Moral Injury

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Both David Puder, M.D., Herbert Harman M.D. have no conflicts of interest.

Introduction

In this episode of the podcast, we interview Dr. Herbert Harman, a psychiatrist who works as a practice line director for Vituity. He graduated medical school from the University of Virginia and performed his residency at the Western Psychiatric Institute and Clinic at The University of Pittsburgh Medical Center in Pittsburgh, PA. He would go on to be commissioned by the United States Air Force and later be deployed to Afghanistan through the United States Army attached to the 82nd Airborne Division serving as a Combat Operational Stress Control Officer in Operation Enduring Freedom.

We will be discussing “moral injury”, an emerging term defined as “perpetuating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations” (Griffin et al., 2019). Moral injury is similar to PTSD but has distinct differences. While it is often seen in military settings, various front-line careers also present opportunities for moral injury, including psychiatry.

What is moral injury?

There are considered to be two types of moral injury: betrayal-based events and perpetuation-based events.

- **Betrayal-based:** when a person of authority makes a person do something they do not want to do or does something to them that violates them in some way. It has been described as “a character wound that stems from a betrayal of justice by a person of authority in a high-stakes situation” (Griffin et al., 2019).
    - Displayed in higher levels of anger (Griffin et al., 2019)
- **Perpetuation-based:** when a person violates their own values or religious experiences, “perpetrating or witnessing actions that violate one’s core beliefs” (Griffin et al., 2019).
    - Examples of perpetuation-based injurious events could include causing or failing to prevent injury or death of a fellow soldier, killing oppositional fighters, harming or killing civilians (Griffin et al., 2019).
    - Displays higher levels of reexperiencing, guilt/shame, and self-blame (Griffin et al., 2019)

These events are often the stories patients don’t tell you. What they will tell you is the narrative they have told others, during which there will not be a lot of affect, but when they do begin to talk about the perpetrating events it will usually become so difficult that they cannot continue to talk about them.

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Those who have experienced a moral injury, while likely not using this term, would be describing a reaction to an event in which their individual sense of identity or justice is shattered by this event. The event is very personal and visceral to them, such as a deployment where a deploying officer exercises unethical behavior and may even give orders for a soldier to perform the unethical behavior, as well. This could include hurting someone or violating a personal moral code.

If a soldier has violated a deeply held conviction, often seen when they have had to kill someone, they can be faced with ruminating thoughts, trying to reconcile that after perhaps a typical upbringing, how they could end up killing someone. They are left to reconcile opposing thoughts and actions, questioning if this is who they are now or if they may have even enjoyed the experience. It is overwhelming to confront a reality of experiencing the exhilaration of saving a comrade and yet still having to face the action of killing others to do so.

Risks of Moral Injury

“Moral injury presents an increased risk of mental disorders, suicidal ideations and attempts”, feelings of guilt/shame, anger (especially with betrayal-type events), social isolation, resentment by feeling misunderstood by civilians, self-deprecation, substance abuse. This can also be seen in religious struggles, doubt, feeling abandoned by God, realizing that their actions are a violation of their beliefs and feeling they are unforgivable (Griffin et al., 2019).

Differentiating from PTSD

Moral injury can overlap with PTSD, but it is not exactly the same. With moral injury we do not see so much of the startle response, dissociation or re-experience; it manifests more in avoidance, self-loathing, depression, anhedonia, isolation, guilt and shame (Griffin et al., 2019). PTSD is also more closely related to near death experiences than moral injury. We find evidence of these behaviors and beliefs in the narrative a person tells themselves and divulges within the therapy context. They may describe not knowing who they are anymore, express a lack of motivation to care for themselves or not feel worthy of caring for others.

Because moral injury has elements that may fall under multiple diagnoses, such as depression or PTSD, it doesn’t fit nicely into any one DSM-5 box and benefits from a keen awareness of how moral injury presents differently from these other similar diagnoses. There isn’t a specific therapy known to treat it as it is in the very early stages of being researched, but a provider who knows about moral injury will know the right questions to ask and be prepared to put together a plan of care.

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	PTSD	Moral Injury
Who exposed	Anyone	Military Police CPS officer Health Care Worker
Exposure	Near death	PMIE (Potentially morally injurious event) ● Betrayal based event (betrayal by a leader or trusted authority) ● Perpetration-based event (perpetrating or witnessing actions that violate one's core belief ○ Violating own values ○ Rejecting previously held religious beliefs
Symptoms	Startle reflex, memory loss, flashback, nightmares, insomnia	● Increased risk of mental disorder and Suicidal ideation and attempts in 564 Iraq and Afganistan vets exposed to PMIEs ● Guilt, shame (especially in perpetration) ● anger (esp in betrayal) ● Anhedonia ● social alienation, ruptured social bonds ○ Perceived or actual rejection by friends/family ○ Resentment due to feeling misunderstood by civilians ○ Increases risk of suicide ● Depression (when one appraises actions as wrong) ● Internalizing problems: Self-depreciation and social isolation ● Externalizing problems: destructive behavior, aggression towards others, substance abuse ● Religious/spiritual struggles: ○ Feeling abandoned by God, doubting one's beliefs, questioning one's purpose, perceiving one's actions to be in violation of their religious and spiritual ethic ○ Felt unforgivable

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Returns from Deployment

Dr. Harman has spent much time meeting with men who have come back from deployment. Many were then usually sent on to recruitment. They would go to high schools to recruit and found themselves trying to convince the kids' parents why joining the military was a good decision; they found themselves devastated by these conversations. Marines began to talk to Dr. Harman about this combination of depression and identity understanding, the experience of what we now describe as moral injury.

Dr. Harman offers a story of an officer who had led a group in 2003 during which an Iraqi fighter was taken captive and questioned. Over time and throughout questioning they began to humanize one another, realizing they were each two humans defending what they thought was right. The U.S. soldiers wanted to work with the Iraqi fighters and befriended them with the purpose of helping set up the Iraqi military. During this time they became "battle buddies", even learning about each other's family and friends. But when one of the Iraqi fighters would be killed it was extremely difficult for the U.S. soldiers to reconcile this, as they had come to feel responsible for the Iraqi fighters. They felt like they had betrayed them, becoming friends and then sending them into battle where decisions were made that led to their death.

Also described by Dr. Harman is a Marine who was deeply patriotic and had a strong sense of honor to his country. During his deployment he had killed many people at close range. At first he felt accomplished and that he was making a difference, but over time he became less enchanted with the luster of war and began to identify himself as simply a person who kills people. He did not want that to be who he was. During his sessions, Dr. Harman noted that how he presented as a father and person was completely different from his narrative as a soldier. He was trying to figure out who he was, wondering how he could be a loving parent, a good citizen. He had to reconcile these new identities/narratives because the narrative of himself had shifted after war.

Moral Injury in Other Front-line Fields

Moral injury within a military setting is a more obvious field in which these events may be given opportunity to occur, but other front-line fields present frequent opportunities for these events, as well, such as police officers, healthcare providers, those involved with child protective services, educators and refugees (Griffin et al., 2019).

Even as psychiatrists we can feel this way, becoming disenchanted with the original purpose we set out to accomplish, burned out by the political and global difficulties that we face. The

humanitarian aspect of psychiatric work is always meaningful, but at times our profession can still slip into the pitfall of just feeling like a job. The challenges of the healthcare system can make it hard for it to continue being meaningful because the system often does not allow us to provide the treatment we think would be best for the patient. Therefore, we cannot always get people the help they truly need due to the holes in the medical and political systems. At the same time, it would be equally unfulfilling not to attempt to ensure our patients receive the best care possible despite the setbacks of the system or to fall into the notion that it is someone else's problem to deal with. But when you go into a career wanting to accomplish something great but then begin to feel like a cog in the wheel, it can feel disenchanting and become an experience of moral injury to the professional.

How can we help morally injured patients?

We often see morally injured patients prescribed benzodiazepines (sedatives might help with sleep initially, but long-term use disrupts sleep), opiates (for chronic pain even amidst the epidemic of overprescription) and stimulants (these patients can be perceived as not paying attention which could be interpreted as ADD). It is imperative to ensure these medicines make sense for them. If they do not, we should help them get off and instead move to SSRIs (at higher doses) or mood stabilizers (at average doses). We need to make sure that the medications they are on are going to make them better, not worse.

But we shouldn't necessarily consider ourselves as "med management." No one truly performs med management because it implies that the patient is the pill, that we are not reducing suffering but just facilitating a transaction. Simply managing medicine does not leave room for holding the space needed to figure out the context of why they may need an SSRI or other medication, which can leave them feeling invalidated. It is missing the point of *why*, as it relates to the rest of their body. We should appreciate and understand the context of the individual and their experiences.

When we make space to understand the complete context of our veteran patients, we should look for congruent affect in conversations. They could be talking about their symptoms but their internal and external affect be different (they look cheerful and happy but that affect doesn't match with what they are describing). If what they look like and what they are saying seem incongruent, use different ways to find congruence where what they are saying and feeling match up. Different methods to do this could include talking, writing, drawing. Use whatever method produces congruency. It is also important to connect with them over their successes. Connect with the positive and congruent negative emotion.

It is also crucial to pay attention to what is best for the patient and not always remain tunnel-visioned to strict protocol. Sometimes what is best for the patient may veer from the

standard path of care. Developing the ability to discern when it is necessary to break procedure in lieu of pursuing what the patient actually needs can be extremely valuable.
Additionally, humanizing the people who come to you is important. Some may have a history of violence in war but that doesn't mean they will be violent in your office, even if others view them as scary. Instead, consider an alternate perspective such as the possibility that they may be more of a danger to themselves outside of your office than to you in your office. This element of humanization, especially if you have the shared experience of being a war veteran, represents something unique to the vets you are serving.

Another man came into the ER with new-onset diabetes. The man said he hadn't slept well since Vietnam, which was 40 years prior. He was guarded, but shared two stories of what we would now consider moral injuries. He had never in his life told anyone either of these stories. The first was how he shot an enemy in a tunnel at close range, then realized it was a child. This experience continued to evoke considerable guilt and shame, constantly reminding him that he broke his moral code. The second experience he described was a time they were receiving heavy fire. His friend was injured with multiple shots to his abdomen and in an attempt to relieve his suffering, he gave him morphine, also realizing it might kill him. When it did, he struggled with self-blame and significant survivor's guilt. After sharing these stories, he used his Catholic belief system and prayed. Over the next few days Dr. Puder said that he was smiling and reported sleeping well. He checked in with the man a few months later to learn that he was continuing to sleep well. What the man had needed was to tap into the idea that he could be forgiven for these events and that a human being could hear his story and not reject him, and, actually, have compassion for him.

Recognize and Avoid Bias

As a provider, we cannot let our bias slip in when treating patients. (For example, if we are treating a victim of sexual assalt and, as a provider, wonder what they may have done to deserve the assault.) When we discover a bias, we should lead the patient to an alternate provider; we should probably not be the one working with this person. As with working with a vet, our thought shouldn't immediately be "you shouldn't have enlisted" or "you knew what you were signing up for". If you cannot look at the patient with compassion and understand the whole scenario and what they went through, look for someone else to care for them.

Recovery and Secondary Gains

Morally injured patients often believe their problem will keep them disabled for the rest of their life, especially in the presence of secondary gains; it is important for them to believe they can get better. Financial and political systems that are intended to help the suffering sometimes

backfire for the patient, as the patient begins to identify himself as a sick person. While it can help them get by, the financial reward and camaraderie can keep them in the disability mindset.

As therapists, we need to lean in with hope and optimism ("I believe you are going to get better."). We cannot care about their financial benefit that comes from being classified as disabled, we want to see them get better and improve their quality of life. When patients hear this, some don't come back at all and some come back thankful we gave them a new perspective. But the question of how we reach the people who are turned off by the reframing and giving up the secondary gains remains. There would have to be a systemic shift.

If the patient believes they can't rejoin society then they do not move forward; it becomes a case of learned helplessness. Even their families can try to keep them in the sick role (presumably for their own gain). These people are obviously suffering (socially disconnected, depressed, addicted). When working with patients who have become dependent on the system, be compassionate to the fact that they have been molded into this by others. We must do our own work to understand what may cause us to feel contempt or negative emotions towards them, because not addressing this keeps us from helping them. Be a voice of hope and be empathic to their distress.

Motivating people to get off medicine and onto another path is very difficult. They truly may want that deep down, but on a surface level it is very hard to do. We can ask ourselves questions that provoke us to understand who they are: What were they like before this experience? How do we help them progress with meaning in life? They need someone to help guide them back to meaning. They need someone to sit with them in the discomfort of their experiences and not be afraid of it. That's where the work is really done. Creating space so they can divulge what those things are; diagnoses can happen quickly, but relationships and space take time.

References:

Griffin B., Purcell N., Burkman K., Litz B., Bryan C., Schmitz M., Villierme C., Walsh J., Maguen S. Moral Injury: An Integrative Review. *Journal of Traumatic Stress* 2019, 00. 1-13. DOI 10.1002/jts