682 (1999).

3 J. E. McCarroll et al., "Posttraumatic Stress Symptoms Following Forensic Dental Identification: Mt. Carmel, Waco, Texas," *American Journal of Psychiatry* 153 (June 1996): 778–82.

4 A. A. Howsepian, "Post-traumatic Stress Disorder Due to Needle-stick Contaminated with Suspected HIV-positive Blood," [letter] *General Hospital Psychiatry* 20 (1998): 123–24.

5 Lisa McCann and Laurie Anne Pearlman, "Vicarious Traumatization: A Framework for Understanding the Psychological Effects of Working with Victims," *Journal of Traumatic Stress* 3, 1 (1990): 131–49.

6 R. Krell, "Aspects of Psychological Trauma in Holocaust Survivors and Their Children," in A. Grobman and D. Landes, *Genocide: Critical Issues of the Holocaust* (Chappaqua, New York: Rossel, 1983), 371–80.

7 Michael T. Lambert et al., "Malignant Post-Vietnam Stress Syndrome Revisited," *Journal of Nervous and Mental Disease* 184, 6 (1996): 354–57.

8 L. A. King et al., "Resilience/Recovery Factors in Posttraumatic Stress Disorder among Female and Male Vietnam Veterans: Hardiness, Postwar Social Support, and Additional Stressful Life Events," *Journal of Personality and Social Psychology* 74 (1998): 420–34.

9 Alan Fontana and Robert Rosenheck, "Trauma, Change in Strength of Religious Faith, and Mental Health Service Use among Veterans Treated for PTSD," *Journal of Nervous and Mental Disease* 192, 9 (2004): 579, emphasis added.

10 Ibid., emphasis added.

11 Ibid., 583.

12 Plato's *Apology* 41d.

13 Brett T. Litz et al., "Moral Injury and Moral Repair in War Veterans: A Preliminary Model and

Intervention Strategy," *Clinical Psychology Review* 29 (2009): 695–706.

14 See, e. g., Jerome Kroll and Elizabeth Egan, "Psychiatry, Moral Worry, and the Moral Emotions," *Journal of Psychiatric Practice* 10, 6 (November 2004): 352–60.

15 T. Kramer et al. ,"The Comorbidity of Post-Traumatic Stress Disorder and Suicidality in Vietnam Veterans," *Suicide and Life-Threatening Behavior* 24 (1994): 58–67.

16 Herbert Hendin and Ann Pollinger Hass, "Suicide and Guilt as Manifestations of PTSD in Vietnam Combat Veterans," *American Journal of Psychiatry* 148, 5 (1991): 586–91.

17 "Moralinjury" is a term introduced in Jonathan Shay, *Achilles in Vietnam: Combat Trauma and the Undoing of Character* (New York: Maxwell MacMillan International, 1994).

18 Plato, 41d.

19 See, e.g., Farr A. Curlin et al., "Religion, Conscience, and Controversial Clinical Practices," *New England Journal of Medicine* 356 (2007): 593–600.

20 For an extended discussion of this argument, see A. A. Howsepian, "On Referring," *Ethics and Medicine* 25, 1 (Spring 2009): 31–49.