Moral Repair, Meaning Reconstruction, And Social Reintegration in Post-Traumatic Stress Disorder: A Mixed-Methods Study of a Sequential Therapeutic Protocol

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ABSTRACT

Moral injury is increasingly recognized as a significant dimension of posttraumatic suffering, involving guilt, shame, betrayal, and disruptions in meaning and moral identity. Although evidence-based treatments for posttraumatic stress disorder (PTSD) effectively reduce trauma-related symptoms, they may not adequately address these moral and existential consequences. This exploratory mixed-methods case series examined the feasibility of a sequential therapeutic protocol integrating emotional stabilization, trauma reprocessing, meaning reconstruction, and community consolidation. Three adults meeting DSM-5 criteria for PTSD associated with moral injury participated in a structured outpatient intervention. Quantitative assessments were conducted at baseline, during treatment, post-treatment, and at a 3-month follow-up using the CAPS-5, PCL-5, TRGI, and WHODAS 2.0. Qualitative data were collected through semi-structured interviews, therapeutic journals, and clinical notes. Quantitative findings showed reductions in PTSD symptoms, trauma-related guilt, and functional impairment, with gains largely maintained at follow-up. Qualitative analyses identified four recurring themes: emotional desensitization, meaning reconstruction, symbolic repair, and social validation. These preliminary findings suggest that interventions targeting traumatic, moral, and relational dimensions are feasible and merit further investigation in larger controlled studies.

Keywords: post-traumatic stress disorder; moral injury; meaning reconstruction; moral repair.

INTRODUCTION

Posttraumatic stress disorder (PTSD) is one of the most extensively studied psychological consequences of exposure to potentially traumatic events. Owing to its high prevalence, substantial impact on individual and social functioning, and tendency toward chronicity, PTSD represents a major public health concern. Contemporary models of PTSD have primarily focused on fear conditioning, avoidance behaviors, cognitive distortions, and emotional processing mechanisms associated with traumatic experiences. These approaches have led to significant theoretical and clinical advances and have contributed to the development of evidence-based interventions. Nevertheless, they do not fully account for certain forms of suffering characterized by persistent guilt, profound shame, experiences of betrayal, disruptions in identity, and enduring losses of meaning that may persist despite substantial reductions in core PTSD symptoms (Litz et al., 2009; Nash & Litz, 2013).

Within this context, the concept of moral injury has emerged as an important framework for understanding the moral and existential dimensions of posttraumatic suffering. Initially introduced by Shay (1994) through his work with military veterans, moral injury refers to the psychological distress that may arise when individuals perpetrate, fail to prevent, witness, or are subjected to acts that violate deeply held moral values. Beyond the traumatic event itself, moral injury concerns the moral meaning attributed to what one has done, failed to do, witnessed, or endured. Contemporary conceptualizations describe moral injury as a multidimensional phenomenon involving emotional, cognitive, relational, spiritual, and identity-related disturbances (Drescher et al., 2011; Litz et al., 2022). Common manifestations include guilt, shame, self-condemnation, anger, feelings of betrayal, loss of trust in oneself or others, and enduring disruptions in personal integrity.

Although research on moral injury initially developed within military populations, growing evidence has demonstrated its relevance across a wide range of civilian settings. Experiences consistent with moral injury have been documented among survivors of interpersonal violence, healthcare professionals facing ethical dilemmas, humanitarian workers, first responders, and individuals exposed to collective or institutional violence (Maguen et al., 2010; Bryan et al., 2014). These findings suggest that moral injury is not limited to military contexts but rather constitutes a broader dimension of posttraumatic suffering that may affect diverse populations confronted with profound violations of moral expectations and values.

Evidence-based treatments for PTSD, particularly trauma-focused cognitive-behavioral therapies and Eye Movement Desensitization and Reprocessing (EMDR), have consistently demonstrated effectiveness in reducing posttraumatic symptoms (Foa et al., 2007; Bisson et al., 2013; Schnyder et al., 2015). However, several authors have argued that symptom reduction does not necessarily resolve moral conflicts, restore a damaged sense of integrity, or rebuild the meaning disrupted by traumatic experiences (Litz et al., 2009; Nash & Litz, 2013). Consequently, individuals may continue to experience profound guilt, shame, and existential distress even after substantial clinical improvement.

To address these limitations, therapeutic approaches emphasizing moral repair and meaning reconstruction have progressively emerged. These models propose that recovery involves not only alleviating emotional distress but also re-evaluating perceived responsibility, restoring moral identity, and reconstructing coherent personal narratives (Nash & Litz, 2013; Evans et al., 2023). This perspective is consistent with meaning-making theories, which suggest that psychological adaptation following trauma depends on individuals' ability to integrate the traumatic experience into broader systems of beliefs, values, and self-understanding (Park & Folkman, 1997; Park, 2010).

At the same time, a growing body of literature highlights the importance of relational and social factors in recovery. Experiences of recognition, validation, and support appear essential for restoring dignity, rebuilding interpersonal trust, and strengthening social belonging following traumatic experiences (Herman, 1992; Honneth, 1995; Charuvastra & Cloitre, 2008). From this perspective, healing is not solely an intrapsychic process but also involves relational repair and social reintegration.

These theoretical developments support the implementation of integrative therapeutic approaches that simultaneously address the emotional, cognitive, moral, and relational dimensions of posttraumatic suffering. Clinically, such an approach may be structured around a sequential protocol comprising four complementary phases: emotional stabilization, trauma memory reprocessing, meaning reconstruction through narrative exploration and value clarification, and a consolidation phase aimed at promoting relational and community reintegration.

This perspective may be particularly relevant in sociocultural contexts where suffering and recovery are understood within collective frameworks of meaning. In many African societies, processes of guilt, forgiveness, reconciliation, and healing are closely embedded within family, community, and spiritual networks. Experiences of recognition and reconciliation frequently play a central role in recovery. Consequently, interventions targeting moral injury may benefit from explicitly incorporating social and community resources into treatment processes.

Despite increasing interest in moral injury, important gaps remain in the literature. Few studies have examined interventions that simultaneously integrate trauma processing, meaning reconstruction, moral repair, and community reintegration. Furthermore, the mechanisms underlying therapeutic change remain insufficiently understood. In addition, most available research has been conducted in Western military populations, limiting current knowledge regarding the applicability of these models across other cultural contexts. Finally, ongoing debates continue concerning the conceptual boundaries among moral injury, moral distress, moral trauma, and related constructs (Metcalf et al., 2022; VanderWeele et al., 2025).

Against this background, the present study reports an exploratory mixed-methods case series examining the feasibility of a sequential therapeutic protocol integrating emotional stabilization, trauma reprocessing, meaning reconstruction, and community consolidation among individuals presenting with PTSD associated with moral injury. More specifically, the study aimed to describe changes in posttraumatic symptoms, trauma-related guilt,

and overall functioning, while exploring participants' experiences of meaning reconstruction, moral repair, and social validation throughout the therapeutic process. Consistent with the exploratory nature of a case-series design, the primary objective was to generate hypotheses and inform future research rather than to establish the efficacy of the proposed intervention.

METHOD

Study design

This study employed an exploratory multiple-case series using a convergent mixed-methods design. The primary objective was to examine the feasibility of a sequential therapeutic protocol integrating emotional stabilization, trauma reprocessing, meaning reconstruction, and community consolidation among individuals presenting with posttraumatic stress disorder (PTSD) associated with moral injury.

A mixed-methods approach was selected to capture both measurable clinical changes and participants' subjective experiences of recovery. Quantitative and qualitative data were collected concurrently throughout the intervention and integrated during the interpretation process. Consistent with recommendations for exploratory case-series research, the study was intended to generate hypotheses regarding potential change processes and clinical relevance rather than to establish treatment efficacy.

Participants

Three adults presenting with PTSD and clinical features consistent with moral injury participated in the study. Participants reported distinct potentially morally injurious experiences, including involvement in the death of a civilian during a military patrol, the inability to save a close relative during an armed attack, and responsibility associated with a fatal road traffic accident.

Participants were required to meet DSM-5 diagnostic criteria for PTSD and to present clinically significant manifestations of moral suffering, including guilt, shame, moral conflict, loss of meaning, or perceived violation of deeply held values. Additional inclusion criteria included the capacity to provide informed consent and willingness to participate in the complete intervention protocol.

Exclusion criteria comprised active psychotic disorders, acute suicide risk requiring specialized intervention, severe substance use disorders, and serious neurological or medical conditions likely to interfere with participation. Sociodemographic and clinical characteristics are presented in Table 1.

Procedure

Following informed consent, participants received a structured outpatient intervention lasting approximately six months and comprising approximately 20 individual sessions.

Assessments were conducted at five predefined time points: baseline (T0), completion of the stabilization phase (T1, Week 4), completion of trauma reprocessing (T2, Week 10), completion of treatment (T3, Week 14), and three-month follow-up (T4).

Quantitative measures and qualitative interviews were administered at predetermined stages of treatment. Clinical notes and therapeutic journals were collected throughout the intervention to document participant experiences and clinically relevant therapeutic processes. All participants completed the intervention and follow-up assessments.

Intervention

The intervention consisted of four sequential therapeutic phases.

Phase 1: Emotional stabilization

The initial phase focused on establishing psychological safety and strengthening emotional regulation capacities. Interventions included psychoeducation regarding PTSD and moral injury, grounding exercises, breathing techniques, emotional regulation strategies, and resource activation procedures.

Phase 2: Trauma reprocessing

The second phase focused on the processing of traumatic memories through evidence-based trauma-focused interventions. Treatment primarily incorporated Prolonged Exposure and Eye Movement Desensitization and Reprocessing (EMDR). The pace and intensity of trauma processing were adapted according to each participant's level of emotional stability and clinical tolerance.

Phase 3: Meaning reconstruction

The third phase addressed the cognitive, moral, and existential consequences of traumatic experiences. Therapeutic work emphasized narrative exploration of traumatic events, examination of perceived responsibility, clarification of personal values, cognitive reappraisal of moral beliefs, and the development of alternative narratives integrating the traumatic experience. Particular attention was devoted to themes related to guilt, shame, self-condemnation, moral identity, and meaning-making.

Phase 4: Community consolidation

The final phase focused on strengthening social and relational reintegration. Participants were encouraged to identify and mobilize family, community, spiritual, and social resources available within their environments. Particular emphasis was placed on social recognition, acceptance, interpersonal support, and engagement in actions perceived as symbolically reparative.

Intervention fidelity

The intervention was delivered by a licensed clinical psychologist trained in psychotraumatology, trauma-focused psychotherapy, and moral injury interventions.

To enhance treatment fidelity, standardized intervention guidelines were developed for each phase of treatment. Clinical supervision was conducted on a biweekly basis by senior psychologists with expertise in trauma treatment. Session objectives, intervention strategies, and therapeutic progress were documented using structured clinical forms that were regularly reviewed during supervision meetings.

Although all assessments and interventions were conducted by the same clinician to ensure procedural consistency, this approach may have increased the risk of evaluator bias and should be considered when interpreting the findings.

Measures

Quantitative measures

PTSD symptom severity was assessed using the *Clinician-Administered PTSD Scale for DSM-5* (CAPS-5) and the *PTSD Checklist for DSM-5* (PCL-5). Trauma-related guilt was assessed using the *Trauma-Related Guilt Inventory* (TRGI), whereas functional impairment was assessed using the *World Health Organization Disability Assessment Schedule 2.0* (WHODAS 2.0).

Although moral injury constituted the central focus of the study, no dedicated standardized moral injury instrument was administered. Identification of moral injury was based on clinical interviews informed by contemporary conceptual definitions proposed in the literature (Litz et al., 2009, 2022).

Qualitative measures

Qualitative data were collected through semi-structured interviews conducted at baseline and post-treatment, participants' therapeutic journals, and therapist clinical notes. Interview guides explored experiences of guilt, shame, loss of meaning, moral conflict, perceived responsibility, identity transformation, symbolic repair, social validation, and perceived recovery.

Particular attention was given to culturally meaningful narratives and locally relevant understandings of suffering, reconciliation, and healing.

Data analysis

Quantitative analysis

Given the exploratory nature of the study and the small sample size (n = 3), inferential statistical analyses were not conducted.

Analyses focused on individual clinical trajectories, temporal changes in scores, and the magnitude and direction of observed changes across assessment points. Descriptive statistics and graphical representations were used to facilitate interpretation of longitudinal trends.

Qualitative analysis

Qualitative data were analyzed using the six-phase thematic analysis framework proposed by Braun and Clarke (2006). The analytic process included data familiarization, initial coding, theme generation, theme review, theme refinement, and report production.

To enhance analytical credibility, coding was conducted independently by two researchers. Discrepancies were discussed until consensus was achieved. Reflexive memos were maintained throughout the analytic process to document interpretations and reduce potential researcher bias.

Data integration

Consistent with the convergent mixed-methods design, quantitative and qualitative findings were initially analyzed separately and subsequently integrated during interpretation.

Integration focused on identifying convergence, complementarity, and divergence between standardized outcome measures and participants' subjective reports of change. Particular attention was paid to processes related to meaning reconstruction, symbolic repair, identity transformation, and social reintegration.

Ethical considerations

The study was conducted in accordance with the ethical principles outlined in the Declaration of Helsinki. All participants provided written informed consent prior to participation and received detailed information concerning study objectives, procedures, potential benefits, and possible emotional discomfort associated with discussing traumatic experiences.

Participant confidentiality was protected through data anonymization and secure data storage procedures. Clinical support remained available throughout the intervention in the event of increased emotional distress. Ongoing supervision was maintained to ensure participant safety and the quality of clinical care.

Because moral injury frequently involves culturally embedded beliefs regarding responsibility, guilt, forgiveness, and reconciliation, particular attention was devoted to respecting participants' personal, spiritual, and sociocultural frameworks during both assessment and intervention procedures.

RESULTS

Participant Characteristics

Three participants meeting DSM-5 criteria for posttraumatic stress disorder (PTSD) and presenting clinical features consistent with moral injury were included in the study. Potentially morally injurious experiences included involvement in the death of a civilian during military operations, inability to save a close relative during an armed attack, and responsibility associated with a fatal road traffic accident. PTSD duration ranged from 11 to 26 months. Baseline assessments indicated clinically significant levels of posttraumatic symptoms, trauma-related guilt, and functional impairment across all participants (Table 1).

Table 1 Participant Sociodemographic, Clinical, and Treatment Characteristics at Baseline (T0)

Characteristic	**P1**	**P2**	**P3**
Age	32 years	28 years	41 years
Sex	Male	Female	Male
Family status	Married, 2 children	Single	Married, 3 children
Occupation	Former military personnel	Teacher	Driver
Index trauma	Killed a civilian during a military patrol	Unable to save her sister during an attack	Road traffic accident involving the death of a passenger
Primary moral injury	Guilt and shame	Survivor guilt	Guilt and anger
PTSD duration at T0	18 months	11 months	26 months
Primary comorbidity	Moderate depression	Generalized anxiety disorder	No diagnosed psychiatric comorbidity (occasional alcohol use)
Previous treatment	None	Three discontinued supportive counseling sessions	Religious support and spiritual practices only
CAPS-5 at T0	38	44	35
PCL-5 at T0	46	52	41
TRGI at T0	62	68	58
WHODAS 2.0 at T0	48	55	42

Note. PTSD = posttraumatic stress disorder; CAPS-5 = *Clinician-Administered PTSD Scale for DSM-5*; PCL-5 = *PTSD Checklist for DSM-5*; TRGI = *Trauma-Related Guilt Inventory*; WHODAS 2.0 = *World Health Organization Disability Assessment Schedule 2.0*.

Feasibility of the Protocol

All three participants completed the full intervention and all scheduled assessments. No participant withdrew from the study during the follow-up period.

Table 2 Feasibility Indicators

Indicator	**Value**
Participants enrolled	3
Participants who completed the intervention	3
Completion rate	100%
Dropouts	0
Participants assessed at follow-up (T4)	3

Note. Indicators refer exclusively to participants included in this case series.

Changes in Clinical Outcomes

Changes in clinical scores across assessment points are presented in Table 3.

Table 3 Clinical Scores Across Assessment Points

Participant	**Measure**	**T0**	**T1**	**T2**	**T3**	**T4 (3-month follow-up)**	**Δ (T0–T3)**
P1	CAPS-5	38	35	28	21	22	-17
	PCL-5	46	42	33	24	26	-22
	TRGI	62	58	50	38	40	-24
	WHODAS 2.0	48	45	38	28	29	-20
P2	CAPS-5	44	41	34	26	28	-18
	PCL-5	52	48	39	29	31	-23
	TRGI	68	64	55	42	44	-26
	WHODAS 2.0	55	51	44	33	35	-22
P3	CAPS-5	35	32	26	19	20	-16
	PCL-5	41	38	30	22	23	-19
	TRGI	58	55	47	36	37	-22
	WHODAS 2.0	42	40	34	24	25	-18

Note. T0 = baseline; T1 = end of stabilization phase; T2 = end of trauma reprocessing phase; T3 = end of treatment; T4 = three-month follow-up; Δ = difference between T0 and T3.

The evolution of clinical scores at the different measurement time points is presented in Table 3.A decrease in scores was observed between T0 and T3 for all reported measures in the three participants. This evolution concerned both post-traumatic symptoms (CAPS-5 and PCL-5), trauma-related guilt (TRGI), and functional limitations (WHODAS 2.0).

Regarding post-traumatic symptoms, CAPS-5 scores decreased by 17 points in P1, 18 points in P2, and 16 points in P3 between inclusion and end of treatment. Similarly, PCL-5 scores showed respective decreases of 22, 23, and 19 points. The observed trajectories suggest progressive improvement across the different phases of the protocol, with the largest reductions generally appearing between T1 and T3.

Guilt scores measured by the TRGI also decreased in all three participants. The changes observed between T0 and T3 were 24 points for P1, 26 points for P2, and 22 points for P3. This evolution was accompanied by a parallel decrease in functional limitations assessed by the WHODAS 2.0, with respective reductions of 20, 22, and 18 points.

Data collected at the three-month follow-up (T4) show overall maintenance of the improvements observed at the end of treatment. A slight increase in some scores is nevertheless visible between T3 and T4 for all participants. Despite this fluctuation, all scores remained lower than the values observed at inclusion.

Overall, the quantitative trajectories indicate improvement in symptomatic, cognitive, and functional indicators in the three participants over the course of follow-up.

Qualitative findings

Thematic analysis of the semi-structured interviews, therapeutic journals, and clinical notes identified four interrelated themes: emotional desensitization, meaning reconstruction, symbolic repair, and social validation. Although these themes were evident across all participants, their manifestations varied according to the nature of the traumatic event, the specific form of moral suffering involved, and individual recovery trajectories. Collectively, the findings suggest that the therapeutic process extended beyond symptom reduction and involved broader transformations in emotional regulation, moral appraisal, identity reconstruction, and interpersonal functioning.

Table 4 Summary of Qualitative Themes

Theme	**Description**
Emotional desensitization	Reduced emotional intensity associated with traumatic memories
Meaning reconstruction	Changes in representations of the traumatic event and perceived responsibility
Symbolic repair	Engagement in actions perceived as reparative
Social validation	Experiences of recognition and support reported during follow-up

Note. Themes were derived from thematic analysis of semi-structured interviews, therapeutic journals, and clinical notes

Emotional desensitization

The first theme concerned changes in participants' emotional responses to traumatic memories. At baseline, recollections of traumatic events were typically characterized by intense psychological distress, intrusive emotional experiences, and, in some cases, a subjective sense of reliving the event. Participants described memories that remained highly affectively charged and closely associated with experiences of guilt, helplessness, fear, or moral anguish.

Over the course of treatment, participants reported a marked reduction in the emotional intensity associated with these memories. Although the events remained accessible and retained their personal significance, their recollection no longer elicited the same degree of emotional activation. Importantly, this evolution appeared to reflect a transformation in the emotional processing of traumatic memories rather than avoidance or suppression.

For instance, P1 reported being able to discuss the event "without feeling as though I am reliving it." Similarly, P2 described being capable of remembering her sister's death "without immediately breaking down," whereas P3 noted that the images of the accident "were still present but no longer controlled" his daily life. These accounts suggest that trauma processing contributed to the development of a more regulated relationship with traumatic memories, thereby facilitating emotional integration.

Meaning reconstruction

The second theme reflected a progressive transformation in participants' interpretations of traumatic events and their perceived responsibility. Initial narratives were frequently dominated by rigid and globally self-condemning interpretations in which participants attributed the consequences of the event almost exclusively to their own actions or omissions.

As therapy progressed, participants gradually incorporated contextual, situational, and interpersonal factors into their interpretations. This process appeared to foster a more differentiated understanding of the event and a clearer distinction between actual responsibility and retrospective self-blame.

For example, P2 reported developing a greater awareness that she was not solely responsible for her sister's death. Similarly, P1 increasingly acknowledged the operational constraints and contextual circumstances surrounding the military incident. P3 described a growing ability to distinguish those aspects of the event that were within his control from those that were not.

These narrative changes suggest the emergence of a meaning reconstruction process characterized by greater cognitive flexibility and a more balanced appraisal of personal responsibility. Rather than denying their role in the events, participants appeared to integrate their experiences into more coherent and contextually grounded personal narratives.

Symbolic repair

The third theme concerned engagement in actions experienced as morally or symbolically reparative. As guilt became more manageable, participants reported a growing need to restore a sense of moral coherence and to act in ways that reflected their fundamental values.

Forms of symbolic repair varied across cases. Some participants engaged in letter-writing activities directed toward deceased or absent individuals, whereas others pursued acts of reconciliation, community engagement, or helping behaviors.

P2 described letter writing as an opportunity to express feelings that had remained unspoken for many years. P1 viewed involvement in community-oriented activities as a means of transforming guilt into constructive action. Likewise, P3 emphasized the importance of helping individuals facing circumstances similar to his own.

Despite their differences, these activities appeared to serve a common psychological function. They facilitated a shift from helplessness, shame, and self-condemnation toward agency, responsibility, and prosocial engagement. Symbolic repair therefore emerged as a process through which participants sought to restore a sense of personal integrity while maintaining acknowledgment of the traumatic event and its consequences.

Social validation

The final theme concerned experiences of recognition, acceptance, and interpersonal validation. Several participants reported that prior to treatment they had endured their suffering in relative isolation due to shame, guilt, or fear of negative judgment.

The opportunity to disclose their experiences within a supportive and nonjudgmental environment was consistently described as a meaningful aspect of recovery. Participants associated these experiences with increased feelings of legitimacy, understanding, and acceptance.

P3 described feeling, for the first time, that someone genuinely recognized the significance of what he had experienced. P2 emphasized the importance of being allowed to tell her story without criticism or blame, whereas P1 reported that having his suffering acknowledged fundamentally altered his perception of himself and his experience.

Beyond the therapeutic relationship, participants also described supportive interactions with family members, peers, and community networks. Such experiences appeared to reduce feelings of isolation and promote the gradual restoration of interpersonal trust. Social validation thus emerged as a central component of the recovery process, contributing simultaneously to identity reconstruction and relational reintegration.

Summary of qualitative findings

Taken together, the qualitative findings highlight a multidimensional process of change encompassing emotional, cognitive, moral, and relational domains. Reductions in the emotional salience of traumatic memories were accompanied by more nuanced interpretations of responsibility, engagement in reparative actions, and increased experiences of social recognition and support.

These findings suggest that recovery in the context of PTSD associated with moral injury extends beyond the alleviation of posttraumatic symptoms. Rather, it appears to involve processes of meaning reconstruction, restoration of moral identity, symbolic repair, and relational reintegration. Collectively, these dimensions represent key components of the therapeutic transformations observed across participants and provide further support for integrative approaches addressing both the traumatic and moral consequences of adverse experiences.

DISCUSSION

The present exploratory study examined the feasibility of a sequential therapeutic protocol integrating emotional stabilization, trauma reprocessing, meaning reconstruction, and community consolidation among individuals presenting with posttraumatic stress disorder (PTSD) associated with moral injury. Overall, quantitative findings indicated reductions in PTSD symptoms, trauma-related guilt, and functional impairment, whereas qualitative findings highlighted processes of emotional desensitization, meaning reconstruction, symbolic repair, and social validation. Together, these findings suggest that recovery from morally injurious experiences may involve emotional, cognitive, moral, and relational transformations extending beyond symptom remission.

Recovery beyond symptom reduction

Consistent with previous evidence supporting trauma-focused interventions for PTSD (Bisson et al., 2013; Foa et al., 2007; Schnyder et al., 2015), participants demonstrated progressive reductions in posttraumatic symptoms across treatment. However, the qualitative findings suggest that recovery was not limited to the attenuation of trauma-related distress. Participants described persistent concerns regarding guilt, responsibility, self-perception, and meaning, supporting theoretical perspectives that distinguish moral injury from fear-based manifestations of PTSD (Litz et al., 2009; Nash & Litz, 2013).

These findings reinforce the view that symptom reduction and moral recovery represent related but distinct therapeutic processes. While trauma-focused interventions may reduce emotional distress, addressing moral suffering may require additional work on identity, values, and personal meaning.

Meaning reconstruction and moral appraisal

A central finding concerns participants' evolving interpretations of traumatic experiences. Across cases, rigid self-blaming narratives progressively gave way to more balanced and contextualized understandings of

responsibility. Participants appeared increasingly able to acknowledge situational constraints and differentiate personal responsibility from factors beyond their control.

This observation is consistent with contemporary models of moral injury emphasizing the role of moral appraisals in maintaining psychological distress (Litz et al., 2022; Evans et al., 2023). It also aligns with meaning-making theories suggesting that adaptation following trauma involves restoring coherence between lived experience and pre-existing systems of beliefs and values (Park & Folkman, 1997; Park, 2010). In this regard, meaning reconstruction appears to represent a key therapeutic process through which traumatic experiences are integrated into a more coherent self-narrative.

Symbolic repair and restoration of moral identity

Another important finding concerns participants' engagement in actions perceived as morally reparative. Activities such as letter writing, reconciliation efforts, and helping behaviors were consistently described as meaningful components of recovery. These actions appeared to facilitate the restoration of a positive moral identity and a renewed sense of personal agency.

Rather than seeking to eliminate guilt entirely, participants appeared to transform moral suffering into constructive action. This observation supports theoretical models proposing that moral repair involves the restoration of integrity, dignity, and coherence between personal values and subsequent behavior (Herman, 1992; Litz et al., 2009). Symbolic repair may therefore constitute an important pathway through which individuals rebuild a morally acceptable sense of self following potentially morally injurious experiences.

Social validation and relational reintegration

The findings further highlight the importance of social validation as a component of recovery. Participants consistently emphasized the significance of being able to disclose their experiences within supportive and nonjudgmental environments. Experiences of recognition and acceptance appeared to reduce feelings of isolation and contribute to the reconstruction of trust and social belonging.

These observations are consistent with relational models of trauma recovery, which stress the role of interpersonal support and social acknowledgment in psychological healing (Charuvastra & Cloitre, 2008; Herman, 1992). They also support theories of recognition suggesting that validation from others contributes to the restoration of self-worth and social identity (Honneth, 1995).

Clinical implications

The findings suggest that assessment of individuals presenting with PTSD may benefit from greater attention to moral and existential concerns, including guilt, shame, moral conflict, and disruptions in meaning. They further indicate that interventions integrating meaning reconstruction, symbolic repair, and social reintegration may complement established trauma-focused treatments, particularly when moral suffering remains prominent despite symptom improvement.

Limitations and future directions

Several limitations warrant consideration. The very small sample size, the absence of a comparison group, and the heterogeneity of traumatic experiences limit the transferability of the findings and preclude causal conclusions. In addition, moral injury was not assessed using a dedicated standardized instrument, and no specific measures of meaning reconstruction or moral identity were included.

Future research should examine this therapeutic model using larger samples, controlled designs, and longer follow-up periods. The inclusion of validated measures of moral injury, meaning-making, and posttraumatic growth would contribute to a more precise understanding of the mechanisms underlying change. Further exploration of cultural and community dimensions of moral repair may also help refine interventions addressing the moral consequences of traumatic experiences.

In conclusion, the present findings provide preliminary support for an integrative approach that addresses not only posttraumatic symptoms but also the moral and relational dimensions of suffering. Meaning reconstruction, symbolic repair, and social validation emerged as central processes in participants' accounts of recovery, suggesting their relevance for future clinical and research developments in the field of moral injury.

CONCLUSION

This exploratory mixed-methods case series examined the feasibility of a sequential therapeutic protocol integrating emotional stabilization, trauma reprocessing, meaning reconstruction, and community consolidation among individuals presenting with posttraumatic stress disorder (PTSD) associated with moral injury. Across participants, quantitative findings indicated reductions in posttraumatic symptoms, trauma-related guilt, and functional impairment, while qualitative findings highlighted processes of emotional desensitization, meaning reconstruction, symbolic repair, and social validation.

Taken together, these findings suggest that recovery following morally injurious experiences may extend beyond the alleviation of PTSD symptoms and involve broader transformations in moral identity, personal meaning, and interpersonal functioning. In particular, the results underscore the potential relevance of interventions that address not only trauma-related distress but also experiences of guilt, shame, moral conflict, and disruptions in self-understanding. The prominence of meaning reconstruction, symbolic repair, and social validation across participants further supports contemporary models emphasizing the moral and relational dimensions of posttraumatic recovery.

The findings should nevertheless be interpreted with caution given the exploratory nature of the study, the small sample size, the absence of a comparison group, and the lack of a dedicated standardized measure of moral injury. Consequently, no conclusions regarding treatment efficacy can be drawn.

Despite these limitations, the present study contributes to the growing literature on moral injury by providing preliminary evidence supporting the feasibility of an integrative therapeutic approach that combines trauma-focused interventions with processes of moral repair and social reintegration. Future research involving larger samples, controlled designs, validated measures of moral injury, and longer follow-up periods is required to clarify the mechanisms of change and to further evaluate the clinical utility of this intervention model**.**

RÉFÉRENCES

1. Bisson, J. I., Roberts, N. P., Andrew, M., Cooper, R., & Lewis, C. (2013). Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults. Cochrane Database of Systematic Reviews, 2013(12), CD003388. https://doi.org/10.1002/14651858.CD003388.pub4
2. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101. https://doi.org/10.1191/1478088706qp063oa
3. Bryan, C. J., Bryan, A. O., Morrow, C. E., Etienne, N., & Ray-Sannerud, B. (2014). Moral injury, suicidal ideation, and suicide attempts in a military sample. Traumatology, 20(3), 154–160. https://doi.org/10.1037/h0099852
4. Charuvastra, A., & Cloitre, M. (2008). Social bonds and posttraumatic stress disorder. Annual Review of Psychology, 59, 301–328. https://doi.org/10.1146/annurev.psych.58.110405.085650
5. Cloitre, M., Courtois, C. A., Charuvastra, A., Carapezza, R., Stolbach, B. C., & Green, B. L. (2011). Treatment of complex PTSD: Results of the ISTSS expert clinician survey on best practices. Journal of Traumatic Stress, 24(6), 615–627. https://doi.org/10.1002/jts.20697
6. Drescher, K. D., Foy, D. W., Kelly, C., Leshner, A., Schutz, K., & Litz, B. T. (2011). An exploration of the viability and usefulness of the construct of moral injury in war veterans. Traumatology, 17(1), 8–13. https://doi.org/10.1177/1534765610395615
7. Evans, W. R., Farnsworth, J. K., Drescher, K. D., Currier, J. M., Nieuwsma, J. A., & Levi-Belz, Y. (2023). Moral injury and moral repair: Contemporary developments and future directions. Frontiers in Psychiatry, 14, Article 1189324. https://doi.org/10.3389/fpsyt.2023.1189324
8. Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2007). Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences. Oxford University Press.

9. Herman, J. L. (1992). Trauma and recovery. Basic Books.
10. Honneth, A. (1995). The struggle for recognition: The moral grammar of social conflicts. MIT Press.
11. Litz, B. T., Kerig, P. K., Nash, W. P., Silk, K. R., & Maguen, S. (2022). Moral injury and moral repair in psychological practice. American Psychological Association.
12. 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
13. Maguen, S., Lucenko, B. A., Reger, M. A., Gahm, G. A., Litz, B. T., Seal, K. H., Knight, S. J., & Marmar, C. R. (2010). The impact of reported direct and indirect killing on mental health symptoms in Iraq war veterans. Journal of Traumatic Stress, 23(1), 86–90. https://doi.org/10.1002/jts.20434
14. Metcalf, O., Conradie, M., Kidd, C., Varker, T., Dollman, J., Forbes, D., O'Donnell, M., Bryant, R. A., Greenberg, N., Lewis, V., & Phelps, A. (2022). Moral injury in mental health: A systematic review. European Journal of Psychotraumatology, 13(1), Article 2031769. https://doi.org/10.1080/20008198.2022.2031769
15. Nash, W. P., & Litz, B. T. (2013). Moral injury: A mechanism for war-related psychological trauma in military family members. Clinical Child and Family Psychology Review, 16(4), 365–375. https://doi.org/10.1007/s10567-013-0146-z
16. Park, C. L. (2010). Making sense of the meaning literature: An integrative review of meaning making and its effects on adjustment to stressful life events. Psychological Bulletin, 136(2), 257–301. https://doi.org/10.1037/a0018301
17. Park, C. L., & Folkman, S. (1997). Meaning in the context of stress and coping. Review of General Psychology, 1(2), 115–144. https://doi.org/10.1037/1089-2680.1.2.115
18. Schnyder, U., Ehlers, A., Elbert, T., Foa, E. B., Gersons, B. P. R., Resick, P. A., Shapiro, F., & Cloitre, M. (2015). Psychotherapies for PTSD: What do they have in common? European Journal of Psychotraumatology, 6(1), Article 28186. https://doi.org/10.3402/ejpt.v6.28186
19. Shay, J. (1994). Achilles in Vietnam: Combat trauma and the undoing of character. Scribner.
20. VanderWeele, T. J., Griffin, B. J., McElroy-Heltzel, S. E., et al. (2025). Conceptual and measurement issues in moral injury research: Current debates and future directions. Psychological Trauma: Theory, Research, Practice, and Policy, 17(2), 145–154.