STRONG STAR TRAINING INITIATIVE

Addressing Moral Injury Through Prolonged Exposure & Cognitive Processing Therapy

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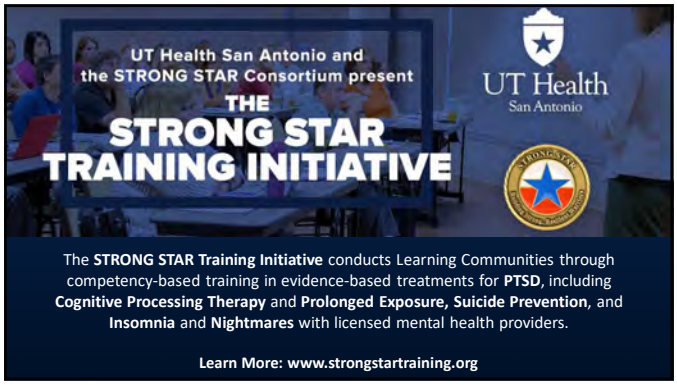
1



The **STRONG STAR Training Initiative** conducts Learning Communities through competency-based training in evidence-based treatments for **PTSD**, including **Cognitive Processing Therapy** and **Prolonged Exposure, Suicide Prevention**, and **Insomnia** and **Nightmares** with licensed mental health providers.

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2

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4

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5

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6

I have no conflicts of interest to disclose.

7

Potentially Morally Injurious Events

- A betrayal of **what is right** by someone in authority or one's self in a *high stakes* situation (Shay, 1994, 2014).
- "…perpetrating, failing to prevent, or bearing witness to acts that transgress **deeply held moral beliefs**…" (Litz et al., 2009, p. 697).
- "…bearing witness to perceived **immoral acts**, failure to stop such actions, or perpetration of immoral acts, in particular actions that are inhumane, cruel, depraved, or violent, bringing about pain, suffering, or death of others" (Drescher et al., 2011, p. 9).
- "…a situation occurring in a *high-stakes* environment where an individual perceives that an important **moral value** has been violated by the actions of self or others" (Farnsworth, Drescher, Evans, & Walser, 2017, p. 392).
- ***Next Step*:** Clarifying the scope of potentially morally injurious events.

8

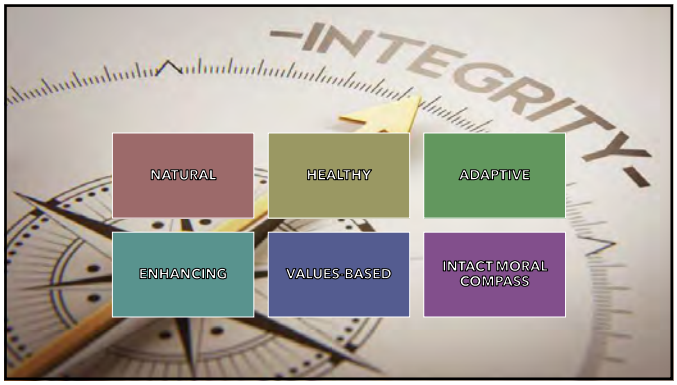
Moral Pain

"…the experience of dysphoric moral emotions and cognitions (e.g., self-condemnation) in response to a morally injurious event" (Farnsworth et al., 2017, p. 392).

Emotions
- Shame
- Guilt
- Anger
- Disgust
- Contempt

Thoughts
- Condemnation of *(in)actions* of self or others
- Criticism of inefficiencies or system errors
- Requirement of restitution or reconciliation

9



10

Moral Injury

- "…the lasting psychological, biological, spiritual, behavioral, and social impact of [exposure to PMIEs]" (Litz et al., 2009, p. 697).
- A trauma syndrome including psychological, existential, behavioral, and interpersonal issues (Jinkerson, 2011).
  - Core symptoms include guilt, shame, spiritual/existential conflict, loss of trust.
- "…expanded social, psychological, and spiritual **suffering** stemming from costly or unworkable attempts to manage, control, or cope with the experience of moral pain" (Farnsworth et al., 2017, p. 392).

11

Conceptualizing Moral Injury*

1. Syndromal (Jinkerson, 2011; Litz et al., 2009)
2. Stress injury (literal wound; Nash, 2007, 2019)
3. Heuristic continuum (Litz & Kerig, 2019)
4. Social functional (Evans et al., 2020; Farnsworth et al., 2014, 2017, 2019)

**The question remains an empirical one*

12

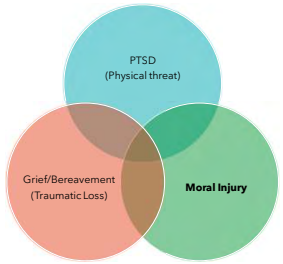
Assessments of MI & MIE exposure

- Moral Injury Events Scale (Nash et al., 2013)
- Moral Injury Questionnaire (Currier et al., 2015)
- Moral Injury Symptom Scale (Koenig et al., 2017)
- *Expressions of Moral Injury Scale* (Currier et al., 2017)

- Upcoming:
  - Moral Injury Outcomes Scale (Litz Consortium)
  - Expanded MIES & MIQ (Frankfurt)
  - Non-military adaptions of EMIS, MIES, and MISS

13

Choosing Treatment Targets



14

Why Target/Tailor Interventions?

- Neurobiology of PTSD appears to differ based on trauma type (danger, non-danger; Boccia et al., 2016; Ramage et al., 2016)
- Moral injury and PTSD have distinct neural underpinnings and subtypes (perpetration, betrayal) of morally injurious events are different in neural responses (Sun et al., 2018).
- Behaviors driving distress have different functions across distinct experiences
  - Avoidance, Avoidance, & Avoidance

15

Considerations for Using Existing PTSD Treatments

- Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT) are EBPs for **PTSD**
- Moral Injury does not always co-occur with PTSD
- However, treatment procedures can be targeted to address many aspects of moral injury
- In some cases, procedures are already in place
  - Right-sizing responsibility
  - Contextualizing events
- In other cases, *as-written* protocol may be augmented with conceptually compatible components

16

Cognitive Processing Therapy

17

Therapeutic Stance

Even with the presence of evidence to the contrary, patients may firmly experience their moral judgments as being appropriate (Farnsworth et al., 2017)

Ill-targeted attempts to restructure or reduce perceptions of culpability may be perceived as an affront to patient's personal values, potentially damaging the provider's perceived credibility (Gray et al., 2017)

May also be interpreted as an attempt to minimize or "launder" the patient's experience of moral pain (Singer, 2004)

Gentle exploration → compassionate challenging → *willingness to sit with moral pain*

18

CPT for Moral Injury (Wachen et al., 2020)

- Establishing reality-based, balanced beliefs remains the primary mechanism when targeting moral injury in CPT.
- When trauma-related beliefs represent a failure to accurately or comprehensively incorporate contextual information, the goal of CPT is to explore these incomplete or distorted and ***incorporate missing information or resolve discrepancies between the available evidence and the beliefs.***
- When trauma-related cognitions represent a troubling, albeit accurate thought about a past moral violation, the goal of CPT is to *encourage the patient to* ***accept the reality of the situation and to feel the natural emotions associated with it*** that may have been avoided in the context of PTSD.
- The purpose of Socratic questioning is to uncover the truth of the situation, and often involves reappraisal of certain aspects of the traumatic experience *and* acceptance of certain realities.

19

Recommendation #1

- **Titrate pacing and directivity in guided inquiry.**

⊗ Ineffective to move too quickly from a focus on *developing awareness* of thoughts to *challenging* of problematic beliefs.

⊗ Stuck points that develop after morally injurious events are frequently comprised of *both* evidence-based *and* distorted components.

20

Recommendation #2

- **Prevent imposition of personal values by therapist.**
- Given the role of CPT therapists as guides – shepherding the patient to more balanced beliefs – we must be aware of our own values as well as our patients'.

21

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PASSWORD #1:

strong

22

Recommendation #3

- **Acknowledge patients' important cultural values.**
- Therapists should be aware of the values of cultures with which patients identify, the moral rules prescribed by these cultures, and the way these rules may be applied (or misapplied) in different contexts.
- It is important for a CPT therapist not to seek to undermine those values but to help patients *identify where rigid beliefs about moral rules are keeping them stuck.*
- Awareness of values is necessary for optimal application of CPT for moral injury, which entails both reappraising inaccurate beliefs and accepting the reality of the event.

23

A Note on Manufactured Emotions

- When self-blame is appropriate and accurate, guilt is *not* a manufactured emotion.
- When other-blame is appropriate and accurate, contempt and even anger may be primary rather than manufactured emotions.
- The objective of CPT then remains the same: To openly experience the natural emotions and to establish a balanced belief that facilitates optimal functioning and quality of life going forward.

24

Socratic Questioning for Change AND Acceptance

- Socratic dialogue is a flexible tool that may facilitate moral healing via both cognitive change and acceptance.
- Example: After exploring the stuck point "I am a monster," a new balanced belief that facilitates acceptance of past moral transgressions may read, "I have done monstrous things, and I plan to atone by doing good things in the future."
- When delivering CPT with a patient experiencing moral injury, do *not* to assume that all cognitions related to the event are erroneous. It is important not to attempt to prematurely or inappropriately challenge the veracity of these cognitions, but rather to allow the patient to acknowledge the reality of the event, but *within the larger context of the patient's existence*.

25

New Balanced Beliefs: 3 Key Points

Consideration of event context *and* life as context

Explicit acknowledgement of the moral violation

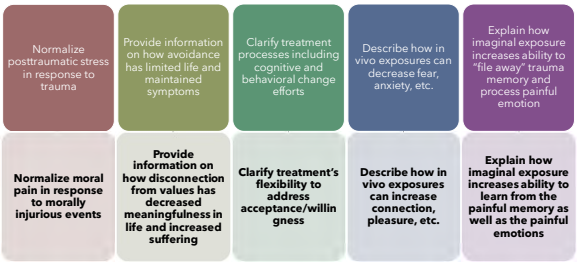
Forgiveness and/or self-compassion language

26

Prolonged Exposure Therapy

27

Psychoeducation (Session 1)



28

In Vivo Exposure (Evans et al., 2021)

- PE protocol describes in vivo exposure as "confronting feared stimuli" and the objective of in vivo exposure is new learning via habituation (Foa et al., 2007).
- The manual includes three types of situations that may be helpful to include among in vivo exposures: situations perceived as dangerous, reminders of the trauma, and activities in which the patient has lost interest.
- Recently, recommendations for augmenting in vivo exposures include:
  - Social engagement (Smith et al., 2013)
  - Forgiveness of self and others (Gray et al., 2012)
  - Reengagement with values (Farnsworth et al., 2017)
  - Emotional expression (Hall-Clark et al., 2019)

29

Recommendations for Targeting In Vivo Exposure

Include a broad range of in vivo exposures with a variety of targets.

When encouraging intentional attentional focus (i.e., to regulate safety behaviors), select a high-value "anchor" that allows the patient to pay attention to a source of meaning.

Facilitate forgiveness via in vivo exposures chosen and enacted because they overtly align with values previously violated.

30

Hierarchy Example

*Reduction of fear/anxiety

†Values-based behavioral activation

+ Emotional expression

° Social engagement

Activity	SUDs Rating
Watching football on TV	30†
Playing video games	30†
Working out at home	30†
Talking to brother on phone	30†+
Talking to grandfather on phone	30†+
Visiting grandfather's home	60*+°
Sitting with full congregation at church	70*°+
Having friends over to his house	70*°+
Food court on post	70*
Local grocery store	75*
Post Exchange	75*
Walking around neighborhood with family	80*†
Taking children to park off post	95*°+
Movie theater with wife	95*†
Going to a football game	100*°+
Working out at gym	100*†
Movie theater by self	100*
Go to Chuck E. Cheese	>100*°+

31

Imaginal Exposure

- The PE manual includes five points in the rationale for imaginal exposure:
  1. Organizing the memory
  2. Differentiating "remembering" and "reexperiencing"
  3. Habituation (extinction)
  4. Differentiating traumatic event(s) from similar events
  5. Increasing sense of self-control
- Guiding inquiry throughout imaginal exposures brings patient into contact with fear/anxiety *and* painful moral emotions.

32

Contacting Moral Emotions

- The purpose of contacting moral emotions during imaginal exposure was different than the goal of contacting fear and anxiety.
- The goal of contacting moral emotions is *expansion of behavioral repertoire* for responding to them. This allows for behavioral flexibility, which can decrease suffering and increase functioning.
- Habituation is not the goal of contact moral emotions. Habituation cannot occur for as long as the individual continues to value the moral/principle that was violated.
  - With life threat-based traumas, the memory can be presented without the threat to life and, thus, fear/anxiety no longer represent adaptive responses.
- Guilt remains a functional, adaptive response to reflecting on the moral violation, as it orients the transgressor to restorative action and/or motivates disengagement from (or prevention of) future values-inconsistent action.

33

Recommendations for Imaginal Exposure

1. Deliver rationale for the imaginal exposure with an openness to the patient's beliefs about what can (or should) change about his or her interpretations of this event.
2. Goals of imaginal exposure and emotional processing should include both reducing excessive or undue distress *AND* accepting meaningful emotional and cognitive responses.
3. Though the imaginal exposure procedure remains consistent, awareness of differential learning processes should guide selection of prompts/questions and for processing.

34

Resources*

35

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37

Questions!
Answers?

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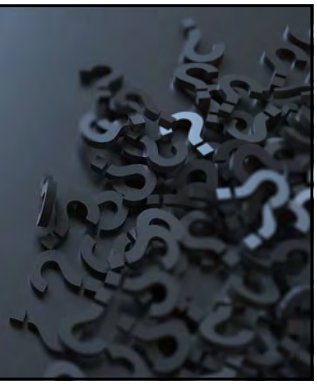

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39

Next Month's Webinar

- ***The Role of Emotions – Reducing Posttraumatic Emotional Numbing Using CPT and PE***
- Presented by **Vanessa Jacoby, PhD, ABPP**, Assistant Professor within the Psychiatry and Behavioral Sciences at The University of Texas Health Science Center at San Antonio
- **When**: Wednesday, January 12 at 1pm CT

40