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Moral Injury: An Overview of
Conceptual, Definitional,
Assessment, and Treatment
Issues

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Keywords

potentially morally injurious events, moral injury, social-functional model of moral emotions and moral injury, adaptive disclosure

Abstract

Moral injury (MI) is a potential clinical problem characterized by functionally impairing moral emotions, beliefs, and behaviors as well as adverse beliefs about personal or collective humanity and life's meaning and purpose. MI can arise from personal transgressive acts or from being a victim of or bearing witness to others' inhumanity. Despite widespread interest in MI, until recently, there was no reliable measure of MI as an outcome, and prior research has revealed little about its causes, consequences, and intervention approaches. This review provides background information on the history of MI, defines key terms, and critically reviews assessment tools. Additionally, we describe a social-functional theory of the etiology of MI and a social-functional rehabilitation approach to treatment. This treatment approach, which can be used by any clinician regardless of clinical context, employs cross-cutting change agents to promote lasting corrective and humanizing prosocial experiences, enhancing belonging through valued actions and relationships.

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INTRODUCTION

A man drove home from work, parked his car, and opened the car door without first looking at the rearview mirror. A child riding his bike rammed into the car door, and the man tried to help, but the child subsequently died from his wounds. In 1994, the Rwandan state sponsored a 100-day period of mass killing that resulted in the deaths of over one million Tutsi people. Operating under a United Nations mandate that forbade offensive action, peacekeepers deployed to Rwanda helplessly witnessed the indiscriminate mass killings of Tutsi civilians by Hutu militias armed with machetes. A person who lived in East Germany shared their activities to promote democracy with their close friend and neighbor. Unbeknownst to the person, the neighbor worked for the Stasi and, fearing for their own safety, recorded their conversations. The Stasi imprisoned and psychologically tortured the person for years. Released after unification, the person found out about their friend's betrayal from declassified Stasi files. In a busy, urban, under-resourced hospital, a demoralized and taxed emergency department nurse, working a double shift, behaved cruelly toward an irritable and severely intoxicated indigent person. A service member, who was hopeful about a military career, was sexually assaulted by a superior. The officer then covered up the incident and harassed the woman, who eventually was discharged without redress. These diverse experiences led to lasting harm because they entailed grave transgressive behavior. In this review, we provide a framework for clinicians and clinical researchers to conceptualize and assess these types of experiences. We also describe the unique phenomenology, mental and behavioral health outcomes, and treatment targets and strategies that arise from exposure to moral harms, otherwise known as moral injury (MI).

The human story is replete with individuals, groups, and nations wittingly and unwittingly perpetrating cruel and pernicious acts of inhumanity against others. The idea that people can be consumed and haunted by their inhumane acts and be transformatively harmed by others' inhumanity predates the Abrahamic religions and is a pervasive theme in literature and art. One of the challenges to the study of MI is to not pathologize (i.e., conceptualize as abnormal) moral challenges and stressors that are either ubiquitous and part of the human condition or not potential clinical problems. Although moral emotions (e.g., anger, guilt/shame) and the experience

of regret, resentment, and aggrievement are universal, the aftermath of serious transgressive behavior can entail functionally impairing psychosocial problems that may affect the treatment of a presenting clinical problem or, as we argue below, should be considered as a distinguishable and targetable issue. The construct of MI as a distinct clinical problem has emerged from the recognition that existing event-linked mental and behavioral health constructs and disorders, such as prolonged grief, posttraumatic stress disorder (PTSD), and depression, fail to fully account for the phenomenology of the aftermath of exposure to morally injurious events. Moreover, existing evidence-based therapies for PTSD and depression may fall short in addressing MI. Yet, MI is also an inherently transdiagnostic problem that may arise in any clinical setting and co-occur with a myriad of primary treatment targets and presenting problems. Consequently, we aim to provide state-of-the-art practical knowledge about MI in an integrative, cross-cutting, and pan-context fashion. We want to help clinicians in diverse subdisciplines and contexts assess and potentially help people who struggle with moral emotions and behaviors regardless of their core theoretical and practical ideas about psychopathology and psychotherapy.

There has been an explosion of interest in the idea of MI since Litz et al. (2009) introduced the construct to the clinical science and psychotherapy communities. Before 2009, there were 2 PubMed citations and 40 Google Scholar citations with “moral injury” in the title; since 2009, there have been 473 PubMed citations and 1,970 Google Scholar citations. Yet, until very recently, there has been no definition of MI as a putative clinical outcome and no unified way of conceptualizing, assessing, and treating MI. In this review, we first describe the historical roots of the concept of MI and define relevant terminology. We then review assessment tools and provide a revised definition of MI as a clinical problem. Additionally, we present a framework to distinguish the clinical problem of MI from moral frustration and moral distress. We also describe a unifying integrative model that can be used to guide case conceptualization and to promote research based on a firm set of evidence-based assumptions, followed by a depiction of treatment strategies that stem from this model.

BACKGROUND AND KEY TERMS

Shay (1994) coined the term MI in his reexamination of Homer’s *Iliad*, framing the experiences of Vietnam Veterans with chronic mental and behavioral health problems as akin to the plight of Achilles and his soldiers during the Trojan War due to Agamemnon’s betrayal and poor leadership. Shay argued that MI, which he asserted entails an “undoing of character,” stems from severe violations of trust because of leaders’ high-stakes betrayal in combat (e.g., capricious decision making, repudiation and rejection of warriors’ experiences and behaviors). Shay’s metaphorical framework has considerable explanatory validity in describing the conflicts and inner turmoil that some combatants face when they lose self-esteem and trust in others due to personal transgressive behaviors or victimization by capricious leaders. Valued, honorable, caring/valuing, selfless, and supportive leadership and kindred attachments are crucial in sustaining and substantiating personal sacrifice in the face of grave moral challenges (e.g., combat) (Nash 2022). The term “undoing of character” can be framed as unspecified alterations in personal and collective value and compassion toward the self and interdependent others when expectations of virtuous behavior from peers and leaders are dashed under life-and-death circumstances. Although Shay failed to operationalize the boundary conditions for MI, his use of Homer’s themes of anomie and ennui served as an excellent starting point for the discourse about MI and is an enduring and rich framework to explain brokenheartedness, shame, rage, and alienation among combat Veterans with pervasive psychiatric and social problems. Yet, Shay’s explication of MI was limiting because the tacit assumption was that severe moral challenges were applicable only to combatants.

Litz et al. (2009) offered a conceptual framework for MI, which was also limited to combatants and war Veterans. Like Shay, Litz et al. used the construct of MI to explain the unique lasting outcomes that may arise from exposure to moral and ethical challenges in war zones and to explain the persistent and challenging-to-treat psychosocial problems faced by some war Veterans. They also conducted a review of the evidence that supported this perspective. The noteworthy features of this first attempt to leverage psychological and clinical science to explicate the idea of MI were as follows:

1. Framing MI as a high-magnitude, stressor-linked problem. Litz et al. (2009) distinguished exposure to potentially morally injurious events (PMIEs) and the putative outcomes from those experiences (i.e., MI). This is analogous to the distinctions between stressors and stress reactions and between potentially traumatizing events and PTSD.
2. Defining MI as the life-altering, multisystemic impact of doing things or failing to do things, or being the victim of/bearing witness to acts that transgress deeply held moral beliefs and expectations. However, Litz et al. (2009) did not explicate or operationally define the multisystemic outcomes associated with exposure to transgressive events.
3. Critically reviewing whether cognitive behavioral theories of PTSD are sufficient to explain and describe the aftermath of exposure to PMIEs. Litz et al. (2009, p. 699) found that existing models were inadequate, which can be expected because “theories of PTSD attempt to explain the long-term phenomenology of individuals harmed by others (and other unpredictable, uncontrollable, and threatening circumstances) and have not considered the potential harm produced by perpetration (and other moral transgressions) in traumatic contexts.”
4. Positing that MI overlaps with PTSD and depression symptoms. The purported overlapping symptoms of MI are as follows: being haunted by the experience (reexperiencing is fundamental to any stressor-linked problems), being motivated to avoid memories and related contexts, anhedonia, and social withdrawal. Litz et al. (2009) also posited that MI has unique symptoms and problems: covert and overt forms of self-harm and self-handicapping; confusion; bewilderment; self-loathing; and a sense of futility, demoralization, and hopelessness.
5. Emphasizing that interest in MI has far outpaced the available evidence to support the validity of the construct. In particular, there was no consensus definition of the putative syndrome, nor was there any gold standard measure of it.

ASSESSMENT

There are two types of assessment measures germane to the MI construct: questionnaires that assess PMIE exposure and questionnaires that assess the putative unique outcome associated with PMIE exposure. At present, there is no structured clinical interview for determining the sufficient elements of a PMIE and related MI symptoms. Most questionnaires have been conceived and validated in the context of war Veterans. MI scale developers have (except in one instance; Litz et al. 2022) derived content from existing scales or generated new content based on Litz et al. (2009) and the judgments of purported experts and stakeholders. This is problematic because there is no paradigmatic theory of MI or consensus operational definition of MI as an outcome, particularly for outcomes that may be unique to bearing witness to or being directly victimized by transgressive behavior. The risk for experts relying on idiosyncratic constructions of existing literature and varied personal experience is high (e.g., Drescher et al. 2011).

Not surprisingly, there is no gold standard measure of PMIEs or MI, no standard or working definition that epidemiologists and clinicians can use to determine caseness, and no consensus

about the necessary structural features of questionnaires that assess for PMIEs and MI. In terms of the latter, the following questions remain unaddressed:

1. Should there be a magnitude requirement to determine if exposure to a PMIE is distinguishable from a moral challenge or moral stressor (Litz & Kerig 2019)?
2. Should a PMIE be required to meet the DSM-5 Criterion A definition of a traumatic event?
3. Is there incremental explanatory and clinical value in linking MI symptoms to a specific PMIE? Or should symptoms be assessed independent of PMIE exposure?
4. Should symptoms be indexed to a time frame, and if so, how long (a month, a year)?
5. Should functional impact be a necessary element in the determination of clinical cases?

In the subsections below, we provide a detailed, critical review of the most widely used measure of PMIE exposure—the Moral Injury Events Scale (MIES) (Nash et al. 2013; for a less-used alternative, see Carrier et al. 2015)—and two measures that are arguably the most content-valid, paper-and-pencil assessment instruments for MI. These are the Moral Injury and Distress Scale (MIDS) (Norman et al. 2024) and the Moral Injury Outcome Scale (MIOS) (Litz et al. 2022). For a comprehensive review and comparison of other measures of moral distress and MI, readers are referred to Houle et al. (2024).

Assessment of Exposure to Potentially Morally Injurious Events

The item content of the MIES was rationally generated by Bill Nash, a combat stress expert, for an epidemiological study of deployed US Marines. The MIES prompts respondents to endorse items referencing military experiences on a scale from 1 (strongly disagree) to 6 (strongly agree). The MIES has items that cover reports of personal acts of commission and acts of omission, bearing witness to transgressive behavior, and betrayal experiences (three separate items cover betrayal by leaders, by peers, and by others outside the military). All items except the betrayal items include yoked questions about whether the person is troubled by each experience. Because the MIES has these “troubled by” items, many researchers have used the MIES to index MI as an outcome. This is problematic because the term is vague and can only suggest some degree of unspecified distress; the MIES fails to assess diverse and specific outcomes. Consequently, the MIES is not a valid measure of MI as an outcome.

Psychometric validation of the MIES has been confusing because, although the scale is chiefly an index of agreement about exposure to moral stressors, three of nine items inquire regarding agreement about being troubled by those stressors. The most important psychometric benchmarks for scales that assess reports of exposure to stressors are content validity (i.e., does the scale accurately measure exposure to applicable stressors?) and short-term temporal reliability (i.e., stability). With respect to exposure content, it seems that the MIES assesses broad themes about exposure to military-related PMIEs. Nash et al. (2013) also found that postdeployment total scores on the MIES were highly correlated with scores at 3 months postdeployment in a study group of deployed Marines. However, because the exposure items are interspersed with (albeit limited) response items, the meaning of total scores is unclear. With respect to response items (putative outcomes), the MIES conceptualizes MI exclusively and narrowly as unspecified global distress. Also, respondents can rate their distress even if they disagree that they were exposed to specific events. The internal consistency reliability of the MIES is strong, suggesting that the items measure the same underlying construct (Nash et al. 2013). However, it is difficult to discern what this construct is when exposure to PMIEs is ostensibly confounded with putative response items.

Assessment of Moral Injury as an Outcome

The MIDS and the MIOS share several structural elements:

1. Respondents are asked to endorse exposure to a PMIE. Both scales assess personal acts of commission or omission and witnessing transgressions; the MIOS also assesses being directly affected by the transgressive acts of others (including betrayal experiences).
2. The self-identified worst and most currently distressing experience is used to anchor reports of possible MI symptoms.
3. If no exposure is endorsed, the scale is not completed.
4. Respondents rate the impact of their worst event during the last month.

Predictably, there is also content overlap between the two scales.

The initial pool of MIDS items was generated by two authors, Shira Maguen and Sonya Norman, based on the work of Litz et al. (2009) and their clinical experience as psychologists in the VA (Veterans Affairs) health care system. They also received feedback from Veterans and from colleagues in health care and the first-responder community. Due to the limitations of Litz et al.'s (2009) nearly exclusive focus on the aftermath of personal transgressions, and the anecdotal and likely narrow understanding of MI among the stakeholders who judged item content (who may have construed MI as an outcome pertaining to personal transgressive acts of omission or commission), the MIDS item creation and selection process falls short with respect to content validity. The biggest concern in this regard is that the MIDS underrepresents the MI construct. It appears that the unique outcomes associated with bearing witness to grave inhumanity, observing others' transgressions, and being the direct victim of others' transgressive acts were not fully considered. The MIDS has one item that asks respondents the degree to which they "feel betrayed by leaders and institutions." This single item may be problematic for several reasons: (a) It arguably is a rating of exposure to a betrayal experience rather than a reflection of content associated with betrayal experiences (i.e., externalizing outcomes), and consequently, the MIDS does not assess the outcomes associated with serious betrayal experiences; (b) it appears to rule out reports of (and potential feelings about) trust violations by peers, intimates, or stranger- and bystander-based experiences; and (c) it is unclear how a rating of agreement with the item "I feel betrayed by leaders or institutions" (the harm) would necessarily change in psychotherapy. Perhaps the authors' tacit theory is that judgments regarding the relative truth about being betrayed are the clinical problem, which may change if the treatment goal, for some reason, is to help someone change how true it is for them that they feel betrayed.

The strengths of the MIDS are that the scale (a) is structured well (i.e., requiring exposure and constraining symptom reports to 1 month), (b) was validated on three occupational groups at risk for PMIE exposure, (c) has some very good psychometric characteristics, and (d) has a high degree of content validity with respect to the aftermath of personal transgressions (Norman et al. 2024). The trimmed 18-item scale was found to have excellent convergent validity with mental and behavioral health measures, and there was a high degree of internal consistency, suggesting that the MIDS is unidimensional. Unfortunately, a simple bivariate correlation between two administrations completed 2 weeks apart suggested poor temporal stability (0.68).

Litz et al. (2022) employed a bottom-up, grounded theory approach to develop operational definitions of the subconstructs of MI, which informed the item content for the MIOS. This approach was driven by a comprehensive, multicultural study aimed at discovering and validating the lasting mental and behavioral health impact of PMIEs. Hundreds of service members and Veterans in the United States, Israel, England, Canada, and Australia were administered a semistructured interview to assess participants' reports of the lasting phenomenological impact of exposure to

PMIEs. Psychotherapists with extensive experience helping Veterans with PTSD and other behavioral health problems in each country were also interviewed and were asked to describe their observations of the impact of PMIEs among patients in their care.

Litz et al. (2022) used qualitative data reduction and analysis techniques to extract invariant, content-valid, higher-order themes, which they operationalized as domains of impact (i.e., subconstructs) of PMIEs and specific components within those domains. Transcribed interview content that overlapped with PTSD and depression symptoms was excluded. The labels and operational definitions of the distinct domains of impact of MI were as follows:

1. Alterations in perceptions of self and others, defined as disruptions in how individuals define themselves or the world with respect to what they or others are capable of in terms of transgression; this is similar to the construct of shattered assumptions about a just world and personal invulnerability (Janoff-Bulman 1992, Pearlman & McCann 1990)
2. Alterations in moral thinking, which entails judging the self or others harshly, moralistically, and with condemnation (self-censure, grievance, embitterment)—also posited by Herman (1992), Shay (1994), and Janoff-Bulman (1992)
3. Social impacts, defined as alterations in degree of comfort with others, connectedness, social acceptance/belonging, and changes in the frequency and quality of engaging with others (see Bowlby 1988, Herman 1992, Litz et al. 2009)
4. Moral emotions and moods, defined as predominant, pressing, and easily triggered moral emotions (see Herman 1992)
5. Self-harming/sabotaging, defined as deliberate and nondeliberate behaviors that negatively affect functioning, health, personal safety, and quality of life/well-being (see Litz et al. 2009)
6. Changes in beliefs about life meaning and purpose, defined as alterations in individuals' religious or spiritual beliefs and behaviors (e.g., Litz et al. 2009)

The first part of the MIOS assesses PMIE exposure. The specific event-type options are a stressful experience in which the respondent (*a*) did something (or failed to do something) that went against their moral code or values, (*b*) saw someone (or people) do something or fail to do something that went against the respondent's moral code or values, or (*c*) was directly affected by someone doing something or failing to do something that went against the respondent's moral code or values. Individuals are asked whether any of these stressors occurred, and if yes, which type(s). The research version of the MIOS assesses whether a PMIE meets the Criterion A definition of a traumatic event and uses a PTSD screener to assess the degree to which PTSD symptoms are currently present as well. In the research and brief versions of the MIOS, respondents are instructed to keep the worst event in mind and rate various outcomes experienced in the last month. Each version also entails a second part, an eight-item functioning scale based on the Brief Inventory of Psychosocial Functioning (BIPF) (Kleiman et al. 2020) that asks respondents to rate the degree to which the MIOS symptoms endorsed make it hard for them to function across various domains. The authors posited that MI should be considered a potential clinical problem only if the symptoms significantly affect multiple domains of functioning.

The investigators generated a large pool of potential items for the MIOS from each domain of impact and components of the higher-order domains. The validated MIOS, a 14-item questionnaire that was found to be invariant and reliable across cultures, has two factors: seven-item subscales that the authors labeled as shame-related and trust-violation-related outcomes (Litz et al. 2022). The MIOS has strong structural and configural validity, internal consistency, and strong test-retest reliability. Total and subscale scores were also found to have strong convergent validity, and PMIE endorsers had substantially higher MIOS scores compared to nonendorsers. Although the MIOS has been validated in a study group of acute care nurses (Tao et al. 2023),

unlike the MIDS, it was initially validated solely on active-duty service members and Veterans (and clinicians). In addition, the incremental and discriminatory validity of the MIOS has yet to be examined. We argue that the MIOS stands out because content validity is very strong, it has subscales that assess the unique internalizing outcomes that arise from personal transgressions and externalizing outcomes from being victimized by others' transgressive acts, and it includes an index of the current functional impact of MI symptoms.

EMPIRICAL STUDIES

Epidemiology

To date, there have been no large-scale epidemiological studies of the prevalence of MI as an outcome. There have been two nationally representative cohort studies (Maguen et al. 2020, Wisco et al. 2017) of reports of PMIE exposure among Veterans (many of whom were deployed to war zones); both of these studies used the MIES. There are no known population studies of PMIE exposure in nonmilitary populations. In the two US Veteran studies, the frequency of reports of personal transgressions ranged from 10.8% to 18.8%, transgressions by others ranged from 25.5% to 27.9%, and betrayal events ranged from 25.5% to 41.1%. The varying frequencies of PMIE endorsement were likely due to differing operational definitions of endorsement using the MIES (Maguen et al. used a more liberal criterion).

Descriptive Psychopathology

We found 288 empirical studies on PubMed and Google Scholar since 2009 where the terms "moral injury" or "morally injurious" were included in the title and/or abstract of the paper. We carefully reviewed publications if they were peer-reviewed empirical studies with a primary focus on the topic of PMIEs and/or MI. Of the 288 publications, 86 met these screening criteria. We read each of these 86 studies carefully and discussed the validity of study design and methods, using Carlson & Morrison (2009) and King & King (1991) as guides. Most empirical studies were not theory driven, failed to use psychometrically sound measures of MI (until recently), and used measurement tools that conflated PMIE exposure with MI as an outcome. Additionally, we did not include studies that were exploratory, had very small effect sizes, and were not replicated. This admittedly subjective and informal process yielded 14 studies that we judged to have acceptable internal validity.

The 14 studies had reasonably large samples, some were longitudinal (bolstering validity), and each had some medium to large effect size findings. Most studies assessed Veteran cohorts (64.3%; Ames et al. 2019, Chesnut et al. 2020, Currier et al. 2019, Kelley et al. 2019, Levi-Belz et al. 2024, Litz et al. 2018, Maguen et al. 2020, Nichter et al. 2021, Zerach & Levi-Belz 2019), three (21.5%; Hoffman et al. 2019, Hoffman & Nickerson 2022, Nickerson et al. 2018) studied refugee samples, one (7.1%; Rushton et al. 2022) was a health care sample, and one (7.1%; DeCaro et al. 2024) studied formerly incarcerated people who were serving life sentences. Investigators used a wide variety of measurement tools to assess PMIE exposure. By no fault of their own, researchers could not assess the symptoms of MI as an outcome.

We do not have the space to describe each study in depth. In general, across studies, PMIE exposure was associated with mental and behavioral health problems. Here, we describe several studies that have particularly noteworthy results (again, subjectively determined). One epidemiological study that used the MIES found gender differences in reports of exposure to PMIEs and related outcomes (Maguen et al. 2020). For men, perpetration events were related to greater functional impairment compared to other PMIE types, whereas for women, betrayal events were specifically associated with poorer functioning (Maguen et al. 2020). With respect to outcomes,

one study found that, compared to other PMIE types, reports of personal transgressions were tied to more reexperiencing symptoms, guilt, posttraumatic sadness, and self-blame (Litz et al. 2018). Compared to other PMIE types, being subject to others' transgressive behavior was predictive of lower social well-being and poorer social functioning, and personal transgressions were associated with less social engagement over time (Chesnut et al. 2020). Finally, Levi-Belz et al. (2024) found that more frequent PMIE exposure was associated with reports of more severe current guilt and suicide risk during a 5-year period, particularly among those struggling with self-forgiveness and feeling disconnected from others. If these findings are replicated, it would suggest that self-forgiveness and building social connections are implicated in the etiology and maintenance of MI and are important treatment targets.

A CROSS-CUTTING THEORETICAL FRAMEWORK

The results of the well-designed empirical studies of MI to date are somewhat disjointed with respect to yielding knowledge about the causes and consequences of the supposedly unique problem of MI, and in our view, there is little actionable information about how to help people with MI. One of the biggest hindrances has been the lack of a comprehensive conceptual framework that can be used to generate testable hypotheses and to guide the selection of targets and change agents in clinical care. To address this problem, we propose a conceptual framework that (a) defines MI as a potential clinical problem and distinguishes it from moral frustration and moral distress; (b) incorporates a social-functional model of morality, moral emotions, virtuous behaviors, and innate action tendencies in the self and others triggered by transgressive behaviors that threaten kinship; (c) frames the causes and consequences of MI within the sociocultural dynamic of "Us" versus "Other"; and (d) suggests heuristics for cross-cutting intervention strategies to heal and repair MI. The overarching aim is to develop a model that could arguably generate a consensus across disciplines and professional contexts and that can be used to create testable predictions for empirical research as well as guidance about intervention strategies.

A Revised Definition of Moral Injury

We contend that MI is a dimensional syndrome of cohering symptoms that are psychological, biological, social, behavioral, and spiritual expressions of the domains of impact described by Litz et al. (2022). Our new definition is as follows: MI is a potential clinical problem that comprises significantly functionally impairing alterations in the following (paraphrased from Litz et al. 2022, p. 4): (a) perceptions of self and others (i.e., shifts in ideas about personal or collective humanity), (b) moral thinking (i.e., moralistic judgments of self and others, such as self-censure and condemnation), (c) social behavior (i.e., social exclusion, social rejection, and loss of valued, valuing, and kindred attachments), (d) moral emotions and moods, (e) self-harming/sabotaging, and (f) changes in beliefs about life meaning and purpose (i.e., questioning faith and the meaning of life, disengaging from religious communities, and a sense of emptiness/purposelessness) indexed to a worst and most currently distressing experience that entails doing or failing to do things or being the victim of/bearing witness to acts that transgress deeply held moral beliefs and expectations.

Although there is overlapping phenomenology, especially when there is a blend of self and other transgressions, MI has shame-related and trust-violation-related subtypes (Litz et al. 2022). Within the dimensional Hierarchical Taxonomy of Psychopathology (Kotov et al. 2017), shame-related MI lies on the internalizing spectra, and trust-violation-related MI chiefly lies on the externalizing spectra but potentially has internalizing features as well (e.g., withdrawal, self-esteem deficits).

We distinguish MI from moral distress by virtue of the former being a potential clinical problem (see the section titled *A Dimensional Model of Moral Stressors and Harms*), which means that the intensity of MI symptoms and the degree of functional impact related to the moral harm and current symptoms are at a threshold such that a person may need additional reparative resources to recover, professional or nonprofessional. In other words, the symptoms and impairment may be overwhelming, and attempts at coping, mitigation, and recovery may not be helping.

Notwithstanding the fact that there are numerous examples of viable clinical syndromes that are not formalized as medical diseases (e.g., irritable bowel, chronic fatigue, fibromyalgia, metabolic syndrome, premenstrual syndrome), questions will arise about whether MI can be a viable clinical construct if it is not a categorical disease codified in the nosology. If MI were treated as a categorical mental disorder, it would have the same validity problems as other putative mental diseases—namely, the arbitrary nature of caseness criteria and the tremendous variability in symptom presentations, the fuzziness of categorical caseness thresholds, the fact that functional impact as a criterion is rarely ensured, and the extensive content overlap between seemingly distinct disorders. With respect to the latter issue, as a high-magnitude, stressor-linked problem that is unbidden and that intrusively affects mood, behavior, hedonic repertoires, and relationships, MI overlaps with both PTSD and depression (as do most other mental disorders).

Another challenge to the viability of the MI construct is the proposition that PMIEs are (or need to be defined as) Criterion A events and that MI is fully explained by PTSD symptoms. It is true that people can “have” PTSD because of morally injurious Criterion A events (e.g., Litz et al. 2018). Yet, while many PMIEs meet the Criterion A definition of traumatic events, this is not necessary for clinically significant MI (e.g., Litz et al. 2022). Also, though some PTSD symptoms capture aspects of the MI syndrome (e.g., reckless/self-destructive behavior, moral emotions), MI includes unique problems that are not captured by PTSD (or depression), and PTSD fails to distinguish shame-related and trust-violation-related MI (see Litz 2020). In addition, the DSM-5 criteria for PTSD fail to distinguish negative emotional states and overemphasize distorted blame (and fail to distinguish self-blame from blame of others). Nevertheless, because nearly all traumas arguably have either a transgressive element or raise moral concerns, PTSD researchers and treatment providers would benefit from assessing the moral implications of traumatic events (see Herman 1992) and tracking MI symptoms when PTSD is the primary target, where indicated.

Although we posit that MI is a dimensional problem, a criterion for MI caseness is essential in epidemiological research and required for insurance reimbursement and most legal contexts. At present, a lack of empirical research precludes identification of the necessary number or kinds of domains of impact that need to be endorsed and the intensity of symptoms and degree of functional impact required for caseness. For case conceptualization and treatment planning, we recommend that providers identify the worst and most currently distressing aspect of a major life stressor or trauma, determine whether the event is a PMIE (for a brief, self-report scale to determine event type, see Benfer et al. 2024), and identify whether moral emotions [i.e., anger (resentment, grievance), guilt/shame] are prominent via history, observation, or interview. When administering the MIOS, if three or more symptoms are rated 3 or 4 and there are at least two BIPF items rated 4 or 5, providers should assume clinically significant and potentially targetable MI (for a MIDS-based caseness recommendation, see Maguen et al. 2024). With respect to treatment planning, providers should determine the relative degree of shame-related versus trust-violation-related symptoms. When the morally injurious event is focally a personal act of omission or commission, this may indicate shame-based outcomes and internalizing problems, whereas a highly charged, high-stakes violation of trust or bearing witness to grave cruelty and inhumanity suggests a trust-violation subtype and externalizing outcomes. Finally, providers should summarize and provide

Continuum of moral harms and outcomes

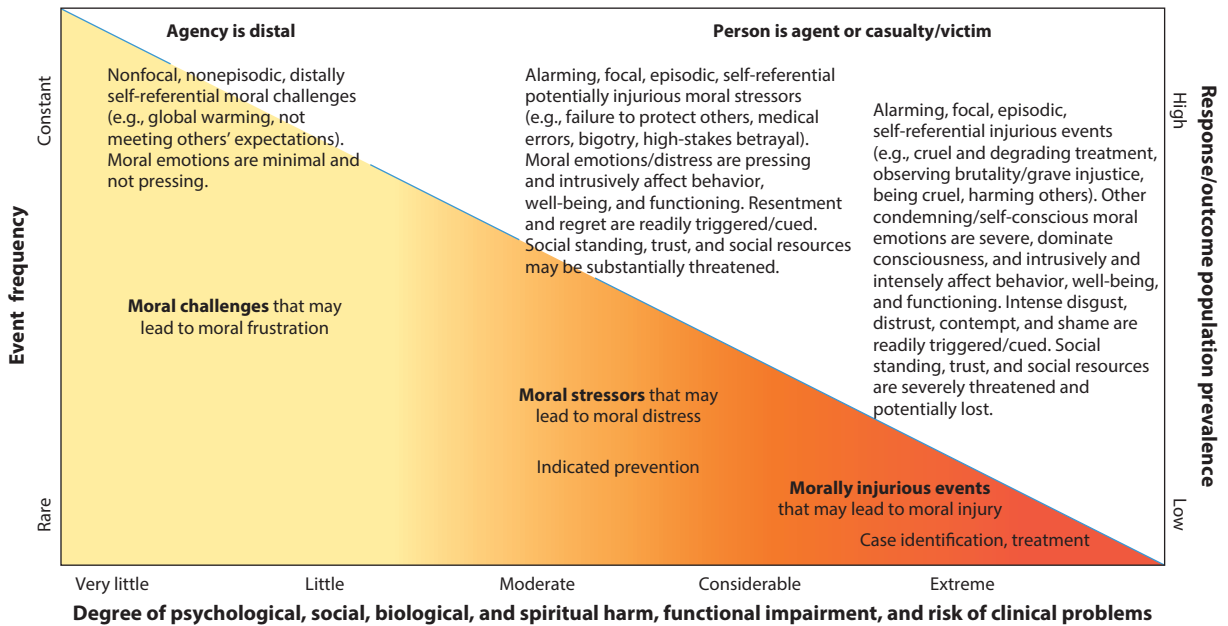


Figure 1

A dimensional model of moral stressors and outcomes. Moral harms and outcomes lie on a continuum from (*left*) nonepisodic moral challenges that may be morally frustrating to (*center*) focal, episodic moral stressors that may lead to acute moral distress to (*right*) even higher-magnitude but less prevalent morally injurious stressors that may lead to the clinical syndrome of moral injury.

feedback to the patient: Does MI fit as the central problem, and is this something they would like to work on changing?

A Dimensional Model of Moral Stressors and Harms

Figure 1 shows a model illustrating experiences that violate deeply held beliefs about right and wrong and the responses to these experiences. The figure shows a continuum of moral stressors varying in frequency, magnitude, and self-reference, with responses ranging in prevalence and severity of outcome. The outcome variable depicted on the x-axis of **Figure 1** is a combination of differing degrees of moral emotions and other domains of impact depicted by Litz et al. (2022), coupled with varying degrees of PTSD and depression symptoms that overlap with moral outcomes (e.g., reexperiencing, avoidance, dysphoria, anhedonia), and functional impairment from these symptoms and problems. In this framework, any moral provocation cues response potentials that differ only in severity and functional impact. This is particularly true with respect to the experience of moral emotions (see Farnsworth et al. 2017). As we discuss in more detail below, moral emotions are cross-cultural repertoires that arise early in development when expectations of virtuous behaviors are violated. There are two varieties: (*a*) the other-condemning moral emotions of anger and disgust and (*b*) self-conscious moral emotions—namely, guilt and shame (see Haidt 2001).

We argue that moral challenges are statistically ubiquitous parts of the human condition. These experiences typically do not have a fixed beginning, middle, and end in a specific context (i.e., they are not episodic), and the person is not directly an agent. Therefore, moral frustration is not an acutely threatening state; the experience entails fleeting and low-intensity moral emotions.

Moral frustration arises because of either incredulity about the state of things or displeasure about personal behavior. An example of a moral challenge that could lead to moral frustration is global warming and inaction to redress it.

We posit that moral distress arises from moral stressors. These are less prevalent than moral frustrations, and these experiences, by contrast, are alarming, focal, episodic, and self-referential. Moral stressors trigger more intense moral emotions, and reactions are pressing and intrusively affect behavior, well-being, and functioning. Resentment or regret can be readily triggered, and social standing, trust, and social resources may be threatened. Moral distress is a subclinical problem. Consequently, from a public health perspective, indicated prevention would be appropriate (rather than clinical care). This might be in the form of self-help or paraprofessional-assisted self-help designed to aid the person in understanding their experience and to generate a reparative action plan to mitigate moral distress. An example of a moral stressor would be cheating on a faithful, committed partner who is loved. Moral stressors are de facto PMIEs because the main distinction between moral distress and MI is in the intensity of MI symptoms endorsed and the requirement for the symptoms to cause significant functional impact.

In the context of psychotherapy for a given behavioral health problem, one way to distinguish moral distress from MI is to conceptualize the former as a potential parallel problem that may intensify the target issue or influence motivation, engagement, and so forth. The therapist should monitor the impact of the therapy on MI symptoms and related impairment, adopting a watchful waiting or indicated prevention approach regarding moral distress.

By contrast, we conceptualize MI as a functionally impairing, potentially targetable clinical problem that entails severe and consuming outcomes (Litz & Kerig 2019). Like moral stressors, the events that lead to MI are focal, episodic, and self-referential, but they are even less prevalent, and the stakes to life and well-being are more severe (see examples in the Introduction). We hypothesize that MI is statistically abnormal (low base rate). Moral emotions are severe, dominate one's consciousness, and intrusively and intensely affect behavior, well-being, and functioning. Intense disgust, distrust, contempt, and shame are readily triggered. Social standing, trust, and social resources may be severely threatened and potentially lost.

A Social-Functional Model of Morality and Moral Injury

A complete review of moral and social epistemology is beyond the scope of this review. However, it is inarguable that people acquire knowledge about morality, operationalized as the parameters and consequences of prosocial/virtuous and antisocial/transgressive behavior, from familial, pedagogical, legal, religious, and community/cultural sources over the lifespan. The phrase “deeply held moral beliefs” used by Litz et al. (2009) references the intensity and breadth of these moral schemas. Acquired knowledge about morality in part defines how PMIEs are construed and defined for the individual, within a community and culture, and how transgressive behaviors are addressed in families and communities.

The social-functional model of moral emotions and behaviors posits that acquired moral beliefs and rules in large part stem from biologically selected, cross-cultural, developmentally early, and unconditioned repertoires that support reciprocal altruism (RA) (Trivers 1971; see also Barrett 2006, Haidt 2001, Keltner & Haidt 1999). RA is the tacit social bargain that if people treat others like they want and need to be treated, others will not be a hindrance to their viability (i.e., they will reciprocate). Humans are social animals; cooperation within kinship or “Us” groups enhances the viability of life-supporting relationships (Sapolsky 2017). Divergent moral emotions and related behavioral repertoires are triggered when a person violates expectations of RA (shame, embarrassment, concealment, submission, withdrawal) (Tangney et al. 2007) and when people are subjected

to others' violations of expectations of RA (hurt, anger, retaliation, validation- and justice-seeking) (Haidt 2003, Keltner 1998).

Virtuous behavior is rewarding due to innate neurobiological mechanisms. The ventral striatum, a component of the brain's reward system, is activated when individuals engage in altruistic acts (e.g., Harbaugh et al. 2007). Frequent prosocial connections are also associated with higher levels of oxytocin (e.g., Kosfeld et al. 2005) and the release of endorphins (e.g., Pearce et al. 2017) and dopamine (e.g., Moll et al. 2006). Similar neurobiological responses are associated with being treated in virtuous ways, observing others' virtuous behaviors (e.g., Morelli et al. 2014), and witnessing Us-group members receiving rewards (Mobbs et al. 2009).

Through these mechanisms, the building blocks of moral behavior—empathy, compassion, altruism, generosity, cooperation, responsibility-taking, obedience, and conformity—are hedonically reinforcing, promoting cycles of positive social interactions and well-being (Ellemers & van Nunspeet 2020). Cohesive prosocial relationships and communities also have a salubrious effect on resilience in the face of life stressors and both mental and physical health (e.g., Seeman 1996). Ultimately, the idea of humanity is built upon the social contract, which starts with unlearned biological repertoires. In this sense, humanity can be defined as shared identity, shared social vulnerability and social fallibility, and shared responsibility-taking and responsibility-expecting.

However, empathy, responsibility-taking, the motivation to treat others with respect and kindness, reactions to virtuous treatment, and responses to bearing witness to compassionate and cooperative behavior are moderated by membership in Us groups versus Other groups. There is inherent motivation and openness to doing virtuous things for and receiving virtuous behaviors from Us-group members when someone is in good standing within the group, which fosters safety and comfort. By contrast, we are more likely to shun, dehumanize, and fail to cooperate and empathize with non-Us-group members (i.e., Others) (e.g., Cikara et al. 2011, Hein et al. 2010). There is less reward and motivation to behave morally with Others (Yudkin et al. 2016). Negative behaviors toward Others can enhance Us-group bonds, further increasing safety and comfort (e.g., Brewer 1999). Hostility toward Others can trigger dopamine release because it can elevate Us-group standing (e.g., Crockett et al. 2008). Similarly, enhancing Us-group status by devaluing and dehumanizing Others boosts self-esteem and positive affect (e.g., Bandura 1999).

Standing (i.e., power/influence, social efficacy) in an Us group is dynamic. People who do cruel, selfish, exploitative, and violent things to Us-group members are at risk of experiencing unconditioned stress, fear, and loss of standing (becoming an Other after being part of an Us group). In the context of personal violations of expectations of RA and Us-group viability, Us-group members may dehumanize the perpetrator and act to exclude and shun the person. Loss of standing, social rejection, and exclusion activate the anterior cingulate cortex, anterior insula, and medial prefrontal cortex, respectively—brain regions that process social pain and rejection (e.g., Ellemers & van Nunspeet 2020). The neurobiological response can be as intense and distressing as physical pain, and, in contrast to physical pain, it can be saliently and intensely cued and reexperienced (Eisenberger 2012, Eisenberger et al. 2003, Kross et al. 2011, Rotge et al. 2015). Becoming an Other threatens safety and well-being; the amygdala is activated, increasing threat perception and acute fear and leading to sustained anxiety and stress (Phelps & LeDoux 2005). Whereas Barlow (2002) emphasized the experience of alarm as central to the etiology and maintenance of anxiety problems, we argue that moral harms are systemically alarming because they also trigger arousal and anxiety, stemming from threats to social safety. People are greatly alarmed when trusted others are dehumanizing, leading to a loss of comfort and cohesion in formerly prosocial relationships (or in humanity writ large). When transgressors experience demonstrable social rejection or have expectations of social rejection, this acutely cues unlearned shame-related behaviors, which lead to new conditioned knowledge. Perpetrators believe that they can no longer be part of a group

that they previously associated with safety and comfort. If people cannot count on others to value them and they feel undervalued, there is a loss of pride, meaning, purpose, and belonging. Loss of prosocial relationships and communities leads to loneliness, which negatively affects resilience and has pernicious effects on health and quality of life (e.g., Hawkey & Cacioppo 2010).

When formerly reliable Us-group members thwart or harm a member (which includes being harmed by strangers or enemies who share a common humanity), this alters the capacity for social connections to be rewarding, affecting one's capacity to rely on valued others. The loss of one's ability to rely on formerly dependable Us-group members can affect not only one's sense of safety but also one's sense of trust, belonging, and identity. Noncontingent painful rejection and betrayal by former Us-group members lead to a neurobiological response that, arguably, initially entails having a broken heart: social pain, anxiety, vigilance, and hedonic deficits. The latter involve reward and pleasure deficits caused by reduced dopamine and reward signaling, which lead to dysphoria and anhedonia (e.g., Haber & Knutson 2010). However, in contrast to the shame and shame-related behaviors that arise from personal transgressions, noncontingent betrayal by Us-group members eventually leads to anger and externalizing behaviors (e.g., Coccaro et al. 2007), which can result from disinhibition of the prefrontal cortex (Davidson et al. 2000). This process is exacerbated by hypothalamic–pituitary–adrenal axis activation, leading to the release of cortisol and further lowering the threshold for anger and aggression, making externalizing behaviors more likely. Ill treatment by group members can also lead to reduced serotonin levels, which can increase aggression and impulsivity (Siever 2008). Further, anger and aggression can be rewarding (linked with dopamine release) when frustration is temporarily reduced and control is reasserted. Finally, in intense emotional states, such as anger, the anterior insula is stimulated, which can magnify anger and externalizing behaviors (Craig 2009).

Morality and outcomes from transgressive behaviors are thus inherently social phenomena (e.g., Fehr & Gächter 2002). The neurobiology of moral behavior fosters viability and social success (i.e., kinship) and supports reactions to personal transgression and noncontingent betrayal by Us-group members that signal the motivation to repair (shame-based) or declare (trust-violation-based) violations of RA. These processes form the scaffolding that shapes and supports an individual's understanding of what is right and just and what is not, guiding their actions in the social world. Connections to Us groups form the building blocks of personal and collective humanity. They help people define who they are and where they fit in the social world and provide a sense of shared value, contributing to positive self-schemas and self-esteem (Tajfel & Turner 1986). The sense of belonging to something valued, as well as being valued and accepted within a group, fosters feelings of connectedness and happiness, enhancing well-being and quality of life (e.g., Baumeister & Leary 1995).

MI, at its core, is about the loss of kinship (i.e., belonging and being part of something meaningful), pride in self and others, and caring and trusting relationships at home, at work, and in communities. Perpetrators experience explicit and/or implicit social rejection and dehumanization and think, feel, and behave in ways that are self-stigmatizing and self-dehumanizing (e.g., Kouchaki et al. 2018). The moral emotion of shame entails expressive behaviors and internal experiences that signify culpability, being unworthy, and being lesser than. For victims of others' transgressive behavior (or bearing witness to grave inhumanity), MI involves brokenheartedness (at least in the beginning), distrust and a loss of faith in humanity, righteous blaming and externalizing, and the moral emotion of anger, which reflects a violation of RA. Being victimized by others' transgressions can also erode self-respect and dignity (Herman 1992). Each type of MI leads to isolation, alienation, and loss of humanity. MI also entails hedonic deficits caused by the loss of otherwise rewarding dependable virtuous repertoires (i.e., doing good, expecting good, receiving good) and pleasurable relationships. In the social-functional model of MI, the injury is

Table 1 Phenomenology and challenges of, and corrective pathways for, shame- and trust-violation-related moral injury

Moral injury subtype	Others' behavioral, emotional, and belief-based reactions	Behavioral, emotional, and belief-based signs of harm	What is potentially lost?	Recovering what is lost by leveraging/creating corrective learning opportunities in therapy, at home, at work, and/or in communities
Shame-related phenomena	Anger, fear, empathy failure, bitterness, disowning, exclusion/rejection, condemnation, fundamental attribution bias (the event defines the transgressor; it is a trait)	Submission, avoidance of intimacy and scrutiny, isolation, anxiety from loss of social standing, dysphoria, anhedonia, self-dehumanization, desire for the community to know that the event does not define the person (unless the person believes the event is self-defining)	Pride, value/self-worth, self-compassion, social cohesion, prosocial relationships, belongingness, humanity, the balance of personal goodness relative to badness, comfort and safety, deservedness, hedonic relational experiences	<ul style="list-style-type: none"> ■ Confess/disclose the harm, share/express impact, get compassionate validation, clarify meaning/implication, and get feedback from caring others (and professionals) about the implication of the event and help generating a repair plan ■ Daily purposeful virtuous behaviors, especially compassion, in ad hoc and planned ways ■ Mindful allowing of others to show their humanity and be kind, trustworthy, and selfless ■ Working on belonging: increasing the size and reach of "Us" groups and reducing the size and reach of "Other" groups ■ Doing valued things and being a part of groups that are valuing ■ Taking misdeeds, missteps, and unempathetic, rejecting, and selfish behaviors by oneself and others in stride—developing perspective and tolerance ■ Generating a maintenance plan and planning response to setbacks
Trust-violation-related phenomena	Fear, helplessness, frustration, empathy failure, disconnection, disbelieving, fundamental attribution bias (the person is angry and bitter)	Brokenheartedness; anger; disillusionment; intolerance; grievance; outrage; cynicism; indifference; loss of faith in humanity, authorities, and institutions; social vigilance and distrust; justice-seeking; confirmation-seeking; demoralization	Social comfort and cohesion; prosocial relationships; trust/faith in humanity; belongingness; compassion; optimism; beliefs/expectancies about mattering, justice, and the potential for good in others; hedonic relational experiences	

social pain, a loss of rewarding, comforting, and safe relationships, and the neurobiological, emotional, psychological, and social consequences of losing Us-group standing or trust in and viability of former Us groups (i.e., being treated as an Other). **Table 1** depicts what might be lost when there is shame- and trust-violation-related MI, the respective signs of social pain, and potential community responses to transgressions.

We posit that the fundamental attribution bias sustains MI. People who transgress and are contrite want others to appreciate that what they did or failed to do does not represent them as a person (it is not a trait). By contrast, people who are harmed by transgressive behavior tend to be firm in their belief that transgressive behavior defines the person (it is a trait). This fundamental attribution bias fosters Othering. It makes it hard for the aggrieved to consider the humanity of perpetrators or their potential for goodness, and it leads to distrust of contrition and reparative behaviors. This means that social resources that might otherwise be leveraged to repair moral harms and MI may be lost or damaged. When perpetrators sense that they are viewed as inherently bad

and incapable of redemptive change, this is ostracizing, and it makes people struggle to see their own potential for repair. The process of repairing or addressing the consequences of witnessing or being directly affected by others' transgressive behaviors is exceedingly challenging, as Sophocles aptly noted circa 410 BCE: "Trust dies but mistrust blossoms" (Sophocles 2017, p. 56).

A Social-Functional Model of the Treatment of Moral Injury

The social-functional model predicts that the most parsimonious, direct, and measurable targets to promote clinically significant change in MI are corrective humanizing and virtuous experiences and connections. The main goal is to help individuals build, restore, and maintain supportive and healing relationships and social experiences—namely, valued and valuing connections with intimates, friends, and groups (Us groups) and ad hoc experiences in the social world that foster personal and collective humanity and belonging. In theory, these experiences enhance mood, reduce anxiety and stress, and reduce the centrality, intensity, and impact of MI symptoms.

Although it is decidedly more behavioral/experiential, like cognitive behavioral approaches to behavioral health problems, the social-functional model of treatment entails promoting corrective experiences (i.e., inhibitory learning) that compete with the accessibility of moral-harm-related associations (see Ehlers & Clark 2000, Foa & Kozak 1986, Litz et al. 2017). Even when treatment is successful—putatively because the person has had sustained success building and broadening kindred connections, restoring balanced beliefs about their own or collective humanity—revised meaning/associations and repertoires related to the moral harm compete with the accessibility of original meaning and innate and learned repertoires. Therefore, we posit that a recovery or rehabilitation approach to care is best (e.g., Litz et al. 2024). The recovery approach is strengths-based, focuses on restoration, building, and sustaining social resources, and treats an episode of psychotherapy as the start of a reparative plan over the life course, which may require follow-ups, check-ins, and a relapse prevention frame.

The social-functional approach to the treatment of MI is cross-cutting, flexible, personalized/ideographic, problem-focused, and process-based (see Hofmann & Hayes 2019). Any strategy that motivates, facilitates, supports, and reinforces corrective action in the social world is appropriate. Clinicians should strategically model and leverage the compassionate therapeutic relationship and employ any number of strategies (e.g., problem-solving, role-playing) to address obstacles to trying on habitative humanizing activities. Clinicians need to also assess, conceptualize, integrate, and track nonpsychological and not strictly psychotherapy-based prosocial change agents and contexts in the person's family, occupation, community, and recreational activities. This includes an assessment of the degree to which faith plays a part in the person's life and whether engaging in faith communities should be part of the treatment plan. As an area of cultural competence, clinicians need to know about how the various faith traditions conceptualize and repair transgressive behaviors and victimization by others' transgressions (e.g., Wortmann et al. 2017). This will help clinicians comfortably and collaboratively foster prosocial religious activities in the treatment plan or foster participation in various co-led clergy/clinician groups for MI (e.g., Nieuwsma et al. 2022). It is equally important for clinicians to be prepared to integrate a variety of other prosocial kinship and helping communities, such as Alcoholics Anonymous (AA), when applicable.

Existing novel cognitive behavioral approaches to address MI and researchers who propose the use of trauma-focused psychotherapies for PTSD focus largely on shame-based personal transgressions and MI-specific mental and behavioral health problems that arise from distorted beliefs about culpability or distorted beliefs about the experience (Jones et al. 2021, Maguen et al. 2017, Norman et al. 2014, Wachen et al. 2021). These approaches argue that MI entails

overaccommodation of blame and event-linked inferences about the self and the world. Although there is observational evidence that some of these treatments lead to changes in trauma-related guilt and self-blame (Held et al. 2018, Dillon et al. 2020), it is unknown whether they are adequate to mitigate diverse MI outcomes. There are two common themes related to cognitive behavioral therapies for putative MI. One is providing moral reassurance by helping the person contextualize and reframe their culpability about a transgression, if possible. The other is the use of cognitive therapy strategies (e.g., Socratic questioning, promoting awareness of the impact of thoughts and beliefs on emotions and behaviors) to lessen any rigid, overaccommodating beliefs (e.g., overgeneralization) about the meaning of the moral harm.

Existing cognitive behavioral approaches to MI have incorporated behavioral strategies to promote change (e.g., making amends through letter writing, visiting burial sites, volunteer work) (Jones et al. 2021, Wachen et al. 2021). We applaud the addition of these social-functional treatment strategies to bolster the approaches. Novel treatments for PTSD, such as Impact of Killing (IOK) (Maguen et al. 2017) and Trauma-Informed Guilt Reduction (TrIGR) (Norman et al. 2014), which primarily target the aftermath of personal transgressions, each acknowledge that beliefs about culpability may be best targeted through acceptance and self-forgiveness, when applicable, rather than solely through attempting to change beliefs about responsibility. IOK flexibly tailors treatment to individuals' cultural views and practices (e.g., added religious/spiritual elements; Burkman et al. 2022). Norman et al. (2022) found that TrIGR led to lower levels of PTSD, depression, and guilt compared to supportive therapy, but the therapy did not lead to differential changes in functioning (Norman et al. 2022).

We argue and predict that new prosocial learning suffices and is the most efficient path to change and that a singular focus on shaping belief change, with the hope of producing collateral change in emotional and behavioral repertoires, is less efficient and potentially inadequate. However, when cognitive therapy employs behavioral experiments to inform a person's morally injurious constructions about themselves or others, this is de facto a path to reparative activities and corrective learning. The empirical question is whether cognitive therapy strategies are necessary in all cases. In our view, an overemphasis on finding ways to reframe the moral harm and its aftermath by attempting to change beliefs about personal culpability and to address overaccommodation can be problematic for at least three reasons: (a) The therapies have little to say about trust-violation-related MI, which raises thorny issues about assigning blame; (b) when culpability is clearly accurate and personal actions are cruel, the therapies offer prescriptions for reparative social action that are not part of cognitive therapy; and (c) if the focus of treatment is MI, by definition, the symptoms and impairment are substantial and consuming. The social-functional model of MI posits that, in this context, there is little therapeutic value in trying to shape the person's constructions of the degree of harm, and in most cases, this would be inappropriate and represent an empathy failure. Ultimately, inferences about culpability and inferences about how much moral harms are representative of the person or people in general are never binary. For example, if a person can shift personal culpability from 100% to 40%, this may not affect their social pain and MI symptoms, and they still face a world that has excluded them (or from which they have excluded themselves) and could use help and support doing reparative prosocial things in the world.

Table 1 describes others' often understandable but potentially contributory and harmful responses to transgressions, the diverse signs of different types of MI in the individual, a depiction of the things that might be lost because of the different types of harms, and treatment strategies. With respect to the first of these, clinicians may need to ask a transgressor or a victim of a transgression how individuals and communities have responded since the event. This will identify: (a) harmful elements (e.g., condemnation, disbelief), (b) obstacles to seeking support and other prosocial reparative actions (e.g., empathy failure, transgressors seen as undeserving of a second

chance), (c) chronic versus new-onset behaviors, and (d) baseline motivation and confidence about engaging with potentially reparative social resources (if applicable).

The behavioral, emotional, and belief-based signs of MI described above and summarized in **Table 1** can be seen as responses to multidimensional components that are lost by a morally injurious event (see the third column of **Table 1**), and the social-functional treatment elements depicted in the last column of **Table 1** are change agents designed to restore what was lost. Although shame-related and trust-violation-related MIs are phenomenologically distinct, and the treatment aims and expected outcomes are different (as is depicted in **Table 1**), the broad treatment approach is the same. This is a win-win in that a person's worst and most currently distressing PMIE may involve blends of shame-related and trust-violation-related experiences, and asking the person to choose a single worst experience may overlook other, equally distressing PMIE types that affect behavior and well-being.

As we have underscored, a treatment plan needs to help people create, embrace, engage, and avail themselves of sustainable humanizing corrective social and emotional experiences to address (i.e., repair, reclaim, correct) the things that were lost in shame-related and trust-violation-related MI. This is a difficult uphill climb due to individuals' anxious expectancies about being vulnerable, the punitive (and thus confirmatory) reactions of others and the community, entrenchment, withdrawal, and enduring injustice (see Herman 1992).

An example of a cross-cutting treatment plan is provided in **Figure 2**. In this hypothetical example, an 18-year-old with a history of abuse and neglect, truancy, and alcohol use disorder was driving a car during a violent chase with another vehicle and crashed into a pedestrian, who suffered life-threatening injuries and lost a leg. Both reckless drivers fled the scene, leaving the victim isolated and alone, and it took weeks to find the perpetrators. While incarcerated, the main perpetrator engaged in a Christian faith community, attended AA meetings, and was sober. He also participated in a restorative justice program and met with the victim and his family. Restorative justice focuses on repairing the moral harm caused by criminal behavior and involves the victim, the offender, and the community (U.N. Office on Drugs and Crime 2006). The process involves one-one-one testimonials (with other stakeholders present) so that each party can appreciate the humanity of the other and acknowledge the harm and its consequences, allowing perpetrators to express contrition and disclose their plans to repair the harm, all in the service of promoting recovery and preventing future harm. In the meeting in the hypothetical case under discussion, the perpetrator shared his plan to regularly attend AA, engage in community service, and receive psychotherapy to manage stress and to address feelings of shame and unworthiness. In psychotherapy, the clinician and the young man determined that there had been a cycle of moral harms throughout the lifespan and that the man not only was ashamed and felt less than human at times but also was angry and distrustful of others because of serious mistreatment over the lifespan, and he expected to be taken advantage of by strangers. At various points in time, specific change agents (see the blue hexagons in **Figure 2**) were employed to address social avoidance and withdrawal and to motivate, shape, plan, reinforce, and accommodate the experiences described within the red hexagon in **Figure 2**.

It is worth underscoring that there is a reciprocal agent (or agents) in the background of nearly all MI cases, whether it be a perpetrator (witting or unwitting) or a casualty. In the hypothetical case above, there is the victim of the violence and the inhumane neglect (leaving the scene). For the victim and the perpetrator, contrition is necessary but not sufficient. Recovery for both parties requires sustained reparative actions. Forgiveness of the person (not the harm) may be something desired for some to start a path of healing, but it can be fraught and problematic. First, victims may feel pressure based on religious or societal factors (tacit or otherwise), which is particularly problematic when the moral harms are egregious, leading to empathy failure, withdrawal, and



Figure 2

Example of a treatment plan to treat moral injury using cross-cutting change agents (*blue hexagons*). Various intervention strategies that fit a given case should be used flexibly in a thematically integrated fashion to promote valued and valuing prosocial experiences and attachments. Abbreviation: AA, Alcoholics Anonymous.

resentment. Second, forgiving someone, or focusing solely on self-forgiveness, might overshadow other important aspects of restorative justice, such as accountability, reparation, and the long-term empowerment of victims. It may also create unrealistic expectations for what restorative justice can achieve. Third, forgiving one's perpetrator is construed by many as a sufficient step, which will fall short given the possibility of relapse by the perpetrator and the vagaries of kinship attachments in general.

Several of the change agents depicted in **Figure 2** were derived from adaptive disclosure (AD), a manualized, flexible, and individualized psychotherapy originally for PTSD related to MI (Litz et al. 2017). In the original therapy, moral harms were disclosed in real time to an imagined compassionate moral authority. This was designed to unearth meaning and provide feedback from

trusted others, experientially, in the service of building a prosocial repair plan (Litz et al. 2021). An enhanced, 12-session version of AD (AD-E) (Litz et al. 2024) aligns more closely with the social-functional model of MI in the following ways: (a) Disclosure and processing are optional and depend on the case conceptualization, the likelihood of a successful experience, and shared decision making; (b) AD-E added optional letter writing (e.g., to someone who was victimized by a transgression) to process the experience and receive feedback about the event, its aftermath, and healing suggestions, as well as mindfulness and loving-kindness meditation training to increase compassion for self and others and repair lost faith in humanity or one's own humanity (Litz & Carney 2018); and (c) a central focus is on generating a dynamic corrective plan of activities and leveraging all aspects of the therapy to promote successful experiences in various social contexts. However, AD-E was overly PTSD-centric and was developed before our work defining the MI syndrome and before there was a scale to evaluate MI symptoms and related impairment. Consequently, it is still an empirical question whether AD-E, as a stand-alone therapy, is an efficacious treatment for MI.

The heuristic content in **Table 1** and the social-functional model of treatment described above were designed to help clinicians regardless of the professional context and specialty area, the presenting problems of the person seeking care, or the theoretical orientation and typical therapies used. When MI is partly or fully targeted, we recommend that clinicians conceptualize the case, leverage elements of applicable interventions they know well, and flexibly use change agents to promote prosocial change and MI symptom change. Various change agents in the AD-E manual can be used flexibly in any treatment plan. Clinicians should also apply an evidence-based, measurement-based care approach to track changes in symptoms and impairment using the MIOS (public domain and available by request) and shift their approach when it is not working.

Finally, in our anecdotal experience, clinical cases of MI that stem from personal acts of omission or commission tend to be less complicated than cases involving individuals who bore witness to grave and grotesque inhumanity or who were directly victimized by the inhumanity of others. People who transgress, deliberately or accidentally, and seek help are painfully contrite (a necessary precondition to change) and acutely aware of the need to change their behavior to make amends for their actions or inactions. They also typically appreciate an approach that centers on their role as agents of prosocial behavior and fully understand how and why members in the community might shun them. By contrast, there are unique challenges and potential obstacles to recovery for people who have witnessed cruelty and grave inhumanity and for people who struggle because they were victimized directly by others' inhumanity. People who bear witness to human cruelty and loss of life may be so brokenhearted, disgusted, and haunted by unprecedentedly grotesque memories that it is hard to conceive of actions that they or others can take to counter the enormity and implications of what happened; the scale and existential impact are too overwhelming to even ponder repair. People who are directly victimized by the cruelty and inhumanity of others face a similar challenge because their experiences are amplified by overaccommodation and exacerbated by unempathetic reactions from others. Additionally, they may be in a context where redress and justice are impossible or attempts at seeking them are punishing.

To address these issues, Herman (1992) posited that clinicians should help individuals acknowledge, process, and grieve both tangible losses (e.g., lifespan physical and behavioral health impacts) and intangible losses (e.g., the enduring reality of human cruelty). We have also argued that clinicians need to allow individuals to share and process the existential impact of morally injurious experiences (Litz 2024). By contrast, people may be reluctant to share the depths of their feelings and beliefs with caring friends and relatives, and if they do disclose, out of discomfort and helplessness, then loved ones may provide reassurance and offer comforting advice. However, in the clinical context, if someone is sorrowful, angry, despairing, and hopeless about humanity,

clinicians need to fully, nonjudgmentally, and compassionately honor the painful truths rather than wait for openings to offer reassurance or question the validity of any overaccommodated conclusions.

The hypothesis is that if a person can feel validated and compassionately supported when they unburden the depths of their feelings and beliefs and reflect on the implications of their experience in terms of their beliefs about themselves and humanity, this may bolster trust, and they may be more open to a case conceptualization and an initial treatment plan. In AD-E, there is a provision for processing and sharing the emotional truth of any transgressive experience and the depths of social pain and other moral harms to an empathic clinician and a compassionate moral authority (e.g., a grandparent). This disclosure is imaginal and in real time, with the individual's voice articulating the compassionate other's reaction and feedback. The aim is not to ensure buy-in but to be open to feedback from the loving other and for the clinician to invite the person to be vigilant about the degree to which observing, allowing, and doing prosocial acts reduce the severity and impact of their MI symptoms. The other aim is to facilitate and promote compassion for the self and others. In ad hoc and planned ways, the person may face other people and situations that appear to confirm their beliefs about humanity. A compassionate reaction might entail wondering whether people may be struggling because they have also been exposed to cruelty or were treated cruelly. This enhanced awareness may motivate the person to behave virtuously to provide disconfirming experiences for others.

CONCLUDING COMMENTS

We have described a social-functional model of MI that is multilevel, starting with biological predispositions and moving to higher-order and acquired aspects of psychosocial behavior, social pain, and social resources that can be used to aid in recovery. The model is also cross-cutting and inherently interdisciplinary. Moral emotions and behaviors, as well as moral distress and MI, are not solely psychological, social, biological, or spiritual/faith-based phenomena. Consequently, interventions should not prioritize one of these aspects over the others. We have argued that MI treatment requires flexible and personalized change agents that help people do things and avail themselves of things in their social world that lastingly humanize the self and others. We also have sought to generate operationalizable and measurable ideas, which should generate a host of empirical questions, hypotheses and predictions, and methodologies to advance the clinical science of MI. We particularly welcome empirical research that challenges the social-functional model using predictions born from alternative theoretical models.

Clinicians should understand that no one is immune to causing grave social pain or being victimized by inhumanity. Clinicians should also understand that each can lead to the other, forming a cycle of moral harm. For example, Primo Levi [1988 (1986), p. 45], describing a moral "gray zone," depicted concentration camp victims who became guards to save their own lives. An additional example is the overworked and undersupported nurse described above in the Introduction, which illustrates how chronic exposure to potentially morally injurious institutional betrayal and failed leadership might lead to transgressive behavior, echoing themes described by Shay (1994). An appreciation of how flawed and vulnerable we are, and how impossible it is for people to be all good or all bad, will reduce judgmentalism about the self and others and lead to greater compassion toward the self and others, which are essential characteristics in MI treatment. It is equally important to have confidence that virtuous behaviors are hedonically reinforcing and affect well-being and to have confidence that people can feel and benefit from social pleasure (e.g., belonging, acceptance, love, joy). This is a reductionist starting place that should be augmented with an appreciation of the myriad ways in which intimates, strangers, groups, communities, agencies, and

governments—in small, fleeting, unexpected, sustained, and grand ways—can be compassionate, empathic, selfless, honorable, and just, thereby acting in corrective and beneficial ways to concentric circles of humanity. The challenge is to build a collaborative treatment plan that generates opportunities for successful experiences creating, availing, and grasping opportunities that counter social pain.

FUTURE RESEARCH DIRECTIONS

Our hope is that recent advances in assessment and the information in this review will initiate a new era of empirical research on MI, given that so many empirical questions about MI remain unaddressed. For example, there are no studies on the epidemiology of MI as an outcome, and no clinical trial to date has demonstrated efficacy using MI and functional impairments linked to MI as the end points. Another empirical question that can be readily tested is whether a cognitive therapy approach to MI leads to prosocial behavior (e.g., doing things that are valued, engaging with people and activities that value the person and enhance a sense of belonging) and the degree to which the latter explains variance in MI symptoms and functioning. Finally, we recommend that for clinical and case identification purposes, MI symptoms and resulting functional impairment should be indexed to a worst and most currently distressing PMIE. This overlooks the cumulative impact of PMIEs across the lifespan with respect to current MI symptoms and functional impairment. Consequently, research is needed to determine the validity of a construct of what might be best labeled the “moral scars” that can result from chronic moral harms.

SUMMARY POINTS

1. There are unique life stressors that are potentially morally injurious events (PMIEs), which entail (a) personal transgressive acts of commission or omission and/or (b) being the victim of or bearing witness to others' transgressions.
2. Moral injury (MI), a potential functionally impairing dimensional clinical problem that arises after exposure to PMIEs, entails loss of faith in personal or collective humanity, moralistic judgmentalism, loss of valuing and kindred attachments, self-conscious or other condemning moral emotions, self-harming behaviors, and demoralized beliefs about life's meaning.
3. The Moral Injury Outcome Scale (MIOS) is a questionnaire that assesses MI symptoms and resulting functional impairment. It has excellent content coverage and psychometric characteristics.
4. Although there are overlapping symptoms—namely, loss of kinship, pride in self and others, and caring and trusted relationships—MI has two distinct subtypes. Shame-related MI entails internalizing experiences (e.g., self-conscious moral emotions, social pain from exclusion, dysphoria), whereas trust-violation-related MI entails externalizing behaviors (e.g., anger, loss of trust in others).
5. The social-functional model of MI is derived from the social-functional theory of moral behavior and the biological underpinnings of responses to transgressive experiences. The model posits that MI entails social pain and that change agents need to help individuals engage in corrective prosocial and kinship-building actions to restore their faith in personal and/or collective humanity.

FUTURE ISSUES

1. Future epidemiological studies should explore the prevalence of MI and moral distress in various populations.
2. Clinical trials, along with quasi-experimental and real-world observational research, need to test the efficacy and effectiveness of emerging MI treatments.
3. Future research should examine whether cognitive therapy approaches to MI lead to meaningful changes in prosocial behaviors by patients and in patients' environments and the creation or expansion of kinship relationships and positive leisure and self-care activities.
4. Longitudinal research is needed to assess the cumulative impact of PMIEs across the lifespan.

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