Part of my daily social work function is to provide services to combat vets who have served in Iraq and Afghanistan (Operation Iraqi Freedom and Operation Enduring Freedom respectively). Sometimes we use an evidenced based practice (EBP) which has been demonstrated as being effective by testing veteran reported symptoms before and after treatment using standardized testing. Most times these outcome measurements are a Beck Depression inventory or a test called a PCL (post traumatic checklist). Other outcomes might include a reduction in suicidal thoughts or actions, reduction in thoughts of harming other people, reduction in anger or anxiety, or a change in behaviors. These also come from the veteran’s self-report—what they tell you. Often a veteran is not ready to start therapy with an EBP as these seem to be re-triggering traumas and bringing up feelings they have been trying to avoid. Some of the work we might do then I call ‘readiness’ and this might be supportive therapy—helping them to stay present, being aware of the feelings they have been hiding or blocking, and helping them practice using other behaviors to change thoughts or feelings. If you are aware of cognitive behavior therapy you probably recognize this as sounding very much like dialectical behavior therapy (DBT). You would be correct—we are using a shortened version of DBT skills training.

I found that some of the men I work with have been having a really hard time and, frankly, it was disquieting to sit with them and bear witness to their level of emotional pain even though they are so good at blocking it. One of my peers told me to look into moral injury and I have been studying this and trying to find out more for about the past year or so.

The purpose of this article is to ‘translate’ from psychologist behavior speak into ‘regular language’ one of the best publications I have come across so far, Moral Injury: A Mechanism for War-Related Psychological Trauma in Military Family Members. My intention is to compile my findings in a white paper to be uploaded to this web site. Please review the original publication for source material. The remainder of this article is my interpretation and should not be misconstrued as having any relationship or connection to the original document. The authors have done extensive research and other published numerous studies. They are completely devoted to helping those who have served and suffer.

I will be following their format and putting it into my words; my apologies for any misinterpretation of material that presents any understanding not intended by the authors. For the purposes of simplicity, pronouns are male oriented with no disrespect intended to female veterans and service women.

Introduction & Previous Models

Post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI) are considered signature wounds of Iraq & Afghanistan wars. Federal programs have been learning how to prevent and treat these conditions for returning service men. Research is now showing (more than 10 years later) that we have been unable or unprepared to deal with the family problems that have come up from service men and
women that have been deployed. There are mental health problems that have come up from multiple deployments, separations, the reaction to PTSD symptoms of the spouse and children. While there is testing to check on results for service persons and veterans, there is not the same level of research on how families have responded or for what type of treatment works. The authors strongly felt that the concept of moral injury also applies to family members and look at how to help them deal with their reactions to the changes in their combat veteran and the family lives. The authors looked at studies of wives from Israeli combat veterans and wives and children of Vietnam-era veterans as well as talking to clinicians working with OEF/OIF families and vets. As you can imagine, these studies showed that wives of combat veterans often feel strong levels of stress from what they hear or see on the news or what their partners tell them even though they did not witness or participate in the combat events. This type of vicarious trauma affects the family function as now both parents and the children may be reacting to the vet’s numbing of feelings and pulling away emotionally.

**PTSD Rates in Military and Veteran Family Members**

Diagnosis standards for PTSD are clinically identified by severity and dysfunction of specific types of symptoms. Therapists are familiar with a clinical term called compassion fatigue. The authors point out family members might be having compassion fatigue from the stress of caring for their veteran rather than secondary PTSD. Family members may have very similar symptoms and behaviors. Generally, when therapists are working with veterans and their families they are looking to treat symptoms—what the behaviors are that cause problems in daily life or how to better cope with feelings. Sometimes people read or hear about this and it is good to have the background information explained to them.

**Moral Injury**

If you google moral injury, more than 25 million hits appear within seconds. Dr. Litz has been quoted as explaining it as “a deep soul wound that pierces a person’s identity, sense of morality and relationship to society. In short, a threat in a solder’s life.” One of his counterparts, Dr. Jonathan Shay added “They have lost their sense that virtue is even possible...it corrodes the soul.” Both point out morally injured veterans may feel the victims of others’ wrong doings. It is a breach of the social moral contract and damage to belief systems. It is not only the disruption of the personal belief system. There is uncertainty in what the veteran had held as their inner core. It is a loss of trust in what had been perceived as the belief system of their fellow soldiers, service branch, their military leadership, the community they grew up in, or their faith. It is the new belief these things are not true.

The article outlines further research and studies done by Veterans Affairs (VA) and Department of Defense (DOD) with OEF/OIF vets. It also references a series of interviews with mental health providers and chaplains. The following war-zone events were identified as leading to moral injury: betrayal, disproportionate violence, incidents involving civilians and within-ranks violence. Betrayals were explained as coming from leaders, peers, trusted civilians (could be a significant other), or from failing to live up to their own moral standards. Some of these examples included mistreatment of enemy combatants, acts of revenge, and wanton destruction of civilian property. Within rank violence included military sexual trauma, friendly fire and fragging. I have had several veterans tell me they were sexually
harassed, verbally abused or physically hit or threatened if they showed too much emotion or resorted to self-harming behaviors, i.e. cutting. Other vets have shared that they had weapons or ammunition withheld if they had threatened or attempted suicide. Others said they had been left behind intentionally or in error in combat situations.

Dr. Nash had done a Moral Injury Event Scale to identify things the veteran or service member saw as 1) transgressions of moral codes by themselves or others and 2) betrayals of trust. A study using this measurement found that moral injury events could be separate from combat events that threaten life and safety.

The mental health and ministry professionals provided themes of moral injury from their experiences of working with veterans and service members. These included social and behavioral problems, trust issues, spiritual and existential issues, psychological problems, and self-deprecation. Social and behavioral problems were identified as social withdrawal and alienation, aggression, misconduct, and sociopathy. Spiritual and existential symptoms listed loss of faith, loss of trust in morality, loss of meaning and fatalism. Psychological symptoms often included depression, anxiety, and anger. Many vets and service members reported feeling and constant thoughts of shame, guilt, self-loathing, and feeling damaged.

Litz et al developed a model of moral injury that assigned a central role to shame, guilt, and self-destructive impulses. These behaviors often continue because of an inability to forgive oneself for not living up to one’s own moral expectations. Intense anger and impulses to seek revenge are central in moral injury. These can come from other’s actions or failure to act—leadership that sends them to events with known poor intelligence, watching peers do things they normally would not do. These feelings and thoughts become patterns and habits that the veteran seems unable to stop and the re-experiencing with nightmares, flashbacks, images and other intrusive recollections is similar to what happens with fear-based PTSD.

Adapting the Moral Injury Model to Military Families

Moral schemas, the filters from which we interpret life, are built step by step. We make meaning of life changes based upon these schemas. Sometimes we change our perspective on how we interpret events and interactions with others to better fit these expectations. There is always more information and stimulus than can be absorbed or understood without fracturing the moral schemas throughout developmental stages. We consciously or subconsciously deny what might erode or break apart our belief system. Moral cognitive development is an ongoing process. When moral beliefs and values are shared across social boundaries it makes interactions predictable and meaningful, laying the foundation for trust and safety. Moral injury is conceptualized as the consequence of challenging those moral belief systems—going beyond what a person can handle at their stage of development.

In non-combat situations, this might be similar to childhood incest or significant abuse in the family of origin. Many of our service members and veterans come from abusive backgrounds. Those fortunate to have learned resiliency usually take on the code of their branch of service. Some of our veterans with
multiple combat deployments may not be aware of an erosion of their earlier moral schemas but have a strong reaction to the perceived violations of their new belief system.

Military spouses and children can experience potentially morally injurious wartime events through news or social media, stories shared by family and friends, and other community sources—a direct impact to their belief system. Indirect impacts come from emotional withdrawal, violence, or self-destructive behaviors of the veteran or service member. The most morally damaging and betrayals of trust by family member are suicide or homicide. We are aware that partners and family members will internalize the emotional withdrawal and often blame themselves if there is not open and frequent sharing. With the strong apparent competency and unwillingness to show emotional vulnerability—perceived as weakness—this does not occur in most military families. Nash and Litz identify the most powerful of all wartime betrayals as those people accuse themselves of committing. Examples of marital infidelity and neglect or abuse of their children. There are deeper moral injuries beneath this including those who spent deployments retrieving body remains of peers, readying these remains by carefully going through pockets and belongings for return to their homes, those who found they grew to like the excitement of shooting, killing, or destroying property and then feeling extreme shame. There are also those who tried to help severely wounded peers and basically just held onto their hands while men their own age died.

**Implications for Clinical Care**

There is not a standard for dealing with moral injury. Each person’s background and environment, their families, and the reactions of family members needs to be taken into account. Many existing EBP interventions seem to help somewhat.

Nash and Litz recommend conceptualizing goals for treatment of moral injury by comparing them to goals for overlapping problems of fear-based loss and trauma. Recovering from fear based trauma involving life threat might mean restoring feelings of safety in a dangerous world. Healing from loss of person or object may mean relearning and reconnecting with the world in this absence—accepting—of what has been lost. Many therapists forget and vets and servicemen may not have internalized that physical and mental injury brings about the great loss of time with family, loss of a military career, loss of dreams, loss of capacity, and loss of self. Forgiveness is identified within this research as being central in recovering from moral injury. This is either of the self or others, depending on who is assigned the blame.

These differences are pointed out as EBP for PTSD will often not touch the moral injury. Cognitive processing therapy (CPT), prolonged exposure (PE), and eye movement desensitization reprocessing (EMDR) deal with exposure and changing the cognitive process. These interventions often help reduce symptoms and change behaviors because they pair the experience of safety, trust, and non-judgment in the therapist office with repeated and detailed recall of the trauma. They do not provide sufficient correct experience in terms of forgiveness for the guilt, shame, and anger of moral injury to be extinguished through the repeated telling.
Forgiving requires strenuous emotional, cognitive, and spiritual work including sustaining compassion (for self and others), attaining wisdom, and forgoing justice (such as acts of revenge). The authors point out there are many ways persons can come to forgiveness but that little is known about which interventions best promote forgiveness. One study they reviewed proposed spiritual faith, religious rituals, life transformations, making amends, community service, disclosure, and cognitive restructuring.

Many vets and servicemen feel strong urges to teach others a lesson or to right wrongs. Some of the plans are lengthy and time-consuming as it seems easier for the mind to do this rather than allow feelings that seem overwhelming. Forgiving means forgiving the self as well as others. Many of the interventions available include Native American healing ceremonies, church programs, healing retreats and other community based, agency based, or clinical interventions that are not fully utilized providing partial relief to those who participate. Veterans and their families may burn with the frustration of suffering from loss and demand recognition or compensation for their injuries only to find no resolution with this reward. It seems virtually impossible to approach them individually to suggest self-compassion and forgiveness may be the path to ease the pain. Clinicians may be unwilling to begin these conversations fearing the clients will leave, report them as inadequate, or deteriorate further. Each treatment must be collaborated with the individual client and modified for growth or shift. Do we keep veterans within the EBP because it is safer—with the hope of some resolution—rather than risk the exploration of the soul with them?

The authors and other researcher/clinicians propose the following elements to treat moral injury.

1) Establishing trust and rapport. Breaches of trust are indicated as the cardinal features of moral injury. Building strong levels of trust will be required within therapy to overcome barriers to disclosures posed by shame, guilt, and anger. Patience, persistence and a neutral stance are required.

PTSD is a disorder of avoidance. Veterans are trained in the military to redirect their thoughts to avoid feelings and can easily redirect therapy sessions. Many veterans will share the high level trauma of a combat experience. It seems they may have a few that they have shared often enough—generally for PTSD compensation and ratings, diagnoses, and for ‘cover stories’ in group or individual therapy—that their exposure has minimized. Getting deeper requires the veteran to have the learned skills to tolerate the physical responses to emotions generated by not avoiding memories, thoughts about what they did or saw, and what it meant to them then and what impact it has had on them now as a man. They do not share deeper levels of their stories or thoughts easily, fear shame and judgment and worry about traumatizing their therapist. Most of these things are not discussed within the home or family or with peers. Indeed, when first hearing some of the stories—even though I thought I had prepared with readings, movies, DVDs, other trauma work with clients—I had such a physical reaction from sitting with veteran’s levels of emotional distress that I suffered with them long after they had gone. Therapists who are in attunement with their clients may experience this on a deeper level and will need to carefully balance compassion satisfaction with their exposure and service work.
2) Imaginal dialog with a compassionate moral authority. Veterans or service members are asked to have a real-time conversation with an imagined compassionate, generous, supportive and forgiving moral authority. The patient plays both roles of confessor and mentor, answering his or her own statements of blame and condemnation with a current rational thought process and compassion in order to promote forgiveness and acceptance without avoiding or minimizing.

I have asked veterans to imagine a conversation with themselves. Example, If you were able to talk to yourself at 20, having to pick up dead body parts for the whole deployment. Is how that happened what the recruiter explained to you would be the MOS? Would you blame the 20 year old you for those feelings? What were those feelings? What would you tell yourself about how to get through it from what you know now, almost 10 years later?

The imaginal dialog can be done in session with the veteran with the therapist guiding the discussion points. Example: Therapist-- imagine you are sitting with the leader who sent your unit on a mission where they knew it was not safe—there had been a recent attack in the same area. There was a blast and several people were seriously hurt and three died. What would you want to say to that leader? Veteran—why did you do that? You put us at risk? People were hurt, people—good people died! Their families would never be the same! We aren’t the same! I wanted to hurt you! Other guys talked about hurting you! We almost did it. How could you do that to us? What was it for? A medal? For glory? Because you were told to? What were you thinking? T—how old was the captain? V—I don’t know, I think 27, 28. T—how many deployments had he had? V—this was his first. T—how many had you had then? V—this was my 2nd. T—imagine what he would say if he was scared, too? If he did not know what to do? V—like I didn’t know, I didn’t know? T—how do you think he would have wanted to respond, if he could be safe and tell you right now what he was feeling about it? What do you think you’d say if you were him? V—I’d like him to apologize, to say he was so sorry, he’d take it back if he could.

3) Apportioning blame. Morally injured persons may assign blame to themselves or those they feel as responsible at 100% for those events that violated the moral beliefs. Veteran and service members will not accept the concept that war-related events do not incur fault. The authors encourage a rational and fair appropriation of blame, having it listed out ensuring it adds up to 100%.

Example: Vet who opened fire from a roof top and caused an accident resulting in death of a family driving a car. He had been following orders, the car was not to cross a specific intersection. The driver ignored signs posted, did not pay attention to Iraqi police who yelled at him to stop. The car hit a building, the persons in the car including at least one child and one woman died. The vet has assumed 100% of the blame. The driver may not have seen the signs, may not have understood the police, may have had a bomb afterall—vet did not know. Vet reassigns 50% of the blame to the driver, 30% to the police—who knows what he really said? And keeps 20%.
4) Make or seek amends. Many veterans and service members who have been in 12 step or substance abuse programs will be familiar with this concept. It may be necessary for self-forgiveness. The authors point out the ultimate self-punishment is suicide, the ultimate punishment of others is homicide yet neither leads to forgiveness. Volunteer or service work may be helpful. Veterans and service members may appreciate some suggestions but will need to make the decision on their own and enact upon it.

5) Acceptance. This may take a lifetime for some depending on the nature of the moral injury. Some veterans may need a model, books like Man’s Search for Meaning or talking to older vets who have found acceptance may be helpful.

Adapting moral injury treatment to children and family systems

The approach to moral injury was not designed as a systems intervention but as an individual approach using cognitive behavioral therapy operating outside existing social systems. Veterans and service members who have the supportive structure of family, a partner, friends, work or a sense of mastery--a balanced life seem to do better and appear to recover faster. When they have ‘blips’, they have the sense they can return. Families can be an agent of healing. When using this approach for moral injury pertaining to families the level of disclosure changes. Deeper sharing can lead to greater moral injury to the family members who then share the burden. As therapists we can help the family members to understand the levels of responsibility for perceived moral transgressions and walk them through making amends and acceptance. We can provide the place where it is safe to talk about feelings and emotions and look at how thought processes and patterns can build or erode trust.