



Critique of the standard model of moral injury[☆]

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ABSTRACT

This article seeks to describe in general terms what has become the standard way of conceptualizing moral injury in the clinical psychological and psychiatric literature, which is the key source for applications of the concept in other domains. What we call “the standard model” draws on certain assumptions about beliefs, mental states, and emotions as well as an implicit theory of causation about how various forms of harm arise from certain experiences or “events” that violate persons’ moral beliefs and systems. Our analysis makes these assumptions more explicit and subjects them to critical scrutiny. In so doing, we survey the current literature and identify basic features of how moral injuries are defined, how they are thought to occur, and the forms of treatment or repair that appear to be indicated. We caution that it matters how moral experience is characterized and argue that an alternative understanding of what is the *moral* in moral injury is important for overcoming critical challenges to the standard model. Moreover, recently evolving approaches to moral repair could be more consistent with an alternative model. Our concluding suggestion is that a more robust account of the nature of moral experience and its relations to self-identity and social experience more generally could advance understanding of the etiology of moral injury and promote rehabilitation.

1. Introduction

Moral injuries have been identified and characterized as a form of trauma in the context of clinical psychiatric practice, principally among military populations. In this article, we elaborate what we call ‘the standard model’ of moral injury. Our aim is to articulate the most common and influential ways of characterizing moral injuries and their presumed etiology, namely how such injuries occur and what they ultimately *are*. Several problems with the standard model are identified. In particular, the standard model of moral injury construes morality as reducible to a set of beliefs and related emotional responses. On this account, when a person observes or experiences violations of those beliefs, this is potentially psychologically injurious, and strong negative emotional reactions follow. Moral injury is most often characterized in the clinical literature as a form of intra-psychic dissonance, a psychological state and manifestation of stress, something *in our heads*, so to speak. Therapeutic interventions and standards of care largely revolve around dissolving, reducing, or mitigating the dissonance or psychological stress, or regulating the related emotional responses to it. Our chief claim is that the location of the *moral* in moral injury in a *set of beliefs or mental states* produces numerous challenges for the etiological

characterization, including explaining how and why some people get injured and how to promote healing or repair. We then make some suggestions for modification of the conceptual model that could facilitate advances in research and pathways for repair. The latter are speculative, since the modified conceptualization would still need validation and refinement in its applications and implications for treatment.

1.1. Moral phenomenology

Colloquially speaking, we propose that research on moral injury could be advanced by getting morality *out of our heads*, by which we mean limited to a personal code, set of principles or norms or values, specific beliefs about right and wrong or good and evil, and various senses of agency and responsibility. Our primary contribution to the discussion entails placing greater emphasis on moral *experiences* rather than moral *beliefs*. Moral beliefs can take many forms and can be rooted in a variety of worldviews, spiritual and otherwise. Moral beliefs can be derived and refined from a variety of deliberative and evaluative processes, including those that have an evolutionary biological basis. Moral experiences are rooted in relationships—to others, ourselves, and our natural and social environments. Moral experiences primarily occur in

[☆] No artificial intelligence was used in writing this paper.

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<https://doi.org/10.1016/j.newideapsych.2024.101107>

Received 23 December 2023; Received in revised form 29 June 2024; Accepted 29 June 2024

Available online 24 July 2024

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contexts of experiences of relatedness rather than repositories of moral statements, codes, rules of conduct, norms, or specific principles or values. Moral experiences inform beliefs but are not reducible to them. Moral beliefs also influence experiences, and experiences certainly shape beliefs. Minimally, this is how *morality* appears and becomes concrete in persons' lives, what philosophers describe in terms of moral phenomenology.¹

1.2. Experiences and relationships

Our ultimate claim is that moral injuries emanate from ruptures or breaks in the *relationships* that provide the basis for moral experiences for persons, including their senses of themselves as moral agents with moral worth and possibilities.² Instead of considering morality as a set of discrete beliefs subject to stress, injury, and repair, we argue that moral injuries are observable as linked with experiences *in the world*. These are, at least partially and substantially, derived from relationships with others, communities, social and cultural organizations and institutions, workplace environments, and even shared physical spaces and natural environments. In this light, moral injuries arise from ruptures and fissures in the conditions for moral life and not solely from conflicts within and among specific moral beliefs or belief systems.

1.3. Impacts on (and of) treatment and care

There is significant potential impact to be realized from adopting this perspective. A more adequate conception of the experiences underlying moral injuries could advance clinical care and treatment and potentially facilitate identifying more effective preventive efforts. Once we get morality out of our heads and see it as evident in broader relational contexts, it becomes clearer that failing to attend to moral injuries also deepens harms to the broader communities. This is because communal recognition and assertion of moral norms and values—and *their violations*—is how those very same moral views gain their weight and force. Because moral injuries have social and communal contexts, they are likely to reflect damages that are also evident in the broader community or society.

1.4. Methodology

Our effort is a narrative review, chiefly of the scientific literature on the topic of moral injury. Our primary focus is on the literatures arising from and referring to the analyses emanating from the clinical context, which we summarize below. This is not to say that there are not considerable literatures that are rooted in other contexts and traditions, and we include references to those to the extent to which they refer to the target literatures. Our selection of this target is consistent with

¹ Philosophers have developed complex taxonomies of facets and types of human experiences and how these determine or influence what and how we think. Phenomenology concerns the character of human experience; informally, this includes what-it-is-like to experience something or to have a certain type of experience. A well-known example of this is “flow experience” (Csikszentmihalyi, 1991). Philosophers have also developed a variety of scientific methods of analysis of various types of experience, including moral experience. For examples of this approach, see Audi, 2013, Annas, 2008, Horgan & Timmons, 2008.

² The theoretical grist for this particular conception of moral experience is informed by the phenomenology of relational ethics (e.g., Walker, 2006), but this account of how moral experience occurs can be compatible with other forms of moral systems and ways of grounding particular moral frameworks.

bibliometric indicators of the most frequently cited literature defining moral injury and applying it to other contexts.³ Our disciplinary approach is philosophical, drawing on methods of conceptual analysis, theories of morality, analyses of moral experience, and contemporary literature in moral psychology. The goal of this article is to identify the predominant conceptual model of moral injury and subject it to critical scrutiny,⁴ particularly as evident in the context of observable human experience and structures of meaning. Our effort seeks to *revise*, not replace, the prototypical model of what a moral injury is in order to support further advancement.

2. The standard model of moral injury

In this section, we briefly summarize the development of the concept of moral injury as it is most commonly cited in the current literature. Our aim is to identify and characterize the conceptual construct that is most often relied upon by others who elaborate or develop accounts of moral injury, demonstrating how what we call ‘the standard model’ is reproduced. This is not to deny that there are other accounts, however we observe that even views that appear to challenge widely accepted characterizations can end up recapitulating certain key features. In the subsequent sections, we offer a critique of the standard model by identifying some problematic and limiting assumptions it entails. In particular, we argue that the way these accounts characterize what is *moral* in moral injury constrains conceptualization of *what* is injured and *how* one becomes injured. These limitations impact the options for reducing or remediating moral harms.

2.1. Evolution of clinical moral injury research

Research on moral injury includes what might be regarded as first and second wave conceptualizations. The most influential definitions arise from observations and analyses of moral injury in contexts of experiences of war (Shay, 1995, Litz et al., 2009; Nash et al., 2013; Jamieson et al., 2020). A distinctive feature of moral injury literature arising from clinical settings of veterans' hospitals is that it was observed in cases in which people were *perpetrators* of violence as well as among those who witnessed it second-hand. Related conceptualizations of moral harms that could be experienced by those subjected to violence were previously observed in other contexts (see Walker, 2006 for examples in the context of *moral repair*; see also Murphy & Hampton, 1988, particularly on *forgiveness* and *retribution*). Similar phenomena have been and continue to be observed by others in contexts other than experiences in war. The most relevant are applications of the moral injury concept to experiences of healthcare workers, particularly among nurses (Dean et al., 2019; Epstein et al., 2021; Ulrich & Grady, 2019; Campbell 2016; Murray et al., 2018; Fourie, 2017) but more recently expanded to include physicians and all healthcare workers in the context of response to the COVID-19 pandemic (Borges et al., 2021; Lowry et al., 2023; Mewborn et al., 2023; Murthy, 2022; Rushton et al., 2021; Shale, 2020;

³ As of June 19, 2024, Litz et al., 2009 is the most-cited work related to moral injury with 2900 citations as captured by Google Scholar. This work is also the foundational study referenced in the entry on “moral injury” on the website of the U.S. Department of Veterans' Affairs, “PTSD: National Center for PTSD” http://www.ptsd.va.gov/professional/treat/cooccurring/moral_injury.asp.

⁴ In essence, our identification of what we describe as the “standard model” of moral injury is intended to support a critique of the prototypical construction that underlies the conceptualization of moral injury as a distinctive and observable phenomenon available for investigation. An underlying presupposition is that such prototypical formulations influence *how* one organizes, advances, and conducts research (Lakoff, 2008). For example, the prototypical construction of the atom as like a solar system, as Bohr characterized it, shaped (and limited) the development of atomic physics. Advances in science can be realized when prototypical constructions that are fundamental for characterizing the phenomena subject to investigation are revised or replaced.

Williamson et al., 2020), first responders and those engaged in policing (Joannou et al., 2017; Koenig & Al Zaben, 2021) and in accounts of trauma and generational trauma, particularly among victims of widespread and extreme violence such as survivors of genocide and rape (Wiinikka-Lydon, 2020; Bernstein, 2015), in the contexts of slavery and institutionalized racism (Stoute, 2021; Kelle, 2020; Norris & Primm, 2023), and in experiences of displacement (Dunn, 2021; Hoffman & Nickerson, 2021; Potts & Abadal, 2023).

First wave research on moral injury stems from the work of Jonathan Shay, whose clinical experiences with U.S. veterans of the Vietnam war allowed him to observe symptoms resembling post-traumatic stress (Shay, 1995).⁵ Notably, these patients did not meet formal criteria at the time for post-traumatic stress, because the traumatizing events revolved around participating in and observing violence, rather than being its subject, and experiencing non-life-threatening betrayal. From this beginning, trauma has been the dominant interpretative framework for moral injury, and this has shaped the clinical diagnostic and assessment apparatus as well as efforts to develop therapeutic treatments (Wiinikka-Lydon, 2019).

While Shay drew heavily on sources in ancient literature (and to some extent, classical and contemporary philosophy and moral psychology), a second wave of moral injury literature focuses on clinical psychological and psychiatric research, theories of human development, and to some extent hypotheses drawn from evolutionary biology (e.g., Litz, 2024). This body of literature focuses largely on extension of the tools of modern clinical diagnosis and practice along with formal treatment protocols. In the second wave of moral injury research, diagnostic criteria and an event-scale series were developed to support a clinical apparatus for treatment, including a typology of forms of moral injury (Litz et al., 2009; Nash et al., 2013; Litz & Kerig, 2019), and formal protocols for treatment (Farnsworth et al., 2014; Litz et al., 2015; Koenig & Al Zaben, 2021; Kelley et al., 2022; Litz, 2024; see also Wiinikka-Lydon, 2019). Second wave research on moral injury also occurs in the context of treating veterans and active-duty military combat personnel, primarily from the U.S., connected with the wars in Afghanistan and Iraq, although this scope and the application of psychometric measures have expanded (Litz, 2024).

Both “waves” of moral injury clinical studies have influenced the studies that extend and expand the concept of moral injury and apply it to other circumstances, populations, and experiences. In particular, second wave research on moral injury has been applied to analysis and interpretation of the experiences of persons in combat zones in other parts of the world and in the context of service among persons other than U.S. citizens (Kellison, 2021, Litz, 2024). An early diagnostic instrument, the Moral Injury Event Series (MIES) has been administered to groups outside of combat situations (Koenig & Al Zaben, 2021). However, this influence of research beyond the original context of experiences in war is generally not bi-directional: while researchers concerned with identifying moral injuries in contexts other than war (such as healthcare settings during the COVID-19 pandemic, experiences with racial discrimination, and conditions of displacement) draw on the literature arising from observation and treatment of war veterans, generally speaking, it is rare for clinical researchers focused on identifying and treating moral injury in the military context to draw on examinations of moral injury in other domains (Nieuwsma et al., 2022; Williamson et al., 2020). Thus, moral injury clinical research and its applications are firmly rooted in a pathological trauma model, which has shaped the predominant conceptualization and definitions.

2.2. Paradigmatic definitions

Shay’s capacious and lyrical conception of moral injury construes it

⁵ See also Bica, 1999 for an earlier, first-person account and a philosophical framework of moral experience.

as arising from harms done to a person’s moral worldview, what Shay describes in terms of a deeply personal sense of “what’s right”. Specifically, moral harms arise from betrayal of “what’s right” by an authority figure. The transgression of this boundary ultimately results in the unravelling of the person’s moral character, which psychological developmental theory tends to treat as fairly stable after maturation (Shay, 1995, pp. 37, 169). Shay is particularly focused on how this “undoing” manifests in what he describes as a “berserk state” (Shay, 1995, p. 77), including explosive violence. The “wrath of Achilles” in Homer’s *Iliad*, and particularly Achilles’ rage evident in his treatment of the corpse of Hector, exemplifies what Shay describes. In Shay’s account, moral injury among combat veterans becomes characterized in terms of persistent trauma, emotional dysregulation and dysfunction, and suicidal ideation.

The most frequently cited discussion in the literature inaugurating the second wave definition of moral injury defines it as stemming from “an act of transgression that creates dissonance and conflict because it violates assumptions and beliefs about right and wrong and personal goodness [...] resulting in psycho-bio-social impairment characterized by diminished opportunity for ‘life affirmation’” (Litz et al., 2009, p. 698). Clinicians and researchers in this vein characterize moral injury as arising from an event in which one experiences a violation of one’s moral beliefs. In this context moral beliefs are broadly construed as including conceptions of rightness and wrongness, deeply held values, or a personal code of conduct. According to this account, moral beliefs inform expectations about how we and those around us should act. Moral injury occurs for some people when these expectations are transgressed in some significant way. While there are some exceptions, this definition of moral injury is relatively standard among clinicians in the second wave (e.g., Cahill et al., 2023; Carey et al., 2023; Farnsworth, 2019; Koenig & Al Zaben, 2021; Maguen et al., 2023; Nash et al., 2013; Williamson et al., 2021). This formulation of moral injury is also standardly used outside of the clinical realm. Philosophers and ethicists writing about moral injury often cite Litz et al., 2009 when defining what moral injury is (e.g., Kirkpatrick, 2015, 2022; Tessman, 2023).

Nancy Sherman is the most substantial contributor to the philosophical literature on moral injury in a military context. Her work somewhat bridges first and second wave efforts as she describes moral injury in terms of “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; see also Sherman, 2023, p. 132). Sherman also brings to bear extensive knowledge of philosophical theories of morality and their connections with broader human experience. Essentially, Sherman retains the standard model formulation of locating the primary site of traumatic injury intra-psychically as evident in the definitions above, although she offers a much richer sense of what moral experience is.⁶

Recent formulations of moral injury consider how moral injury is evidence of maladaptive coping with moral distress, including maintaining distorted *moral meaning* (Farnsworth et al., 2017, 2019). In this case, the therapeutic remedy includes engaging in cognitive processing to fix the faulty appraisal and alleviate the (resultant) emotional responses. Nash relies on a stress-injury construct and regards moral injury as a stress disorder, which he describes in terms of “literal harm to

⁶ More recently, Sherman has focused on what she describes as the “pragmatics of expression and the subtle interpersonal transactions and reciprocations that can sow the seeds for moral healing” (Sherman, 2023, p. 131). We agree that moral injuries arise in pragmatic, socially embedded contexts and therefore that addressing them or making amends, should focus not only on psychological “repair” for the person most immediately affected but also the broader social context, as we discuss below. Our goal in this paper is to explicitly identify the conceptual model of injury that appears to be an impediment to pursuing this line of inquiry in the clinical context in which Sherman’s work has not had much uptake.

intrapyschic structures and processes regardless of coping tactics” (Nash, 2019, p. 466; see also Nash, 2011). When these intrapsychic harms occur “the boundary between normal, reversible moral strains and irreversible (even if repairable) moral injuries is defined by the appearance of distress or alterations in functioning that persist despite adequate rest” and “on an identifiable continuum with the multi-system deteriorations and premature aging” that are also characteristic of Post-traumatic Stress (Nash, 2019, p. 468; see also Nash, 2011).

2.3. Presentation/manifestation of moral injury

In both waves of literature, symptoms of moral injury include dysfunctional ideation, such as intrusive recall; dysfunctional behavior, including avoidance; dysfunctional emotional regulation, including numbing or proneness to overreaction and explosive anger; and experiencing the world as fundamentally corrupt or meaningless, including being unwilling or unable to sustain meaningful relationships even among family and friends.

The clinical apparatus of the second wave includes development of various psychometric instruments, diagnostic assessments, and prospective treatment protocols. These vary, but those most frequently cited in the literature include: the Moral Injury Events Scale (MIES) with subscales of different types of violations, including: “Perpetration Other,” “Perp Self,” and “Betrayal” (Farnsworth et al., 2017; Hoffman & Nickerson, 2021; Koenig & Al Zaben, 2021; Litz et al., 2022; Nash et al., 2013; Bryan et al., 2016; Williamson et al., 2020); the Moral Injury Outcome Scale (MIOS), which relies on “event linkage” as indicated in the MIES (Litz et al., 2022, p. 3) and captures specific outcomes related to subtypes and their intensity; and a treatment protocol that is relative to the subtype and outcome, called “Adaptive Disclosure-Enhanced” (AD-E) (Litz, 2024).⁷ We emphasize that these are not the first or the only instruments to attempt to measure and indicate treatment for moral injury and related distress, but these are the most frequently cited in the literature and the most expansively subjected to validation studies, particularly in cross-country contexts.

The most current applications of the clinical apparatus to standards of care includes: (1) assessment of exposure to potentially morally-injurious events (MIES; this is taken as a critical first step); only then (2) assessing for symptoms of moral injury (the MIOS), and (3) aligning care with the indicated subtype of moral injury (for some, this is AD-E, which we discuss below in the section on treatments). In addition to these measures that have been developed specifically for moral injury assessment, there are trauma-related measures and standards appropriate for construal of moral injury as ultimately a subtype of trauma.⁸ Benefits of the recent efforts to validate the MIOS instrument include realizing the opportunity to observe evidence of moral injury across multiple cultural contexts and service experiences, including also among first responders, and realizing the ability to observe and measure change in moral injury outcomes and symptoms.

Analysis of the initial screening instrument, which is supposed to establish relevant “event linkage,” the MIES, provides some insight into clinical assumptions about the substance and distinction of what constitutes and distinguishes morality as the facet of an individual’s experience that is subject to damage. The MIES instrument uses a 6-point

⁷ Adaptive Disclosure-Enhanced is a revised version of the Adaptive Disclosure treatment protocol (Litz et al., 2017). The full manual for Adaptive Disclosure-Enhanced is still in press, but it has been used in a clinical trial. See Litz et al., 2024 and discussion by Litz in Litz 2024.

⁸ Our account in this paragraph largely follows and is consistent with the characterization of the current state of clinical research and treatments as represented in the entry “Moral Injury,” Sonya B. Norman, and Shira Maguen, on the PTSD: National Center for PTSD website of the U.S. Department of Veterans Affairs: https://www.ptsd.va.gov/professional/treat/cooccurring/moral_injury.asp (accessed June 19, 2024).

scale (without a neutral midpoint) to register levels of agreement or disagreement with a variety of statements, including.

- I saw things that were **morally wrong**.
- I am troubled by having witnessed others’ **immoral acts**.
- I acted in ways that violated my own **moral code or values**.
- I am troubled by having acted in ways that violated my own **morals or values**.
- I violated **my own morals** by failing to do something that I felt I should have done.
- I am troubled because I **violated my morals** by failing to do something I felt I should have done
- I **feel betrayed** by leaders who I once **trusted**.
- I **feel betrayed** by fellow service members who I once **trusted**.
- I **feel betrayed** by others outside the US military who I once **trusted**.

The MIES and other instruments make a variety of assumptions that it is worthwhile to articulate. They assume that respondents will have moral beliefs about rightness and wrongfulness, morality and immorality, and that these same beliefs are observable, self-recognizable, and discrete (from other beliefs). They also assume that moral beliefs are largely coherent and primarily relative and personalized (evident in repeated references to “my own”). They further assume that these moral codes or values (there is significant equivocation in use of these terms) are linked with specific compulsory actions; and that trust and betrayal are fundamentally connected and have moral salience. From a philosophical perspective, there are many questions to consider with respect to these assumptions, but that is not our main concern. What we want to highlight is that in all cases, the instrument assumes that morality resides in beliefs and related reactive emotions. Ultimately, what is characterized as ‘morality’ in these presentations and discussions is something that persons think and feel, affirm and deny. In essence, it is *in our heads*, something that is a feature of our mental and psychological make-up. This atomistic and individualistic account of what morality is presents challenges for characterizing the etiology of moral injury, or how such moral harms occur.

2.4. Etiology of moral injury

As mentioned, the clinical formulations identify three subtypes of moral injuries, depending on how they arise. These are distinguished by the nature of the event through which the violation occurs, including being the agent of violence (doing harm), witnessing violence (observing harms committed by others), or experiencing betrayal (experiencing non-violent harm). But it is not the case that everyone who has these experiences ends up with moral injuries, and a refinement scale was renamed “Potentially Morally Injurious Event Scale” (PMIES) (Farnsworth et al., 2017).

What we describe as the standard model of moral injury can be distilled along these lines. Even those who examine moral injuries in other contexts (Haight et al., 2016; Hoffman & Nickerson, 2021; Koenig & Al Zaben, 2021; Williamson et al., 2020) and even those who describe other influences and who recognize broader contexts through which moral beliefs, values, and norms are formed (Bonson et al., 2023; Potts & Abadal, 2023) still largely reiterate the etiological model, or causal structure or pattern, of moral injury in this same way.

1. People have beliefs about moral matters.⁹
2. Events occur that run contrary to those beliefs, creating a conflict.¹⁰
3. The conflict of '2' is itself so significant that it is traumatic. This **internal conflict** is the source and site of the injury in persons experiencing moral injury.

In the standard model of moral injury, the causal account supposes that violations of specifically moral beliefs, themselves, are somehow traumatizing. Explaining this as a form of trauma has proven difficult for clinical researchers.¹¹ Generally speaking, the type of conflict it creates is variously described in terms of cognitive dissonance, a stress injury, a “shattering of character,” or an experience laden with moral residue of intense emotional responses to the conflict (Farnsworth et al., 2014; Nash, 2019; Williamson et al., 2021).

Moral injury resembles post-traumatic stress insofar as it is conceptualized as a form of trauma, however, the primary source of violence in these cases is not physical harm but rather psychological harm, specifically to those beliefs that are moral in nature. Importantly, this psychological harm threatens or puts at perilous risk one's sense of one's moral self, resulting in significant and intense emotional distress leading to dysregulation. In some accounts, the very fact of being injured in this way is laden with moral consequences (i.e., by violating the view that it is wrong to damage a person's moral self), leading to a global sense of loss of meaning and value in a patient's personal relationships and life overall (e.g., Bernstein, 2015; Edmonds, 2015; Shay, 1995). What the clinical apparatus observes is serious harm to what might be called a person's moral identity—of themselves, others, their community (or primary social group), or even humanity as such. The clinical presentations provide robust support for this insofar as persons who are morally injured often present with global impairments that are not limited to their relations associated with the particular contexts in which they experienced moral challenges. Thus, we wish to make it clear that we agree that the standard model clearly identifies a real problem in need of a response.

2.5. Treatments for moral injury

Clinical approaches to treatment and forms of “moral repair” have included various modalities. Rather than evaluating specific forms of treatments, we seek to gain insight into the moral epistemological and ontological assumptions in the standard model of moral injury as evident in the treatment mechanism and hypotheses. A quick review of

⁹ The presumed sources of these beliefs can vary considerably, as stated above, including a personal code, or character formations arising from cultural and social organizations, such as Shay's idea of the army as a moral construction (Shay, 1995; Brock and Lettini 2013). Other sociological and anthropological accounts include recognition of larger social and cultural influences (Zigon, 2007; Molendijk et al., 2022). Some discussions also integrate spiritual and religious ideas (Brock and Lettini 2013; Carey et al. 2016, 2023), culturally derived senses of right and wrong (Potts & Abadal, 2023), and values and norms arising from evolutionary bio-psychological bases (de Waal, 2003; Litz & Kerig, 2019; Litz 2024).

¹⁰ This is measured by and confirmed through the MIES – Morally Injurious Events Scale. Three specific types of belief-violation are observed in clinical assessments of those in combat and emergency health settings (Litz et al., 2022; Williamson et al., 2021).

¹¹ The problem is compounded by the fact that very same events that are instances of actions that are presumed to run counter to the injured person's moral beliefs might also be susceptible to prompting high levels of fear and therefore potentially traumatizing in their own right. The standard model is compatible with this overlap: the same event in the context of war, for example, can prompt post-traumatic stress in the way it is more commonly understood. But the moral injury researchers assert that there is a distinctive form of psychological trauma resulting having one's moral beliefs violated and that is the root cause of moral injury.

some of these treatments further discloses how researchers construe moral experience and their hypotheses about how moral injuries occur. Emotional processing treats symptoms of injury manifesting as emotional dysregulation. It prioritizes regulating the moral emotional responses over sorting through the moral contents, and it is a treatment modality associated with PTSD. Schematic restructuring is consistent with the view that moral experience is filtered through a personal code or other mental structure or content. It is presumed to work by modifying the schematic structure or model persons use to define and make sense of events to remodel it in such a way that it produces a less stressful or anxiety-producing interpretation of events. Exposure therapy or Prolonged Exposure attempts to mitigate traumatic stress by tempering the fearful response to a perceived threat by recreating that event in an otherwise safe and supportive environment (Held et al., 2018; Smith et al., 2013). Adaptive disclosure is a therapeutic treatment that involves creating the conditions for forgiveness (of self or others) by imaginatively engaging with persons harmed, perpetrators, or a recognized moral authority to resolve the conflict and develop compassion (Litz et al., 2017; Gray et al., 2012).¹² Other treatment protocols, including those that have been studied in clinical trials, have also targeted restoration of a relationship with a Higher Power following traumatic events, such as those experienced in war, in which persons “violate their previous sacred beliefs and values” resulting in spiritual distress and “disintegration” (Harris et al., 2018, p. 420).¹³

3. Limitations of the standard model

As suggested in the overview above, there remains work to be done in the clinical literature in characterizing what is the moral in moral injury. Until this is clearer, it is difficult to understand what is injured and how it might be repaired. We have identified at least two problematic assumptions evident in the standard model: namely, the problem of definition (i.e., what is injured) and the problem of etiology (i.e., how these injuries occur). Once these two problems are further elaborated, we turn to a general limitation moral injury clinical research currently faces. It might well be the case that the framework of trauma is not the best (or at least not exclusively so) for understanding the mechanisms of moral injury and the most promising pathways for treatment. The predominant framework of the standard model, in which morality is characterized in terms of personally held beliefs and feelings, limits the assessment and repair of moral injury.

3.1. The problem of definition

As shown above, there is significant equivocation and lack of precision in the standard model with respect to moral contents: what is violated in moral injury is sometimes identified as a personal code, a set of principles or norms or values, specific beliefs about right and wrong or good and evil, and various senses of agency and responsibility. The standard model construes the locus of moral existence as inherent in features of our psychological constitution, as though morality were somehow reducible to a set of beliefs or ideas. This makes what it is that is moral difficult to observe and challenging to address. This may be one of the most significant limitations of the standard model of moral injury

¹² Adaptive Disclosure-Enhanced, a revised version of the earlier treatment, has recently been used in a controlled study. See Litz et al., 2024; Carey et al., 2023 describes a similar rehabilitation protocol that can be conducted through pastoral counseling, combining Adaptive Disclosure and “Confessional Practice” in the form of what they call “Pastoral Narrative Disclosure” (see also Carey et al., 2016; Hodgson & Carey, 2017).

¹³ The relevant intervention is called “Building Spiritual Strength,” and it targets post-traumatic stress broadly rather than moral injury alone. Dimensions of “Building Spiritual Strength” appear to be integrated in “Adaptive Disclosure-Enhanced” (Litz, 2024).

and a primary impediment for making progress in understanding how moral injuries occur and how they might be remediated and prevented.

3.2. The problem of etiology and site of conflict

The standard model of moral injury also cannot account for how specifically moral beliefs are entwined with, distinct from, and interact with other features of mind such that they could explain *why* the violation of those beliefs is traumatic (or potentially so), and how that results in the types of global impairments that accompany cases that rise to the level of clinical observation. This presents challenges for identifying and characterizing the types of conflicts that rise to the level of injury, including how it is that some people experience these while others do not. For example, in what contexts is it injurious to witness others acting in ways that are inconsistent with a person's moral beliefs? We have exposure to witnessing others engaged in activities that violate our moral beliefs with some regularity. This occurs in our everyday experience, although perhaps not in life and death situations, and we do observe it with a similar degree of high-stakes situations in news reports and in fictionalized accounts in literature. Those instances are not injurious.¹⁴ Furthermore, dissonance alone is not necessarily harmful, much less injurious (Lang & Schott, 2023). Contradictions among and between our moral beliefs happen with some regularity. In such cases, these conflicts are "resolved" by suspending some beliefs. This occurs even in contexts of war, and some have explored how this potentially prevents or avoids moral injury (Molendijk, 2023). A more robust explanatory model would need to account for why some circumstances lead to injuries and only among some persons. Furthermore, if witnessing the violation of our moral beliefs is harmful, then we might expect that this same mechanism could be utilized to promote moral rehabilitation, namely, that having experiences that are consistent with and affirm one's deeply held moral beliefs should facilitate moral repair—but witnessing events that affirm one's moral beliefs does not undo the damage caused by moral injury. This casts doubt on the assumption that moral injury is *primarily* caused by a violation of one's moral beliefs, in the first place.

3.3. Potential limitation of the trauma framework: 'events'

That moral injuries might arise in contexts other than exposures to "events" in the way that the standard model considers can be observed when considering moral injury outside of veteran combat experiences. These other contexts include, for example, workplace examples such as so-called "dirty jobs" (Press, 2021), experiences with forms of institutional and structural racism and discrimination, and experiences of displacement. In these cases, moral injuries seem to arise from the *accretion* of seemingly ordinary events and circumstances, or, as in the case of displacement, the radical disruption of the general conditions that anchor everyday life and ordinary interactions that ground and found moral communities (Stoute, 2021; Hoffman & Nickerson, 2021; Potts & Abadal, 2023). The clinical limitation of scope and construal is a potential problem both for understanding moral injury in the military context and for what we stand to glean, positively, about what morality is. In other words, it potentially limits our ability to discern what is important about moral experience in human life and its centrality in our everyday lives through observation of the ways it can breakdown.

¹⁴ There are potentially relevant exceptions to more remote exposure in observing instances of others engaged in behaviors that involve moral violation. This includes, for example, "commercial content moderators." "When I left MySpace," one reported, "I didn't shake hands for, like, three years because I figured out that people were disgusting. I just could not touch people. I was disgusted by humanity when I left there. So many of my peers, same thing. We all left with horrible views of humanity." For a recent study, see Spence et al., 2023, Naughton 2017.

3.4. Examples of moral injury that are challenging for the standard model

Some first-person accounts of moral injuries among veterans also suggest that event exposure might not be the only available framework. For example, Tyler Boudreau (Boudreau, 2011) recounts his experience as a Marine in Iraq. Although he endorses the view that he experiences moral injury, he does not identify a traumatic event of violating personal beliefs. Instead, he recounts that he began to experience what he later identified as moral injury during an otherwise peaceful interaction with Iraqi civilians (Boudreau, 2011, p. 746). For Boudreau, his moral injury resulted from a long-term experience of being a soldier occupying Iraq and interacting with civilians, not from any one specific or individual event (Boudreau, 2011, p. 752).

Lieutenant Colonel Bill Russell Edmonds' account of his moral injury (Edmonds, 2015) provides another helpful case study for discerning *how* at least some kinds of moral injuries occur and, importantly, what it is like to experience one. It also challenges features of what we have described as the standard model of moral injury.

Edmonds was a seasoned U.S. Special Forces Captain when he arrived in Iraq in 2005 as part of an early group of "advisors" whose mission was to help with training Iraqi forces to combat insurgence. In Mosul, he was responsible for training and observation of Iraqi officers. He did not give orders and did not have a mandate for control. In this context, questions of responsibility might be regarded as somewhat different from some other types of situations in war. Edmonds claims, that his "injury—was not the result of any single event but was instead the slow accumulation of experiences and their cumulative effect" (Edmonds 2015, p. 21). His exhaustion from "struggl[ing] to navigate a year-long moral minefield" did not catch up with him until years later, but when it did, he found himself not only morally disoriented but also psychically fragmented (Edmonds, 2015, p. 32).

The cases of Boudreau and Edmonds are both challenging for the standard model to explain even though both Boudreau and Edmonds clearly exhibit symptoms of moral injury, affirm the diagnosis, and sought treatments for it. There is no specifiable event in which they experience a violation of deeply held moral beliefs or a moral code. They have experiences over a period of time, and it is the connections of those experiences with others in their lives that lead them to despair. In both cases, a breakdown in their relationships with *others*, not a breakdown in their moral thoughts, provides the *basis* of the experiences they associate with their moral injuries. Through this "slow accumulation of experience," cited above, Edmonds had not just violated his personal code; instead, his interactions with prisoners and the Iraqi officers changed how he thought about himself and others. It so significantly modified those relationships that it, in some respects, impacted his sense of relatedness overall: "I had become the person I hated, and the killer I hated had become a person" (Edmonds, 2015, p. 271).

4. Potential modification to the standard model: getting morality out of our heads

The main purpose of this article has been to identify the basic structure of how moral injury has been conceptualized in clinical research and treatments. In this respect, our goal has been to articulate the features of this framework and critically challenge some of the larger assumptions in order to create opportunities for conceptual refinement that ultimately advance research. We have demonstrated how the assumption of what constitutes what is *moral* in this model lacks clarity: it is rife with equivocation and relativization, and this permeates the clinical research. Additionally, we have argued that the presumed causal mechanism of internal conflict lacks sufficient precision. This is because ordinary moral experience is replete with competing demands and conflicting expectations, and these are *not* generally injurious. Thus, minimally, for research that is reliant upon the standard model of moral injury to advance, these two challenges of definition and clarification should be met. Moreover, we have also suggested that it is worth

exploring whether the situational context for initial clinical observation and diagnosis of moral injury might be overdetermining the phenomenon insofar as moral injury research remains bound to a framework of pathological trauma.

Implicit in our critical analysis is the suggestion that a prospective modification to the standard model could be to relocate *the site of violation*: from deeply held personal moral beliefs to moral relations. We think this is more consistent with moral experience, namely *how* people come to their moral beliefs and how those beliefs take on significance in their lives. It also potentially provides more concrete circumstances for clinicians to observe and address. Elaboration of this potential alternative would require considerably more detail, which we are developing in a companion article to this piece. Translation of this into specific psychometric measures and tools lies outside of our expertise. However, by way of conclusion, we outline some features of our proposed modification and suggest some implications for further research.

4.1. From violations of moral beliefs to moral experiences

Our proposal is to shift the focus from violations of *moral contents* (i. e., specific beliefs, values, norms, or sets of rules or codes) in contexts of *specific events* to considerations of *moral experiences* and conditions of *relationships*. In addition to having moral beliefs, people have interactions in the world, and these interactions inform our beliefs. Indeed, these interactions are complex. We do not simply have experiences that confirm or deny our beliefs: Sometimes we draw on beliefs to guide or *inform our actions*, and in the course of doing that, we might have to navigate potentially conflicting beliefs or expectations. Sometimes we draw on beliefs and further shape them *after action*, when we praise, condone, or condemn activities and interactions. The latter interactions, in particular, are observable, and there are various disciplines, including psychology, sociology, and history, that provide tools for analyzing the functional character and quality of these interactions.

The case of Tyler Boudreau, referenced above, might help to clarify the distinction we are making. He had multiple interactions with fellow servicemembers and Iraqi families as he entered and searched their homes, their personal and family spaces. Based on his description of the creeping sensation he had that these encounters amounted to a form of inappropriate, even violent, force, he likely had (or came to develop) a set of beliefs that included a sense of entitlement to personal space, expectations for privacy, and ideas about power relations and forms of consent. There was *no single event* that breached any of these beliefs, at least as he recounts it, but through the repeated experience of using force to enter and render public the private spaces of family and home, Boudreau became acquainted with forms of violation that he had not experienced in other contexts. Ultimately, it is not his *beliefs* that were violated—at least not primarily. Instead, the violation occurred in his relationships—with strangers, civilians, perhaps even with his fellow servicemembers who either did or did not share in his *growing* (and eventual) sense that what was occurring and had become their routine was really something that transgressed a boundary of what was acceptable or justifiable.

Another way of contemplating our suggestion would be to ask what is the best way to capture *how* Boudreau's injury occurred? Since we do not have a definitive test for moral injury, what is the better explanation? Is it most illuminating to ascertain the event or events that violated his beliefs, or is it more helpful to try to understand how his interactions became dysfunctional to the point that he was harmed? Our suggestion is that *it is enough* to focus on the observable, describable relational situation. We agree that is important to know that Boudreau had the experience that something “wrong” was happening. But to understand the wrongdoing he *experienced*, one has to understand the ruptures that occurred in his relationships. Moreover, we suggest that it is possible that once we understand those ruptures, we have some indications for pathways to repair: namely, they entail *restoring* or *repairing the relationships*—in *practice* and not only imaginatively.

4.2. Elements of moral phenomena

Reframing moral injury as arising from moral *experiences* differs from considerations of the *sources* of particular moral beliefs, and it differs from exploration of a particular provocative event. There is a vast literature, spanning thousands of years, describing and analyzing the elements of what is called ‘morality,’ and there are many varieties of *moralities* and considerable disagreements about how they are brought to bear in practice and their relative merits. We are not suggesting that these need to be resolved for the clinical research to advance. However, we do think that the clinical perspective could be improved by the understanding of some widely accepted distinctions among types of moral phenomena.

For example, persons could give reasons for believing that murder is wrong—and these reasons could differ greatly—but *how* that moral belief is given meaning in individuals' lives is similar insofar as it occurs in contexts of developing trusting relationships that reinforce the view that mortally harming each other is prohibited, and through practices of punishment of those who violate that belief. Moreover, this moral commitment and expectation is enshrined in laws and institutions that punish those who violate that moral principle. Even if one thought that moral prohibitions against murder have an evolutionary basis that preserves the species and that state punishment of those who violate the principle that “murder is wrong” is not really a distinctively moral belief at all and is largely a form of pragmatic self-protection, one can still recognize that the *meaning* of “murder is wrong” becomes concrete only when people hold each other accountable for living by that principle. In such a case, then, *failing* to punish murders would not only potentially hurt surviving loved ones of the person who was murdered but would also diminish the grip of the moral view that murder is wrong or to whom it applies (Walker, 2006).¹⁵ In this view, relationships and practices—interpersonal relationships and their instantiation in institutions—are how moral contents are given meaning, and account for the *durability* of that meaning over time. If what is *moral* in moral injury would be considered in this context, then it would be more closely connected with *moral experience* than conflicting specific *moral contents*.

4.3. Moral experience as anchored in experiences of relationship, not experiences of beliefs

If research shifted from a focus on violations of *moral contents* to examining *how morality is experienced* in persons' lives, this would take into account how moral beliefs are connected with and stem from interactions that are rooted in interpersonal relations and which are formalized in social and political institutions (for elaboration of this view, see Walker, 2006). Our claim is that moral responses and expectations arise from these contexts of experiences of relationships rather than, primarily, from personal codes or sets of specific beliefs or values that we form and hold independently (Audi, 2013). This is true even though first-person ways of articulating these beliefs might vary with reference to and in terms of codes, norms, or values. Our suggestion is that moral injuries might stem primarily from ruptures in relationships rather than violations of personal beliefs. Put another way, our claim is that moral injuries not only *affect* and impact relationships limiting persons' ability to participate in their communities and workplaces—something widely acknowledged in all of the literature on moral injury regardless of context or disciplinary focus—moral injuries also *stem* from breakdowns in relationships and communal contexts, and these are highly relevant for understanding how the injury occurred and, potentially, how it might be repaired.

Again, we agree that moral beliefs are relevant, because they shape how we interpret situations and relationships and inform our senses of

¹⁵ Walker (2006) specifically links failure to punish moral wrongdoers as a secondary injury to the person wronged.

responsibility, but we do not think these beliefs are static or that they are radically personal, which is to say that we think they are at least partially a product of social construction through collective practices of affirmation and condemnation.

4.4. Moral injuries as damages to moral relations

Understood in this context, moral harms are not caused by harms to *our beliefs* but rather arise from damages to moral relations. Importantly, moral experience is *not* the experience of the beliefs we hold—and life affirmation is not dependent upon intrapsychic equilibrium *viz* a *viz* our moral beliefs—rather moral experience is something realized in interactions with others in the world. In this respect, it might be more appropriate to think of morality as something that we *do* or something we practice—through interactions, as relational—rather than strictly something that we believe. These relations can be both interpersonal and intrapersonal, which is to say that moral experience can also arise through a relation with oneself, a sense of oneself as someone with moral worth and possibility.¹⁶ Dehumanization, for example, is a broken relationship with others, and it can be internalized such that a person is unable to relate to oneself as human.

With this modification to the standard model, moral injury is not just in our heads but instead is in the world, arising from and evident in our own actions, interactions, and the actions of others. Thus, when moral injuries occur, they are not *only* or even *primarily* psychological phenomena, although they can lead to significant psychological distress that is evident in strong emotional reactions, dysregulation, and disfunction. Moral injuries arise from ruptures in those moral support and reinforcement systems; they impact our relationships, our sense of ourselves and others as moral agents (Winiikka-Lydon 2022; Kellison, 2021). Understanding the damaged moral relationship could be highly relevant to thinking about how to facilitate repair.

4.5. Implications for treatment and future research

This modification of the standard model to focus on moral *experiences* rather than moral *contents* linked with specific *events* also has implications for treatment and forms of repair. It suggests that remedies need to aim at the restoration or re-establishment of moral relations.¹⁷

Treatment of the emotional responses to moral damage might alleviate symptoms but will not treat root causes. In fact, there is already evidence that focusing on communal response as a pathway to repair is generally more efficacious than other forms of treatment that construe moral injury as pathological. Effective forms of moral repair are reliant on *moral reconstitution*. This includes the revitalization of moral practice in asserting and reinstating the moral ideas and beliefs that have been damaged (Walker, 2006). It is becoming more widely recognized in the clinical literature (e.g., Litz, 2023; Litz et al., 2024) and this development suggests a bridge between the clinical literature and the approaches found in pastoral and spiritual care (e.g., Carey et al., 2023; Carey et al., 2016; Hodgson & Carey, 2017).

Moreover, because moral injuries reflect a broader set of damaged relationships, and these damages have ramifications beyond the distress of the person with greatest proximity to the injurious moral harm, attending to moral injuries is important for the persons who are suffering

¹⁶ The role of dehumanization as a contributing factor to moral injury and as a resulting consequence is evident in the literature, including Shay, 1995; Bernstein, 2015.

¹⁷ This has been extensively explored by those who have considered moral damages and injuries in contexts of being subjected to violence at the hands of others. See for example, Walker, 2006. In a recent overview article, a focus on re-establishing moral relations is prevalent (Litz, 2023) and this is also part of some treatment protocols that have been used in the context of treating moral injury as a variety of post-traumatic stress.

as well as their broader communities. Importantly, damages to moral relationships in our communities also potentially drain our moral beliefs of meaningful content. Addressing them is important for everyone who relies upon them and not only those experiencing the primary injury. Thus, research on moral injury is important and highly relevant to the general population.

4.6. Limitations

A limitation of our proposed modification to the standard model is that it potentially slows progress toward achieving a “gold standard” account of moral injury, which is recognized as a problem in the clinical and non-clinical literature alike. There is an apparent virtue in linking moral violation with a specific event because it might seem to make moral injury more concrete whereas the focus on experience, which could be more diffuse and subject to shifts in perception over time, might seem to make the concept of moral injury more nebulous. This would be unfortunate, because moral injury does appear to be a significant problem in need of effective response. However, if we are right that there are more helpful formulations of the nature and causes of moral injury, then this could also support increasingly more effective treatment and repair.

4.7. Conclusion

As discussed above, the standard model of moral injury presents several limitations that are likely to hinder progress in understanding moral injury and treating it. However, it also highlights important dimensions of human experience that have been less studied even by those in the humanities and humanistic social sciences. Thus, there is potential benefit to be gained in multiple fields by continuing to refine the model of moral injury and examination of its etiology and consequences. This would also potentially help to distinguish moral injuries from other kinds of moral harms and facilitate research in other domains of experience where persons are potentially exposed to morally injurious circumstances, including those domains in which the standard model research is applied (for example, healthcare settings).

Finally, we suggest that moral injury discloses something important about ordinary moral experience that allows us to grasp positive features that are otherwise difficult to observe. Seeing how something breaks down often reveals how certain features or facets are crucial for routine and effective functioning. Moreover, differing contexts potentially disclose different dimensions of these positive features of morality. Our proposed modification makes evident these further opportunities for research.

CRediT authorship contribution statement

Christa Davis Acampora: Conceptualization, Investigation, Methodology, Writing – original draft, Writing – review & editing. **Ditte Munch-Jurisc:** Conceptualization, Investigation, Methodology, Writing – original draft, Writing – review & editing. **Andrew Culbreth:** Conceptualization, Investigation, Methodology, Writing – original draft, Writing – review & editing. **Sarah Denne:** Investigation, Writing – review & editing. **Jacob Smith:** Investigation, Writing – review & editing.

Declaration of competing interest

The authors have no competing interests.

Data availability

No data was used for the research described in the article.

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