



The future of moral injury and its treatment

Given the expanding popularity in the media of the idea of moral injury among affected groups (such as Veterans) and other stakeholders (e.g., mental health providers, family members, governmental leaders), clinical research and clinical care approaches pertaining to moral injury will be expanding in the coming months and years. Our hope is that the articles in this special issue will help stimulate empirical research, especially with respect to establishing the epidemiology of moral injury and the development and testing of approaches to help people with moral injury. In this editorial, I offer some observations and recommendations that I believe will help guide this new wave of exciting research and help providers hit the ground running with respect to helping people with moral injury, regardless of their theoretical orientation and approach to stress and trauma.

CAN ANY TRANSGRESSION CAUSE MORAL INJURY?

Moral injury is primarily distinguishable from moral frustration and moral distress because it is a putative clinical problem caused by the severity of moral stress symptoms and the degree of functional impact.¹ Researchers and leaders have thus far not sufficiently wrestled with or addressed the challenges providers may face when treating people who perpetrate horrific transgressive acts and the legitimacy of the idea that the clinical syndrome of moral injury should be considered as a result of any of the most awful things of which humans are capable. The question that has eluded providers, researchers, and leaders is this: is it morally and psychologically tenable and acceptable to treat someone for the clinical problem of moral injury (which requires compassion, empathy, and non-judgementalism) if the person committed deliberate, horrific, unnecessary, and illegal acts of violence and cruelty? I believe this state of affairs is partly due to the existing discourse about moral injury being primarily about war combatants and Veterans. In the military and Veteran context, providers and clinical scientists have not observed enough phenomenology pertaining to horrific acts of perpetrated violence and cruelty because these cases are the least prevalent in specialty care, and shame and a lack of legitimacy motivates individuals to retreat from society and

not seek help, let alone participate in research studies. If severe, deliberative, horrific personal transgressions were frequently observed, they would likely have led to a discourse about these types of cases.

It has previously been argued that behavioural health providers should assume that moral injury from any transgressive act is possible and treatable because suffering and impairment can only arise from an intact conscience, and help-seeking should inherently signal contrition and an intact humanity and desire to heal and repair harm done.² The prevailing cognitive-behavioural therapies (CBTs) that putatively address moral injury appeal to change agents and entail Socratic questioning aimed at skirting what I argue should be the existential reality of personal culpability by contextualizing personal transgressive acts (e.g., due to the fog of war) or trying to help patients change their beliefs about moral culpability and self-blame. The foundational assumption of these CBT approaches is that moral injury arises from inaccurate self- and other-condemning beliefs regarding culpability. In the extant CBT approaches, if responsibility is not malleable and an event cannot be contextualized and reconstrued, then psychotherapy is not indicated (rather, the person needs to solely make amends in their life). With respect to moral injury, I argue that existing CBT models offer a “yes-but” framework — yes, you did this transgression, but let’s work on reappraising and contextualizing this experience. I posit that psychotherapists should be equipped to deal with any type of harm and should avoid being an arbiter of moral relativism and, notwithstanding the need to use cognitive therapy strategies when self-blame is grossly inaccurate, use a “yes ... and” approach. The yes in this case acknowledges the lasting existential reality and phenomenology of any moral harm and provides enough time and space in the psychotherapy for the person to unburden and share what is true and to experience compassion, non-judgemental understanding, and empathy (thus the ellipses after the word yes). This should be followed by a focus on what can be done to heal and repair the experience to rebalance beliefs about personal (or other) goodness relative to badness.³ In the last section of this editorial, I offer some specific recommendations for the “yes ... and” approach.

I note that the legitimacy of the clinical syndrome of moral injury especially remains to be fully realized and appreciated outside combatant and Veteran contexts. As Litz and Kerig stated, “In the wider traumatic stress community, the challenge for clinicians is to open our hearts to the suffering of those who have perpetrated trauma and thus have harmed the victims, who are our *raison d’être*.”⁴(p. 341)

CAN MORAL INJURY BE A TREATABLE CONDITION IF IT IS NOT IN THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS?

Soon, the field of moral injury will be contending with claims of a lack of legitimacy because moral injury is not codified as a diagnosable mental disease. The substantive problems that may arise if moral injury remains a dimensional clinical syndrome, uncoded in nosological schemes, is that third-party payers will be unable to cover the cost of care. In legal contexts, it will be hard for moral injury to be used as a defense or mitigating factor for crime or, in tort cases, as proof of harm, and it will be challenging to determine the epidemiological prevalence of clinically impairing moral injury (without a caseness definition).

Ideally, the presence or absence of a mental disorder would help providers and patients understand and predict problems and generate a reliable evidence-based treatment approach. However, decision rules about mental disease caseness are arbitrary. People who miss a diagnosis of a disorder by a single symptom could have worse symptom severity and functional impairment than people diagnosed with the mental disease — these so-called sub-syndromal mental health problems are associated with functional problems and comorbidities equal to cases that meet diagnostic thresholds — and the determination of a mental health diagnosis does not capture the unique constellation of presenting problems and does not help clinicians substantively conceptualize the individual case and plan a personalized approach. Consequently, with respect to treatment planning, although the entry of moral injury into the mental disease nosology would have its advantages, codifying moral injury as a mental disease arguably has no incremental case conceptualization and treatment planning value.

In the meantime, researchers and clinicians need to be undaunted and study, assess, and target moral distress and injury as a dimensional problem that can shape and limit current behaviour, distort identity, and

limit the availability of habilitative social, work, and leisure assets, regardless of whether there is a putative diagnosable disorder, or whether moral injury is the primary problem. Given that moral emotions (guilt, shame, anger and rage, disgust) are targetable problems and mediators of putative mental disorders being treated, and the emerging consensus that moral injury is a separable, targetable clinical problem, my best-practice recommendation is that the Moral Injury Outcome Scale (MIOS;¹ see <https://www.mirecc.va.gov/visn17/moralinjury/scale.asp>) routinely be used in a standard battery of questionnaires in primary and specialty care.

The MIOS is a brief 14-item public domain scale that identifies exposure to an index potentially morally injurious experience and assesses the presence and severity of index-event-linked moral injury symptoms and the degree of functional impairment resulting from the endorsed symptoms (the MIOS has Shame and Trust Violation sub-scales). Although there is currently no cut-point that defines moral injury caseness, the MIOS can be used to establish probable caseness and initiate a shared decision-making dialogue with patients about whether moral injury is a clinically targetable problem, with the presence of at least a mathematically moderate total score (29-42) and at least one area of functioning rated as above moderate. The MIOS can be used to track changes in moral injury symptoms, if targeted in treatment, in a measurement-based care framework.

A PRUDENT APPROACH TO CONCEPTUALIZING MORAL INJURY AND ITS TREATMENT

After 20 years of developing, applying, and testing psychotherapies to target moral injury, I have observed and concluded that the lasting biological, psychological, social, and spiritual impacts of high-stakes moral violations are not principally caused by the way transgressive events are appraised or construed, and any purely psychological approach to healing and repairing will fall short because these approaches require moral injury to be caused by morally relativistic appraisals and constructions. The implication of the predominant purely psychological approach is that severe, high-stakes deviations from moral responsibility and what is right and just are malleable. In my view, this moral relativism flies in the face of the biological imperative of expectations of reciprocal altruism and the transcendent and life-altering nature of most high-magnitude, acute (e.g., opening a car door and killing a child on a bike; being

brutally sexually assaulted by peers aboard a navy ship) or chronic (e.g., countless instances of degrading and cruel treatment by an enemy) moral injuries. I would extend the reality of traumatic memories to moral injury — namely, that memories of morally injurious experiences cannot be eradicated or permanently lessened by reframing. The aim is to make those memories and the implication of those experiences compete with countering memories and experiences, inhibiting the accessibility of the immutable existential reality of moral harm. Consequently, at the end of the day, helping people with clinically impairing moral injury entails helping them to do things and avail themselves of things in the world they inhabit that are corrective learning experiences with respect to judgements about how good or bad they, or people, are or can be. This requires action in service of shifting the balance of how good or bad someone is or how good or bad the world is. This perspective can help any clinician, regardless of their theoretical orientation.

This perspective will also help clinicians to consider what is lost as a result of various morally injurious experiences when they conceptualize cases and plan treatment. In contrast to threat-based stressors, in high-stakes morally injurious experiences, people can lose faith in their own humanity, or in humanity overall, as well as bankable trusting and nourishing relationships and activities that otherwise sustain identity; the sense of safety; and valued connections to people, families, and communities. Bill Nash, a thought leader on moral injury, posited that there are three types of sustaining attachments, each of which can be altered and lost as a result of moral injury:⁵ 1) valuing others, 2) being valued, and 3) being part of a valued kindred group. Moral injury damages these attachments, which are sources of comfort, safety, trust, love, virtuous behaviors, pride, meaning, and relational agency. Healing and repairing moral injury requires rebuilding or establishing these building blocks to personal and collective humanity and being exposed to new corrective learning experiences that counter the implication and meaning of moral harms.

Existing mental and behavioural health treatments — such as 1) medication designed to address dysphoria and anhedonia or anxiety; 2) cognitive therapy strategies designed to help one learn that some appraisals are malleable and can affect mood and to change one's broad beliefs; 3) exposure therapy strategies designed to help one approach dreaded internal experiences and contexts and to enhance agency; 4) behavioural strategies that address anhedonia, withdrawal, and poor

self-care; and 5) spiritual counselling — can all be used to help people with moral injury. Arguably, when these work to reduce moral injury, they help people open up to doing reparative things or to availing themselves of reparative attachments in their worlds.

The treatment planning issues germane to this framework are as follows:

- 1) Does the person have a history of virtuous behaviors? Were they part of a group or something they valued and were they a valuable member of the group? Were people a source of comfort and care? Were people trusting and trustworthy?
- 2) What is the quality of the current social, work, and community context? Is there at least one person who is loving, compassionate, and trustworthy? Is there an example of such a person historically? Are there current sources of reparative good attachments?
- 3) In the case of personal transgressions, has the person been contrite and taken responsibility? In the case of being the victim of others' transgressive acts, has there been any truth telling and attempt at repair and reconciliation?
- 4) Is the person currently vilified or excluded (cancelled) by others? Or is the person cancelling others or groups of others?
- 5) To what extent has faith, loss of faith, spirituality, or the loss of spirituality caused various functional impairments related to moral injury symptoms? To what extent would the individual want to, or consider being, involved in faith or spiritual communities or rituals and habits?

The change agents to first consider are classically behavioural (e.g., behavioural contracting). The aim is to collaboratively generate a list of experiences that can counteract the predominant lessons learned from moral harm. Examples include reconnecting with people and activities that are valued or who value the person or to be open to new connections and activities that are morally nourishing (e.g., feeling as though you belong, that you and others can be kind, caring, and trusting). Behavioural contracting items can arise from questions such as “Are there people that you admire, look up to, and honour who will understand your struggle?” “Are there organizations, activities, and relationships that may provide a common sense of value, trust, and purpose?” Providers can tell patients that these experiences may help them correct the core of moral injury, which is either seeing oneself as bad, unforgivable, excluded, and

unworthy or seeing the world around you as untrustworthy, unworthy, and selfish.

The meta task is to help people find opportunities to rebalance goodness relative to badness. People who harm others are not looking for forgiveness for the harming act, but they do not want to be defined by what they did and want to be able to make amends in some way. People who suffer from the moral failures of others should not be burdened by the expectation of forgiveness, but it will help them heal if they can see the transgressors as human and not representative of all humanity.

With respect to moral injury from personal transgression, I provide some heuristic suggestions providers can use to guide a course of action to help patients rebalance goodness relative to badness:

- 1) If necessary, provide an opportunity to help the person own what they did and, if possible, own the transgression to others who care about the person. Taking responsibility and feeling and expressing remorse may be clarifying and motivating. It may set the stage to make amends and to counteract what was done by making a positive difference.
- 2) If possible, facilitate the person confessing to at least one caring, compassionate, and wise person about what they did, the harm it caused, and how they have been affected since. The assumption is that if someone is compassionate, they will know the person's goodness, give caring feedback about what they think, and provide hope and support moving forward.
- 3) Facilitate an action plan to do good for others, to be compassionate toward others, and to establish or re-establish connections with people who are compassionate.
- 4) Foster patience and compassion. There should be no set timetable to rebalance goodness relative to badness. There may be stops and starts and setbacks.

If someone was harmed by someone else's immoral acts, or witnessed immoral activities, I also offer the following heuristic steps to guide patients to rebalance goodness relative to badness in the world:

- 1) If necessary, help the person acknowledge the harm to themselves and, if feasible, share the harm done and the lasting impact of the experience with at least one caring, compassionate, and wise person.
- 2) Facilitate the person having dialogues with compassionate people who can acknowledge the harm and damage done in a non-judgemental way.

- 3) Help the person generate an action plan about things to do or valued people or groups to join that corrects the balance of the world's goodness relative to badness. At a minimum, this requires an openness to good deeds and trying to trust others. It also requires being compassionate about others who struggle with their own moral imbalances.
- 4) Help the person think of ways of using supports to try on various corrective activities, while trying to commit to being compassionate about their struggles to regain trust and the struggles of others to be good.

In this editorial, I offered some ideas and strategies that I hope will be both useful and challenging to researchers and clinicians. I believe that it is critically important for researchers and clinicians to appreciate that the scientific discourse about moral injury is embryonic and the quality and quantity of evidence to support intervention strategies to help people with moral injury base is thin. Yet, people seeking help for suffering from their own or others serious transgressive behaviors need to be helped. It goes without saying that clinicians cannot turn people away because there is not enough evidence to support a given approach. In this regard, I urge clinicians to assess people with the MIOS and to use the results to determine treatment focus, establish a baseline, and to see if their conceptualization and approach is working. I also urge clinicians to assess what is going on in patients' current living context and to help people rebalance the scale of good and bad and to restore faith in one's own or collective humanity by being open to one's or others' goodness, being compassionate, and establishing or leveraging valued, valuing, and kindred attachments (e.g., doing/allowing good, belonging, feeling pride).

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