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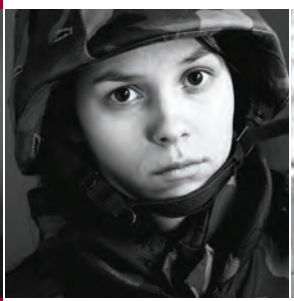

SPECIAL ISSUE: RELIGIOUS AND SPIRITUALLY-ORIENTED INTERVENTIONS WITH VETERAN AND MILITARY POPULATIONS

INTRODUCTION TO SPECIAL ISSUE

ARTICLES

POINT OF VIEW

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Religious and Spiritually-Oriented Interventions with Veteran and Military Populations

Introduction: Special Issue on Religious and Spiritually-Oriented Interventions with Veteran and Military Populations

Dexter Freeman & Laurel Shaler

This introduction provides a brief, yet comprehensive synopsis of this special edition of Social Work & Christianity that was designed to address the dearth of literature on how to effectively incorporate spiritual and religious beliefs and content in the assessment and treatment of service members and veterans. The authors provide a conceptualization of the context of the problems that service members present with, as well as a review of what the reader can expect to receive from each article within this uniquely designed special edition.

In *The Cost of Courage* (2012), Pryce, Pryce, and Shackelford recount the heart-breaking story of an Army First Sergeant by the name of Jeff McKinney. They explained how war changed him and it all ended one hot July day when he fired off two shots from his weapon into his chin. There was no suicide note or indication to his soldiers that he was considering such a drastic escape from the pain he had been trapped in for so many years. Although Sergeant McKinney's story is tragic, not just for him, but also for those who are left behind, this is a story that is far too common

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for service members and veterans. Paquette (2008) described the relentless and unyielding atrocities of war that soldiers of today and yesterday are continuously enslaved to when she said, "The soldiers also bear witness to their dehumanizing behavior of not only killing the enemy but also innocent civilians…The inability to forget what they experienced and what they did in the name of war is the private hell many veterans live with for the rest of their lives" (p. 143). Some refer to the battle-wounds that soldiers return with as wounds to the soul as well as wounds to the body. A plethora of studies have been performed over the past decade and have confirmed the effectiveness and significance of spirituality and religion in the healing process of soldiers and veterans who may be seeking to cope with wounds to their body and soul. This special issue invited practitioners, researchers, and educators to submit papers with an emphasis on demonstrating the effectiveness of integrating religious and spiritually-focused interventions with military populations.

This special issue of *Social Work & Christianity* was designed to equip social workers, counselors, psychologists, psychiatrists, and other behavioral health providers who may be grappling with how to address the deep spiritual needs of service members and veterans who may be hampered by the wounds of war. Studies have shown that there is a significant relationship between religion/spirituality and traumatic injuries related to war (Currier, Holland, & Drescher, 2015; Falsetti, Resick, & Davis, 2003; and 2012; and Fontana & Rosenheck, 2004). Nevertheless, there remains a dearth of information about how to actually incorporate and address spiritual and religious issues with military populations. This special issue seeks to address this void.

In the first article, Blinka and Harris discuss moral injury among warriors and veterans. They state that as more warriors survive severe physical injuries, there is increased awareness of the immense spiritual toll inflicted on warriors, veterans and their families by wounds to the spirit and soul. This paper defines moral injury, outlines its history, explores metrics already developed to measure it, discusses programs to address it, and reviews ongoing research.

In the second article, Freeman describes the diversity of spiritual and religious resources that support and compel military service members to pursue a career in the military. Moreover, this article exposes the reader to an assessment instrument, the family circle, that enables clients and social workers to identify spiritual, emotional, and social resources to help service members and their families cope with the consequences of defending America's freedom.

In the third article, Shaler examines the ethical integration of Christian faith in social work interventions with veterans. Shaler takes a cogent

look at the faith of the military member and how providers can ethically integrate their faith into the treatment milieu. This article is designed to increase the awareness and competency of clinicians who work with service members and veterans.

In the fourth article, Wade describes how clinicians can effectively incorporate spirituality with cognitive processing therapy when treating service members who present with symptoms of post-traumatic stress. Wade presents the relevance and effectiveness of incorporating spirituality with evidence-based treatment for service members who are struggling with combat-related PTSD.

In the fifth article, Foley, Albright & Fletcher describe a unique model for integrating spirituality into social work practice with military populations. Their model depicts how signs and symbols can be used to facilitate the integration of religion and spirituality into social work with service members and veterans.

In the sixth featured article, Kick and McNitt state, "duty to country and one's battle buddies surmounts all else. The underside of 'service before self' is the shame and guilt a service member experiences when they are unable to manage fear and anxiety once they return to the civilian world." The authors discuss how the use of Terror Management Theory can assists the person in conceptualizing the world as a "just place" that helps create a space for the person's spiritual views and belief system.

There are two final components of this special edition. The first is a point of view article by Thomas. She describes her personal journey as a Marine officer, and the lessons she learned about religion, health, and healing. This is followed by a compilation of resources to assist providers who might desire additional information and training about this very important subject.

This special edition of Social Work & Christianity is far from complete in terms of providing an all-inclusive compendium of resources to enable practitioners to meet the spiritual needs of service members and veterans who may be seeking wholeness due to their hidden wounds from war. However, this journal will definitely help practitioners who desire to incorporate spirituality into their practice with military populations to feel more confident and knowledgeable to respond to the spiritual needs of their clients. ❖

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Moral Injury in Warriors and Veterans: The Challenge to Social Work

Dee Blinka & Helen Wilson Harris

Each generation grapples with the enduring trauma of war. As more warriors survive severe physical injuries, there is increased awareness of the immense spiritual toll inflicted on warriors, veterans and their families by wounds to the spirit and soul. In the face of high suicide rates in both warriors and veterans, the concept of moral injury has emerged as this generation's contribution to the challenge of healing these men and women. This paper will review the definition of moral injury, the metrics developed to measure it, the social work role and programs to address it, spiritual implications, and ongoing research. The particular spiritual and professional relevance of this concept to social work and the integration of faith and practice is discussed.

The soldier answered, 'Heal me if you will,
Maybe there's comfort when a soul believes
In mercy, and we need it in these hells.
But be you for both sides? I'm paid to kill
And if I shoot a man his mother grieves.
Does that come into what your teaching tells?'
(Sassoon, 1916 as cited by Hart-Davis, 1983)

War has always inflicted moral injury on its participants; mankind's innate horror and taboo against killing another human being is recorded throughout civilization. "The moral anguish of warriors defines much literature about war from ancient times to the present" (Brock & Lettini, 2012). Shay (1994, 2002) wrote that the literature

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of the world is rich in stories depicting this suffering. As a British poet of the First World War, later killed in combat in 1918, Wilfred Owen distilled into his poems the utter desolation of his dreaming and awake world (Silkin, 1972). A loving Christian God is nowhere to be found in Owen's work (Owen, 1963). His poems speak to the loss of hope for humanity, made more profound by the sheer irrationality of what was happening.

Defining Moral Injury

In 1994, drawing on over 20 years of experience of treating Vietnam vets, Shay published *Achilles in Vietnam: Combat Trauma and the Undoing of Character,* which was welcomed by veterans and warriors alike. Shay stated in the introduction that his aim was to "put before the public an understanding of catastrophic experiences that not only cause life-long disability but can ruin good character" (p. xiii). In 2002, *Odysseus in America: Combat Trauma and the Trials of Homecoming,* Shay called for the prevention of "psychological and moral injury in military service" (p. 6). More recently, Shay (2011) stated that while there are broader meanings that have become associated with the words "moral injury," the current, most precise and narrow definition has three parts. Moral injury "is present when 1) there has been a betrayal of what's right 2) by someone who holds legitimate authority 3) in a high stakes situation" (p. 183). Further, when all three are present, moral injury is present, "and the body codes it much in the same way it codes physical attack" (Shay, 2014, p.185).

Out of many years of service to the military as a psychiatrist and in a number of consultant/advisory roles, Shay became convinced that "ethical leadership is a combat strength multiplier" (2011, p. 183). The author believed that leaders who deviate from what is right and moral contribute to a significant reduction in motivation and loyalty that can lead to disobedience to military authority. Instead, the author stated that troops "do want to know that what they are doing has a constructive purpose" (2011, p. 183). It is arguable that this is more significant in the wars of recent centuries where troops, whether on the ground, sea or air, may experience more and more meaninglessness when there is no front, where victory remains elusive and unclear, where collateral damage occurs on a daily basis, and where perceived allies become attackers. These circumstances without constructive purpose can make the many deaths and injuries of both warriors and civilians all the more painful.

A broader and equally useful concept of moral injury has been defined and elaborated in a carefully researched landmark paper by Litz, Stein, Delaney, Lebowitz, Nash, Silva, & Maguen (2009). Their working definition of situations that may cause moral injury and thus define the response has been widely accepted:

> ….perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations (p. 700).

The authors clarified that transgressing one's own moral code can include active participation or passive witness of actions understood to be immoral. The very act of bearing witness to the unbearable can cause moral injury.

These clarifications of moral injury are often part of war, but not always. Shay's definition provided a starting place for understanding moral injury. Litz et al. provide the working definition for this article and much social work response.

Moral Injury and PTSD

While moral injury is a fairly new term in the literature, Post Traumatic Stress Disorder (PTSD) is a psychiatric diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). While the DSM-5 enumerates criteria for diagnosis of PTSD, practitioners and scholars continue to define the latest thinking about PTSD, particularly in warriors and veterans (Guina, Weton, Broderick, Correll, & Peirson, 2016). Litz and associates (2009) wrote to clarify war injury as spiritual wounds that in some cases does not include the physiological arousal seen in PTSD (2009, p. 697). However, Shay (2014) stated, "From my observation, where leadership malpractice inflicts moral injury, the body codes it as a physical attack, mobilizes for danger and counterattack, and lastingly imprints the physiology every bit as much as if it had been a physical attack" (p. 185.) What then is the relationship of moral injury to PTSD, if any?

There is ongoing discussion as to where moral injury stands in relation to the diagnosis of Post-Traumatic Stress Disorder (PTSD). Most researchers in moral injury emphasize that moral injury is separate from PTSD (Shay, 2014; Maguen & Litz, 2014; Litz et al., 2009; Drescher, Nieuwsma, & Swales, 2013). Certainly if PTSD is understood simply as a severe anxiety disorder it makes no sense to classify moral injury under the same label (Litz et al., 2009).

As Maguen and Litz (2014) stated in an article entitled *Moral Injury in the Context of War,* there is a need for additional research on the commonalities and distinctions between the two. The authors stated "although the constructs of PTSD and moral injury overlap, each has unique components that make them separable consequences of war and other traumatic contexts" (p. 4). They go on to describe PTSD as a mental disorder, requiring a diagnosis, but define moral injury as a "dimensional problem," with no threshold:

> At any point in time a Veteran may have none, or mild to extreme manifestations. Transgression is not necessary for PTSD to develop nor does the PTSD diagnosis sufficiently capture moral injury (shame, self-handicapping guilt, etc.) (p. 4).

It is therefore important when evaluating a warrior or veteran to assess mental health symptoms and moral injury "as separate manifestations of war trauma" (p. 4), in order to get a clear picture and recommend relevant treatment. Additionally, Maguen, and Litz (2012) reported both that moral injury is a significant risk factor for the development and worsening of PTSD and that PTSD has responded to treatment for moral injury.

One of the important aspects to this whole debate is that warriors and veterans consistently verbalize their discomfort with treatment and the word disorder (Shay, 2011; Barrus, D., personal communication, 2015). Consequently, a more constructive and useful term might be *war injury,* which can encompass both PTSD and moral injury. Shay's use of the terminology "wound," referring to the damage of war or trauma, offers a sense of partnership between the warrior and veteran and the clinician. Shay (2011) said, "the surgeon's concepts of *primary* wounds in war and of wound *complications* and *contamination* serve as models for psychological and moral injury in war" (p. 179). Shay feels that these ways of phrasing war injuries (even when these are psychological, as in moral injury) are much less stigmatizing than PTSD. By using the term *war injury,* the helping professional working with a warrior or veteran can remain watchful for a variety of conditions and symptoms including physiological arousal and dissociation.

Moral Injury and Dissociation

Dissociation has long been considered a symptom of psychological injuries sustained in war, and it is another important characteristic in considering war injury and PTSD. Van der Hart, van Dijke, van son, and Steele (2015) convincingly describe somatoform dissociation in traumatized World War I combat soldiers. Reading their descriptions of the conditions suffered in the trenches during those war years and of "the constant bombardment of shelling, one is vividly reminded of the many stories today from our warriors, of collecting body parts, often of their buddies, with the constant noise, smell, blast and incineration from exploding mines; but also of the massive power of their weapons to blow an insurgent to bits in front of their eyes, ~~ta~~les of horror which provoke 'the two thousand yard stare'" (Lea, 2008, p. 195; Barrus, D., personal communication, 2015). Dissociation with moral injury suggests that PTSD is also present.

Moral Injury and Suicide

In 2014, Bryan, Bryan, Morrow, Etienne, and Ray-Sannerud (2014), National Center for Veterans Studies-University of Utah, reported the results of their study that examined moral injury, suicidal ideation, and suicide attempts in a military sample. Their purpose was to see if certain aspects of moral injury serve as risk factors for the development of self-injurious thoughts and behaviors (SITB) among military personnel. Using the MIES (Nash et al., 2013) to assess moral injury, the findings from this sample of 151 active duty Air Force personnel seeking outpatient mental health care supported the hypothesis that certain aspects of moral injury serve as risk factors for SITB. They stated, "military personnel and veterans who express distress regarding the 'rightness' or 'wrongness' of their actions may be at increased risk for SITB and *may experience more intense suicidal crises"* (Bryan et al., 2014, p. 5). They also made the point that such inner, intense conflict can occur in warriors and veterans who may have never directly experienced life-threatening situations. Since killing is a major objective of war, the risk factor of what Litz et al. (2009) term "transgression other" needs to be evaluated when looking at combat through the lens of taking life rather than fear about losing one's own.

Nasarov and associates (2015) connect moral injury to the likelihood of succumbing to debilitating PTSD. They reviewed nineteen articles and concluded "there is strong evidence linking exposure to and the perceived perpetration of moral transgressions with experiences of guilt and shame" (pp. 1, 11). The authors found that there was a relationship between the participants' guilt and shame and their mental health outcomes, specifically negative mental health including PTSD, increasing their vulnerability to self-harm and suicide. Brock and Lettini (2012) found that "the consequences of violating one's conscience…can be overwhelming…and the only relief may seem to be to leave this world behind" (pp. xv-xvi).

Maguen & Litz (2014, p. 6) found in their sample of Vietnam War veterans a statistically significant relationship between the experience of killing the enemy and incidence of suicidal ideation. Veterans who had killed were twice as likely to consider suicide, even when accounting for PTSD diagnoses, depression, and substance abuse.

Moral Injury as Insufficient Concept

Drescher and associates (2011) assessed whether moral injury suffices as a concept in a study in which participants (chaplains, mental health providers, academic researchers and policy-makers) were asked to respond to a questionnaire about moral injury. Participants gave strong support for the concept but found the definition to be inadequate. Some named the response

to these challenges as "moral repair" (p. 8). While moral injury maintains its distinction in the literature, in certain theological centers moral injury is sometimes spoken of at the same time as "soul repair" (Brock & Lettini, 2012). These terms are focused more on responses to moral injury than to assessment or identification of the phenomenon.

Professional Responses to Moral Injury

The identification of moral injury is only the beginning of treatment. Chaplains with therapy training and skills and social workers and other mental health professionals with spiritual sensitivity and religious cultural competence are well suited for this work. Social workers engaged in work with those with moral injury must have several areas of competence including (1) the quality of therapeutic presence and unconditional regard, (2) treatment modalities for trauma, (3) the ethical integration of faith and practice, and (4) moral injury specific assessment and intervention. Preparation for these competencies begins with social work education and requires professional development through continuing education as the field develops.

Therapeutic Presence

The role of social worker as mental health practitioner is important when clients present with the possibility of moral injury. The holistic approach of social workers, including sensitivity to spirituality and the valuing of each person, provides significant space for persons with moral injury to seek help. As is true with all clients, there is a clear need for the warrior or veteran experiencing moral injury to perceive that he or she is listened to and respected (Harrington-LaMorie & McDevitt-Murphy, 2011; Shulman, 2012). Civilian social workers with the U.S. military will often comment that warriors will thank them for "just being with," just sitting and listening; this is often the first time the soldier has been received in that way (personal communication, Barrus, D., 2015). Litz and associates (2009) spoke to the need for a therapist "who must portray unconditional acceptance and the ability to listen to difficult and morally conflicted material without revulsion" (p. 702). Social workers whose training and ethics, from the beginning, urge the need to "start where the client is" (Clark, 2015; Shulman, 2012) are ideally suited to this role of unconditional acceptance and regard. This is particularly true in the current climate in which fewer families and fewer social workers are exposed to the military. "…the social work community, with a few exceptions, has been slow to come to terms with the worldwide conflict in which we have been engaged for several long years with no definite end yet in site (Pryce, Pryce, & Shackelford, 2012). This calls for the social work skill of therapeutic presence, i.e. the ability

to "be with" the client in their circumstance without judgment. Drescher, Nieuwsma, and Swales (2013) discuss treatment for moral injury as "soul repair" and described how a helper can best support a veteran or warrior in this work, with the opinion that

> [S]oul repair…best happens when helpers sit alongside the veteran in the midst of pain and anguish and bear hopeful witness to the long journey of transformation that may occur. When helpers too quickly jump in to fix or answer, the focus can be on the social worker's journey or answers rather than that of the client (p. 53).

This is important to remember when discussing concepts like forgiveness. The offering of quick forgiveness or suggestion of self-forgiveness may be dismissive of the depth of pain of the client and is sometimes more about the worker's need for resolution than sensitivity to the client's pain. Attention to the integration of faith and practice in social work is essential to avoid this fundamental error.

Faith and Practice

Social work practice addresses this in self-awareness, the use of consultation, and starting where the client is. This is particularly true in the ethical integration of religion and spirituality with social work practice. The three organizing principles of the ethical integration of faith and practice include the (1) the faith or religion of the client, (2) the faith or religion of the social worker, and (3) the organizational context (Harris, Yancey, & Myers, unpublished manuscript, 2016).

In work with clients experiencing moral injury, the principle of understanding and working with the client's religious and spiritual worldview and values is fundamental to the helping process. Tick (2005) pointed out that there can be a disconnect in the understanding that war and religion are both "linked since the beginning of time" (p. 269) and simultaneously apparently contradictory to human relationships. It is the very violation of the warrior's own moral code in the horror that is war that can result in moral injury.

Second, the social worker's awareness of his or her own spiritual life and lens is also important to the process. What does the social worker believe about the concept of "just war" and the difference between "Thou shalt not kill" and "Thou shalt not murder"? (Tick, 2005). Social workers often serve in settings where they manage the tension of their own values and those of their clients with skill and dignity.

Third, in a military setting and with military clients, an understanding of how faith and spirituality are honored and how they are separated is also important to the therapeutic intervention. Social workers may seek train-

ing to understand military culture and may use the skills of ethnographic interviewing to experience the client as cultural guide and expert. The National Association of Social Workers' (NASW) Standards and Indicators of Cultural Competence in Social Work (2015) include the concept of cultural humility, which includes social workers taking a listening, non-judgmental stance and relating to the particular religion, faith, or worldview the warrior or veteran, espouses.

The issues that cause most pain in moral injury arise from feelings of deep shame, self-disgust, and guilt (Litz et al., 2009; Steenkamp, Nash, Lebowitz & Litz, 2013; Nazarov et al., 2015). Social workers, with their long-standing knowledge and skills in treating and advocating for victims of abuse and violence, have a deep grasp of how to treat long-term companions of moral injury: "poor self-care, alcohol and drug abuse, severe recklessness and parasuicidal, self-handicapping behaviors, such as retreating in the face of success or good feelings, and demoralization, which may entail confusion, bewilderment, futility, hopelessness, and self-loathing" (Litz et al., 2009 p. 701). Guina, et al. (2016) reported that the potential for successful identification and treatment of war-related problems in the military includes the need for reducing stigma and unintended negative consequences for disclosure. The context of the military focuses on the strength of warriors. Social workers may help normalize the moral strength of seeking treatment in service members.

These three principles of the ethical integration of religion and spirituality and social work practice are fundamental to effective helping (Harris, Yancey, & Myers, unpublished manuscript, 2016). They are also essential to interdisciplinary work, including military settings where chaplains are identified as providers of spiritual or religious care with their focus on the service person's religion or spirituality. Social workers are prepared to work closely with chaplains and other religious leaders so that the issues of moral injury repair can be most effectively treated. The value of social work in this inter-professional team is the social workers' role as therapist/clinician and family systems facilitator.

Therapeutic Role

One particular contribution of social workers to the team addressing moral injury is professional focus on understanding the more recent conceptualizations of the neuro-biological underpinnings of PTSD (Yehuda & McFarlane, 1995). This includes the study of peri-traumatic and somatoform dissociation and complex PTSD (van der Hart, Nijenhuis, & Steele, 2005; Frewen & Lanius, 2015). Social workers trained to work with persons who have experienced trauma are prepared to listen for the themes of moral injury and to provide evidence-based response. Frequently, those who are less traumatized will find their way to their spiritual leaders, but the

majority, though troubled by moral injury, may need the informed skills of the trauma-informed social worker, who supports those with moral injury and establishes safety to facilitate seeking further healing.

The spiritually-sensitive and competent social worker is able to assess war injury differentially for dissociation, for PTSD, and for moral injury. This assessment includes the warriors' or veterans' belief systems and how they make meaning out of their war experiences. Social workers who integrate religion, spirituality, and worldview into their practice are able to help clients discuss and apply concepts from the client's own belief system like forgiveness, restoration, and peace. The spiritually-sensitive, culturally-competent social worker begins where the client is, learns his/her language for spiritual concepts, and helps the client to integrate the complexities of meaning-making. Further, their assessment includes competencies for assessing, understanding, and intervening with trauma.

Trauma-informed Social Work

The social worker whose clients have experienced trauma must be prepared with clinical skills for psychotherapies that are evidence-based and evidence-informed. At minimum, this means understanding them well enough so as to be able to refer appropriately as needed. Familiarity with the three evidence-based psychotherapies approved for the treatment of PTSD in 2010 by the World Health Organization (WHO) (2013), the Veterans Administration (VA), and the Department of Defense (DOD) is essential. These treatments are Cognitive Processing Therapy (CPT), Prolonged Exposure (PE), and Eye Movement Desensitization and Reprocessing (EMDR).

A trauma-informed social work therapist will be able to recognize dissociation and be able to calm and handle dissociative symptoms. They will similarly be competent to help those clients experiencing physically tense or numbed psyche and body. Advanced therapeutic approaches which are valuable in helping social workers learn and practice these skills include Sensorimotor Psychotherapy (Ogden, Minton, & Pain, 2006), Somatic Experiencing (SE) (Payne, Levine, & Crane-Godreau, 2015); Emotional Freedom Techniques (Church, Pina, Reategui, & Brooks, 2011). These are therapies which already have significant evidence for effectiveness with trauma. Additional new therapies are emerging for trauma that also have potential for effectiveness with moral injury.

The trauma-informed social worker can develop knowledge and skills by study and training and at a minimum, visiting or volunteering at these programs in order to be able to assess their value for clients. Knowledge of such programs can be valuable to the social worker because warriors and veterans will depend on the social worker for intervention and for referral. Additionally, social workers who work with veterans and warriors need to begin their own research projects including single-subject design with measurement of effectiveness.

Additionally, social workers assisting veterans and warriors will need to be familiar with programs described later in this paper designed particularly to treat moral injury in military settings, including Adaptive Disclosure, Acceptance and Commitment Therapy, and Impact of Killing. A short term treatment program currently gaining recognition for trauma is Accelerated Resolution Therapy (ART). Initial research by Kip, et al. (2015) appears promising and needs additional research to determine how effective the combination of elements of CPT, PE, and EMDR are compared to the other evidence-based therapies.

Competent trauma-informed practice begins with a good understanding of the major threats to mental health in all populations with specific attention to risk in warriors for suicide, substance abuse, major depression and bi-polar disease, and Complex PTSD (C-PTSD). Nickerson and Goldstein (2015) provide one compelling narrative and overview of these risks, including their negative experiences and client outcomes with flawed systems. Their experience speaks to the importance of macro as well as clinical change necessary to effectively treat moral injury and PTSD.

Implications for Social Work Education and Training

In a seminal paper, *Moral Injury: An Emerging Clinical Construct with Implications for Social Work education*, Kopacz, Simons, and Chitaphong (2015) suggested that core competencies be developed for work with clients suffering from moral injury. The authors observed that Advanced Social Work Practice in Military Social Work (Council on Social Work Education–CSWE, 2010) does not address moral injury. They addressed this gap in competencies through a series of recommendations for social work education, including teaching practice behaviors related to military social work and to the treatment of moral injury. There are increasing numbers of programs with concentrations and specializations in military social work. The authors also addressed the important role that religion and spirituality play in social work practice as part of developing a social worker's holistic view of the person-in-environment. This, in turn, emphasizes the significance of social work education in preparing students with the knowledge and understanding of the many diverse religious beliefs practiced by warriors and veterans.

The social work approach to the client's religious or spiritual beliefs and experiences includes cultural competence. Leigh (1998) suggested that cultural competence is achieved through ethnographic interviewing in which clients are the experts on their own experience. The 2015 Educational Policy Statement and Standards include religion as culture as do The DSM-5 (2013) and the NASW Code of Ethics (NASW, 2008). Teaching the ethnographic approach of client as expert provides skills to take a spiritual

history as an integral part of the client's story, ideally in the intake process to open up further avenues for discussion. This may include issues of moral injury experienced by the warrior or veteran. There are many examples of this possibility. Perhaps if Alyssa Peterson, a young intelligence analyst who committed suicide in 2003 (Pryer, 2014), could have entrusted a social worker with her personal conviction that she could not take part in so called "torture-lite" interrogations and that her shame included that she was reprimanded in her chain of command, her death might have been prevented and perhaps more could have been done to begin a conversation about moral injury. Cases such as these are ideal for social work education and professional continuing education and skill development.

Assessment and Treatment Modalities

Social workers understand that best practice with clients begins with an examination of the research literature. The commitment to evidence-informed practice is an important component of effective social work practice. The adaptation of treatments for related conditions is also an important hallmark of evidence-informed treatment. Appropriate treatment begins with assessment. There are several assessments being used and tested for moral injury which we discuss here. We then turn our attention to intervention modalities including Adaptive Disclosure (AD), Acceptance and Commitment Therapy (ACT), Impact of Killing in War (IOK) techniques, and Peer Group Support. Additional therapies being used by social workers and mental health practitioners treating moral injury are mentioned briefly as well.

Assessment Metrics for Moral Injury

Defining a problem or response is the beginning of understanding. Measuring the construct allows improved assessment necessary to treatment and evaluation of treatment. The Moral Injury Events Scale (MIES) (2013) is a brief, 11 item, scale developed by the Association of Military Surgeons of the U.S. This tool is specifically designed to assess for suicidal ideation and gives insight to perceived transgressions and perceived betrayals. The scores give insight to exposure to events that might contradict deeply held moral beliefs.

A second tool, the Military version (MIQ-M) (Currier, Holland, Dreshler, & Foy, 2015), was developed and tested with veterans of Iraq and Afghanistan assessing for a number of events which may trigger a response of moral injury. Items address betrayal, violence, suffering and death, civilian population, and moral/ethical conflicts.

Both of these tools are being tested for reliability and validity against other older instruments for PTSD and war injury like the Combat Experi-

ences Scale. Social workers are encouraged to use these scales to assess for moral injury and to contribute their discovery around effectiveness and usefulness to the emerging literature.

Intervention Modalities

Social workers whose client assessments include the possibility of moral injury have available to them several evidence-based treatment possibilities and have evidence that some of the approaches for PTSD may not be the best approaches for treating moral injury. Having defined what they see as the essence of moral injury, Litz and colleagues go on to delineate specific treatment strategies. They make the case that traditional, empirically validated, fear-based conceptual treatments for PTSD such as Cognitive Behavioral Therapy (CBT), Prolonged Exposure (PE), and Cognitive Processing Therapy (CPT) may not be sufficient to successfully treat moral injury with its strong component of guilt and overwhelming shame (Litz, et al., 2009, p. 702). At the heart of their concern is their conviction that the theories about the development of post-traumatic syndromes have been based on the concept of harm done to an individual by others. These theories and resultant responses have not included consideration of "potential harm produced by perpetration (and moral transgressions) in traumatic contexts" (Litz, et al. 2009, p. 699). In other words, the shame and self-blame that accompanies violation of one's own moral code and is part of moral injury requires a different, if related, approach to therapeutic intervention.

The approaches of Adaptive Disclosure, Acceptance Commitment Therapy, the Impact of Killing in War (IOK), Eye Movement and Reprocessing Desensitization (EMDR), and Peer Support are introduced here as current therapies being explored with moral injury. Readers are provided a brief overview here with the recommendation that social workers who are interested in competence in a particular modality train with an experienced practitioner who has used the model successfully.

Adaptive Disclosure. Litz and associates (2009) developed "Adaptive Disclosure," an eight-step pilot program for Marines redeployed from Iraq and Afghanistan.

- Step One is Connection, defined as "a strong and genuinely caring and respectful therapeutic relationship" in which, to encourage disclosure, "the therapist must portray unconditional acceptance and the ability to listen to difficult and morally conflicted material without revulsion" (p. 702).
- Step Two is Preparation and Education, which helps the warrior understand moral injury and normalize the path to wellness.

- Step Three is Modified Exposure, which includes a "focused reliving of the event."
- Step Four is Examination and Integration, which is an exploration of the warrior's moral code and understanding before the war events to provide a baseline.
- Step Five is Dialogue with a Benevolent Moral Authority, which includes a technique similar to the Gestalt empty chair with a trusted person to whom to tell their story.
- Step Six is Reparation and Forgiveness, which allows the warrior to make amends and reconnect with personal values.
- Step Seven is Fostering Reconnection, which includes connecting and reconnecting with others moving toward normalcy in relationships.
- Step Eight is Planning for the Long Haul, which includes preparing for times when the trauma may be retriggered in the future and skills for managing that.

The thoughtfulness with which this program is elaborated reminds the reader of how important Litz and colleagues feel the understanding of moral injury is in treating the despair felt by many warriors and veterans. The incorporation of spiritual concepts, including forgiveness and a higher power, serve to address important dimensions of moral injury. It also appears to us that social work education has the potential to prepare social workers to take on the role of treating moral injury with Adaptive Disclosure and including forgiveness and reconciliation, particularly when social workers are prepared to ethically integrate spirituality and social work practice.

Acceptance and Commitment Therapy. A second approach is Acceptance and Commitment Therapy (ACT). This therapy was developed during the past decade as the result of the new research regarding moral injury. Grounded in Cognitive Behavioral Therapy (CBT), ACT stems from a growing body of research (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Lappalainen, Lehtonan, Sharp, Taubert, Ojanem, & Hayes, 2007; Powers, Zum Vorde Sive Vording, & Emmelkamp, 2009; and Ruiz, 2010) that supports shifting the focus away from simply treating cognitions to an emphasis on expanding skills and flexibility to deal with life's challenges. "Patients are supported in mindful awareness of their experience and acceptance techniques" (Nieuwsma, Drescher, & Nash, 2015, p.196). Work centers on present awareness and managing the ambiguity of cognitions where the trauma of the past is juxtaposed against the "normality" of the present.

ACT, with its accent on avoiding rigidity, may have additional contributions by protecting "the construct of moral injury from developing into an overly medicalized phenomenon" (Nieuwsma et al., 2015, p. 204). The

focus on mindfulness and skill building and the emphasis on working in community and with chaplains and other spiritual leaders may also be helpful to social workers in their efforts to help warriors and veterans struggling with the guilt and shame of moral injury. This therapeutic model connects mindful awareness of what life brings us with tolerance or acceptance of unpleasant feelings without a need to do anything in response to them. This combination of the CBT connection of thoughts, feelings, and behaviors is enhanced by mindful awareness in the present with acceptance of ambiguity.

The Impact of Killing in War (IOK). A third approach is a relatively new program entitled the Impact of Killing in War (IOK) (Maguen & Litz, 2012; Maguen & Litz, 2014). This experimental, six-session course consists of a series of lessons to be used in conjunction with ongoing clinical treatment for PTSD for veterans suffering from moral injury. The first session takes an educational approach concerning the biological, psychological, and social aspects of killing in war and how these aspects can relate the development of moral injury. The later sessions build on this base, looking at meaning, the self-blaming cognitions that develop, and the opportunities to experience self-forgiveness and the development of an action plan to make amends, where possible. Social workers working outside military settings may also see clients who attend these sessions.

Eye Movement Desensitization Reprocessing (EMDR). EMDR, discovered more than 20 years ago by Dr. Francine Shapiro, has been empirically validated in more than 24 random controlled studies for the treatment of trauma. The therapy uses an eight step process that includes history taking, preparation, assessment, desensitization, installation, body scan, closure and reassessment. The therapy is centered in bilateral stimulation to activate neural pathways, adaptive information processing of mal-adaptively stored memories, and dual attention (present focus with memory processing) (Shapiro, F., 2016; Shapiro, F., 2014; Shapiro, R., 2005). Licensed therapists may complete approved training provided by certified trainers and consultants.

Peer Groups. Shay (2011) advocates strongly for peer support for warriors and veterans. It makes sense, in view of the military emphasis on cohesion and the "buddy" system, that, on redeploying, warriors and veterans will relate most easily to their "reference group." A survey conducted by the Wounded Warrior Project (WWP, 2014) found that 59% of warriors and veterans who had served during OEF/OIF (Operation Enduring Freedom and Operation Iraqi Freedom), identified talking with other OEF/OIF veterans "as a top resource for coping with stress" (WWP, 2015, p. 15). They state that "veterans remain reluctant to seek care, with half of those in need not utilizing mental health services" (Hoge, 2011, p. 549). This is significant because of the poor retention of veterans in treatment for PTSD.

> Among veterans who begin PTSD treatment with psychotherapy or medication, a high percentage drop out….With only 50% of veterans seeking care and a 40% recovery rate, current strategies will effectively reach no more than 20% of all veterans needing PTSD treatment (WWP, 2015, p.15).

Is it possible that issues with moral injury are part of the reason for this failure in treatment and retention, particularly as moral injury is related to PTSD but not necessarily responsive to the same interventions as PTSD? In that case, it will be helpful for social workers, in addition to understanding moral injury, to be knowledgeable about local and national peer support groups. Examples are "Real Warriors," "Bootcamp In. Bootcamp Out," "teamRedWhiteandBlue," "stopsoldierssuicide.org," and "vets4warriors."

Emerging Treatments. There are additional trauma-related treatment modalities which are being explored by clinicians working with moral injury. Some are showing positive results and are the focus of current research.

Progressive Counting. One of the trauma treatments developed as an adaptation of EMDR is Progressive Counting. This therapy includes the EMDR concepts of dual attention, memory consolidation, scaling of symptoms, and negative cognitions. It also integrates motivational work, cognitive-behavioral integration, and other treatment skills in "three steps: (a) client preparation…; (b) exposure….; (c) review" (Greenwald 2013, p. 49).

Soul Repair. Already mentioned in this article is Drescher, Nieuwsma, and Swales' (2013) work on moral injury and the treatment called soul repair. The authors describe this method as being one primarily used by clergy, chaplains, spiritual care providers, and mental health providers. The response focuses on "connecting within a supportive community, building friendships, emotional expression through the arts, recovering meaning and purpose through service, and 'deep listening' on the part of the helpers (p. 53). The central concepts are those of bearing witness and therapeutic presence.

Equine Assisted Therapy. Ferruolo (2015) and others observed that veterans with psychological impairments may resist traditional talk therapies and seek alternative treatments. The author reports that one of those alternative treatments, equine assisted therapy, is showing good outcomes. Ferruolo reported on a pilot study with significant improvement in depression, anxiety, and PTSD in veterans. Most certified equine therapists in the United States are social workers with additional training and certification (p. 50).

Research in Moral Injury

Further research is ongoing, but more is needed before clear recommendations can be made to address increasing suicide rates in warriors and

veterans (Hurley, 2015; Shinsheki, 2010, p. 1). An insightful paper prepared by eight authors (Steenkamp, Litz, Gray, Lebowitz, Nash, Conoscenti, Amidon, & Lang, 2010) described the development of a pilot program to provide evidence-informed treatment specifically designed for Marines deploying to the Middle East war zone. The concern was that veterans/warriors were not benefitting from the traditional progressive exposure approaches. Prior to the introduction of the pilot program, the researchers reported that issues presented by the warriors/veterans were more centered on guilt and shame, consistent with moral injury and grief rather than PTSD. So the interventions needed to be tailored to the presenting problems. Steenkamp et al. (2010) emphasized that for many of the veterans in their study, their most troubling symptoms did not involve PTSD issues of "threat of death, injury, or loss of physical integrity" (DSM-IV-TR, APA, 2000, p. 467). Their issues were not traditional fear-based events but were those involving perceived moral transgressions. The resulting therapeutic approaches already discussed in this paper, Adaptive Disclosure, ACT, and IOK call for further research. Random controlled trials of AD, funded by the Department of Defense (DOD) began in 2013. Social workers with a commitment to the evaluation of practice effectiveness are uniquely positioned to continue this research. Further, the integration of concepts around forgiveness, reconciliation, and moral and soul repair fit the social work model for the integration of faith and practice.

Conclusion: A Spiritual Endeavor of the Highest Order

As we have seen, so many questions are unanswered. By viewing the issues to work on in terms of moral injury, the social worker is able to bring to the table a better understanding of the issues, a professional approach to evaluation of practice that will inform evidence for future treatment, and the hope that these approaches begin to address despair and resulting suicide rates. Although we believe passionately that a trauma-informed approach to the suffering that veterans and warriors experience with PTSD and moral injury is necessary and that using the terminology of moral injury will bring better results, the reality is that for insurance and compensation reasons, diagnoses for the immediate future may need to be made in terms of disorders. Development of evidence for the phenomenon of moral injury and appropriate and effective treatment may lead to changes in diagnostic labels in the future.

In the meantime, attitudes and decisions toward treatment do not have to be confined by diagnostic labels. The movement to promote understanding of moral injury has helped social workers and therapists see a wider area of pain and suffering than was previously recognized or addressed. Van der Hart, Nijenhuis, and Steele (2005), for example, made a convincing case for their belief that dissociative symptoms and dissociative

disorders are essential features of PTSD, evident in the somatoform nature of the warrior or veteran's clinical presentation. They found that it is the presence of these symptoms that contributes to the failure in treatment to integrate traumatic experience. The same concepts may well be true in the exploration of and response to moral injury.

One concern and promise is that, while the concept of moral injury offers a valuable place to start in understanding warrior and veteran suffering post deployment and on redeployment, social workers, whether employed as civilians in military settings or in the community at large, may often be the first clinicians to sit down with the warriors or veterans and actually hear their stories. It is vital to listen for themes of moral injury; it is also vital that other important issues and symptoms such as dissociation and physiological response to trauma are noticed and addressed with appropriate therapeutic interventions including trauma-focused CBT, EMDR, and in some cases, PE.

The issue of moral pain and injury in time of war is not new. The terror of battle and the sickening fear of death resulted in shell shock and PTSD. Those who survived war and their physical wounds may have lived long with the wounds to their understanding of humanity and with their own moral compass badly damaged. Dickson (1950) wrote a biography of Richard Hillary, an English fighter pilot who took part in the Battle of Britain at age 22 and whose plane failed to gain height on the second mission of the night. Dickson, a personal friend of Hillary's, writes about a metaphor of the war response quoting Arthur Koestler that we live our lives alternating between a trivial plane and a tragic plane. "When we live on the tragic plane, the joys and sorrows of the other are shallow, frivolous, trifling" (Dickson, p. 183). Living for a long time, as in war, on the tragic plane has consequences; "as few people can bear it for long, they elaborate conventions and formulae" (p. 183). One thinks here of slang and acronyms widely used by the military. Recent suicide rates and mental health struggles have made it impossible to ignore the impact of moral injury and PTSD. The labeling and compartmentalizing has not worked. In the end, this attempt to try to integrate the tragic with the trivial plane fails. Dickson quotes Koestler's final dictum: "It is one of the mechanisms of the evolution of civilization; to petrify the violent and tragic into conventional formulae" (p. 183).

We referred earlier to Owen's poetry that included his own moral injury that intruded in his waking hours and disturbed his dreaming world. Owen's struggle with the moral depravity of war and the violation of his own values gives no indication of hope, of redemptive love, of forgiveness, or of healing. That need not continue to be so for those of our age who suffer moral injury. We have the opportunity before us to understand the great pain and suffering of those who have borne the burden of war and to develop and refine therapeutic, spiritually sensitive practices to support them and address and heal the pain. This generation's task in facing the disaster and suffering

that war inflicts on our warriors and veterans is represented in the powerful concept of moral injury. Social workers of all faiths and worldviews will find working with this concept a spiritual endeavor of the highest order. ❖

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