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EDITORIAL

Invisible wounds and suicide: Moral injury and veteran mental health

Mental ill health can affect anyone at any time, but some groups are more vulnerable than others. Defence Force veterans are one such group. Veterans are defined here as those who have or are currently serving in the military. Veterans are often faced with experiences that can leave them feeling isolated and stigmatized, including events that are acts of war as well as the unique experiences of military service. These acts of war and service experiences can deeply transgress veterans' moral codes which can result in what has been termed moral injury (MI) (Litz *et al.* 2009). MI can leave veterans in a precarious predicament of needing support but not wanting or feeling able to engage in traditional mental healthcare models.

Moral codes are shaped and evolve throughout our lives and provide the schema or the compass from which we make decisions and actions. When our moral compass is violated, a MI can occur. MI is the bio-psycho-social-spiritual distress that occurs following a violation and/or betrayal of one's moral compass (Boudreau 2011; Drescher *et al.* 2018; Shay 1994; 2014). MI has been shown to heighten poor mental health outcomes and increase the risk of suicidality in veterans postservice (McCarthy 2016; Wisco *et al.* 2017; Yan 2016).

MI is also experienced by those outside of the military, extending to any individuals who experience the emotional effects of actions (either their own or from others) that violate or disorient their moral compass (Molendijk 2018). For example, health professionals are often tasked with life and death decisions which can compromise their moral code (Ford 2019). Similarly, victims and/or perpetrators of sexual abuse may experience MI due to the nature of the abuse, as can those working in the child safety system where exposure to child abuse and limitations of protection can conflict with an individual's moral compass. Increasing suicide rates and burnout among healthcare and social care professionals have led to increased interest in how these event exposures and moral conflict intersect through a lens of MI (Ford 2019).

Empirical interest in MI to date has primarily focussed on military/veteran experiences, particularly in regard to deployment experiences. Deployment to active service heightens risk of developing MI. Service experiences and other military-related traumas such as exposure to killing and/or military sexual trauma can create environments whereby moral codes are betrayed or violated, thus creating an environment for MI to develop. However, MI has been reported among those who have not ever been deployed, suggesting that other activities of training or being in the military can also transgress moral codes. Transgressions, acts, or behaviours undertaken in military service can incite deep feelings of distrust, anger, shame, and guilt (Litz *et al.* 2009; Tangney *et al.* 2007; Vargas *et al.* 2013). The transgressive act or behaviour may be intrapersonally evaluated as a threat to the integrity of one's moral schema, or a moral disorientation (Molendijk 2018) resulting in negative psychological and emotional consequences that can heighten the risk of suicide in veterans (Bryan *et al.* 2014; Corona *et al.* 2019; Kelley *et al.* 2019; Koenig *et al.* 2019b).

ABOUT MORAL INJURY

In the last decade, an increasing focus on understanding military service-related trauma has paralleled increasing understanding of MI. Tyler Boudreau, a former Marine Captain, describes MI following his service experience in Iraq as

> Moral injury is about the damage done to our moral fiber when transgressions occur by our hands, through our orders, or with our connivance. When we accept these transgressions, however pragmatic (for survival, for instance), we sacrifice a piece of our moral integrity (2011, p. 749)

Dr Jonathan Shay, a US psychiatrist first coined the term defining MI as 'betrayal of what is right by someone who holds legitimate authority in a high stakes situation' (Shay 1994, 2014). Litz *et al.* (2009), in their seminal paper on MI, describe it as the result of 'perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations' (p. 695). The core

characteristics of MI have not yet reached universal consensus (Kelley *et al.* 2019). Notwithstanding this, MI is often theorized as resulting in shame, guilt, distrust, anger, grief, turmoil with God or a higher power, self-condemnation, and disgust (Bryan *et al.* 2014; Currier *et al.* 2019; Jinkerson 2016; Litz *et al.* 2009; Shay 2014). MI can be self-directed (individual perpetrated an act that led to a transgression of moral boundaries) or other directed (witnessing or hearing about a transgression; Schorr *et al.* 2018) and is linked with suicidality (suicidal ideation, plans, behaviour, and/or attempt) in veterans (Bryan *et al.* 2014; 2018). MI represents an existential set of issues spanning psychological behavioural, spiritual, and interpersonal from an actual or perceived violation of one's moral beliefs (Jinkerson 2016) resulting in a profound 'moral disorientation' (Molendijk 2018, p. 6) in other words 'the loss of one's moral frame of reference and one's moral self-perception' (Molendijk 2018, p. 6). These experiences cause severe intrapersonal dissonance and can lead to the development of MI characteristics and result in intrapersonal conflict, negative mental health outcomes (Jinkerson 2016; Kelley *et al.* 2019). Feelings of being a 'bad' person, through acts or inaction, can lead to feelings of unworthiness and isolation and reduce help-seeking behaviour (Dennis *et al.* 2017; Dombo *et al.* 2013; Jinkerson 2016). Such feelings can contribute to lower self-worth, lower confidence, and depression, ultimately, increasing the risk of suicidality (McCarthy 2016).

While accounts of MI appear as early as in The Iliad and Shakespearean eras, the literature on MI is mostly drawn from contemporary research in relation to the US Armed Forces where some studies have been conducted. Jordan *et al.* (2017) found around 25% of a large sample of active-duty US Marines (n = 867) endorsed perpetration and/or betrayal items on a measure for MI. Similar results were found by Wisco *et al.* (2017) in a study of US combat veterans. In the USA, psychometrically validated brief measures exist to measure symptoms of MI among veterans (Koenig *et al.* 2018). Research using that measurement tool showed that >50% of veterans with PTSD symptoms had four or more symptoms of MI in the severe range (9 or 10 on a 1–10 scale; Volk & Koenig 2019), and almost 60% of veterans with PTSD had five or more symptoms of MI (Koenig *et al.* 2018). Extending this work beyond the United States has, however, been slower, with work currently underway for an Australian version of a MI scale.

In the Australian Defence Force (ADF), suicide and self-harm cause more deaths and injury postservice than overseas operational service (Department of Defence 2016). Veteran suicide in Australia has doubled from 19 in 2001 to 42 in 2017 (Australian Institute of Health & Welfare 2019).

Comparatively, the USA loses more veterans to suicide than Australia (~22 deaths each day or 8000 per annum) and the UK loses considerably less than Australia (309 deaths between 1998 and 2017, ~15 per annum). In Australia, ADF veterans under 30 years of age are dying by suicide at twice the rate of the civilian average (Australian Institute of Health & Welfare 2019). From 2001 to 2017, the Australian Institute of Health and Welfare (2019) recorded 419 suicide deaths in serving, ex-serving, and reserve ADF members. The age-adjusted suicide rate was recorded as 18% higher for ex-serving members (Australian Institute of Health & Welfare 2019) and lower for those serving and in the reserves. Suicide-related behaviour is four times higher in the ADF than the general population (Australian Institute of Health and Welfare 2019), and poor mental health is more prevalent with trends increasing (Department of Defence 2010; 2016). The incidence of the rising suicide by veterans in Australia will continue to be an issue demanding national attention. Risk factors most often associated with combat experiences, such as PTSD, do not sufficiently explain increases in suicide in the military service; however, many theorists are now suggesting that MI may provide greater insight into this phenomenon (Bryan *et al.* 2018; Hodgson & Carey 2017; Jinkerson 2016; Jordan *et al.* 2017; Kelley *et al.* 2019; McCarthy 2016).

CLINICAL CONSIDERATIONS

MI can have devastating effects on mental health (Maguen & Litz 2012; McCarthy 2016) and has been linked to suicidality (Ames *et al.* 2018; Bryan *et al.* 2018; Kelley *et al.* 2019; Koenig *et al.* 2019b). MI symptoms are often misdiagnosed or mistaken for PTSD, and although PTSD and MI can comorbidly exist, there is growing research indicating that PTSD and MI are distinct constructs albeit with some overlapping features (Bryan *et al.* 2018; Jinkerson 2016; Koenig *et al.* 2019a). Clinicians are regularly left treating PTSD symptoms and comorbid disorders (e.g., mood disorders, substance abuse, and risk of suicide) without identifying the underlying symptoms of MI. Despite having access to numerous evidence-based treatments for PTSD, MI may go some way to explain why outcomes for PTSD are so poor (Koenig *et al.* 2017). Without understanding MI and the military

culture, clinicians can be dismissed as 'not understanding' or 'not getting it', impairing the therapeutic alliance and subsequently hindering treatment. Failure to recognize and address MI may also damage successful rehabilitation of veterans.

Unlike PTSD, MI is not considered to be a mental illness, yet it does affect mental health. Until recently, the longer-term implications of MI have not been understood or addressed when diagnosing and treating PTSD. However, since the concept of MI first emerged, mental health clinicians and others with interests in the mental health of defence force service personnel and subsequent discourse are increasing exponentially. To date, MI does not feature in the current Diagnostic Statistical Manual and debates continue as to whether MI should be considered a diagnosable mental health condition or a normal human response to an abnormal event(s) (Frame 2015; Molendijk 2018; Nakashima & Lettini 2012). The reality is that to feel shame and guilt at having participated in acts that are considered immoral is an indication of an intact and functioning moral code (Molendijk 2018). Distress therefore is the consequence of being a moral person, and in some cases, self-blame may not be inaccurate. Thus, we could view MI as a natural reaction to an unnatural experience, questioning the validity of diagnosis and treatment approaches for MI.

Meanwhile, treatments traditionally used to target PTSD symptoms may be counterproductive for those with a MI, particularly exposure therapies which can worsen shame-based symptoms (Steenkamp *et al.* 2015).

Cognitive processing (CPT) and prolonged exposure therapies (PET) are the preferred approaches for the treatment of PTSD in both the USA and the Australia, but the evidence shows that dropout rates are high and success rates are low (with approximately two thirds of patients receiving CPT or PET still meeting the criteria for PTSD at completion) (Steenkamp *et al.* 2015). Nevertheless, new approaches to address the outcomes of MI are emerging and being tested. Adaptive Disclosure Therapy and Acceptance and Commitment Therapies (Farnworth *et al.* 2017; Litz *et al.* 2017; Pearce *et al.* 2018) show some promise. These treatments provide hope and possibility of relief to veterans who currently experience PTSD and related disorders but are not experiencing improvements.

CONCLUSION

Moral codes intrinsically underpin the human condition; thus, it is questionable whether MI will ever be completely avoided (especially during conflict) and to avoid deeper moral questioning of any act of force (lethal or otherwise) by a society is unacceptable (Meagher & Pryer 2018). Therefore, pragmatically it is important for all who work or engage with veterans to firstly understand the veteran population and how their training, conditioning, and service exposure(s) can lead to the development of MI, and also understand MI as a distinct construct from PTSD that can arise in both serving and non-serving members of the Defence Force.

Ultimately, therapeutic or mitigating actions could well be taken against this increasing issue. Therefore, clinicians would also benefit from enhancing their understanding of MI in other specific populations; knowing how to identify MI, who to refer to, and what kinds of treatments/supports are available for those living with MI. Research into MI is still in its infancy in Australia, and several gaps in our understanding remain. Clearly, further research is required into MI from an Australian context.

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