Moral Injury: Thinking Beyond the Portraits of Victims and Perpetrators in Trauma Studies

by

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Abstract

The idea of “moral injury” pioneers a different way of conceptualizing traumatic stress. Moral injury moves beyond assuming the homogeneity of the life-threat, fear-based model of traumatic stress to consider both more broadly and deeply the consequences of perpetrating, failing to prevent, bearing witness to, or learning about traumatic acts that transgress one’s moral beliefs. This thesis interrogates the viability and usefulness of the psychological concept of moral injury from the perspectives of psychology, history, and science and technology studies. It traces researchers’ efforts to establish the scientific validity and status of the phenomenon, including the ways that researchers’ reliance upon scientific methods and positivist epistemology has hindered the usefulness of the moral injury concept. Beyond the complications engendered by scientific scrutiny, the culture-specific therapeutics developed to target and alleviate moral injury demonstrate how a model encompassing science, culture, and spirituality/religion can produce better world making for individuals suffering from moral distress.

Moral injury provides a heterogeneous conceptualization of trauma and a deeper understanding of cultural dynamics in both experiences and interpretations of mental distress. The scientific and therapeutic work on moral injury, though focused largely on veterans of war, opens the way for reappraising traumas arising from other life experiences.
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To Clarice Lispector, whose words and writings have kept me grounded during this time. I hope that the epigraphs I have provided diffuse your essence into the crevices of each chapter.

Most importantly, I would like to dedicate this thesis to every person who has felt that their mental distress has been misunderstood, to every person who has been hospitalized for mental health problems and learned more from fellow patients than from their clinicians, and to every person who has been diagnosed with a mental disorder and felt that they would not amount to anything because of it.

Here’s to experts by experience.
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INTRODUCTION
Introduction

Suffering for a being deepens the heart within the heart.
- Clarice Lispector, A Breath of Life

What are the consequences of killing? How are you supposed to feel after watching your brother in arms get his brains blown out in combat while you stand frozen and unscathed next to his mangled corpse? What happens when you bear witness to the bodies of civilian children strewn across the battlefield, laying lifeless with eyes wide open?

I was a squad leader at the time, and my buddy was platoon sergeant. To make a long story short, he got killed by another [M]arine…then he took six of us hostage at gunpoint. I was there next to my platoon sergeant that got killed. (Sullivan & Starnino, 2019, p. 32)

You know, I did it to protect me, and the people around me. And then if someone’s going to shoot at me, I’m gonna shoot back. You thought about it afterwards, and you’re saying, “Who’s right?” You know. The first person you kill, you’re so hyped up the adrenaline is like flowing like mad, and then you go into severe depression…I think we have to answer to our sins afterwards…And I question what I’m going to have to go through when I go there (afterlife) because of Vietnam. (Sullivan & Starnino, 2019, p. 34)
Civilians are collateral damage to me, but I got a 17-year-old, a 6-year-old, and a 3-year-old. Not that I do not love my little fucking kids, but just this shit…that image…it fucks with you, you know? Like, I could have did something different. (Held et al., 2019, p. 399)

Until recently, these traumatic events would be classified as Criterion A stressors qualifying a service member or veteran for post-traumatic stress disorder (PTSD). Some clinical researchers, however, have begun to distinguish between life-threatening traumatic experiences and traumatic experiences that shatter one’s moral conscience. The phenomenological experiences of service members and veterans have motivated researchers to recognize that traumatic events that transgress one’s moral beliefs have different psychological, biological, social, and spiritual consequences compared to traumatic events that evoke fear responses in the trauma survivors. Using qualitative data from the emotionally visceral, personal experiences of service members and veterans, these researchers have developed the concept of “moral injury.” They have also created measurement tools, diagnostics, and treatment strategies for moral injury in an effort to promote better world making for perpetrators of immoral traumas.

What does it mean for internal moral conflict to be brought to bear in presentations of war trauma? Such acknowledgments are more than just ridiculing war for being immoral. After all, explicating the immorality of war does not bring us very far toward helping warriors returning to civilian life mend their broken hearts, nor does it help clinicians treat returning warriors’ shattered ideals of humanity. On the other hand, medicalizing the consequences of war and claiming
them to be a disease in the form of PTSD does not grasp at the spiritual injury to one’s conscience that occurs after engaging in acts that transgress one’s moral beliefs. Nor do current conceptualizations of PTSD take into consideration the complexity of military culture and the adaptive functions of certain so-called pathological symptoms in the context of war. Instead, a medicalized understanding of war trauma conceives of the consequences that service members and veterans face post-war through a black and white lens: service members and veterans are either disordered or not, either pathological or not. Yet, the history behind the construct of PTSD acknowledged the complexity of the symptomatic profile of warriors. Clinicians at the time of the Vietnam War used phenomenological methods to build a bottom-up understanding of war trauma. What has been lost, then, in current models of PTSD is just this humanism and the awareness of military culture that permeate historical descriptions of war trauma. 

Some researchers in clinical psychology have developed the concept of moral injury in response to the inadequacy of existing models of PTSD. Spurned by the publication of Brett Litz and his colleagues’ (2009) conceptual model, moral injury has recently gained attention among trauma researchers. Understood through a dimensional, biopsychosocial-spiritual model of distress, moral injury refers to the lasting psychological, biological, spiritual, behavioral, and social consequences of a potentially morally injurious experience in the context of “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations” (Litz et al., 2009, p. 700). As Litz and his colleagues found, “moral injury involves an act of transgression
that creates dissonance and conflict because it violates assumptions and beliefs about right and wrong and personal goodness” (Litz et al., 2009, p. 698). At its core, the concept of moral injury takes into consideration the heterogeneity of clinical presentations of war trauma, which is not captured by the black and white diagnosis of PTSD.

This project traces the emergence of moral injury and critically examines the viability and usefulness of a clinical, scientific, and morally grounded understanding of trauma. Chapter one describes how the moral injury concept recognizes the complexity and dimensionality of clinical presentations of war trauma, which are not fully explained by the PTSD construct or the fear-based model of traumatic stress. The following chapter outlines the scientific development of moral injury, showing when and where it has gained or failed to gain scientific visibility; it connects these failures to researchers’ close adherence to positivist scientific methods (e.g., reliability, validity, measurement, and classification). Chapter three, then, interrogates the value of these scientific conventions and emphasizes the role of uncertainty in scientific discoveries of clinical kinds of ways of being. Chapter four showcases how some researchers within the United States Department of Veterans Affairs (VA) have moved to develop and use evidence-based treatment strategies for service members and veterans living with moral injury. Notably, they have advanced these strategies despite scientific roadblocks in validating the concept. The moral in clinical psychology warrants reflection, and the concluding chapter draws upon historical cases of clinical psychologists’ morally grounded understandings of trauma. This
reflection shows how shifts in clinical psychology’s epistemological commitments and ontologies have nearly – but not entirely – eliminated the moral dimension of psychic harm. This thesis invites reconsideration of this eclipsing of the moral in our understandings of mental distress.
CHAPTER 1

Beyond the Homogeneity of Fear-based Models of Trauma
Beyond the Homogeneity of Fear-based Models of Trauma

Who has not asked himself at some time or other: am I a monster
or is this what it means to be a person?

- Clarice Lispector, *The Hour of the Star*

Warsriors are coming home from war not only with fear reactions to the atrocities witnessed overseas but also with broken hearts and feelings of immense guilt and shame for violating their moral beliefs. Morals here refer to “the personal and shared familial, cultural, societal, and legal rules for social behavior, either tacit or explicit. Morals are fundamental assumptions about how things should work and how one should behave in the world” (Litz et al., 2009, p. 699). Researchers and clinicians tend to overlook the role of morals in service members’ and veterans’ wartime experiences; instead, focusing attention on one aspect of these experiences (fear), which we have come to equate with PTSD. In contrast, the dimensional, biopsychosocial-spiritual model of moral injury attends to the potential psychological, biological, spiritual, behavioral, and social consequences of morally injurious experiences. The conditions of morally injurious experiences include “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations” (Litz et al., 2009, p. 700). More specifically,

Moral injury requires an act of transgression that severely and abruptly contradicts an individual’s personal or shared expectation about the rules or the code of conduct, either during the event or at some point
afterwards…The event can be an act of wrongdoing, failing to prevent serious unethical behavior, or witnessing or learning about such an event. The individual also must be (or become) aware of the discrepancy between his or her morals and the experience (i.e., moral violation), causing dissonance and inner conflict. (Litz et al., 2009, p. 700)

Moral injury, thus, is an innovative way of giving meaning to the personal experiences and shattered moral consciences of warriors. In this chapter, I provide an overview of the moral injury model and construct and query the homogeneity of the fear-based model of trauma, advocating for moral injury in addition to the fear-based model. First, a brief history of the concept of moral injury finds that researchers considered the moral impact of traumatic experiences long before psychiatrist Jonathan Shay coined the term “moral injury.” Soon, the concept was taken up, largely by the military, and framed as a complex model and construct that describes service members’ and veterans’ experiences of moral distress. This history leads to the question of “is moral injury needed?”, which is taken up in the second part of the chapter. It examines how trauma researchers’ fear-based model of trauma does not account for all traumas experienced at war, and how the morally ambiguous features of recent wars indicate the need for additional ways of conceptualizing trauma. Moral injury is then compared with PTSD, illuminating the two constructs’ differences on psychological, biological, neurological, and phenomenological levels, along with their diagnostic and symptomatic differences. These
examinations show how moral injury better accounts for the context of war and warrior culture than does the decontextualized, generalized PTSD construct.

**The Emergence of Moral Injury**

Observing the moral impact of traumatic experiences is not new. The field of traumatic stress comes from a deep history of describing the consequences of moral transgressions, including Lindemann’s (1944) work after the Coconut Grove Fire, Lifton’s (1968) work on survivors of Hiroshima, Shatan’s (1972) conceptualization of a post-Vietnam syndrome, Lifton’s (1973) descriptions of the distress of Vietnam veterans, and Haley’s (1974, 1985) writings about the therapeutic challenges that arise when Vietnam veterans report atrocities. Likewise, developing a psychological construct to represent moral difficulties is not novel. The term “moral distress” was originally used in 1984 by Andrew Jameton to describe nurses’ psychological distress, including feelings of shame and guilt, when they are prevented from acting in what they believe to be an ethical manner due to institutional regulations (Jones, 2018). Yet, in the field of traumatic stress, this idea of “moral distress” never came to fruition. Though the first iteration of PTSD in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* included the symptom of “survival guilt” (3rd ed.; *DSM-III*; American Psychiatric Association, 1980), this symptom was subsequently dropped in the revised version of the third edition of the *DSM* (3rd ed., rev.; *DSM-III-R*; American Psychiatric Association, 1987), and it has not appeared in any later *DSM* entries of the PTSD construct.
The moral dimension of service members’ and veterans’ distress, then, was absent from conceptualizations of the consequences of trauma until Johnathan Shay’s (1991, 1994, 2002, 2009, 2014) comparison of narrative accounts of Vietnam veterans’ distress with the experiences of Achilles and Odysseus in the Homeric texts of the *Iliad* and the *Odyssey*. Shay coined the term “moral injury” that he later defines as (1) a betrayal of what’s right, (2) by someone who holds legitimate authority, (3) in a high-stakes situation (Shay, 2014, p. 183). He developed his conception of moral injury to understand the aspects of distress in his outpatient veterans that could not be explained by the PTSD construct or, more generally, by the fear-based model of trauma.

Sixteen years after the introduction of the term, the Director of Psychological Health for the United States Marine Corps published an article describing the advantages of using the term “injury” to communicate with warfighters (Nash, 2007). Nash’s article explicates the biological, psychological, and interpersonal mechanisms underlying such stress injury reactions and consequently divides combat and operational stress injuries into three types: traumatic stress, caused by the impact of terror, horror, or helplessness; operational fatigue, caused by the wear and tear of accumulated stress; and grief, caused by the loss of someone or something that is highly valued (Nash, 2007, p. 50). Though not quite moral injury, the conceptualization of combat and operational stress injuries brought to light a non-medicalized, multidimensional understanding of combat and operational stress in the context of the military.
Shay coined moral injury as a term, and Nash brought science to the forefront in his expanded notion of combat and operational stress injuries.

The term “moral injury” and the science behind an understanding of the multidimensional stresses of combat merged in 2009 when Brett Litz and his colleagues devised a clinical science model of moral injury. The model expanded upon Shay’s moral injury criteria to include the *agentic* responsibility of the warrior, noting the individual soldier’s role in participating in acts of commission or omission that transgress one’s deeply held moral beliefs.

Growing awareness of moral injury was not limited to the scientific domain. In 2014, *Huffington Post* published a three-part series on moral injury (Wood, 2014a, 2014b, 2014c), adding to the scattered resources on moral injury already existent in the public media (see also Bica, 2014; Brennan, 2012; Dao, 2011; Hynes, 2013; Junger, 2013; Miller-McCune, 2011; Tick, 2014; Van Buren, 2014). 2016 marked the release of the American documentary *Almost Sunrise* (Collins), detailing the spiritual healing process of two Iraq veterans battling the moral injuries of war. Additionally, in 2010, the Navy and Marine Corps acknowledged the moral consequences of war in an updated version of their Combat and Operational Stress Control (COSC) field manual, stating that stress injuries in the form of “inner conflict” develop “due to moral damage from carrying out or bearing witness to acts or failures to act that violate deeply held belief systems” (p. 1-11).

Looking at this media and military attention, it is evident that Litz and his colleagues’ (2009) model of moral injury sparked a new era of conceptualizing
the moral dimension of trauma not only in the field of traumatic stress but also in the public sector and in military institutions. Yet, their work garners a fundamental question: is the moral dimension of trauma needed?

Is Moral Injury Needed?

Researchers of moral injury have noted the dominance of the fear-based model of traumatic stress in both past and current conceptualizations of the consequences of trauma (Drescher et al., 2011; Farnsworth et al., 2014; Frankfurt & Frazier, 2016; Litz et al., 2016; Litz et al., 2009; Nash, 2019; Vargas et al., 2013). The fear-based model of traumatic stress postulates that a traumatic threat to one’s livelihood evokes a fear reaction in the trauma survivor, and this fear reaction is sustained over time through encounters with stimuli that trigger memories of the life-threat trauma and re-evoke the fear reaction in the survivor. Fear-based mechanisms of distress can explain the consequences of life-threat traumatic experiences, yet not all traumatic experiences lead to fear reactions, and not all traumatic experiences involve threats to one’s livelihood. Focus on life-threat traumas and fear-based mechanisms of distress obscures recognition of the experiences and distress of those involved in traumatic events with moral and spiritual implications. For example, in combat, trauma exposure arises not only through being the direct or indirect victim of violence but also through being the direct or indirect perpetrator of violence.

Furthermore, individuals who have endured perpetration-based and morally injurious traumatic experiences encounter sequelae that are distinct from the sequelae encountered by those with life-threat traumatic experiences. While
life-threat traumas typically arouse fear and elicit hyperarousal difficulties and symptoms of PTSD, perpetration-based and morally injurious traumas tend to be characterized by feelings of shame, guilt, anger, and/or self-blame and elicit reexperiencing, avoidance, self-injurious behavior, and meaning making difficulties, including spiritual struggles and a shattering of one’s assumptive and/or spiritual world (Antal & Winings, 2015; Currier et al., 2019; Drescher et al., 2011; Farnsworth et al., 2014; Frankfurt & Frazier, 2016; Griffin et al., 2019; Harris et al., 2015; Held et al., 2019; Hodgson & Carey, 2017; Kopacz et al., 2016; Kopacz et al., 2015; Litz et al., 2009; Maguen & Litz, 2012; Neria & Pickover, 2019; Sreenivasan et al., 2014; Starnino et al., 2019; Steinmetz et al., 2019; Sullivan & Starnino, 2019; Vargas et al., 2013; Yeterian et al., 2019; Zerach & Levi-Belz, 2019).

The distinctions between life-threat and morally injurious traumatic experiences and their subsequent distinct expressions of distress deserve attention, as the characteristics of the recent wars in Afghanistan and Iraq are particularly conducive to morally questionable or ethically ambiguous situations. Counterinsurgency guerilla warfare, especially in urban contexts, involves unconventional features “that produce greater uncertainty, greater danger for non-combat troops, and generally greater risk of harm among non-combatants” (Litz et al., 2009, p. 696). The conditions also yield a greater likelihood of service members using their weapons, acting unnecessarily aggressive with enemy or civilian non-combatants, violating rules of engagement, being aware that they killed a member of the enemy troops, and being aware that they killed or harmed
non-combatants (Drescher et al., 2011; Kopacz et al., 2016; Sreenivasan et al., 2014; Starnino et al., 2019; Sullivan & Starnino, 2019; Vargas et al., 2013). The use of guerilla warfare, along with the fact that combatants are deployed for longer periods of time, means there is a greater likelihood that service members will encounter a potentially morally injurious traumatic experience (Litz et al., 2009; Vargas et al., 2013).

The increased moral ambiguity in recent wars is not an unfounded observation. There are a handful of significant and relevant statistics from the Mental Health Advisory Team’s (MHAT-V; 2008a) survey with soldiers involved in Operation Iraqi Freedom (OIF) that support the fact that the characteristics of recent wars are more likely to produce potentially morally injurious experiences. Most notably, 60% of surveyed soldiers reported seeing dead bodies or human remains, 72% reported knowing someone seriously injured or killed, and 61% reported seeing destroyed homes or villages (MHAT-V, 2008a, p. 37). Of OIF soldiers surveyed in 2007, 33% reported insulting and/or cursing non-combatants in their presence, 14% reported damaging and/or destroying private property when it was not necessary, and 6% reported physically hitting/kicking a non-combatant when it was not necessary (MHAT-V, 2008a, p. 32). The Mental Health Advisory Team’s (2008b) survey with soldiers involved in Operation Enduring Freedom (OEF) reveals similar numbers. 59% of surveyed soldiers reported seeing dead bodies or human remains, 74% reported knowing someone seriously injured or killed, and 50% reported seeing destroyed homes or villages (MHAT-V, 2008b, p. 165). Of OEF soldiers surveyed in 2007, 37% reported
insulting and/or cursing non-combatants in their presence, 10% reported
damaging and/or destroying private property when it was not necessary, and 4%
reported physically hitting/kicking a non-combatant when it was not necessary
(MHAT-V, 2008b, p. 162). Additionally, about 40% to 50% of OIF soldiers and
65% of OIF Marines reported killing an enemy combatant, about 12% to 15% of
OIF soldiers and 28% of OIF Marines reported killing a non-combatant, and a
Rand Corporation population-based survey of all deployed OIF and OEF veterans
found that 5% reported being directly responsible for deaths of civilians and 5%
reported witnessing brutality toward civilians (Frankfurt & Frazier, 2016).

Thus, post-9/11 soldiers are returning home from war having perpetrated,
failed to prevent, and/or borne witness to wartime atrocities. But service providers
did not have a clear conceptual apparatus or tools to help the returning soldiers
understand and cope with the experiences of potentially morally injurious events.
PTSD only accounts for the fear-based dimension of their distress, leaving out the
moral dimension, and the techniques used to treat distress after a fear-based
traumatic event are less effective at treating the guilt, shame, and spiritual distress
now understood to be prevalent in presentations of moral injury (Blinka & Harris,
2016; Drescher et al., 2011; Farnsworth et al., 2014; Griffin et al., 2019; Hodgson
& Carey, 2017; Jones, 2018; Kopacz et al., 2016; Kopacz et al., 2015; Litz et al.,
2009; Meador & Nieuwsma, 2018; Steinmetz et al., 2019; Vargas et al., 2013).
Not only was there no conceptual language, but clinicians were not trained to deal
with these moral dilemmas and may not have known how to deal with them (Litz
et al., 2009). The lack of attention paid to the moral dimension of returning
soldiers’ distress concerns moral injury researchers because combat guilt has been found to be the most significant predictor of both suicide attempts and preoccupation with suicide (Maguen & Litz, 2012). Events that transgress one’s moral beliefs are also associated with an increased risk of suicidal ideation, suicide attempts, and more intense suicidal crises (Blinka & Harris, 2016; Griffin et al., 2019).

Not surprisingly, interest in the concept of moral injury has been increasing. Since 2009, 243 scientific articles on the refined concept of moral injury have emerged, according to a PsychINFO search of article abstracts from the years 2009 to 2019 that contain the term “moral injury.” To compare, a PsychINFO search of “moral injury” in article abstracts without any publication year limiters (i.e., articles published before 2009 to the present) garners a total of 248 articles. Of these scientific articles, it is of relevance to note that 106, nearly half, were published within the years of 2018 and 2019. There is an increasing demand for more knowledge about the moral impact of war, and this demand is necessary because of the following: the dominance of the fear-based model of traumatic stress does not adequately account for traumatic experiences that are not life-threatening; the actual sequelae of persons suffering from life-threat versus moral traumas are distinctly different; the distinct features of recent wars in Iraq and Afghanistan put soldiers returning home from war at an increased risk of perpetrating or witnessing acts that transgress their moral beliefs; and soldiers are at a much higher risk of suicide because we are unable to help them cope with their morally rooted distress.
Moral Injury Versus PTSD

Empirical research provides evidence that different types of traumas produce different responses, yet one may still question how exactly the trauma responses differ. This section provides a brief review of how moral injury and PTSD can be distinguished using different psychological, biological, neurological, and phenomenological explanatory models. The two also differ in diagnostics and symptom identification.

Psychological Explanatory Models

Comparative research finds differences in the cognitive mechanisms underlying moral injury and PTSD. In particular, social-cognitive theory explains that the emotions experienced by those diagnosed with PTSD are maintained by different cognitive mechanisms than the emotions experienced by those with moral injury. According to social-cognitive theory, emotions associated with PTSD – including fear, anxiety, and sadness, along with alterations in safety, trust, esteem, and control – are considered natural emotions that emanate directly from the physical and affective experience of the trauma itself (Bryan et al., 2018; Litz et al., 2009). In comparison, the emotions associated with moral injury – including shame, guilt, and anxiety – are manufactured emotions emerging from an individual’s thoughts about and interpretations of the traumatic event (Bryan et al., 2018; Litz et al., 2009).

Differences also exist in the types of cognitions made by those diagnosed with PTSD and those with moral injury. Individuals diagnosed with PTSD make descriptive cognitive judgments, whereas those with moral injury make
prescriptive ones (Farnsworth, 2019; Farnsworth et al., 2017). Descriptive cognitions convey “the way things are in terms of nature or causal relationships,” and because these thoughts are about the nature of an object or event, they can be contrasted against concrete evidence and be considered falsifiable (Farnsworth, 2019, p. 375). Prescriptive cognitions are “a person’s judgment about what morally ought to be” and are tied to what an individual believes to be morally preferable regardless of whether those beliefs are actually reflected in reality (Farnsworth, 2019, p. 375).

**Biological and Neurological Explanatory Models**

The use of biological and neurological explanatory models can also differentiate moral injury and PTSD. At the most basic level, researchers postulate that life-threat and morally injurious traumatic experiences result in different physiological reactions. For example, in life-threat traumatic experiences, normal stress responses such as hyperarousal, increased epinephrine, and increased blood flow to muscles are intensified due to the hyperattention produced from activation of the hypothalamic/amygdalic-pituitary adrenal axis (Jinkerson, 2016). Because of the increased attention and elevated arousal, stimuli associated with the life-threat experience can become associated with the amplified stress state. Future exposure to associated stimuli can, thereby, cause stress reactions similar to those experienced during the initial life-threat traumatic event, resulting in symptoms of PTSD (Jinkerson, 2016). Moral injury, in comparison, does not develop through an experience of physiological distress.
Research also examines the neurological mechanisms underlying PTSD and moral injury. In one such related study, functional MRI (fMRI) results show variations and similarities in the brain regions involved in different types of PTSD-causing traumas, specifically combat-related traumas, sexual/physical abuse, and natural disasters. Though areas of greater activation were predominately in the right hemisphere for both the combat-related and sexual/physical abuse trauma groups, there was little to no overlap (Barnes et al., 2019; Boccia et al., 2016). The consequences of specific types of traumatic events are localized differently in the brain. This study does not address neurological differences between PTSD and moral injury, yet it provides evidence that different traumatic experiences in different contexts manifest differently in the brain. Another study corresponds with these findings: it compared the resting-state regional cerebral metabolic rate in veterans who have experienced danger- and/or fear-based traumas (i.e., life-threat) versus veterans who have endured non-danger-based traumas (i.e., witnessing violence, traumatic loss, and moral injury resulting from morally injurious acts perpetrated by oneself or from moral betrayal by another). Regions of interest were brain areas researchers have previously reported as being activated by fear stimuli, including the bilateral amygdala and the right rostral anterior cingulate cortex, and regions reported as being activated by traumatic script imagery, including the right dorsal anterior cingulate cortex, the left posterior cingulate cortex, and the left precuneus. Results show that veterans who had experienced danger- and/or fear-based traumas had higher metabolism in the amygdalae, whereas veterans who had experienced non-
danger-based traumas had higher metabolism in the precuneus, which is interestingly related to self-referential processing (Barnes et al., 2019; Held et al., 2019; Ramage et al., 2016).

Furthermore, another fMRI study of military veterans explored relationships between resting-state brain fluctuation activity (the amplitude of low-frequency fluctuation) and symptoms of PTSD and moral injury. Of the two types of moral injuries studied, moral transgressions made by the self and moral betrayals by others, both correlated with inferior parietal lobule activity, but in opposite directions. This region’s activity was not related to PTSD symptoms. Moral transgressions made by oneself were also positively correlated with the amplitude of low-frequency fluctuation in the fusiform gyrus and posterior insula, and moral betrayals by others were positively correlated with the amplitude of low-frequency fluctuation in the precuneus. Additionally, functional connectivity between the left interior parietal lobule and the bilateral precuneus was positively related to PTSD symptoms and negatively related to both types of moral injuries (Barnes et al., 2019; Sun et al., 2019). These results indicate that the neural correlates of PTSD and moral injury differ at least in part, particularly in the region of the left inferior parietal lobule, which acts as a major hub for integrating multisensory information inputs for comprehension and manipulation (Sun et al., 2019).

Overall, the biological and neurological explanatory models for moral injury and PTSD have found salient differences, providing additional evidence that the two are distinct constructs that differently affect regions of the brain and
bodily functions. The individual processes the “moral” and the “fearful” differently in the brain, suggesting that fear-based understandings of trauma miss something on the physiological and neurological level as well as on the psychological level.

**Phenomenological Explanatory Models**

Phenomenological explanatory models can further differentiate moral injury and PTSD. Theories of PTSD attempt to explain the phenomenology of individuals who have experienced harm by others and threats to their life, whereas moral injury attempts to acknowledge the distress produced by harming others (perpetration) and other moral transgressions (Litz et al., 2009). Veterans report that the subjective experience of killing in combat extends beyond the subjective experience of life-threat traumas. Beyond fear, some veterans’ experiences involve feelings of supremacy, physiological arousal, and transcendence, while others experience nausea or revulsion and feelings of guilt and shame (Farnsworth et al., 2017; Purcell et al., 2016). Veterans also experience ambivalence and confusion about killing after returning home from war, even when the killing was sanctioned by rules of engagement (Farnsworth et al., 2017; Litz & Kerig, 2019). Narrative analyses of veterans’ lived experiences with transgressions of their moral beliefs similarly show that the feelings experienced after a moral transgression are qualitatively different from those described by individuals diagnosed with PTSD (Drescher et al., 2011; Held et al., 2019; Sullivan & Starnino, 2019; Vargas et al., 2013). Thus, the PTSD construct only partially describes the development and subsequent sequelae of moral injury.
Diagnostics and Symptom Identification

Moving to the specifics of diagnostics and symptom identification, some moral injury researchers consider PTSD and moral injury to be diagnostically and symptomatically distinct (Bryan et al., 2018; Farnsworth, 2019; Farnsworth et al., 2017; Jinkerson, 2016). Criterion A for PTSD in the fifth edition of the *DSM* describes the features of a stressor that qualify the diagnosis of PTSD but does not list acts of perpetration. Rather, the stressor types detailed in PTSD diagnostics include exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence through direct exposure, witnessing the trauma, learning a loved one was exposed to the trauma, or through indirect exposure to aversive details of the trauma (5th ed.; *DSM-5*; American Psychiatric Association, 2013). Because PTSD has historically been framed as a victim-based, life-threat disorder, PTSD is applicable only to moral injuries occurring in the context of life-threatening trauma (Farnsworth et al., 2017; Litz & Kerig, 2019). Yet, as discussed previously, morally injurious events frequently are not life-threatening.

Differences in the descriptive and prescriptive cognitions in PTSD and moral injury, respectively (see Farnsworth, 2019), also distinguish moral injury from the diagnostic criteria of PTSD. The *DSM-5*’s Criterion D for PTSD “requires negative trauma-related beliefs, expectations and cognitions to be ‘exaggerated’ (D2) or ‘distorted’ (D3)” (Farnsworth, 2019; Farnsworth et al., 2017, p. 393). Cognitions are considered “exaggerated” or “distorted” when they are not consistent with factual events. Because descriptive cognitions make
factual claims about the empirical nature of an object or event (e.g., “The world is not a safe place”), they can be compared and falsified against existing data and experience. In other words, the cognitions described in Criterion D for PTSD are descriptive and falsifiable through treatment, unlike the prescriptive cognitions present in those with moral injury. Instead, prescriptive cognitions include thoughts of how the world ought to be, or what individuals believe to be morally right or wrong (e.g., “The world should be a safe place”), which cannot be evaluated as “exaggerated” or “distorted” because they are subjective judgments of moral righteousness and reflect personally chosen moral values.

One final difference between PTSD diagnostics and the features of moral injury concerns PTSD’s Criterion C. Criterion C, avoidance behaviors, is one of the two *DSM-5* criteria of PTSD also present in the features of moral injury (the other being Criterion B: intrusion symptoms) (Litz et al., 2009). Yet, there are differences in the function, or the purpose, of avoidance behaviors for those diagnosed with PTSD and those with moral injury. While PTSD avoidance behaviors serve as a defense to ease fear and safety concerns (i.e., those diagnosed with PTSD avoid stimuli and situations related to their life-threatening experiences due to fear for their personal safety), avoidance behaviors in moral injury are related to avoiding shame and guilt (i.e., those with moral injury avoid stimuli and situations related to their moral transgressions because of the shame and guilt they feel about violating their moral beliefs) (Farnsworth et al., 2017). For example, those diagnosed with PTSD and those with moral injury may both avoid public spaces; however, avoidance in PTSD is likely related to fear for
one’s livelihood in the public space, whereas avoidance in moral injury is likely related to an overwhelming feeling of shame for what one has done and a desire to avoid exposing others to one’s immorality. Though the avoidance behaviors in PTSD and moral injury appear to be the same, the avoidance behaviors in PTSD are a function of the fear individuals feel after experiencing a threat to their livelihood, whereas the avoidance behaviors in moral injury occur due to individuals’ feelings of moral inadequacy.

Thus far, I have discussed how moral injury does not adhere to the same diagnostic criteria as does PTSD. Now, I turn to how researchers symptomatically distinguish the two. Moral injury researchers propose separate, yet overlapping, symptom profiles of both constructs. The following symptoms are associated specifically with PTSD: “startle” reflex, memory loss, fear, and flashbacks (Bryan et al., 2018; Wood, 2014a). The following symptoms are associated solely with moral injury: anhedonia, grief, guilt, shame, social alienation, lack of trust, difficulty with forgiveness, and spiritual/existential conflict (Bryan et al., 2018; Drescher et al., 2011; Jinkerson, 2016; Vargas et al., 2013; Wood, 2014a). Both PTSD and moral injury, however, have been associated with anger, depression, anxiety, insomnia, nightmares, and substance abuse or self-medication with alcohol or drugs (Bryan et al., 2018; Wood, 2014a).

In support of these distinct characteristics, a study of the emotional health of journalists who covered the recent migrations of refugees across Europe found that, after measuring symptoms of PTSD, depression, and moral injury in journalists, symptoms of PTSD and depression were low, but those pertaining to
moral injury and guilt were prominent (Feinstein et al., 2018). This study is unique in that it targeted an experience that was distinctly morally injurious rather than life-threatening. Thus, the findings suggest that morally injurious experiences lead to distinct consequences and symptoms outside the purview of the consequences of life-threat traumas and the symptoms of the PTSD construct.

Though it remains to be determined whether moral injury should be codified as a distinct psychiatric category in the DSM, a question I will explore in later chapters, it is evident that the experience of moral injury has characteristics distinct from those of the PTSD construct. Researchers and service providers alike agree that the experience of moral injury is not adequately covered by PTSD diagnostic criteria and symptoms (Drescher et al., 2011; Kopacz et al., 2016; Kopacz et al., 2015; Litz et al., 2009).

**Military Culture and Mental Distress**

Overall, the idea of moral injury pushes beyond the perceived homogeneity of the fear-based model of trauma. It challenges the assumption of “traumatic equipotentiality,” “the assumption that all traumas and traumatic contexts are basically the same” (Litz et al., 2016, p. 23). Though early researchers of war trauma understood that military ethos and the context of combat play a role in service members’ and veterans’ feelings and expressions of distress after a traumatic experience (see Friedman, 1981; Lifton, 1973; Shatan, 1972), this contextual specificity is entirely lost in current conceptualizations of trauma. Instead, all types of traumatic stressors are supposedly contained within PTSD’s Criterion A, and the PTSD construct is taken to encompass the
consequences and distress experienced by individuals after any type of trauma and in any traumatic context. Yet, equalizing all traumas and traumatic contexts detracts from considering how different traumas and traumatic contexts might produce different psychological, biological, spiritual, social, and behavioral consequences. Because of the traumatic equipotentiality in the field, “there has not been an adequate consideration of the unique cultural and contextual elements of military trauma; the phenomenology of warriors; or the clinical issues that arise from combat and operational stressors, losses, traumas, and moral injuries” (Litz et al., 2016, p. 23). The moral injury model, thus, brings military context to the forefront in its conceptualization of service members’ and veterans’ experiences of distress.

Foremost, the moral injury model considers how military culture fosters a specific moral and ethical code of conduct that differs from the moral and ethical rules typically accepted in a civilian context. In war and combat, being violent and killing is sanctioned and normal, and military training prepares service members to participate in and bear witness to the violence and killing in war (Antal & Winings, 2015; Doehring, 2019; Drescher et al., 2011; Farnsworth et al., 2014; Harris et al., 2015; Litz et al., 2009). In order to survive in such a threatening and intense context, service members must be nonreactive, make quick decisions, put their lives at risk, and perform acts that would otherwise be illegal or unethical in most other contexts (Davies et al., 2019; Drescher et al., 2011; Farnsworth et al., 2014; Held et al., 2019). In military culture, when a leader tells you to do something, it is morally sanctioned. If you do not do what
the leader tells you to do, you and your whole unit could die. The actions warriors
perpetrate during war are adaptive and serve to protect both themselves and their
unit members, but that does not mean that these actions do not raise moral
questioning and moral emotions in warriors after the fact, nor does it mean that
warriors are exempt from making unanticipated moral choices and demands in
combat (Drescher et al., 2011; Farnsworth et al., 2014; Harris et al., 2015; Litz et
al., 2009; Sreenivasan et al., 2014). Most warriors are able to assimilate their
actions and the atrocities witnessed during war into their self- and world-schemas
because of their “training and preparation, the warrior culture, their role, the
exigencies of various missions, rules of engagement and other context demands,
the messages and behavior of peers and leaders, and the acceptance…by families
and the culture at large” (Litz et al., 2009, p. 697). However, once warriors return
home and reintegrate into civilian culture, they face a starkly different moral
system that firmly rejects the violence and killing viewed as normal or acceptable
during combat (Antal & Winings, 2015; Doehring, 2019; Farnsworth et al., 2014;
Held et al., 2019; Houtsma et al., 2017; Litz et al., 2009). The distinction between
the moral and ethical values ingrained in military culture versus civilian culture is
essential to understanding the moral dissonance that occurs in service members
and veterans after encountering a morally injurious experience at war. How can a
service member or veteran reconcile their moral values as a warrior with their
moral values as a civilian after perpetrating, failing to prevent, bearing witness to,
or learning about acts that transgress deeply held moral beliefs and expectations?
Moral injury researchers also explicitly respect “the warrior ethos” of service members and veterans, a “highly spiritual, though not religious, devotion to living by a set of core values for the good of others” (Litz et al., 2016, p. 42). There are several core values, guiding ideals, and ways of life in the warrior ethos that service members and veterans take up for the rest of their lives, including the dedication to live every day by a moral code; the dedication to defend the social order, which, in the United States, arguably means defending the Constitution; selflessness; a personal relationship with physical, mental, and emotional suffering; a personal relationship with death and embracing one’s fear of death; taking joy in fighting and being able to exercise emotional, mental, and physical self-control in fighting; and pride, including shared pride, or esprit de corps (Litz et al., 2016). Recognition of the warrior ethos accounts for the phenomenology of warriors in a way that is otherwise unaccounted for in the assumption of traumatic equipotentiality. Acknowledging the warrior ethos contextualizes researchers’ understandings of warriors’ distress and guides development of specific treatment strategies for warriors.

Underscoring the traumatic equipotentiality in dominant understandings of trauma makes evident that the field of traumatic stress is reductionist in its focus on life-threat traumatic stressors and fear-based mechanisms of distress. It is likewise reductionist in its failure to consider how the context of a traumatic event informs the phenomenology of trauma survivors and the consequences faced by survivors. Moral injury, thus, exposes the homogeneity of perceived consequences of trauma. Furthermore, recognition of the homogeneity of
perceived consequences of trauma is necessary because, as moral injury research has shown, service members and veterans are not receiving sufficient help for the spiritual and moral issues that remain outside of the dominant life-threat, fear-based model of trauma. Nor is the military culture that permeates warriors’ phenomenology considered in conceptualizations of war trauma. The moral injury model interrupts this homogeneity by proffering an additional way of looking at what constitutes a traumatic event and the consequences of such a traumatic event. It adds heterogeneity to the field of traumatic stress that is essential to account for the heterogeneity of traumatic experiences occurring in the world. However, the moral injury model is far from achieving the same visibility as the fear-based model of trauma in the field of traumatic stress and the larger clinical psychological community. The next chapter traces the scientific and empirical development of moral injury, examining how moral injury has attempted to gain greater visibility in the scientific community.
CHAPTER 2

Mechanisms of Visibility Under Scientific Development
Reliability, validity, measurement, and classification are four scientific practices necessary to hold a construct or theory as empirically sound. It is important to note that the idea of empiricism is tied to positivist and logical positivist epistemologies, which induce the idea of scientism – privileging the natural-scientific method as the only valid way to understand the world and solve social problems (Comfort, 2019; Zammito, 2004). Epistemology here refers to the assumptions that are taught, disseminated, refined, and applied within the context of clinical psychology (Hacking, 2007). Positivist and logical positivist epistemologies hold that theories may correspond with reality, and reality can be reproduced through value-free, atomistic observational language. More recently, many psychological researchers recognize the implausibility of pure objectivity in human observations of reality. Some have since migrated toward a post-positivist epistemology that recognizes the inescapable role of interpretation in science, regardless of researchers’ attempts at objectivity (Zammito, 2004).

Yet, conventional notions of reliability, validity, measurement, and classification still dominate psychological research (Neuman, 2006; Porter, 1994). Reliability, validity, measurement, and classification of a construct are necessary for the scientific community’s acceptance of the construct as representative of
reality (Hacking, 2007). This is the case with moral injury: researchers are attempting to achieve reliable and valid consensus on the definition of moral injury; measure what moral injury is, what constitutes a potentially morally injurious experience, and the outcomes (i.e., symptoms) of moral injury; and classify moral injury as a distinct kind of experience.

With this in mind, we can interrogate how moral injury research has attempted to gain visibility in the scientific community by utilizing these four mechanisms of scientific methodology: (1) reliability, (2) validity, (3) measurement, and (4) classification. In this chapter, I begin by examining the scientific reliability and validity of moral injury definitions, noting the lack of consensus concerning what moral injury is. Then, a review of the scales and self-report measures used to assess, quantify, and compare the severity, types, and dimensions of potentially morally injurious experiences and moral injury outcomes reveals how measurement tools attempt to bring visibility to moral injury research. Next, an exploration of attempts to classify moral injury as a syndrome/distinct kind showcases the way in which psychiatry enforces the classification of clinical kinds. The chapter concludes with an appraisal of trauma researchers’ critiques of the construct’s scientific development, which exposes doubts about its reliability, validity, measurement attempts, and pathological boundary conditions.

**Moral Injury and its Many Definitions**

Despite the dominance of Litz and his colleagues’ (2009) definition of moral injury, this is not the consensus definition of the construct. No strict
consensus definition currently exists, though some definitions are more similar than others. I postulate that the similarities and dissimilarities between moral injury definitions develop because of the uptake of moral injury by two distinct subfields of psychology: scientifically oriented clinical psychology and spiritually oriented pastoral psychology. Nevertheless, the binary is not so simple, and certain definitions combine both clinical and pastoral elements. The following overview describes the various definitions distinct to each subfield (clinical and pastoral psychology) and the definitions that show overlap between subfields.

Warranting attention, then, is how the multiplicity of moral injury definitions impacts the scientific reliability and validity of the construct.

“Clinical” Definitions

In clinical psychology, many of the moral injury definitions acknowledge the spiritual component of the construct, though spirituality tends to be one factor in a slew of other explanatory mechanisms. The clinical definitions generally present moral injury as a multidimensional clinical phenomenon (Forbes et al., 2015; Jinkerson, 2016; Litz et al., 2009; Nash et al., 2010). These definitions tend to locate the root of moral injury outcomes in some disruption of the individual’s cognitive framework, such as disrupted confidence and expectations, dysphoric emotions and cognitions, and internal conflict or cognitive dissonance (Davies et al., 2019; Drescher et al., 2011; Farnsworth et al., 2017; Forbes et al., 2015; Litz et al., 2009). Examples are as follows:

…changes in biological, psychological, social, or spiritual functioning resulting from witnessing or perpetrating acts or failures to act that
transgress deeply held, communally shared moral beliefs and expectations. (Nash et al., 2010, p. 1677)

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 acts that are inhumane, cruel, depraved, or violent, bringing about pain, suffering, or death of others. (Drescher et al., 2011, p. 9)

Moral injury is defined as a psychological state that arises from events and experiences associated with perpetuating, failing to prevent or bearing witness to inhumane or cruel actions, or learning about acts that transgress deeply held moral beliefs and expectations. Events associated with such transgressions and internal conflict leading to a moral injury can include acts of commission or omission, behaviours of others in the unit, bearing witness to human suffering or horrific acts of violence perpetrated by oneself or by others. (Forbes et al., 2015, p. 6)

The experience of dysphoric moral emotions and cognitions (e.g., self-condemnation) in response to a morally injurious event. (Farnsworth et al., 2017, p. 392)
In all of these definitions, moral injury is a predominately *psychological* phenomenon that affects the individual’s thoughts, behaviors, emotions, and moral beliefs.

*“Pastoral” Definitions*

Pastoral psychology, in comparison, tends to treat moral injury as a primarily *spiritual* wound, invoking philosophical and religious paradigms. Pastoral definitions move beyond a psychological framework and refer to the damage done to the soul and spirit, experiences of existential despair, ancient insights, God and the divine, conceptions of good and evil, and the moral self (Brock & Lettini, 2011; Doehring, 2019; Graham, 2017; Hodgson & Carey, 2017; Liebert, 2019; Moon, 2019; Ramsay, 2019; Yandell, 2019; Zust, 2015). Examples are as follows:

Moral injury is a wound in the soul, an inner conflict based on a moral evaluation of having inflicted or witnessed harm. It results from a capacity for both empathy and self-reflection on moral values, which means it happens to healthy human beings…Moral injury can result not only from active behavior, such as torturing or killing, but also from passive behavior, such as failing to prevent harm or witnessing a close friend be slain. And it can involve feeling betrayed by persons in authority. (Brock & Lettini, 2011, p. 1)

Military moral injury is a recent term that describes the ancient insight that, in addition to physical wounds, war wounds the souls of those who,
in combat, transgress otherwise deeply held values related to human life because they kill and maim one another and often innocent civilians. (Ramsay, 2019, p. 108)

Moral injury describes a trauma to the moral sensibility grounding our personhood, a trauma in which one’s moral moorings are so challenged that it is experienced as a wound to the very spirit. This wound comes from having transgressed one’s basic moral identity by violating a core moral belief or from having failed to do something that one’s conscience demands be done, or from having sustained blows to one’s spirit from another person or from the context in which one is living such that one’s moral compass is shattered. (Liebert, 2019, p. 42)

The most common forms of moral injury are the personal diminishment and moral challenges that result when individuals and communities recognize that they failed to live in accordance with their moral values. In these cases, moral injury refers to the impairment that results because we acted against our moral center and feel regret for what happened. (Graham, 2017, p. 82)

The moral and the spiritual are central to pastoral definitions. These definitions emphasize the spiritual hit one takes after transgressing moral beliefs rather than emphasizing biological or psychological mechanisms of distress, such as cognitive dissonance or a physiological stress reaction. The definitions, however,
are not confined to religious and spiritual explanatory models. Notions of inner conflict in the form of negative self-judgments, moral dissonance, and an array of affective and behavioral symptoms are present in pastoral definitions of moral injury, just as existentialism and spirituality feature in clinical definitions of moral injury. We now turn toward these binary-breaking definitions.

**Binary-breaking Definitions**

It would be reductionist to claim that one can sort all moral injury definitions into the two subfields of clinical and pastoral psychology. Instead, the subfields I define provide an elementary framework for considering similarities and differences in moral injury definitions. Yet, this framework is frequently broken and dismantled by definitions that incorporate both spiritual and clinical elements. Certain pastoral psychologists use clinical terms in their descriptions of moral injury, and certain clinical psychologists use pastoral terms. For example:

Moral injury is a negative self-judgment based on having transgressed core moral beliefs and values or on feeling betrayed by authorities. It is reflected in the destruction of a moral identity and loss of meaning. Its symptoms include shame, survivor guilt, depression, despair, addiction, distrust, anger, a need to make amends and the loss of a desire to live. (Brock et al., 2012, p. 1)

…experiences of serious inner conflict arising from what one takes to be grievous moral transgressions that can overwhelm one’s sense of goodness and humanity. (Sherman, 2015, p. 8)
Moral injury originates (1) at an individual level when a person perpetuates, fails to prevent or bears witness to a serious act that transgresses deeply held moral beliefs and expectations which leads to inner conflict because the experience is at odds with their personal core ethical and moral beliefs, and/or (2) at an organisational level, when serious acts of transgression have been caused by or resulted in a betrayal of what is culturally held to be morally right in a ‘high-stakes’ situation by those who hold legitimate authority. (Carey et al., 2016, p. 1220)

Moral injury, therefore, may represent an existential, spiritual ‘hit’ taken by the solider. (Sreenivasan et al., 2014, p. 28)

Of these examples, the first three definitions come from pastoral psychologists, whereas the last comes from a group of clinical psychologists. Of relevance are references to negative self-judgment, clinical symptoms, and transgressions of moral beliefs and expectations leading to inner conflict in the former definitions, along with spiritual notions of morality and the mention of the existential and spiritual “hit” of moral injury in the latter definition. The multidisciplinary nature of these definitions results from the crossover between pastoral and clinical epistemologies, thus breaking boundaries between the scientific and the spiritual. The binary-breaking definitions showcase how these two schools of thought can merge to create more holistic and dynamic conceptions of what moral injury is.

Reliability and Validity
Though the multitude of definitions evidences the diversity in moral injury research, it also stains the scientific reliability and validity of the moral injury construct. Critiques of the current scientific state of moral injury are directly related to the lack of a strict consensus definition of the construct (Frankfurt & Frazier, 2016; Griffin et al., 2019; Hodgson & Carey, 2017). A consensus definition gives rise to external reliability, or consistency of a construct, entity, or measurement across various tests (Neuman, 2006). Without consensus, a scientific concept cannot be reliable because the concept being tested might not be the same in the minds of various researchers. Further, without a consensus definition, researchers cannot conduct uniform validity tests to confirm that the concept represents a natural phenomenon observed in reality. Instead, tests of validity without a strict consensus definition would work to validate different versions of the moral injury construct. In other words, without a consensus definition, a scientific concept cannot be reliably tested or considered valid. In scientific research, the lack of sufficient reliability and validity is particularly problematic because both are important in establishing the truthfulness, credibility, and believability of a concept (Neuman, 2006). Thus, given the scientific importance of reliability and validity, moral injury cannot be granted adequate visibility in the scientific community without consensus on a definition.

**From Abstract to Measurable: The Operationalization of Moral Injury**

A third scientific mechanism working to bring visibility to moral injury is measurement. To date, there are four prominent multidimensional psychometrics used to measure two aspects of the moral injury construct: potentially morally
injurious experiences and moral injury outcomes. More specifically, these scales attempt to reliably define what types of potentially morally injurious experiences exist and the types of symptoms one may have following a potentially morally injurious event. These tools aim to give moral injury greater visibility in the scientific community, which is necessary for the construct to remain alive in the field of clinical psychology.

**Moral Injury Events Scale**

The Moral Injury Events Scale (MIES; Nash et al., 2013) is the first measure to assess multiple dimensions of moral injury in a military population. The scale has nine-items and assesses three dimensions of moral injury: transgressions by self (three items), perceived transgressions by others (three items), and perceived betrayal by others (three items). In these three dimensions of moral injury, the MIES assesses both the types of potentially morally injurious events one might endure (i.e., witnessing acts of commission, perpetrating acts of commission, or perpetrating acts of omission) and moral injury symptoms (i.e., feelings of distress over acts of commission, omission, or betrayal). The greatest strength and the greatest weakness of the MIES is that it measures both the incidence of transgressive events and the symptoms associated with those events. Including events that might be the cause of moral injury symptoms makes it excellent as a screening measure, as it identifies specific events that might be the target of interventions (Koenig et al., 2019). The inclusion of events, however, means that the MIES might be less useful in intervention studies assessing changes in moral injury symptoms over time; the inclusion of morally injurious
events in the MIES complicates the assessment of MI symptom change in response to treatment (Koenig et al., 2019). The scale works by measuring morally injurious events and their subsequent symptoms. To assess symptom change over time, the symptoms would need to be assessed apart from the event which sparked their manifestation, and the MIES does not separate the two.

*Moral Injury Questionnaire-Military Version*

The Moral Injury Questionnaire-Military Version (MIQ-M; Currier et al., 2015) is the second multidimensional scale developed specifically to assess moral injury in military populations. The scale contains 19 items and is made up of a single factor that assesses numerous aspects of moral injury, including both potentially morally injurious events and the symptoms that result from those events (similar to the MIES). Events include acts of commission involving betrayal of personal values, acts of revenge or retribution, witnessing or committing moral violations, and witnessing or involvement in the death of innocents or fellow soldiers. The symptoms assessed include feelings of betrayal by others or self, guilt over failing to protect others, guilt for surviving when others did not, and feeling changed from experiences had during war. Like the MIES, the greatest strength and weakness of the MIQ-M is that it measures both the occurrence of transgressive events and the symptoms resulting from such events. Thus, it works well as a screening measure, but it cannot measure changes in moral injury symptoms over time.

*Moral Injury Symptoms Scale-Military Version*
The Moral Injury Symptoms Scale-Military Version (MISS-M; Koenig et al., 2018) is the first multidimensional scale that measures both the psychological and spiritual/religious symptoms of moral injury, and it comprehensively measures moral injury symptoms alone. The 45-item MISS-M-LF (long form) assesses 10 dimensions of moral injury symptoms that capture both the psychological and the spiritual/religious symptoms of the construct. Each dimension of the MISS-M-LF was chosen based on the definitions of moral injury reported in the literature, and the items making up the scale were derived largely from existing scales published in the literature. The MISS-M-LF assesses eight psychological symptoms: guilt (four items), shame (two items), betrayal (three items), moral concerns (three items), loss of meaning and purpose (four items), difficulty forgiving (seven items), loss of trust (four items), and self-condemnation (10 items). The scale assesses two spiritual and religious symptoms: religious struggles (six items) and loss of religious faith and hope (two items). All items are rated on a scale from one to 10. Additionally, to facilitate efficient use by clinicians and researchers, an abbreviated version of the MISS-M was developed. The 10-item MISS-M-SF (short form) assesses the same 10 dimensions as the 45-item MISS-M-LF, but it does so with only one item per dimension (Koenig et al., 2019). Because the MISS-M-LF and MISS-M-SF measure symptoms alone, the scales can be used to track symptom severity over time. They can, therefore, be used in both clinical practice and to conduct research that examines treatment strategies for service members and veterans that specifically target moral injury symptoms.
Expressions of Moral Injury Scale-Military Version

The Expressions of Moral Injury Scale-Military Version (EMIS-M; Currier et al., 2018) is another multidimensional scale that comprehensively measures moral injury symptoms alone. The EMIS-M includes 17 items and assesses the symptoms of moral injury across two dimensions: self-directed and other-directed moral injury. The self-directed subscale measures symptoms of guilt, shame, moral concerns, self-condemnation, social withdrawal, and inability to forgive oneself. The other-directed subscale measures anger and feelings of betrayal, revenge, and disgust over what others have done. The EMIS-M is a solid measure of the psychological symptoms of moral injury, though it does not assess the spiritual or religious symptoms, in contrast to the MISS-M. Regardless, because the EMIS-M measures solely the symptoms of moral injury, it can be used by clinicians to track symptom change over the course of treatment and by researchers to assess the efficacy of interventions targeting moral injury (Koenig et al., 2019).

Reliance on Measurement in Science

The scales described above are all psychometrics of morally injurious events and moral injury outcomes used by clinicians and researchers to reliably validate and quantify the prevalence, dimensions, and severity of moral injury. How do these psychometric tools help give moral injury scientific visibility? We can learn from critical historical examinations of the intelligence test.

The development of the intelligence test during World War I (WWI) is an example of “what can happen when members of a particular scientific
community, in this case American psychology, must persuade a different
community, the military, of the value and authority of their knowledge and
practices” (Carson, 1993, p. 278). The intelligence test was proffered to supplant
elite judgments with a simpler, objective, and reliable, one-number quantitative
measure. The expertise and authority of the psychologist became embedded in the
psychologist’s psychometric tools. The simplification of assessment methods into
numbers and statistics allowed for more effective widespread administration of
the intelligence test to the entire army, while still maintaining the objectivity of
scientifically supported assessment. It also allowed for quick testing and effective
widespread comparison of intelligence between groups. As the military accepted
this precise, test-based standard for intelligence, the authority of psychology’s
scientific testing of intelligence grew (Carson, 1993). Yet, to this day, can one
explain what intelligence really is? There is an abundance of intelligence tests to
assess and categorize individuals, but what are these tests really testing for? The
test made intelligence “real” in the sense that Edwin Boring stated in 1923:
intelligence is what the intelligence test tests.

Measurement, which allows for differentiation between individuals and
populations, gives psychology the certainty and exactness of the physical
sciences. It is assumed to allow researchers to discover the consistency of mental
processes, their interdependence, and their variation under different conditions
(Rose, 1985). Experimental psychologists and champions of psychometrics abide
by the idea that the phenomena of any branch of knowledge cannot assume the
status and dignity of science until submitted to measurement and number (Stark,
2018). Moral injury, by these assumptions, cannot achieve true scientific value until measured and quantified. That is exactly what the previously described moral injury scales attempt to do: they simplify measures of morally injurious events and moral injury outcomes into numbers, allow researchers to retest and compare these numbers over time, and can differentiate morally injurious events and moral injury outcomes in both individuals and populations. Despite the construct’s lack of a consensus definition, the scales attempt to make moral injury objectively observable across varied contexts, across a wide range of individuals, and across time. Without these scales, researchers would not be able to reliably identify moral injury in reality. Just as the intelligence test brought intelligence into the world as a real and universal phenomenon, the measurement of moral injury attempts to bring visibility to the construct as a real phenomenon experienced by a wide range of individuals.

However, though psychometrics for moral injury exist, they do not have the content validity, scope, or reliability necessary to be constituted as “good enough science” in the clinical psychological community. Therefore, three novel psychometrics for moral injury are currently in development: the Perpetration-Induced Distress Scale (PIDS), the Moral Injury Scales for Youth (MISY), and the Moral Injury Outcome Scale (MIOS). The PIDS focuses on extending moral injury to nonmilitary populations, the MISY extends the construct to youth populations, and the MIOS ensures content validity and attempts to distinguish the boundary conditions of moral injury as a clinically severe problem (Chaplo et al., 2019; Steinmetz et al., 2019; Yeterian et al., 2019). All three psychometrics
are being tested using mixed qualitative and quantitative methodologies and scientifically rigorous protocol. Making these measures as precise, valid, and reliable as possible ensures that they help moral injury garner visibility in the scientific community.

**Classifying of Clinical Kinds**

The previous sections make evident the importance of scientific reliability, validity, and measurement in psychological research. The fourth scientific mechanism working to make moral injury visible is classification. Thus far, moral injury has evaded becoming a categorical, medicalized diagnosis in the *DSM*, the bible of United States psychiatry (Anand & Malhi, 2011; Pickersgill, 2012). Though some researchers (Jinkerson, 2016; Jinkerson & Battles, 2019) have proposed a formal moral injury syndrome, few moral injury researchers advocate for the syndrome approach. Many are hesitant to codify moral injury into a distinct psychiatric syndrome: they express concerns about thinking of moral injury as a clinical condition and thus medicalizing and pathologizing normal responses to moral conflicts (Farnsworth et al., 2017; Farnsworth et al., 2014; Litz & Kerig, 2019; Litz et al., 2009; Nash, 2019; Nieuwsma et al., 2015).

Nevertheless, for moral injury to be viable and useful, it is assumed that the boundary conditions and features of the construct must be specified and found to have construct validity; “[i]n the clinical realm, this means that MI [moral injury] needs to be defined as a reliably measured syndrome” (Litz & Kerig, 2019, p. 344). Let us turn, then, to further examine the rise of this reliance on classification in clinical psychology.
Reliance on Classification

The regime of medicine arose as a collective effort to “enhance” society, and medicalization served as a means to discipline and control persons of the state and the city, along with poor people and labor workers (Foucault, 1974/2001). Medicalization here refers to the extension of medical authority to more aspects of human life that were not previously considered pathological (Rose, 2007a). As medical authority became prevalent in the everyday lives of individuals, individuals’ minds and bodies increasingly became objects of observation and control (Foucault, 1963/2003; Rose, 1990). Individualistic views of the mind and body soon became assimilated into psychiatric practice. Most notably, psychiatry came to focus on the individual as the locus of pathology and responsibility. Psychiatry, then, began to distinguish between those exhibiting deviant traits antithetical to the tenets of modern society and those seemingly “normal” individuals.

However, to effectively discipline deviants in American society, psychiatrists needed a standardized way to classify many different people: there needed to be a unified diagnostic system to determine the rates and different kinds of psychiatric illness (Suríš et al., 2016). Thus, in 1952, the American Psychiatric Association (APA) released its first version of the DSM; though at this point, it had not established reliability and validity of the disorders it described (Suríš et al., 2016). It was with the publication of the DSM-III that psychiatric disorders became “evidence-based” and formally operationalized under the medical model. Emil Kraepelin, the father of modern scientific psychiatry, wanted to prove a
biological basis for all psychiatric disorders and attempted to classify disorders into common patterns with distinct boundaries (Granek, 2010). With the authority of empiricism and the methods of the natural sciences, the *DSM* became a legitimate tool of scientific evaluation and expertise in a positivist society.

Today, psychiatric classification influences our everyday lives. Psychiatric classification does not just encompass traditional mental disorders, such as depression and schizophrenia, it also includes neurogenerative disorders (e.g., Alzheimer’s disease), complaints such as anxiety and panic, more recent diagnoses (e.g., dyslexia), and conditions like addiction, substance abuse, and obesity, which some do not consider mental disorders at all (Rose, 2019). In attempting to discipline individuals in our society, psychiatrists, under the authority of medicine, label, classify, and examine different “types” of people (Hacking, 2007). However, in current psychiatric practice, rather than label, classify, and examine only the most severely distressed and dangerous persons in society, psychiatrists have been extending the boundaries of pathology to include reactions and experiences typical of everyday life (Rose, 2019). The extension of pathology is evident in the growing number of mental disorders included the *DSM* with each new addition: 180 categories in 1968, 292 in 1987, and 350 in 1994 (Lane, 2010; Rose, 2019).

Now, in the United States, the *DSM* is the main mechanism dictating which patients receive help and which researchers receive funding and get published. To be covered by insurance and thus reimbursed for mental health treatment, one must have a *DSM* diagnosis (Rose, 2019). Until recently, if
psychiatrists hoped to receive funding for their research, they needed to use DSM diagnoses in their grant applications (Rose, 2019). To be published in scientific journals, psychiatrists had to select the subjects of their research and present their findings using DSM diagnoses (Rose, 2019). In essence, the DSM dictates what kinds of mental health problems deserve attention and treatment. The visibility of moral injury is, therefore, contingent on its classification.

**Doubts About Moral Injury**

Overall, critiques of moral injury focus mainly on threats to moral injury’s reliability and internal and external validity. Critics within the field of traumatic stress note the absence of a consensus definition, disagreement about what does and does not constitute a potentially morally injurious event, lack of a theoretically comprehensive and psychometrically sound measure of morally injurious outcomes, minimal study outside of military-related contexts, clinical investigations weakened by small sample sizes and unclear mechanisms of therapeutic effect, and the lack of defined boundary conditions distinguishing pathological moral injury from normal experience (Frankfurt & Frazier, 2016; Griffin et al., 2019; Litz & Kerig, 2019; Neria & Pickover, 2019). These critiques can be alternatively framed as calling moral injury research “not good enough science” because the scientific mechanisms working to make moral injury more visible are not precise enough, not established enough, and not up to the standards of the physical sciences. Moral injury is an uncertain psychological kind, and the science behind it reverberates this uncertainty. Researchers’ critiques of the construct, thus, call for greater certainty in moral injury and the science behind
the construct. Nevertheless, in making these critiques, researchers fail to recognize the inescapability and benefits of uncertainty. The next chapter offers an alternative perspective, one that embraces scientific uncertainty over reliability, validity, measurement, and classification.
CHAPTER 3
The Uncertainty of Clinical Kinds
The Uncertainty of Clinical Kinds

*Reality is the raw material, language is the way I go in search of it – and the way I do not find it. But it is from searching and not finding that what I did not know was born, and which I instantly recognize.*

- Clarice Lispector, *The Passion According to G.H.*

The previous chapter detailed four scientific mechanisms working to bring moral injury visibility in the clinical community. While these mechanisms are crucial to dominant positivist conceptions of scientific certainty, they are not the only way to produce objective science. In a post-positivist framework, uncertainty in the scientific process has the potential to perform a critical role in the continuation of scientific knowledge production and making more objective clinical kinds of ways of being. Here, uncertainty refers to psychological researchers’ uncertainty regarding the methods used to understand a psychological kind and researchers’ uncertainty about whether they have fully grasped a phenomenon. This chapter takes up the role of uncertainty in scientific research. First, an examination of three clinical kinds of ways of being (psychopathy, grief, and passive-aggressive personality disorder) illustrates how the “certainty” of the *DSM* and the medical model does not necessarily lead to more objective clinical kinds. Then, the introduction of alternative frameworks for understanding objectivity in scientific kinds showcases the virtues of scientific uncertainty.
Thus, let us first look at the case of a psychological construct that functions as a more thorough diagnostic tool than its *DSM*-codified counterpart, along with two cases that show how the *DSM* does more harm than good in its pathological distortion of normal reactions to everyday life. These cases inform the idea that the inclusion of moral injury in the *DSM* would not make the construct more objective.

**Psychopathy**

Conceptions of psychopathy, like those of the moral impact of war, existed before the creation of a specified psychiatric disorder and set the foundation for the official clinical disorder of antisocial personality disorder (ASPD). Yet, psychopathy remains outside clinical classification systems.

Psychopathy and the Psychopathy Checklist-Revised (PCL-R; Hare, 1980, 1991, 2003) provide more comprehensive diagnostic guides in research and practice in the same way that the moral injury construct and its scales do: they each encompass aspects of individuals’ behaviors and feelings of distress that their formal diagnostic counterparts do not. Thus, with psychopathy and ASPD, we see something similar to moral injury and PTSD. Psychopathy and moral injury are both clinical constructs outside of the *DSM* that have operational measurement scales to ensure their validity, whereas ASPD and PTSD are diagnostic categories that, while encompassing aspects of psychopathy and moral injury, respectively, fail to get at the specifics of these niche experiences and fail to inform treatment strategies that target these experiences.
Just as PTSD was assumed to account for all traumatic experiences and subsequent consequences, ignoring warriors’ moral dimensions of distress, so ASPD was believed to account for all psychopathic traits and behaviors, ignoring differences in those with antisocial personalities and psychopathic personalities. The first definitive conception of psychopathy in the United States came from psychiatrist Hervey Cleckley during the mid-twentieth century. Cleckley considered psychopaths to be superficially charming, often intelligent individuals, who had shallow emotional depth and engaged in antisocial, occasionally violent, behavior (Pickersgill, 2012). The *DSM-I*, published in 1952, took up the problem of psychopathy under the category of Sociopathic Personality Disturbance, which was divided into three diagnoses: antisocial reaction, dissocial reaction, and sexual deviation (Kiehl & Hoffman, 2011). With the publication of the *DSM-II* in 1968, the diagnoses of antisocial reaction and dissocial reaction were lumped together into the single category of antisocial personality (Kiehl & Hoffman, 2011). During this time, psychopathy was assumed to be equivalent to antisocial personality, and this assumption persisted into the 1980s with the publication of the *DSM-III*.

At the same time, early in 1980, Robert Hare, heavily influenced by Cleckley, created the Psychopathy Checklist (PCL) to measure and validate the presence of psychopathy in individuals. Hare’s psychopathy research and creation of the PCL sparked further diagnostic interest in the construct and laid the foundation for the latest ASPD diagnosis in the *DSM-III* (Pickersgill, 2012). Despite contestations from researchers claiming that antisocial personality and
psychopathic personality were fundamentally different entities and developed for
different reasons, the psychopath became codified into the descriptive, symptom-
based syndrome of ASPD, which represented the standard antisocial individual
(Pickersgill, 2012). Even in the revised fourth edition of the *DSM (DSM-IV-TR)*,
published 20 years after the *DSM-III*, the ASPD diagnostic criteria states that the
behavior covered by the diagnosis might also be referred to as psychopathy
(Pickersgill, 2011).

Elsewhere, however, the two classifications were presented differently,
taken to be fundamentally distinct categories with different explanatory
frameworks as to why the personality developed. Hare’s (1991, 2003) revised
Psychopathy Checklist differentiated the characteristics of psychopathy and
ASPD. In Hare’s view, only a few individuals diagnosed with ASPD could also
be considered psychopathic (Hare et al., 1991; Pickersgill, 2011). The ASPD
diagnosis fixates on the behavioral indicators of an antisocial personality,
ignoring the affective traits of a psychopath that center around an innate lack of
moral sensitivity (Kiehl & Hoffman, 2011). Because of this fixation on behavioral
indicators, ASPD encompasses many different individuals with antisocial
behaviors, but many of these individuals lack the affective personality traits of a
psychopath (Kiehl & Hoffman, 2011). Hare’s PCL-R allowed clinicians and
researchers to differentiate those labeled with ASPD who also possessed the
affective traits of a psychopath from those with ASPD who lacked those traits.
Neuroscience research further distinguished the constructs by finding the origins
of antisociality in psychopaths as neurodevelopmentally distinct from individuals not meeting PCL-R criteria for psychopathy (Pickersgill, 2011).

Psychopathy, like moral injury, did not have a consensus definition of the construct, yet clinicians found the PCL-R to be more useful than an ASPD diagnosis to employ in research and practice: it can parse out the differences between psychopathy and ASPD and better distinguish between the underlying motivators of antisocial behavior and psychopathic behavior (Kiehl & Hoffman, 2011; Pickersgill, 2011). Similarly, one might consider moral injury as more useful to employ in research and practice than PTSD because of its ability to distinguish moral traumas from life-threat traumas and to differentiate the mechanisms underlying moral distress from those underlying fear-based distress.

**Grief**

Whereas the case of psychopathy and the PCL-R showcases how a pathological construct outside of the *DSM* and its corresponding measurement tool was taken to better explain the nuances of a pathological personality than its descriptive DSM-codified counterpart, the case of grief does something quite different. A historical trace of the psychological concept of grief shows how the psychological community turned a non-pathological, everyday experience into a medicalized disease. Grief can be seen as an example of what moral injury is in danger of becoming should researchers wholly adopt a syndrome approach. In other words, grief is a case of the trajectory of moral injury gone wrong. Though it never formally entered the *DSM* (not considering the removal of the bereavement exclusion in the *DSM-5*; see Pies, 2014), conceptions of grief
nevertheless were influenced by the *DSM*’s medical model and categorical diagnostics, studied via empirical, objective methods of analysis, similar to moral injury. However, in the case of grief, reliance on scientific methodology resulted in an uptake of grief by psychiatrists, who developed a grief syndrome and medicalized what was originally a normal, everyday experience. The moral injury construct diverges here because, though relying on the tenets of empiricist, scientific methods to make it visible, it rejects the medical model and advocates for a biopsychosocial-spiritual framework. Additionally, grief quickly became decontextualized from its explanatory frameworks in post-Freudian conceptions of the phenomenon. Moral injury, in contrast, is committed to the importance of military context and warrior phenomenology in understanding service members’ and veterans’ moral distress.

That said, the development of grief scales notably parallels those of moral injury. Grief scales were developed as diagnostic tools to differentiate normal grief from pathological grief. As of now, researchers use moral injury scales to develop valid and reliable descriptions of morally injurious events and moral injury outcomes. Yet, with the development of the MIOS, researchers have claimed that they seek to establish boundary conditions of normal and pathological reactions to potentially morally injurious events (Yeterian et al., 2019). Currently, moral injury researchers advocate for a dimensional understanding of pathological reactions to morally injurious events (Litz & Kerig, 2019; Litz et al., 2009), but this might be subject to change with the development of pathological boundary conditions for moral injury outcomes. Moral injury
researchers would, therefore, be wise to take note of the history of grief conceptualizations.

In 1651, Burton conceived of grief as a transitory melancholy that affects everyone at some point in their lives; he distinguished between melancholy as a disease and melancholy as a normal reaction to everyday events (i.e., the death of a loved one) (Granek, 2010). Thus, in Burton’s conception, melancholy was always context-specific and attached to the reason why it developed, as opposed to being symptom-based and removed from its explanatory framework (Granek, 2010). Theories of grief continued to sprout throughout the eighteenth and nineteenth centuries, wherein they began to list the descriptive traits of someone suffering from grief and distinguish between types of grief (Granek, 2010). Yet, all of these conceptualizations still treated grief as a normal reaction.

It was Freud’s psychoanalytic theories during the twentieth century that triggered grief research’s turn toward the pathological. Freud introduced two novel ideas that laid the foundation for the establishment of grief as a pathological kind: he focused on everyday life as sources of interest for psychoanalysis, and he placed health and pathology on a continuum with no clear boundary between them (Granek, 2010). This was the first time one could evaluate a behavior or condition on a continuum of pathological dysfunction (Granek, 2010). Western psychologists interpreted Freud’s work as suggesting that those who do not do their “grief work” could end up with a psychiatric illness due to their pathological grieving (Granek, 2010). However, Freud never intended to pathologize grief and,
in fact, stated that it was not a pathological condition needing medical treatment (Granek, 2010).

Freud never intended for grief to become a pathology, yet the disease perspective of grief nevertheless was established in the mid-twentieth century. In 1937, Helene Deutsch claimed that there are normal and abnormal ways of grieving and worked to distinguish the conditions between the two (Granek, 2010). By 1940, grief was thought of by psychologists as a disease (Granek, 2010). With the continued rise of psychiatry and the move to the DSM-III, grief conceptions entirely shifted from psychoanalytic to psychiatric. As psychiatry sought to be in a league with the natural sciences, the field became dominated by scientific methodology and empirical, quantitative research (Granek, 2010). Freud’s continuum of pathological dysfunction was subsumed by a discrete categorical system in which psychiatrists could reliably diagnose pathology, and psychiatry began operating within a medical model rather than a biopsychosocial one (Granek, 2010). With this came the shift to thinking about grief as a diagnostic pathology that could be treated by mental health professionals (Granek, 2010). Clinical psychologists, also seeking to be seen as a scientific discipline, joined psychiatrists in studying a psychological concept of grief, but opted for scientific measures to test their concepts (Granek, 2010). Their grief scales measured and evaluated the degree of pathology in grief reactions, drawing boundaries between the normal and the dysfunctional. In the current era, disease models of grief still dominate, and in response, psychologists have begun to focus on developing and evaluating grieving treatment interventions (Granek, 2010).
It is important to note that, in contrast to the trajectory of grief, moral injury was first developed as a way to inform treatment strategies for service members and veterans (Gray et al., 2012; Steenkamp et al., 2011). Development of moral injury scales came afterward, as researchers began to refine, validate, and operationalize this construct that appeared to be more effective in treating those with moral traumas than traditional PTSD treatment strategies. With grief, the construct was first medicalized, placed into the hands of psychiatrists, and operationalized with grief scales. Only after the operationalization of grief did professional grief interventions materialize. This distinction is important because, with moral injury, psychologists still value the spiritual dimension of service members’ and veterans’ distress. Spirituality is an integral part of treating moral injury, and psychologists do not discount the role of chaplains and religious figures in assisting with and performing treatment strategies (Carey et al., 2016; Hodgson & Carey, 2017). Because grief was first medicalized and its treatment strategies were created after the fact, psychiatrists rebuked the role of spirituality in treatment interventions for grief. Though in danger of following the trajectory of psychological conceptions of grief, moral injury’s evasion of medicalization, in contrast to grief, is made evident in how moral injury and grief differently value the role of spirituality.

**Passive-aggressive Personality Disorder**

The last construct of interest is passive-aggressive personality disorder. While psychopathy illustrates a valuable psychological construct operationalized and validated outside of the *DSM*, and grief exhibits overmedicalization and
pathologizing normal reactions to everyday experiences, passive-aggressive personality disorder provides an example of a construct that has lived inside (then outside) the *DSM* and that medicalizes normal reactions to everyday life. Passive-aggressive personality disorder resided in the manual for forty-two years (though it was relegated to the Appendix in the fourth edition of the *DSM*) until the publication of the *DSM-5*, wherein it was removed (American Psychiatric Association, 2013; Lane, 2010). This personality disorder’s travel through *DSM* publications gives both an example of the overt medicalization of a normal reaction to wartime experiences and the ambivalence of *DSM* classification and diagnostics.

Passive-aggressive personality disorder, for a time, became exactly what moral injury explicitly rejects: medicalizing a normal reaction to the atrocities of war. A critical historical analysis of passive-aggressive personality disorder reveals the costs of taking an adaptive reaction and pathologizing it out of context. In contrast, moral injury makes clear that injury to one’s moral conscience is normal after perpetrating, failing to prevent, witnessing, or learning about acts that transgress deeply held moral beliefs (Litz et al., 2009). Thus, the history of the personality disorder can warn researchers what could happen should moral injury be codified in the *DSM*. Context would be erased, replaced with biological and neurological explanations of distress, and a normal reaction would become a pathology ingrained within some dysfunction of soldiers’ brains.

Conceptions of passive-aggressive personality disorder were first constructed during World War II (WWII). Colonel William C. Menninger issued
a Technical Bulletin expressing concern about soldiers intentionally avoiding duty, not by open defiance, but through passively aggressive behaviors such as stubbornness, inefficiency, and pouting (Lane, 2010). Though the soldiers’ behaviors could be considered rational strategies to avoid getting killed, Menninger saw them as immature reactions to the “routine” stresses of war (Lane, 2010). After WWII, the term “passive-aggressive” continued to linger in the military, as armed forces found it convenient for characterizing unwelcome behavior (Lane, 2010).

Despite the context-specific nature of the phenomenon, namely soldiers’ reluctance to perform acts that would get them killed in war, psychiatrists took interest in the construct and began applying it to civilians. In the first edition of the DSM, the APA copied relevant phrases from Menninger’s memo, transforming the colonel’s frustration at his troops into a lasting pathology applicable to any layperson in society (Lane, 2010). Notwithstanding the DSM’s prominence in American psychiatry and its supposed scientific foundation, passive-aggressive personality disorder made it into the manual based on nothing more than sketchy military memos. Thus, a contextually driven phenomenon became redefined as malfunctions of biology and neurology: in the DSM-II, passive-aggressive personality disorder was changed from a set of descriptive behaviors into a life-long, neurological malfunction ingrained in a person’s personality (Lane, 2010).

The DSM-III emphasizes “evidence-based” and “rule-driven” categories, yet passive-aggressive personality disorder persisted as a psychiatric disease, this
time with the additional symptoms of “dawdling” and “forgetfulness” (Lane, 2010). The unscientific basis of these additional symptoms is evidenced in the following example. One member of the Personality Disorders committee for the *DSM-III* suggested that “it would be fine to say” that a person with passive-aggressive personality disorder displayed two of these qualities: indecisiveness, lack of assertion, and lack of self-confidence, concluding in parentheses that “perhaps only one of three is sufficient” (Lane, 2010, p. 110). What is the scientific basis of concluding that one is sufficient rather than two? The answer remains unclear. As support for the personality disorder waned amid the publication of the fourth edition of the *DSM (DSM-IV)*, those in support of maintaining the construct attempted to bolster its value by offering empirical data; yet, examination of those data shows that out of a sample of 1,200 psychiatric patients, only 35 met criteria for the disorder, and most of the patients were white and about half were married women (Lane, 2010).

The uncertainty in the validation and codification process of passive-aggressive personality disorder as a formal diagnostic is not atypical. Close examination “of almost any disorder in the *DSM* would likely yield the same cringing results” (Lane, 2010, p. 117). In other words, the *DSM* should not be taken as a valid bible of all psychological kinds, nor should psychiatrists and psychologists strive toward the inclusion of their psychological constructs and models of distress in the manual. Instead, psychiatrists and psychologists should accept the uncertainty of their psychological constructs; they should maintain that their constructs are not entirely “real” or “set-in-stone” or “valid.” With the
acceptance of uncertainty, then, psychiatrists and psychologists might be able to generate greater and more fruitful research on their constructs of interest. I explore this more in-depth in the final sections of this chapter, suggesting that researchers of moral injury should accept the construct as an uncertain category rather than attempt to make it a formal syndrome in the *DSM*.

**Accepting Uncertainty**

Reliability, validity, measurement, and classification are four mechanisms of scientific research that give a construct, phenomenon, or theory a “truth” value. Yet, dominant conceptions of reliability, validity, measurement, and classification are not the only means to establish rigorous and reliable knowledge. Alternative approaches to objective research favor scientific uncertainty and reject consensus. Considering these theoretical frameworks that acknowledge the value of ontological and epistemological uncertainty, moral injury researchers are able to reframe their idea of what makes a scientific concept valuable and objective.

The leading epistemology at work in psychiatric research, outside of the medical model, incorporates biology, psychology, and sociology (Pickersgill, 2014). The discourses intertwine to form the “biopsychosocial” framework sometimes used to interrogate psychiatric kinds. Yet, because of the multiplicity of scientific disciplines in the biopsychosocial approach, there exist contradictory opinions about the ontologies of psychiatric kinds (Pickersgill, 2014). Thus, as researchers attempt to reach objective consensus on what a psychiatric kind is, its measurement, and its classification, they may find that the heterogeneity of the biopsychosocial matrix prevents them from defining a unified theory for the
psychiatric kind in study. Theories of ontological and epistemological uncertainty reject the idea of a unified, objective theory for psychiatric concepts due to the lack of a unified epistemological framework in the discipline. Instead, they argue that there is a reflexive loop wherein ontological and epistemological uncertainties in psychiatry constantly produce a cycle of more research and uncertainty. For example, the theory of “ontological anarchy” argues that the plurality of opinions in psychiatric research leads to a more objective science due to the immense amount of complex research that the plurality produces (Pickersgill, 2009, 2011, 2014, 2016). A similar concept comes from Feyerabend (1975), who holds that science is a historical process wherein theories about a scientific concept, though factually sound, come to be refuted by development of other overlapping theories about the same concept. As history progresses, new epistemological frameworks and methodologies gain prominence in scientific research. Through a cycle of contradictory, epistemologically inconsistent (yet factually adequate) theories, the objectivity of a concept is bolstered through the plurality of research produced about the concept. This anarchistic theory of knowledge – also known as “the mangle” (Pickering, 1993) – rejects the virtues of reliability and validity; rather, the theory values inconsistency and the multifaceted research that emerges from inconsistency. Uncertainty will always be a part of science, and theories of ontological and epistemological uncertainty recognize this uncertainty and use it to encourage and reinforce scientific research. Overall, they emphasize the value of exploration in scientific research.
Critiques of moral injury center around its lack of reliability, validity, sufficient measurement tools, and defined boundary conditions distinguishing pathological moral injury from normal experience. To address the criticisms, moral injury researchers might learn something from considering theories of ontological and epistemological uncertainty. Certainly, there is a lack of consensus regarding the definition of moral injury. What is not acknowledged in the critiques, however, is that the absence of consensus allows researchers from various theoretical paradigms, such as pastoral psychology, clinical psychology, and religion/spirituality studies, to produce varied research about the construct. The plurality of perspectives means that we are not getting a solely psychiatric or solely religious perspective of moral injury; rather, multiple frameworks come together to make moral injury a more dynamic and generative construct. Thus, this research can be seen as more objective because it is not constrained by one particular school of thought or operationalized definition. Moreover, researchers’ uncertainty regarding moral injury scales, the methods used to create them, and their capacity to encompass the experiences of those outside the military can motivate more in-depth study of moral injury in different populations and using different tools. The uncertainty of moral injury scales allows researchers to use different scientific frameworks to produce more varied research, more dynamic scales, and, thus, more objective science. Uncertainty regarding the boundary conditions of a pathological form of moral injury also has the potential to stimulate more complex research. Though a categorical syndrome approach to moral injury as a form of pathology currently exists (Jinkerson, 2016; Jinkerson &
Battles, 2019), the category’s ontological uncertainty encourages those working outside of the *DSM* system to consider more complex understandings of what makes moral injury a clinically severe problem. In fact, the lack of defined boundary conditions has prompted moral injury researchers working outside of the framework of categorical diagnosis to conduct mixed methods studies focused on service members’ and veterans’ differing lived experience after encountering a potentially morally injurious event (Yeterian et al., 2019). If these studies are joined by varied research from others working outside of the *DSM* system, this research can eventually lead to a more dimensional, dynamic understanding of pathological moral injury outcomes.

There are multiple grounds for assessing the scientific value of a psychological construct and different routes to producing objective research. Ontological anarchy, Feyerabend’s anarchist theory of knowledge, and Pickering’s “mangle” are three examples of alternative ways besides the dominant positivist system. Moral injury researchers should consider the virtues of these perspectives and other nonconventional routes.

**Limitations to Uncertainty?**

At the same time, theories of ontological and epistemological uncertainty do have one salient limitation. Because these theories reject a unified theory for psychiatric kinds, they advocate for an approach that promotes a plurality of research opinions about a psychiatric kind as opposed to a singular, certain category for the kind of way of being. Theories of uncertainty challenge the possibility of refined categorical diagnostics. Though taking an uncertain
approach to moral injury avoids reification of the construct and helps prevent erasure of the importance of military context, it becomes problematic when one turns to the practical treatment of moral injury under our contemporary treatment regime. Under the current imposed system, one must have a *DSM* diagnosis to be covered by insurance and reimbursed for mental health treatment (Rose, 2019). The limitations of our current treatment system raise the question, if moral injury does not become an official *DSM* diagnosis, how can individuals experiencing distress after a potentially morally injurious event receive professional care?

Though moral injury is not a refined psychiatric diagnosis, treatments targeting moral injury are still made available to service members and veterans with a PTSD diagnosis. In other words, practitioners are dealing with the limitations of the current *DSM* system by drawing upon the uncertainty of moral injury. Treatments catered toward moral injury are generally administered to those with a PTSD diagnosis who show signs and features of moral injury. Retaining the PTSD diagnosis but treating for moral injury gives service members and veterans the benefit of insurance coverage without reifying the moral injury construct into a categorical diagnosis.

Thereby, access to different treatments for moral injury can actually be facilitated by accepting and engaging the uncertainty of the construct. Psychiatric diagnoses are lived with in multiple and contradictory ways, yet the *DSM* assumes that the phenomenological experiences of each of its diagnoses are universal. For example, if one has PTSD, their experience is supposed to fit the *DSM*’s diagnostic criteria for PTSD and is assumed to respond to universally applicable
treatment strategies for PTSD. By having an uncertain psychiatric category, however, clinicians can use the ambivalence of the diagnosis as an excuse to apply numerous, diagnosis-nonspecific treatments to the problem (Callard, 2014). Because moral injury is an ambiguous category, one is not restricted to diagnosis-specific treatments. If necessary, clinicians can apply diverse treatments to help an individual cope with a morally injurious experience. Additionally, without a distinct diagnosis to guide treatment, clinicians must attend to the phenomenology of the person seeking treatment in order to determine the treatment best suited for that person. Acknowledging the uncertainty of moral injury, therefore, encourages more complex and thorough treatments, some of which are discussed in the next chapter.
CHAPTER 4

Moral Injury in Clinical Practice
Moral Injury in Clinical Practice

*It is because I dove into the abyss that I am beginning to love the abyss I am made of.*

- Clarice Lispector, *The Passion According to G.H.*

The previous chapters considered the conception of moral injury, its scientific development, and the virtues of uncertainty. This chapter turns to the practical use of moral injury in clinical treatment models. This chapter goes to the heart of why moral injury researchers find the concept to be a necessary addition to current conceptualizations of trauma: it enables clinicians to better treat service members and veterans returning from war. During a conversation with Brett Litz, one of the preliminary researchers of moral injury, I recall asking him, “Why is this concept so important? Why do we need moral injury?” His response centered around soldiers’ feelings of demoralization after 9/11. Litz could tell that soldiers would be demoralized by the War on Terror, similar to Vietnam veterans’ demoralization after the Vietnam War. His first thought was, “How are we going to treat these people?” (B. Litz, personal communication, September 13, 2019). He knew that the existing treatment models for PTSD would be inadequate for treating the shattered moral consciences of Afghanistan and Iraq War veterans. Thus, the scientific moral injury model was developed to inform VA treatment strategies for preventing and healing soldiers’ broken consciences.

This chapter asks whether treatments targeting moral injury are necessary and important and provides an overview of the various moral injury treatment
models that researchers and clinicians currently employ. These treatment models show how moral injury, being a culturally sensitive psychiatric kind, paved the way for culture-sensitive treatment for warriors. However, the chapter begins by giving an overview of PTSD treatment models, which many believe are sufficient for the treatment of moral injury. It then critically examines PTSD treatment models’ efficacy in attending to the distress faced by those with moral injury.

After considering PTSD treatments’ failure to account for military culture and the spiritual/religious cultures of warriors, the chapter examines more closely why understandings of the culture of the military and the spiritual/religious cultures of service members and veterans are needed in treatments targeting moral injury. The chapter then moves to a brief history of one VA psychiatrist’s quest to develop culturally sensitive treatments for military moral injury. Next, an overview of current moral injury treatment recommendations showcases the culture-sensitive elements in pastoral and clinical approaches to care. Afterward, I describe four of the most prominent (most widely referenced) professional moral injury treatment models in depth, noting how each of these models attends to military culture and spirituality/religion.

**PTSD Treatment Models**

There are two prevalent ways of thinking about the treatment of moral injury. Some researchers and clinicians believe that current evidence-based psychotherapies for PTSD – specifically Prolonged Exposure Therapy (Foa & Cahill, 2001; Foa et al., 2007; Foa & Kozak, 1986) and Cognitive Processing Therapy (Resick et al., 2014; Resick & Schnicke, 1992) – sufficiently target the
moral injuries that service members and veterans face. Conversely, others claim that there is a need to develop alternative treatments for moral injury distinct from PTSD psychotherapies, which target predominately life-threat, fear-based traumas. Researchers and clinicians who support the use of evidence-based psychotherapies for PTSD to target moral injury hold that these methods sufficiently address the cognitive mechanisms underlying the distress of moral injury (Griffin et al., 2019; Koenig et al., 2019).

**Prolonged Exposure Therapy**

For Prolonged Exposure Therapy (PE), researchers and clinicians in support of applying the therapy to moral injury note its ability to challenge service members’ and veterans’ distorted and inaccurate perceptions of reality and its success in reducing trauma-related guilt. Through imaginal exposure conducted in sessions and *in vivo* exposure in homework assignments, PE challenges service members’ and veterans’ erroneous associations and maladaptive beliefs about their role in a morally injurious event. Though PE traditionally works to disconfirm beliefs about fear and danger stemming from a life-threat trauma, the therapy can be applied to other emotions, such as shame and guilt. Introducing new information that is incompatible with service members’ and veterans’ erroneous cognitions about a potentially morally injurious event makes way for modifying thoughts and feelings about the moral wrongdoing. This then allows the individual to redefine their feelings, associations, and thoughts about the event (Farnsworth, 2019; Griffin et al., 2019; Held et al., 2018; Paul et al., 2014; Smith et al., 2013). Further, there is empirical evidence that PE leads to reductions in
trauma-related guilt over the course of treatment (Griffin et al., 2019; Held et al., 2018; Paul et al., 2014; Smith et al., 2013).

Considering this therapy, critics assert that morally injurious outcomes may persist even with reappraisal of erroneous cognitions. They also note that PE does not engage mechanisms of change found to be effective in the treatment of moral injury (e.g., self-forgiveness and self-compassion) (Griffin et al., 2019).

**Cognitive Processing Therapy**

Researchers and clinicians who endorse Cognitive Processing Therapy’s (CPT) efficacy in treating moral injury claim that CPT goals, including accepting naturally occurring emotions and challenging unrealistic cognitions, can promote moral repair in those with moral injury (Farnsworth, 2019; Griffin et al., 2019). CPT uses cognitive restructuring techniques to modify maladaptive cognitions related to a trauma (Held et al., 2018). In cases of moral injury, cognitive restructuring interrogates individuals’ maladaptive and erroneous beliefs about a morally injurious event and addresses feelings of guilt, shame, or betrayal (Farnsworth, 2019; Griffin et al., 2019). Such restructuring can challenge overgeneralizations about perceived wrongdoing or failure that contribute to a global sense of personal inferiority (Griffin et al., 2019).

Researchers have also developed Spiritually Oriented CPT (SOCPT) to target existential and religious/spiritual problems associated with moral injury (Held et al., 2018; Koenig et al., 2017; Pearce et al., 2018; Resick et al., 2014; Resick et al., 2017; Wade, 2016). In SOCPT, the spiritual concepts of mercy, repentance, forgiveness, spiritual surrender, prayer/contemplation, divine justice,
hope, and divine affirmations are discussed as means to engage with service members’ and veterans’ shame, guilt, anger, humiliation, spiritual struggles, and loss of faith. These techniques are supplemented by rituals involving confession, penance, and faith community involvement, depending on what is most appropriate given an individual’s religious/spiritual beliefs and tradition (Koenig et al., 2017). Overall, SOCPT accounts for religious/spiritual aspects of individuals’ distress that are otherwise unaccounted for in traditional PTSD treatment models. However, it is important to note that SOCPT was specifically developed for the treatment of moral injury and spiritual/religious struggles in service members and veterans with a PTSD diagnosis: CPT alone proved insufficient for treating the religious/spiritual struggles faced by those with moral injury (Koenig et al., 2017).

**Do PTSD Treatment Models Target Moral Injury?**

Recall from chapter one the PTSD diagnosis’ failure to attend to individuals’ moral values and the role of religion/spirituality in mental distress, and how PTSD research’s reliance on traumatic equipotentiality ignores salient aspects of military culture that are critical to warriors’ phenomenological understandings of their distress. PTSD treatments have similar issues. Though PE and CPT are both associated with statistically significant reductions in trauma-related guilt (Farnsworth, 2019; Griffin et al., 2019; Held et al., 2018; Paul et al., 2014; Smith et al., 2013), a putative sign of moral injury, the mechanisms of this change are unclear (Steenkamp et al., 2013). Both PE and CPT fail to attend to service members’ and veterans’ spiritual/religious cultures and the moral
dimension of their distress. Moreover, they do not consider the role military culture may have on service members’ and veterans’ receptibility to treatment.

Additionally, it is important to note that PE and CPT rely on falsifiability in their approaches to trauma-related cognitions. Recall from chapter one, individuals diagnosed with PTSD typically have descriptive cognitions, wherein their thoughts about the nature of an object or event can be falsified with concrete evidence. Individuals with moral injury, however, have prescriptive cognitions, which are tied to beliefs about what is morally preferable that cannot be falsified (Farnsworth, 2019). PE and CPT do not account for such prescriptive statements. CPT explicitly excludes moral statements from direct consideration and prompts clinicians to reformulate clients’ prescriptive cognitions into more falsifiable, descriptive statements (Farnsworth, 2019). PE believes that prescriptive judgments of “perceived perpetration” can be altered by focusing on clarifying descriptive evidence through exposures (Farnsworth, 2019). The descriptive focus of these techniques incompletely addresses the prescriptive cognitions associated with moral injury (Farnsworth, 2019).

Further, PTSD emerges from the context of victimization, whereas moral injury emerges from the context of perpetration. Chapter one previously explained that moral injury is a necessary addition to the life-threat, fear-based model of trauma because of the lack of attention paid to the context of war and perpetration in fear-based theories of traumatic stress. Such ignorance of the context of war and perpetration is also evident in PTSD treatments. PTSD treatment models are rooted in research that deals with the phenomenology of victimization, where fear
is the most relevant emotion (Steenkamp et al., 2013). Treatments targeting moral injury, in contrast, are rooted in the phenomenology of perpetration, where fear is less relevant. Thereby, the fear- and victimization-based models of trauma on which evidence-based psychotherapies for PTSD rely upon cannot be said to sufficiently target the mechanisms hypothesized to be central to moral repair (Barnes et al., 2019; Bryan et al., 2018; Drescher et al., 2011; Farnsworth, 2019; Farnsworth et al., 2014; Griffin et al., 2019; Jones, 2018; Litz et al., 2009; Meador & Nieuwsma, 2018; Neria & Pickover, 2019). Nor do the PTSD models address military culture and individuals’ moral values that are essential to consider during the recovery process for service members and veterans who have experienced moral traumas (Blinka & Harris, 2016; Litz et al., 2016). The next section addresses why this ignorance of military culture and warriors’ moral values is problematic in treatment.

**Culture in Treatment**

In general, culture informs one’s subjective illness experience, one’s interpretation of the illness, and one’s agency and desired outcomes in treatment (Jenkins & Kozelka, 2017). Overall, it is important for treatments directed at service members and veterans to account for military culture and warriors’ spiritual/religious cultures because culture-sensitive treatment is a predictor of treatment efficacy, good therapeutic alliance, and treatment adherence (Ng & Bousman, 2018; Tantam & Sayar, 2018). For example, with psychotropic medication use, a veterans’ subjective illness experience can incorporate both symptomatic relief and troubled social preoccupation with stigma. Military
culture’s role in subjective experience, thus, can give providers insight into why patients decide to drop out of treatment (e.g., the stigma of treatment and medication in military culture). Additionally, if a patient interprets their distress as a spiritual/religious problem stemming from moral transgressions made during war, expresses this to their provider, and is prescribed medication or given generic cognitive restructuring techniques to treat their symptoms, they may experience poor treatment efficacy and have a poor therapeutic alliance with the provider. Without consideration of culture, treatments appear to falter.

One account detailing a veteran’s experience returning home and seeking mental health care from the VA gives us insight into some of the culturally flawed treatments given to veterans. The wife of an Afghanistan veteran explains how her husband’s tremors and night terrors led the couple to seek care at the VA. Though her husband was first diagnosed with PTSD by the admitting psychiatrist at the VA, the psychiatrist assigned to him for continued treatment decided to diagnose him with bipolar disorder and placed him on two medications. Any time he mentioned that he was not reacting well to the medication, the psychiatrist would double his current dosage. After several days of the wife visiting her husband on the unit, she noticed that every single one of her husband’s psychiatrist’s patients had the same diagnosis and the same medication, and each time any of them said they were not improving, their medication was also doubled. While struggling to change psychiatrists, her husband eventually went off his medication, leading to hallucinations, vomiting, and fever. Only after two years and nine suicide attempts did he finally receive sufficient help from the VA
(Nolan, 2013). The husband’s symptoms were directly related to his wartime experiences, yet his primary care psychiatrist paid no attention to the context of war or military culture when diagnosing and treating him. The narrative of this Afghanistan veteran showcases what can occur if a patient is not properly diagnosed or treated and why culture is critical to mental health treatment. If culture is not taken into account in treatment, the result may be poorer therapeutic outcome, mistrust in one’s service provider, and poor treatment adherence.

In contrast, treatments targeting moral injury recognize that different traumatic contexts produce different psychological, biological, spiritual, social, and behavioral consequences for individuals. Rather than equalize all traumas, moral injury treatments attend to the most common context that can lead to potentially morally injurious experiences: war and combat. Treatments targeting moral injury, therefore, understand that the distress felt by service members and veterans is directly related to their wartime experiences (Blinka & Harris, 2016; Brock & Lettini, 2012; Graham, 2017; Griffin et al., 2019; Litz et al., 2016; Maguen & Burkman, 2013; Maguen et al., 2017).

In addition, many clinicians administering treatments targeting moral injury acknowledge both explicit and implicit elements of military culture. Explicit elements of military culture include hierarchies, ranks, uniforms, missions, occupational specialties, organizational structures, military acronyms, and other military jargon (Litz et al., 2016). When treating a service member or veteran, it is important to learn the patient’s rank, position, responsibilities, and their role in the military (Litz et al., 2016). This information is part of a service
member’s or veteran’s personal identity: during the process of becoming part of the military, “each inductee relinquishes aspects of his or her previous personal identity in favor of a new shared identity that is earned by passing both metaphorical and literal trials of strength and character” (Litz et al., 2016, p. 32). Furthermore, attention to these explicit aspects of military culture and a willingness to learn about them can facilitate rapport between provider and patient by showing a service member or veteran that the provider genuinely cares about these elements of military culture that are important to the retelling of the patient’s military deployment experience (Litz et al., 2016).

Implicit aspects of military culture include the values of the military and the warrior ethos of service members and veterans. Providers administering treatments targeting moral injury recognize that the specific moral values of the military differ from those of civilian life. They do not make judgments about warriors’ actions and the way in which warriors tend to take responsibility for acts of commission or omission, even if the acts were not “objectively” the warriors’ fault (Litz et al., 2016; Maguen & Burkman, 2013; Maguen et al., 2017). Additionally, those developing treatment models targeting moral injury recognize the stigma surrounding pathology in the military and have accordingly adjusted the way that they frame and name their treatments (Litz et al., 2016; Maguen et al., 2017; Nieuwsma et al., 2015). They also appreciate the communal, brotherly ethos of the military, which is reflected in the communal nature of many moral injury-targeted treatments (Doehring, 2019; Fawson, 2019; Graham, 2017; Harris et al., 2011; Liebert, 2019; Ramsay, 2019; Starnino et al., 2019; Yandell, 2019).
Moreover, moral injury treatment models’ integration of spirituality/religion into their approaches to care further attends to the spiritual/religious cultures of service members and veterans. The models’ awareness of warriors’ spiritual/religious cultures allows providers to address spirituality/religion’s role in shaping warriors’ interpretations of their wartime moral transgressions (Barnes et al., 2019; Brock & Lettini, 2012; Carey et al., 2016; Doehring, 2019; Frankfurt & Frazier, 2016; Graham, 2017; Griffin et al., 2019; Harris et al., 2011; Hodgson & Carey, 2017; Koenig et al., 2019; Kopacz et al., 2016; Liebert, 2019; Meador & Nieuwsma, 2018; Ramsay, 2019; Starnino et al., 2019).

Therefore, researchers have been working on developing alternative treatments that acknowledge the culturally specific elements of moral injury. The next section of this chapter gives a brief history of the pursuit for alternative, culture-sensitive treatments for moral injury.

The Quest for Culture-sensitive Treatments

The first instance of the term “moral injury” and the first proposal for a different kind of treatment for war veterans come from VA psychiatrist Jonathan Shay. Shay acknowledged PTSD treatments’ failure to account for spirituality/religion and military culture when it came to healing veterans’ distress. He, thus, recommended an alternative treatment for the moral traumas of war, one that considered the role of moral values and military culture in veterans’ experiences of distress. Shay’s first book, *Achilles in Vietnam: Combat Trauma and the Undoing of Character*, focuses on what occurs when an authority figure
betrays “what’s right,” from a societal standpoint, in a high stakes situation. More specifically, Shay (1994) draws parallels between Achilles’ experience of a betrayal of “what’s right” from his commander-in-chief, Agamemnon, in the Iliad and the betrayals veterans faced from their military leaders in Vietnam. In the book, Shay (1994) explains that the essential injuries of combat trauma are social and moral, and so the treatment of these injuries must be social and moral. He suggests the power of narrative, stating, “The advice that veterans consistently give to trauma therapists is ‘Listen! Just listen’” (Shay, 1994, p. 189). The listener of a narrative gives a trauma survivor a nonjudgmental witness to their suffering and allows the survivor to feel less alone. Shay (1994) pushes the importance of the role of the listener, explaining that peer recognition (i.e., sharing trauma stories with other veterans) can do even more than simply make survivors feel less alone: speaking to other veterans can help survivors realize that others can relate to their experiences. This communalization of trauma is similar to Lifton and Shatan’s Vietnam veteran rap groups in the 1970s (Lifton, 1973), but it is a treatment model that has presently failed to gain much clinical recognition.

In Shay’s second book, Odysseus in America: Combat Trauma and the Trials of Homecoming, Shay (2002) focuses not on the soldier but on the leader of troops as he describes the moral betrayals that Odysseus committed during his journey back home to Ithaca in the story of the Odyssey. Here, Shay (2002) explains that after the war, veterans’ capacity for social trust is destroyed as they return to civilian life. He again advocates for social, communal healing as a way to aid recovery after a betrayal, concentrating on the power of group recovery. He
provides the example of taking the Vietnam veterans in his outpatient clinic (who are diagnosed with PTSD but show signs of moral injury) to “The Wall” as part of their recovery process – “The Wall” being the Vietnam Veterans Memorial in Washington, D.C. (Shay, 2002). Visiting the Vietnam Veterans Memorial is a culturally sensitive form of healing that is rooted in the importance of community and meaning making. Shay, being a VA psychiatrist, understood the importance of being surrounded by one’s “brothers,” or fellow soldiers, both during war and during recovery after the war. His extensive knowledge about military culture and the moral dimension of veterans’ distress, along with his willingness to learn about the warrior ethos from his patients, informed his pursuit of culture-sensitive treatments for the moral injuries of war.

**Current Treatment Models Targeting Moral Injury**

As mentioned, treatment models targeting moral injury first emerged from the VA: Shay pioneered culture-sensitive care for service members and veterans after critically considering the phenomenology of the warriors in his outpatient clinic. More recent moral injury treatment models continue to consider the specific culture of war. The recent models also emphasize the importance of the role of religion/spirituality during the healing process. The following section reviews current culture-sensitive treatments targeting moral injury in both the pastoral and clinical literature before delving into an in-depth description of the four most prominent moral injury treatment models in the literature: Adaptive Disclosure, Building Spiritual Strength group intervention for military trauma
survivors, Impact of Killing intervention, and Acceptance and Commitment Therapy.

“Pastoral” Treatment Models

Similar to moral injury definitions, moral injury treatment models appear to be split into two subfields: pastoral treatment models and clinical treatment models. Though growth after moral injury is commonly referred to as “moral repair” in both the clinical and pastoral fields (Carey et al., 2016; Litz et al., 2009), many of the pastoral researchers and clinicians also refer to the growth process as “spiritual repair” or “soul repair” in their suggestions for treatment (Antal & Winings, 2015; Brock & Lettini, 2012; Graham, 2017; Hodgson & Carey, 2017). Pastoral treatment models tend to treat the “soul” and religion/spirituality as central to the moral injury healing process and often suggest the use of rituals or religious/spiritual figures (i.e., chaplains, clergy, or spiritual care providers) to aid the recovery of moral injury (Brock & Lettini, 2012; Carey et al., 2016; Doehring, 2019; Graham, 2017; Hodgson & Carey, 2017; Liebert, 2019; Meador & Nieuwsma, 2018; Ramsay, 2019; Starnino et al., 2019). Many of the pastoral treatment models emphasize the importance of lamentation, specifically sharing anguish, interrogating causes, and reinvesting hope (Doehring, 2019; Graham, 2017; Liebert, 2019; Ramsay, 2019). Other ritual practices also tend to be used in pastoral care, such as circle processes wherein individuals in a circle speak without interruption as the others contemplatively listen (Liebert, 2019), writing your own psalm (Liebert, 2019), reflective prayer (Liebert, 2019), witness poetry to convey the complexity of one’s emotions in
ways that other modes of language cannot (Fawson, 2019; Ramsay, 2019), and, simply, mutual active listening (Graham, 2017; Liebert, 2019; Yandell, 2019). Overall, pastoral treatment strategies frequently align with Shay’s community recovery strategies: they tend to focus on regaining social trust through the communalization of trauma and making meaning out of one’s experience.

While individuals can undertake these lamentation and ritual practices either inside or outside of healthcare institutions and with or without the guidance of a religious/spiritual professional, two professional pastoral interventions have been developed to treat moral injury using VA chaplains: Pastoral Narrative Disclosure (PND) and Search for Meaning (SFM). PND is essentially a revised confessional model comprised of eight stages: rapport, reflection, review, reconstruction, restoration, ritual, renewal, and reconnection (Carey & Hodgson, 2018). This individual treatment model allows individuals to describe, reflect upon, and reconstruct their morally injurious experience with the guidance of a chaplain, hopefully leading to the restoration and renewal of their moral conscience. SFM follows a similar confessional process that takes place over eight sessions guided by a VA chaplain, except in a group therapy setting (Starnino et al., 2019). Though PND and SFM are structured and professional models of treatment, they still provide culturally sensitive and contextualized care. The treatment models’ emphasis on the role of chaplains over clinicians places them under the label of pastoral interventions rather than clinical interventions. Chaplain care, however, is not limited to pastoral treatment models;
clinical treatments also acknowledge the role of religious/spiritual professionals in moral repair.

“Clinical” Treatment Models

Pastoral treatment models treat religion/spirituality as central to the moral injury healing process and advocate for religious/spiritually oriented healing practices. While clinical treatment models tend to be guided by clinical professionals, they also recognize the importance of spirituality in the recovery process and do not discount the role of spiritual professionals in treatment. The clinical treatment models for moral injury tend to be researched using clinicians to guide the care, but researchers also highlight the importance of interdisciplinary treatment teams and pastoral/chaplain care (Barnes et al., 2019; Blinka & Harris, 2016; Griffin et al., 2019; Kopacz et al., 2016). Additionally, though clinical treatments tend to operate under psychological recovery mechanisms, they accommodate spiritual mechanisms into their models, such as mindfulness and the communalization of trauma. For example, the mindfulness-based approaches of mindfulness-based stress reduction (MBSR) and mindfulness-based cognitive therapy (MBCT), when used in group therapy settings, are viable options for addressing the distress of moral injury (Kopacz et al., 2016). Peer groups also function as a sustainable clinical treatment for moral injury, as they value the cultural importance of cohesion and the “buddy” system in the military (Blinka & Harris, 2016). As with pastoral treatment models, mindfulness and peer groups provide culturally sensitive and contextualized care to service members and veterans with moral injury. Attention to the context of war and the warrior ethos
is evident even in the most widely known moral injury treatment models, which are discussed next.

**Adaptive Disclosure.** The first treatment strategy designed specifically to target moral injury in those with a PTSD diagnosis is Adaptive Disclosure (AD) (Gray et al., 2012; Litz et al., 2009; Steenkamp et al., 2011). AD came into being because treatments for combat-related PTSD typically applied protocols that were developed and tested on civilians, and these treatments failed to acknowledge difficulties related to grief and guilt (Steenkamp et al., 2011). Taking into consideration the phenomenology of warriors and the warrior ethos, AD recognizes the strong attachments that develop between service members during war and the grief that follows after the death of a friend (Steenkamp et al., 2011). AD also considers how experiences during war (i.e., potentially morally injurious experiences) can cause feelings of guilt, shame, and inner conflict in service members (Steenkamp et al., 2011). Clinicians are trained to accept rather than question the responsibility-taking that is endemic in military culture and the warrior ethos (Gray et al., 2012; Litz et al., 2016; Steenkamp et al., 2011). In addition, AD attends to warrior culture by avoiding the term “therapy” or “treatment” in its title, which can be stigmatizing for service members who are reluctant to view their problems within a medical model (Litz et al., 2016; Steenkamp et al., 2011). Thus, though the treatment is completed with clinical professionals, it avoids the jargon of the medical model and recognizes the harm of medicalization.
Designed for active service members, AD promotes therapeutic change by targeting recognized mechanisms of moral repair, including a secular confessional process designed to open up the possibility for compassion, forgiveness, and reparative action. Based on cognitive behavioral therapy methods, the treatment is comprised of six-to-eight sessions. In these sessions, service members undergo individual cognitive-based and interdisciplinary (e.g., Gestalt, psychodynamic therapy, mindfulness) intervention.

The treatment has three main components: “(a) a core imaginal exposure component; (b) a ‘breakout’ component designed to target loss/traumatic grief; and (c) a ‘breakout’ component designed to target moral injury (and attendant shame and guilt)” (Steenkamp et al., 2011, p. 101). First, service members work on disclosing their transgressive event narratives in a safe therapeutic environment. Then, they participate in a therapist-facilitated imaginal dialogue about the transgressive event with a key “relevant other,” such as the deceased person being grieved or a forgiving and compassionate moral authority (Litz et al., 2016). The dialogue is meant to “engender alternative emotional experiences that plant corrective information such that the experience and internalization of the original trauma is modified positively” (Litz et al., 2016, p. 9). Though it is an individual therapy process, it encourages community engagement and social trust with family, peers, and clergy (Litz et al., 2016; Steenkamp et al., 2011).

**Building Spiritual Strength.** Building Spiritual Strength (BSS) is the first trauma treatment designed specifically to address religious strain and enhance religious meaning making for military trauma survivors (Harris et al., 2011). BSS
is designed for the treatment of moral injury in those with a PTSD diagnosis. It is widely acknowledged within the moral injury community due to its focus on service members and military culture. It also addresses service members’ spiritual/religious cultures with its focus on alleviating “religious strains” (e.g., feeling alienated from one's higher power, shame, guilt, fear related to sin or perceived sin, expectations of punishment or abandonment from a higher power, and difficulties in relationships with leadership or peers in a faith community) (Barnes et al., 2019; Frankfurt & Frazier, 2016; Griffin et al., 2019; Harris et al., 2011; Koenig et al., 2019). Furthermore, BSS is a group-based intervention, which makes it ideal for cultivating social trust and community support for service members (Griffin et al., 2019; Harris et al., 2011).

BSS is an inter-faith, eight-session spiritually integrated group intervention for trauma survivors, available in both civilian- and military-specific versions (Harris et al., 2011). First, group members establish rapport and identify their spiritual development goals. Next, members begin a “prayer log” to establish open communication with a higher power. The following sessions explore theodicy and individual prayer/meditation practices. Finally, members address forgiveness, facilitate conflict resolution, and plan for continued personal spiritual development (Harris et al., 2011). Wholly, the intervention is designed specifically to treat war traumas (in the military version), and it abides by notions of recovery through prayer and community.

**Impact of Killing Intervention.** The Impact of Killing (IOK) intervention acts as a supplement to evidence-based treatments for PTSD. The intervention
was created due to PTSD treatments’ failure to attend to killing-related cognitions and moral injury (Maguen & Burkman, 2013). The IOK treatment model uses a cognitive behavioral framework to facilitate the processing of killing-related thoughts and feelings, and it introduces targets for intervention such as self-forgiveness and amends-making (Griffin et al., 2019; Maguen & Burkman, 2013; Maguen et al., 2017). Though the model does not treat all types of moral injury (i.e., moral injury stemming from a betrayal by an authority figure), it does address perpetration-based moral injury in those with a PTSD diagnosis. It also attends to the stigma of clinical treatment in the military by framing the intervention as “educational lessons” rather than “therapy” (Maguen & Burkman, 2013; Maguen et al., 2017). The model’s specific focus on killing during war also means that the IOK intervention can provide contextualized, informed care about military-specific experiences. The IOK intervention further recognizes that the context in which killing occurred may be complex, and individuals may have killed after experiencing sadness and anger in response to losing someone close to them in combat (Maguen & Burkman, 2013).

The IOK intervention is a six-session course consisting of a series of lessons to be used in conjunction with ongoing clinical treatment for PTSD. The first session takes an educational approach concerning the biological, psychological, and social aspects of killing in war and how these aspects can relate to the development of moral injury. The later sessions build upon this base, attending to meaning making, self-blaming cognitions that develop, opportunities to experience self-forgiveness, and development of an action plan to make
amends, where possible (Blinka & Harris, 2016; Maguen & Burkman, 2013; Maguen et al., 2017).

**Acceptance and Commitment Therapy.** Finally, Acceptance and Commitment Therapy (ACT) is a third-wave behavioral intervention proven effective in the treatment of shame (Blinka & Harris, 2016; Griffin et al., 2019; Kopacz et al., 2016; Nieuwsma et al., 2015). Grounded in cognitive behavioral therapy, ACT stems from a growing body of research that supports shifting the focus away from simply “treating” cognitions to an emphasis on expanding one’s mental and behavioral skills in order to deal with life’s challenges (Blinka & Harris, 2016; Nieuwsma et al., 2015). With its accent on avoiding rigidity, ACT also protects “the construct of moral injury from developing into an overly medicalized phenomenon” (Nieuwsma et al., 2015, p. 204). The aim of ACT is to develop psychological and behavioral flexibility among patients to promote nonjudgmental acceptance of interpersonal experiences and committed action toward value-congruent behavior (Nieuwsma et al., 2015). ACT was developed with moral injury in mind and has been studied and proven effective among veterans with a PTSD diagnosis who show signs of moral injury (Blinka & Harris, 2016; Griffin et al., 2019; Nieuwsma et al., 2015). Effective employment of the therapy depends on taking into consideration the context of a specific experience, and thus the treatment must be context-specific regardless of the population receiving care. Furthermore, ACT attends to the warrior ethos by treating human suffering as normative, rather than pathologizing and, thus, stigmatizing the problems of service members and veterans (Nieuwsma et al., 2015).
ACT uses six core therapeutic processes that lead to helpful behavioral change and promote psychological flexibility: acceptance, defusion from thoughts and emotions, mindful contact with the present moment, perspective taking, considering values, and committed action (Kopacz et al., 2016; Nieuwsma et al., 2015). The treatment model is able to address multiple aspects of moral injury, including understanding human suffering as normal, predictable, and potentially meaningful; fostering forgiveness in a way that acknowledges guilt as a marker for underlying values; and engaging with morally injurious experiences in a way that respects current suffering (Kopacz et al., 2016; Nieuwsma et al., 2015).

Each of the various treatments targeting moral injury attends to both military culture and the moral values of service members and veterans. Acknowledgment of explicit and implicit elements of military culture and the spiritual/religious cultures of service members and veterans are critical components of the treatments. The personal identities of service members and veterans are defined, in part, by military culture, and their potentially morally injurious experiences are located in the context of war. Not only that, but service members’ and veterans’ spiritual/religious cultures are crucial to understanding their experience of moral injury and their needs during treatment, such as the need for lamentation or chaplain care. In the next chapter, I take a closer look at how spirituality/religion and conceptions of morality function in explanations of clinical psychological concepts and in clinical interpretations of distress.
CHAPTER 5

Reflections on the Moral in Psychology
Reflections on the Moral in Psychology

*I don’t want to have the terrible limitation of those who live merely from what can make sense. Not I: I want an invented truth.*

- Clarice Lispector, *Água Viva*

As psychology sought to gain prominence as a scientific discipline, it aimed to be secular and objective, borrowing the methods of the natural sciences to produce what was taken to be value-free research. Instead of treating moral values as a matter in itself, psychologists turned to study morality as an empirical, value-free object. Historically, however, this was not entirely the case: clinical psychologists periodically sought to understand their subjects’ psychic distress as morally grounded and stemming from events that were discordant with their subjects’ moral beliefs. Yet, there is a recent deficit of literature on moral dimensions of distress in clinical psychological kinds (i.e., psychiatric diagnoses). Moral injury is one rare example of a clinical concept being developed in the twenty-first century that both takes into account moral dimensions of distress and also considers spirituality and moral values as central to mental health. The moral injury model, therefore, disrupts current psychology’s distinction between science and the moral.

This chapter examines the role of the moral in clinical psychology. It begins by tracing select psychiatric diagnoses that show that clinical psychiatry addressed moral dimensions of distress long before the introduction of moral injury. More recently, clinical psychiatric methods have eschewed acknowledging
moral dimensions of psychic harm, designating them to the purview of other social sciences. Examining clinical psychologists’ epistemological commitments and ontological shifts illuminates some of the reasons why they have neglected moral dimensions of distress and enables appreciation of moral injury as a transgressive way of conceptualizing psychic harm.

**History of the Moral**

The moral played a surprisingly prominent role during the early days of modern psychology. In philosophy, the predecessor to psychology, *science morale* was understood as every aspect of man that was not physical (i.e., the mental side as a whole) (Werlinder, 1978). In the late-eighteenth to early-nineteenth century, physicians believed that the primary causes of mental illness were “the moral,” which referred to affective reactions (Werlinder, 1978). The moral was taken to be the emotional side of the mind, and it was contrasted with the intellectual side of the mind. Thus, in nineteenth century cases of pathology, psychologists often interpreted mental problems as stemming from a person’s moral derangement, or the absence of moral faculty (Werlinder, 1978). It was held that moral derangement eventually led to “moral insanity.” Moral insanity described a pathological condition wherein an individual had a morbid perversion of natural feelings, impulses, inclinations, and moral dispositions in that one was egotistic, governed by immoral motives, and was morally insensitive (Holmes, 1991; Werlinder, 1978). However, by 1930, a moral understanding of pathology was abandoned. With the rise of scientism, or the privileging of science as the best and only objective way to understand the world, moral values became less
relevant in psychology. Instead, what was once known as moral insanity was
turned into “sociopathy” and defined as “deviated or pathological social relations”
(Holmes, 1991, p. 79).

Talk of the moral and considerations of moral values did not reappear in
clinical psychology until the 1940s when trauma researchers began to notice and
describe the consequences of moral transgressions. By the time of this
reemergence, clinical psychology had discarded pathological notions of
immorality, and most had abandoned altogether consideration of moral
components of mental distress. However, starting in the mid-1940s, some began
to observe and report how a traumatic immoral situation could influence the moral
values of individuals and cause them to experience severe, potentially
pathological distress and anxiety about the trauma. Attention to the consequences
of moral transgressions first appeared in Erich Lindemann’s (1944) work with
bereaved victims of the Cocoanut Grove Fire (i.e., those who had lost someone in
the fire) and relatives of members of the armed forces. Lindemann described these
consequences as “acute grief,” a syndrome that is a normal reaction to a
distressing situation but, without proper care, could become potentially
pathological. Lindemann’s (1944) descriptions of bereaved victims focus on their
moral feelings of guilt, as well as their distorted perceptions and loss of social
interactions. He did not explicitly state that the acute grief experience alters
victims’ moral values and moral interpretations of the world (for the word
“moral” never appears in his writings). However, he did explicitly describe
victims’ desire for self-punishment due to the guilt they felt over the loss,
implying that the victims felt morally implicated in the loss of their loved ones. In other words, the victims felt a moral obligation to save their loved ones and prevent them from dying. Lindemann’s understanding of this dimension of the victims’ distress is also evident in his recommendations for grief management. He emphasized the role religious agencies should have in addressing the guilt and anger associated with these cases of bereavement; he recognized religion and morality as valuable assets to psychological practice.

After Lindemann introduced the acute grief syndrome, years passed without any notable psychological accounts of moral dimensions of trauma. In 1968, Lifton’s report on the psychological experience of survivors of Hiroshima sparked a resurgence of morally grounded trauma research. Lifton demonstrated how the immoral acts of war can have severe psychological consequences for wartime survivors; in this case, survivors of Hiroshima. More specifically, immoral traumas such as nuclear war can create a divided self in survivors of the war, a dividing that he explained prevents them from religious reassurance. In other terms, immoral traumas can lead to a loss of faith for the trauma survivors (Lifton, 1968). Similar to Lindemann’s cases of acute grief, the survivors studied by Lifton experienced judgments of moral guilt and self-condemnation for not being able to prevent the nuclear deaths of those around them. Lifton’s descriptions of survivors of Hiroshima brought new awareness to the moral dimension of psychic harm.

Moral understandings of trauma continued to be examined in clinical psychology with the demoralization of American soldiers during and after the
Vietnam War. Thinking about the moral, however, was atypical in clinical psychology, and these moral understandings of trauma deviated from dominant biological and psychological understandings of mental distress that were common at the time. Most notable among the moral understandings of trauma are Shatan’s (1972) conceptualization of a post-Vietnam syndrome; Lifton’s (1973) study of the distress of Vietnam veterans; and Haley’s (1974, 1985) reports on the therapeutic challenges that arise when veterans report atrocities. In all of these psychological accounts of the distress experienced by Vietnam veterans, guilt plays a prominent role in veterans’ phenomenology. Veterans reported feeling as if their moral consciences had been shattered due to their involvement in an immoral war and their immoral acts during war. The immorality of the war and veterans’ immoral acts of commission or omission during the war resulted in a morally rooted distress, which each of these three researchers detailed in their work. Shatan (1972), Lifton (1973), and Haley (1974, 1985) also made note of religion’s role in understanding wartime atrocities. They recognized that a soldier’s religious upbringing shapes his moral values and moral worldview; involvement in war can create a dissonant moral understanding of the world and a distrust in society; and religion impacts veterans’ recovery trajectories and the coping mechanisms veterans use to deal with the reality of their moral transgressions. Overall, some psychologists working with Vietnam veterans considered the moral dimension of psychic harm, engaging religious and spiritual concepts to further psychological understandings of their patients’ problems.
After the Vietnam War era, the moral was briefly sidelined in clinical psychologists’ understandings of distress until the 1980s and early 1990s with the publication of Judith Herman’s work on the diagnosis of Complex PTSD. Her landmark book, *Trauma and Recovery* (1992), described the moral legitimacy of the antiwar movement and the way in which morality functioned in the phenomenology of traumatized Vietnam veterans. Herman understood that morality is an inherently social phenomenon, and traumatic immoral events destroy the sense of connection between individuals and their communities, leading to a crisis of faith and feelings of guilt and shame. Crises of faith and the destruction of social trust are especially likely to occur in instances of traumatic betrayal. Herman explained that particularly serious betrayals include rape, domestic violence, and childhood physical and sexual abuse. She described these betrayals as physical, psychological, and moral violations of a person. In order to understand and treat the consequences of rape, domestic violence, and childhood abuse, thus, one must realize how moral judgments shape survivors’ interpretations of and reactions to the trauma along with how moral principles and ideals become skewed in traumatic situations. Moreover, clinicians cannot be morally neutral in these situations; instead, they must stand in moral solidarity with the survivor.

At the same time as Herman’s (1992) work on Complex PTSD, Jonathan Shay (1991) began publishing his work on moral injury. He wrote at length about the role of morality in veterans’ experiences of distress after war, using the Homeric tales of the *Iliad* and the *Odyssey* to ground his observations of moral
distress in his Vietnam veteran outpatients (Shay, 1994, 2002, 2009, 2014). Shay’s anti-war stance, descriptive methodology, and morally informed understanding of traumatic stress were not received well by the wider clinical psychology community. Without sufficient scientific mechanisms of visibility, Shay’s concept of moral injury was largely ignored in clinical psychology until the development of Brett Litz and his colleagues’ (2009) clinical science approach to moral injury. Even still, moral injury is not formally recognized by the APA, nor are any other recent, morally situated understandings of traumatic stress (e.g., Complex PTSD) (Shay, 2014). Since its shift to a categorical system of classification, the DSM ignores any conceptions of mental health that imbue moral value judgments or suggest that immoral acts can influence the moral propensities of individuals. The APA’s lack of recognition of moral understandings of psychological distress suggests that clinical psychology’s epistemological footings and ontological shifts influence which explanations of mental health problems it chooses to acknowledge.

**Epistemological Commitments and Ontological Shifts**

Recall from chapter two, positivist and logical positivist epistemologies in clinical psychology value empirical methods of observation and scientific testing. These epistemologies hold that all meaningful scientific statements must be verifiable or confirmable by observation, and metaphysical theories of humanity are essentially meaningless (Zammito, 2004). Logical positivism further posits that theories emerge from scientists’ neutral, logical interpretations of sensory reality (Zammito, 2004). Post-positivism, in comparison, takes a step beyond
positivism and logical positivism, positing that there are no neutral interpretations of reality (Zammito, 2004). However, post-positivism still embraces notions of empiricism and objectivity.

As clinical psychology became more evidence-based, especially after WWII, it more fiercely engaged a positivist epistemology. The enormous number of psychological and psychiatric casualties produced by WWII necessitated that psychologists aid psychiatrists with treatment and assessment (Frank, 1984). Yet, psychiatrists were reluctant to accept psychologists as equal partners in the mental health business. To gain credibility, psychiatrists via the APA developed in 1949 what came to be known as the Boulder Model, a scientist-practitioner model that encouraged students in clinical psychology to be trained in research skills in addition to clinical skills (Frank, 1984). Adopting a positivist epistemology, it was held that clinical psychologists needed to be trained in empirical research methods in order to establish the same authority as psychiatrists. With the rise of the pharmaceutical industry in the 1950s, positivism continued to dominate clinical psychology. As pharmaceutical companies promoted the idea that pathology was located in the brain, psychiatrists and psychologists used the methods of the natural sciences (e.g., biology and chemistry) to understand the psychological states of persons in society (Herzberg, 2009). As the biological revolution unfolded in the 1980s, psychopharmaceuticals became a vehicle for popularizing the brain sciences and a biochemical understanding of pathology.

With the evolution of positivism came changing conceptions of objectivity. Though psychologists recognized that their values and the values of
their subjects could influence their research, they attempted to eliminate those values through the strict “objectivity” of the natural scientific method. During the early- to mid-nineteenth century, psychiatrists attempted to use the objectivity of the “clinical gaze,” or trained expert observation, to locate abnormalities and features on the surface of the body that would determine the presence of pathology (Rose, 2007b). These methods did not prove to be sufficient for objectively understanding the complex mental states of others. Instead, the discovery of scientific imaging in biology led to a more stringent objectivity in the late-nineteenth century: mechanical objectivity. The rise of mechanical objectivity reduced the importance of human intervention in scientific results and put in its place a set of procedures that aimed to let science speak for itself without scientists’ interpretive biases (Daston & Galison, 2007). As statistics developed rapidly in the 1900s, psychologists became imbued with the tools necessary for mechanical objectivity. Statistics functioned as a mechanical measurement procedure that allowed psychologists to create purportedly unbiased, quantified psychometrics to compare how groups performed under different experimental conditions. Empiricist, mechanically objective methods that used quantifiable psychometrics to verify observations of reality set the groundwork for modern clinical psychological and psychiatric research (Richards, 1996). The rise of a series of technologies in the late-twentieth century, such as Computerized Tomography (CT), Positron Emission Tomography (PET), Magnetic Resonance Imaging (MRI), and Functional Magnetic Resonance Imaging (fMRI), also buttressed mechanical objectivity in psychological research,
as researchers were able to visualize molecularized pathology in the brain to produce empirical statements about normal and pathological functioning (Rose, 2007b).

The rise of positivist and mechanically objective science led to ontological shifts in clinical psychology. During the early- to mid-twentieth century, mental illness was broadly conceived of as psychosocial, as it took from Meyerian psychobiologic and Freudian psychoanalytic traditions the beliefs that maladaptive external behaviors and internal psychologies were influenced by the environment (Green, 2010; Wilson, 1993). The psychosocial framework assumed that the boundaries between the normal mind and the abnormal mind were fluid; mental illness existed along a continuum of severity; and noxious environments and psychic conflict caused mental illness. These assumptions were supported in the first and second editions of the *DSM*. However, by the 1960s, the psychosocial model was being challenged: psychiatric diagnoses came to be seen as unreliable due to insufficient diagnostic measurement tools, and efficacy of treatment was impossible to judge because there were no standardized criteria for diagnosis and treatment outcomes. Additionally, the rise of psychopharmaceuticals and the need to empirically test the efficacy of these psychopharmaceuticals led to a need for more explicit diagnostic criteria in order to assemble homogeneous research samples for clinical trials, adding urgency to the call for a more experimentally- and empirically-based psychiatry. In an attempt to regain its status as a legitimate science, psychiatry adopted the medical model (Engel, 1977). The ascendency of this medical model is evident in the development of the *DSM-III* in 1980. The
DSM-III attempted to use objective, “visible” criteria in the form of descriptive categories to enhance the reliability of diagnoses, and it sought to separate disorders by their etiological roots (Deacon, 2013; Rose, 2007b; Wilson, 1993). Informed by the biomedical model, the DSM-III and the subsequent editions of the DSM corresponded with beliefs that mental disorders have etiological explanations that can be traced to the biology of the brain, or biomarkers (Deacon, 2013; Rose, 2007b).

**Current Conceptions of Morality in Psychology**

The moral dimension of individuals’ mental health has been eclipsed under clinical psychology’s epistemological commitments and ontological shifts.\(^1\) Obscuration of the moral is most evident in contemporary trauma work, as researchers operating under the current PTSD framework attempt to use biological and psychological explanations to interpret the repercussions of traumatic immoral situations such as rape, abuse, and the atrocities of war. The concept of moral injury flourishes as an exception in certain spaces. Moral injury, in contrast to PTSD, attends to the moral dimension of psychic distress that can emerge from a traumatic event. In other domains of psychology, both historically and currently, the moral has been taken up as an object of study using positivist technologies and quantification that turn the moral into an empirical object isolated from wider society.

\(^1\) It is of relevance to note that, though the current field of clinical psychology tends to eschew the moral dimension of psychic distress, other perspectives in clinical psychology – most notably, humanistic psychology and liberation psychology – attend to the moral in their considerations of the pathological distress of individuals and communities (see Martín-Baró, 1994). This is the case even when the term “moral” does not explicitly appear in the language and writings of those working within these perspectives.
Psychology undertook morality as an empirical object in the early-twentieth century as increasingly positivist science and society attempted to explain the development of one’s moral conscience. With the rise of the cognitive revolution in the 1960s, developmental psychologists turned to studying the cognitive development of morality. Then, with psychology’s affective revolution and the rebirth of sociobiology in the 1980s and 1990s, cognitive understandings of morality were joined by study of the evolutionary functions of morality. Now, with psychology’s adoption of eclecticism, morality is studied by an array of different disciplines (e.g., philosophy, religion, social psychology, cognitive psychology, developmental psychology, evolutionary psychology, and neuroscience), which come together under the label of “moral psychology.” Moral psychology studies morality as an empirical object, using quantitative and neurological analyses to understand morality within an individual (Gray & Graham, 2018).

In contrast, while moral injury researchers still abide by the empiricism and objectivity of positivism, moral injury looks at the dynamic effects of moral conflict using generative, contextual, and qualitative methods. The model comes from affect-laden, rich personal experience and is part of an interventionist project to better the mental health of service members and veterans. Moral injury research, thus, does not simply assess the scientific nature of morality; rather, it seeks to understand moral dimensions of distress to produce better world making. The moral injury model actively works against the medical model of psychiatry while simultaneously expanding the biopsychosocial model to include the moral
domain (Litz et al., 2009). Moral injury strives, like the biopsychosocial model once did (Engel, 1977), to see and treat individuals as whole persons with physical, emotional, social, and, most recently, spiritual dimensions (Koenig, 2000; Puchalski, 2001; Sulmasy, 2002).
Conclusion

At the bottom of everything there is the hallelujah.
- Clarice Lispector, Água Viva

Moral injury invites a dynamic and complex way of conceptualizing psychic distress, one that embraces the spiritual and moral dimensions of one’s mental health experience alongside biological, psychological, and social dimensions. This thesis has interrogated the viability and usefulness of the moral injury framework in clinical theory and practice. The compelling evidence of moral injury beckons us to imagine a future where the spiritual and moral dimensions of distress are a fundamental part of clinical inquiry and treatment. In this imaginal world, the moral is an integral aspect of one’s mental health and, therefore, is addressed in clinical psychological kinds and ways of being. The reader here is invited to imagine what the clinical landscape would look like if moral injury and Complex PTSD gained precedence over the simple PTSD framework; if depression in the context of bereavement took on a moral dimension; and if morally situated conceptions of addiction were at the forefront. To better conceptualize such a clinical landscape, I offer three fictional case studies of a morally situated understanding of each of these psychiatric kinds.

Moral Injury and Complex PTSD

Rose is a 24-year-old caseworker at the Department of Children and Families (DCF). She lost both of her parents in a car crash when she was four years old and was in and out of the foster care system for the next fourteen years.
Her first foster parents were retired high school teachers, and she lived in the spare room in their basement. Rose’s foster mom would make pancakes every morning and turkey sandwiches for lunch. She would do puzzles throughout the day as her foster parents listened to the buzz of the daily news on the television. At first, she loved it there; her foster mom was always cooking, and her foster dad barely spoke. As she grew older, however, her foster dad became more vocal about her appearance, dictating how she was supposed to dress and wear her hair. When she entered fourth grade, she started to notice how her foster dad would touch her when he dropped her off from school, grazing over parts that the other dads didn’t. At age 11, he started coming into her room at night and sleeping next to her. It wasn’t until Rose was 14 when she realized that something was wrong. She called DCF from her counselor’s office at school and filed a sexual abuse report. After the first DCF investigator arrived at their house, the abuse escalated. Rose fled home, only to be forced to return. The investigation took three months; only afterward was Rose transferred to a different home. After high school, she went on to community college and decided to become a DCF caseworker. She felt morally obligated to protect young children from having the same experience as her. Since working, she’s managed several sexual abuse cases like her own, but she’s also witnessed some notably unethical separations done by DCF: she has seen mothers cry as they watch their kids be taken away and borne witness to children running out of investigators’ arms just to stay with their families.

Rose started seeing a therapist in college, and since then, her therapist has seen Rose’s mindset turn from that of a victim to that of a perpetrator. According
to her therapist, Rose has both Complex PTSD and moral injury. Her distress is primarily moral and spiritual: Rose has never felt fear in response to the sexual abuse she’s witnessed in her line of work, nor did she ever fear for her own life when she was being abused. Instead, she believed that she deserved whatever treatment she received. Rose and her therapist spent the first two years of therapy trying to understand how Rose’s moral values and moral understanding of the world had been skewed by her experiences. Through the combination of individual therapy and spiritually oriented group therapy, Rose built up her moral conscience and began to think about how her foster dad’s moral violations of her mind and body influenced her worldview. Then, after starting her caseworker job, Rose’s moral conscience took a blow. Rose was no longer the one being violated: she became the violator. Separating families manipulated her worldview once more, as she felt that all of the work she had done building up her moral value system came crashing down. With the support of her therapist and fellow group members, however, she started learning how to accept and forgive herself for her moral transgressions. Instead of drowning in her own guilt, she could put her actions into context. During individual therapy sessions, her therapist always brought her past to bear in understanding current emotions. The two would explore how her experience of being morally violated related to her interpretations of her current moral violations. Recently, Rose has been going to pagan festivals with a few of the members from her group, and she’s found that the spiritual rituals help her make meaning out of her past and present.

**Depression and Bereavement**
Marvin, age 37, arrives at the clinic for psychiatric assessment. His left leg drags slightly when he walks, and deep bags sink his eyes into the hollows of his skull. The clinician on duty retrieves his intake form from the cabinet, and the two of them walk toward the open door at the end of the hallway. Inside, Marvin sits on the chair closest to the door, and the clinician sits opposite. They make light conversation before the clinician begins asking Marvin about his sleeping schedule, eating habits, and social life. He sleeps four hours a day on average, as most of the night he’s kept awake by his thoughts; he consistently eats two meals a day, usually frozen prepared meals, unless his wife is willing to cook; and he rarely leaves his home unless it is absolutely necessary. He explains that his first and only son died three years ago, and he hasn’t been able to enjoy socializing since then. The clinician asks him how his son died. He slowly begins to release the story, recounting that before his death, he would pray every night for a child—a baby. He and his wife had trouble conceiving, and their adoption paperwork had been under review for over a year. One night, Marvin got a call from the adoption agency: their application had been processed, and they had the opportunity to adopt a seven-month-old baby boy. Marvin says that he felt something special in the universe that day. The next morning, Marvin left for work and planned to meet his wife and their child at the adoption center downtown. When they both arrived and were introduced to their son-to-be, the couple cried tears of pure joy. Marvin needed to pick up the bedding for the crib before going back home, so his son went with his wife. Marvin got the call 35 minutes later that the boy suddenly stopped breathing on their way home, and by the time his wife had noticed, he
was limp in the backseat. At the hospital, the doctors said it was sudden infant
death syndrome and that they could not have predicted such an outcome and
weren’t to blame.

The clinician inhales slowly, and on the exhale, she pushes him further,
asking him if he felt he was to blame. Marvin nods. “Why?” She asks. “Because I
was supposed to keep him alive. He was my son. I was supposed to protect him,
and I didn’t,” Marvin responds. Marvin’s guilt and shame are palpable, and the
clinician attempts to further grasp Marvin’s subjective perspective, asking him if
he felt a moral obligation to protect his son, and now that he hasn’t, if his moral
understanding of the world has been altered. Marvin shifts slightly in his seat. He
explains that he’s never been religious, but he’s always felt that the universe
brings people what they deserve. He can’t understand why the universe would
bring him a child only to take it away. The clinician nods and leans back. “You’re
grieving,” she says, “and everything you’re feeling is normal, but you’ve taken a
spiritual hit. I want us to try to delve into those moral emotions, to put your
experience in context, and to try to understand how this death has affected your
understanding of the world and your emotional well-being.” Throughout the
session, the clinician makes no mention of pathology or abnormality. She looks at
Marvin through a dynamic lens, understanding that his values have influenced his
interpretation of his son’s death, and he must rebuild his moral belief system. “We
have a support group for grieving parents that you and your wife are welcome to
join. Otherwise, I think it’d be beneficial to combine something called
Acceptance and Commitment Therapy with some meaning making work.” Marvin nods, uncrossing his arms and placing them on the tops of his knees.

Addiction

Alessandra is a 20-year-old recovering heroin addict. She would attend church with her family every Sunday since she was little, but when her mom and dad got divorced during her first year of high school, she avoided all church activities. She started stealing her mom’s old prescription opiates from her medicine cabinet and soon developed a dependency. She was then introduced to heroin by a friend when she was 15, and she dropped out of high school at 16. Alessandra’s mother tried putting her through Narcotics Anonymous (NA), then rehab, but she continued to use each time she was released. She started stealing from her mother, eventually amassing about 1,600 dollars in cash. When she turned 18, she moved out and began living with her 23-year-old boyfriend in a hostel in the city. The two quickly ran out of money and were thrown onto the streets. Their heroin supply became less and less clean, and Alessandra soon found herself in the hospital suffering from severe abdominal pain. She tested positive for hepatitis B and was put on an ammonia reducer. During her stay at the hospital, Alessandra was forced into sobriety. In her sober state, she first called her boyfriend to no avail, and Alessandra was thus reduced to calling her mother. The two reconnected, and Alessandra agreed to go back to living at home on the condition that she attend weekly NA meetings.

Each meeting, Alessandra arrives with oily hair and yellowed eyes. The first time she addressed the group, she explained that she stopped believing in
God when her dad left her for another family: “Why would God want to ruin my life? If God were real, my dad never would’ve left. If God were real, he would’ve never let me start using.” When she stopped believing in God, she lost all ability to trust those around her. The heroin high became the most reliable and consistent feeling in her life, so she placed her trust and faith entirely in the drug. The NA group members try to bring Alessandra’s spirituality to the forefront in their meetings, helping her to reconnect with God. A chaplain tends to visit the meetings once in a while, and Alessandra has started having one on one meetings with him every other week. She also started going to a therapist specialized in addiction. The two discuss the break in Alessandra’s moral belief system that led her to drug use, and her therapist stays in communication with her chaplain to ensure that she is getting both the psychological and spiritual support that she needs. Throughout treatment, Alessandra is constantly reminded that her drug use is not abnormal – her dad leaving caused Alessandra to lose her faith, and she found a different faith in heroin. The NA members, her chaplain, and her therapist contextualize Alessandra’s addiction as a response to an immoral situation, and they recognize how reigniting Alessandra’s spirituality has helped her cope with her moral dilemma.

**The Moral Future**

These case studies imagine a possible future where the moral is forefront in conceptions of psychological kinds and ways of being. In each case, the diagnosis could have been rendered as a solely psychological and/or biological problem and treated using conventional treatments such as cognitive behavioral
therapy and psychotropic medication. However, in this morally grounded future, service providers took a moral and spiritual approach to assessment and care. Taking a moral and spiritual approach, the providers engage the patients’ moral beliefs and worldviews to contextualize their psychic distress. These providers thus recognize that the behaviors of the individuals are dynamic and borne, at least partly, from morally distressing personal events, which have disrupted their understandings of the world. Their focus is not on the pathology of the brain. Instead, their approach to understanding mental distress considers the moral; it thus shows how our social and spiritual worlds are inherently tied to our mental well-being. Pathology is relocated from inside to outside the individual and to the wider social world. Acknowledging the moral dimension of psychic distress, as the concept of moral injury does, allows clinical models to observe persons’ suffering in its totality and assess the context of suffering in ways that are not possible in traditional clinical medicine.
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