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Introduction to Moral Injury

Joseph M. Currier, Kent D. Drescher, and Jason A. Nieuwsma

> Philosophers of science have repeatedly demonstrated that more than one theoretical construction can always be placed upon a given collection of data. History of science indicates that, particularly in the early developmental stages of a new paradigm, it is not even very difficult to invent such alternates. . . . so long as the tools a paradigm supplies continue to prove capable of solving the problem it defines, science moves fastest and penetrates most deeply through confident employment of those tools. The reason is clear. As in manufacture so in science—retooling is an extravagance to be reserved for the occasion that demands it. The significance of crises is the indication they provide that an occasion for retooling has arrived. (Kuhn, 1964, p. 76)

The post-9/11 era has presented psychologists and other mental health clinicians with many occasions for retooling paradigms for posttraumatic stress disorder (PTSD) and other possible trauma-related issues among service members and veterans (SM/Vs). Recent military conflicts in Iraq and Afghanistan mark the longest sustained ground combat operations in U.S. history. Due to an influx of veterans from these campaigns and renewed motivation for help-seeking among veterans from previous conflicts, PTSD diagnoses in the Veterans Administration (VA) system roughly doubled within just 5 years after 9/11 (e.g., Rosenheck & Fontana, 2007). As these conflicts persisted, new waves

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The authors have worked to ensure that all information in this book is accurate at the time of publication and consistent with general mental health care standards. As research and practice continue to advance, however, therapeutic standards may change. Moreover, particular situations may require a particularized therapeutic response not addressed or included in this book.

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of men and women enlisted to serve their country for varying lengths of time. However, given a record low percentage of U.S. adults (18 years and up) who serve in the military (U.S. Census Bureau, 2014), many veterans have endured exceptionally heavy physical, emotional, and spiritual burdens from their wartime service.

Amid this backdrop, suicide has emerged as a particularly troubling occurrence among SM/Vs. Although a variety of nonmilitary factors may also increase risk of a suicide attempt (Ursano et al., 2017, 2018), SM/Vs have been dying by suicide at roughly twice the rate as nonmilitary persons for over a decade (Kang & Bullman, 2008)—to the point where suicide deaths surpassed combat-related fatalities in active duty personnel in 2012 (Armed Forces Health Surveillance Center, 2014), and roughly 17 to 20 veterans continue to die by suicide each day (U.S. Department of Veterans Affairs, 2018). Importantly, PTSD and other mental health conditions are among many possible chronic risk factors for suicide and other life-threatening health-related conditions (Pompili et al., 2013). However, given that evidence-based practices for PTSD often do not generate the same favorable outcomes in SM/Vs compared with other trauma-exposed groups (Steenkamp & Litz, 2013; Steenkamp et al., 2015), this troubling epidemic has fueled an alarming sense of crisis for many clinicians to retool models and methods of addressing the possible emotional, physical, social, and spiritual burdens of SM/Vs.

Although these statistics for the post-9/11 era are concerning, every sustained period of major ground combat operations in U.S. history has created extraordinary challenges for clinicians or helping professionals tasked with caring for traumatized SM/Vs. Clinical accounts and findings from the Civil War (Pizarro et al., 2006), World War I (Myers, 1915), and World War II (WWII; Archibald & Tuddenham, 1965) highlight the lasting alterations in emotion, cognition, and behavior that may emerge for SM/Vs exposed to the diverse types of traumas that occur in times of war. For example, focusing on the war with the greatest number of casualties of U.S. personnel, a creative archival analysis of the military and medical records of 17,700 Civil War veterans revealed exposure to potential military traumas (e.g., being wounded, percentage of company killed) was associated with worse risk of a range of postwar mental health issues, as well as cardiac and gastrointestinal diseases (Pizarro et al., 2006).

In light of such physical and mental health costs, clinicians caring for SM/Vs from each U.S. military era have attempted to retool paradigms for describing and understanding the trauma-related symptomatology among SM/Vs seeking their care. For instance, the term "soldier's heart" was often used in conjunction with the Civil War, "shell shock" with World War I, and "combat fatigue" or "battle fatigue" with World War II. Building on insights of these prior generations of clinicians and researchers, the term "posttraumatic stress disorder" was not used in mental health professions until the 1970s in response to severe adjustment issues of many Vietnam veterans (Kulka et al., 1990). In turn, although core features of the traumatic stress response in

the diagnostic criteria for PTSD have not changed over subsequent decades (reexperiencing, physiologic arousal, behavioral avoidance, and emotional numbing), the specific symptoms and composition of symptom clusters evolved with each iteration of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*; Friedman et al., 2011).

The formalization of a PTSD diagnosis after the Vietnam War has fueled innovation in scientific research and clinical practice in many ways. However, when considering the emphasis on moral aspects of military trauma in art and literature dating back to some of human societies' earliest records (Crocq & Crocq, 2000), as well as astute theoretical and clinical observations of traumatologists working with SM/Vs in the pre-PTSD era (e.g., Haley, 1974), an increasing number of voices have questioned why *trauma* has been nearly exclusively defined as a fear-evoking encounter with death or life-limiting injury for oneself and/or others (e.g., Nash, 2019). Although the term "moral injury" is still new in mental health fields, clinicians who cared for prior generations of SM/Vs often discussed the central importance of moral transgressions, betrayal-related events, and the role of ensuing painful moral emotions and cognitions in hindering recovery from posttraumatic issues. For example, after caring for veterans in an outpatient mental health setting in the years after WWII, Futterman and Pumpian-Mindlin (1951) reported the following observation in the *American Journal of Psychiatry*:

> A factor prevalent among our patients was that of guilt around killing, injuring, or striking a defenseless enemy. As long as the killing of enemy soldiers was done during active combat when it was a question of "kill or be killed," there was relatively little guilt. However, if enemy soldiers or noncombatants were shot when they were unarmed, or unprepared for the attack, or while in a seemingly defenseless position, great guilt was engendered. . . . At such times, apparently, the military code and superimposed group conscience, which gave permission to kill or destroy under certain circumstances, was quickly dissipated and replaced by the usual civilian morale and conscience, which places sharp limited on such impulses. Under such circumstances, conflict and guilt were quickly generated, and difficult to master. (pp. 402–403)

In many ways, this account mirrors the observations of clinicians throughout the United States who care for traumatized SM/Vs in this current post-9/11 era. However, like clinicians of earlier military eras retooling their predecessors' models of addressing traumatic stress reactions to be optimally responsive to SM/Vs seeking their help, many clinicians today are struggling to operate neatly within existing paradigms to understand and respond to these types of severe moral challenges in their work.

Specifically, until the recent fifth iteration of the *DSM* (*DSM-5*; American Psychiatric Association, 2013), there was not even a partial acknowledgment of severe moral challenges as a viable precipitating event for enduring traumatic stress reactions. Further, before *DSM-5*, painful moral cognitions and emotions were similarly not reflected in the symptom criteria for PTSD. However, even with the recent restructuring of symptom clusters, addition of new symptoms (e.g., reckless behavior), and the inclusion of Cluster D's negative

changes in beliefs and emotions into the diagnostic criteria in a manner that may capture possible outcomes of a moral injury as the construct is loosely defined at this time (e.g., self-condemnation and shame, profound mistrust and anger; Friedman et al., 2011), these issues may only contribute to a PTSD diagnosis if they arise after exposure to an event featuring actual or threatened death, serious injury, or sexual violence. As such, many of the severely morally challenging events for SM/Vs and other trauma-exposed groups (e.g., first responders) that clinicians should anticipate encountering in their therapeutic work currently do not fit neatly into the definition of trauma in *DSM-5*. At present, it is not apparent whether the continuum of morally injurious sequelae cannot be adequately captured by the PTSD diagnostic criteria such that a Kuhnian paradigm shift might be indicated (Litz & Kerig, 2019). Instead, as highlighted in the coming chapters, clinicians are attempting to adapt their models and methods to varying degrees to holistically and effectively heal the possible moral, emotional, social, and spiritual wounds of war.

This book is a testament to the growing number of researchers and clinicians who are studying and developing interventions targeting the prevention and treatment of moral injury. As we discuss later, there are likely more questions than answers about the essential features of moral injury and how to conceptualize, assess for, and treat this underdefined condition in clinical practice. Nonetheless, whether occurring in military service, civilian peacekeeping occupations (e.g., law enforcement), or other situations in which persons witness and/or engage in acts that violate one's basic sense of humanity and morality, unresolved wounds of morally injurious events continue to burden many persons in a manner that might lead to serious health-related consequences and decrements in psychosocial functioning. As such, clinicians working in this current post-9/11 era are seeking to address moral injury now in an efficacious manner based on the emerging clinical research literature. The approaches and interventions in this book were selected largely according to the extent to which they have been deployed and systematically evaluated to date (even if not yet in formal clinical trials), with a recognition that many other psychotherapeutic, sociocultural, and spiritual approaches may also have benefit for persons struggling with moral injury. In so doing, we hope this book will inform and guide mental health clinicians, chaplains, and other helping professionals about relative conceptual issues in moral injury and promising therapeutic approaches to possibly incorporate in their work with morally injured patients who seek their care.

DEFINING MORAL INJURY

In keeping with the varying ways in which military trauma and ensuing traumatic stress reactions have been conceptualized over the centuries, there is presently no unanimous definition of moral injury. Drawing on philosophical and psychological insights from Homer's tragedies (e.g., the story of Achilles

in the *Iliad*) to understand the suffering of Vietnam veterans entrusted to his care, Shay (1994) first introduced this concept in the mental health literature following the first Gulf War. However, partly in response to the burgeoning numbers of veterans from recent conflicts in Iraq and Afghanistan seeking treatment for trauma-related issues after 9/11, serious scientific inquiry on moral injury arguably did not begin until the publication of Litz et al.'s (2009) seminal review article. Since then, moral injury has increasingly captured empirical and scholarly attention from psychologists and other mental health professionals, physicians, chaplains, theologians, and philosophers. Although such interdisciplinary appeal offers a unique opportunity for collaboration and innovation, a lack of definitional specificity across fields also creates challenges with reliability and communication. Further, consistent with understanding posttraumatic reactions in general, important distinctions should be made between different aspects of this emerging construct (e.g., exposure, appraisal, outcomes). However, even within a single discipline, such as psychology, clinicians and researchers often do not maintain precision in their terminology. In turn, attempts at both intra- or interprofessional communication between clinicians, researchers, and/or scholars about moral injury can be quite difficult. Therefore, although many of the chapter authors adopt their own terminology and might disagree about the overall process of moral injury development, we now offer preliminary definitions of key terminology that will be used throughout this book.

Potentially Morally Injurious Events

Contrary to the *DSM-5* Criterion A for a PTSD diagnosis, there are no established criteria for the required features of potentially morally injurious events (PMIEs). However, moral injury is thought to emerge after exposure to severely morally troubling events that fit into two general categories on the basis of perceived moral responsibility. First, PMIEs may entail actions or decisions in which SM/Vs somehow transgressed a moral belief or value by what they did or failed to do. Also referred to as *transgressive acts* and *perpetration-based events*, this category was defined by Litz et al. (2009) as "perpetrating, failing to prevent, or bearing witness to acts that threaten to transgress deeply held moral beliefs and expectations" (p. 700). Whether intentionally or not, such events may entail incidents involving mistreatment or harm to civilians (particularly women and children) or inability to prevent death and suffering, as well as killing an enemy combatant or another person. Depending on the context of the situation, SM/Vs might also find themselves in the role of a witness to or victim of others' moral wrongdoing. Shay (1994) captured this second category of PMIEs in a three-part definition: (a) betrayal of "what's right," (b) by someone who holds legitimate authority, (c) in a high-stakes situation. Given the need for interdependency within units and collaboration with indigenous persons in asymmetrical warfare contexts, we suggest Shay's emphasis on leadership malpractice within the military can be expanded to

include "betrayal-based events" from other relationships or sources as well (e.g., peers, trusted civilians, authority figures outside the military ranks).

To date, research has revealed three sets of findings for PMIEs with special relevance for clinical practice. First, when accounting for effects of other types of military traumas (e.g., life threat), exposure to PMIEs emerged in many studies as a salient indicator of common mental health conditions in military populations (e.g., PTSD, depression, suicide ideation or attempts; for reviews, see Frankfurt & Frazier, 2016; Griffin et al., 2019; Litz et al., 2009). Second, drawing on qualitative findings from trauma narratives written at the start of evidence-based interventions for PTSD with a therapeutic exposure component, research found self- and other-focused PMIEs were identified as the Criterion A stressors for a substantive subset of military service members seeking care at a large army base (Litz et al., 2018; Stein et al., 2012). Third, beyond the higher conditional risk of mental health conditions in service members with greater exposures to PMIEs, findings from treatment-seeking samples indicated those who identified PMIEs as their most distressing events also reported more complexity in their distress symptom presentations (Litz et al., 2018). In combination with other work (e.g., Bryan et al., 2018; Jordan et al., 2017; Litz et al., 2018; Stein et al., 2012), these findings raise questions about whether PTSD, as traditionally defined and assessed, captures all clinical concerns that may emerge from exposure to PMIEs.

Moral Violation

Notwithstanding the seemingly morally challenging nature of PMIEs, clinicians should refrain from pathologizing the occurrence of such stressors in the dangerous and violent contexts that can characterize military service. Just as longitudinal work suggests the majority of persons who experience events that meet the *DSM-5* Criterion A do not go on to develop chronic PTSD (Galatzer-Levy et al., 2018), SM/Vs who encounter PMIEs may similarly not become morally injured. For example, Jordan et al. (2017) supported a trend toward resilience or recovery with 867 active duty marines from an infantry battalion that engaged in heavy combat operations between 2008 and 2011 in Afghanistan. Specifically, using Nash et al.'s (2013) Moral Injury Event Scale (MIES), they found that only one third of these marines reported exposure to perpetration- and/or betrayal-based PMIEs in the month following their war-zone deployments. Although the MIES may confound exposure and consequences of PMIEs (Frankfurt & Frazier, 2016), it is quite notable that individuals in Jordan et al.'s sample arguably served in the most demanding combat operational roles during one of the most violent and chaotic periods in this lengthy conflict. As such, these findings highlight a need for clinicians to not assume that SM/Vs with even the heaviest levels of combat exposure will inevitably experience their war-zone stressors in terms of a transgressive act or betrayal of trust.

Instead, whether beginning in the immediate aftermath of the event or upon negotiating varying moral conventions and expectations in civilian life,

it is assumed that moral injury only develops when an SM/V has appraised the event as somehow being morally wrong or violating deeply held beliefs or values. Further, whether as a perpetrator, witness, or victim, he or she may feel a sense of personal agency about the occurrence of such events or strong desire to see moral violations committed by others punished or rectified. Unlike mental health conditions that are characterized partly by an absence of conscience or concern with living congruently with moral values or beliefs (e.g., psychopathy), the development of moral injury therefore assumes an SM/V possesses an intact moral code or system of personal morality that might be violated. Lancaster and Erbes (2017) supported the importance of moral appraisals in moral injury development. Namely, focusing on 182 war-zone veterans, Lancaster and Erbes found those who evaluated their combat-related actions, comrades' actions, and/or actions of their commanding officers as being morally wrong were more likely to report worse outcomes that align with emerging definitions of moral injury (e.g., PTSD, anger, shame). Importantly, these findings held in the presence of exposure to combat stressors in general, supporting the role of moral violation in the course of moral injury development.

Moral Pain

When considering how moral violation may lead to development of a moral injury, SM/Vs may experience painful moral emotions (e.g., shame, guilt, anger) and cognitions (e.g., moral culpability or responsibility, self- or other-condemnation) in response to PMIEs that cause significant intrapsychic tension and conflict (Farnsworth et al., 2017). Whether this moral pain emerges immediately after the event or later on, Farnsworth et al. (2017) argued that clinicians should at least initially conceptualize these emotional–cognitive reactions as expected, natural, and nonpathological. For instance, as described in Chapter 2, this volume, painful moral cognitions and emotions can be essential for maintaining shared moral beliefs or values that promote and protect the cohesion of human communities. Further, in the aftermath of PMIEs that are viewed as morally wrong, these responses can prompt appraisals and behaviors that facilitate healing and repair ties to one's larger social community (e.g., disclosure of trauma-related difficulties and shared acknowledgment of tragedy). Therefore, moral pain may provide adaptive functions for the larger social group as a whole but sometimes at the expense of an SM/V's relationships and ability to derive a sense of meaning and belonging in culturally sanctioned activities for a time-limited period (e.g., family, work, religion). Put differently, moral pain in itself can represent a healthy response to PMIEs that violate sacred values or beliefs of the SM/V's larger community, while also fueling distressing patterns of thinking and feeling that have to be honored and resolved in a supportive community or social group (Farnsworth et al., 2017).

In these ways, moral pain can be likened to the experience of grief after bereavement. In cases of common or normal grief after the death of an attachment figure, indications of distress (e.g., sadness and crying, cognitive confusion,

social withdrawal, reduced productivity) in the initial postloss period can be an unreliable predictor of mental health status and psychosocial functioning in the distant future (Galatzer-Levy et al., 2018). Instead, even with spousal or child bereavement (e.g., Maccallum et al., 2015), longitudinal findings suggest most grievers display a resilient (i.e., little to no distress or impairment after loss) or recovery (i.e., initial increase in distress after loss and return to baseline functioning) trajectory with respect to depression and other bereavement-related conditions (Galatzer-Levy et al., 2018). However, even in the year after a major loss, certain forms or expressions of grief (e.g., intense sorrow and rumination over the loved one's death, persistent and preoccupying longing for deceased) might be indicative of a complicated and prolonged course of suffering that will not resolve without clinical intervention (Prigerson et al., 2009). In such cases, clinicians have to avoid pathologizing anticipated and normal reactions to the loss of a cherished relationship while also deciphering instances when the grieving process has somehow gone awry. Similarly, although moral pain is necessary for a moral injury to develop, not all SM/Vs who experience such cognitions and emotions will need care from mental health professionals and/or possible religious and informal sources in their lives.

Building on these insights, Litz and Kerig (2019) recently offered a useful heuristic model for differentiating between moral stressors of varying levels of magnitude and impact. For example, when considering a constant need for moral judgments and decision making in human societies, certain stressors may represent *moral challenges* but not be viewed as directly relevant to one's life (e.g., lack of responsiveness to children dying by malnutrition in developing world) in a manner that may not cause moral emotions such as anger or disgust. In contrast, Litz and Kerig contended that *moral stressors* (e.g., infidelity or other ways of mistreating a loved one) must precipitate distressing behavioral and psychological consequences that lead to some degree of impairment. For example, someone may ruminate daily or lose sleep over a moral stressor but not be incapacitated or overly define themselves according to the painful experience. In this way, moral stressors likely occur less frequently than moral challenges and have a greater probability of moral pain and possible dysfunction in life roles and relationships. However, according to Litz and Kerig, moral stressors should not be equated with PMIEs in that they are less likely to entail salient threats to personal integrity or loss of life in a manner that might lead to severely painful moral thoughts or emotions that could constitute injurious and scarring experiences in themselves.

Moral Injury

Unfortunately, whether due to the severity of PMIEs, lack of psychosocial resources, or other factors (e.g., premilitary trauma exposure, personality, moral development), many SM/Vs do not negotiate moral pain in a manner that supports meaning making and social connectedness. In such cases, SM/Vs may display a trajectory of chronic emotional, social, and spiritual suffering

characterized by severe impairments in psychosocial functioning and a range of potentially self-destructive behaviors (e.g., self-handicapping, social isolation, substance abuse, suicide attempt). Building on Shay's (1994) insights about moral injury being a character wound from a betrayal-related event, Litz et al. (2009) provided this working definition of moral injury:

> disruption in an individual's confidence and expectations about one's own or others' motivation to behave in a just and ethical manner. . . . brought about by perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations. (p. 700)

Further, Litz et al. suggested aspects of the PTSD symptom criteria would characterize the long-term impact of morally injurious events (i.e., intrusive reexperiencing of event, behavioral avoidance of painful thoughts or emotions and triggering contexts, and emotional numbing), as well as self-harm or self-handicapping (e.g., poor self-care, substance abuse, lack of social or professional advancement) behaviors and enduring changes in identity. More recently, Farnsworth et al. (2017) defined moral injury as the "expanded and additional psychological, social, and spiritual suffering stemming from costly dysfunctional and or unworkable attempts to manage, control, or cope with the experience of moral pain" (p. 392).

At present, there is a lack of consensus about the specific symptoms or outcomes that may signify this state of being morally injured. However, to distinguish between perpetration- and betrayal-based outcomes, Griffin et al. (2019) highlighted possible continua of moral injury according to the extent to which SM/Vs appraise themselves as (a) committing moral violations and (b) being the victim of another person's transgressive behavior. Further, drawing on an anonymous survey and in-depth interviews with subject experts, Currier et al. (2018) found agreement that self-directed forms of moral injury appear to be characterized by feelings of pervasive shame and guilt; beliefs and attitudes about being unlovable, unforgivable, and incapable of moral decision making; and self-handicapping behaviors. In contrast, in cases of betrayal or witnessing others' acts of moral wrongdoing for which they do not feel personally responsible, subject experts agreed that betrayal-based or other-directed outcomes of a moral injury might include feelings of anger and moral disgust, beliefs and attitudes related to mistrust of others, and revenge fantasies about the responsible person(s). Others have also posited that moral injury typically includes PTSD symptoms (e.g., Litz et al., 2009). However, as highlighted in the upcoming chapters, subject experts disagree as to whether the PTSD diagnostic framework should be retooled to account for distress symptoms associated with a possible moral injury.

PLAN FOR THE BOOK

With these definitions and concepts in mind, this book is intended to support clinicians who are seeking to serve as instruments of healing and change with morally injured SM/Vs and other patients. The editors of this book are clinical

psychologists with varying professional backgrounds in clinical practice and research with SM/Vs and civilian traumas. Following his internship and fellowship at a large VA medical center when the initial waves of Iraq and Afghanistan veterans were first enrolling in VA health care, Joseph M. Currier has continued serving these men and women in an academic career at a research university and partnerships with community-based organizations. Also someone who trained at a VA medical center, Jason A. Nieuwsma has served SM/Vs via training and education, research, and administration with VA's Mental Health and Chaplaincy program office for the past decade. Now (partly) retired, Kent D. Drescher has devoted the past quarter-century to caring for veterans in numerous ways, both within a major VA medical center and a community-based program. In many cases, we serve as lead authors on chapters that are within our areas of professional expertise. However, in most cases, we invited leading mental health experts from VA medical centers, academic medical centers, universities, and community-based organizations to author chapters in their relative areas of expertise with respect to theory and practice for moral injury. In so doing, we proudly assembled a set of authors who are on the frontlines of caring for morally injured SM/Vs and advancing scientific understandings of this construct in the process. Although these subject experts also have backgrounds in clinical or counseling psychology, this book was intended for clinicians from all mental health disciplines, chaplains, and other helping professionals who are seeking direction in promoting recovery from moral injury in their work with military-connected populations and possible other trauma-exposed groups.

Notwithstanding a shared commitment to science–practice integration with respect to moral injury, you will see a diversity of views and opinions about whether mental health fields are in a state of crisis that may lead to a possible paradigm shift with respect to moral injury. For example, in some cases, authors conceptualize moral injury as a traumatic theme or aspect of PTSD, whereas others assume the conditions are interrelated but separate. You will also find the authors using different language at points about varying components of the moral injury construct (e.g., moral injury outcomes vs. moral injury–based distress). In many ways, this diversity of viewpoints highlights the absence of a paradigmatic framework and comprehensive model for moral injury that may guide clinical practice and research in the decades to come. Looking ahead, it is likely that many of the chapter authors will support this scientific work of discovery and operationalization. However, in the absence of a consensus definition at this time, we ensured synchrony across the authors on these basic components of the moral injury construct when inviting them to contribute to this book:

- Military service can entail morally troubling situations that violate SM/Vs' deeply held moral values and beliefs, whether through perpetrating, witnessing, or being victimized via such events.
- These perceived moral violations elicit strong moral emotions and cognitions directed toward self or others. When a moral injury occurs, these thoughts

and emotions may endure and motivate unhelpful or dysfunctional behaviors that impact social or relational, psychological, and spiritual well-being. In many cases, mental health diagnoses such as PTSD and major depressive disorder can co-occur and be interrelated.

- In cases when a moral injury develops, SM/Vs have appraised the morally injurious event(s) as being morally wrong and often feel a sense of personal agency related to the occurrence of the event(s) or have a strong desire to see those violations committed by others punished or rectified.

Beyond these points of agreement, authors nonetheless make different assumptions and statements about moral injury. In an era of polarization of thought leaders with divergent ideas (Lukianoff & Haidt, 2018), we hope this book will promote the necessary respect and dialogue among clinicians and researchers for advancing evidence-based practices for moral injury that may truly support SM/Vs and other trauma-exposed groups in the years to come.

In designing the table of contents and recruiting the chapter authors, this book was not intended to privilege any particular theoretical orientation or conceptual framework. Rather, whether in a controlled outcome study or another type of intervention trial, we opted to prioritize treatment models in which proponents had taken steps to clearly describe and formalize their therapeutic procedures (e.g., manualization), evaluate outcomes with potentially morally injured patients in some manner, and disseminate their research findings to the public. With this said, few of the treatments in this book would likely satisfy established standards for determining best practices in mental health care (e.g., one or more well-designed randomized clinical trials). Further, this commitment to science–practice integration led to an overrepresentation of approaches that are based on cognitive behavior therapy (CBT) models. In keeping with an unfortunate trend in psychotherapy research for proponents of non-CBT approaches to less frequently operationalize, describe, and evaluate their methods, a similar pattern appears to be emerging in the clinical research literature on moral injury—likely for similar reasons (e.g., epistemological differences, lack of funding or other resources). However, beyond a strong reliance on focal components of empirically supported treatments for PTSD (e.g., imaginal exposure, revising unhelpful cognitions), many of the CBT-based treatments in this book also incorporate approaches from alternate theoretical models that have not been emphasized as often in the clinical research literature (e.g., experiential strategies in emotion-focused therapy; Greenberg, 2015).

For readers who are not trained in CBT or align with other theoretical orientations, many of the treatments in this book are rooted in well-established understandings of trauma, stress, and psychopathology. Specifically, many of the authors believe that, unless definitive evidence indicates that existing scientifically supported approaches and models for PTSD do not work for moral injury, we should rely on them whenever possible. For example, multiple chapters rely on seminal ideas by Beck (1983), Foa and Kozak (1986), Lazarus and Folkman (1984), and other historically prominent figures about stress-related

responses and the interplay between cognition, emotion, and behavioral attempts at coping with traumatic events.

Recently, when considering the application of Lazarus and Folkman's ideas to moral injury, in particular, Nash (2019) raised concerns about using a stress-appraisal-coping framework to explain why some individuals disconnect from others and experience decrements in psychosocial functioning after a morally injurious event. Specifically, if clinicians assume the choice of coping strategies is fully under an individual's control, Nash cautioned that overreliance on the idea of maladaptive coping with these traumas threatens to stigmatize moral injury when it occurs and reduce the likelihood of help seeking and engagement in the types of treatments in this book. Nash raised concerns that CBT-minded researchers and clinicians, in particular, should consider in their work. However, many of this book's contributors likely vary in their alignment with a stress-appraisal-coping framework, and we, the editors, attempted to include a diversity of theoretical models without evaluating them per se. Further, even in chapters with a broad grounding in CBT, authors often suggest alternate frameworks for conceptualizing moral injury or highlight that painful trauma-related cognitions about morally injurious events may not always be inaccurate or distorted in nature.

Although chapter authors represent many of the best clinical minds and hearts for addressing moral injury, we must also offer a final disclaimer that many of the pressing questions facing clinicians will not be resolved in this book: What is moral injury? What is not moral injury? What are the necessary and sufficient features of moral injury? How can these features differentiate nonclinical manifestations of moral reactions to transgressive acts and/or betrayals? What are unique nonoverlapping features of moral injury relative to PTSD and other common mental health conditions in SM/Vs (e.g., depressive and anxiety disorders), if any? What are the unique collateral consequences of moral injury compared with these existing mental health conditions? Should moral injury symptoms or outcomes be characterized as manifestations of an underlying disease or medical syndrome or in a less traditional framework in mental health disciplines today? When should military leaders and peers, family members and nonmilitary friends, and/or clinicians be concerned that an SM/V, employee, or loved one needs help to prevent chronic or disabling problems from arising from a PMIE? What threshold should be crossed for clinicians to target moral injury, and how can they evaluate the success of their helping efforts? In this process, how can clinicians be certain they are not pathologizing moral pain when treating moral injury in their work? More broadly, what does moral injury say about society and the justness of wars in general? To what extent are leaders and members of society complicit in morally questionable acts of their fellow citizens?

In the absence of scientifically based answers to satisfy these foundational questions, this book will not provide a definitive compendium of best practice guidelines for caring for morally injured persons. Instead, we compiled convergent and divergent views of addressing moral injury from leading experts who are advancing theoretical models and suggestions for clinical practices at

this early stage of intervention development and dissemination. In so doing, this book will hopefully aid clinicians by summarizing the major scholarly and empirical contributions in this increasingly variegated area and structuring the conversation about how to care for morally injured SM/Vs and possible civilian groups in the coming decades. Looking ahead, addressing these larger aims will also ideally enhance the efficacy of clinicians who are looking for practical guidance now about how to conceptualize moral injury and apply therapeutic strategies that afford the greatest probability of supporting men and women who are seeking their help. Rather than simply restating findings that have been adequately summarized in other scholarly sources (e.g., Frankfurt & Frazier, 2016; Griffin et al., 2019; Litz et al., 2009), we encouraged the authors to assume a more practically oriented approach in organizing their chapters and to utilize material from their clinical cases to illustrate conceptual points and potential therapeutic strategies that others may also apply.

This book is organized to flow from more conceptual concerns related to treating moral injury to specific intervention models that have been subject to some scientific inquiry to date. Accordingly, Chapters 1 and 2 describe prominent possible conceptual frameworks for understanding moral injury that could inform the clinician's process of selecting and delivering treatment methods (CBT, social functionalism). Next, this book addresses religious and spiritual (Chapter 3) and forgiveness (Chapter 4) issues in moral injury followed by a possible framework for case conceptualization with value for clinicians working from different theoretical models (Chapter 5) and discussion of unavoidable issues facing clinicians who desire to care for morally injured persons (e.g., cultivating a therapeutic alliance, managing vicarious trauma; Chapter 6). In turn, the "meat" of this book entails discussions of emerging evidence-based interventions for treating moral injury, five of which are based in a CBT framework (Chapters 7–11) and two spiritually integrated approaches with potential benefit for SM/Vs with certain cultural values and beliefs (Chapters 12 and 13). Last, we attempt to synthesize the authors' insights and offer ideas for advancing scientific and clinical work in the concluding chapter (Chapter 14). By the end of this book, clinicians will not become experts in treating moral injury. However, we are all learning together, and we hope that all of us may grow more equipped to facilitate recovery from moral injury and identify promising clinical models for which additional education and training might be pursued in the future.

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