Journal of Psychiatry
Psychotherapy & Communication

Haverkampf, C. J. (2023). Moral Injury in Healthcare and the Helping Professions: Shame, Betrayal, and Psychotherapeutic Repair. J Psychiatry Psychotherapy Communication, 2023 Sep 30;12(3):81-90

Moral Injury in Healthcare and the Helping Professions: Shame, Betrayal, and Psychotherapeutic Repair

Christian Jonathan Haverkampf

Narrative Clinical Review

Abstract—Moral injury offers language for suffering that follows perpetrating, failing to prevent, witnessing, or being betrayed around events that violate deeply held moral expectations. In healthcare and helping professions, such events may arise where responsibility for vulnerable people meets scarcity, unsafe systems, hierarchical power, discriminatory policy, or repeated institutional silence. Moral injury is not a formal psychiatric diagnosis and should not become a replacement label for burnout, moral distress, post-traumatic stress disorder (PTSD), depression, or ordinary regret. This narrative clinical review considers evidence available through 30 August 2023. It examines shame, guilt, anger, betrayal, grief, loss of trust, and spiritual or existential conflict while keeping realistic responsibility and systemic constraint in view. Assessment should clarify the event, role, available choices, power, consequences, appraisals, symptoms, and current safety without presuming either innocence or culpability. Direct treatment evidence for healthcare workers remains sparse; most psychotherapeutic models and trials come from military populations. Clinicians can nevertheless draw cautiously on trauma-informed guilt work, cognitive therapy, compassionate witnessing, values-guided action, peer support, and chosen spiritual care. Psychotherapy cannot repair an organization that continues the violation. Credible care therefore links individual treatment with acknowledgment, ethics, safer staffing and policy, accountable review, and material opportunities for restitution and prevention.

Index Terms—moral injury, moral distress, healthcare workers, burnout, shame, organizational repair

I. INTRODUCTION

Helping professions ask people to act responsibly inside institutions whose conditions they do not fully control. A clinician may be unable to secure a bed, adequate staffing, interpretation, time, medication, or safe discharge. A social worker may have to enforce a threshold they believe excludes a family in need. A therapist may witness discrimination or concealment by an authority. Distress can then concern not only exhaustion or fear, but who one has become and whether one's moral world remains trustworthy.

Moral injury was developed in military and trauma literature to describe lasting psychological, social, spiritual, and behavioral consequences of potentially morally injurious events. These may involve acts of commission or omission, witnessing, or betrayal by legitimate authority in high-stakes circumstances (Litz et al., 2009; Griffin et al., 2019). The event is potentially injurious; the outcome is not automatic. People can experience sorrow, regret, or anger without a persistent injury.

The term has resonated strongly in healthcare, especially during COVID-19. Resonance is not proof of diagnostic validity. Moral injury has no agreed status as a DSM or ICD disorder, definitions and measures vary, and much healthcare research is cross-sectional. Used carelessly, the label can overpathologize proportionate moral protest or suggest that therapy should help a worker tolerate conditions that remain wrong.

This review treats moral injury as a formulation lens, not a verdict. It asks what happened, what moral expectation was threatened, what choices and constraints existed, who held power, what consequences followed, and what maintains suffering now. Repair may include psychotherapy, but it also belongs to teams, professions, regulators, and institutions. An injured conscience is not simply an individual's faulty cognition.

Professional identity intensifies the stakes. Codes, training, and public promises tell helpers that they will protect dignity, confidentiality, safety, and access. When routine work makes those commitments impossible, distress can feel like hypocrisy rather than workload. Yet professional ideals can

Christian Jonathan Haverkampf, M.D., LL.M., is a psychotherapist working in private practice in Dublin, Ireland. Correspondence: jonathanhaverkampf@gmail.com. Website: www.jonathanhaverkampf.com.

Haverkampf, C. J. (2023). Moral Injury in Healthcare and the Helping Professions: Shame, Betrayal, and Psychotherapeutic Repair. J Psychiatry Psychotherapy Communication, 2023 Sep 30;12(3):81-90

also become absolute and punitive, leaving no room for finite knowledge or tragic choice. Treatment needs enough moral seriousness to honor duty and enough realism to recognize what no individual could control.

II. SCOPE AND REVIEW METHOD

This narrative clinical review considered literature publicly available through 30 August 2023. Searches addressed moral injury, potentially morally injurious events, moral distress, burnout, PTSD, shame, guilt, betrayal, healthcare workers, nurses, physicians, mental-health and public-safety personnel, psychotherapy, peer support, spiritual care, and organizational intervention. Systematic and scoping reviews, meta-analyses, healthcare measurement studies, relevant trials, and influential conceptual papers were prioritized.

The evidence crosses constructs and occupations. Some studies measure exposure, some symptoms, and some endorse a moral-injury label without a common diagnostic interview. Pandemic studies were often rapid, cross-sectional, self-selected, and conducted while exposure continued. Associations with distress cannot establish that a morally injurious event caused a later disorder or that the measured construct is distinct from depression, PTSD, or burnout (Hall et al., 2022; Thibodeau et al., 2023).

Treatment evidence is even less direct. Psychotherapies addressing trauma-related guilt, moral appraisals, or spiritual struggle have mainly been developed and tested with military veterans. They inform possible components for healthcare workers but do not constitute an established occupation-specific treatment. Organizational recommendations draw on moral-distress intervention research and professional synthesis; claims are bounded accordingly.

The earlier JPPC archive was searched for relevant work and the 2016 article on treatment-resistant PTSD was read in full (Haverkampf, 2016). It is cited only to contextualize communication, meaning, interpersonal safety, and trauma treatment. Its local and published page-range discrepancy is documented in the source audit, and it is not used as authority for moral injury as a construct.

The review does not decide whether particular clinical controversies have one correct moral answer. Literature was used to identify recurring contexts, associations, and possible responses, while ethical conclusions remain case-specific. Terms such as perpetration and betrayal are retained because they occur in the field, but in assessment they are hypotheses about experience until the event, role, standards, and perspectives have been examined.

III. WHAT MORAL INJURY NAMES—AND WHAT IT DOES NOT

Moral injury names an enduring aftermath organized around a perceived violation of deeply held moral commitments. The precipitating event may involve doing, failing to do, witnessing, or being betrayed in a high-stakes context. Possible consequences include guilt, shame, anger, disgust, grief, loss of trust, spiritual struggle, withdrawal, and changes in identity or behavior. No single emotion or symptom is necessary in every proposed model (Griffin et al., 2019; McEwen et al., 2021).

Moral distress is related but historically emphasizes knowing, or believing one knows, the ethically appropriate action while constraint prevents it. Narrative synthesis shows that the concept itself has been defined inconsistently, including uncertainty and conflict as well as constraint (Morley et al., 2019). Moral distress may resolve, recur, or contribute to enduring moral injury; the terms should not be collapsed.

Burnout concerns occupational exhaustion, cynicism or depersonalization, and reduced professional efficacy. It can follow chronic workload, poor control, unfairness, value conflict, and inadequate reward or community (Maslach & Leiter, 2016). Moral conflict may contribute to burnout, and the constructs can overlap, but exhaustion does not establish a moral violation. The influential call to reframe clinician distress as moral injury usefully restored system responsibility while risking an either-or distinction that later discussion has moderated (Dean et al., 2019).

PTSD requires a qualifying traumatic exposure and a defined syndrome of intrusion, avoidance, negative mood or cognition, and arousal. A morally injurious event may also be traumatic, and shame or guilt can be central to PTSD, but not every moral violation satisfies the trauma criterion or produces PTSD. Depression, adjustment reactions, grief, substance problems, and ordinary regret likewise require separate assessment.

The distinction prevents two clinical errors. One is to call all clinician distress burnout and prescribe recovery skills to someone protesting a serious ethical breach. The other is to call every value conflict moral injury, granting the phrase diagnostic certainty it does not possess. A formulation should show which construct explains which part of the person's experience and where uncertainty remains.

Ordinary moral disagreement also needs protection from pathology. Colleagues can disagree conscientiously about proportionality, autonomy, risk, or allocation and remain psychologically well. A painful decision may yield sadness and learning without persistent shame, avoidance, or loss of trust. The presence of an ethical question is not a symptom. Clinical involvement becomes relevant when distress, risk, or

Haverkampf, C. J. (2023). Moral Injury in Healthcare and the Helping Professions: Shame, Betrayal, and Psychotherapeutic Repair. J Psychiatry Psychotherapy Communication, 2023 Sep 30;12(3):81-90

impairment requires care, or when a person seeks a confidential place to think—not because professional disagreement itself needs treatment.

Table 1. Differentiating related forms of distress

Construct	Organizing feature	Typical but nonexclusive features	Clinical implication
Moral injury	Enduring aftermath of a perceived moral violation or betrayal	Shame, guilt, anger, grief, loss of trust, spiritual conflict	Clarify event, responsibility, authority, meaning, symptoms, and repair
Moral distress	Ethical concern under constraint, uncertainty, or conflict	Frustration, powerlessness, anger, compromised integrity	Address decision process and remove remediable constraint
Burnout	Chronic occupational stress and work-system mismatch	Exhaustion, cynicism, reduced efficacy	Change workload and organization; restore recovery and control
PTSD	Defined post-traumatic syndrome after qualifying exposure	Intrusion, avoidance, altered cognition or mood, arousal	Use evidence-based PTSD assessment and treatment when criteria are met
Ordinary regret or grief	Painful appraisal or loss without persistent syndrome	Sadness, remorse, reflection, changed intention	Do not pathologize; support proportionate processing and action

IV. FROM MORAL EVENT TO PERSISTENT INJURY

An event becomes psychologically significant through appraisal, relationship, and aftermath. Two workers may face the same shortage but hold different roles, information, duties, alternatives, and histories. One experiences tragic necessity; another believes they abandoned a patient; a third feels betrayed by leaders who concealed preventable risk. A list of events cannot substitute for understanding what was morally at stake.

Early models emphasized transgression, global beliefs about the self and world, withdrawal, and failed attempts at repair (Litz et al., 2009). Later reviews describe multiple pathways, including perpetration, omission, witnessing, and betrayal, with heterogeneous outcomes (Griffin et al., 2019). A dimensional contextual review of healthcare workers similarly argues for attention to event, context, interpretation, and impact rather than a single syndrome (Griffin et al., 2023).

Responsibility has several layers. Causal contribution, professional duty, foreseeability, available alternatives, intention, authority, and outcome are not identical. Hindsight can make an outcome seem predictable; hierarchy can make a theoretical option unusable; repeated small acquiescences can still matter. Therapy should neither issue premature absolution nor accept the harshest self-sentence as fact.

The aftermath can consolidate injury. Silence from leadership, retaliatory investigation, a family's unanswered complaint, colleagues' avoidance, public praise that erases harm, or another similar event can confirm that the institution will not acknowledge what happened. Conversely, honest review, apology, changed policy, and material support may interrupt the conclusion that values are meaningless.

Individual vulnerability is not moral weakness. Prior trauma, depression, perfectionism, minority stress, isolation, or a history of institutional betrayal may affect impact and recovery. So can moral seriousness and empathic identification with those harmed. The formulation should not turn the qualities that drew someone to care work into defects simply because an unsafe system exploited them.

Time course can distinguish an acute alarm from a consolidating injury, but there is no validated diagnostic clock. Early sleeplessness and replay may settle after transparent review and support; years-old events can become newly salient when a similar policy returns or a professional hearing begins. Clinicians should document transitions: when the moral meaning changed, when avoidance or self-condemnation began, and whether organizational responses improved or intensified the outcome.

V. HEALTHCARE AND HELPING PROFESSIONS: WHERE VALUES MEET CONSTRAINT

Healthcare moral conflicts often arise at the junction of limited resources and intimate responsibility: triage, unsafe staffing, inadequate personal protective equipment, delayed treatment, discharge to poor conditions, restricted visiting, discriminatory care, nonbeneficial intervention, or inability to provide time and dignity. COVID-19 intensified many of these circumstances but did not create them (Xue et al., 2022; Laher et al., 2022).

Helping professions beyond medicine encounter parallel tensions. Therapists may be asked to manage risk without beds, enforce attendance or documentation rules that undermine care, disclose information under legal duties, or work in services whose thresholds exclude people in crisis. Social-care staff may ration basic attention while carrying responsibility for neglect they cannot prevent. The morally salient feature is not occupation but the relation among duty, power, constraint, and harm.

Scoping work in healthcare finds wide variability in definitions, measures, samples, and proposed events (Čartolovni et al., 2021). Reviews focused on forensic and psychiatric settings identify exposure to violence, coercive practices, organizational constraint, and conflicts between care and control, but evidence is still largely qualitative and observational (Webb et al., 2023). These findings identify credible domains for inquiry, not a prevalence for an individual service.

Haverkampf, C. J. (2023). Moral Injury in Healthcare and the Helping Professions: Shame, Betrayal, and Psychotherapeutic Repair. J Psychiatry Psychotherapy Communication, 2023 Sep 30;12(3):81-90

Hierarchy influences who can object. Trainees, nurses, aides, agency staff, minoritized workers, and those dependent on visas or references may carry risk for speaking. The person with least decision authority may have most contact with the harmed patient. An ethics pathway that exists on paper but invites retaliation is not a meaningful option.

The clinical interview should therefore ask not only 'What did you do?' but 'What system were you in, who decided, what information and alternatives did you have, what happened when concern was raised, and is the situation continuing?' Without those questions, therapy can inadvertently reproduce the institution's transfer of responsibility downward.

Communication records can help reconstruct constraint, but they are not emotionally neutral. Incident reports, emails, notes, policies, and rota data may clarify what was known and escalated; repeated private review can also become rumination or expose confidential patient information. The therapist should not invite records they are not entitled to hold. Where documentation matters for legal, regulatory, or employment action, the client needs appropriate independent advice about preservation, disclosure, and privacy.

VI. MORAL DISTRESS, MORAL RESIDUE, AND ORGANIZATIONAL POWER

Moral distress can be an ethically informative response. Anger, agitation, or dread may signal that a worker's professional obligations and actual practice have become incompatible. The first intervention is sometimes an ethics consultation, staffing change, second opinion, legal clarification, or protected escalation—not emotion regulation. Regulation matters, but should make effective action more possible rather than quiet legitimate alarm.

When constraints recur, distress may accumulate as moral residue: earlier compromises alter the meaning of the next. A worker who repeatedly apologizes for systemic delay may come to feel personally fraudulent; a team may normalize a condition that once produced protest. Research on moral distress uses variable language, but consistently points to institutional context and the limits of exclusively individual solutions (Morley et al., 2019; Dzeng & Wachter, 2020).

Interventions to mitigate moral distress have included ethics education and consultation, reflective groups, debriefing, resilience activities, communication processes, and organizational change. A systematic review found heterogeneous, generally low-quality evidence, limiting conclusions about which interventions work and under what conditions (Morley et al., 2021). A reflective meeting cannot compensate for staffing that remains foreseeably unsafe.

Power also shapes whose morality counts. Institutional accounts may privilege efficiency, risk management, or reputation; patients and families may prioritize access, dignity, or repair; workers may disagree among themselves. Moral injury language should not authorize the clinician's moral view as neutral. The assessment needs the person's values, relevant professional obligations, affected stakeholders, and legitimate disagreement.

Organizations sometimes invite staff to tell painful stories without offering confidentiality, protection, or a route to change. This can become extractive. Before a group discussion, participants should know who will hear the information, what will be recorded, what action is possible, and how retaliation will be prevented. Silence can be self-protection, not avoidance.

Leaders carry a distinct communicative task after a morally serious event. They can state known facts, acknowledge uncertainty and harm, explain immediate protections, invite information through safe routes, and return with decisions. Euphemism, premature praise, or a generic wellness message can deepen betrayal. An apology without authority to change conditions may still matter, but it should not promise closure or ask injured staff to reassure management.

VII. SHAME, GUILT, ANGER, BETRAYAL, AND GRIEF

Guilt is commonly directed toward an act or omission: I did something wrong. Shame globalizes the conclusion: I am unworthy, contaminated, or unfit to belong. The distinction is clinically useful but not absolute. Meta-analysis links both shame and guilt with PTSD symptoms, with shame showing a stronger relationship in many analyses, while causality and measurement vary (Shi et al., 2021).

Realistic guilt can carry information and motivate restitution. Excessive guilt may depend on hindsight, inflated responsibility, impossible standards, or omission of constraint. Premature reassurance—'you did your best'—can close the story before responsibility is understood. Premature condemnation does the opposite. Careful work reconstructs what was known, possible, intended, chosen, and caused.

Betrayal-based injury may center less on self-blame than anger, disgust, disbelief, and loss of trust in leaders, colleagues, profession, or society. A worker can be proud of their own conduct and still feel morally injured by institutional abandonment. Treatment that searches only for distorted guilt will miss the injury. Organizational acknowledgment is especially relevant because the offending relationship is institutional, not solely intrapsychic.

Grief may concern a patient, colleague, career, team, professional identity, faith, or imagined moral community. Some losses are concrete; others concern the belief that one's organization would protect patients and staff. Grief work permits recognition without requiring restoration of trust. The person may decide that leaving a role or profession is a values-consistent act rather than avoidance.

Haverkampf, C. J. (2023). Moral Injury in Healthcare and the Helping Professions: Shame, Betrayal, and Psychotherapeutic Repair. J Psychiatry Psychotherapy Communication, 2023 Sep 30;12(3):81-90

Anger can protect dignity and orient action, but it can also become generalized, isolating, or dangerous. The clinician asks what the anger identifies, toward whom it is directed, what it urges, and what consequences follow. The goal is not moral sedation. It is enough choice to pursue accountability without allowing the institution's failure to consume every relationship.

Forgiveness should not be used as a proxy for recovery. A person may release a consuming demand for a different past while continuing to judge an act wrong, seek accountability, or withhold trust. Another may understand an error and still not forgive it. Where self-forgiveness is desired, it can follow accurate responsibility and repair rather than bypass them. The therapist's need for a redemptive ending is not evidence that reconciliation is clinically necessary.

VIII. ASSESSMENT WITHOUT A PREWRITTEN VERDICT

Assessment starts with a concrete account: what happened, who was affected, what the person's role was, what they knew at each point, what alternatives existed, who held authority, what they did before and afterward, and what remains unresolved. This sequence distinguishes the event from later global conclusions and makes structural constraints visible without deciding the moral meaning in advance.

The clinician asks which value, duty, relationship, or identity was violated. Was the central experience perpetration, omission, witnessing, or betrayal? Did the person violate their own judgment, follow a contested professional rule, or confront an impossible choice between harms? Moral disagreement is not settled by a symptom measure. Ethics consultation, supervision, legal advice, or cultural and spiritual consultation may be needed.

Measures can support inquiry but remain non-diagnostic. The Moral Injury Symptom Scale–Healthcare Professionals includes religious struggle among several domains and was developed in a particular sample (Mantri et al., 2020). Scores should not be used to declare that an event was morally injurious, compare moral worth, or require spiritual framing. Healthcare reviews continue to find measure and definition heterogeneity (Thibodeau et al., 2023).

Symptoms and function are mapped separately: intrusion, avoidance, hyperarousal, depression, anhedonia, sleep, substance use, shame, anger, relationship withdrawal, work capacity, spiritual struggle, and occupational decisions. PTSD, major depression, anxiety, grief, or burnout may coexist and require established assessment. Moral injury language does not replace a full psychiatric formulation.

Current context completes assessment. Is the person still exposed? Has retaliation occurred? Are patients still at risk? Is the worker able to take leave, speak safely, or access independent support? Treatment cannot assume a post-event phase while the same conflict repeats each shift.

Confidentiality deserves unusually explicit discussion. Occupational referrals, fitness assessments, litigation, regulatory duties, and patient-safety concerns can alter who receives information and for what purpose. The clinician should distinguish treatment from evaluation, state limits before detailed disclosure where possible, and avoid broad releases. Fear of career damage may otherwise make apparent avoidance entirely realistic. Trust begins with an accurate account of what the therapy setting can and cannot protect.

A seven-part moral-injury formulation

- Event: describe acts, omissions, witnessing, betrayal, and consequences without global labels.
- Moral stake: name the duty, value, relationship, identity, or community understood to be violated.
- Agency: reconstruct knowledge, intention, alternatives, constraint, authority, and causal contribution.
- Aftermath: identify acknowledgment, concealment, retaliation, repetition, restitution, and support.
- Response: assess shame, guilt, anger, grief, trust, spirituality, PTSD, depression, burnout, substance use, and function.
- Safety: ask about suicide, self-harm, violence, impairment at work, ongoing exposure, and patient risk.
- Repair: separate what belongs to the person, relationships, profession, and organization.

IX. RISK, PTSD, DEPRESSION, BURNOUT, AND SUICIDALITY

Systematic reviews associate moral-injury measures with PTSD, depression, anxiety, suicidality, and functional difficulties, but most underlying studies are military, cross-sectional, and unable to establish direction or independent diagnosis (Williamson et al., 2018; Hall et al., 2022; McEwen et al., 2021). The associations justify assessment. They do not justify presenting moral injury as the cause of every symptom.

Healthcare surveys similarly link moral-injury symptoms and burnout. One pandemic study found overlap while treating the constructs as distinguishable, and comparative work identified different patterns among healthcare workers and veterans (Mantri et al., 2021; Nieuwsma et al., 2022). Convenience sampling, self-report, and extraordinary pandemic conditions limit transportability.

Suicide inquiry should be direct. Shame, perceived unforgivability, social withdrawal, occupational loss, insomnia, substance use, and access to lethal means can combine dangerously. The clinician asks about thoughts, intent, plans, preparation, prior behavior, protective connections, and whether professional fears prevent disclosure. A worker should not have to accept an occupational label in order to receive urgent care.

Haverkampf, C. J. (2023). Moral Injury in Healthcare and the Helping Professions: Shame, Betrayal, and Psychotherapeutic Repair. J Psychiatry Psychotherapy Communication, 2023 Sep 30;12(3):81-90

Patient safety and practitioner safety may intersect. Severe sleep loss, intrusive memories, intoxication, panic, or suicidal crisis can impair work. A plan may require temporary duty change, leave, confidential occupational assessment, or emergency intervention. These steps should be proportionate and should not become punitive removal for raising an ethical concern.

When PTSD or depression criteria are met, evidence-based treatment for those disorders should be offered, with the moral meaning included rather than bracketed out. Burnout requires work-system attention even when psychotherapy is also useful. Multiple formulations can coexist; clarity about each target makes monitoring and accountability possible.

X. ORGANIZATIONAL REPAIR BEFORE RESILIENCE RHETORIC

An organization cannot refer a worker to mindfulness and call the moral breach repaired. Individual coping may help someone sleep, think, and choose, but it does not create staff, reverse discriminatory policy, disclose an error, or protect a whistleblower. Accounts of clinician anxiety and mental-health risk during COVID-19 emphasized concrete needs—being heard, protected, prepared, supported, and cared for—which are organizational obligations as well as psychological ones (Greenberg et al., 2020; Shanafelt et al., 2020).

Credible repair begins with acknowledgment. Leaders identify what occurred, who was harmed, what remains uncertain, and who has authority to act. Review should be independent enough to be trusted and nonpunitive enough to learn, without eliminating accountability for reckless or abusive conduct. Material correction—staffing, equipment, access, policy, compensation, reporting protection—matters more than symbolic appreciation.

Moral resilience has been described as the capacity to sustain or restore integrity under adversity. Healthcare-worker research during COVID-19 suggests relationships among moral injury, resilience, and distress, but observational associations do not show that resilience training repairs causation (Rushton et al., 2022). Resilience becomes rhetoric when responsibility travels downward while decision power and resources remain unchanged.

Team-level practices include protected ethical discussion, access to consultation, psychologically safer challenge, transparent allocation criteria, consistent supervision, and follow-through. Group reflection should lead to an accountable response: what will change, by whom, by when, and how staff will know. If no change is possible, leaders should say why rather than solicit disclosure under a false promise.

External accountability may be necessary where the institution cannot investigate itself. Professional bodies, unions, regulators, legal counsel, patient representatives, or independent advocacy can have roles. A psychotherapist should not provide legal advice outside competence, but can help the client think about goals, risks, documentation, support, and the emotional consequences of each route.

Table 2. Repair responsibilities across levels

Level	Possible repair	Evidence of credibility	Failure mode
Individual	Safety, treatment, rest, values-based choice, proportionate restitution	The person has more agency and less concealment	Making the worker adapt to ongoing harm
Team	Witnessing, supervision, ethics discussion, peer support, changed practice	Concern can be raised and followed through without retaliation	Debriefing without authority or action
Organization	Acknowledgment, investigation, staffing, policy correction, protection, compensation	Material conditions and accountability change	Wellness programs substitute for prevention
Profession and system	Guidance, reporting routes, regulation, resource allocation, public truth	Standards align responsibility with power	Celebrating sacrifice while normalizing scarcity
Community and relationship	Apology, restitution, memorial, dialogue when desired and safe	Affected people shape the form of repair	Pressuring forgiveness or reconciliation

XI. PSYCHOTHERAPEUTIC STANCE: WITNESS, ACCURACY, RESPONSIBILITY

The therapist first offers a setting in which morally charged detail can be spoken without immediate exoneration, prosecution, or institutional management. Witnessing means sustained attention to the event and its consequences. It does not require agreeing with every appraisal. Premature reassurance may protect the therapist from discomfort while leaving the client alone with the moral question.

Accuracy work reconstructs the decision context. What information was available then, not now? What options were feasible rather than imaginable? What authority did the person possess? What harm did each option carry? What action followed? This can reduce hindsight and inflated responsibility while leaving realistic responsibility intact. An honest formulation can contain both 'the system constrained me' and 'I wish I had acted differently.'

Shame often requires careful interpersonal testing. The person may expect disgust, expulsion, or loss of professional belonging if the event is known. The therapist responds neither with moral spectacle nor evasive neutrality. Specific behavior, impact, context, remorse, repair, and present values are separated from a total identity. Confidentiality and its limits should be explicit, especially where patient safety or mandatory reporting may arise.

Haverkampf, C. J. (2023). Moral Injury in Healthcare and the Helping Professions: Shame, Betrayal, and Psychotherapeutic Repair. J Psychiatry Psychotherapy Communication, 2023 Sep 30;12(3):81-90

Responsibility becomes therapeutic when it is proportionate and actionable. Possible steps include an apology, disclosure through appropriate channels, changed practice, restitution, advocacy, or accepting a consequence. Some actions are unavailable or could harm patients and families further. Therapy should not use confession to relieve the worker at another person's expense.

Prior trauma-focused JPPC writing emphasizes a safe communicative relationship and restoration of meaning (Haverkampf, 2016). That stance is relevant, but moral repair may also require disagreement and social action. Safety is not a promise that the therapist will neutralize anger or return the person to the same role. It is a relationship in which difficult responsibility and constrained choice can be examined without abandonment.

XII. TREATMENT COMPONENTS AND INDIRECT EVIDENCE

No psychotherapy had, by the cutoff, an adequate evidence base establishing a preferred treatment for moral injury in healthcare workers. Most clinical approaches are adaptations from military PTSD, guilt, or spiritual-care contexts. This limitation should be part of consent. Treatment can target a defined comorbid disorder, a maintaining process such as shame and withdrawal, or a moral-repair goal without claiming to cure a settled syndrome.

Trauma-Informed Guilt Reduction Therapy uses appraisal of responsibility, hindsight, and justification alongside values-consistent action. A randomized trial in veterans found benefit relative to supportive care for trauma-related guilt and PTSD outcomes, but occupation, exposures, and treatment setting limit direct inference to healthcare workers (Norman et al., 2022). Its useful lesson is structured accuracy, not automatic absolution.

Cognitive therapy for moral injury within PTSD has been described through clinical models and cases, focusing on appraisals of self, others, and the world, memory updating, and behavioral change (Murray & Ehlers, 2021). Where PTSD is present, established trauma-focused treatments should not be withheld merely because moral emotions are prominent. Adaptation should preserve the active treatment while addressing realistic guilt and betrayal.

Spiritual integration may be helpful when the client identifies faith, existential meaning, or moral community as central. Spiritually integrated models have been proposed for moral injury, but evidence remained preliminary and largely outside healthcare populations by the cutoff (Winkeljohn Black & Klinger, 2022). Clergy or spiritual-care involvement requires the client's invitation; forgiveness, confession, or a theological interpretation must not be prescribed.

Compassion-focused, acceptance-based, narrative, and interpersonal methods may help with shame, avoidance, identity, and reconnection, but direct moral-injury trial evidence is limited. The clinician should name the target, choose observable outcomes, monitor possible worsening, and change course when work increases self-condemnation, suppresses ethical action, or becomes disconnected from the continuing institutional problem.

Outcomes should extend beyond a moral-injury score. Relevant changes include sleep, PTSD or depressive symptoms, substance use, capacity to speak about the event, accuracy of responsibility, social connection, work decisions, ethical action, and whether the person can experience valued life without denial. Reduced anger is not automatically improvement if it reflects resignation. Leaving an institution is not automatically deterioration if it restores safety and integrity. The chosen indicators should reflect what treatment can influence and what remains an organizational obligation.

Table 3. Treatment components, evidence, and boundaries

Component	Possible target	Evidence status by cutoff	Boundary
Detailed event and context formulation	Confusion, global blame, hidden constraint	Supported conceptually across reviews	Do not turn therapy into a court or ethics ruling
Responsibility and guilt work	Hindsight, inflated or realistic responsibility, repair	Veteran RCT evidence; indirect for healthcare	Neither automatic absolution nor total self-condemnation
Trauma-focused treatment	PTSD intrusion, avoidance, threat, negative appraisals	Established for PTSD; moral-injury adaptations developing	Confirm PTSD and retain trauma-treatment competence
Compassion and reconnection	Shame, isolation, damaged belonging	Plausible component; limited direct trials	Compassion does not erase accountability
Chosen spiritual care	Faith conflict, meaning, forgiveness questions	Preliminary model literature	Never impose religion, confession, or forgiveness
Values and restitution	Agency, professional identity, future conduct	Clinically reasoned; outcome research sparse	Avoid actions that burden those already harmed

XIII. PEERS, SUPERVISION, ETHICS, AND SPIRITUAL CARE

Moral suffering is relational, and confidential peer contact can counter isolation. A peer can understand role realities that an outside clinician may miss, notice normalization of unsafe practice, and accompany a worker through reporting or return. Programs need training, boundaries, escalation pathways, and protection from compulsory disclosure. Peer support is not a substitute for treatment, representation, or investigation.

Supervision can locate professional responsibility before shame becomes private and total. Good supervision asks about

Haverkampf, C. J. (2023). Moral Injury in Healthcare and the Helping Professions: Shame, Betrayal, and Psychotherapeutic Repair. J Psychiatry Psychotherapy Communication, 2023 Sep 30;12(3):81-90

uncertainty, hierarchy, values, alternatives, and impact; records decisions; and carries concerns upward. Poor supervision reassures without action or invites reflection while preserving the supervisor's deniability. The worker should know whether the conversation is clinical, managerial, educational, or investigatory.

Ethics consultation can clarify competing duties and create a contemporaneous record, but access and authority vary. It is most useful before and during difficult decisions, not only after harm. Consultation should include the perspectives of patients, families, and frontline staff where appropriate. It cannot be assumed neutral if its mandate protects the organization more than those affected.

Spiritual care may help a person examine guilt, meaning, lament, belonging, ritual, forgiveness, or a damaged relationship with faith. It may also be harmful where a tradition or leader contributed to shame. The person chooses whether this domain enters care and who is safe to involve. Secular existential work must remain equally available.

Communication across these supports requires consent. The psychotherapist, supervisor, occupational service, peer program, chaplain, union, and employer may have different confidentiality rules. Before information moves, the client needs a clear account of recipient, purpose, minimum content, storage, and possible consequence. Vague assurances of a supportive team are not enough.

XIV. LIMITATIONS

Moral injury remains conceptually and psychometrically unsettled. Reviews find overlapping definitions, exposure lists, and symptom measures, with evidence concentrated in military populations and cross-sectional designs (Williamson et al., 2018; Griffin et al., 2019; Hall et al., 2022). Associations with PTSD, depression, burnout, or suicidality do not by themselves establish a distinct causal syndrome.

Healthcare evidence expanded rapidly during COVID-19 and captured real distress, but self-selection, common-method measurement, changing exposure, and exceptional conditions constrain inference. Scoping and systematic reviews identify plausible circumstances and consequences while repeatedly noting heterogeneity and study-quality limits (Čartolovni et al., 2021; Xue et al., 2022; Thibodeau et al., 2023).

Direct intervention research for healthcare and helping professionals is sparse. Moral-distress interventions are heterogeneous and generally weakly evaluated; moral-injury psychotherapies are derived mainly from veteran work (Morley et al., 2021). There is little comparative evidence on timing, adverse effects, organizational prerequisites, or outcomes valued by patients, families, and workers.

Language itself can cause harm. A medicalized label may individualize protest; an exclusively systemic account may leave personal responsibility unexplored; spiritual language may exclude or coerce; and moral certainty may harden contested facts. This narrative review offers a framework, not a diagnostic instrument or ethical adjudication. Each conclusion should remain open to evidence, consultation, culture, and the perspectives of people affected by the event.

Future research needs prospective designs that distinguish event exposure from outcome, compare measures, include non-pandemic and nonmilitary settings, and follow occupational as well as psychiatric outcomes. Intervention studies should identify organizational cointerventions and adverse effects rather than attributing all change to the worker's therapy. Patients and families affected by the underlying events should help define repair; otherwise the field risks studying professional distress while leaving the original harm outside the frame.

XV. CONCLUSION

Moral injury can name a form of suffering that burnout language misses: a wound to responsibility, trust, identity, and moral belonging after transgression, omission, witnessing, or betrayal. It remains a formulation construct rather than a formal diagnosis. Moral distress, PTSD, depression, burnout, grief, and ordinary regret should be assessed rather than absorbed into it.

Psychotherapy offers witness, accurate reconstruction, proportionate responsibility, trauma treatment when indicated, work with shame and guilt, reconnection, values-guided action, and chosen spiritual care. The direct evidence for healthcare workers is limited, and consent should include that uncertainty. Forgiveness, return to role, and symptomless acceptance are not universal endpoints.

Repair becomes credible when responsibility follows power. Individuals may need care and opportunities for restitution; teams need ethical voice and supervision; institutions need acknowledgment, prevention, material correction, and accountability. Asking a worker to become resilient while the violation continues is not repair. A professional response helps the person recover agency while also insisting that systems answer for the conditions they create.

XVI. CONFLICTS OF INTEREST AND DISCLOSURES

Conflicts of interest—The author developed and writes about Communication-Focused Therapy (CFT). Where CFT is discussed, it is presented as a formulation perspective and not as a substitute for established assessment, evidence-based treatment, or independent replication. No other conflict of interest was reported.

Funding—No specific funding was reported for this article.

Haverkampf, C. J. (2023). Moral Injury in Healthcare and the Helping Professions: Shame, Betrayal, and Psychotherapeutic Repair. J Psychiatry Psychotherapy Communication, 2023 Sep 30;12(3):81-90

Author contributions—Christian Jonathan Haverkampf is the sole named author and is responsible for the conception, literature review, manuscript preparation, and approval of the final draft.

Patient material—No identifiable patient material is presented. Any brief examples are generic composites created to illustrate clinical reasoning and are not case reports.

XVII. REFERENCES

Čartolovni, A., Stolt, M., Scott, P. A., & Suhonen, R. (2021). Moral injury in healthcare professionals: A scoping review and discussion. Nursing Ethics, 28(5), 590-602. https://doi.org/10.1177/0969733020966776

Dean, W., Talbot, S., & Dean, A. (2019). Reframing clinician distress: Moral injury not burnout. Federal Practitioner, 36(9), 400-402. https://pmc.ncbi.nlm.nih.gov/articles/PMC6752815/

Dzeng, E., & Wachter, R. M. (2020). Ethics in conflict: Moral distress as a root cause of burnout. Journal of General Internal Medicine, 35(2), 409-411. https://doi.org/10.1007/s11606-019-05505-6

Greenberg, N., Docherty, M., Gnanapragasam, S., & Wessely, S. (2020). Managing mental health challenges faced by healthcare workers during the COVID-19 pandemic. BMJ, 368, m1211. https://doi.org/10.1136/bmj.m1211

Griffin, B. J., Purcell, N., Burkman, K., Litz, B. T., Bryan, C. J., Schmitz, M., Villierme, C., Walsh, J., & Maguen, S. (2019). Moral injury: An integrative review. Journal of Traumatic Stress, 32(3), 350-362. https://doi.org/10.1002/jts.22362

Griffin, B. J., Weber, M. C., Hinkson, K. D., Jendro, A. M., Pyne, J. M., Smith, A. J., Usset, T., Cucciare, M. A., Norman, S. B., Khan, A., Purcell, N., & Maguen, S. (2023). Toward a dimensional contextual model of moral injury: A scoping review on healthcare workers. Current Treatment Options in Psychiatry, 10(3), 199-216. https://doi.org/10.1007/s40501-023-00296-4

Hall, N. A., Everson, A. T., Billingsley, M. R., & Miller, M. B. (2022). Moral injury, mental health and behavioural health outcomes: A systematic review of the literature. Clinical Psychology & Psychotherapy, 29(1), 92-110. https://doi.org/10.1002/cpp.2607

Haverkampf, C. J. (2016). Treatment-resistant PTSD. J Psychiatry Psychotherapy Communication, 5(3), 66-76. https://jonathanhaverkampf.com/wp-content/uploads/2020/04/Haverkampf-CJ-Treatment-Resistant-PTSD-J-Psychiatry-Psychotherapy-Communication-2016-Sep-30-53-66-76.pdf

Laher, Z., Robertson, N., Harrad-Hyde, F., & Jones, C. R. (2022). Prevalence, predictors, and experience of moral suffering in nursing and care home staff during the COVID-19 pandemic: A mixed-methods systematic review. International Journal of Environmental Research and Public Health, 19(15), 9593. https://doi.org/10.3390/ijerph19159593

Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C., & Maguen, S. (2009). Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. Clinical Psychology Review, 29(8), 695-706. https://doi.org/10.1016/j.cpr.2009.07.003

Mantri, S., Lawson, J. M., Wang, Z., & Koenig, H. G. (2020). Identifying moral injury in healthcare professionals: The Moral Injury Symptom Scale-HP. Journal of Religion and Health, 59(5), 2323-2340. https://doi.org/10.1007/s10943-020-01065-w

Mantri, S., Song, Y. K., Lawson, J. M., Berger, E. J., & Koenig, H. G. (2021). Moral injury and burnout in health care professionals during the COVID-19 pandemic. Journal of Nervous and Mental Disease, 209(10), 720-726. https://doi.org/10.1097/NMD.0000000000001367

Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: Recent research and its implications for psychiatry. World Psychiatry, 15(2), 103-111. https://doi.org/10.1002/wps.20311

McEwen, C., Alisic, E., & Jobson, L. (2021). Moral injury and mental health: A systematic review and meta-analysis. Traumatology, 27(3), 303-315. https://doi.org/10.1037/trm0000287

Morley, G., Field, R., Horsburgh, C. C., & Burchill, C. (2021). Interventions to mitigate moral distress: A systematic review of the literature. International Journal of Nursing Studies, 121, 103984. https://doi.org/10.1016/j.ijnurstu.2021.103984

Morley, G., Ives, J., Bradbury-Jones, C., & Irvine, F. (2019). What is moral distress? A narrative synthesis of the literature. Nursing Ethics, 26(3), 646-662. https://doi.org/10.1177/0969733017724354

Murray, H., & Ehlers, A. (2021). Cognitive therapy for moral injury in post-traumatic stress disorder. The Cognitive Behaviour Therapist, 14, e8. https://doi.org/10.1017/S1754470X21000040

Nieuwsma, J. A., O'Brien, E. C., Xu, H., Smigelsky, M. A., & Meador, K. G. (2022). Patterns of potential moral injury in post-9/11 combat veterans and COVID-19 healthcare workers. Journal of General Internal Medicine, 37(8), 2033-2040. https://doi.org/10.1007/s11606-022-07487-4

Norman, S. B., Capone, C., Panza, K. E., Haller, M., Davis, B. C., Schnurr, P. P., Shea, M. T., Browne, K., Norman, G. J., Lang, A. J., Kline, A. C., Golshan, S., Allard, C. B., & Angkaw, A. (2022). A clinical trial comparing trauma-informed guilt reduction therapy (TrIGR), a brief intervention for trauma-related guilt, to supportive care therapy. Depression and Anxiety, 39(4), 262-273. https://doi.org/10.1002/da.23244

Rushton, C. H., Thomas, T. A., Antonsdottir, I. M., Nelson, K. E., Boyce, D., Vioral, A., Swavely, D., Ley, C. D., & Hanson, G. C. (2022). Moral injury and moral resilience in health care workers during COVID-19 pandemic. Journal of Palliative Medicine, 25(5), 712-719. https://doi.org/10.1089/jpm.2021.0076

Shanafelt, T., Ripp, J., & Trockel, M. (2020). Understanding and addressing sources of anxiety among health care professionals during the COVID-19 pandemic. JAMA, 323(21), 2133-2134. https://doi.org/10.1001/jama.2020.5893

Shi, C., Ren, Z., Zhao, C., Zhang, T., & Chan, S. H.-W. (2021). Shame, guilt, and posttraumatic stress symptoms: A three-level meta-analysis. Journal of Anxiety Disorders, 82, 102443. https://doi.org/10.1016/j.janxdis.2021.102443

Thibodeau, P. S., Nash, A., Greenfield, J. C., & Bellamy, J. L. (2023). The association of moral injury and healthcare clinicians' wellbeing: A systematic review. International Journal of Environmental Research and Public Health, 20(13), 6300. https://doi.org/10.3390/ijerph20136300

Webb, E. L., Ireland, J. L., Lewis, M., & Morris, D. (2023). Potential sources of moral injury for healthcare workers in forensic and psychiatric settings: A systematic review and meta-ethnography.

Trauma, Violence, & Abuse. Advance online publication. https://doi.org/10.1177/15248380231167390

Williamson, V., Stevelink, S. A. M., & Greenberg, N. (2018). Occupational moral injury and mental health: Systematic review and meta-analysis. British Journal of Psychiatry, 212(6), 339-346. https://doi.org/10.1192/bjp.2018.55

Winkeljohn Black, S., & Klinger, K. (2022). Building Spiritual Strength: A spiritually integrated approach to treating moral injury. Current Treatment Options in Psychiatry, 9(4), 313-320. https://doi.org/10.1007/s40501-022-00276-0

Xue, Y., Lopes, J., Ritchie, K., D'Alessandro, A. M., Banfield, L., McCabe, R. E., Heber, A., Lanius, R. A., & McKinnon, M. C. (2022). Potential circumstances associated with moral injury and moral distress in healthcare workers and public safety personnel across the globe during COVID-19: A scoping review. Frontiers in Psychiatry, 13, 863232. https://doi.org/10.3389/fpsyt.2022.863232