An Exploration of the Viability and Usefulness of the Construct of Moral Injury in War Veterans

Kent D. Drescher, PhD[1,2], David W. Foy, PhD[3], Caroline Kelly, MA[3], Anna Leshner, MA[3], Kerrie Schutz, MA[3], and Brett Litz, PhD[4,5]

Abstract

It is widely recognized that, along with physical and psychological injuries, war profoundly affects veterans spiritually and morally. However, research about the link between combat and changes in morality and spirituality is lacking. *Moral injury* is a construct that we have proposed to describe disruption in an individual's sense of personal morality and capacity to behave in a just manner. As a first step in construct validation, we asked a diverse group of health and religious professionals with many years of service to active duty warriors and veterans to provide commentary about moral injury. Respondents were given a semistructured interview and their responses were sorted. The transcripts were used to clarify the range of potentially and morally injurious experiences in war and the lasting sequelae of these experiences. There was strong support for the usefulness of the moral injury concept; however, respondents chiefly found our working definition to be inadequate.

Keywords

PTSD, war, veterans, spirituality, morality, moral injury, killing

It is axiomatic that the degree of exposure to combat and operational adversity, trauma, and losses are the best predictors of war-zone-related posttraumatic stress disorder (PTSD) and other psychosocial problems among war veterans (Foy, Sipprelle, Rueger, & Carroll, 1984; Hoge et al., 2004; Kulka et al., 1990; Smith et al., 2008). It is also true that a small but salient percentage of war veterans suffer across the life-span, psychiatrically, behaviorally, occupationally, socially, and medically (e.g., Buckley, Mozley, Bedard, Dewulf, & Greif, 2004; Hoge et al., 2004; Kulka et al., 1990). Until recently, it had been assumed that the chief cause of postcombat mental health problems was life-threat trauma and to a lesser degree war-zone traumatic loss(es). Although recognized extensively in historical literature (e.g., Shay, 1995), and descriptive accounts (Grossman, 2009), there has been renewed interest in the emotional, spiritual, and psychological wounds that stem from the ethical and moral challenges that warriors face in combat, especially nontraditional forms of combat, such as guerilla war in urban environments (Litz et al., 2009). The term that has been used to describe the impact of various acts of omission or commission in war that produces inner conflict is *moral injury*.

As most researched traumas involve victimization and because the exposure criteria for PTSD doesn't mention perpetrating trauma, little attention has been paid to the consequences of inflicting trauma. Yet combat is one of the very few experiences where trauma exposure comes not only through being the direct or indirect victim of violence and witnessing the aftermath and human toll of violence but also through inflicting (perpetrating) violence and destruction upon others (generally with societal sanction). Trauma may be inflicted upon both combatants and noncombatants, both intentionally and unintentionally. All military personnel are trained with the understanding that they may be called upon to place their own lives at risk and perhaps to wound or kill the enemy as part of their duty. Morality and ethics are part of that initial military training. However, research has identified several ways in which individuals morally disengage and act selectively at times in ways inconsistent with their moral code (e.g., Bandura, 1999, 2002). During war, service members are at times required (e.g., for survival, to accomplish a mission objective) to perform acts that would be illegal in most other contexts (i.e., killing). In

[1]VA Palo Alto Health Care System, Menlo Park, CA
[2]The Pathway Home: California Transition Center for Care of Combat Veterans, Yountville, CA
[3]Pepperdine University, Encino, CA
[4]VA Boston Healthcare System, Boston, MA
[5]Boston University, Boston, MA

Corresponding Author:
Kent D. Drescher, PhD, National Center for PTSD, Dissemination & Training Division, VA Palo Alto Health Care System, Menlo Park, CA
Email: kent.drescher@va.gov

addition, at times, exposure to threats and losses, especially in guerilla wars of insurgency can motivate service members to act unnecessarily and inappropriately aggressive (with identified enemy or civilian noncombatants) and violate rules of engagement. In the most extreme case, these behaviors entail atrocities. However, actual death and maiming is arguably not the only source of potential moral injury. For example, a recent military study reported higher rates of mistreating civilians among those with the heaviest combat exposure and most deployments (Mental Health Advisory Team, 2006).

Can moral and ethical violations be uniquely and lastingly injurious to war veterans? Although systematic research on the bio-psycho-social-spiritual impact of inflicting injury and death has been lacking to date, there is some evidence that this is the case. For example, symptoms that extend beyond the diagnostic criteria for PTSD have been noted for veterans who have reported committing atrocities (Ford, 1999; Singer, 2004). Maguen and colleagues (Maguen et al., 2009, 2010) have also shown that sanctioned war-zone killings are associated with unique variance in symptom outcome both for Vietnam era and Iraq and Afghanistan war veterans, respectively.

Some of the symptoms not included as PTSD diagnostic criteria, but reported among combat veterans with PTSD in the literature that arguably might be related to moral injury include: (a) Negative changes in ethical attitudes and behavior (Mental Health Advisory Team, 2006); (b) change in, or loss of spirituality (Drescher & Foy, 1995; Fontana & Rosenheck, 2004), including negative attributions about God (Witvliet, Phipps, Feldman, & Beckham, 2004); (c) guilt, shame, and forgiveness problems (Kubany, Abueg, Kilauano, Manke, & Kaplan, 1997; Witvliet et al., 2004); (d) anhedonia and dysphoria (Kashdan, Elhai, & Frueh, 2006, 2007); (e) reduced trust in others and in social/cultural contracts (Kubany, Gino, Denny, & Torigoe, 1994); (f) aggressive behaviors (Begic & Jokic-Begic, 2001); and (g) poor self-care (Schnurr & Spiro, 1999) or self-harm (Bras et al., 2007; Lyons, 1991; Pitman, 1990; Sher, 2009). These are problems not included as criterion symptoms leading to a PTSD diagnosis (though some are listed as associated symptoms) but are frequently reported by combat veterans under clinical care.

Although MacNair (2005) argued for a new diagnostic entity related to trauma perpetration, this is neither our intention, nor the focus of this research. Rather, this effort entails an initial exploration of specific aspects of combat and operational experiences arguably neither represented in the exposure criterion within the PTSD diagnosis, nor corresponding sequelae. We further argue that because current evidence-based PTSD treatments are chiefly based on fear conditioning and extinction models, they may be less well suited to help warriors for whom moral conflict, rather than fear, is the most salient source of postdeployment difficulties. Although isolated aspects of these issues are addressed with specific treatments (e.g., traumatic guilt, complicated bereavement), and although clergy/chaplains have provided care around moral distress, guilt/forgiveness for many years, to date no broad systematic examination of these issues has been conducted.

The first step to studying, identifying, and ultimately treating moral injury is operationalizing the construct (Litz et al., 2009). In this study, we generated the following working definition of moral injury, and sought feedback from experts about it: Disruption in an individual's confidence and expectations about one's own or others' motivation or capacity to behave in a just and ethical manner. This injury is brought about by bearing witness to perceived immoral acts, failure to stop such actions, or perpetration of immoral acts, in particular actions that are inhumane, cruel, depraved, or violent, bringing about pain, suffering, or death of others.

We used a standardized semistructured interview to evaluate our working definition of moral injury among a diverse group of health and religious professionals experienced in working with active-duty military personnel and veterans suffering from the stresses of military deployment and exposure to combat. We sought answers to the following questions: (a) How do these professionals view the construct of moral injury as expressed in the working definition? (b) What are the elements of war zone combat experience (i.e., both trauma exposure and trauma perpetration) that are most likely to produce moral injury? (c) What are the signs and symptoms that might be expected to result from moral injury? and (d) What types of intervention strategy might be useful for targeting moral injury?

Method

Participants

Twenty-three interviews were conducted by the first author with a variety of health care and religious professionals. Participants included representatives from both Veteran Affairs (VA) and Department of Defense (DoD), and included chaplains, mental health providers, academic researchers, and policymakers. All participants had knowledge of and experience with military service personnel or war zone veterans, and many had experience with the veterans from the current wars. Seventeen were male and four were female. Eleven participants were chaplains, and 11 were trained as mental health providers, one had specific training as an educator. Nine of the participants were currently working in the VA, eight were currently working in the DoD (several had been deployed as care-providers in theatre), and four were working outside of either the VA or DoD. Participants reported between 5 and 37 years of direct experience in working with service members/veterans (M 19.1, SD 9.4). Five participants had served in infantry roles prior to their training as helping professionals and had personally undergone traumatic experiences while in the military.

Procedures

The project protocol received exempt human subject approval both from the Stanford University Internal Review Board (IRB), and the local VA Research and Development (R&D) committee. The study used a purposeful snowball sampling

strategy (Lincoln & Guba, 1985). Recruitment was conducted in the following manner: Investigators generated a list of initial potential contacts. Two of the authors had extensive contacts within both VA and DoD due to prior research and educational activities. The identified individuals were contacted by e-mail with a standard cover letter, an attached information sheet, and a list of interview questions. The cover letter requested that individuals read the information about the project and respond to the investigators if they were willing to participate in an interview. Interested participants were then scheduled for a telephone interview with the principal investigator. Initial interviewees were asked at the end of the interview if they knew of other professionals that would be appropriate to interview. Additional contacts were generated through recommendations from the interview participants.

The interview questions used for the study are listed in Figure 1. At the beginning of each interview, the investigator reviewed the information sheet with the participant, and verified his or her willingness to participate as well as to have the interview digitally recorded. The investigator clarified that any accidental identifying statements made during the course of the interview would be removed at the time of transcription of the audio recordings, and that no record of their participation would be retained. Digital recording files were destroyed as soon as the completed transcript had been reviewed for accuracy.

Data Analysis

The data obtained through the interviews was analyzed descriptively on a per-question basis. The initial questions in the semistructured interview elicited "yes/no" responses with associated additional explanatory comments. Percentages of endorsement across interviewees were calculated for each of these items. The final three interview questions were open-ended. The transcripts for these items were analyzed in three stages: First, a set of trained coders who were not part of the study team read the transcripts and categorized comments for each of these questions into major themes. Second, using these major themes, all transcripts were reviewed and coded by individual coders (Strauss & Corbin, 1998). Third, all coding was then reviewed by the primary investigators, and discrepancies were resolved through discussion and consensus of all coders and investigators.

Finally, the frequency and extensiveness of comments for each theme were calculated (Krueger, 1998). Frequency (F) was defined as the total number of times a theme, such as "betrayal by authorities," was mentioned during the interview. For F, a percentage represents the total number of times this theme is mentioned by all respondents from the total number of comments coded for that interview question. Extensiveness (E) was conceptualized as the total number of participants who made at least one comment within the theme. The percentage for E represents the number of participants who mentioned that theme out of all of the participants. Both E and F are

- How long have you worked in the trauma field?
- Would you consider yourself primarily a care provider/ clinician, a clinical researcher, an educator, or a policy maker?
- How many years have you worked with or done work related to service members or veterans?

I want to share our working definition of moral injury and get your opinion about its viability or validity:

- First, what do you think about the term *moral injury*?
- Second, what do you think of our definition?
- Is there anything you would add or change?
- Do you think that PTSD is adequate to describe the long-term impact of various morally injurious elements of combat?
- Using the definition for moral injury that I just read, what types of events that occur in a war zone might contribute to moral injury?
- What do you think are the long-term mental health and social consequence of moral injury? Is there anything that care providers can do to help a veteran with moral injury? What specific strategies might be helpful?
- Do you have any additional thoughts or comments about the construct of moral injury?

Figure 1. Interview Questions

indicators of the importance of a topic to the participants (Krueger, 1998).

Results

Four of the questions were designed to elicit yes or no responses. Among these study questions there were three for which the experts gave unanimous responses.

Is the concept of moral injury needed? There was universal agreement among the subject matter experts that the concept of "moral injury" is needed; it was seen as a useful construct for describing the complex range of consequences of combat.

Is the present definition of moral injury adequate? All respondents found the present definitional statement of moral injury listed earlier to be inadequate and made suggestions for changes. Suggestions included the language used in the definition so as to be more easily understood by veterans. Some respondents thought that adding examples of events or qualifying experiences help clarify the definition.

Is PTSD adequate to describe the morally injurious aspects of combat? All of our panel members agreed that the construct of moral injury is not adequately covered by the PTSD diagnostic criteria and related features. Thus there was unanimity in considering PTSD and moral injury as separate but frequently co-occurring problems.

Is the term or label moral injury *adequate?* Most respondents (65%) agreed that it was adequate as is; however, a sizeable minority (35%) disagreed and offered suggestions for alternative terminology. Suggested changes were of two types: those that eliminated the term *moral* but retained the term *injury*; and those that kept the term "moral" but substituted another term to replace "injury." Among the suggestions of the first type, alternatives included *spiritual* injury, *emotional* injury, *personal values* injury, and *life values injury*. Recommended changes in terminology of the second type included: moral *trauma*, moral *wounds*, and moral *disruption*.

Three other interview questions asked for specific information rather than an agree/disagree response. The first of these, "What types of warzone events might contribute to moral injury?" elicited multiple responses from all respondents. Themes in the types of morally injurious events mentioned included: betrayal, disproportionate violence, incidents involving civilians, and within-rank violence. Sixteen respondents (70%) mentioned betrayal as a warzone event that might contribute to moral injury. Examples of betrayal events included: leadership failures; betrayal by peers; failure to live up to one's own moral standards; and betrayal by trusted civilians. Disproportionate violence, mentioned by 17 respondents (74%), included the examples mistreatment of enemy combatants and acts of revenge. Eighteen respondents (78%) described destruction of civilians' property and assault as examples of incidents involving civilians. Military sexual trauma, friendly fire, or fragging was mentioned by seven respondents (30%) as examples of within-rank violence.

A second question of this type asked respondents, "What are the signs or symptoms of moral injury?" Again, respondents provided multiple responses that were sorted into themes or categories. The themes included: social problems, trust issues, spiritual/existential issues, psychological symptoms, and self-deprecation. Sixteen respondents (70%) included social problems in their response to this question. Examples given were: social withdrawal, sociopathy, problems fitting in; legal and disciplinary problems, and parental alienation from their child. Loss of trust or a sense of betrayal was mentioned by six respondents (26%). Spiritual/existential issues were given by 11 respondents (48%), including: giving up or questioning morality, spiritual conflict, profound sorrow, fatalism, loss of meaning, loss of caring, anguish, and feeling haunted. Fourteen respondents (61%) gave examples of psychological and social functioning problems, including: depression; anxiety; anger; reenactment; denial; occupational dysfunction; and exacerbated preexisting mental illness. Finally, nine respondents (39%) mentioned self-deprecation, including: guilt, shame, self-loathing, feeling damaged, and loss of self-worth.

A third question was a follow-up to the "signs and symptoms" question in which panel members were asked for suggested interventions to help combatants suffering from moral injury. Themes included in the interventions suggested included: spiritually-directed, socially directed, and individually directed. Eight respondents (35%) mentioned spiritually directed interventions, including: spiritual counseling, spiritual ritual, forgiveness, amends, and transformation. Socially directed interventions were described by six panel members (26%), including: community service, social reconnection, and corrective feedback from valued sources. Finally, individually directed interventions were mentioned by nine respondents (39%), including: Disclosure; connecting feelings to experiences, cognitive restructuring, expressive writing, and writing from victim's perspective.

Finally, we examined respondents' transcripts for other information about their perceptions of helper characteristics that promote healing among combatants struggling with moral injuries. Three qualities of effective helpers were mentioned: nonjudgmental attitude, positive listening skills, and normalization skills.

Discussion

This preliminary study asked chaplains, mental health clinicians, and researchers to critically evaluate the construct of moral injury. Our primary goal was to get initial feedback from subject experts about the viability and usefulness of the moral injury concept. We also wanted to generate new knowledge about the construct of moral injury.

The results suggest that there is consensus that there are uniquely morally injurious experiences in war and that these experiences create an array of psychological, spiritual, social, and behavioral problems. There was unanimous agreement that the concept of "moral injury" is useful and needed; and that it was seen as a helpful construct for better addressing a wider range of the complex consequences of combat for many warriors. There was also universal agreement that the construct of moral injury was not fully encompassed by the PTSD diagnostic criteria and its related features.

However, clearly more research is needed to delineate the boundary conditions and symptom/problem parameters of moral injury. For example, all participants felt that changes should be made to our working definition. A significant minority of participants felt that the label of moral injury was inadequate, and that another term should be coined. In addition, many felt that the definition could benefit from the addition of concrete examples of the construct. In addition, all participants suggested a number of additional potential indicators and consequences of moral injury.

The participants also identified several potential sources of war-related moral injury and made some useful recommendations for what might be called *moral repair*.

As of the potential spiritual changes/consequences following moral injury, and the sparse attention historically paid to spirituality in mental health more generally, it may be that additional interventions to address these issues might be considered, as

well as improved collaboration between health professionals and chaplains.

This study has several limitations that may affect the generalizability of the findings. First, as a preliminary qualitative study, the goal was not to identify generalizeable findings, but rather to explore professional opinion as to the presence, the utility, and the phenomenology of the construct of moral injury. To accomplish this, we purposefully sampled caregiver professionals who would have the greatest likelihood of encountering the construct of moral injury that is, military and VA chaplains and mental health providers with extensive experience in caring for service members and veterans. Though the sample broadly represented several types of experienced providers that work with veterans and active-duty military personnel, we used a self-selected relatively small sample of convenience of professional care-providers. Although veterans and active-duty warriors who were currently providers or researchers were included in the sample, no nonprovider veterans were interviewed. Future research efforts should address this limitation. It would be useful to conduct a similarly qualitative investigation of the construct with combat veterans of the present and previous wars. In addition, as a next step it is recommended that a multidisciplinary consensus group be formed to conduct a concept analysis.

Another element that must be developed before quantitative research and ultimately clinical trials can proceed is reliable and valid measures of the moral injury construct. Development of such a scale should have a high priority among teams interested in investigating moral injury. This effort should be driven by a conceptual framework (e.g., Litz et al., 2009), and a data-driven evaluation of phenomenology directly from veterans struggling with moral injury.

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