Reframing Recovery

A Practice-Based Eight-Dimension Model for Moral Injury in Civilian and Institutional Contexts

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Good afternoon, Durham University, and to everyone who has travelled to be here today.

It's a privilege — and genuinely humbling — to have the opportunity to speak with you.

What I'm sharing today comes from a journey I didn't expect to take, but one that has become a central focus of my work.

Before I begin, I want to frame this in the spirit of collaboration.

The model I'll describe today is still evolving. Alongside it, I am developing associated screening tools designed to better identify and track psychological injury — particularly where moral injury is present but not yet recognised.

At the centre of this work is what I describe as a central spine.

The spine is the organising structure that allows us to understand not just symptoms — but where a person is positioned in relation to disruption, system interaction, and psychological recovery.

Everything I share today sits along that spine.

A Brief Working History

I began my career as a school psychologist in 2000 in the Tasmanian State Education System, working in that role for a decade, before moving into private practice, where I've now worked for the past fifteen years.

Like many general psychologists, I initially worked across a wide range of presentations.

Over time, I developed a strong interest in working with post-traumatic stress disorder. My primary approaches were trauma-informed cognitive behavioural therapy and exposure-based techniques.

But looking back now — along the central spine of my own clinical development — I can see, with hindsight, that I wasn't just treating threat-based injury.

I was increasingly encountering what I now understand as an ethical and moral, violation-based injury.

Without making a deliberate decision, my referral base began to shift. I began to specialise in trauma presentations. And for the past five years, my work has been almost entirely with individuals navigating the workers' compensation system.

Because my caseload became so specialised, I was able to observe patterns very clearly.

Not just patterns in symptoms — but patterns in how the injury was organised and maintained over time.

At the time, I described what I was seeing as **betrayal.**

Clients spoke about being treated in ways that felt unjust, being required to engage in processes that felt unreasonable, experiencing silence, delays, lack of transparency, and a strong sense of becoming profoundly isolated.

Along the central spine, these are not simply examples of stressors.

They are points of moral disruption.

They represent violations of what the individual believed to be fair, reasonable, expected, or right.

Often after several decades of professional service.

Recognising Moral Injury

Then a client introduced me to the concept of moral injury.

When I engaged with that literature — particularly through the work of Dean Yates and his book *Line in The Sand* — it resonated immediately.

Because what I had been describing as betrayal, I now understood was more accurately described as moral injury.

But I also realised something I need to be clear about. The type of moral injury I was seeing was different to the phenomenon described in military contexts. It was being caused differently.

Military Versus Civilian Moral Injury

In military settings — and I must be clear that I am not a specialist in this area — moral injury from my research is typically event-based.

It is more likely to be anchored to a specific rupture — a moment, or series of moments, where something occurs that violates deeply held beliefs. Often, the person can name it. There is a before, and there is an after.

But in the populations I work with, the injury rarely arrives that cleanly.

It accumulates. Through delay, disbelief, procedural demand, and repeated contact with systems that treat a person as a claimant rather than a human being.

The rupture is not a single moment — it is a slow erosion of trust in the institutions that were supposed to help.

And critically — unlike the soldier whose combat is over — this injury is still unfolding.

Along the central spine, this means the injury is not contained in the past. It is repeatedly activated, reinforced, and at times amplified in the present.

Every medical review, every form, every phone call with an insurer is not just a potential trigger — it can serve as a continuation of the injurious process itself.

The system doesn’t simply fail to heal. It becomes part of the injury mechanism.

So rather than a single rupture, we are working with cumulative moral disruption over time.

There is another distinction worth naming here.

Military moral injury tends to produce shame — the unbearable weight of something done, or not done, that cannot be undone.

In civilian contexts, what I more often encounter is rage — or the silence of depression. And sometimes, the emergence of rage is itself the first sign of recovery.

And this distinction is critical. Because if we apply only an event-based model to a process-based injury — we may get the timing wrong. We may misunderstand the presentation. And we risk reaching for the wrong clinical tools entirely.

Developing the Framework

As I reflected on my caseload with growing awareness, I realised that moral injury was not rare in my work.

It was defining.

And importantly, along the central spine, even when it wasn't present at the beginning — it often developed through the process itself.

So I began documenting my work in detail. What I was doing. What was helping. Where clients were getting stuck.

And over time, this led to the development of what I now call the Eight-Dimension Moral Injury Framework.

Recognition • Regulation • Reactivation • Rumination • Rage • Reconstruction • Reconnection • Reorientation

Six of the eight dimensions begin with re— encoding the idea of return, of something being restored or re-engaged.

But Rage and Rumination sit differently. They are not processes the person initiates. They arrive as symptoms — signals that the injury is still active and still demanding a response.

Each dimension represents a position along the central spine. Not a rigid sequence — but a way of understanding where the person is within the pattern.

Im going to walk you through the model with an applied example Walking the Spine with Ray

Ray is not a single real person — but every element of his story comes from real clinical experience.

Ray spent nearly thirty years serving his community as an emergency services worker in a small country town.

In a town that size, everyone knows everyone. That’s part of what makes the work meaningful — and part of what makes it dangerous.

One day, Ray arrives at a motor vehicle accident. Standard call. Except it isn’t. Because among the critically injured is someone he knows. Someone close to him.

He does his job. Because that’s what Ray does. That’s what thirty years teaches you.

But something breaks that day. Quietly, and completely.

Ray takes a month off work. He gets some support. And then, because he is the kind of person he is, he goes back.

Two months later, his employer places him on a performance management process.

Three months after that, he is overlooked for a promotion he had every reason to expect.

No explanation that makes sense. No acknowledgement of what he has just been through. Just the machinery of the organisation, grinding forward.

And this is where Ray's story stops being about what happened at the accident — and starts being about what the system does next.

Because the original wound was devastating. But it was the response of the institution — the performance process, the silence, the overlooking — that transformed that wound into moral injury.

Ray didn't just lose something that day on the roadside. Over the months that followed, he lost his trust in the organisation he had given three decades to. He lost his sense that doing the right thing is recognised and protected. He lost his footing in the world.

That is who walks into the room when I first meet Ray.

And that is where the spine begins.

Recognition

When I first met Ray, he believed that everything that had happened was his fault.

The accident. The time off. The performance process. All of it.

Thirty years of service, and his conclusion was that he had simply failed.

Recognition, along the spine, meant helping Ray see his experience differently. That what had happened to him was not just failure — it involved violation. Particularly in the way his organisation had responded in the months after the accident.

A performance process. A promotion withheld. No acknowledgement of what he had witnessed or what it had cost him.

That reframe — from failure to violation — begins the healing journey.

Regulation

Ray was highly dysregulated when we met. Flashbacks. Hypervigilance. Alcohol use that had quietly become a way of managing what nothing else was managing.

But here is what was important clinically — this wasn't simply fear.

Ray's system was responding to ongoing perceived violation, not only to what had happened on the roadside. Every unanswered question. Every formal process. Every day the organisation said nothing. His nervous system was tracking all of it.

Regulation had to account for that. We weren't just calming a past event. We were working with a system still under threat.

Reactivation

Every contact with the workers' compensation system would destabilise Ray.

Emails. Medical assessments. Legal correspondence. Each one landed like a fresh injury.

These weren't neutral administrative events. They were reactivating the injury along the spine — confirming, again and again, that the institution did not see him, did not acknowledge what had happened, and was not going to.

For Ray, the system wasn't part of the solution. It was part of the mechanism.

Rumination

Ray became stuck.

Repetitive thinking that circled the same questions, day and night. Why did they do this? What did I do wrong? How could thirty years count for nothing?

This wasn't overthinking in any ordinary sense. It was Ray's mind doing exactly what minds do when they encounter something that cannot be resolved — searching, repeatedly and exhaustingly, for a way to make it make sense.

Because it didn’t make sense. And that is the nature of an unresolved moral contradiction.

Rage

As this cycle continued, something shifted in Ray’s presentation.

For a time he had been numb — flattened by depression into a silence that could easily be mistaken for resignation. But as healing began, stronger emotions started to surface.

Particularly rage.

Not the rage of someone who had lost control — but the rage of someone who had finally, after months of confusion and self-blame, begun to locate the injustice accurately.

Along the spine, this is a critical moment. Because rage in this context reflects two things simultaneously — the recognition of violation, and the frustration of being unable to resolve it.

It is a symptom. A signal that the injury is still active and still demanding a response.

Clinically, this is where things can go wrong if the framework isn’t right.

Rage that emerges from moral injury is not a behavioural problem to be managed.

It is information. And it needs to be heard as such.

Reconstruction

As Ray stabilised, we began the slower work of making meaning.

Separating what he was genuinely responsible for from what he was not. Holding both with honesty — neither collapsing into self-blame, nor locating everything outside himself.

This is where the spine begins to reorganise. Where the narrative starts to shift from what was done to him, toward who he is in relation to it.

Moral coherence — a sense that his values and his understanding of himself can coexist with what happened — begins, carefully, to return.

Reconnection

Moral injury had fractured three things for Ray.

His relationships with other people. His relationship with himself. And his relationship with the systems and institutions he had once trusted.

Reconnection didn’t happen all at once, and it didn’t happen equally across all three.

He found his way back to people before he found his way back to himself. And systems — cautiously, partially, with appropriate scepticism — came last.

That sequencing matters. It can’t be forced.

Reorientation

Eventually, Ray was able to look forward.

Not by minimising what had happened. Not by forgiving what perhaps should not be forgiven.

But by reaching a place where what had happened was part of his story — without being the only chapter left to tell.

He could consider what came next. What he still wanted. Who he still was, beneath everything the injury had taken.

That is reorientation.

Not resolution in the tidy sense. But integration.

The injury no longer defining him more loudly than everything else.

And what became clear across Ray's journey is this.

If we had treated his presentation as purely trauma-based — if we had focused only on the accident, only on the roadside — we would have missed that the injury was still actively unfolding in the months and years that followed.

The performance process. The silence. The system.

These weren't background noise. They were the injury continuing. And that required a different clinical approach entirely.

Clinical Implications

First, we must differentiate threat-based injury from violation-based injury. They share surface features — dysregulation, avoidance, hypervigilance — but their origin, their maintenance, and the clinical response they require are fundamentally different.

Second, we must resist the pull toward premature pathologising. Many of the responses we see in this population — rage, rumination, withdrawal, distrust of systems — are proportionate responses to ongoing moral disruption.

Treating them as disorders before treating the underlying injury risks compounding the harm.

Third, timing matters.

The central question is not simply “what happened” — but “where is this person along the central spine?”

Reconstruction offered too early, before regulation and recognition have taken hold, will not land. The spine is not a rigid sequence — but sequence matters. Meeting the person where they are is not just good practice. In this work, it is the practice.

System Implications

Moral injury in civilian systems is rarely a single event. It is cumulative and ongoing.

Many individuals presenting to clinicians are not failing to recover. They are being repeatedly re-injured by the very systems they must engage with in order to access support.

This is often not intentional. The system is not designed to cause harm. But design and impact are different things. And the impact, for many people, is the continuation of injury through process.

This pattern is predictable. The same pressure points appear repeatedly — delays, silences, procedural demands that feel disproportionate, assessments experienced as adversarial.

And if it is predictable — it is preventable. That is not a clinical claim. It is a systemic one. And it is, I believe, where much of the important work still needs to happen.

Conclusion

Moral injury is not simply distress.

It is a disorientation following ethical rupture.

And along the central spine, if we understand how that unfolds — we can intervene more precisely, reduce re-injury, and support recovery in a way that is clinically honest.

Recovery that does not ask people to make peace with what was wrong.

Recovery that does not ask people to move on before the injury has been named.

Recovery that does not ask individuals to abandon what they know to be true.

Thank you.