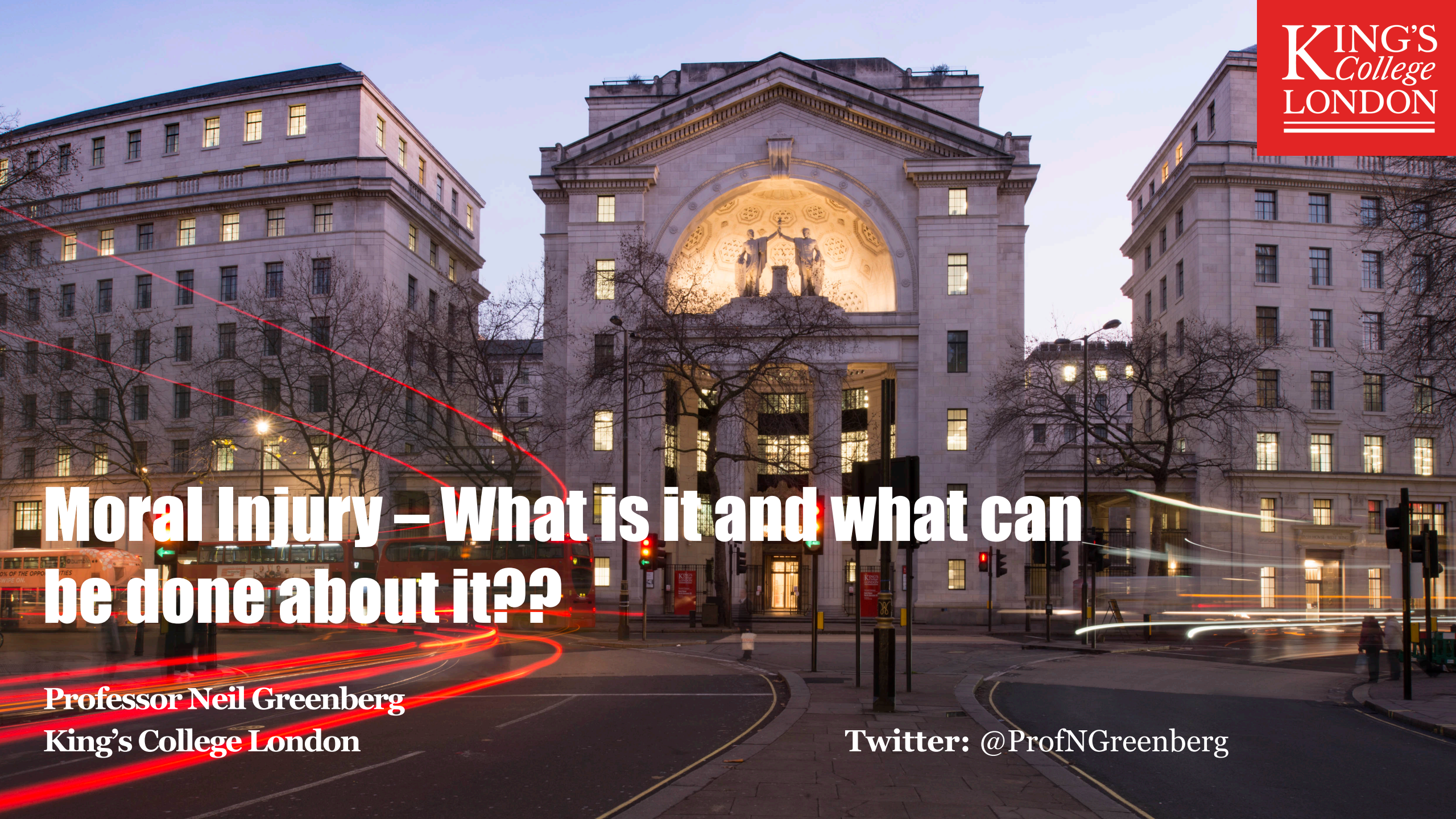


Moral Injury – What is it and what can be done about it??

Professor Neil Greenberg
King's College London

Twitter: @ProfNGreenberg

Who am I? Twitter: @Profngreenberg

- Professor at King's College London
- Served in the Royal Navy for 23+ years
- Managing Director of March on Stress Ltd
- Trustee for Society and Faculty of Occupational Medicine
- Led on World Psychiatric Association Position Statement on Mental Health at Work
- Member of NHS England Expert Advisory Group on Staff Wellbeing
- Clinician – mainly occupational mental health

Moral Injury?

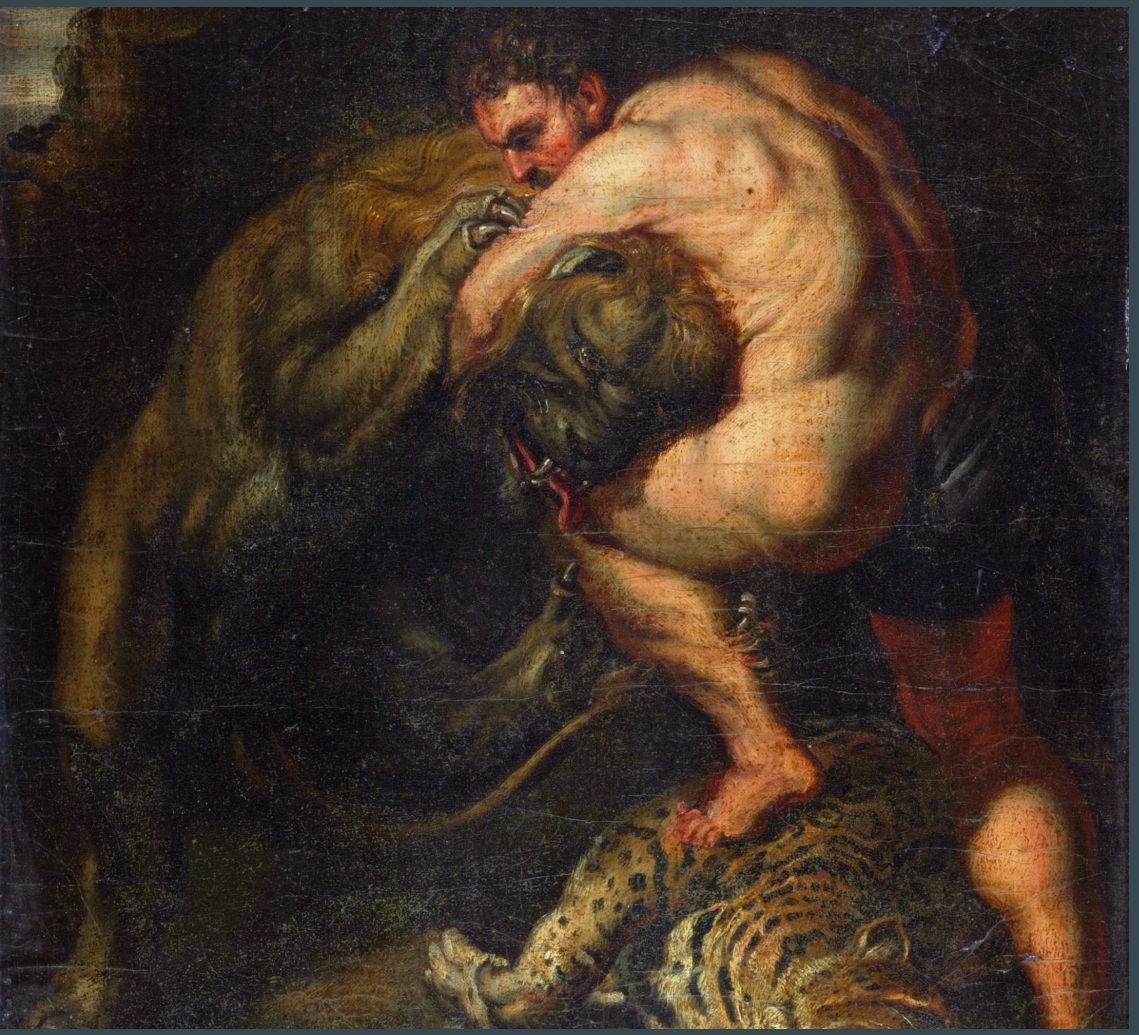
Profound distress following a ‘transgressive act’ that violates one’s moral or ethical code

well – moral distress – moral injury – illness

Potential Morally Injurious Events

- Commission
  - I did things I should not have done
  - I am a monster
  - My team did things they should never have done
- Omission
  - I froze and people died
  - I just let it happen
- Betrayal [often, but not always, by a higher authority]

Roots of moral injury



Miasma: Ancient Greek concept of moral defilement or pollution, often resulting from unjust killing

And overpowered by memoryBoth men gave way to grief. Priam wept freelyFor man - killing Hector, throbbing, crouchingBefore Achilles' feet as Achilles wept himself,Now for his father, now for Patroclus once againAnd their sobbing rose and fell throughout the house.

— Homer, The Illiad, 762 B.C

What is missed by current conceptions of PTSD

	PTSD	Moral Injury
Triggering Event (A1 Criterion)	Actual or threatened death or serious injury	Acts that violate deeply held moral values
Individual's role at time of event	Victim or witness	Perpetrator, victim, or witness
Predominant painful emotion (A2)	Fear, horror, helplessness	Guilt, shame, anger
Reexperiencing (B Criteria)?	YES	YES
Avoidance or numbing (C Criteria)?	YES	YES
Physiological arousal level (D Criteria)?	YES	NO
What necessity is lost?	Safety	Trust

See: Litz B.T, Stein N., Delaney E., Lebowitz L., Nash W.P., Silva C., & Maguen S. (2009). Moral injury and moral repair in war veterans: a preliminary model and intervention strategy. *Clinical Psychology Review,* doi:10.1016/j.cpr.2009.07.003.

Complex PTSD

- ICD11 – PTSD and....disturbances in self-organisation (DSO)

- The domains of DSO include

- Emotional dysregulation
- Negative self-concept
- Interpersonal difficulties

- And...tentative evidence that DSO is strongly related to Moral Injury (and thus CPTSD) (Currier, Murphy et al, 2021)

Problems with the moral injury concept

- “it’s just a sort of PTSD isn’t it”?
- What’s the threshold for what a PMIE might be?
- It’s not a diagnosis, so why bother with it?
- We don’t have any treatments or interventions for it anyhow?

Why investigate moral injury?

Impact on mental health

Meta-analysis: Associated with poor mental health outcomes

Majority of research US based

Linked to PTSD, depression and suicidality (?co-morbidity or risk factor)

BJPsych The British Journal of Psychiatry (2018) 212, 339–346. doi: 10.1192/bjp.2018.55

Review article

Occupational moral injury and mental health: systematic review and meta-analysis

Victoria Williamson, Sharon A.M. Stevelink and Neil Greenberg

Background

Many people confront potentially morally injurious experiences (PMIEs) in the course of their work which can violate deeply held moral values or beliefs, putting them at risk for psychological difficulties (e.g. post-traumatic stress disorder (PTSD), depression, etc.).

Aims

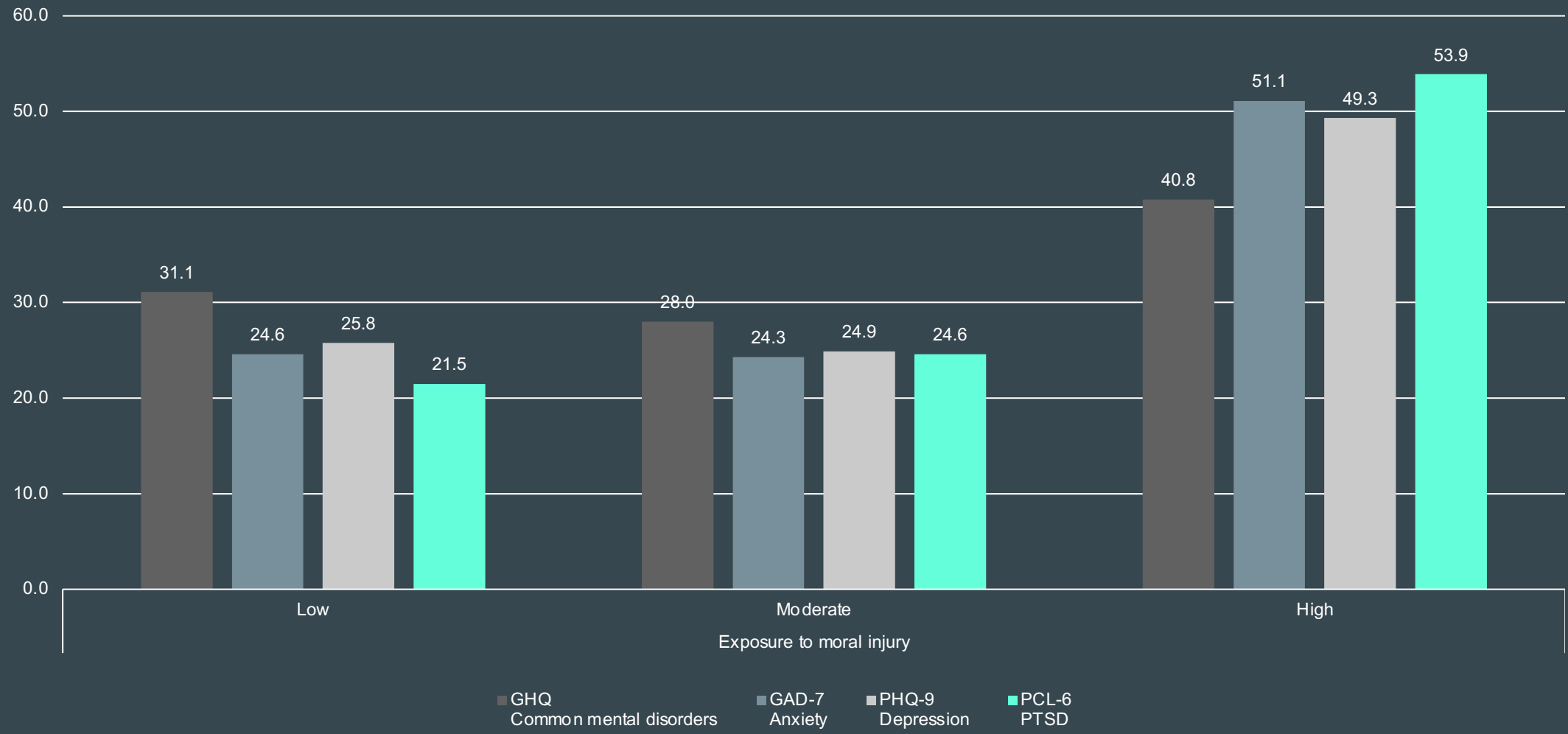
We aimed to assess the effect of moral injury on mental health outcomes.

was not consistently significant. Moderator analyses indicated that methodological factors (e.g. PMIE measurement tool), demographic characteristics and PMIE variables (e.g. military *v.* non-military context) did not affect the association between a PMIE and mental health outcomes.

Conclusions

Most studies examined occupational PMIEs in military samples and additional studies investigating the effect of PMIEs on civilians are

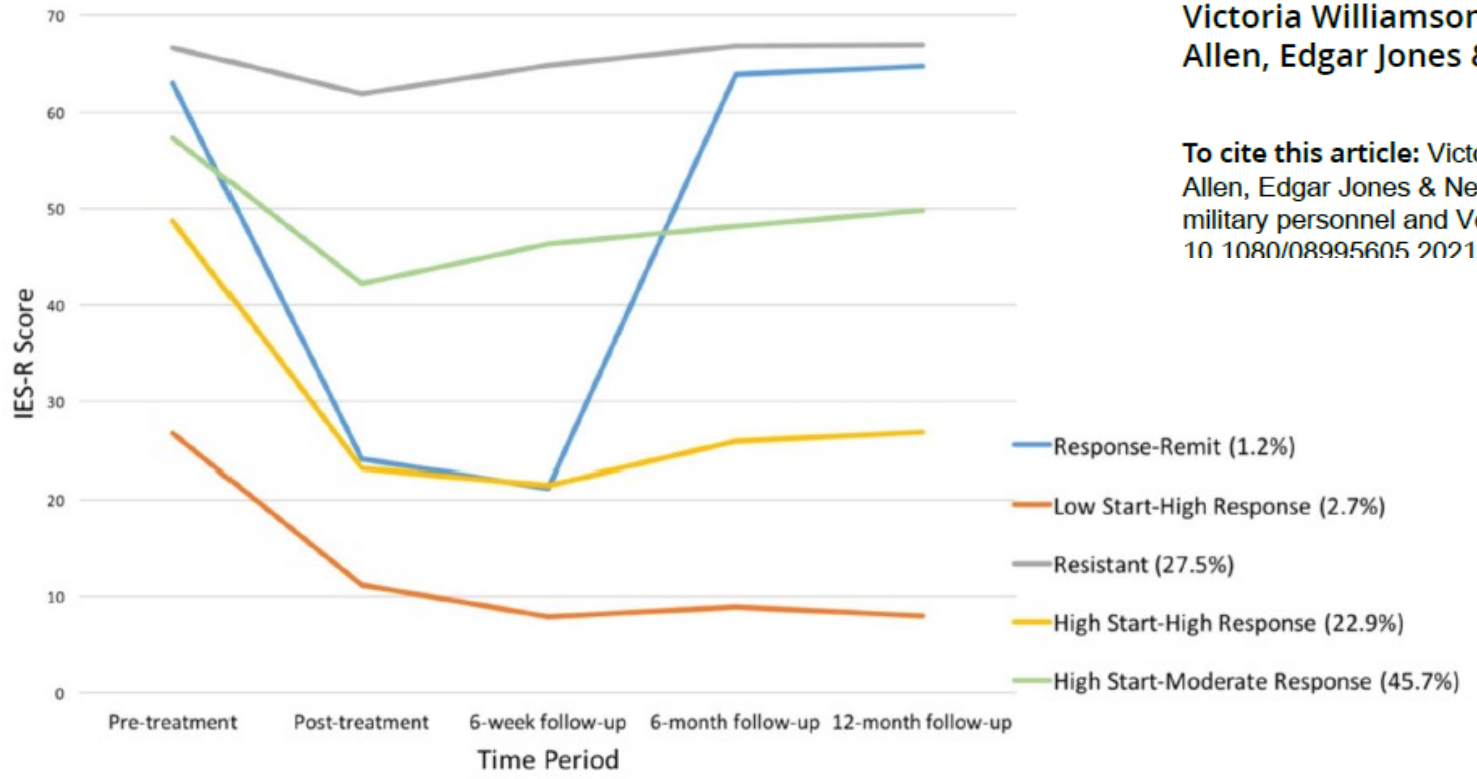
Potentially morally injurious events (PMIEs) and mental health outcomes in HCWs



UK veterans appear to benefit less from PTSD treatments

UK PTSD TREATMENT OUTCOMES

PTSD Trajectories



Delivering treatment to morally injured UK military personnel and Veterans: The clinician experience

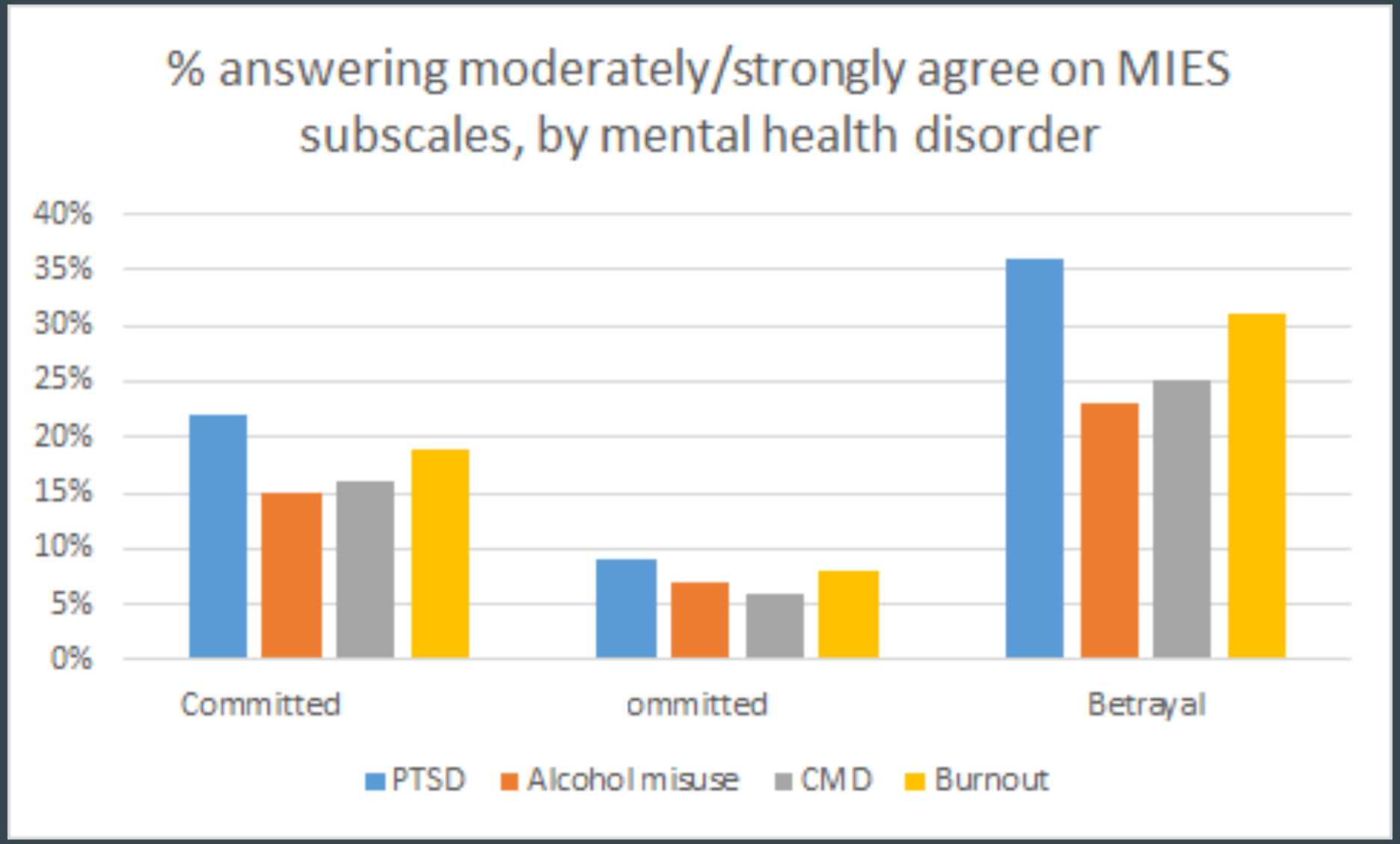
Victoria Williamson, Dominic Murphy, Sharon A. M. Stevelink, Shannon Allen, Edgar Jones & Neil Greenberg

To cite this article: Victoria Williamson, Dominic Murphy, Sharon A. M. Stevelink, Shannon Allen, Edgar Jones & Neil Greenberg (2021): Delivering treatment to morally injured UK military personnel and Veterans: The clinician experience, Military Psychology, DOI: 10.1080/08995605.2021.1897495

Some evidence that exposure-based treatments (e.g. prolonged exposure) may cause harm in those presenting with moral injury related PTSD (Maguen & Burkman, 2013)

Overview of relevant MI research

Types of moral injury and MH disorders in HCWs



IMAGINE Study

Qualitative interviews:

- Military veterans (n=30)
- Clinicians (n=15)

Online questionnaire:

- Military veterans (n=204)

Key findings

Moral injury experienced by UK veterans alongside ‘classic trauma’

“You are in the middle of a riot…and you are trying to deal with 250 [people] who are all throwing bottles, bricks and everything else at you… The only time I hit a woman was in Northern Ireland… I’m not proud of that, it was just one of those things.”

Mental health outcomes

Moral injury and 'mixed' events associated with:

- PTSD
- Anxiety disorders
- Suicidal ideation*

Williamson *et al. BMC Psychol* (2021) 9:73
https://doi.org/10.1186/s40359-021-00578-7

BMC Psychology

RESEARCH ARTICLE Open Access

The impact of moral injury on the wellbeing of UK military veterans

Victoria Williamson[1,4*], Dominic Murphy[1,2], Sharon A. M. Stevelink[1,3], Shannon Allen[1], Edgar Jones[1] and Neil Greenberg[1]

Abstract

Background: Experiences of potentially morally injurious events (PMIEs) have been found to negatively impact the mental health of US personnel/veterans, yet little is known about the effect of PMIEs on the mental health of the UK Armed Forces (AF). This cross-sectional study aimed to examine the association between PMIEs and the mental health outcomes of UK AF veterans.

Method: Assessments of PMIE exposure and self-report measures of common mental disorders were administered using an online questionnaire to 204 UK veterans. Subjects were classified as having experienced a morally injurious event (n = 66), a non-morally injurious traumatic event (n = 57), a 'mixed' event (n = 31), or no event (n = 50).

Results: Potentially morally injurious experiences were associated with adverse mental health outcomes, including likely anxiety disorders and suicidal ideation, compared to those who reported no event exposure. The likelihood of meeting criteria for probable PTSD was greatest in those who had experienced a non-morally injurious trauma. No statistically significant association between alcohol misuse and experiencing a PMIE or traumatic event was observed.

Conclusions: The results provide preliminary evidence that potentially morally injurious experiences are associated with adverse mental health outcomes in UK AF veterans. Further work is needed to better understand the interplay between morally injurious events and threat-based trauma in order to design effective pathways for prevention and intervention for people exposed to highly challenging events.

Challenges in treatment

- Clinician perspective

No standard way of treating MI associated MH problems

Not always clear whether to ask about MI and how to do so?

Challenges in treatment

Managing patient disclosures

Challenging symptoms

Impact on clinician wellbeing

Accessible resources & training

Confidentiality and psychological treatment of moral injury: the elephant in the room

Victoria Williamson ,[1] D Murphy,[2] S A M Stevelink,[3] E Jones,[4] S Wessely,[5] N Greenberg[6]

Box 1 Suggestions for ethically sound clinical practice in cases of moral injury

- Non-disclosure is advocated wherever possible, especially in cases where a patient poses no current threat to themselves/others and when the incident occurred several years ago.
- Patients should be routinely provided with clear guidance about the limits of confidentiality on engagement with mental health services, with specific examples about the types of events that may lead to a breach of confidentiality.
- Where disclosure is being considered, good practice is to seek advice from senior colleagues and/or organisational lawyers to help guide such decision making.

Challenges in treatment

- Veteran perspective

Existing treatments have not helped with shame & guilt

Difficulty disclosing event

Rapport with therapist is key

"You can tell me all those things until you are a blue in the face. I made a decision, on the ground with the best information I had, and it went wrong. And that's a fact...CBT there are just some bits of that just aren't relevant like I get the fact that it's not happening 'now' so this whole cyclical thoughts, feelings, beliefs [is] fine, [I] get what you are doing, but that's not my issue. . it's more deep, it's more rooted in my psyche."

Key points

1. Moral injury provides an insight into causes of poor mental MH over & above classic ‘trauma’ especially relevant over the last two years

2. Challenging to treat MI associated mental health problems (esp impt in some occupations) and clinicians need to know about the concept so they don’t miss it

3. Some challenges for clinicians in terms of their MH and decision making

4. Prevention/management (rather than treatment) different to ‘classic trauma)

5. ICD12 and DSM-6????

What can be done about moral injury?

Possible ‘targets’ of intervention

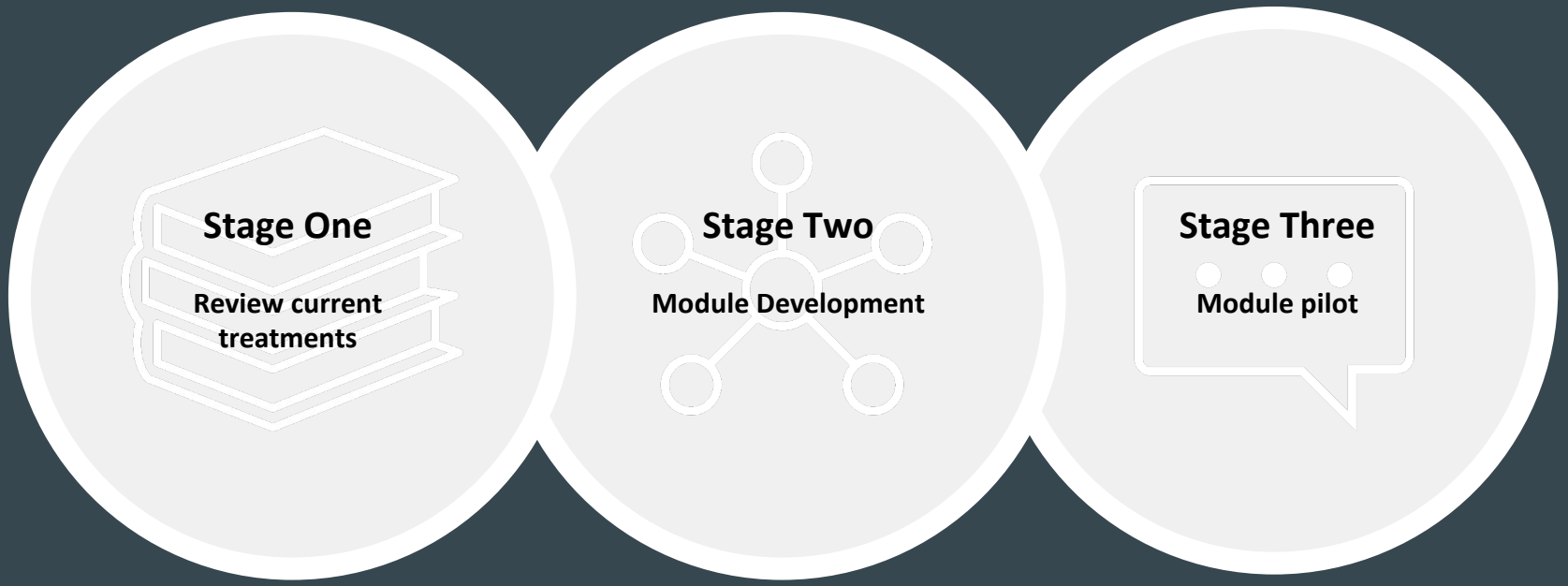
- Reduce exposure
- Reduce impact (primary prevention)
- Early intervention (secondary prevention)
- Effective treatment (tertiary prevention)
- BREAKOUT

Early intervention

- ‘Reflective practice’ and Schwarz Rounds
    - FINE (facts, Impact, functioning Now, Education)
- But team-led could be problematic as betrayal often ‘higher up’
- Town halls (‘Ask the CEO/CNO/CMO’) may be a balance of fact and politics
- So….can we do an organisational RP?
- BREAKOUT (what are the potential pitfalls?)

DEVELOPING A TREATMENT FOR MORAL INJURY

DEVELOPING A TREATMENT FOR MORAL INJURY ASSOCIATED MENTAL ILL HEALTH



MRC Medical Research Council

Developing and evaluating complex interventions

Stage 1: Review of Current Treatments

MRC | Medical Research Council

Developing and evaluating complex interventions

1. Literature review of current approached
2. Consultation with leading professionals & service users
3. Re-examination of data from veterans and clinicians

Literature review:

Guilt (CPT)
Shame (CF-Therapy)
Value/Reconnecting (ACT)

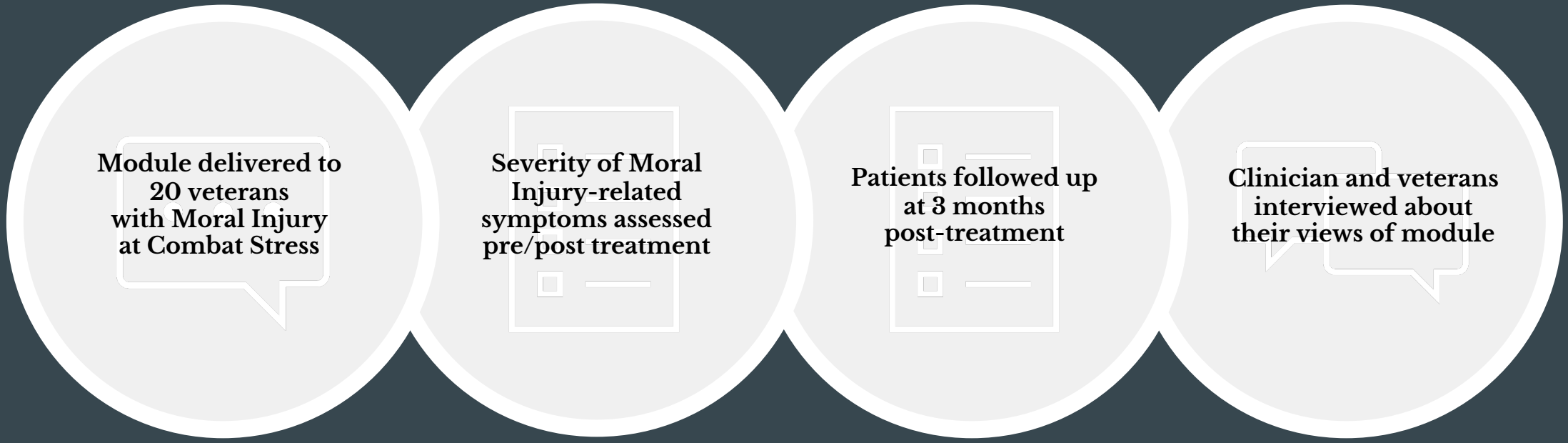
Allows for strong theoretical underpinning to manual design

Co-production to support feasibility & engagement

Stage 2. Rebuilding and Reconnecting: Psychological Treatment After Challenging Events (R&R)

Sessions 1-2	Sessions 3-8	Sessions 9-12	Sessions 13-18	Sessions 19-20
Resource building	Focusing on the event(s)	Moving on from the event(s)	Rebuilding connections	Ending
RB1 Formulation & treatment	**FE3-5** Recounting the event	**MO9-10** Core values & pre-event self	**RC13-14** Raising self-compassion	**E19** Tying it together
RB2 Emotional regulation	**FE6-8** Evaluating the response to event	**MO11-12** Reviewing changes	**RC15-16** Restoring relationships	**E20** Reviewing progress
			RC17-18 Renewal & reconnection	

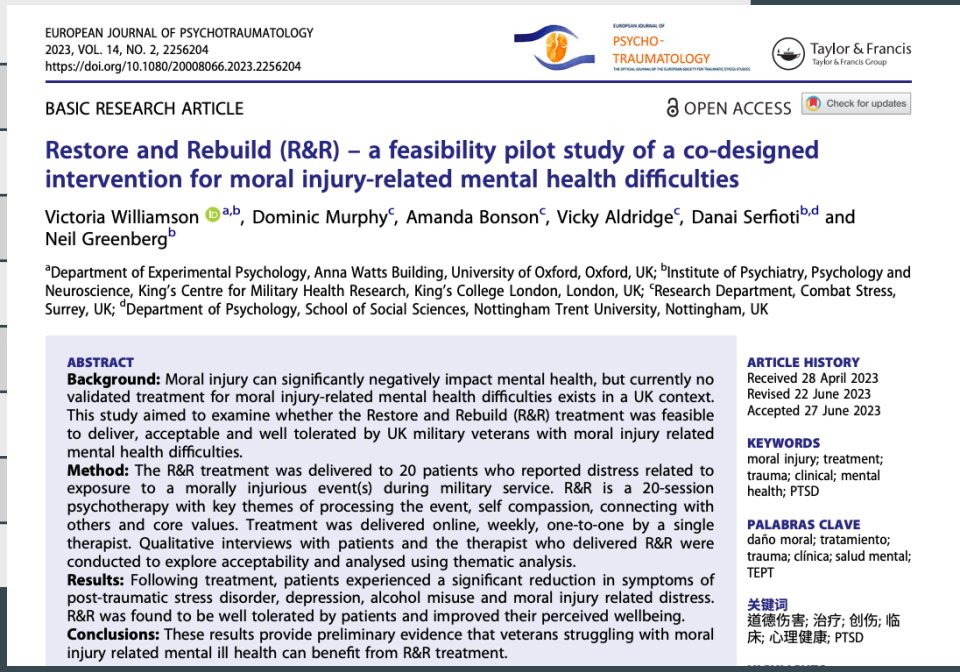
STAGE THREE: R&R PILOT STUDY



- **Benefits of this approach**
  - Evidence of acceptability of the manual
  - Tentative evidence for treatment outcomes
  - Primary outcomes PTSD and Moral Injury

R&R patient demographic information

Index	Total sample (n=20)
Mean age, M (SD)	45.15 (9.17)
Male, n(%)	18 (90%)
Marital status, n(%)	
Single	2 (10%)
Married/living with a partner	15 (75%)
Divorced/separated	3 (15%)
Education attainment, n(%)	
School ≥18 years	3 (15%)
Further education	11 (55%)
Higher education (BSc)	3 (15%)
Masters/doctoral degree	3 (15%)
Branch, n(%)	
British Army	14 (70%)
Royal Air Force	2 (10%)
Royal Marines / Royal Navy	4 (20%)
Length of service, M(SD)	12.65 (6.12)
Number of times deployed, M(SD)	4.55 (2.25)
Years since left the military, M(SD)	13.5 (10.69)



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2023, VOL. 14, NO. 2, 2256204
https://doi.org/10.1080/20008066.2023.2256204

BASIC RESEARCH ARTICLE

OPEN ACCESS Check for updates

Restore and Rebuild (R&R) – a feasibility pilot study of a co-designed intervention for moral injury-related mental health difficulties

Victoria Williamson [a,b], Dominic Murphy[c], Amanda Bonson[c], Vicky Aldridge[c], Danai Serfioti[b,d] and Neil Greenberg[b]

[a]Department of Experimental Psychology, Anna Watts Building, University of Oxford, Oxford, UK; [b]Institute of Psychiatry, Psychology and Neuroscience, King's Centre for Military Health Research, King's College London, London, UK; [c]Research Department, Combat Stress, Surrey, UK; [d]Department of Psychology, School of Social Sciences, Nottingham Trent University, Nottingham, UK

ABSTRACT

Background: Moral injury can significantly negatively impact mental health, but currently no validated treatment for moral injury-related mental health difficulties exists in a UK context. This study aimed to examine whether the Restore and Rebuild (R&R) treatment was feasible to deliver, acceptable and well tolerated by UK military veterans with moral injury related mental health difficulties.

Method: The R&R treatment was delivered to 20 patients who reported distress related to exposure to a morally injurious event(s) during military service. R&R is a 20-session psychotherapy with key themes of processing the event, self compassion, connecting with others and core values. Treatment was delivered online, weekly, one-to-one by a single therapist. Qualitative interviews with patients and the therapist who delivered R&R were conducted to explore acceptability and analysed using thematic analysis.

Results: Following treatment, patients experienced a significant reduction in symptoms of post-traumatic stress disorder, depression, alcohol misuse and moral injury related distress. R&R was found to be well tolerated by patients and improved their perceived wellbeing.

Conclusions: These results provide preliminary evidence that veterans struggling with moral injury related mental ill health can benefit from R&R treatment.

ARTICLE HISTORY
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Revised 22 June 2023
Accepted 27 June 2023

KEYWORDS
moral injury; treatment; trauma; clinical; mental health; PTSD

PALABRAS CLAVE
daño moral; tratamiento; trauma; clínica; salud mental; TEPT

关键词
道德伤害; 治疗; 创伤; 临床; 心理健康; PTSD

Baseline	Met case criteria, n(%)	Mean score (SD)	Mean change from baseline (95% CI)	t-test P value
PTSD (PCL-5)	19 (95.0%)	69.5 (15.3)	-	-
Alcohol misuse (AUDIT)	17 (100.0%)	21.8 (2.7)	-	-
Depression (PHQ-9)	20 (100.0%)	23.65 (6.70)	-	-
MORIS (Moral Injury Scale)	15 (83.3)	17.6 (6.7)	-	-
EMIS (Expressions of Moral Injury Scale)	n/a	56.6 (12.6)	-	-
1-month follow up				
PTSD	10 (50.0%)	34.85 (19.07)	34.65 (23.6 – 45.71)	<0.001
Alcohol misuse	8 (44.4%)	12.11 (8.07)	9.07 (4.88- 13.25)	0.001
Depression	13 (65.0%)	11.30 (7.36)	12.35 (7.85-16.85)	<0.001
MORIS	8 (40%)	9.35 (5.96)	8.26 (4.10 12.42)	0.001
EMIS	n/a	50.0 (11.47)	6.63 (-1.42 -14.68)	0.10
3-month follow up				
PTSD	4 (21.1%)	30.63 (16.70)	38.87 (28.5 – 49.25)	<0.001
Alcohol misuse	4 (22.2%)	8.66 (7.52)	12.51(8.58 – 16.44)	<0.001
Depression	8 (42.11%)	8.84 (5.04)	14.81 (10.95-18.67)	<0.001
MORIS	4 (25.0%)	8.56 (5.18)	9.05 (4.83 – 13.26)	0.001
EMIS	n/a	52.63 (12.34)	4.0 (-4.19 -12.2)	0.33

Evidence of R&R feasibility

N=20 patients recruited to phase 1 pilot

NO DROP OUTS

NO ADVERSE EVENTS

Reduction in PTSD & depression symptoms

Good acceptability

Feasible to recruit & deliver R&R

Well tolerated

It really works. I like it, I enjoy it, I look forward to the sessions....I'm quite self-punishing... It's kind of made me look at myself a little bit and give myself a bit of a break

Improvements in family life

"I am able to open up a little bit more and just be a little bit kinder to myself... Conversations are getting better, softer and more understanding since starting this, which is fantastic."

R&R next steps

- RCT with military veterans underway
- Looking to expand to non military occupations
- Deconstructing to find out what the key elements are (and shorten the therapy if possible)
- Working out a training regime if the RCT is successful

Conclusions

- MI is a problem for many organisations including HCWs
- Intervention may be useful; reduction in exposure is ideal
- Need to think from a systems point of view especially in early intervention
- Watch this space for some results in due course

Any Questions?- Fire Away!

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