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Too Many Moral Injuries

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*Hamlet (to* *Polonius)* Good my lord, will you see the players well bestowed?...  
*Polonius*: My lord, I will use them according to their desert.  
*Hamlet*: Use every man after his desert, and who should ’scape whipping?  
 Hamlet II 2

The term moral injury has recently become prominent in mental health studies(Williamson, Murphy, Phelps, Forbes & Greenberg, 2021). While it is not a diagnostic term, it does describe phenomena related to psychopathological responses to traumatic experiences. Unfortunately, there are at least two disparate versions of the term “moral injury” (MI). Both were introduced to call attention to psychological harm that the originators of each version did not believe had been adequately addressed in the clinical or scientific literature. The two versions have been succinctly and accurately defined by Griffin, Williams, Shaler, Dees, Cowden, Bryan & Litz (2020).

“There is currently no consensus about what events are potentially morally injurious or about the outcomes or impairments that characterize *moral injury*. Jonathan Shay (2014. P.183) coined the term *moral injury* to ascribe the consequences of experiencing a “betrayal of what’s right by someone who holds legitimate authority in a high stakes situation.” On the other hand, Litz and colleagues (2009. P. 697) defined *moral injury* as the psychological social, and religious or spiritual impact of ‘perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations.””

The many recent publications related to MI indicate that this work has succeeded in calling scientific and clinical attention to these phenomena, which include betrayal, on one hand, and perpetration or failure to prevent, on the other. However, there are inherent problems with both definitions, (in addition to the fact that there are two**)** and even in the introduction of the term MI using either definition. This essay will point out some of these problems, including failure to acknowledge prior work and therapies, and propose reconsideration of terminology and practice that may be helpful in more productively focusing future work in the field. This will include a comparison of definitions of MI from work by Litz and associates, and Shay, and making of connections between these phenomena to previous, relevant, scholarship.

It should also be said here that this situation is not unique to MI. There is a long history in the mental health scientific endeavor of asserting ideas as being new though they have very similar if not identical precursors. Horowitz (1976), offers one fairly recent example of this being noted, before the establishment of the PTSD diagnosis:

“The absence of a fixed terminology for ‘traumatic neurosis’ in the official nomenclature has led to an ‘every author for himself’ effect in psychiatric textbooks. Some of the terminology variants are ‘Gross Stress Reaction,’ ‘Traumatic Neurosis,’ and ‘Neurosis following Trauma.’” (p. 28).

While the establishment of the DSM PTSD diagnosis seemed to unify these and other nomenclature for the effects of psychological trauma, even that has not held, as there now two well-known and different authoritative definitions of PTSD (DSM V vs ICD 11). This article is intended to contribute to the clarity of future discussions of MI within the field by drawing together previous, but little-recognized scholarship around the multiple phenomena that have come to be associated with the term.

**Earlier scientific and clinical literature subsumed by the Litz et al( 2009) MI**

*Back*

by Wilfred Gibson (1915/1991)

They ask me where I’ve been,

And what I’ve done and seen.

But what can I reply  
Who knows it wasn’t I,

But someone just like me,

Who went across the sea

And with my head and hands

Killed men in foreign lands...

Though I must bear the blame,

Because he bore my name.

Attention to previous work when discussing a scientific problem is the essence of the endeavor to build knowledge, scientific or otherwise. Litz and colleagues (2009) do acknowledge some of the work done before them (as shown in the following quotation) but there are significant omissions.

“In the first iteration of the PTSD construct (DSM-III) guilt about surviving while others have not *or about behavior required for survival* (emphasis added**)** was a symptom of PTSD. This was chiefly the result of the predominance of thinking about the phenomenology of Vietnam veterans and clinical care experience with veterans of war. Consequently, prior to the DSM-III-R, clinicians in VA settings arguably tackled moral conflict and guilt (e.g., Friedman, 1981). Since then, there has been very little attention paid to the lasting impact of moral conflict-colored psychological trauma among war veterans in the clinical science community. A possible reason for the scant attention is that clinicians. and researchers who work with service members and veterans focus most of their attention on the impact of life-threat trauma, failing to pay sufficient attention to the impact of events with moral and ethical implications; events that provoke shame and guilt may not be assessed or targeted sufficiently. This explanation seems plausible given the emphasis on fear memories in evidence-based models of treatment (e.g., Foa, Steketee, & Rothbaum, 1989). It is also possible that some clinicians believe that addressing ethical conflicts and moral violations is outside the realm of their expertise, preferring to recommend religious counseling…” (Litz, Stein, Delaney, Lebowitz, Nash, Silva & Maguen, 2009 p. 3).

*Clinical Attention*

The assertion in the Litz et al. (2009) passage above that clinicians have paid “scant attention” to issues related to morality, ethics, guilt and shame is offered without supporting data, and contradicted in a paper by Kubany (et al. (1992) who reported that there is “widespread recognition that trauma related guilt is extremely common among Vietnam Veterans” (p.1). Also not acknowledged is the statement by two of the researchers Litz et al. (2009) cite in making their point about the absence of consideration of moral issues, Foa and Rothbaum. In the seminal book *Traumatic Stress* (van der Kolk., McFarlane, & Weisaeth, 1996), Foa and Rothbaum state “Given the prominent role of guilt in PTSD sufferers, it is imperative to develop and evaluate techniques for guilt reduction” (p. 499).

Another precursor worthy of mention is the work of Larry Dewey, whose 2004 book *War and Redemption* distinguishes PTSD from other effects of being in war.

Our current PTSD diagnosis is primarily based on the conditioned responses people develop because of their traumatic experiences. These conditioned responses to combat become the readily recognizable symptoms that trouble vets later. However, my veteran patients have taught me that as troubling as these conditions are (nightmares, intrusive thoughts, startle reactions, and many others) they are not what disturbs them most over the course of their lives. What they are most troubled by is the guilt over killing (p14).

Dewey goes on to present much material further describing this problem and therapeutic responses.

Admittedly, in the apparent absence of research confirming or refuting the “scant attention” assertion, only the contradictions from other experts can be offered. Nonetheless, there are several of them; they are well known figures in this field, and their observations are consistent with those made by myself and my colleagues when I was the director of a USVA inpatient PTSD program (1986 – 1993) and in my work with combat veterans since. This informal clinical impression was supported by a structured questionnaire on which half of 14 veterans reported some of the distress from their most troubling traumatic experience was related to their harming another person (Lipke, 1991). Thus, while acknowledging the important role of chaplains, who Litz et al. (2009) describe as the primary providers of counseling in this area, such work has clearly been in the purview of mental health clinicians.

*Research attention and the naming of the phenomena*

The discussion above describes recognition of guilt from harming others prior to the Litz et al (2009) claim. Considerable specific research and labeling of these issues has been presented in the scientific and clinical literature. Kubany (1994) refers to what Litz et al. (2009) call MI as “dysfunctional guilt” and recognizes earlier works, both his own and that of Glover (1988). The failure to recognize Glover’s contribution has led to subsequent errors as Boska and Capron (2021) writing “Although distorted cognitions are core components of PTSD symptomatology, there is no research on cognitions in moral injury.” (p 861) when, in fact, Glover et al (1990) published a factor analytic study on the subject in the *Journal of Traumatic Stress*.

Research by Yehuda et al. (1992) supported the proposition that exposure to atrocities was correlated with PTSD symptom severity. Likewise, Breslau and Davis (1987) found that participation in atrocities independent of combat exposure added risk for posttraumatic stress disorder. McNair (2002) considering the same phenomena introduced the term “Perpetration-induced Traumatic Stress (PITS)” which she later reported others sometimes call ” Participation-induced Traumatic Stress.” McNair (2002) cites previous scientific work of many others including Green (1990) and Nader et al. (1993) and even writings by Plato (reflecting Socrates) in *Gorgias*.

Predating any of the terminology so far discussed is the work of Andrew Jameton (1984), for which there is a subsequent body of research, primarily related to medical personnel ( Lamiani,  Borghi &  Argentero, 2017). In his book *Nursing Practice: The Ethical Issues,* Jameson relates several terms for the issues being addressed here. One of his terms, “moral distress” (though he applies it to an ongoing situation in which the person was required to do something they believe is wrong by an authority) can easily be adapted to describe feelings about what has happened in the past.

**Acknowledgement of previous psychotherapeutic treatment protocols as they relate to MI**

In sharing their own treatment for MI, Litz et al.(2009) review (and find wanting) exposure therapy as well as cognitive processing therapy and other cognitive therapy models They also completely neglect acknowledging the seminal contributions to psychotherapy outside the cognitive/behavioral tradition. While Sarah Haley’s (1974) seminal psychodynamic work must be mentioned, an exhaustive discussion of these neglected efforts , is beyond the scope of this paper as examples could be drawn from many schools of psychotherapy. The two specific examples of overlooked contributions offered here can be seen as part of the cognitive and behavioral therapy traditions.

Noted first is work by Gerrard and Hyer (1994) in the edited volume *Trauma Victim: Theoretical Issues and Practical Suggestion* (Hyer and Associates 1994), and found in the chapter titled Treatment of Emotions: The Role of Guilt. There is considerable overlap between the Litz (et al., 2009) suggestions and those from the work of Gerrard and Hyer (1994), and in fact, Litz was the first author of the immediately preceding chapter in the Hyer and Associates (1994) volume. The first of many overlaps begins in the discussion of the initiation of therapy. Gerrard and Hyer write: “Information starts with validation of the person, especially in the understanding of guilt. The therapist allies self with the patient in exploring the personal meaning of the guilt related to the material. Accurate empathy is the goal…” (p. 476) Litz el al. write “Because of the sensitive and personally devastating and disorienting nature of moral injury, a strong and genuinely caring and respectful therapeutic relationship is critical. (section 7.2.1). Soon after, Gerrard and Hyer (1994) write: “Secondly, clients universally desire to forget. The victim must be reminded that he/she has tried unsuccessfully to forget for a long time and yet the symptoms continues (p.476.).” Litz et al. (2009) write: “Patients need to appreciate that concealment and avoidance, although understandable, is maladaptive, as it not only narrows the repertoire of wellness behaviors, it restricts exposure to corrective and reparative experiences.” (section 7.2.2)

The second ignored method of psychotherapy is Eye Motion Desensitization and Reprocessing (EMDR), one of only three methods considered in the first rank of evidence-based methods by the VA/DoD standards. This method explicitly considers client dysfunctional beliefs relating to responsibility among the three types of beliefs (with their concomitant emotions) generally targeted for processing. In this context, EMDR has an extensive literature relating to treatment of dysfunctional guilt (e.g. Shapiro & Forest, 1997; Shapiro, 1993; Lipke, 2000; Silver & Rogers, 2002). The failure of Litz (et al., 2009) to acknowledge these and many other previous works addressing dysfunctional guilt or perpetration again calls into question the need for introducing MI as a new term to describe well-known phenomena.

**Referring to the behavior that leads to dysfunctional guilt as an “injury”**

To refer to combat veterans as having sustained an injury based on how they have harmed (or believe they have harmed others) or could not protect them, suggests that the therapist does not understand many clients’ thoughts and feelings about themselves or of their morality. This seeming failure violates the basic rule of treatment of showing the client that the therapist wants to understand them in their own terms. In my clinical experience, clients often cycle between guilt over what they have done and anger at others for causing the situation and leaving them with the blame, much as they cycle between intrusive symptoms and denial (Lipke, 2013).

The problem might be best illustrated by the following fictional therapeutic dialogue:

*Therapist: So, Mr. X what brings you here to see me today.*

*Client: After I told my last therapist what we had done on our first patrol he said I had a moral injury. Then I told him what we did on the second patrol, and I asked if I had a double moral injury, and did I have at triple moral injury after what I did on the third. After that we didn’t talk much.*

Treatment goals for this kind of problem don’t start with accepting that one has been injured, but rather through understanding what happened, how it happened and ultimately finding some measure of self-forgiveness (see Lipke, 2011). This is very different from finding a way to recover from what we usually consider an injury, where for most cases one must find some version of forgiveness of others, and enough of a resolution so that the destructive cycle of anger and guilt does not lead to further damaging others or the self – which of course damages others. To paraphrase Donne, without, hopefully, not losing too much of his poetry - No person is an island unto themselves...

***Forgiveness***

To their credit, the Litz et al. (2009) treatment proposals do, like those that precede them recognize the need for forgiveness. However, to tie the treatment to having the clients consider themselves injured has the potential to undermine their own first step as well as that of, frankly, any other competent therapist, including those who addressed these issues earlier and as cogently.

**MI vs. Betrayal Trauma**

As with the Litz group, Jonathan Shay (2014) does not acknowledge previous work on what he calls MI, nor the previous use of the term. What Shay (2014) describes as MI appears to meet the criteria of “betrayal trauma” as described by Jennifer Freyd (1994) and later considered along with many colleagues (e.g. Freyd, DePrince & Cleaves, 2007; Freyd, DePrince, & Zurbriggen, 2001). Freyd (1994) endorses this definition: “Betrayal trauma occurs when the people or institutions we depend on for survival violate us in some way.”  Shay’s failure to acknowledge previous scientific work (but, famously, not literary contributions) appears to be somewhat more understandable in that it is work that was mainly related to childhood traumatic situations, though it has been extended to adults (e.g. Goldsmith, Freyd & DePrince, 2011). In Shay’s MI the moral injury occurs due to someone else’s acting immorally toward the morally injured person, in contrast to the Litz (et al. 2009) version in which the injured person is the “victim” of their own action (or inaction). Thus, it seems that Shay’s version of MI is similar to the “betrayal trauma” described in work prior to his.

**Summary and Conclusions**

While both versions of MI ,importantly, help call attention to the phenomena they address, there are many problems in how they do so. Essentially, they give the same name to two different phenomena, and thereby add confusion to the field’s understanding of what they name. While it appears that Litz and colleagues (2009) group got there first, the issue would have been irrelevant, and consistent with the standards of the scientific enterprise if both parties had recognized earlier work in the field. For example, Litz et al. (2009) group might have centered their research around the terms “dysfunctional guilt” or “Perpetration (or Participant)- Induced Traumatic Stress,” and Shay around “betrayal trauma.” This is not to mention Jameton’s (1984) “moral distress” which might have been more difficult to find given the disconnect among the research in different disciplines ( a topic for another time)..

The Litz research team with its connections to academia and the National Center for PTSD would have still had considerable influence in fostering research and clinical attention to this important problem. Shay, with his profound exploration of betrayal trauma as he observed it clinically and connected it to classic literature, would still have notably advanced clinical understanding. Hopefully this article will stimulate some further conversations among those working in the field, and help to make connections with previous work that may be both relevant and helpful to reaching agreements around the phenomena associated with MI.

Compliance with Ethical Standards

The author states that there is no conflict of interest, other than those inherent to reference to one’s own work. All research subjects referred to were in the context of reports from researchers in other papers.

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