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Moral–Spiritual Injury in Trauma-Informed Care in Iran: An Integrative Review and Culturally Grounded Clinical Framework

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ABSTRACT

Moral and spiritual dimensions of trauma-related suffering may be clinically important in acute care but may be less visible than fear-based posttraumatic symptoms. This integrative review examined moral–spiritual injury as a preliminary clinical formulation for trauma-informed care in Iran, including emergency, trauma, critical care, early post-discharge, and family-facing pathways. PubMed, PsycINFO, Scopus, Web of Science, Scientific Information Database, MagIran, and IranDoc were searched for English- and Persian-language sources published from 1997 to 9 July 2026. Thirty-six substantive sources were included in the final synthesis. Source selection was documented using a PRISMA-informed flow diagram. Sources were critically appraised using the Mixed Methods Appraisal Tool and relevant Joanna Briggs Institute tools, as appropriate to source type. International evidence associates moral injury with posttraumatic stress, depression, burnout, and suicidal ideation or behavior. Iranian evidence supported the contextual relevance of trauma exposure, religious coping, religious and spiritual struggles, mental health stigma, healthcare moral distress, and Persian-language assessment of moral-injury-related constructs. Direct evidence among Iranian trauma survivors, family caregivers, acute-care recipients, and counselling clients remained limited. Moral–spiritual injury is therefore proposed not as a diagnosis or validated treatment model, but as an exploratory formulation for presentations involving guilt, shame, betrayal, perceived unforgivability, spiritual rupture, personally salient family or reputational concerns, and loss of moral self-trust. Clinical implications emphasise anti-pathologizing, client-led, professionally bounded assessment and care, alongside priorities for referral, service development, and research in Iran.

Keywords: Moral Injury; Religious and Spiritual Struggles; Religious Coping; Trauma-Informed Care; Acute care; Iran

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Introduction

Trauma-related injury and psychological distress are important public health concerns in Iran. A national estimate for 2019 identified approximately 16.6 million injury events and an economic burden exceeding US$10 billion through medical costs, disability, productivity losses, and premature mortality [1].

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Iranian studies conducted after major floods have documented clinically relevant posttraumatic stress symptoms, particularly among socially and economically vulnerable groups [2,3]. These findings support the importance of trauma-informed care across emergency, trauma, critical care, early post-discharge, rehabilitation, and family facing pathways.

Clinical assessment after trauma appropriately considers established conditions such as posttraumatic stress disorder (PTSD), major depressive disorder (MDD), anxiety disorders, adjustment disorders, prolonged grief disorder, and related forms of distress [4]. These diagnoses remain essential, but they may not fully describe presentations in which suffering is organized primarily around perceived wrongdoing, failure to prevent harm, betrayal, shame, spiritual rupture, or loss of moral self-trust. A person may experience intrusive memories, avoidance, sleep disturbance, depressed mood, or arousal while interpreting the event principally through appraisals such as "I failed someone," "I am unforgivable," or "I no longer deserve care." Moral–spiritual injury is used in this review as a contextual clinical formulation for such presentations, not as a new diagnosis or substitute for established diagnostic assessment.

Moral injury was initially developed in military and veteran contexts and has subsequently been examined in civilian, healthcare, occupational, humanitarian, and first responder populations [5–10]. It broadly refers to psychological, relational, behavioral, and sometimes spiritual distress following events perceived to violate deeply held moral values, duties or expectations. Potentially morally injurious experiences may involve commission, omission, betrayal, witnessing cruelty or injustice, or surviving circumstances in which others are harmed [5,6]. Moral injury is not a formal psychiatric diagnosis. It is better understood as a dimensional clinical problem that may involve guilt, shame, moral anger, disgust, betrayal, self-condemnation, loss of trust, social withdrawal, and difficulty in forgiving oneself or others [6,10–13].

Systematic reviews and meta-analyses have associated moral injury with posttraumatic stress, depression, anxiety, burnout, and suicidal ideation or behavior across diverse populations [7–9,14–17]. These associations indicate clinical relevance but do not establish that moral injury is reducible to any specific psychiatric outcome.

This distinction is clinically useful but should remain heuristic. PTSD is often organized around threat, danger, and recurrence; MDD around persistent low mood, anhedonia, hopelessness, and global devaluation of the self; and religious or spiritual struggle around doubt, grief, protest, repentance, or conflict concerning sacred matters [4,18–21]. Moral–spiritual injury may be considered when a traumatic or ethically salient event is organized around perceived moral failure, betrayal, condemnation, spiritual abandonment, or exclusion from the possibility of repair. Substantial overlap may occur, and guilt, shame, negative self-beliefs, and spiritual distress can appear in several conditions. Therefore, the purpose of the formulation is to guide enquiries into the dominant meaning of distress rather than to create a new differential diagnosis.

This distinction may be relevant in Iran, where trauma can be interpreted through personal, familial, institutional, cultural, and religious lenses. Iran is religiously, ethnically, linguistically, and socially diverse, and clinicians should not assume uniform religiosity, family structure, theological interpretation, or concern for reputation. Iranian research supports the relevance of religious meaning-making to mental health and adjustment, including positive and negative religious coping [22,25]. Iranian measure-development studies provide additional evidence concerning the assessment of religious coping and attitudes [23,24].

Research on barriers to mental health care has also identified shame, stigma, labelling concerns, cultural barriers, and fear of social consequences as relevant to help-seeking [26]. These findings support individualized assessment of religious, relational, and reputational meanings when they are important to the client, while avoiding the assumption that concepts such as repentance, divine judgment, family obligation, or aberoo are universally applicable.

Emerging Iranian evidence further supports the local relevance of moral injury, religious and spiritual struggles, and healthcare-related moral distress. Persian versions of the Moral Injury Symptoms Scale–Health Care Professionals version and the Abbreviated Moral Injury Outcome Scale have been evaluated among Iranian healthcare and emergency health professionals [27,28].

A Persian short form of the Religious and Spiritual Struggles Scale has also undergone psychometric evaluation, and religious and spiritual struggles have been associated with suicidal behavior in an Iranian adult sample [29,30]. Studies on Iranian nurses and healthcare professionals have documented moral distress and its relationships with mental health, compassion fatigue, professional quality of life, self-compassion, burnout, and secondary traumatic stress [31–33].

This evidence remains indirect and incomplete. Existing Iranian studies do not establish the prevalence, longitudinal course, mechanisms, or

treatment response of moral–spiritual injury among trauma survivors, family caregivers, acute-care recipients, or counselling clients. Much of the broader literature is derived from Western military, veteran, occupational, and healthcare populations [5–17], and its applicability to Iranian clinical settings cannot be assumed. A culturally grounded formulation must therefore distinguish direct Iranian evidence from international findings and culturally informed clinical interpretation.

Accordingly, this integrative review aimed to: (1) clarify moral–spiritual injury as a preliminary formulation for trauma-informed care settings in Iran; (2) distinguish it heuristically from PTSD, MDD, and normative religious or spiritual struggles; (3) synthesize the strengths and limitations of the international and Iranian evidence; and (4) identify cautious implications for assessment, referral, training, and service development.

Table 1 summarizes the working clinical distinctions used in the review. Given the scarcity of direct Iranian clinical evidence, the proposed framework is exploratory and hypothesis-generating.

Materials and Methods

Design

This integrative review and clinical synthesis examined how international and Iranian evidence on moral injury, moral distress, religious and spiritual struggles, and trauma-informed care could inform a culturally grounded clinical formulation for acute and post-acute care in Iran.

The review was not intended to estimate pooled effects, determine prevalence, or develop clinical practice guidelines. An integrative design was selected because it permits synthesis of heterogeneous evidence, including empirical and psychometric studies, systematic and narrative reviews, conceptual papers, books, diagnostic sources, and practice-oriented literature [34].

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*Table **1.** Heuristic Clinical Distinctions Among Posttraumatic Stress Disorder, Major Depressive Disorder, Normative Religious or Spiritual Struggle, and Moral–Spiritual Injury*

Clinical construct	Typical organizing appraisal	Common clinical features and impact on self-concept	Trauma-informed acute-care implication
Posttraumatic stress disorder	"I remain in danger"; "The world is unsafe"; "This may happen again."	Intrusive memories, avoidance, hyperarousal, threat sensitivity, anger, and possible dissociation. The self may be experienced as threatened, powerless, damaged, or unsafe. Moral beliefs may also be affected but are not necessarily the central organizing feature.	Assess trauma exposure, intrusion, avoidance, alterations in mood and cognition, arousal, dissociation, functional impairment, and immediate safety. Provide or refer for evidence-based trauma-focused care.
Major depressive disorder	"Nothing will improve"; "I am worthless"; "The future is closed."	Persistent low mood, anhedonia, hopelessness, fatigue, diminished motivation, guilt, and despair. The self may be globally devalued across situations rather than primarily in relation to one morally salient event.	Assess mood, anhedonia, neurovegetative and cognitive symptoms, functional impairment, medical contributors, and suicidal ideation or behavior. Provide or refer for depression-focused treatment.
Normative religious or spiritual struggle	"I am trying to understand what happened"; "I am grieving, questioning, repenting, or searching for meaning."	Grief, doubt, longing, protest, moral concern, or anger toward God. Although substantial distress may be present, the person generally retains flexibility and the capacity for relationship, responsibility, meaning-making, and repair.	Avoid automatic pathologization. Support client-led exploration of grief, values, beliefs, prayer, ritual, community, or spiritual resources when desired and clinically appropriate.
Moral–spiritual injury	"I violated or failed a moral duty"; "I was betrayed in relation to something morally or spiritually important"; "I am unforgivable or beyond repair."	Guilt, global shame, betrayal, self-disgust, moral anger, spiritual alienation, and perceived abandonment or condemnation. The moral self may be experienced as fundamentally damaged, contaminated, condemned, or excluded from the possibility of repair.	Assess the potentially morally injurious experience, actual and perceived responsibility, guilt, shame, betrayal, spiritual meanings, avoidance, self-punishment, functional impairment, and suicidal ideation or behavior. Provide nonjudgmental, client-led, culturally responsive, and professionally bounded care.

Record identification, screening, eligibility assessment, and inclusion were reported using relevant PRISMA 2020 elements [35].

A PRISMA-informed flow diagram documented the selection process. The review was not prospectively registered and was not designed as a conventional systematic review or meta-analysis.

Because direct evidence from Iranian trauma survivors, family caregivers, acute-care recipients, and counseling clients was limited, the synthesis distinguished direct Iranian evidence, evidence from Iranian healthcare professionals, international moral-injury research, and culturally informed clinical interpretation. Conclusions based primarily on indirect evidence were treated as exploratory and hypothesis-generating.

Search Strategy and Information Sources

Searches were conducted during 2025 and updated through 9 July 2026. The databases searched were PubMed, PsycINFO, Scopus, Web of Science, Scientific Information Database, MagIran, and IranDoc. Eligible publications were dated from 1 January 1997 to 9 July 2026 and written in English or Persian. The lower date limit was selected to include foundational religious-coping literature. No restriction based on clinical setting was applied.

Reference lists of included sources and relevant reviews were hand-searched, and backward and forward citation searching was used to identify additional records. Database searching identified 286 records from PubMed, 234 from PsycINFO, 367 from Scopus, 231 from Web of Science, 162 from Scientific Information Database, 141 from MagIran, and 88 from IranDoc. An additional 62 records were identified through supplementary searching.

The search combined free-text terms and database-specific subject headings, where available, across five domains: moral injury and moral distress; trauma and posttraumatic stress; healthcare and acute care; religious coping and religious or spiritual struggles; and Iranian, Persian, Muslim, or regional contexts. Terms within domains were combined using OR, and domains were combined using AND.

A representative PubMed free-text strategy was:

("moral injury"[Title/Abstract] OR "morally injurious event"[Title/Abstract] OR "morally injurious events" [Title/Abstract] OR "moral distress"[Title/Abstract] OR "moral suffering"[Title/Abstract] OR "moral emotion" [Title/Abstract] OR "moral emotions"[Title/Abstract] OR guilt[Title/Abstract] OR shame[Title/Abstract]) AND (trauma*[Title/Abstract] OR "posttraumatic stress" [Title/Abstract] OR PTSD[Title/Abstract] OR "trauma-informed care"[Title/Abstract] OR "acute care" [Title/Abstract] OR emergency[Title/Abstract] OR hospital*[Title/Abstract] OR nurse*[Title/Abstract] OR physician*[Title/Abstract] OR "healthcare worker" [Title/Abstract] OR "healthcare workers"[Title/Abstract])

Complementary searches combined moral injury and moral distress terms with Iranian, Persian, Muslim, Islamic, and regional terms. Searches concerning religious coping, religious or spiritual struggles, spiritual distress, forgiveness, repentance, and moral repair were combined with trauma and mental-health outcomes. Measurement-focused searches included the Moral Injury Symptoms Scale–Health Care Professionals version, Moral Injury Outcome Scale, Abbreviated Moral Injury Outcome Scale, and Religious and Spiritual Struggles Scale, together with translation, validation, cultural adaptation, and psychometric terms.

Persian-language searches used accepted academic equivalents and common spelling variants relating to moral injury, moral distress, trauma, posttraumatic stress disorder, religious coping, religious and spiritual struggles, spiritual distress, suicide, depression, anxiety, grief, healthcare personnel, emergency care, hospitals, and intensive care.

Search syntax was adapted to the functions of SID, MagIran, and IranDoc. Representative database-specific strategies, limits, search dates, and retrieval counts are provided in Supplementary File 1.

Eligibility Criteria

Sources were eligible when they made a substantive contribution to at least one prespecified synthesis domain. Eligible sources:

1. Defined, measured, or synthesized moral injury, moral distress, potentially morally injurious experiences, moral emotions, or moral repair.
2. Examined relationships between moral injury or moral distress and posttraumatic stress, depression, suicidal ideation or behavior, burnout, compassion fatigue, professional quality of life, or related outcomes.
3. Addressed religious coping, religious or spiritual struggles, spiritual distress, forgiveness, repentance, or meaning-

making in relation to trauma or mental health.
4. Provided Iranian or Persian-language evidence concerning trauma, religious coping, moral injury, moral distress, spiritual struggle, stigma, or healthcare-related ethical strain.
5. Provided clinically relevant guidance concerning trauma-informed, spiritually sensitive, culturally responsive, or morally focused care.

Eligible evidence included quantitative, qualitative, mixed-methods, psychometric, systematic-review, meta-analytic, conceptual, diagnostic, and practice-oriented sources with sufficient methodological or argumentative detail for evaluation.

Exclusion criteria were exclusively theological or doctrinal content without clinical relevance; non-peer-reviewed opinion without transparent evidentiary support; conference abstracts without sufficient data; duplicate reports without distinct findings; tangential relevance; and insufficient methodological or bibliographic information.

Reports based on overlapping study populations were linked and interpreted together to minimize double-counting. Eligibility was not restricted to emergency departments or hospitals; hospital-linked outpatient, early post-discharge, rehabilitation, family-facing, and community-care pathways were included when directly relevant to acute or post-acute formulation.

Thirty-six substantive sources met the eligibility criteria and were included in the synthesis. Four additional methodological references concerning integrative-review methodology, PRISMA reporting, MMAT, and JBI appraisal [34–37] supported the review process but were not counted as included evidence sources.

Study Selection

All records were consolidated in a reference-management database (Zotero) and deduplicated using automated matching followed by manual comparison of titles, authors, publication years, journal details, and digital object identifiers.

Two reviewers independently screened titles and abstracts against the predefined eligibility criteria. Records considered potentially eligible by either reviewer proceeded to full-text assessment. The same reviewers independently evaluated full-text reports for relevance, methodological transparency, and contribution to the synthesis domains.

Decisions were compared after each stage. Disagreements were resolved through discussion, re-examination of the record or full-text report, and consensus based on the predefined eligibility criteria. All disagreements were resolved by consensus; therefore, third-reviewer adjudication was not required. Reasons for full-text exclusion were documented using predefined categories and are reported in Figure 1.

Data Extraction and Synthesis

Two reviewers independently extracted data using a standardized matrix. Extracted items included publication details, country and cultural context, population, setting, study design, sample size, constructs, measures, trauma exposure or potentially morally injurious experience, religious or spiritual variables, outcomes, principal findings, limitations, reported funding or conflicts of interest, and relevance to trauma-informed acute care in Iran.

Extraction records were compared, and discrepancies were resolved through discussion and re-examination of the original source. Information supporting the main findings, evidence tables, and clinical framework was cross-checked against the full texts.

Evidence was organized into four domains:

1. Conceptualization of moral injury and moral–spiritual injury.
2. Relationships with posttraumatic stress, depression, suicidal ideation or behavior, burnout, and related outcomes.
3. Iranian evidence concerning trauma, religious coping, religious and spiritual struggles, stigma, moral injury, and moral distress.
4. Clinical and service implications for assessment, formulation, referral, training, and professional boundaries.

A structured narrative synthesis was used because the sources were heterogeneous in design, populations, settings, construct definitions, and outcome measures. The synthesis mapped recurring concepts, compared international and Iranian evidence, and developed a heuristic framework distinguishing posttraumatic stress disorder, major depressive disorder, normative religious or spiritual struggle, and moral–spiritual injury.

Direct Iranian evidence was prioritized when available. International evidence was treated as indirect when corresponding Iranian research was absent. Causal, prevalence, and treatment-effect conclusions were not inferred from cross-sectional, profession-specific, culturally indirect, or conceptual sources.

Critical Appraisal and Interpretive Weighting

Two reviewers independently appraised sources using criteria appropriate to the evidence type. Primary empirical studies were assessed using the Mixed Methods Appraisal Tool, version 2018 [36]. Psychometric studies were additionally evaluated for sampling adequacy, translation and cultural adaptation, reliability, internal consistency, construct validity, and appropriateness of statistical analyses.

Systematic reviews and meta-analyses were assessed using the relevant JBI checklist for systematic reviews and research syntheses. Conceptual, expert, narrative, and practice-oriented sources were assessed using the relevant JBI tools for textual evidence [37].

Books, diagnostic manuals, and methodological documents were not assigned formal risk-of-bias ratings but were evaluated for authority, relevance, currency, and consistency with the review purpose. Criterion-level judgments were compared between reviewers. Disagreements were resolved through discussion, re-examination of the source, consultation of the relevant appraisal criteria, and consensus. No overall numerical MMAT or JBI scores were calculated, and sources were not excluded solely because of appraisal findings.

Interpretive weighting considered methodological quality, directness, consistency, cultural relevance, clinical applicability, and population similarity. Contributions were described as strong, moderate, limited, or contextual; these descriptors were narrative judgments rather than standardized MMAT, JBI, or certainty-of-evidence ratings.

International moral-injury findings were not assumed to generalize automatically to Iranian populations. Evidence from Iranian healthcare professionals was not treated as direct evidence concerning trauma survivors, family caregivers, or counseling clients, and culturally informed interpretations were presented as hypotheses requiring empirical evaluation.

Results

Study Selection and Evidence Profile

Database and supplementary searches identified 1,571 records. After removal of 376 duplicates, 1,195 records underwent title and abstract screening, of which 897 were excluded. Full-text retrieval was sought for 298 reports; 21 could not be retrieved. Of the 277 reports assessed for eligibility, 241 were excluded, leaving 36 substantive sources in the final evidence synthesis. The identification, screening, eligibility, and inclusion process is presented in Figure 1.

psychometric primary empirical studies [1–3,9,14,19,22,25,26,30–33], seven psychometric or measure-development studies [12,21,23,24,27–29], 10 systematic, integrative, or narrative reviews and meta-analyses [5–8,10,11,13,15–17], four books, book chapters, diagnostic sources, or treatment manuals [4,18,20,38], and two conceptual or practice-oriented journal articles [39,40]. Four methodological references concerning integrative-review methodology, PRISMA reporting, MMAT appraisal, and JBI appraisal [34–37] supported the review process but were not counted among the 36 substantive evidence sources. Because the evidence was heterogeneous in design, population, setting, construct definition, and cultural relevance, findings were synthesized narratively rather than pooled

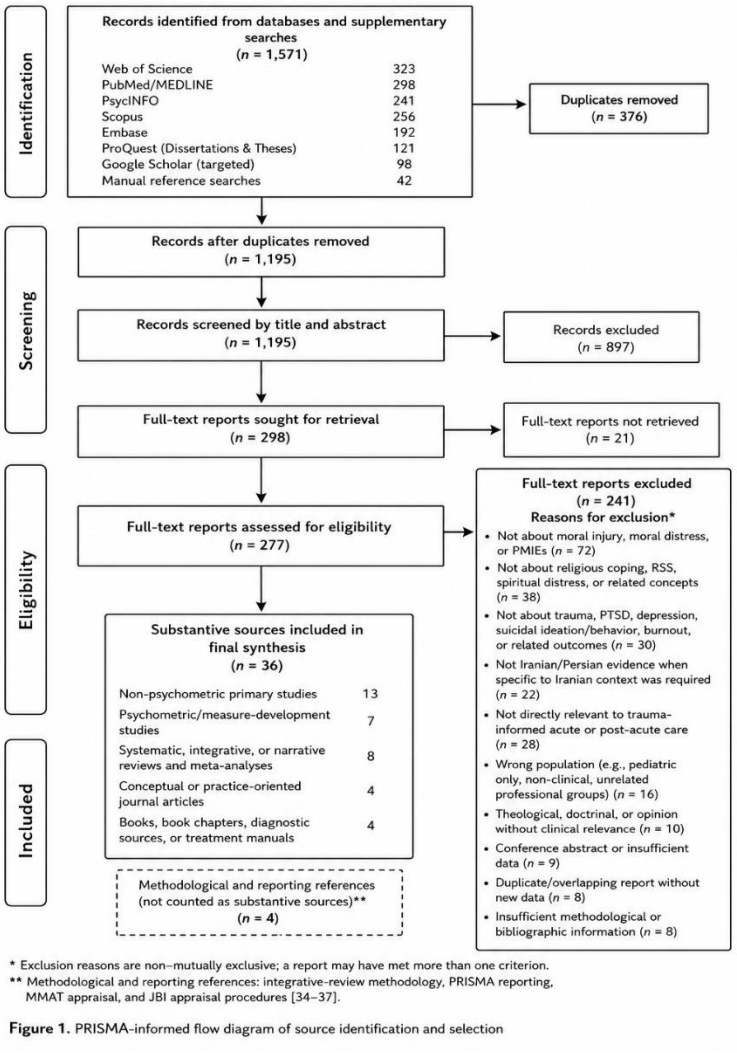


Figure 1. PRISMA-informed flow diagram of source identification and selection

Critical Appraisal and Evidentiary Profile

Systematic reviews and meta-analyses provided the strongest contributions regarding associations between moral injury and posttraumatic stress, depression, burnout, and suicidal ideation or behavior [7,8,15–17]. Measure development and psychometric studies supported the assessment of moral injury, religious coping, religious attitudes, and religious and spiritual struggles within the populations examined [12,21,23,24,27–29]. The Iranian evidence included national and post-disaster trauma studies [1–3], religious-coping studies [22,25], religion-related measure-development studies [23,24], qualitative research on barriers to mental health care [26], psychometric studies of moral injury and religious and spiritual struggles [27–29], an adult study of religious and spiritual struggles and suicidal behavior [30], and healthcare moral-distress studies [31–33].

Common methodological limitations included cross-sectional designs, convenience sampling, single-region recruitment, profession-specific samples, and reliance on self-report measures. Much of the international moral-injury evidence was also culturally indirect. No included Iranian study directly examined the prevalence, longitudinal course, mechanisms, or treatment response of moral–spiritual injury among trauma survivors, family caregivers, counseling clients, or acute-care recipients. Table 2 summarizes the evidence domains, their interpretive contributions, principal limitations, and roles in the synthesis.

Conceptualization of Moral–Spiritual Injury

Across foundational, conceptual, empirical, and review sources, moral injury was described as psychological, relational, behavioral, and sometimes spiritual distress following events appraised as violating deeply held moral values, duties, or expectations [5,6,10–12]. Recurring consequences included disruption of moral agency, trust, self-worth, relational belonging, and coherence of the person's moral worldview.

Table 2.Evidence Domains, Contributions to the Synthesis, and Principal Limitations

Evidence domain	Representative sources	Contribution to the synthesis	Principal limitations
International moral-injury theory, empirical research, and reviews	Foundational models, empirical studies, systematic and integrative reviews, and meta-analyses [5–17]	Defined moral injury, identified recurring forms of potentially morally injurious experience, described common emotional and relational features, and documented associations with posttraumatic stress, depression, burnout, and suicidal ideation or behavior.	Evidence was derived predominantly from Western military, veteran, occupational, civilian, and healthcare populations. Definitions and measures varied across studies, limiting direct generalizability to Iranian settings.
Iranian trauma and disaster evidence	National injury-burden and post-flood studies [1–3]	Established the public-health and clinical relevance of trauma exposure and posttraumatic stress symptoms in Iran.	The studies did not directly assess moral injury, moral–spiritual injury, or morally injurious appraisals.
Iranian religious coping, religious attitudes, and religious or spiritual struggle evidence	Religious-coping studies, religion-related measure-development studies, the Persian RSS-14 study, and suicidal-behavior research [22–25,29,30]	Supported the contextual relevance of religious meaning-making and religious or spiritual struggle and demonstrated preliminary measurement feasibility in Iranian populations.	Evidence was predominantly cross-sectional and did not directly examine moral–spiritual injury, acute-care recipients, trauma survivors, or counseling clients.
Iranian moral-injury measurement and healthcare moral-distress evidence	Persian MISS-HP and AMIOS studies and healthcare moral-distress research [27,28,31–33]	Supported the feasibility of assessing moral-injury-related constructs among Iranian healthcare professionals and established the relevance of moral distress in emergency, hospital, and critical-care settings.	Samples were primarily healthcare professionals and were frequently region-specific, cross-sectional, and based on self-report. Findings cannot be generalized directly to patients, family caregivers, or counseling clients.
Conceptual, diagnostic, and practice-oriented evidence	DSM-5-TR, religious-coping and spiritual-struggle theory, moral-injury treatment literature, and moral-resilience literature [4,18–21,38–40]	Provided diagnostic context, theoretical differentiation, professional-boundary principles, and preliminary approaches to moral repair and organizational support.	These sources did not provide direct empirical validation of moral–spiritual injury or its treatment in Iranian acute-care populations.

The synthesis provisionally defined moral–spiritual injury as a formulation in which morally injurious appraisals interact with religious or spiritual meanings, including perceived sin, divine judgment, abandonment, punishment, mercy, repentance, forgiveness, or rupture in a sacred relationship. Moral–spiritual injury was not identified in the included literature as a formal diagnosis, validated subtype, or established treatment model. Rather, it emerged from the synthesis as an exploratory formulation for presentations in which moral emotions and spiritual meanings are central to distress, impairment, avoidance, shame, relational disconnection, or risk. This formulation does not imply that moral injury is inherently religious or that religious and spiritual struggles are necessarily pathological. It describes a possible interaction between moral self-appraisal and spiritual meaning-making after traumatic or ethically salient events.

Categories of Potentially Morally Injurious Experiences

Five overlapping categories of potentially morally injurious experiences were identified: commission, omission, betrayal, witnessing or exposure, and systemic or professional constraint.

Commission, omission, betrayal, and witnessing or exposure were derived primarily from the broader moral-injury literature [5,6,10,11]. Commission involved perceived participation in wrongdoing or harm. Omission involved perceived failure to prevent harm or fulfill a moral duty. Betrayal involved a violation of trust by individuals, institutions, authorities, or systems expected to provide protection or act ethically. Witnessing or exposure involved cruelty, injustice, degradation, or preventable suffering judged to be morally intolerable.

Systemic or professional constraint was particularly salient in healthcare moral-injury and moral-distress research [15,16,31–33]. It involved the inability to act consistently with ethical or professional obligations because of organizational conditions, resource limitations, institutional policies, or conflicting demands. These categories were not treated as diagnostic subtypes and could overlap within the same event or presentation. Their provisional formulation implications are presented in Table 3.

Table 3. Synthesized Categories of Potentially Morally Injurious Experiences and Provisional Formulation Implications

Category	Illustrative core appraisal	Common affective, moral, or spiritual features	Provisional formulation priorities
Commission	"I did something that I believe was wrong or harmful."	Guilt, shame, self-disgust, fear of punishment, or perceived loss of moral worth following an act understood as violating a moral, professional, relational, or religious duty.	Assess the conduct, intent, coercion, actual and perceived responsibility, proportionality of guilt, global self-condemnation, possibilities for repair, and suicidal ideation or behavior.
Omission	"I failed to act, fulfill a duty, or prevent harm."	Guilt, regret, grief, helplessness, and self-blame associated with a perceived failure of family, caregiving, professional, relational, or religious responsibility.	Assess actual control, available knowledge at the time, hindsight bias, unrealistic or impossible responsibility, grief, and possible avenues for repair.
Betrayal	"A person, institution, or authority that should have protected me violated my trust."	Anger, humiliation, grief, mistrust, and disillusionment following perceived failure by family members, clinicians, institutions, authorities, or community systems.	Assess current safety, relational or institutional betrayal, humiliation, accountability needs, loss of trust, social withdrawal, and barriers to future help-seeking.
Witnessing or exposure	"I witnessed or endured something that I believe should never have occurred."	Horror, moral outrage, grief, helplessness, and disruption of beliefs concerning justice, human dignity, divine meaning, or the moral order of the world.	Assess trauma symptoms, moral outrage, grief, meaning disruption, religious or spiritual struggle, available support, functional impairment, and clinical risk.
Systemic or professional constraint	"External conditions prevented me from acting according to my ethical or professional duty."	Moral distress, frustration, guilt, helplessness, anger, or burnout arising from resource scarcity, institutional policy, workload, hierarchy, or conflicting obligations.	Assess structural constraints, realistic personal responsibility, occupational impairment, organizational contributors, supervisory support, and the need for systemic rather than solely individual intervention.

Clinical Features and Heuristic Differentiation

Guilt and shame were the most consistently reported emotional features [6–8,13]. Guilt was generally directed toward a specific act, decision, or omission, whereas shame involved a broader negative appraisal of the self. Behavior-focused guilt could remain compatible with responsibility, restitution, or repair, whereas global shame was more closely associated with secrecy, withdrawal, self-condemnation, self-punitive behavior, and suicidal ideation [13,14].

Other recurring features included moral anger, disgust, betrayal, loss of trust, difficulty forgiving oneself or others, social withdrawal, avoidance, and disruption of moral meaning [5–12]. When religious or spiritual concerns were present, reported experiences included perceived abandonment by God, fear of divine punishment, anger toward God, disruption of religious practice, estrangement from religious communities, difficulty experiencing forgiveness, and conflict between beliefs and emotional experience [18–21]. Associated behavioral and relational patterns included secrecy, withdrawal, impaired trust, self-punitive behavior, and suicidal ideation or behavior [6–9,14,16,30].

The synthesis generated heuristic distinctions among posttraumatic stress disorder, major depressive disorder, normative religious or spiritual struggle, and moral–spiritual injury. Moral–spiritual injury could overlap with posttraumatic stress disorder but was formulated as being organized primarily around perceived transgression, betrayal, guilt, shame, or moral failure rather than threat and danger alone [4–6,14]. It could also overlap with major depressive disorder but was more specifically anchored to a morally or spiritually salient event, perceived responsibility, sacred obligation, or relational duty rather than generalized depressive worthlessness [4,7,8,14].

Religious and spiritual struggles—including doubt, grief, lament, repentance, anger toward God, and searching for meaning—were not considered pathological in themselves [18–21]. Within the proposed framework, clinical salience was inferred when such struggles were persistent, functionally impairing, globally self-condemning, socially isolating, self-punitive, or associated with suicidal risk [18–21,30]. Table 1 summarizes these heuristic distinctions, which are intended to support formulation rather than replace formal diagnostic assessment.

Iranian and Culturally Relevant Evidence

National injury-burden and post-flood studies established the relevance of trauma exposure and posttraumatic stress symptoms in Iran [1–3]. These studies did not assess moral injury, moral–spiritual injury, potentially morally injurious experiences, or morally organized appraisals.

Iranian religious-coping studies supported the relevance of religious meaning-making to mental health and adjustment [22,25]. Religion-related measure-development studies provided additional evidence concerning assessment of religious coping and religious attitudes in Iranian populations [23,24]. However, these sources did not directly examine moral–spiritual injury or establish the function of specific concepts such as tawbah or tawakkul in trauma-related clinical presentations. Their possible relevance was therefore treated as a culturally informed hypothesis rather than a direct empirical finding.

Research on barriers to mental health care identified shame, labeling concerns, limited awareness, and cultural and structural barriers to help-seeking [26]. It did not directly measure aberoo, family reputation, marriageability, or family dishonor. These concepts were therefore retained only as possible areas for individualized assessment when personally relevant.

Persian versions of the Moral Injury Symptoms Scale–Health Care Professionals version and the Abbreviated Moral Injury Outcome Scale provided preliminary psychometric support for moral-injury assessment among Iranian healthcare and emergency-health professionals [27,28]. The Persian RSS-14 study similarly supported assessment of religious and spiritual struggles in an Iranian adult sample [29]. These findings indicate measurement feasibility in the populations studied but do not establish equivalent validity among trauma survivors, family caregivers, acute-care recipients, or counseling clients.

Iranian nursing and healthcare studies documented moral distress and its associations with mental health, compassion fatigue, professional quality of life, self-compassion, burnout, and secondary traumatic stress [31–33]. These findings support the local relevance of moral distress and moral-injury-related assessment

within healthcare systems but cannot be generalized directly to patients or non-professional populations.

Provisional Formulation Outputs

The synthesis produced three provisional formulation outputs. First, trauma-informed assessment may need to examine not only trauma exposure and syndromal symptoms but also the person's perceived role in the event, dominant moral appraisal, moral emotions, religious or spiritual meanings, relational context, perceived possibility of repair, and indicators of clinical risk. This formulation is intended to complement, not replace, established diagnostic and suicide-risk assessment [4]. Moral-injury measures may provide supplementary information when appropriate, although their validity remains population-specific [12,27,28]. Second, the framework distinguished moral–spiritual injury from normative moral, religious, or spiritual struggle according to persistence, functional impairment, global self-condemnation, social isolation, self-punishment, and amplification of clinical risk. Third, the framework maintained a boundary between culturally responsive psychological care and theological instruction. Religious and spiritual material was considered clinically relevant only when salient to the client and explored with consent. The synthesis did not support prescribing religious interpretations, declaring theological conclusions, or substituting religious guidance for psychological assessment and care.

Overall, moral–spiritual injury emerged as a preliminary and hypothesis-generating formulation rather than a diagnosis, validated subtype, prevalence category, or established Iranian treatment model.

Discussion

This integrative review proposes moral–spiritual injury as a preliminary formulation for trauma-related distress in acute and post-acute care in Iran. Its value lies not in creating a new diagnosis, but in drawing attention to presentations in which guilt, shame, betrayal, spiritual rupture, perceived unforgivability, or loss of moral self-trust may organize the person's suffering. Because no included Iranian study directly evaluated this integrated formulation among trauma survivors, family caregivers, acute-care recipients, or counseling clients, its clinical application should remain exploratory and hypothesis-generating.

Clinical Interpretation

Trauma-informed assessment may be incomplete when it focuses primarily on threat exposure, fear-based symptoms, and syndromal diagnosis. Some individuals may interpret traumatic or ethically distressing events through appraisals such as having caused harm, failed in a duty, been betrayed, or become undeserving of forgiveness or care. These meanings may coexist with posttraumatic stress disorder, depression, grief, or anxiety, but they may require different clinical emphases.

The proposed formulation should therefore complement, rather than replace, established diagnostic assessment, validated symptom measures, and suicide-risk evaluation. Clinicians should consider not only what happened and which symptoms followed, but also how the event affected the person's moral identity, relationships, spiritual meanings, perceived responsibility, and belief in the possibility of repair.

In Iranian settings, these meanings may be shaped by personal, familial, institutional, cultural, or religious contexts. Concepts such as duty, repentance, divine judgment, family obligation, public exposure, or aberoo may be relevant for some individuals but should never be presumed. The included evidence did not establish these concepts as universal features of Iranian trauma responses. They should therefore be explored as possible dimensions of an individual case rather than applied as fixed cultural assumptions.

Assessment and Case Formulation

The categories of commission, omission, betrayal, witnessing, and systemic or professional constraint may assist case formulation without being treated as diagnostic subtypes [5,6,10,15,16,31–33]. Commission-related distress may involve actual or perceived wrongdoing, whereas omission-related distress may involve regret, hindsight bias, grief, or exaggerated responsibility for outcomes that could not have been prevented. Betrayal may require attention to safety, trust, humiliation, and institutional accountability. Witnessing may be associated with moral outrage, helplessness, and disruption of assumptions about justice or human dignity. Systemic constraint may reflect organizational conditions or resource limitations rather than personal moral failure.

These distinctions are particularly relevant in acute-care environments because patients, family caregivers, and healthcare professionals may experience the same event from different moral positions. A patient may experience betrayal, a relative may experience guilt for perceived inaction, and a clinician may experience moral distress because institutional constraints prevented ethically preferred care. The source and

function of each person's distress should therefore be assessed separately.

Moral–spiritual formulation may also help prevent premature intervention. Encouraging forgiveness, acceptance, reconciliation, or religious coping may be inappropriate when the person first requires safety, acknowledgment of harm, grief support, realistic appraisal of responsibility, or assessment of suicidal risk. Repair-oriented work should follow careful listening, stabilization, and clarification of the person's needs and meanings.

Guilt, Shame, and Repair

Guilt and shame were among the most consistently reported emotional features of moral injury [6–8,13]. Guilt generally concerns a specific act, decision, or omission, whereas shame involves a broader negative appraisal of the self [13]. Proportionate guilt may remain compatible with responsibility, apology, restitution, or corrective action. By contrast, global shame may contribute to secrecy, withdrawal, self-condemnation, and self-punitive behavior [13]. Moral injury has also been associated with suicidal ideation or behavior [9,14,16,17].

Clinical responses should neither minimize genuine responsibility nor reinforce global condemnation. Assessment should distinguish actual from perceived responsibility, consider intent, coercion, available knowledge, and control at the time of the event, and identify whether repair remains possible. Where harm occurred, care may support acknowledgment and accountable action while separating the person's moral worth from a single act or outcome.

Existing moral-injury interventions may provide useful principles, but they were developed primarily in non-Iranian and often military populations [38,39]. They should therefore not be presented as validated treatments for Iranian acute-care settings. Religious processes such as tawbah, prayer, forgiveness, restitution, or renewed commitment to duty should be explored only when personally meaningful and introduced or endorsed by the client.

The clinical relevance of religious practice depends on its psychological function. It may support responsibility, hope, mercy, reconnection, and realistic acceptance of human limits. Alternatively, it may reinforce passivity, self-neglect, compulsive reassurance seeking, fatalism, or beliefs that forgiveness is impossible. Clinicians should explore how these meanings affect agency, safety, relationships, and engagement with care without prescribing theological interpretations.

Anti-Pathologizing and Professional Boundaries

Moral, religious, and spiritual struggles should not be pathologized merely because they involve doubt, grief, repentance, lament, anger toward God, or searching for meaning [18–21]. Clinical concern increases when these experiences become persistent, rigid, functionally impairing, globally self-condemning, socially isolating, self-punitive, or associated with suicidal ideation or behavior.

Professional boundaries are therefore essential. Clinicians should not issue theological rulings, declare divine forgiveness, prescribe religious interpretations, or direct patients toward predetermined religious conclusions. Their role is to assess meaning and risk, reduce shame-based isolation, support agency and safety, examine responsibility, and facilitate psychologically appropriate forms of repair.

When explicit religious guidance is requested, collaboration with a trusted religious or spiritual-care provider may be appropriate with informed consent and protection of confidentiality, autonomy, safety, and treatment goals. Such consultation should complement rather than replace psychological or psychiatric care.

Service and Training Implications

Brief questions concerning moral meanings may be incorporated selectively into trauma, mood, grief, and suicide-risk assessments. Clinicians may ask whether the person believes that they violated a central value, failed in an important duty, experienced betrayal, witnessed something morally intolerable, or feels unable to forgive themselves. Religious or spiritual questions should be introduced only when relevant and should not become routine interrogation.

Iranian evidence also indicates that moral distress and moral-injury-related concerns are relevant among nurses, emergency-health professionals, and intensive-care staff [27,28,31–33]. Staff support should therefore address both individual distress and organizational contributors, including workload, resource scarcity, conflicting duties, ethically constrained care, and inadequate institutional support [40].

Training should help acute-care professionals recognize moral injury and moral distress, distinguish them from established psychiatric conditions and normative spiritual struggle, and discuss guilt, shame, responsibility, betrayal, and suicidal risk without judgment. Supervision may be particularly valuable when moral or spiritual material evokes rescuing, avoidance, moralization, excessive reassurance, or theological debate.

Overall, moral–spiritual injury may provide a useful language for aspects of trauma-related suffering that

are insufficiently captured by fear-based or mood-based formulations alone. Its use in Iranian clinical practice should nevertheless remain individualized, culturally cautious, professionally bounded, and subordinate to established assessment and safety procedures until direct empirical evidence becomes available.

Limitations

This review has several limitations. First, it used an integrative narrative synthesis rather than meta-analysis because the included sources were heterogeneous in design, populations, settings, constructs, and outcomes. Although two reviewers independently conducted screening, extraction, and appraisal, the review protocol was not prospectively registered, and no formal certainty-of-evidence framework was applied.

Second, searches were limited to English- and Persian-language sources and may have been affected by publication bias, incomplete indexing in Iranian databases, and limited retrieval of grey literature. Much of the international evidence was derived from Western military, veteran, occupational, and healthcare populations and may not generalize directly to Iranian clinical contexts [5–17].

Third, Iranian evidence was limited, heterogeneous, and frequently cross-sectional, profession-specific, geographically restricted, or based on convenience samples [1–3,22–33]. No included study directly established the prevalence, longitudinal course, mechanisms, or treatment response of moral–spiritual injury among Iranian trauma survivors, family caregivers, acute-care recipients, or counseling clients. Cultural and religious meanings also vary substantially across Iranian communities; the proposed framework should therefore not be applied as a uniform cultural template.

Finally, the clinical implications were generated through integrative formulation rather than direct intervention evidence. No culturally adapted moral–spiritual injury intervention has been evaluated in Iranian acute or post-acute care populations. The recommendations should therefore be interpreted as preliminary principles for assessment, formulation, referral, training, and research rather than evidence-based treatment guidelines.

Research Priorities

Future Iranian research should directly examine how trauma survivors, family caregivers, healthcare professionals, and counseling clients experience morally injurious appraisals, guilt, shame, betrayal, spiritual rupture, forgiveness, tawbah, tawakkul, aberoo, and moral repair. Qualitative and mixed-methods studies should include diverse geographical, ethnic, linguistic, religious, socioeconomic, and clinical populations without assuming that religious or reputational meanings are universally relevant.

Psychometric research should evaluate the MISS-HP and AMIOS across diverse Iranian healthcare settings and examine broader measures, including the MIOS and RSS-14, among trauma survivors, family caregivers, acute-care recipients, and counseling clients. Instruments transferred to new populations should undergo appropriate cultural adaptation and assessment of reliability, validity, and measurement equivalence.

Longitudinal studies should determine whether moral–spiritual distress predicts posttraumatic stress, depression, suicidal ideation or behavior, functional impairment, help-seeking, and treatment response. Research should clearly distinguish moral injury from moral distress, religious or spiritual struggle, guilt, shame, depression, and posttraumatic stress.

Intervention development should begin with co-designed feasibility and acceptability studies of assessment procedures, shame-sensitive counseling, responsibility appraisal, spiritually sensitive formulation, referral pathways, staff-support programs, and organizational responses to moral distress. Subsequent controlled studies should evaluate effectiveness and monitor potential harms, including religious coercion, intensified shame, premature pressure to forgive, breaches of privacy, and substitution of religious guidance for psychological or psychiatric care.

Conclusion

Moral–spiritual injury is a promising but preliminary formulation for understanding trauma-related suffering in acute and post-acute care in Iran. It may assist clinicians in recognizing presentations organized around guilt, shame, betrayal, spiritual rupture, perceived unforgivability, fear of reputational harm, and loss of moral self-trust that may not be fully explained by threat-based posttraumatic symptoms or depression alone.

The formulation is not intended to serve as a diagnosis, a validated Iranian subtype, a prevalence category, or an established treatment model. Its clinical application should be approached with caution, focusing on individual needs and preferences, avoiding pathologization, and adhering to professional boundaries. Further research within Iran is necessary before this framework can support validated

assessment procedures, culturally adapted interventions, or formal clinical recommendations.

Authorship contribution statement

All authors have reviewed and approved the final version of the manuscript. SY conceived and designed the study. SY, and R conducted the study and collected the data, and performed the data analysis and interpretation.

Ethical Consideration

The review analyzed publicly available literature and did not involve human participants, identifiable private information, clinical records, or new patient contact. Institutional ethics approval and informed consent were therefore not required.

Declaration of Competing Interest

The authors have no conflict of interests related to this article.

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Data Availability

This study is a narrative review and does not include any new, primary data. All data supporting the findings of this study are derived from previously published articles and sources, which are cited within the manuscript. Therefore, no additional data are available.

Declaration of Generative AI

The authors declare that they have not used any type of generative artificial intelligence for the writing of this manuscript, nor for the creation of tables, or their corresponding captions.

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