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Moral injury in veterans : a theoretical investigation of the psychic, moral and social sequelae of war trauma

Sarah C. Towers
Smith College

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ABSTRACT

Although the idea that a violation of deeply held moral and ethical values can result in a profound psychic, social and spiritual wounding is an ancient one, the exploration of the phenomenon of moral injury in the field of mental health has only recently gained traction. Moral injury is increasingly being regarded as its own psychological phenomenon, one that shares symptomology with PTSD, but is also distinct, and as yet not sufficiently accounted for in current PTSD criteria. This theoretical thesis charts the evolving clinical construct of moral injury and draws on two bodies of theory, narrative theory and adult onset trauma theory, to further explore the psychic and social sequelae of war trauma. The work of the public health project Theater of War, and the text of Sophocles' *Ajax* are used as case examples to illustrate the treatment implications for social work practice of applying narrative theory and adult onset trauma to moral injury.

MORAL INJURY IN VETERANS: A THEORETICAL INVESTIGATION OF THE PSYCHIC, MORAL, AND SOCIAL SEQUELAE OF WAR TRAUMA

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Sarah Constance Towers

Smith College School for Social Work
Northampton, Massachusetts 01063

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I dedicate this thesis to all the veterans I met at the Greenfield Community-Based Outpatient Clinic in 2013-2014. I am humbled by their experiences, inspired by their fortitude, and forever honored to have worked alongside them.

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CHAPTER I

Introduction

On a warm, late April evening this past spring, the actors Reg E. Cathey and Erica Newhouse sat on folding chairs in front of an audience at Amherst College. On the table before them were microphones, water bottles, and scripts of Sophocles' *Ajax*. Standing to their side was Bryan Doerries, the artistic director of Theater of War, a New York City-based social impact company that presents dramatic readings of classical texts followed by town hall discussions in order to raise awareness about the devastating effects of war on the human psyche. The performance at Amherst was Theater of War's 299th, and they have thus far reached over 40,000 military members and veterans around the country (Outside the Wire, 2015). The organization considers itself a public health project and sees damming this country's current flood of military suicides, which has more than doubled since Operation Enduring Freedom began in 2001, as part of its mission (Outside the Wire, 2015; Bryan, Bryan, Morrow, Etienne, & Ray-Sannerud, 2014).

Before the reading began, Doerries set the contextual stage for the audience, explaining that this was the tenth year of the Trojan War, and that Ajax, who would kill himself in the second act of the play, had recently suffered grave betrayal at the hands of his commanding officers. At issue: the armor of slain Achilles, the greatest of all Greek warriors, had been bestowed upon Odysseus, rather than the more deserving Ajax. Reeling from the wound of non-recognition, not to mention the mental disorganization of a decade of combat, Ajax, Doerries told the audience, enters a berserk state and slaughters the animals in his compound, thinking that they are Odysseus and his men. Doerries then took a seat at the table (he would be reading

Odysseus' lines) and Newhouse, instantly in character as Tecmessa, Ajax's grief-stricken wife, began to tell of Ajax's carnage—both literal and psychological:

> I can't tell you what happened out there,
> But he returned dragging tethered bulls,
> Herdsmen's dogs and captured sheep.
> He slit the throats of some; others he hung up
> And butchered cleaving them in two.
> The rest were tied up and tortured
> As if they were men, not livestock. …
> Then suddenly he came storming back inside.
> Slowly and painfully he returned to his senses.
> And when he saw the carnage under his roof,
> He grasped his head and screamed,
> Crashing down onto the bloody wreckage,
> Then just sitting in the slaughter, fists clenched,
> His nails tearing into his hair. (Sophocles, 2007, 295-310)

For the next two hours, some of the nuances of what I see as Ajax's moral injury—the acts of betrayal and the acts of perpetration that can cause it; the states of shame, guilt, rage, and suicidality that it can induce—were held aloft. Together, the audience, the actors, and Doerries explored just how much a Greek tragedy written nearly twenty-five hundred years ago has to say to us about the present-day experience of veterans and their families, be those veterans of the Vietnam War or the conflicts in Iraq and Afghanistan. As just a brief example, Tecmessa's description of Ajax in a berserk state, slaughtering animals he believes are men, has an uncanny

echo in the descriptions of the My Lai massacre that took place in Vietnam in 1968. Robert Jay Lifton (1973), in his seminal work on the war, noted that some eyewitness accounts had American troops

> gunning down the Vietnamese with "no expression on . . . [their] faces . . .very businesslike," with "breaks for cigarettes or refreshments." Yet others described the men as having become "wild" or "crazy" in their killing, raping, and destroying. The My Lai survivor described one GI engaging in a "mad chase" after a pig, which he eventually bayoneted; and others in uncontrolled ways, tossing grenades or firing powerful weapons into the fragile "hootches" that made up the village. (p. 51)

The mechanism of dehumanization—or *conditioning*, as the American military calls it—is what allows human beings to override their innate aversion to killing other human beings (Milgram, 1974; Grossman, 2009; Smith, 2011). There is, of course, a continuum of acts committed in war, ranging from the just to the atrocious. But whether a service member is ordered to use deadly force to stop a teenager suspected of wearing a bomb from approaching a military base, or witnesses the shrieking grief of an eight-year-old boy who has just seen his mother shot in the face by American troops, or, in a moment of collective rage, terror, and traumatic grief, as Lifton (1973) believes the troops at My Lai were propelled by, confuses pigs with human beings and human beings with pigs, a fundamental transgression—a moral injury—has occurred. "The telling truth," notes the humanities scholar Robert Meagher (2014),

> is that a great many combat veterans are haunted more by what they have done than by what they have endured in war…. 'Kicking ass' does not include facing

> the possibility that all killing kills something in the killer and that, as a result, there is no such thing as killing without dying. (p. xviii)

For thousands of years, writers, artists, philosophers, historians, and of course combat veterans have recognized moral injury as a state of being, but only in the last five hundred years have the psychological sequelae of war been explicitly named. According to Tick (2005), the cluster of symptoms soldiers seemed to commonly experience post-battle were first diagnosed by Swiss doctors in 1678 and called *nostalgia.* During the Civil War, the psychic effects of war were referred to as *soldiers' heart,* and in World War I as *shell shock.* In World War II and the Korean War, soldiers were thought to suffer from *combat fatigue,* and in the post Vietnam-era, the term *posttraumatic stress* was introduced. Now *moral injury* is being viewed as a valid and valuable construct within the clinical scientific community and beyond (Litz et al., 2009; Nash & Litz 2013; Morris, 2015). It is in the early stages of being operationalized—a complicated task, given how individual and perhaps fundamentally unquantifiable moral injury may be (Vargas et al. 2013; Kinghorn, 2012).

Jonathan Shay (1994, 2014), a psychiatrist who over the last twenty years has worked extensively with Vietnam veterans and has authored two seminal texts on the subject, is credited with first coining the phrase *moral injury* in the late 1990s and embedding it in the mental health lexicon (Litz et al., 2009; Kinghorn; 2012; Nash & Litz 2013,). Shay's most current (2014) definition of moral injury is the following:

> - A betrayal of what's right.
> - By someone who holds legitimate authority (e.g. the military—a leader).
> - In a high stakes situation.
>
> All three. (p. 183)

The Department of Veterans Affairs-based psychologist Brett Litz and his colleagues picked up this understanding of moral injury in 2009 and have expanded the definition for service members and veterans, offering additional nuance and empirically supported clinical texture to include the idea that the betrayer of what's right does not have to be "someone who holds authority" but can also, devastatingly, be oneself. Nash & Litz (2013) state that moral injury can be seen as

> the enduring consequences of perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations. Central to the concept of moral injury is an event that is not only inconsistent with previous moral expectations, but which has the power to negate them. Moral injury is not merely a state of cognitive dissonance, but a state of loss of trust in previously deeply held beliefs about one's own or others' ability to keep our shared moral covenant. (p. 368)

Betrayal—by others or by oneself—is the common denominator of these two conceptions of moral injury, and in each case, shame, guilt, and self-destructive behaviors are the signature after-effects. The broader scope of symptomology includes social withdrawal, anger, anhedonia and dysphoria, avoidance, change or loss in spirituality and/or meaning in life, and negative changes in ethical attitudes and behavior (Drescher et al., 2011; Gray et al., 2012; Nash & Litz, 2013; Bryan et al., 2014). It is worth noting that in the moral injury model that Nash & Litz (2013) have put forth,

> intense anger and impulses to seek revenge are central in moral injuries resulting from others' acts or failures to act that seem to violate communally shared moral values, and these emotions and cognitions are maintained through an inability to forgive perceived perpetrators. (p. 369)

We are thus back to Ajax and his particular feedback loop of moral injury: vengeful, homicidal rage toward Odysseus, which leads to unsurvivable shame and guilt.

On September 20th, 2015, *The New York Times* ran a front page story entitled "A Unit Stalked by Suicide, Trying to Save Itself," in which the reporter, David Philipps, describes the post-deployment death and despair encountered by veterans of the Second Battalion, Seventh Marine Regiment, who served a harrowing, combat-filled stint in Afghanistan in 2008. As Philipps reports, of the 1,200 Marines who were there in 2008, at least 13 have since committed suicide. In addition to detailing the lack of adequate mental health care from the Department of Veterans Affairs, Philipps, through the voices of the Marines, evokes the often lethal psychic collapse that occurs for those who have killed or seen others killed in combat—and outlines just how intractable a crisis this has proven to be. As Philipps notes,

> For years leaders at the top level of the government have acknowledged the high suicide rate among veterans and spent heavily to try to reduce it. But the suicides have continued, and basic questions about who is most at risk and how best to help them are still largely unanswered. (Philipps, 2015)

This thesis takes as its starting point the reality that the psychological state of our recent combat veterans is dire. Because clinical social workers are often on the front lines of psychic defense for these men and women, it is urgent that we continue to research, to theorize, and to disseminate information about war trauma. The evolving construct of moral injury is, in my mind, a highly worthy attempt to do just that. Since Litz et al.'s (2009) call to operationalize moral injury, a growing number of psychologists (many based at the Department of Veterans Affairs and grounded in cognitive behavorial theory) have responded to that challenge. This thesis will review their contributions. I will begin by laying out some of the current factors that

have brought the urgency of understanding and conceptualizing moral injury to the fore, and chart some of the key ways in which it has evolved from past conceptualizations of post-traumatic stress disorder. In reviewing the clinical literature, I will offer more detailed descriptions of the primary causal and resultant mechanisms of moral injury—perpetration, guilt, and shame—as well as describe some of the burgeoning models for moral repair.

I will apply concepts of narrative theory and practice from the work of Michael White in order to better understand the dominant—and psychically damaging—storylines that exist around war and veterans. I will also apply concepts of adult onset trauma theory from the work of Ghislaine Boulanger in order to better understand the unconscious processes and psychodynamic implications of moral injury. Because Theater of War's public health project functions as an iteration of narrative practice, this thesis will also specifically consider the treatment implications of Theater of War for moral injury, as well as the clinical revelations that Sophocles' *Ajax* offers with regard to the moral injury construct.

Narrative theory and practice, which developed out of various disciplines, including anthropology, sociology, and social psychology, take as their starting point the notion that human beings create narratives to make sense of their lives, narratives that are constitutive of experience. From a narrative perspective, human beings are often over-influenced by dominant narratives and lose touch with—or are never permitted to recognize in the first place—alternative, de-pathologizing storylines that are more in keeping with their actual lived experience. Narrative practice, which takes a de-centered approach, seeks to aid people in locating their own preferred narratives through uncovering and thereby externalizing dominant historical, social, and intra-personal narratives. As White (2007) notes, such externalizing allows for "objectification of the problem against cultural practices of objectification of people" (p. 9).

Narrative theory and practice is particularly well-suited to social work practice as it is a mode of therapeutic inquiry that seeks to uncover the "politics of the problem…the power relations that people have been subject to and that have shaped their negative conclusions about their life and their identity" (p. 27). It is a therapeutic practice that is always highly attuned to the forces in society that dominate, discriminate, and exploit.

Adult onset trauma theory, which the psychoanalyst and scholar Ghislaine Boulanger, formulates in her book, *Wounded by Reality* (2009), is located within a relational framework and offers a compelling perspective on what happens to the adult self when it is confronted with catastrophic trauma. According to Boulanger, such trauma shatters the self's ability to reflect, symbolize, connect to a sense of a historic self, and retain access to internal and external others. Her theory is particularly concerned with the crucial distinctions in the dissociative processes between adult onset trauma and developmental trauma, and the further injury that can occur when these distinctions are conflated or misunderstood. Her understanding of adult onset trauma has valuable implications for the treatment of individuals experiencing moral injury. Not only does it delineate the sequelae of the shattering of an adult self and challenge long-held psychoanalytic notions about "the durability of psychic structure" (p. 12), but it also breaks from the classical psychoanalytic tendency to view adult reactions to external events as driven exclusively by the individual's developmental history and particular object relations. Boulanger takes issue with the notion that the adult survivor of adult onset-trauma can be reduced only to "psychic infancy" (p. 96). Instead, she gives deserved weight to the reality of the catastrophic event(s) encountered in adulthood, a crucial stance for social workers confronted with moral injury and the particular horrors of war.

At the same time, Boulanger conceives of adult onset trauma theory from within a relational framework—she does not throw out the baby, so to speak, with the bathwater—and I also believe it is crucial to examine moral injury from a psychodynamic perspective, to conceive of it in relation to our conscious and unconscious processes, to our methods of psychic defense, and to our object relations with self and other. Finally, adult onset trauma theory offers a useful counterpoint to the cognitive behavioral orientation of most of the moral injury construct builders in the clinical scientific community, and thus provides additional intellectual space in which to conceptualize moral injury and consider how best to treat it.

Conclusion

Philip Klay, a veteran of the war in Iraq and the author of *Redeployment*, a National Book Award-winning collection of stories, made a plea last year in a *New York Times* opinion piece for there to be a greater willingness in this country to enter into a collective conversation about the psychic costs of war:

> If we fetishize trauma as incommunicable then survivors are trapped — unable to feel truly known by their nonmilitary friends and family. . . . If the past 10 years have taught us anything, it's that in the age of an all-volunteer military, it is far too easy for Americans to send soldiers on deployment after deployment without making a serious effort to imagine what that means. (Klay, 2014)

The aim of this thesis is to present a picture of moral injury as it is currently being constructed by the clinical scientific community, and to then both enhance and complicate this picture by examining the phenomenon of moral injury through the lenses of narrative theory and adult onset trauma theory. Like Klay, I want to broaden the ways in which the trauma of war can

be communicated. I see the current moral injury construct as one form of communication; I see Theater of War's readings of *Ajax* as another, and I see a psychodynamic understanding of what happens to a person's mind when he or she is faced with the reality of human beings killing other human beings as yet another. None of these modes of communication are incompatible with the others, and indeed, finding lines of connection between cognitive behavioral theory and psychodynamic theory, between theater and social work, between ancient literature and present day military experience—not to mention between civilians and service members—is crucial to this endeavor. I should add too that finding ways to communicate the incommunicable is different from absolute knowing. I, as a civilian social worker, will never fully know what it is like to experience war trauma. But I can listen, and in true listening there is true communication, and therefore true human recognition. As the Norwegian social psychiatrist Tom Anderson once wrote, "to listen is also to see" (p. 121).

CHAPTER II

The Phenomenon of Moral Injury

> *Why me? Why me?*
>
> —*Sophocles,* Ajax

> *Early on, before they'd seen any real action, Billy asked him what being in a firefight was like. Shroom thought for a moment. "It's not like anything, except maybe being raped by angels." He'd say, "I love you" to every man in the squad before rolling out, say it straight, with no joking or smart-ass lilt and no warbly Christian smarm in it either, just that brisk declaration like he was tightening the seat belts around everyone's soul.*
>
> —*Ben Fountain,* Billy Lynn's Long Halftime Walk.

The Stakes

Over two and a half million service members have deployed to Afghanistan and Iraq since 2001, and their acute psychological needs have given rise to a fresh awareness within the government as well as within the fields of mental health to the ways in which warfare damages minds (RAND, 2015; Sherman, 2015).

This damage is thought to be compounded by the nature of our recent conflicts in the Middle East: counterinsurgency and urban guerrilla warfare may be especially conducive to producing traumatic, morally injurious situations due to their unconventional aspects, such as the difficulty of differentiating civilians from combatants (Litz et al., 2009). What's more, the multiple deployments that are required of a voluntary military—less than one percent of the American population has served in the wars in Iraq and Afghanistan—are exponentially taxing the emotional well-being of service members and families who must then navigate multiple disruptions, losses, and sacrifices (Meagher, 2014). Indeed, as Litz et al. (2009) point out,

deployment length has been correlated with an increase in unethical behaviors within the first ten months of deployment.

The suffering is undeniable. The Department of Veteran Affairs estimates that roughly 8,000 veterans kill themselves a year, which translates to a rate of about twenty-two per day—or one every 65 minutes (Department of Veterans Affairs, 2012, as cited in Doerries, 2015, p. 4). According to Nazarov et al. (2015), while sixty percent of all veterans committing suicide are fifty years of age or older—a reflection of how much of the overall veteran population is represented by those who served in Vietnam or Korea—in 2012, the most common cause of death in personnel who were currently serving in the US military was not combat (311 deaths) but suicide (349 deaths and 915 attempts). Since the wars in Afghanistan and Iraq began fourteen years ago, the number of suicides among active duty personnel has doubled (Nazarov et al., 2015; Kinghorn, 2012; U.S. Department of Veterans Affairs, 2012; U.S. Department of Defense, 2011).

Roughly twenty percent of service members coming home from the conflicts in Iraq and Afghanistan meet the criteria for post-traumatic stress disorder (PTSD), and thus suffer from a debilitating symptomology that includes flashbacks, intrusive memories, nightmares, emotional and inter-relational avoidance, isolating, anger, hypervigilance, self-destructive behaviors, especially substance abuse, and negative alterations in cognition and mood (Nazarov et al., 2015, Department of Veterans Affairs 2015; DSM-5, 2013; Kinghorn, 2012; Rauch et al., 2010). While PTSD is the most prominent diagnosis among returning troops, there is also, as Rauch et al. (2010) note, a clear association with anxiety, depression (as cited by Hoge et al., 2004), substance abuse (as cited by Jacobson et al. 2008), physical health problems (as cited by Gironda, Clark, & Walker, 2005 and Hoge et al., 2007), aggression (as cited by Jacupac et al.,

2007), risk-taking behavior (as cited by Killgore et al., 2008), and suicide (as cited by Kuehn, 2009).

In an attempt to mitigate this mental health crisis, the federal government has directed a vast amount of funds towards understanding the etiology and treatment of PTSD: in 2012 alone, it spent three billion dollars on PTSD treatments (Nash & Litz, 2013; Morris, 2015). The Department of Veterans Affairs has two "gold-standard" evidence-based treatments (EBT) that it puts forward for anyone with a diagnosis of PTSD: Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT) (Nash & Litz, 2013; Department of Veterans Affairs, 2015). And yet, with the number of combat veterans diagnosed with PTSD ever growing, it is becoming increasingly clear that these two widely used and heralded treatments are not sufficient. As Steenkamp & Litz (2014) recently stated, "individual CPT and PE work in that they reduce military-related PTSD symptoms. However, it is less clear whether PE and CPT *work well,* that is, decrease symptoms to the point of low impairment and distress. Across studies at least half of, but typically most veterans still meet diagnostic criteria for PTSD following treatment" (p. 706).

While a comprehensive review of the etiology of PTSD is beyond the scope of this thesis, it will nonetheless be useful to contextualize its evolution within the field of trauma studies and the recent changes in its diagnostic criteria, so that we may better understand why moral injury is increasingly being regarded as its own psychological phenomenon, one that crucially shares symptomology with PTSD, but is also distinct and as yet not sufficiently accounted for in current PTSD criteria. As proponents of the moral injury construct argue, this lack of fit of moral injury within standard PTSD criteria accounts for precisely why PTSD treatments designed *without* a clear conception of moral injury are failing to reduce symptoms for so many combat veterans (Gray et al., 2012; Kinghorn, 2012; Steenkamp & Litz, 2013).

Posttraumatic stress disorder

PTSD was officially introduced as a psychiatric diagnosis in the DSM-III in 1980 (APA), marking a crucial paradigm shift in the field of mental health by sanctioning the belief that the stressor for the experienced psychic anguish and symptomology existed *outside* the person—i.e., in the form of a traumatic event, like a car accident, a rape, a natural disaster or combat—rather than *inside* the person, in the form of an intrapsychic neurosis. With this first official iteration, PTSD was categorized as an anxiety disorder, and the criteria indicated that the external traumatic event needed to be directly life threatening. That external event—the index trauma—would then come to dominate the consciousness of survivors, as they entered a cycle of re-experiencing via nightmares, intrusive thoughts, and full-blown sensory flashbacks, and found themselves unable to experience pleasure or vitality in their present life (van der Kolk & van der Hart, 1991; van der Kolk, 2003; Department of Veterans Affairs, 2015). Indeed, the concerns and attachments of present life—along with the concerns and attachments of family members and friends—can fade frighteningly in the face of what Boulanger (2007) calls "the momentous and very private experiences" the survivor is continually reliving (p. 7).

The idea of external traumatic events returning to the trauma survivor in this way was not new. As van der Kolk (2003) delineates, in one extraordinarily trauma-attuned decade at the end of the nineteenth century, first Charcot (1887), then Janet (1919), and finally Freud (1925) explored the metabolization (or lack thereof) of trauma, pinpointing the processes of dissociation, unbidden re-experiencing, and fragmentation of memory that today are integral parts of our understanding of trauma. Freud then famously came to disavow the reality of his patients' experiences of trauma, turning psychoanalysis toward the intrapsychic. At that point, as

van der Kolk (2003) succinctly puts it, “Real-life trauma was ignored in favor of fantasy” (p. 176).

Through the process of what Herman (1992) calls “episodic amnesia” (p. 7), the study of trauma was largely ignored after Freud’s reversal until the beginning of World War II, when Kardner (1941), in an account of the experience of treating World War I veterans, wrote that

> [the] subject acts as if the original traumatic situation were still in existence and engages in protective devices which failed on the original occasion. *This means in effect that his conception of the outer world and his conception of himself have been permanently altered.* (p. 82; emphasis added)

After World War II the study of trauma was again split off, like a dissociated self state, from the core self of psychoanalysis, and did not reemerge again until the psychic suffering of Vietnam veterans reached a saturation point in the early 1970s and the American public had no choice but to listen to their stories and reconsider the way they were seen, heard, and treated (Herman, 1992; van der Kolk, 2003). As an intern at the Department of Veteran Affairs this past year, I sat in on a Vietnam Veterans’ support group and had the privilege of witnessing the pride and sense of agency a number of these veterans had for the key role that Vietnam veterans played in advocating for the inclusion of PTSD as we now know it in the DSM—and their awareness of how much recent veterans of Iraq and Afghanistan have benefited as a result. Understandably, this pride was accompanied by bitterness and anger, for there was no such diagnosis available for them when they came home.

The psychiatrist Robert Jay Lifton (1973) was a key figure in raising national awareness of the trauma experienced by Vietnam veterans and can also be considered an early architect of the currently evolving construct of moral injury. While he did not use that term, he wrote

extensively on the sequelae of combat experiences, particularly the effect that killing in combat could have on an individual's psychic landscape. He was also interested in the emotional and contextual elements that could line up to create what he called "atrocity producing situations" (p. 41) whereby "one had to be a bit exceptional or, in that situation, 'abnormal,' in order to avoid taking part in slaughter" (p. 57).

Renewed interest in trauma stemming from the Vietnam War, the women's movement, and the relational turn in psychoanalysis—which rigorously addressed the realities of sexual abuse in childhood (Herman, 1992; Davies & Frawley, 1994; Bromberg, 1998; Boulanger 2007)—resulted in a wave of research on the interplay of attachment and neurobiology with trauma. According to van der Kolk (2003), PTSD has since come to be regarded as a "physioneurosis": a "mental disorder based on the persistence of biological emergency responses" (p. 177). Research has demonstrated how traumatic experiences can impact the regulatory and integrative capacities of brain function—namely the brain stem and hypothalamus, the limbic system, and the neocortex—and decrease the brain's capacity to respond adaptively to external events (Siegel & Solomon, 2003). It appears that permanent neural changes can occur when the central nervous system is overly stimulated at the time of the trauma, thus impacting a person's ability to evaluate future stimuli; the smell of burning toast, for example, may trigger an emergency physiological response that would in actuality be appropriate if the entire house were on fire (van der Kolk, 2003). This same difficulty with processes of categorization may account for the way in which entire episodes of traumatic experience are held in the mind: not in a narrative fashion, but rather in sensory-loaded fragments. As van der Kolk (2003) notes,

> While most patients with PTSD construct a narrative of their trauma over time, it is characteristic of PTSD that sensory elements of the trauma itself continue to intrude as flashbacks and nightmares, altered states of consciousness in which the trauma is relived, unintegrated with an overall sense of self. Because traumatic memories are so fragmented, it seems reasonable to postulate that extreme emotional arousal leads to a failure of the central nervous system to synthesize the sensations related to the trauma into an integrated whole. (p. 180)

The relevance of human attachment systems to trauma was first made manifest in Judith Herman's conception of "complex posttraumatic disorders" (Herman, 1992). According to Herman, individuals who suffer repeated traumas at a developmentally vulnerable stage—i.e., in early childhood or adolescence, when the brain is undergoing significant neurological changes—experience an array of aftereffects. As Courtois & Ford (2009) point out,

> identifying complex trauma as a distinct subset of psychological traumas provides the clinician and researcher with a basis for identifying individuals who have experienced not only the shock of extreme fear, helplessness, and horror but also disruption of the emergent capacity for psychobiological self-regulation and secure attachment. In addition to hyperarousal and hypervigilance in relation to external danger, complex trauma poses for the person the internal threat of being unable to self-regulate, self-organize, or draw upon relationships to regain self-integrity. (p. 17)

Although complex PTSD was rejected as a separate diagnosis in the DSM IV, it has, in multiple and ongoing ways, expanded the clinical understanding of trauma and inspired clinicians and researchers to more rigorously consider the impact of *chronicity*—on a child who

is sexually abused over a period of years, for example, or on the effects of 'cumulative adversity' due to poverty, racism, genocide, intellectual disabilities, sexual harassment/assault in the work place, or exposure to suffering or death (Courtois & Ford, 2009; Vogt, King, & King, 2007). Along with looking at the salient effects of chronicity, researchers have also paid particular attention to the effects of *closeness*, i.e., the relational position of the trauma survivor to the person or entity that was traumatizing. Courtois & Ford (2009) state:

> The closer the relationship between perpetrators(s) and victim(s) and their group (e.g., in a family, religion, gender, political party, institution, chain of command), the more likely they are to face conditions of divided loyalty. As a self-protective strategy, the group may coalesce around silencing, secrecy, and denial…. This circumstance has been labeled the *second injury* (Symonds, 1975) or betrayal trauma (DePrince and Freyd, 2007). (p. 18)

The thirteen years between the DSM-IV-TR (2000) and the DSM-5 (2013) saw much debate as to how trauma should be diagnosed and treated and what the core criteria of PTSD should ultimately be (Jones & Cureton 2014). The current definition of PTSD in the DSM-5 (2013) incorporates some of the ideas that are contained within the various formulations and comorbidities of complex PTSD and makes some notable revisions, although it arguably still does not fully do justice to the nuances of complex PTSD. Most importantly, PTSD is no longer in the category of Anxiety Disorders, but now serves as the foundational diagnosis of the new Trauma-and-Stressor-Related category. Criterion A for a diagnosis is exposure to actual or threatened death, serious injury, or (this is newly included) sexual violence. Recurrent exposure to traumatic events and/or details, also known as *vicarious traumatization,* is also newly included. Greater emphasis has been placed on the phenomenon of avoidance in relation to

PTSD, such that it now has its own cluster of symptomology. The four clusters are: intrusion, avoidance, negative alterations in cognition and mood, and negative alterations in arousal and reactivity. Three new symptoms were also included: persistent or distorted blame of self or others, a persistent negative emotional state, and reckless or destructive behavior (Department of Veterans Affairs, 2015). These new symptoms have important ramifications for expanding the diagnosis to include individuals—like combat veterans suffering moral injury—whose primary response in the face of a traumatic experience may not just be fear, helplessness, or horror, but also guilt, shame, or numbness (Jones & Cureton, 2014).

Despite such amendments to the definition of PTSD in the DSM-5, Jones & Cureton (2014), in reviewing the extant literature, are not convinced that the current diagnosis of PTSD sufficiently describes the array of symptomology experienced by early childhood survivors of abuse (Herman, 1992; van der Kolk, 2003, van der Kolk et al., 2005). Moreover, as previously mentioned, a growing number of researchers do not find that it fully encompasses the symptomology of some combat veterans, insofar as the DSM-5 continues to dictate that the stressor event must be one that invokes a *fear* response (Nash & Litz, 2013). Fear as a primary causal agent of PTSD (and therefore fear as the primary response to be extinguished through treatment) is what much of the recent research on moral injury calls into question (Gray et al., 2012).

In conclusion, it is worth underscoring how conceptualizations of PTSD have been marked by a kind of theoretical seismic activity: by reversals, by abandonment, and by disagreement. Citing Brewin, Lanius, Novac, Schnyder, & Galea (2009), Jones & Cureton (2014) state that "with the exception of dissociative identity disorder, no other diagnostic condition in the history of the DSM has created more controversy about boundaries of the

condition, symptomological profile, central assumptions, clinical utility and prevalence than PTSD." Nash & Litz (2009) also take note of the ongoing confusion around the criteria for PTSD. "Despite more than three decades of research and multiple revisions of the diagnostic criteria for PTSD," they write, "it remains unclear what stressor types are capable of inducing posttraumatic stress symptoms, and how directly and immediately they must be experienced" (p. 367).

Indeed, in a post 9/11 era, the very phenomenon of PTSD can seem increasingly difficult to ground and examine. On the one hand, there is the clinical conceptualization of this disorder; on the other, there is the culture's incorporation of it. PTSD is everywhere. At a recent forum at Smith College, Edward Tick (2015) called it, only half-jokingly, "posttraumatic societal disorder." His meaning is that, at least with regard to combat veterans, our culture does an exceedingly poor job of recognizing and healing the after-effects of war; the problem, he believes, is less with veteran symptomology than with a society that cannot look directly at what it sanctions. According to the journalist and combat veteran David Morris (2014),

> We live now in an aftermath culture, a culture where being traumatized is presumed to be the appropriate response to just about any overwhelming event…. [PTSD] has become a sort of global lingua franca, a label, an identity, a way of understanding the self, a cultural meme, a political interest group, a scientific mythology, and even a theory of time. (p. 15; p. 20)

Part of what is driving the current proponents of moral injury—and accounts for the undeniable energy and sense of urgency in this field of research—is the need to section off moral injury, to pull the bio-psycho-social sequelae of combat away from a generalized, diluted, even

stereotypical understanding of PTSD and into the realm of the specific, where authentic understanding and repair can flourish.

Defining the Moral Injury Construct

Shay (1994), as noted, is credited with having initiated the current conversation on moral injury. In *Achilles in Vietnam*, he compares the trials of Homer's warriors to the experiences of Vietnam veterans and challenges the notion that veterans suffer from a post-traumatic *disorder*. The psychological after-effects of combat, he insists, should not be viewed as a disorder, but rather as *moral injury*, as real as a leg amputation, and as such should move away from the pathological. Shay (1994) is openly indebted to Herman's (1992) formulations of trauma, and comes to the conclusion that experiencing a "betrayal of what's right" by those in command is the key precipitant for a soldier enduring lasting psychological wounds, in part because of the way that such betrayals mimic developmental betrayals and victimizations. The social trust that is destroyed by such a breach, Shay (1994) theorizes, creates a persistence of combat-readiness (i.e., hypervigilance), betrayal (which he sees evidence of in the high rates of homelessness of Vietnam veterans), isolation (destroyed trust in others), a sense of meaninglessness, and suicidality (169-80).

In 2005, Ed Tick helped to alert the mental health community to the ways in which PTSD as an all-encompassing diagnosis was failing veterans. In particular, he called attention to the "soul wound" (p. 7) of many combat soldiers and lamented the absence of cultural rituals for returning veterans, who, he believes, need the community's support to make the transition from veteran to warrior in order to heal. While he does not use the term moral injury, that is nonetheless precisely what he is talking about. After a decade of treating veterans through

conventional models of therapy and witnessing little true improvement, Tick turned to the rituals of past cultures and explored the benefits of alternative methods of healing, including "purification, storytelling, healing journeys, grieving rituals, meetings with former enemies, soul retrieval, initiation ceremonies, and the creation and nurturing of a warrior class" (p. 5). The pathway to healing, he came to believe, "must deal with our moral and spiritual dimensions" (p. 6).

Four years later, Litz et al.'s (2009) empirically supported theoretical study was published, and true operationalization of moral injury began. Because of this multifaceted study's influence in paving the way for moral injury to be considered a legitimate clinical construct—one worthy of government funding—I will spend some time outlining it.

Litz et al. (2009) begin by theorizing what might be morally injurious in war and identifying some of the primary morally questionable situations that can arise for combat soldiers, e.g., accidentally taking the life of a civilian, being directly responsible for killing an enemy, viewing dead bodies or human remains, and the viewing of injured or distraught women or children whom a soldier is powerless to help. In order to highlight the grave psychic consequences of perpetration, Litz et al. (2009) then provide an overview of the extant research on mental health in the aftermath of military atrocities, which they define as "unnecessary, cruel, and abusive harm to others or lethal violence and killing" (p. 697). The salient points drawn from this body of research are worth summarizing:

1. For Vietnam veterans with chronic PTSD, the connection between committing an atrocity and suffering from PTSD was much stronger than from simply participating in combat (as cited in Yehuda, Southwick, & Giller, 1992; Fontana et al., 1992).

2. Exposure to atrocities correlates with a higher risk of depression and suicidality (as cited in Hiley-Young, Blake, Abueg, Rozynko, & Gusman, 1995).

3. Killing in any situation (i.e. committing an atrocity *or* killing under basic orders and/or self defense) is more highly associated with chronic PTSD than other combat experiences (as cited in Fontana & Rosenheck, 1999; MacNair, 2002).

4. Among Iraq War veterans, *taking another life* is a significant predictor of PTSD symptoms, alcohol abuse, anger, and relationship difficulties (as cited in Maguen et al., 2010).

5. Veterans with greater levels of combat exposure are more likely to seek services from the VA because of guilt and loss of faith rather than PTSD or lack of social support (as cited in Fontana & Rosenheck, 2004).

6. Active roles related to killing (defined as being an agent or failing to prevent killing) point to greater PTSD and suicide than other more passive roles (as cited in Fontana et al., 1992).

Litz et al. (2009) conclude, on the basis of this research literature, that perpetration—killing or committing atrocities—is clearly linked to elevated levels of distress and avoidance symptoms.

Litz et al. (2009) then establish the schema-driven social-cognitive foundation upon which they are building their moral injury construct:

> Similar to social-cognitive theories of PTSD, we argue that moral injury involves an act of transgression that creates dissonance and conflict because it violates assumptions and beliefs about right and wrong and personal goodness. If individuals are unable to assimilate or accommodate (integrate) the event within existing self-and-relational schemas, they will experience guilt, shame, and

> anxiety about potential dire personal consequences (e.g., ostracization). Poor integration leads to lingering psychological distress, due to frequent intrusions, and avoidance behaviors tend to thwart successful accommodation. (p. 698)

In defining the basic concepts necessary for a formulation of moral injury, Litz et al. (2009) cite *morals*, *moral emotions,* and *self-forgiveness.* They define morals as "the personal and shared familial, cultural, societal and legal rules for social behavior, either tacit or explicit," and as "fundamental assumptions about how things work and how one should behave in the world" (p. 699). Moral emotions, they state are "both self-focused and other-focused, [and] serve to maintain a moral code. Morality-related emotions are driven by expectations of others' responses to perceived transgression" (p. 699).

As they note, the bulk of research on negative moral emotions has thus far focused on shame and guilt, and clearly suggests that shame, which involves a wholesale condemnation of the self, is more destructive than guilt, which primarily involves self-condemnation in relation to a specific act or transgression (Tangney and Dearing, 2002). (A more in-depth discussion of the role of shame and guilt in moral injury will follow.)

After defining these basic concepts, Litz et al. (2009) are then able to fully present their conceptual model of moral injury, which, as previously mentioned, they see as the direct result of committing, failing to prevent, witnessing, or learning about acts that violate deeply held moral beliefs. They state, "If the service members feel remorse about various behaviors, they will experience guilt; if they blame themselves because of perceived personal inadequacy and flaws, they will experience shame" (p. 700). Both of these emotions, but shame especially, can lead to withdrawal and "concealment," which will preempt opportunities to shift these new schemas

about the self and thus draw the service member farther and farther away from the possibility of "corrective" experiences and self-forgiveness (p. 700).

In further assessing the relation of moral injury to PTSD, Litz et al. (2009) note the ways in which moral injury mirrors the symptoms of reexperiencing, avoidance, and emotional numbing that are at the heart of PTSD. They argue that the drive to make sense of the dissonant morally injurious experience leads to intrusive thoughts of the event(s) and that this re-experiencing then leads to diminished self esteem, which leads in turn to numbing and avoidance behaviors, thereby foreclosing the opportunity for reaffirming experiences with others that might interrupt this feedback loop. They note that the most damaging outcome of moral injury is the "possibility of enduring changes in self and other beliefs that reflect regressive over-accommodation of moral violation, culpability, or expectations of injustice" (p. 701).

But they emphasize that current formulations of PTSD do not fully explain the evolution and after-effects of moral injury. In their view, 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 moral transgressions) in traumatic contexts" (p. 699). In order to effect any type of repair, they argue, the moral emotions that follow acts of perpetration—shame and guilt—need to be exposed and then adjusted through self-forgiveness. They conclude by offering a preliminary eight-step cognitive-behavioral-based clinical care model and by exhorting fellow researchers to take a multi-disciplinary approach to further construction of moral injury, specifically along psychometric lines, with measures of operational exposures and trials of interventions.

Validating the Moral Injury Construct

With the goal of qualitative construct building, Drescher et al. (2011) gathered a diverse group of 23 chaplains, mental health clinicians, and researchers who had worked with combat and veteran populations for many years and used a semi-structured interview to evaluate the need for a working definition of moral injury. The unequivocal consensus was threefold: that morally injurious experiences did indeed occur in war, that these experiences could cause a variety of long-term psycho-spiritual-social-behavioral difficulties, and that the construct of moral injury was not sufficiently contained within PTSD criteria. Key areas of potentially morally injurious events were identified and have been used as the primary categories for morally injurious experiences in the literature since. These are *betrayal* (by leaders, peers, trusted civilians, or by oneself), *disproportionate violence*, *incidents involving civilians*, and *within-ranks violence*. The authors concluded by cautioning that before further quantitative research or clinical trials could move forward, the field needed to create a scale that could reliably and validly measure moral injury.

Nash et al. (2013) devised the Moral Injury Events Scale (MIES) and administered it to 533 active duty Marines following combat deployment. The scale used a Likert-type response option to gauge responses to nine items split into factors of 1) perceived transgressions by self or other, and 2) perceived betrayal of an other. The nine items are as follows: witnessing of acts of commission, distress resulting from others' acts of commission, perpetration of acts of commission, distress due to acts of commission, perpetration of acts of omission, distress due to acts of omission, perceived betrayal by leaders, perceived betrayal by fellow service members, perceived betrayal by nonmilitary others. Nash et al. (2013) proceeded to rigorously test the scale

by evaluating its internal reliability, its psychometric properties, and its temporal stability, as well as by cross-validating the two-factor structure. They found that the MIES had "excellent internal consistency" and demonstrated temporal stability, and concluded that while further evaluation of the MIES with other branches of the military and with both genders was indicated, it was "a conceptually valid and psychometrically sound measure" (650). In further support of the moral injury model, Nash et al. (2013) found with the MIES scale that exposure to potentially morally injurious situations among these Marines correlated positively with depression, anxiety, and PTSD symptoms, and negatively with perceived interpersonal support.

Bryan et al. (2013) performed a psychometric evaluation of the MIES that resulted in further categorical clarity of the transgressions factors for moral injury: Transgressions-Self (i.e., acting in ways that violate one's moral values), Transgressions-Other (i.e., witnessing others acting in ways that violate one's moral code), and Betrayal. They found that Transgressions-Self overlapped the most with PTSD symptomology and that Transgressions-Self and Transgressions-Other were "moderately associated with pessimism and hopelessness" (p. 155). They did not find that the Betrayal scale was significantly associated with current measures of psychological distress.

In an effort to cement construct validity, Vargas et al. (2013) reviewed narrative responses from the National Vietnam Veterans' Readjustment study in order to corroborate causal events and symptoms of moral injury with older primary source material and found that there was significant overlap. One important difference they noted was that there was a heightened corroboration of "Loss of Trust" themes with the Vietnam veteran sample as compared to Drescher et al.'s (2011) findings with Iraq and Afghanistan veterans, suggesting that there may have been particular elements of the Vietnam war that generated a greater sense of

betrayal for its veterans. Several other studies explored the impact of moral injury on populations other than combat veterans: Gibbons et al. (2013), for example, performed a narrative analysis to look at how combat-deployed nurses and physicians incorporate morally injurious experiences and Dombo et al. (2013) applied Litz et al.'s (2009) model of moral injury to three civilian cases in order to distinguish it from PTSD.

Nash & Litz's (2013) oft-referenced theoretical study of moral injury as a "mechanism for deployment-related psychological trauma in military spouses and children" (p. 366) offered the most extensive model of moral injury to date (by utilizing the supportive research of Drescher et al., 2011 and Nash et al., 2013) and further made the case for moral injury being distinct from PTSD. They argue that because moral development is ideally a gradual process—a five-year-old child is usually not confronted with the hard fact of death or the human capacity for extreme violence—*and* because moral development is not experienced in isolation but always relationally, it can additionally be viewed as the result of a challenge to a moral belief system that is not developmentally or situationally prepared to incorporate it. They state that "[t]he relative toxicity of potentially morally injurious events may correlate not only with how violently they appear to contradict existing moral schemas, but also the extent to which they compromise the ability of existing social and spiritual supports to maintain a secure holding environment" (p. 370).

With this model of moral injury in mind, they propose that military spouses and children are vulnerable to moral injury *directly* through the news or stories shared by family members, churches, and schools, and *indirectly* "through actions or failures to act, perceived to be committed by members of one's moral covenant, including family members, teachers, community leaders, a deity, or oneself" (p. 370). A child, for example, may experience indirect

moral injury as a result of an adult's emotional withdrawal, self-destructive behavior, or suicide. Additionally, they argue, "Community leaders, most especially those in the military, may be agents of indirect wartime moral injury through their perceived failures to honor their commitment to service members, veterans, and their families" (p. 371).

Again, as with a good portion of the clinical scientific moral injury research to date, a driving force here is the need to separate moral injury from PTSD and to lend more weight to the notion that events may be traumatic and morally injurious even when they are not directly life- or safety-threatening.

Expanding Research on Perpetration, Guilt, and Shame

In the wake of Litz et al.'s (2009) working definition of moral injury, the effort to generate more empirically based research on the mechanism of perpetration in relation to moral injury became a priority in the field. Partly because a substantial body of research already existed on the psychologically deleterious effects of killing and abusive violence (Grossman, 2009, Beckham, Feldman, & Kirby, 1998; MacNair, 2002), several publications have already resulted from this effort. In the first study to look at the impact of killing on veterans of the recent conflicts, Maguen et al. (2012) found that the impact of killing on suicidal ideation was mediated by depression and PTSD symptoms, and that the impact of killing on the desire for self-harm was mediated by PTSD. In 2013, Maguen et al. designed a latent class analysis with Iraq and Afghanistan veterans to determine whether those who killed in war were at risk for being the most symptomatic for PTSD. While the findings were limited in that they were retrospective and cross-sectional, they nonetheless demonstrated that those who killed were twice as likely to have the most symptoms of PTSD. In addition, those who killed a civilian or killed in the context of

anger or revenge were more likely to belong to the most symptomatic PTSD group than those who did not kill.

Craig Bryan and his colleagues performed two important studies that looked in different ways at the relationship between severe combat trauma and self-injurious thoughts and behaviors. In Bryan, Ray-Sannerud, Morrow, and Etienne (2012), they sought to determine if guilt was differentially associated with suicidal ideation in military personnel with a clear history of direct combat exposure, and indeed found a positive interaction between guilt and direct combat exposure with 97 active duty Air Force personnel, which in turn suggested to them a strong relationship between guilt and suicidal ideation. In the more ambitious study, Bryan, Bryan, Morrow, Etienne, and Ray-Sannerud (2013) used a general clinical sample of 151 predominantly active duty (98%) Air Force and Army personnel to explore the relationship between moral injury and self-injurious thoughts and behaviors (SITB). The results backed up what previous research had suggested, namely that Transgressions-Other correlates more strongly with traditional symptoms of PTSD, while Transgressions-Self has a stronger relationship with hopelessness, guilt, and shame.

The primacy of guilt and shame as key agents in moral injury has been highlighted in almost all the clinical research on this subject. In their review of the literature on the association between morality and the experience of guilt and shame in the military, Nazarov et al. (2015) include the recent research by Bryan et al. (2013) and also note that guilt and shame are the leading cause of veterans seeking care at the VA (as cited by Fontana & Rosenheck, 2004). They conclude that there are "strong relations between the incurrence of a moral injury, the subsequent development of symptoms of guilt and shame and the emergence of psychopathology, including MDD and PTSD" (p. 10).

The most significant work on the relationship between guilt, shame, and moral injury has emerged from the research of Farnsworth, Drescher, Nieuwsma, Walser, & Currier (2014). Farnsworth et al. (2014) examine moral injury through the complementary lenses of moral psychology and social functionalism, with the intent of providing further insight into the mechanisms of guilt and shame, as well as betrayal and abusive violence. They chart how in the last decade advances in the study of moral psychology have provided new understanding of how human beings both come to their moral judgments and make sense of those judgments. This body of research has differentiated between positive and negative emotional states and examined their adaptive purpose. Negative emotional states, they demonstrate, provide protective functions by engaging the sympathetic nervous system (i.e. fight/flight), while positive emotions engage the parasympathetic nervous system, and tend to enhance human functioning by building resources.

As Farnsworth et al. (2014) explain, moral emotions specifically can hold both positive and negative valences. Negative moral emotions include guilt, shame, anger, disgust, and contempt; positive moral emotions include compassion, elevation, pride, and gratitude. Crucial to note is that moral emotions, unlike nonmoral emotions, are fundamentally concerned with the preservation of social relationships and with helping individuals avoid ostracism by other group members (as cited in Rime, 2009; Haidt, 2003).

Farnsworth et al. (2014) cite a number of studies that demonstrate that when guilt is limited to a specific transgression (and separated from other negative emotions) it has no association with psychopathology (Tangney et al., 2007). Farnsworth et al. (2014), however, distinguish between civilian guilt and combat-related guilt, noting that the latter *has* been "associated with lower psychological well-being in military populations," although "studies

assessing military-related guilt may also be tapping into the more psychologically damaging emotion of shame" (p. 452).

Indeed, shame has been associated in multiple studies with tremendous psychological distress and symptomology (Lewis, 1971; Lansky, 1995; Tangney et al. 2007). As noted previously, shame indicates a global evaluation of the self as being worthless or fundamentally bad. It is accompanied by feelings of powerlessness, exposure, and vulnerability. In a recent essay, Herman (2011) made the case for posttraumatic stress disorder being essentially a shame disorder and stated that,

> Shame can be likened to fear in many respects. Like fear, it is a fast-track physiological response that in intense forms can overwhelm higher cortical functions. Like fear, it is also a social signal, with characteristic facial and postural signs that can be recognized across cultures. (p. 262)

Additionally, Farnsworth et al. (2014) maintain that

> whereas guilt can promote greater empathy and socially reparative actions, shame typically activates social hiding behaviors and decreases empathy due to increased preoccupation with one's own distress and emotional discomfort. Furthermore, shame has been robustly associated with substance abuse, anger, and aggression, whereas guilt often discourages these types of problematic behaviors. (p. 452)

Farnsworth et al.'s (2014) exploration of a social-functional model of morality within the context of the military provides additional nuance to the moral injury construct. Social functionalism is defined as "the pragmatic value of morality for the survival of a social group as a whole" (p. 453). Some of the key moral emotions that are evoked in response to core social issues are caring, fairness, loyalty, authority, and sanctity (as cited in Graham, Haidt, & Nosek,

2009). Since the good of the group depends on the individual holding back in some regard, this holding back is encouraged by self-condemning emotions like anger, contempt or disgust. On the other hand, self-condemning emotions like shame and guilt encourage *repair* of damage to the group by an individual (Farnsworth et. al., 2014).

In a military context, of course, violence and killing are not only sanctioned but viewed as critical for the good for the group. As Farnsworth et al. (2014) note, citing Soeters, Winslow, & Weibull (2006), military training and indoctrination serves the purpose of shifting a new soldier's moral compass so that it is fully in line with the needs of their unit and ensures that under combat situations a soldier *will* pull his or her trigger. As Farnsworth et al. (2014) state,

> In such a moral system, the greatest shame for a service member would be to forsake his or her unit in the face of danger, and the greatest moral anger is typically reserved for those who put group members at risk. However, it is also this tight moral system and its constituent moral emotions that may also enable members of a fighting unit to engage in potentially morally injurious behaviors in certain cases. Threats to or losses sustained within the fighting unit may prompt strong other-condemning moral emotions (i.e., anger, disgust, contempt) that increase the probability of abusive violence. (p. 12)

Farnsworth et al. (2014) also delineate how *witnessing* moral violations can lead to moral injury, and give credence, from a social functionalist perspective, to Shay's (1994, 2014) original claim that betrayal by others is what leads to moral injury. They note how, as part of entering a military universe and acclimating to a military-based moral code, leaders are endowed with positive moral attributes, with a kind of nobility, and if those leaders violate their position and thereby the attached values, the soldiers under them may be psychically impacted by feelings of

betrayal and condemnatory moral emotions. Ajax, it could be said, exhibits condemnatory moral emotions toward Odysseus. But such feelings may also be brought forth when a soldier experiences betrayal from an enemy who posed as a friend or, as in the example Farnsworth et al. (2014) give, from a child who delivers a bomb.

Farnsworth et al. (2014) highlight another potentially morally injurious scenario and time period for soldiers: post-deployment. They point out that there is often a shattering disjuncture between what is morally valued in the military world versus the civilian world. Civilians may react with disgust or contempt upon hearing what soldiers have done in war; soldiers may experience shame and anger in relation to their homecoming. In other words, the soldier may find himself or herself stuck between two fundamentally different moral universes, which can lead to experiences that are morally injurious in and of themselves. As Farnsworth et al. (2014) state, "social-functionalist models of morality clarify not only the moral emotions experienced by service members following moral injury, but also help to explain how moral emotions may contribute to morally injurious behaviors themselves (p. 255).

Moral Repair

It is no accident that Litz et al.'s (2009) defining theoretical exploration of moral injury ends with a preliminary treatment model, and that, indeed, so much of the clinical literature that has followed has also tried to create models of repair or at least address treatment implications: the clinical research community may need measures and conceptualizations in order to move forward with the moral injury construct, but service members and veterans need help *now*.

Litz et al. (2009) define moral repair as "the integration of [a] moral violation into an intact, although more flexible, functional belief system" (p. 701) and conceived their original

treatment model (which would become adaptive disclosure) on the basis of two basic "routes" to repair: "(a) psychological-and-emotional-processing of the memory of the moral transgression, its meaning and significance, and the implication for the service member, and (b) exposure to corrective life experience" (p. 701). Three years later, Grey et al. (2012) published an introduction to and an evaluation of the six-session adaptive disclosure protocol in a study with 44 active duty Marines. Adaptive disclosure first uses imaginal exposure to uncover previously hidden elements and details about the meaning and implications of the morally injurious event and then employs an empty chair exercise, based on gestalt therapy techniques, to allow for corrective experiences.

> We ask the service member or veteran to have a real-time conversation in imagination with a compassionate, generous, supportive and forgiving moral authority figure. . . . [T]he goals are to have the patient ostensibly confess the transgressive act of commission or omission and take on the role of the caring other, reacting for him or her (Steenkamp et al., 2013, p. 474).

Forty three percent of the Marines in the study acknowledged a morally injurious experience as the primary need for treatment and Gray et al. (2012) found that patients highly endorsed the treatment, and that the effect sizes for PTSD (d =.79) and depression *(d =.71)* were large.

By way of further validating adaptive disclosure, Steencamp, Nash, Lebowitz & Litz (2013) argue that there are three ways in which prolonged exposure (PE, Foa & Kozak, 1986)—as previously noted, a widely-used treatment for PTSD at the Department of Defense and the Department of Veterans Affairs—is not appropriate for moral injury. First, PE treatment assumes that "the pathological fear structure is caused by a discrete episodic experience of danger and perceived life threat" (p. 473), whereas certain experiences that have been demonstrated to cause

moral injury are not fear based. Second, PE treatment maintains that guilt and shame, the primary emotions underlying moral injury, have emotional pathways and mechanisms that are different from the pathways and mechanisms of fear, and that repeated retelling of an event, a primary fear-extinguishing technique used in PE, will not only not decrease shame and guilt but will potentially *increase* them. Third, the two main cognitions targeted in PE—"I am incompetent" and "the world is completely dangerous"—are profoundly different than the cognitions that Steenkamp et al. (2013) believe underlie moral injury, namely, "culpability, being damned and unforgiven, and self-loathing" (p. 472). Wholesale contextualizing of the event—i.e., bad things happen in war, as is used in PE—may not feel authentic or reparative to the person who has committed an act that fundamentally violates their moral code.

Two other studies place primary emphasis on the concept of self-forgiveness. Worthington and Langbert (2012), who come from a Christian framework, cite self-condemnation as the aftereffect of a toxic warzone combination of complex trauma and moral injury. They conceive of self-forgiveness as the route to reparation and see it as having two core components: (1) *decisional self-forgiveness,* which is making the choice to act towards oneself without "malice, self-blame or self condemnation" (p. 282) and (2) *emotional self-forgiveness,* which they describe as the "emotional replacement of unforgiving emotions toward the self like self-empathy, self-sympathy, self-compassion and self-love" (p. 282). They propose a six-step model to "responsible" self-forgiveness that hinges on Hall and Fincham's (2005) notion that "forgiveness of the self is related to making amends to the wronged person" (p. 282).

Bryan, Theriault, and Bryan (2015) propose in their quantitative study that because guilt and shame are so strongly associated with suicidal ideation and attempts in a military populations, thinking about the healing and protective properties of self-forgiveness, may prove

critical. They define self-forgiveness as "the act of generosity and kindness toward the self following self-perceived inappropriate action" (p. 40) and note that evidence suggests it has been shown to improve mental health and decrease suicidal ideation (as cited by Doran, Kalayjian, Toussaint, & DeMucci, 2012). Using a sample of 476 service members and veterans enrolled in college, they hypothesized that self-forgiveness would be linked to less severe PTSD and that service members and veterans with a history of suicidal ideation or attempts would report lower levels of self-forgiveness. Both hypotheses were borne out, suggesting that self-forgiveness as a dispositional characteristic may serve as a protective factor for individuals who experience trauma, and thus may be useful for determining in advance those at particular risk. Bryan et al. (2015) note that difficulty with forgiveness "is a symptom of moral injury that commonly occurs in the aftermath of exposure to events that violate service members' sense of right versus wrong (e.g., "use of violence, witnessing of atrocities, exposure to intense suffering)" (p. 41), and argue that their study suggests that another feature besides guilt and shame—i.e., difficulty with forgiveness—can be associated with increased risk for suicidal attempts among service members who have already considered suicide. Their results, they conclude, also point toward the possibility that

> treatments and interventions that facilitate self-forgiveness may reduce the likelihood of suicide attempts, perhaps because self-forgiveness enables the individual to view him-or-herself in a positive manner, to experience personal growth, and to find meaning in behavior that is perceived to be wrong. (p. 45)

The first distinct call for models of moral repair treatment was, of course, put forward by Shay (1994). Given the emphasis in his ground-breaking definition of moral injury on the betrayal perpetrated by powerful others and his belief that the injuries of combat PTSD "are

moral and social" (p. 187), it is not surprising that his ideas around treatment also hinge on the moral and the social. While Shay does not offer a clear-cut treatment protocol, he urges for an overhaul of our response to combat trauma and for a better understanding in the mental health field that the repair of moral injury is dependent on a "communalization of trauma" (p. 194). Veterans need to be able to create narratives around their experience, to remember and to mourn. But simply creating their own trauma narrative is not enough: their narrative also needs to be heard by listeners, both individual and collective, who are "strong enough to hear the story without having to deny the reality of the experience or to blame the victim" (p. 188). This is not an easy mandate, given that "[t]o hear and believe is to feel *unsafe*. It is to know the fragility of goodness" (p. 193). But it is vital. As Shay notes,

> Trauma narrative imparts knowledge to the community that listens *and* responds to it emotionally. Emotion carries essential cognitive elements; it is not separable from the knowledge. Something quite profound takes place when the trauma survivor sees enlightenment take hold. The narrator now speaks as his or her free self, not as the captive of the perpetrator. (p. 191)

Conclusion

In the last third of Virginia Woolf's novel *Mrs. Dalloway* (1925), Septimus Warren Smith, a World War I veteran suffering from what appears to be moral injury, kills himself. Upon hearing of his suicide, Clarissa Dalloway, who has never met him, responds in the following way:

> What business had the Bradshaws to talk of death at her party? A young man had killed himself. And they talked of it at her party—the Bradshaws, talked of death.

> He had killed himself—but how? Always her body went through it first, when she was told, suddenly, of an accident; her dress flamed, her body burnt. He had thrown himself from a window. Up had flashed the ground; through him, blundering, bruising, went the rusty spikes. There he lay with a thud, thud, thud in his brain, and then a suffocation of blackness. So she saw it. But why had he done it? (p. 184)

I would argue that Clarissa's *why* remains with us today, and is precisely what is driving Litz et al.'s (2009) formulation of moral injury and the wave of clinical scientific research that has emerged to validate and expand this construct. But there is another element in the above passage that is pertinent: Clarissa's *resistance* to knowing about Septimus' death. And that, of course, remains as well.

Indeed, alongside the work of Litz et al. (2009), there is a parallel track of insight and investigation into moral injury, galvanized by Shay and now led by contemporary philosophers, theologians, journalists, novelists and even theater directors, that is concerned with our society's collective resistance to the implications of moral injury. Such lines of inquiry, some of which I will incorporate more fully in my discussion chapter, also resist embedding moral injury in a medical model, resist overly qualifying and quantifying this ancient state of being and, in some cases, resist, as Woolf implicitly does, the notion that this injury is located solely within the individual. As Warren Kinghorn (2012), a professor of psychiatry and pastoral and moral theology at Duke, writes,

> The recognition of moral injury therefore forces trauma psychology to regard the human person in all of his or her complexity as a moral agent, fully situated within and constituted by a sociocultural matrix of language and meaning and

> valuation in which "trauma" cannot be understood apart from understanding of that matrix. Trauma of this sort is not an individual reality but a social reality, the social is not the context in which individual trauma is inflicted, but just as plausibly, the individual is the context in which social trauma is inflicted. (p. 62)

Along similar lines, Nancy Sherman (2015), a professor of philosophy at Georgetown, identifies moral injury as a kind of multifaceted relational breakdown: between the soldier and himself, between the soldier and whomever he/she killed or witnessed killed, and between the soldier and civilian society. Recovery, she states, "is a matter of shared moral engagement. The afterwar belongs to us all" (p. 3). This, of course, is a clear extension of Shay's (1994) call for "communalization" of war trauma as a crucial component in the healing of moral injury.

I highly value Sherman's notion that moral injury requires an understanding of the intrapersonal and the interpersonal, and that any kind of moral repair most likely hinges on reconciling what has transpired for the self in relation to itself as well as in relation to others. I also value Litz et al.'s (2009) urgent attempts to identify as precisely as possible what is happening to our service members and veterans. What Litz et al. (2009) and the less construct-bound thinkers like Shay (1994), Kinghorn (2012) and Sherman (2012, 2015)—not to mention Brian Doerries (2015) and Virginia Woolf (1925)—share, is an unwavering belief that moral injury shatters the self and that shattered selves often do not survive.

Chapter III

Narrative Therapy

> *This is to propose that human beings are interpreting beings—that we are active in the interpretation of our experiences as we live our lives. It's to propose that it's not possible for us to interpret our experience without access to some frame of intelligibility, one that provides a context for our experience, one that makes the attribution of meaning possible. . . . It's to propose that we live by the stories that we have about our lives, that these stories actually shape our lives, constitute our lives, and that they "embrace our lives."*
>
> —*Michael White,* Re-authoring Lives: Interviews and Essays

Introduction

Narrative therapy, a collaborative approach to therapy, is well suited for social workers who work with any kind of trauma in their practice, let alone the trauma—the moral injury—that comes from experiences of war. It is a framework that at its heart seeks to separate the person from the problem, to separate the identity of the solider, for example, from the *problem* of killing in combat, the *problem* of grief, guilt, or shame.

Narrative therapy was pioneered in the 1980s in Australia by Michael White, and continued to be rigorously developed and honed by White and his frequent collaborator, David Epston, up until White's death in 2008 (Furlong, 2008). While many other thinkers and clinicians have contributed to our current understanding of narrative therapy and have made possible its widespread use in the field of mental health as an alternative to psychodynamic therapies, White's creativity and brilliance is undeniably the foundation of this practice and therefore his guiding formulations are what I will focus on here (Payne, 2006).

White's conceptualization of narrative therapy, which draws from multiple disciplines, including sociology, anthropology, cybernetics, and social psychology, and from thinkers like Gregory Bateson (1972, 1979), Edward Bruner (1986), Erving Goffman (1961, 1970), and Michel Foucault (1979, 1980, 1984a), is firmly founded on post-modernist terrain (White & Epston, 1990). A post-modernist vantage point holds that human existence cannot be fully pinned down and that no matter the lens through which it is studied—economics, psychology, sociology, etc.—it is too unique and complex and non-static an experience for any definite conclusions to be drawn. Within this framework, the notion of expert knowledge is viewed as biased and limited and "often remote from the specific concrete knowledge of people living their unique lives from day to day" (Payne, 2006, p. 25).

Foucault's (1984) deconstruction of systems of power and knowledge and his emphasis on subjugated "alternative knowledges" (White & Epston, p. 21) were galvanizing for White, who oriented his own thinking around them, particularly with regard to three fundamental assumptions he brought to narrative practices:

1. It is the totalizing, dominant "truths" or narratives about human nature and human existence that have created the problems people suffer from in the first place (White, 2007, p. 24). As White & Epston (1990) note,

> a person's experience is problematic to him because he is being situated in stories that others have about him and his relationships, and that these stories are dominant to the extent that they allow insufficient space for the performance of the person's preferred stories. Or we could assume that the person is actively participating in the performance of stores that she finds unhelpful,

> unsatisfying, and dead-ended and that these stories do not sufficiently encapsulate the person's lived experience or are very significantly contradicted by important aspects of the person's lived experience. (p. 14)

2. The therapist, in order not to unwittingly collude with dominant narratives, must take a collaborative, de-centered position in relation to people who seek help. White likened the therapist's posture to that of an "investigative reporter," a figure who can help "expose" the "politics" of the problems in people's lives (White, 2007, p. 26, p. 27).

3. The key to unbinding people from their problems—from their "canonical narratives" around such things as professional success, parenting, or heterosexuality—(Payne, 2006, p. 21)—is to deconstruct dominant narratives and thereby uncover rich areas of "subjugated knowledges" (White & Epston, 1995, p. 25) that are more in synch with actual lived experience.

White considered narrative therapy to be a post-structuralist therapy, and indeed, an exquisite sensitivity to the practices of power within language, within the analogies and metaphors that are used to describe human experience, is evident throughout narrative practice (Payne, 2006). Language, in the view of White and other post-structuralists, constitutes much of our experience and therefore our sense of ourselves and of our agency in the world. The difference, for example, between using the Freudian psychoanalytic analogy of a "breakdown" to describe a person's situation (which, as White points out, is drawn from the positivist social sciences and represents people and problems as machines) is vastly different than using the analogy of a rite of passage, drawn from ritual processes, which constructs the situation in terms

of a *separation phase* (from a previous identity or state), a *liminal phase*, and a *reincorporation phase* (White & Epston, 1990).

For White it is the text analogy, which rests on the basic notion that we give meaning to our lives and experience, "through the storying of experience" (White & Epston, 1990, p. 12), that is a founding assumption of narrative practice in part because of its inherent potential for "flux" and its "relative indeterminancy" (p. 13). As White & Epston note,

> the text analogy introduces us to an intertextual world. In the first sense it proposes that persons' lives are situated in texts within texts. In the second sense, every telling or retelling of a story through its performance, is a new telling that encapsulates, and expands upon the previous telling. (p. 13)

While White (2007) does not propose that "life is simply a text," he does believe there is much richness to be found in drawing "parallels…between the structure of literary texts and the structure of meaning-making in everyday life" (p. 80). Privileging the notion of a text analogy within narrative therapy opened the door for the exploration of the use of therapeutic documents. As White & Epston (1990) note, "language plays a very central part in those activities that define and construct persons." Since "written language makes a more than significant contribution to this . . . a consideration of modern documents and their role in the redescription of persons is called for" (p. 188). Such documents, which can include letters of introduction, letters of redundancy, letters of prediction, letters of counter-referral, letters of reference, letters for special occasions, letters as narrative, and letters as self stories, as well as documents of certification and of declaration, have remained a vital component of this practice (White & Epston, 1990).

White's prodigious synthesis of ideas, theories, and practices into narrative therapy lasted right up until his death. In his final book, *Maps of Narrative Practice* (2007), published the year

before he died, White drew together four interrelated processes for therapeutic change: *Externalizing, Re-Authoring, Re-Membering, and Definitional Ceremonies*. In my view, this final organization of narrative processes, all of which White had previously written about in a variety of guises and contexts, successfully distills the multiple therapeutic approaches he used throughout his career; they all, in their own way, address White's indefatigable quest to support people's agency in shaping their own lives. In the remainder of this chapter, I will offer a more in-depth description of each, as they offer potentially impactful therapeutic resonance with the phenomenon of moral injury.

Externalizing the Problem

According to Carr (1988) and Payne (2006), the most enduring and central therapeutic technique of narrative therapy is *externalizing the problem*. This entails first naming the problem—giving it its own identity, so to speak, one that is "experience-near" as opposed to "experience-distant" (White, 2007, p. 40)—and then coming to recognize it as something that is affecting a person rather than something that is an innate part of a person. It is fundamentally de-pathologizing because it takes as its premise the notion that "[t]he person is not the problem: the problem is the problem" (Epston, 1989, p. 26) and that, relatedly, the problem is not determinant of a person's identity or life. Movement away from the problem is always possible—as is not necessarily the case, White might argue, in therapies or psychologies that view people as being primarily influenced by intrapsychic forces—because the problem, on both a purely linguistic as well as metaphorical level, is defined as being outside the person. A person is not, in this framework, objectified as a schizophrenic, but is rather a person with the problem called

schizophrenia. (That said, White would undoubtedly rail against the term *schizophrenia* as he stood firmly against what he viewed as the dominant, pathologizing discourse of diagnosis.)

By separating the problem from the person, narrative therapy does not seek to diminish the influence of the problem or to absolve the person from responsibility in the face of the problem. Indeed, as White (2007) notes, such separation makes it

> more possible for people to assume this responsibility. If the person is the problem there is very little that can be done outside of taking action that is self-destructive. But if a person's relationship with the problem becomes more clearly defined, as it does in externalizing conversations, a range of possibilities become available to revise this relationship. (p. 26)

Externalizing conversations, as narrative practice maintains, offers people the opportunity not just to tease out the effects or influence of the problem in their life—i.e., *What has X persuaded you to believe about yourself?* or *What are the effects of X on your relationship with your girlfriend, with your siblings, with your fellow veterans?*—but to also investigate why the effects of a problem are—or are not—okay with a person. This line of inquiry re-instates personal agency and provides people with the opportunity to assess their values, goals, and dreams, thereby "develop[ing] important conceptions of living, including their intentional understanding about life . . . their knowledge about life and life skills, and their prized learnings and realizations" (White, 2007, p. 49).

It is important to note that while externalizing the problem is a core component of narrative practice, White and others operating from within this framework do not consider it to be advisable in every situation (Carr, 1998, Payne, 2006). Indeed, White's entire philosophy, his commitment to narrative theory and therapy, is to subvert any absolutes—in life or practice

(White, 1995, 1997, 2000, 2006). Instead, he counsels rigorous consciousness and respect for the uniqueness of each person, each problem, each situation. He states,

> This consciousness discourages the therapist from inviting the externalizing of problems such as violence and sexual abuse. When these problems are identified, the therapist would be inclined to encourage the externalizing of the *attitudes and beliefs* that appear to compel the violence, and those strategies that maintain persons in their subjugation. (White, 1989, p. 12; emphasis added)

Re-Authoring

Re-authoring in narrative therapy is first about locating and making space for the "unique outcomes" (White & Epston, 1990, p. 15) in people's lives that run counter to dominant stories of suffering or oppression. Unique outcomes are the pockets of experience—again, the "subjugated knowledges" from a Foucauldian frame (White & Epston, 1990, p. 25)—that have previously been overshadowed by totalizing cultural narratives. Unique outcomes stand in direct contrast to problem-heavy narratives that bring people in to therapy in the first place. They are about those moments, large or small, when the so-called problem did not dominate, when resistance or subversion were employed and a flicker of an alternate plotline was made visible. Once recognized, unique outcomes serve as stepping stones to the rebuilding, the reauthoring of alternate narratives to live by, narratives that can be more in synch with a person's true values and actual lived experience.

Drawing directly from the work of the social psychologist Jerome Bruner (1986), White (2007) proposes that stories, be they the stories in novels or the stories of our lives, are composed of two main landscapes: "landscapes of action" (p. 78), which refers to the sequences of events

or plotlines, and "landscapes of identity" (p. 78) which are reflections on and "intentional understandings" of the action. Crucially, in both written and lived texts there are always "gaps" (p. 77) in the storylines. In good novels, these "gaps" allow the reader to bring in their own lived experience, make their own leaps and conclusions, and essentially enter the text.

The "gaps" in the texts of lives are, of course, the "unique outcomes" and again, the job of a good narrative practitioner, through structured landscape of action and identity questioning—what White calls "mapping" (p. 83)—is to help make those moments more visible to the person. An example of a landscape of action question might be *"What sort of step would this be if you took it?"* (p. 96), while a landscape of identity question might be *"What does this step suggest about what you hold precious?* (p. 105). From a narrative viewpoint, both questions thicken personal narratives and in so doing help facilitate for people an experience "of being knowledged" (p. 106) about their own lives. The power of that knowledge allows for movement. As White (2007) puts it,

> The therapist facilitates the development of these alternative storylines by introducing questions that encourage people to recruit their lived experience, to stretch their minds, to exercise their imagination, and to employ their meaning-making resources. People become curious about, and fascinated with, previously neglected aspects of their lives and relationships, and as these conversations proceed, these alternative storylines thicken, become more significantly rooted in history, and provide people with a foundation for new initiatives in addressing the problems, predicaments, and dilemmas of their lives. (pp. 61-62)

As White's words make clear, it is not the simple recalling of unique outcomes that makes a difference. It is instead the expanding of them through linkages to other historic moments that

calls forth the possibility of new understandings, that brings forth "indeterminacy," and enables the rejection of "determined storylines" (Payne, 2006, p. 94).

Re-membering

Re-membering, within White's (2007) narrative framework, is based on the idea that we are always surrounded by influential *others,* by people inside and outside of our families of origin who have played profound roles in shaping who we are. These influential others, in White's view, do not have to be human; they can also be, for example, authors who have mattered to us, fictional characters we have encountered, pets we have owned, beloved toys from childhood. Human identity, within this framework, is "founded upon an 'association of life' rather than on a core self" (p. 129), and to that end narrative therapy highly values the voices of others in the building or re-authoring of lives. Re-membering conversations, White explains, are "purposive reengagements with the history of one's relationship with significant figures and with the identities of one's present life and projected future" (p. 129).

White's conceptualizations of re-membering conversations originated with his dismay over the "normative" and "pathologizing" (White & Epston, 1998, p. 134) response to people who were deemed to be suffering from unremitting grief. He found that the prescription to move through the stages of grief and get over the loss of a loved one not only increased a sense of loss of the loved one, but bored a hole right though a person's sense of self and of their own agency. Instead, White focused on finding ways to incorporate the lost relationship, to use the metaphor of "saying hullo again" to help people "thicken" their experience of themselves as being part of a "membered club" and not an isolated, "encapsulated self" (p. 138). At the same time, the process of re-membering can "revoke" (p. 138) membership and de-emphasize those voices in a person's

life that have contributed to a subjugated sense of self or purpose. In both cases, the movement is toward action and agency, rather than passivity and paralysis. In White's view, the act of re-membering enables people to have a more acute sense of what they know and value, and this in turn "can provide the basis for them to develop specific proposals about how they might proceed with their lives" (White, 2007, p. 138).

Definitional Ceremonies

White's formulation of definitional ceremonies—which are structured occasions that allow a person to tell their "preferred stories" to an actual audience—draws heavily on the work of the cultural anthropologist Barbara Myerhoff (1982, 1986), and also, to a lesser extent, on the reflecting processes developed by the family systems therapist Tom Anderson (1987). Myerhoff, who coined the term "definitional ceremonies," had observed the healing benefits that occurred for a group of elderly Jewish holocaust survivors who came together as a community to create different contexts or "forums" in which they could tell, again and again, the stories of their lives, and in so doing mitigate their isolation—and the inevitable, identity-crushing feeling of invisibility that comes along with such isolation (White, 2007, pp. 180-81). In *Maps of Narrative Practice* (2007), White includes Myerhoff's (1982) elegant analysis of why such forums had such a beneficial effect for this particular marginalized and traumatized community. Given its applicability to communities of combat veterans, her words are worth reproducing here:

> Sometimes conditions conspire to make a generational cohort acutely self-conscious and then they become active participants in their own history and provide their own sharp, insistent definitions of themselves and explanations for their destiny, past and future. They are then knowing actors in a historical drama

> they script, rather than subjects of someone else's study. They "make" themselves, sometimes even "make themselves up," an activity which is not inevitable or automatic but reserved for special people in special circumstances. (p. 100)

Key to the healing and identity-consolidating benefits of such occasions, in both Myerhoff and White's view, is the presence of an active audience—what White (2007) came to call "outsider witnesses" (p. 184). The audience's presence and participation, their active listening, and most of all, their own experience of being changed by the stories is vitally important for these occasions. As White notes, "It was the audience recognition of these stories that so significantly contributed to the community members' achieving a sense of feeling at one with their claims about their lives" (p. 183).

In translating Myerhoff's ideas about the meaning of such occasions into narrative practice's version of definitional ceremonies, White created a very specific structure:

> 1. The telling of the significant narrative by the person.
>
> 2. The re-telling of the narrative by those invited to be present as outsider witnesses.
>
> 3. The retelling of the outsider witnesses's retelling by the person. (p. 185)

White issues a clear warning of the ethical responsibility of therapists on such occasions. They are responsible both for the careful selection of the outsider witnesses and for preventing these moments from devolving into anti-transformative affirmations of the person telling their story. While White is clear that affirmation and validation of experiences can have a helpful place in daily life, they are *not* what definitional ceremonies are about. Definitional ceremonies are also not, in his words, about

> offering congratulatory responses, pointing out positives, focusing on strengths and resources, making moral judgments or evaluating people's lives against cultural norms . . . interpreting the lives of others and formulating hypotheses, delivering interventions with the intention of resolving people's problems, giving advice or presenting moral stories or homilies, reframing the events of people's lives, imposing alternative stories about peoples' lives, trying to help people with their predicaments and dilemmas, or expressing worry for the lives of others. (White, 2007, p. 187)

Instead, they are, at bottom, about one simple thing: resonance. The resonance between the outsider witness and the person at the center of the definitional ceremony creates "rich story development" (p. 189) and vitally aids the person at the center of the ceremony in trusting in their preferred narrative. In order to offer the most effective retellings, White guides his outsider witnesses in their active listening to focus especially on "expressions" within the story, "images" within the story, their own "personal resonances," and finally, on the experience of their own "transport" (White, 2007, pp. 190-91).

In formulating these guidelines for response, White (2007) had in mind the ancient Greek understanding of katharsis, which he pointedly spells it with a 'k' in order to "distinguish it from contemporary notions of catharsis associated with metaphors of discharge, release, abreaction, and so on" (p. 194). The classic definition, he notes, hinges on the experience of witnessing a powerful display of "life's dramas" (p. 195) and in response being emotionally moved and transported to a place of possible new meanings and new understandings of one's own life. What the outsider witnesses need to specifically consider and then relay back, he argues, are the ways in which they "have become someone other than [they] would have been if

[they] had not been present to witness these expressions" (p. 195). White's contention is that for the person at the center of this ceremony to hear of his or her own agency in this regard is revelatory, and often a counter-action to feelings of worthlessness, despair, paralysis and isolation. White particularly notes the benefit of this kind of ceremony for people who have experienced significant trauma in their lives. He states,

> It is common for these people to hold onto a secret longing for the world to be different due to what they have been through or a secret hope that all that they endured wasn't for nothing, a hidden desire to contribute to the lives of others who have had similar experiences or a fantasy about playing a part in relieving the suffering of others, or a passion to play a part in acts of redress in relation to the injustices of the world. . . . [P]erformances of katharsis can be powerfully resonant with these longings, hopes, desires, fantasies, and passions. (p. 200)

White's narrative framework clearly views definitional ceremonies as yet another invaluable tool with which to dismantle totalizing discourses and the exertion of expert knowledge. The person at the center of the ceremony is positioned as both central *and* part of a responsive collective. Agency is experienced by both parties, and hitherto unforeseen narrative "plots" for each, as Meyerhoff (1986, p. 284) points out, are advanced. Lives in this narrative model are indeed more indeterminate, and problems—even the problems of severe trauma—are not cemented in place.

Conclusion

Undoubtedly, had White lived, his explorations of the varied and nuanced ways in which people can take charge of their lives would have continued. Narrative practice for him, as anyone

who enters one of his texts can plainly see, was not reducible to a therapy or an approach. It was, as he said, "better defined as a world view . . . but even this is not enough. Perhaps, it's an epistemology, a philosophy, a personal commitment, a politics, a practice, a life" (White, 1994, p. 82).

At this juncture, I'd like to raise several critical questions, questions that will be developed more fully in my discussion chapter. For example, what might Michael White's conceptualization of narrative theory and therapy—and the various iterations of the practice that have continued since his death—offer to social workers who work with veterans in the grip of moral injury? To what degree is this a useful framework through which to view the trauma of, to quote Litz et al. (2009), "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" (p. 368)? Indeed, would a narrative perspective even accept the term "moral injury," or at least the current operationalizing of a complex set of emotional responses?

Aspects of narrative therapy, of course, are to be found already in many approaches to combat trauma, in, for example, the narrative portions of Cognitive Processing Therapy, one of the Department of Veterans Affairs go-to PTSD treatments (Department of Veterans Affairs, 2015), as well as in Litz et al.'s adaptive disclosure protocol for moral injury, which, as noted earlier, asks the veteran to imagine "a compassionate, generous, supportive, and forgiving moral authority" (Steenkamp et al., 2013, p. 474)—a clear form of re-membering.

But a serious consideration of aspects of narrative theory and practice in relation to the phenomenon of moral injury strikes me as important. If one simply holds in the forefront of one's mind White & Epston's (1990) notion of a receiving context, then from the start "a different construction of the problem would be invited and different questions will be asked" (p.

7). If, for example, one were to shift analogies away from broken parts, broken insides, broken morality, and view a combat soldier's return to civilian life as a "rite of passage" that involved "separating" from a previous identity and status, moving through an uncomfortable, reorganizing "liminal phase," and finally reaching a "reincorporation phase," then that person's position to himself and others might feel radically different (White & Epston, 1990, pp. 7-8). Arguably, the same would be true if one applied the narrative tools of externalizing—separating an identity from the isolating, paralyzing shame and guilt of moral injury and redefining the problem in an "experience-near" way (White, 2007, p. 42)—or re-authoring, so that alternate narratives could be constructed that would de-fang totalizing attitudes around strength, violence and heroism. Both re-membering (those dead, those killed, and those who are knowledged about subjugated aspects of an individual) and the creation of definitional ceremonies (Theater of War is an example of the latter) are, it seems to me, highly relevant to the phenomenon of moral injury and the experiences of combat veterans in general.

That said, I have long been compelled by psychoanalytic approaches to human development, identity formation, and trauma. Given the magnitude of what I believe is experienced internally by those who are morally injured, a psychoanalytically oriented perspective on how human beings experience and respond to trauma must be considered alongside narrative practice. Can there be areas of overlap, of mutual expansion, of "rich story development" (White, 2007, p. 144) in the project of lessening the life-threatening impact of moral injury? With that question in mind, I will turn now to consider the work of the relational psychoanalyst Ghislaine Boulanger, a pioneer in the emerging field of adult onset trauma theory.

Chapter IV

Relational Psychoanalysis and Adult Onset Trauma Theory

> *We pulled Murph free from the tangle of brush and laid him out in some shadow of respectability. We stood and looked him over. He was broken and bruised and cut and still pale except for his face and hands, and now his eyes had been gouged out, the two hollow sockets looking like red angry passages to his mind. His throat had been cut nearly through, his head hung limply and lolled from side to side, attached only by the barely intact vertebrae. We dragged him like a shot deer out of a wood line, trying but failing to keep his naked body from banging against the hard ground and bouncing in a way that would be forever burned into our memories. His ears were cut off. His nose was cut off, too. He had been imprecisely castrated.*
>
> —*Kevin Powers*, The Yellow Birds

Introduction

In the previous chapter, I presented Michael White's formulations of narrative theory and practice, which rest on the belief that as human beings we create stories in order to give meaning to our lives, and that this storying of experience provides a context and determining shape for the actual way we live. Personal agency, in White's (2007) view, hinges on our ability to privilege certain forms of knowledge and experience over others—to construct rich narratives that break from dominant, pathologizing storylines and are instead in synch with lived experience.

The development of rich narratives of experience is also of central concern for the relational psychoanalyst Ghislaine Boulanger (2007), whose pioneering work on the phenomenon of adult-onset trauma will be the focus of this chapter. Boulanger's theory, which explores from within a relational framework what happens to a "self in crisis" (p. 77), a self that has experienced events that the mind cannot digest, hinges on the sharp distinction she makes between the phenomenology of trauma incurred as an adult and the phenomenology of trauma

incurred as a child—a difference that she ardently believes the psychoanalytic community has failed to appreciate. Her understanding of adult onset trauma has valuable implications for the treatment of individuals experiencing moral injury, as it delineates the sequelae of the shattering of an adult self and challenges long-held psychoanalytic notions about "the durability of psychic structure" (p. 12), as well as the classical psychoanalytic tendency to view adult reactions to external events as driven exclusively by the individual's developmental history and particular object relations.

At the same time, Boulanger *is* operating from within a relational framework; she is committed to the importance of conscious and unconscious processes, to the interplay of fantasy and reality, to the representation of mental states in bodily phenomena, and to the belief that the psyche constructs defenses and obstacles in the face of unsettling thoughts and feelings. Her theory thus offers a way to view moral injury through not only a cognitive behavioral lens (such as the one that most of the Department of Veteran Affairs PTSD treatment protocols are based on), nor only through an externalizing, deconstructing lens (such as the one that narrative practice offers), but also through the breadth and complexity of a psychodynamic lens.

To that end I will first offer a brief overview of the relational tradition from which Boulanger's theory springs.

Relational Psychoanalysis

The "relational turn" (Wachtel, 2008, p. viii) in psychoanalysis was driven by a varied group of thinkers and psychoanalysts (Mitchell & Greenburg, 1983; Aron, 2011; Bromberg, 1993; Benjamin, 1988; Davies & Frawley, 1994) who felt a theoretical urgency to crack open the tightly sealed intrapsychic view of human subjectivity that Freud first developed and emphasize

instead the fundamental intersubjectivity of human experience. The developing consensus was that, as Mitchell (1988) put it, "[e]mbeddedness is endemic to human experience" (p. 276).

Drawing on traditions of thought such as object relations, Sullivanian interpersonal theory, self psychology, gender studies, infancy and attachment research, relational theory "recontextualizes" classical notions of internal structures and unconscious processes by conceiving of those structures and processes in relation to an *other,* in relation to a *context* (Wachtel, 2008, p. 40.) Relational theory, which is really an umbrella term rather than one set theory, thus attends simultaneously to 1) the centrality of the self; 2) the self's need for relatedness to objects/others, and 3) the dynamic, on-going tension between self and other, past and present, intrapsychic and interpersonal (Aron, 2011, p. 113). For relational theorists, all exchanges within the therapeutic setting are co-constructed by patient and therapist, just as the relationship between mother and child is intersubjective and co-created. Relational thought is grounded as well in a belief in the determining significance of race, class, and culture as forces that are "an intrinsic part of the psychological depths . . . fundamentally determinative of both conscious and unconscious thought and experience" (Wachtel, 2011, p. 69).

Some key constructs in relational theory include the relational unconscious, self states, and dissociation. The relational unconscious—unlike the Freudian model of the unconscious, where distressing thoughts and feelings are considered repressed—is thought of as a stage for what Bollas (1989) calls the "unthought known," (p. 4), a location for templates of relationships that are not fully known to the individual yet still feel familiar and are determinative of behavior. Self states are a reformulation of the Freudian idea of a compact unitary self and, according to Bromberg (1993), speak to the self as being "nonunitary in origin— a mental structure that

begins and continues as a multiplicity of self-states that maturationally attain a feeling of coherence" (p. 162).

The concept of dissociation is central within relational thought. As Boulanger (2007) notes, the idea of dissociation re-merged when several psychoanalytic thinkers, notably Davies & Frawley (1994), began to grapple with the emotional effects of childhood sexual abuse, viewing the accounts and behavior of their clients as representative of reality rather than fantasy, as had more or less been the dominant psychoanalytic view since Freud abandoned his seduction theory (Boulanger, 2007, p. 26). Dissociation within the context of childhood abuse was understood to be the process whereby painful experiences and thoughts are split off and stored in multiple self-states, rather than repressed in an encompassing unconscious. A relational perspective maintains that when a child encounters abuse "she defensively dissociates in the face of her terror, her confusion, and the unmanageable stimulation she is experiencing, forming split-off self states encapsulating the entire set of traumatic self and object representations, leaving other self states free to engage a less threatening world" (p. 13).

It is important to note that in relational thought dissociation is not just a phenomenon driven by abuse, but is something that happens to all of us, and is a reflection of the multiplicity of our self-states, the different selves we consciously or unconsciously shift into depending on the context. What is considered a "healthy" use of dissociative processes is when we can, as Bromberg (1996) puts it, "stand in the spaces" between these self states and not defensively cordon off certain ones that may contain aspects of a traumatized self, thus hindering emotional flexibility and behavior.

The process of dissociation can also occur on a macro level, and indeed, Boulanger sees just such a process at work when it comes to the failure of society in general and the

psychoanalytic community in particular to respond to the catastrophic events that plague our world. Again, this has implications for the phenomenon of moral injury, given that those who are currently affirming its existence within the healthcare system (Litz et al., 2009) have discovered that the wide gap between the universe of the military and the universe of the civilian world can in and of itself be morally injurious for those attempting to navigate that divide. For Boulanger, such a gap represents that which a collective group does not want to see, and she frames her conception of such a divide, informed by a Lacanian perspective, within the context of adult onset trauma:

> It is as if psychoanalytic theory itself has denied or dissociated the possibility of lasting reactions to late onset trauma, just as childhood seduction was also denied for much of the last century. This stepchild to psychoanalysis is properly located in Lacan's register of the Real. Events that constantly fail to secure a place in social discourse—slipping out of conscious awareness and defying memory's attempts to register them, leaving instead a gap where understanding might be, or a sense of confusion where clarity might be—belong to the Real. The Real is at work in every act of destructive violence that is rapidly normalized, every instance of genocide that is overlooked, every war whose combatants find no socially acceptable avenue in which to describe their experiences and so are condemned to silence. (p. 4)

Wounded by Reality

Ghislaine Boulanger (2007) traces the beginning of her interest in the phenomenon of adult onset trauma to an epidemiological study of Vietnam veterans and their civilian

counterparts that she was a part of in 1976. Her goal was to parse "what had caused the psychological breakdown of so many veterans on their return home" (p. 8). She hypothesized that she would find predisposing factors that led to the development of PTSD; instead, she discovered, quoting Grinker and Spiegel (1945), that "every man had his breaking point" (p. 44, as cited in Boulanger, 2007). Since then, she has published a book—*Wounded by Reality: Understanding and Treating Adult Onset Trauma* (2007)—and numerous articles (2008, 2009, 2010, 2012a, 2012b) on her evolving conception of adult onset-trauma.

A handful of other theorists have offered meaningful conceptualizations of aspects of adult onset trauma, and Boulanger readily acknowledges psychoanalysts like Kardiner (1969), Krystal (1978, 1985), Des Pres (1976), and Laub & Auerhan (1989), many of whom were writing in response to the horrors of World War II and the Shoah. But Boulanger is, to my knowledge, the only writer who has truly synthesized the existing material and offered a systematic formulation of the symptomology and phenomenology of this kind of trauma, not to mention the only one that I have found to claim that "adult onset trauma can actually be more damaging than trauma in childhood" (p. 39).

So what does this kind of damage, this psychic "breaking point" look like from Boulanger's perspective? An utter buckling of the self: "massive psychic trauma collapse[s] the distinction between the world without and the world within" (p. 10). As a result, "nightmares and violent fantasies suddenly find their equivalent in external events, leading to the collapse of psychic space and foreclosing the mind's ability to reflect" (p. 10).

To be clear, with the term "adult onset trauma," Boulanger is referring to those situations where adults face either their own imminent annihilation or the annihilation of those around them; she has little patience for what she sees as the wild overuse of the term "traumatic" within

our society as potentially applying to almost any situation. But in extreme instances of adult trauma she theorizes that an individual's humanity, their sense of themselves as having an intact subjectivity, is abruptly fragmented—that they are reduced to a *"thing* . . . denied history, and denied a meaningful context in which to live and to relate to others" (2008, p. 641). Boulanger sees the individual then existing in a gap "*entre deux morts*"—a Lacanian term that refers to two deaths, a "natural" or "biological" death, which is part of nature's usual process, and an "absolute death." As she explains, "Their biological death has not happened, but they . . . feel themselves to be outsiders; intimate knowledge of mortality has robbed them of their citizenship within the ranks of the living" (2007, p. 38). In a recent *New York Times* article, a marine combat veteran of the war in Afghanistan gave voice to this precise sensation when he said, "Now, when I meet someone, I already know what they look like dead. I can't help but think that way. And I ask myself, 'Do I want to live with this feeling for the rest of my life, or is it better to just finish it off?'" (Philipps, 2015).

Psychoanlysis, in Boulanger's view, has historically not been able to fully mentalize the very specific processes of adult onset trauma because the focus—indeed the very notion of the trauma—has been solely on the individual's response rather than on the event itself. They have also, in her view, "confused reason with reality, arguing that the irrational exists within the psyche, not in the external world" (p. 57). But, as she and a few others (notably Des Pres,1976) point out, truly horrific events turn that which for most of us might be metaphorical or fantasized into actuality. Before other meaning can be made, that terrifying non-symbolic reality must be understood and assimilated. Boulanger states that in the aftermath of such events,

> [s]ymbols and the symbolic lose their currency. . . . When indifferent reality cannot be assimilated or altered psychically, when it cannot be symbolized, it

> becomes traumatic reality. It is a reality that sticks in the psychic craw and cannot be dislodged. The survivor is always choking on the fact of it, always fearing a repetition of the breakdown that has already happened (Boulanger, 2007, p. 56-58, citing Winnicott, 1974).

Catastrophic Dissociation in Adulthood

Relational theory's rediscovery of dissociation (Boulanger, 2008, p. 642) allowed clinicians to understand the mechanism whereby a child, to defend against unbearable stimuli and thoughts and feelings—and therefore a state of utter fragmentation—cordoned off traumatic events and memories into split off self states, leaving other self states to function and develop. As Boulanger notes, "In childhood, trauma becomes part of self-experience" (2007, p. 29).

For adults, who already have a developed self, as well as an observing capacity to understand death, the process is significantly different—and it is precisely catastrophic dissociation, in Boulanger's (2008) view, that *causes* the collapse of the self:

> In adulthood, the dissociative process in the face of trauma does not create further splits in a developed personality but defends against terror, leaving an indelible memory of the dissociative experience itself. Provisionally catastrophic dissociation offers protection from terror, but ultimately it leaves the survivor in a state of confusion and anomie. (p. 643)

Pulling together research and theory from affective neuroscience, emotions theory, Winnicottian object relations and relational theory, Boulanger deconstructs the actual process of a self collapsing through catastrophic dissociation by charting the way it impacts four key interrelated areas: an individual's sense of agency, physical cohesion, continuity, and affectivity. Crucial to

understand here is that her conceptualization of a "core self" is somewhat at odds with relational theory's idea of multiple self states, which she also subscribes to. As she explains it, her understanding of a core self is in synch with Damasio's (1994, 1999) "ever-changing biologically based core self" and with Bucci's (2001) "subsymbolic sources of the self": phenomena that exist at the edge of our consciousness and "are comprised of the tactile, motoric, visual, sensory, and affective senses and are central to one's body and emotional experience" (Boulanger, 2008, p. 643). Boulanger argues that by including these neurologically and biologically-based components into a conceptualization of human subjectivity,

> it is possible to conceive of an underlying core self that establishes broad physiological and psychological parameters, while shifting self states embedded within the core are informed by the relative durability of the core self or—in the case of adult onset trauma—by the traumatically undermined core self. (p. 644)

Agency, Physical Cohesion, Continuity, Affectivity

One's sense of agency is, as Boulanger maintains, inextricably linked to one's sense of a reassuring and reliable existence where one can control one's actions and movement. She notes that Stern (1985) and Fonagy et al. (2002) see this aspect of core self experience first emerging with the infant and young child's ability to control motor behavior. But such control over movement is often obliterated during traumatic experience, in which people freeze or soil themselves or lose control of their body's movement, as can happen in instances of sexual attack. Being under the control of an Other entity, whether it is another human being or a New York City tower collapsing—or even the unwilled process of dissociation itself—brings a person, in Boulanger's mind, back to a paranoid schizoid position where "the self exists only as an object"

(2007, p. 81). From such a position, the self is at the ongoing mercy of "persecutory convictions," be they thoughts, feelings, or sensations prompted by a memory, a sound, a smell, even the quality of the light. "Traumatic memories often resist the survivor's need to make sense of them. Instead, assaulted by memory fragments and unidentifiable sensations, survivors find themselves further alienated from a formerly stable core self" (p. 82).

Catastrophic dissociation's impact on physical cohesion is equally destabilizing. Our skin, our bones, all of the components of our body are, in such moments, revealed to be horrendously fragile. Boulanger (2007) writes that "When the sense of physical cohesion is threatened during trauma, there is a fragmentation of bodily experience, leading to depersonalization, out-of-body experiences, and derealization" (p. 85). Drawing on Winnicottian ideas around handling the baby and thus aiding in the formation of the baby's sense of physical and psychic integrity, Boulanger describes the body as functioning as a kind of "a psychic container" (p. 87) that allows for both a secure sense of self as well as a sense of the separateness of others, which is ultimately necessary for mutually satisfying human connection. But under conditions of extreme trauma, when we lose our sense of physical cohesion,

> [t]he body can no longer contain agency, affect, or objects; the distinction between inner and outer collapses. Space and time cease to be dimensional; there is no escape from the immediacy of the trauma, and the fundamental bonds to a benign other are lost. (p. 88)

In considering the role that continuity, or a sense of time, has for individuals, Boulanger draws again on Winnicott's understanding of optimal development for a true self whereby the baby is allowed a sense of 'going on being' by an attuned mother who creates an environment of gentle intrusions, gentle rhythms around feeding, handling, and holding. During catastrophic

dissociation, the invasion of our sense of *going on being* is violent. The experience is rendered frozen and indigestible by both physiological (i.e neurologically, chemically based fight/flight responses) and psychological processes, and in the aftermath, our 'going on being' is perpetually hijacked by the traumatic memory's reintroduction through nightmares, behavioral reenactments, intrusive thoughts, and full-on flashbacks. The individual lives in a state of continual reaction, a "meaningless now," (p. 90) and thus continuous experience of oneself as a *self* through time is no longer possible. This violation of time, Boulanger believes, also impacts an individual's ability to interact with others, to maintain a healthy sense of "self-other" differentiation, as again, our first sense of time and continuity exists in an intersubjective field between mother and baby. Time is a vital component of that containing original matrix, and when it is trespassed upon in adulthood, "the consequences reverberate throughout the entire psychic system" (p. 91).

Disrupted affectivity in the face of massive trauma is, as Boulanger (2007) points out, a result of the complex interplay between psychic terror and neurophysiological arousal—e.g., the activation of the sympathetic nervous system and the flooding of cortisol that prepares an organism for fight or flight. Krystal (1978, 1985) and others have also noted the effect of *alexithymia* in the aftermath of near annihilation, which is the "failure to differentiate affects and to use them as signals" (Boulanger, 2007, p. 7) One's ability to know one's responses—and thereby to be in relation to a core self—is disturbed. Barraged by an activated nervous system and unspeakable terror, numbness becomes the provisionally adaptive affect of choice, both in the moment of trauma—which is how the body mobilizes to survive mortal threats—and thereafter. But, of course, numbness is deadening. In reflecting on the experience with a combat veteran Boulanger worked with she writes that "[t]he 'I' who experienced a range of feelings is

gone, and with it the sense of ownership of experience. No longer punctuated by affect, his life has become rote. He has, in effect, forfeited his subjectivity" (p. 92).

Boulanger also observes how many who have experienced such trauma continue later on to seek out highly dangerous situations, as though to reenact the circumstances that led to their collapsed self state. While classical psychoanalysis has often argued that this kind of repetition is aimed at mastering the fear so that one can return to a balanced psychic state, she sees it differently for adult onset trauma, as this repetition does not bring relief but reflects more of a desperate attempt to puncture the state of numbness.

Disrupted affect, whether it is a sea of numbness or unwilled states of unbearable anxiety from intrusive stimuli (e.g. burning toast causing the nervous system to react as though the house is on fire) has grave consequences when it comes to human relations:

> With the failure to register one's own feelings comes both the inability to share one's affective state with an other, and the failure to appreciate the other's affectivity, which is the basis of intersubjective experience lying at the heart of the capacity to feel related to others. (p. 94)

Traumatic Aloneness and Key Reconsiderations of Relational Practice with Adult Onset Trauma

In Boulanger's (2007) theoretical framework, the decimation of the intersubjective field has profound, rippling effects on the individual. She notes that it was Ferenczi (1933) who first observed that "traumatic aloneness" is what truly causes the psyche to implode (p. 193, as cited in Boulanger, 2007, p. 96), and sees this kind of aloneness as stemming from three interrelated areas: 1) the loss of internal structuring object relations; 2) the loss of external relations; and 3)

the "imagined loss of membership in the human community" (p. 96). She observes that often in cataclysmic trauma the "world of objects," as Ferenczi called it (as cited in Frankle, 1998, p. 47), vanishes and the individual's desperate (and biologically ordained) efforts to survive render other human beings obsolete. Holding this knowledge forces them up against what the Auschwitz survivor Primo Levi (1958), who ultimately committed suicide, came to believe: "[I]n the end everyone is desperately and ferociously alone" (as cited in Laub and Auerhan, 1989, p. 49). When, as often happens with combat soldiers, a close friend is killed, this abrupt loss, this destruction of a protective Other, can also have an implosive effect on all of the individual's object relations, and easily lead to repetitive, obsessive guilt. From this vantage point, "survivor guilt" can be seen as a way to maintain connection to "both personal continuity and ties to lost objects" (Boulanger, 2007, p. 99).

And although natural-made traumas can destroy faith in a predictable, ordered universe, the internal object world seems to be particularly disrupted, Boulanger stresses, when the source of the adult trauma is another human being, be that a rapist, a sniper or, perhaps most disorienting of all, a child wrapped in a bomb. Boulanger points out that "how we were seen" (presumably by an original loving caretaker) is "less relevant than how we *are* seen" (p. 100)—i.e., as an object deemed not worth living. Often, in the absence of a benign internal world, the individual will choose to identify with the abuser in order to escape the desolation of an objectless world, becoming violent and aggressive themselves.

Upon "return" from massive trauma, the capacity of others to understand what has happened is sorely tested, which of course exponentially increases a sense of isolation. As Boulanger puts it, "With objectlessness comes meaninglessness; there is no internal other to

guide expectations, no external other to understand the experience. The loss of the intersubjective means that inner experience cannot be shared" (p. 102).

Relational theory's emphasis on the co-construction in therapy of intersubjective space is thus seriously challenged: how can there be an intersubjective, reparative space when, in the face of massive trauma, one has lost one's subjectivity? How can there be healing? In response to this question, which is at the core of her book, Boulanger states that,

> Insisting prematurely on an examination of a patient's intersubjective experience, when the patient's internal object world has been so severely compromised by recent reality, denies the patient an opportunity to explore the experience of the collapsed self that should be foremost in the treatment. In the psychodynamic treatment of adult onset trauma, the clinician's task is to hold herself out as the other to whom the patient can, at first tentatively, relate, and to tolerate how irrelevant the patient may believe the entire process to be. The task is to tolerate a feeling of unrelatedness without analyzing it. (p. 102)

The task, as Boulanger goes on to outline, is to first become a witness to the reality of what has happened. This is not a co-constructing position, nor is it one that hinges on intersubjective recognition. Indeed, Boulanger (2008) believes that forced "recognition" for what is, in fact, unrecognizable to those who have not experienced adult onset trauma, is demeaning and further damaging. Indeed, it is the therapist's "involved otherness" (p. 652), that is precisely what is called for. The therapist needs to function as both witness *and* container. In containing the unspeakable horrors and refraining from analyzing them or drawing connections to earlier experiences, the therapist begins to demonstrate that these fragmented sensations and states of

being can be tolerated and slowly made sense of in their actuality. She describes how this process unfolded in her harrowing work with one woman:

> As she described her imprisonment and rape, the tension between joining and observing—the tightrope that clinicians walk in every session—dissolved, I became one with Celeste. My own boundaries were temporarily suspended as I absorbed horror, disgust, humiliation, pain, and grief that were to haunt me for several weeks. In my subsequent conversations with Celeste, I learned that knowing that I was a separate person who had voluntarily stepped into her experience, that I was prepared to bear witness to this experience, and bear up under the experience began the process of reanimating her object world, and reduced her sense of having been rendered untouchable. (p. 652)

As noted earlier, the inability to reflect or symbolize because "meanings are too threatening to entertain" (Boulanger, 2007, p. 115) is precisely what holds people in a locked-down, posttraumatic state. For Boulanger this, in combination with neuropsychological findings of how memories are processed, accounts for the repetitive nature of posttraumatic nightmares, the reliving upon reliving of the terror; the mind's inability to actually convert the material into a dream. "The unconscious has ground to a halt before the work of the Real and the creative dreamwork of condensation and displacement is unavailable" (p. 120).

But again, by experiencing the therapist as an "other" who can "contain" and "detoxify" that which has been too terrible to mentally entertain by the individual, the slow process of trusting that another mind can "reflect on the experience without being deadened" begins, and the individual gains back some of their own reflective processes—and thereby their connection to a subjective center (p. 124).

Living Narratives

In her work with survivors of adult onset trauma, Boulanger has noted time and time again what she calls the "lifeless" trauma narrative. These narratives of traumatic experience are lifeless because they are spoken from a dissociated state, a state that has lost the ability to symbolize. They are "safe," "repetitive," "unelaborated" (p. 132), and spoken as if into a vacuum. The other, the listener, is not called forth in the telling because, as Boulanger has theorized, the other has, on a fundamental level, ceased to exist for the individual.

A living narrative, on the other hand, "is always dialogical" (p. 133) because it speaks to an actual or imagined responsive other, someone "who is a subject in her own right, who listens and is free to have her own thoughts and reactions to what she is hearing" (p. 134). A living narrative, in other words, is predicated on the belief and felt experience of "an internal empathic other" (Laug & Auerhahn, 1988, as cited in Boulanger, 2007, p. 134).

As previously noted, before a person can be helped to create a living narrative, the therapist must demonstrate his or her ability to contain and survive the fragments of memory and horror that have been experienced. But once that has been accomplished, Boulanger believes the construction of a living narrative is critical, as it is a living narrative—with its implication of responsive others—that will offer felt proof to the narrator that he "did not die and was not disintegrated by the experience itself but by the fear of annihilation" (Kardiner, 1969, p. 254, as cited in Boulanger, 2007, p. 137).

For Boulanger, these living narratives can be spoken or written, but the key is that their construction is slowly deepened, elaborated upon, and mutually considered. The benefit Boulanger sees to actually dictating or writing the narratives, and then slowly revising and developing them, is that they can offer a way of "getting the memories outside" (p. 139). One

patient who laboriously dictated to Boulanger at least four versions of her experience of escaping from Ground Zero with her baby, articulated her eventual feeling of release in the following way: "I don't have to remember all the details because they are written down" (p. 145). In the act of transcribing this woman's words, Boulanger saw herself as demonstrating again her capacity to

> contain her memories without distorting or minimizing them. Understanding that I was not damaged—that I could record what she was saying, process it and hand it back to her in this case quite literally verbatim—allowed Jill to feel sufficiently held that she could reflect further on what she had said. (p. 149)

It is at this point in therapy, when a living narrative is being constructed, that the vitality of an intersubjective space comes again into play for survivors of adult onset trauma. The narrative, although fundamentally that of the teller, is nonetheless co-constructed in that it is jointly reflected upon, the process of *creating* it is jointly reflected upon, and the story is shifted back and forth from teller to listener to teller again. In Boulanger's experience the narrative, the text of the trauma, then becomes a "transitional object, neither hers nor mine, both inside and outside at the same time, constantly open to reflection and change" (p. 149). While Boulanger does not hold out tidy endings to trauma that is so shattering to both body and soul, she does see a pathway out of the most deadening aspects of it; a person cannot ever be the same as they were before the trauma, but they can, in her mind, rejoin the living, human community.

Conclusion

Although Boulanger's (2007) theory of adult onset trauma comes from a vastly differently intellectual base—one that believes in the basic efficacy of psychodynamic thoughts and practice—her belief in the constitutive power of narrative echoes White's belief:

> Narrative is transfigured memory that, in its turn if it is a living narrative, further transfigures memory. . . . In privileging narrative we privilege the successive unfolding of increasingly complex experience. To privilege narrative is to understand that to relate a traumatic memory (or any memory) is to construct the memory, to formulate experience that has previously remained unformulated. (p. 149)

For Boulanger, the creation of a trauma narrative that with each telling gains more life, more rich development and reanimated associations, is "an act of subordination" (p. 150) with respect to the gaps in experience where new insight might be located. By formulating a deeper "personal understanding" (p. 150) out of traumatic fragments—in White's language this might be called a preferred narrative—an individual can slowly reclaim the lost parts of him or herself. But this is not a quick fix, in Boulanger's view; this is not "short term therapy" (p. 150). Boulanger is careful to emphasize that a living narrative is always an "open text" and that this "openness," this continual reconstitution, is key if the effects of massive trauma are to be lessened (p. 150). Massive trauma, in her view, is an ever moving, often elusive target. It is always highly individual. It cannot be solved with easy equations. As she notes,

> When details of the trauma itself and of its consequences, have been categorized and fixed in place, the response to terror is reduced to a formula. Rather than encouraging understanding of the experience, it is forced into recognizable and socially prescribed categories that discourage further investigation. In the very act of being labeled, the subject located by this diagnosis has ceased to be a subject, becoming instead an object of curiosity or a statistic. (p. 173)

What then to make of the evolving construct of *moral injury*? What happens to our understanding of this phenomenon as it is currently being defined and operationalized by clinical social scientists, when it is viewed through the lens of White's (2007) narrative theory and Boulanger's (2007) theory of adult onset trauma? Is moral injury a useful construct, a desperately needed recognition of a reality that is experienced by combat veterans, one that has come to a terrifying tipping point as evidenced by the number of veterans taking their own lives? Or is it just one more label, one more way in which we, as a society and as participants in the professional fields of mental health, avert our eyes? Or is there, perhaps, a third view: a tense middle ground, a dialogic relationship between the ways in which the construct is useful and the ways in which it is potentially dangerous? If that is the case, then we must also consider how both narrative therapy and adult onset trauma theory might offer measures of relief to those veterans who have entered a landscape of horror and trauma: those who have trespassed upon other human beings and in so doing have trespassed upon themselves.

Chapter V

Discussion

AIAI! Who would have thought the name
I was given would sound out my misery?
Aias! Ajax! Agony!

—*Sophocles,* Ajax

I learned that words make a difference. It's easier to cope with a kicked bucket than a corpse; if it isn't human, it doesn't matter much if it's dead. And so a VC nurse, fried by napalm, was a crispy critter. A Vietnamese baby, which lay nearby, was a roasted peanut. "Just a crunchie munchie," Rat Kiley said as he stepped over the body.

—*Tim O'Brien,* The Things They Carried

Introduction

Words *do* make a difference—the word *Ajax*, after all, is etymologically "the sound of a blood-curdling scream, a cry of anguish and despair" (Doerries, 2015, p. 106)—and whether it is to shield oneself from trauma or to make meaning of trauma or to simply put *sound* to trauma, the transportive function of words is something that revolutionary thinkers from Sophocles to Shakespeare to Freud have all demonstrated. Narrative theorist Michael White (2007) and adult onset trauma theorist Ghislaine Boulanger (2007) also profoundly believe in the therapeutic efficacy of words and the life-changing narratives those words can create. To that end, applying the theories and insights of White's narrative practice and Boulanger's adult onset trauma theory to the current clinical construct of moral injury will be the basis of this chapter.

Moral injury in combat veterans, whether one favors Shay's (1994, 2014) definition, which highlights the betrayal of others or Litz et al.'s (2009) definition, which considers more specifically the self-betrayal and self-transgressions related to perpetration, is a phenomenon that shatters one's sense of trust in one's world and oneself. My use of trust here is multifaceted and includes trust in oneself—i.e., one's mind, one's perceptions, one's beliefs, one's agency—as well as trust in others: a single individual, like a therapist, or a roomful of listeners in an auditorium. Finding ways to restore that trust is, in my opinion, the key to moral repair, and it seems to me that both narrative practice and adult onset trauma theory offer different and yet complementary pathways to such healing.

Speaking generally, I would argue that narrative theory is particularly (although by no means exclusively) suited to addressing the socio-cultural aspects of moral injury: the betrayals and injuries incurred by dominant, pathologizing discourses, which can be disseminated not only by military commanders and civilians, but by mental health workers as well. As Shay (2014) notes,

> At its worst our educational system produces counselors, psychiatrists, psychologists, and therapists who resemble museum-goers whose whole experience consists of mentally saying, "That's cubist! . . . That's El Greco!" and who never *see* anything they've looked at. "Just listen," say the veterans when telling mental health professionals what they need to know to work with them, and I believe that is their wish for the general public as well. (p. 5)

Narrative practice, of course, also urges listening: listening for preferred storylines, for subjugated knowledges, for unique outcomes. This foundational emphasis on listening—and by extension moving away from realms of expert knowledge— along with a guiding belief in the

defining power of analogy and of de-pathologizing *receiving contexts*, positions narrative therapy as an important first step in the societal re-integration of combat veterans.

On the other hand, adult onset trauma as Boulanger (2007) defines it, is particularly suited to comprehending the psychodynamic components of moral injury: the specific, visceral experience and ensuing symptomology of having a self shattered by catastrophic violence that one has either witnessed or perpetrated—or, as is usually the case for combat veterans, witnessed *and* perpetrated. The symptomology and behavior changes related to moral injury that Nash & Litz (2013) and others (Farnsworth et al., 2014, Drescher, K.D. et al., 2011) have been painstakingly cataloguing in recent years bears repeating at this juncture for its sobering magnitude:

> Reported social and behavioral problems possibly associated with moral injury ranged from social withdrawal and alienation to aggression, misconduct, and sociopathy. Possible spiritual and existential symptoms included loss of religious faith, loss of trust in morality, loss of meaning, and fatalism. Possible psychological symptoms included depression, anxiety, and anger, while the characteristic self-depreciating emotions and cognitions thought to be associated with moral injury included shame, guilt, self-loathing, and feeling damaged. (Nash & Litz, 2013, p. 369)

Given the magnitude of war-related psychological trauma—the fact that twenty-two veterans on average commit suicide every day, which amounts to almost one self-inflicted death *per hour* (Veterans Affairs, 2012, as cited in Doerries, 2015, p. 4)—attending to both the socio-cultural and the psychodynamic dimensions of that trauma is crucial for social workers engaged in

mental health treatment with combat veterans. Neglecting either of these components potentially creates further injury.

Freud, in his essay, "Some Character-Types met with in Psycho-Analytic Work" (1916), turned to the texts of Shakespeare and Ibsen in order to illustrate his clinical points because of "the wealth of their knowledge of the mind" (p. 317). I too am compelled by the news about human beings that artists—be they writers or painters or actors or directors—have to offer the mental health field. In what follows, I will first briefly note several contemporary literary texts as a means of highlighting narrative theory's applicability to moral injury, and then turn to Bryan Doerries' public health organization, Theater of War, as an example of the way in which narrative practice may be brought to bear on moral injury. In the final section of the chapter, I will try to provide a more nuanced account of moral injury by reading Sophocles' *Ajax* through the lens of adult onset trauma theory.

Defining moral injury: a narrative tension

At the outset, it is worth registering that narrative theory and practice, particularly as conceived of by White (2007), sit uneasily with the constructing and codifying of moral injury that is currently taking place in the social science circles connected to the Department of Veterans Affairs and the Department of Defense. Such clear-cut defining is, from the point of view of narrative practice, an example of positivism, a technique of power whereby one group (in this case the psychologists who are primarily defining the terms) holds knowledge of this "injury," which by extension gives it power over those who "have" this "injury." Even if one does not fully subscribe to narrative practice, this caution around defining a state of being that is ancient and utterly individual is warranted. If one were to use a narrative analogy to further this

point, one might say that while there are a limited number of plots in the world with regard to moral injury—plots that involve loss of trust and shame and despair—there are an infinite number of points of view as to what it like to actually experience moral injury. Narrative practice is a therapeutic approach that seeks to privilege the particular experience, the lived experience, and to resist soul-stultifying general narratives.

That said, I should note too that at the moment, at least, the social scientists who are constructing the term are careful to specify, as Farnsworth et al. (2014) note, that they are "not advocating for a new disorder or descriptive diagnosis. Instead, Litz et al.'s (2009) definition affirms the existence of traumatic events that extend beyond the realm of fear and imminent threat to one's physical safety" (p. 250). To dismiss the research and construct-building of moral injury from the social science realm as pathologizing discourse would be too easy: I firmly believe that Brett Litz (2009, 2013) and his colleagues see the psychological trauma of returning veterans as a full-blown crisis, and are mindful of constructing this phenomenon as an *injury* rather than an *disorder*. Their point of view is grounded in cognitive behavorialism; White's (2007) and other narrative practitioners' points of view are grounded in a post-modern, post-constructivist model. Both frameworks are useful, and indeed, the complexity of moral injury seems to require a multi-directional approach. A balanced view can place the questioning of expert opinion and dominant narratives in a dialogic relationship with the evolving research and measures for moral injury and repair of moral injury.

"Thank you for your service"

Upending dominant discourses and re-authoring narratives that can flourish outside of those totalizing storylines is, as I've noted, a key technique of narrative practice. And if, as I've

also suggested, narrative theory and practice are particularly well-suited to addressing the socio-cultural components of moral injury, it is then worth highlighting again several of the socio-cultural phenomena that might in fact be morally injurious for veterans. Farnsworth et al. (2014) note that the re-entry period from deployment is a particularly "risky" (p. 255) time for soldiers and veterans, as they are moving from a military world with one set of moral guidelines to a civilian world with another set. "Whereas morality during deployment may be defined in large part with respect to the survival of the unit," Farnsworth et al. (2014) write, "civilian morality is comprised of a larger number of comparatively trivial moral issues, virtually none of which condones lethal violence or aggression" (p. 255).

Shay (1994) highlights the morally injurious actions of military commanders and the government for the combat soldier: "Lies and euphemisms by the soldier's own military superiors and civilian leaders of course undermine social trust by destroying confidence in language" (p. 34). Shay places particular emphasis on the destructive powers of the "enemy" with regard to social trust: "The enemy does severe damage to a part of mental function that is critical to the maintenance of social trust: the trustworthiness of perception" (p. 43).

The humanities scholar Robert Meagher (2014), while disputing neither the difference between military and civilian moral codes nor the profound injury of enemy action, sees the issue as much larger and insidious, rooted as it is, in the thousand-year-old tradition of "just war." This is, undoubtedly the ground that the social scientists at the Department of Veterans Affairs and the Department of Defense, tread uneasily upon; it is the component of moral injury that they cannot sufficiently address, as Meagher's thesis disrupts the whole basis for our recent—as well as our historical—conflicts. As he notes,

> [t]he deceptive and destructive core of the Christian just war doctrine can be stated very simply. It is the claim that wars, or at least some wars, and all the killing and destruction they entail, are—in addition to being necessary—good and right, even virtuous and meritorious, pleasing in the sight of God. (p. xiv)

Killing, according to this doctrine—according to what narrative practice would identify as a *dominant narrative*—is "radically distinct" from murder; it is "pure" (p. xiv). And yet, as Meagher points out, "[t]he truth is that just war theory has never made sense to those with blood on their hands nor to those whose blood it was. . . . So long as we cling to the moral justification of our wars we remain blind to the moral injury they inflict" (p. xvi).

The "subjugated knowledge" (White & Epson, 1990, p. 25) of veterans "with blood on their hands" is too often obscured by totalizing storylines about spreading democracy, about America's identity as the world's peacekeeper, and about notions of heroism and missions accomplished. This is why the *dissonance*, as the cognitive behavorialists might say, that occurs for returning veterans who are congratulated for their heroism or thanked for their service is so painful and disorienting; it reflects a storyline or a "truth" that others are imposing on them and that is fundamentally not in synch with their actual lived experience. Many of the men I sat with in a Vietnam veteran's group during my internship at the VA expressed their loathing of being called heroes. They felt they had done their job, followed orders. The notion of heroism, in the face of so much brutality, was unpleasant, even shaming, because it implied, in the person doing the congratulating, a blindness to the horrors of war, and was therefore a negation of the veteran's actual experience.

Language, as White (2007) never tires of reminding us, is constitutive: and again, one has only to think of words like *pride* or *courage* with regard to going off to a "just war" to see the dominant narratives that are embedded in those words—and that, from a narrative perspective, determine the choices made by soldiers in and out of combat. The contemporary novelist Ben Fountain underscores this very point in *Billy Lynn's Long Halftime Walk* (2012), a scathing look at the ways in which the civilian world mouths support for troops but ultimately turns away from their suffering. The following is passage is from a scene in which Billy, the Marine at the center of the novel, is being celebrated by the billionaire owner of a football team; all he hears, however, is moral dissonance:

> Pride, he says, but like a tape played too slow the word warps and fattens in Billy's ear, ppprrrr*RRIIiiiddde.* Then courage, coooo*OUURR*raaage. Service, sssserr*rRRRrvvvi*ccce. Ssssac*ccrRRRIiii*fffice. Hoo*ooONNnn*orrrr. Deeet*errRRRminaaaAA*Ation. (p. 111)

At an earlier moment, Billy reflects on how much death his Bravo Company has seen and comprehends another aspect of language-related moral dissonance:

> [G]iven the masculine standard America has set for itself it is interesting how few actually qualify. *Why we fight,* yo, who is this *we?* Here in the chicken-hawk nation of blowhards and bluffers, Bravo always has the ace of bloods up its sleeve. (p. 66)

There is a relentlessly advertised "we" that is part of the dominant narrative about going to war, but that "we" swiftly disappears in the particularities of war. The veteran, like the central figure in Powers' novel, is not a *we* but simply a *he,* left alone to "account for what he's done."

From a narrative perspective, simply exposing what White would call the "techniques of power" that are apparent in dominant storylines and the language of just war, is an act of therapeutic "insurrection" (White & Epson, 1990, p. 32), and would in itself serve to externalize some of the "problem" of moral injury. And once there is some externalized space between the problem and the person, there is room for movement and re-authorship. As White & Epson note,

> Once these techniques have been identified, unique outcomes can be located through an investigation of those occasions when the person could have subjected himself or others to these techniques but refused to do so. . . . Other examples of defiance can be identified and linked together to provide a historical account of resistance. . . . In identifying these unique outcomes, subjugation to the techniques of "normalizing judgment"—the evaluation and classification of person and relationships according to dominant "truths"—can be effectively challenged. "Docile bodies" become "enlivened spirits." (p. 31)

While White (2007) believed these narrative techniques could be highly effective in one-on-one settings, he came to recognize what he saw as an even greater therapeutic value for a person if an audience was also "engaged" in this performance of destabilizing dominant "truths" and unearthing preferred meanings (p. 178).

As noted in my earlier chapter, his idea of definitional ceremonies developed out of his observation that the development of rich personal narratives so often "contradicted . . . socially constructed norms" (p. 179); he saw how critical it was for these new, norm-challenging narratives to be witnessed and "verified" by a group of others. As he points out, referencing Myerhoff (1982, p. 284),

> [t]he prominence given to "collective self-definitions," to the imperative of "appearing before others," to "garnering witnesses to one's worth, vitality, and being," and to "proclaiming an interpretation to an audience not otherwise available" emphasizes the central significance of the contribution of the audience in these definitional ceremonies. It was the audience response to the stories told and performed in these forums that was verifying of these stories. It was the audience's acknowledgment of the identity claims expressed in these stories that was authenticating of these identity claims. It was the audience recognition of these stories that so significantly contributed to the community members' achieving a sense of feeling at one with their claims about their lives. In the context of these forums, the audience found themselves "participating in someone else's drama" and becoming "witnesses who push a plot forward almost unwittingly." (p. 183)

It is the reverberating space between individual and community, the emotional exchange between part and whole that White came to believe had such transcendent—cathartic—potential for healing. Shay (1994), as I noted in Chapter II, also believes that it is precisely this kind of "communalization of trauma" (p. 4), this collective performance of listening to tragedy, that is necessary for the repair of moral injury. Healing, as Shay argues the ancient Greeks knew well, depends on "being able safely to tell the story to someone who is listening and who can be trusted to retell it truthfully to others in the community" (p. 4). His book *Achilles in Vietnam* (1994), ends with a *cri de coeur* for the mental health community to find new ways, beyond insular veteran support groups, to truly communalize the trauma of war: "Combat veterans and American citizenry should meet together face to face in daylight, and listen, and watch, and

weep, just as citizen soldiers of ancient Athens did in the theater at the foot of the Acropolis" (p. 194).

In 2008, at the invitation of Captain William Nash—who one year later would publish with Bret Litz and other colleagues their landmark article on moral injury and moral repair—Bryan Doerries (2015) was able to do just that. Nash invited Doerries to a Marine base in San Diego and Doerries staged his first Theater of War reading in front of four hundred Marines (Doerries, 2015). Doerries demonstrated, unwittingly perhaps, just how relevant and effective an adaptation of White's definitional ceremonies could be as a model of therapeutic repair for moral injury.

Theater of War

In presenting readings from Sophocles' *Ajax* and *Philoctetes* to combined military and civilian audiences, Theater of War's (2015) mission is straightforward:

> to de-stigmatize psychological injury, increase awareness of post-deployment psychological health issues, disseminate information regarding available resources, and foster greater family, community, and troop resilience. Using Sophocles' plays to forge a common vocabulary for openly discussing the impact of war on individuals, families, and communities, these events [are] aimed at generating compassion and understanding between diverse audiences.

Doerries, who first immersed himself in Old Testament languages as an undergraduate, is a writer, actor, director and translator (all of the Sophocles texts used by Theater of War are his translations), as well as a "self-proclaimed evangelist for classical literature and its relevance to our lives today" (Doerries, 2015, p, 8). He is adamant about the emotional, spiritual, and

therapeutic value of Greek tragedies, subscribing to the view, as is stated in the Theater of War literature, "that ancient Greek drama was a form of storytelling, communal therapy, and ritual reintegration for combat veterans by combat veterans" (Outside the Wire, 2015). Sophocles, as Doerries (2015) points out, was himself a retired general and was writing during a war-striated period in which the Greeks had been in bloody battle for twenty years with the Spartans (p. 57). Crucial to remember is that Sophocles' audiences (and his performers) would have been made up of soldiers and veterans. He was a veteran writing for veterans. And what were these veterans watching? In the case of *Ajax*, the mental plummeting, the berserk, bloody outburst, the crippling shame, and the ultimate suicide of a man who had been considered one of the greatest warriors in the Greek army. As Doerries notes in his book, *The Theater of War* (2015), just published this fall,

> At the center of the tragedy is the suicide of a combat veteran, one of the most graphic and iconic depictions of suicide in all of Western literature. Sophocles staged the violence of Ajax's death mere feet from where the generals sat in the audience in the ancient Theater of Dionysus. But he did something else equally remarkable: he cleared the *skene* or "stage," of all other characters and took the audience inside the mind of a person who is actively contemplating suicide, deep inside the insidious logic that leads him to end his own life. (p. 96)

Theater of War is not theater of the kind that American audiences are used to: it is, Doerries writes, "the tool that we're using to catalyze the discussion." What Doerries has learned is that "when people see their own private struggles reflected in an ancient story, they open up and share some of the most personal and profound things—things they've never said out loud—let alone in front of an audience" (Doerries, 2013).

As a public health project, Theater of War has a very specific aesthetic for its readings, starting with the fact that all artifice is stripped away. There are no props, no costumes, and no set. The actors wear their street clothes. They sit behind a table with scripts and bottles of water in front of them. There are usually only two or three actors on stage, accompanied by Doerries, who reads minor parts. The auditorium lights are fully turned up on the actors—and on the audience. Doerries has a carefully considered rationale for this set-up: "by stripping the performance to its bare essentials, by focusing the actors' considerable talents upon the power of the spoken word . . . I hoped to deliver the plays in their purest and most efficacious form" (p. 74).

Once the audience members have settled in their seats, Doerries offers a few opening remarks to set the scene before sitting down at the table with the actors. There is a pause—and then, always, *BAM*: in full character, full agony, the scene is on. Doerries says that he intentionally starts his scenes at full tilt, with an actor, depending on whether he/she is reading Philoctotes, Ajax, or Tesmessa, howling, shouting, or weeping. The audience is, invariably, riveted by this instant transformation, this shocking (as the street clothes, the water bottles, and the full lighting work to disarm expectations) descent into raw, emotional turmoil:

AJAX: I call upon the Furies,
those long-striding
dread maidens who
avenge humans and
see to their endless
suffering: witness
how the generals

have destroyed me!

Train your eyes on
those evil men,
snatch them with
your talons and,
just as I die at
my own hands,
may they also be
murdered by their
own flesh and blood.
It's feeding time! (Doerries, 2015, pp. 80-81)

Theater of War has reached thousands of service members and has held readings around the world, from Brooklyn to Scandinavia to Kuwait (Doerries, 2015, p. 7); media outlets from *The New York Times* to the *Atlantic* to the PBS Newshour have featured Theater of War; and at this point, Doerries has a stable of well-known theater and film actors at his disposal, including David Straitharn, Paul Giamatti, Blythe Danner, Giancarlo Esposito, Frances McDormand, Elizabeth Marvel, Jake Gyllenhaal, John Turturro, Amy Ryan and Martin Sheen (Outside the Wire, 2015). But just as Theater of War is not about theater in the usual way, it is also not about these famous actors: as soon as the reading, which usually lasts about an hour, is over, the actors quickly exit the stage. Their seats are taken by a panel of pre-selected community members, usually a combination of veterans and local mental health workers who have been asked prior to the reading to watch and be prepared to respond, from the gut, to what they have heard. Just like

White's (2007) outsider witnesses, they are instructed not to come with prepared notes, not to take notes, but to just listen (Doerries, 2015).

After the panel members have responded to what they have seen—Doerries considers them to be in the role of "the ancient Greek chorus, intermediaries between the plays and the audience" (p. 83)—Doerries then turns to the audience which, through advertising, recruiting, and word of mouth, has been filled with a diverse combination of active duty troops, veterans, and civilians. Doerries has several questions planned out for the discussion portion of the production, but almost always begins with this one: *Why do you think Sophocles wrote this play?* (Doerries, 2015, p. 4).

From this point on, the audience is in charge. The actors often move around the auditorium, delivering the microphone to each new speaker. In some venues, standing microphones are set up in the aisles. The first time Doerries staged his reading, for the 400 Marines in San Diego, they allotted 45 minutes for this discussion period. The conversation lasted three hours and had to finally be cut off after midnight (Doerries, 2015, p. 87).

Acting as part MC, part therapeutic conduit, Doerries asks more questions, builds off of the audiences words and language. In response to Doerries's question about why Sophocles wrote *Ajax*, one enlisted soldier, as Doerries recounts in his book, declared, "in order to boost morale." Doerries then asked him, "What is morale-boosting about watching a decorated warrior descend into madness and take his own life?" The soldier replied, "It's the truth, and we're all here watching it together" (Doerries, 2015, p. 4.)

As Doerries notes,

> The soldier had highlighted something hidden within *Ajax*: a message for our time. Sophocles didn't whitewash the horrors of war. This wasn't

> government-sponsored propaganda. Nor was his play an act of protest. It was the unvarnished truth. And by presenting the truth of war to combat veterans, he thought to give voice to their secret struggles and to convey to them that they were not alone. (p. 4)

In other words, we are back to Shay's (1994) "communalization of trauma" to heal moral injury and to White's (2007) notion that definitional ceremonies "have the potential to be highly resonant" (p. 189). It is precisely this resonance that "contributes significantly to rich story development, to a stronger familiarity with what one accords value to in life, and to the erosion and displacement of various negative conclusions about one's life and identity" (White, 2007, p. 189).

Theater of War Theory

Over and over again, Doerries (2015) has found that Sophocles' plays speak to the core experience of soldiers, veterans, and their loved ones. At one event, as he recounts, the wife of a Navy Seal stood up and declared, "My husband went away four times to war, and each time he returned, like Ajax, dragging invisible bodies into our house. The war came home with him. And to quote from the play, 'Our home is a slaughterhouse'" (p. 83).

In his efforts to reach as many soldiers and veterans as possible, Doerries has had to counter "two pervasive knee-jerk concerns" (p. 104), from mental health professionals who work with veterans: first, that the plays would be retraumatizing for veterans and exacerbate symptoms of depression and suicidality; and second, that the plays would "fly straight over the heads of those in the lower enlisted ranks" (p. 105).

While Doerries obviously does not know the specifics of the reactions, immediate or delayed, that his audiences bring home (there has not, as yet, been any formal research on the effects of Theater of War for veteran audiences), he has found neither of the concerns to be borne out—and he has a theory as to why. Like White (2007), Doerries returns to Aristotle's writings on tragedy and catharsis, specifically the idea that tragedies are graphic illustrations of "suffering." By bringing about a collective response in the audience to this suffering, by calling forth powerful, shared emotions, a state of catharsis—a cleansed and purified state—is achieved (p. 37). Doerries takes issue with the well-worn idea of the "tragic flaw" of characters in Greek tragedies, as he sees that eliciting in audiences a feeling of judgment rather than empathy. But it is empathy that moves us from one place to another—perhaps from a place of judgment (self or other inflicted) to one of understanding. As Doerries notes,

> tragedies are not designed to teach us morals, but rather to validate our moral distress at living in a universe in which many of our actions and choices are influenced by external powers far beyond our comprehension—such as luck, fate chance, governments, families, politics, and genetics. (p. 13)

Citing the term, *allostatic load,* which was coined by psychologists at Yale and refers to the "physical strain of the body's stress response…upon the cardiovascular system" (p. 37), Doerries also makes the case that perhaps tragedy, with its cathartic release and the emotional movement it induces from a state of "pity and fear" (p. 37) to one of purification, was an ancient therapeutic system for recalibrating the autonomic nervous system; perhaps tragedy, as he argues, is "a powerful tool for positive change, one whose vast and untapped potential for propagating healthy responses to stress remains wholly underestimated" (p. 38).

And I would venture further that there might be a metric explanation, a connection, for example, between the rhythms of our nervous system and the rhythms of verse. As the poet Robert Wallace (1987) observes,

> Why do we live in square rooms? Why do we draw mechanical doodles when we are bored? Why do we tap our feet to music? Perhaps there is a profound link between the meter of verse and the human pulse, the rhythm of life itself—*te TUM te TUM te TUM.* The rhythmical impulse runs deep in us. (Wallace, 1987, p. 8)

Theater of War and Narrative Practice

It is evident to me that Theater of War is therapeutically beneficial because it hinges, consciously or unconsciously, on so many of the basic foundations of White's (2007) narrative theory and practice: exposure and therefore externalization of dominant, pathologizing discourse; re-authoring in the form of the rich story development of preferred narratives by the soldier and veteran audience; re-membering (Ajax and Philoctetes join the membership of veteran's lives); and, of course, definitional ceremonies. Here the overlaps are striking. For example, Doerries' structure for the performances is essentially identical to White's structure of "1. The telling of the significant narrative by the person. 2. The re-telling of the narrative by those invited to be present as outsider witnesses. 3. The retelling of the outsider witnesses' retelling by the person" (White, 2007, p. 185). The only difference is that the figure for whom the ceremony is performed is, in Theater of War, first signified by the character at the center of the tragedy, by *Ajax,* say, and then later, in accordance with White's third step, the central figure is represented by the soldier and veteran members of the audience. White's careful selection of outsider witnesses is

echoed in Doerries selection of his panel-Chorus, as well as his dedication to making sure the audience is a diverse mix of civilians, i.e. those who need to listen and veterans, i.e. those who need to speak.

The fact that Theater of War is a performance of Greek tragedy and perforce employs the ancient technique of catharsis is what enables the audience—the outsider witnesses—to adhere, more or less, to White's "four categories of inquiry" for his outsider witnesses: our focus can't help but be on Ajax's howling *expressions,* the linguistically called forth *images* of bloody carcasses, the *personal resonances* (as a veteran, a spouse, a witness), and on *transport.* As White notes, "It is rarely possible to be an audience to the powerful dramas of other people's lives without this moving us in some way" (p. 191).

For Litz et al. (2009), one of the most lethal aspects of moral injury is the intractability of beliefs about the damaged or 'flawed' self that has perpetrated or witnessed profound violations:

> If the attribution about the cause of a transgression is *global* (i.e., not context dependent), *internal* (i.e. seen as a disposition or character flaw), and *stable* (i.e. enduring; the experience of being tainted), these beliefs will cause enduring moral emotions such as shame and anxiety due to uncertainty and the expectation of being judged *eventually.* If these aversive emotional and psychological experiences lead to withdrawal (and concealment) then the service member is thwarted from corrective and repairing experience (that otherwise would temper and counter attributions and foster self-forgiveness) with peers, leaders, significant others, faith communities, (if applicable), and the culture at large. (p. 700)

This intractability is, as Litz et al. (2009) argue in their model for moral repair, precisely why soldiers and veterans "need to have an equally intense real-time encounter with a countervailing experiencing" (p. 701).

The definitional ceremony that Theater of War, in fact, *is*, provides, as I hope I have made clear, just such an "intense" and "countervailing" experience. Indeed, it is Theater of War's ability to create a platform for the storying of preferred experience, to offer outsider witness retellings, and to temporarily level the hierarchies and boundaries—between generals and the enlisted, between veterans and civilians—that works so powerfully against the aspect of moral injury that Litz et al. (2009) see as an "over-accommodation . . . of expectations of injustice" (p. 701). The resultant co-constructed narrative of shared understanding around the burden of war, be that the killing of others or the wish to kill oneself, *in place of* disavowing, dominant narratives about honor, sacrifice, war-induced psychosis or suicidality, is immensely validating. As one general succinctly put it after listening to a Theater of War performance,

> Perhaps Sophocles wrote these plays because he was in the minority with regard to the compassion he felt for the warriors in his community who were struggling with the issues he portrayed in his plays. Perhaps Sophocles wrote these plays to comfort the afflicted and afflict the comfortable. (Doerries, 2015, p. 108)

And Yet: Examining Moral Injury Through the Lens of Adult-Onset Trauma Theory

Narrative practice—and by extension Theater of War—is, as I have argued, well-positioned to address some of the socially embedded wounds of moral injury, the collective and individual psychic damage that comes from betrayals of "social trust" (Shay, 2013, p. 186) and

the "shrinking of viable social collaborators" (Farnsworth et al., 2014, p. 255). And yet, the whirling dervish of moral injury spins, as Litz et al. (2009) point out, into many areas of distress—social, behavioral, spiritual, and psychological—and a multi-modal approach to understanding the trauma of this phenomenon is critical. To that end, I will now turn to Boulanger's (2007) theory of adult onset trauma and to the morally injured figure of Ajax. By providing a close reading of Ajax's experience, my intent is to both create a visceral, experience-near understanding of moral injury as a form of adult onset trauma, as well as to demonstrate the important clinical implications of Boulanger's theory. Moral injury shatters social trust; it also, certainly, shatters the self, and adult onset trauma theory offers an entry point to the "momentous and very private experiences" (Boulanger, 2007, p. 7) of this phenomenon.

The moral injury of Ajax

At the play's opening, Athena, goddess of wisdom appears to tell Odysseus how Ajax, considered by all to be the strongest of the Greek warriors, has gone insane in the night, and has butchered a collection of livestock. Ajax, we learn, was enraged with Odysseus and the other Greek leaders because the cherished armor of Achilles had been given to Odysseus rather than to him. Ajax considered himself more deserving: not only was he the best warrior, but Achilles was also his dear friend. Enraged by this compounded betrayal, he sets out to murder Odysseus. He is waylaid by Athena, who blinds him with madness so that he kills the livestock rather then the men. Upon awakening the next day from this madness, Ajax is consumed with shame and guilt over his bloody deeds and is reduced to alternately catatonic and weeping states. He kills himself at the beginning of Act II by impaling himself on his sword—the very source of his heroic legacy.

If one is to go by Litz et al.'s model (2009), which conceives of moral injury as "participating in or witnessing inhumane or cruel actions, failing to prevent the immoral acts of others, as well as engaging in subtle actions or experiencing reactions that, upon reflection, transgress a moral code," then Ajax, tragically, scores on all fronts. He has participated in inhumane actions, he has failed to prevent immoral acts, he has transgressed his own moral code. Ajax's symptomology, from within a moral injury framework, could be said to include:

1. Aggression and sociopathy: "He attacked the horned beasts, smashing/Their spines, then hacking out a circle of carcasses/He thought he had hold of the two sons of Atreus/And was slaughtering them with his own hands" (55-58).

2. Alienation and social withdrawal: "And what now? The gods revile me/That is certain. I am despised by the Greeks/And hated by this plain of Troy. Should I go home? Abandon these moorings?" (457-60).

3. Depression: "Now he has been laid low by this evil/He won't eat or drink or say anything (321-322).

4. Shame: "Look at the valiant man! The brave heart!/The one who unflinchingly faced the enemy!/You see the great deeds I have done to harmless beasts?/O, the ridicule runs riot against me!" (364-367).

5. Suicidality: "I also pray to Hermes/Guide to the Underworld, to help me fall on my sword/without a struggle—one quick, sharp thrust" (831-33).

Traumatic Reality

The "divine madness" by means of which Athena overpowers Ajax and the gruesome destruction of the livestock that ensues can be read, as Doerries (2015) points out, as a

dramatization of the "psychological damage of war" (p. 93). The classical psychoanalyst Meyer Lanksy (1996), who has written extensively about shame, regards Sophocles as "the poet of shame" and Ajax's mental collapse as an instance of "dissociated narcissistic rage that arises directly from an experience of shame and results in an escalation of both external and internal shame conflicts" (p. 766). His view is a break from previous psychoanalytic readings of the text, which emphasized Ajax's rage as a function of psychosis.

Boulanger (2007), interestingly, does not explicitly name "shame" in her book, although it seems implicit in her description of the experience of catastrophic dissociation: there is a global collapse of self, hence the self is globally damaged and unworthy. As she writes, "[c]atastrophic experience in adulthood brings each aspect of the core self into question, shattering confidence in the invariants that previously formed and informed experience, jeopardizing the self that cannot, in fact, be separated from experience" (p. 80).

From an adult onset trauma theory perspective, Ajax's bloody rampage, I would argue, can be seen as a distillation of catastrophic dissociation in the face of extreme trauma—a traumatic trifecta, in this case, of years of combat, the death of Achilles, and the betrayal by the Greek generals. It is the moment in which Ajax's *agency*, *physical cohesion, continuity,* and *affect*, the crucial components for a sense of self within this framework, are irreparably damaged. Boulanger notes that such dissociation is an "emergent, complex, and evolving process" (p. 79), and indeed, in the aftermath of his bloodbath, Ajax is left in a "traumatic reality" (p. 59), in Lacan's gap "*entre deux morts*" (p. 38). This is an emotionally suffocating, death-in-life in place where there is, as Boulanger observes of this state, "an emptiness that cannot be contained or defined or reasoned away" (p. 38). Or, as Ajax puts it,

Oh!

Darkness is now my only light;

The gloom of the Underworld

Shines for me. Take me!

I have lost the right to look for

Any help from gods or men. (393-396)

Sophocles' text, with its repetition of Ajax's carnage (we hear extended gory details three times, first from Odysseus, then Athena, and finally Tecmessa) makes manifest this traumatic reality: Ajax's massacre takes place before the play opens, so the text quite literally in this repetition, gives us post-traumatic flashbacks, effectively merging form and content. It is an illustration, to re-quote Boulanger, who is referencing Winnicott, of "a reality that sticks in the psychic craw and cannot be dislodged. The survivor is always choking on the fact of it, always fearing a repetition of the breakdown that has already happened" (p. 59). This, I would argue, is underscored by the intensity of the descriptions of the slaughter—arguably the most vivid sections of the entire play—through the insistent use of action words like "attacked," "smashing," "hacking," "slaughtering," "hurling," "butchered," "ripped," "flogged," and "stinging." These words attest to what Ajax is doing to the cattle, but they also reflect, perhaps, the fragmented, terrifying disarray of his internal state; again, the "emergent, complex, and evolving process" of catastrophic dissociation.

Agency, Physical Cohesion, Continuity, and Affectivity Applied

Ajax's loss of agency is introduced by Sophocles in the first moment of the play: a goddess, an unknowable, mercurial force from above has blinded him with madness, and in a split second, Ajax has descended from his secure, renowned identity as a powerful warrior, a

man who knows his own mind, into the state of a crazed puppet. He had, as Athena tells us, actually reached the doors to Odysseus's tent with his awareness intact. But then, she says, "I held him at the brink of his deadly moment of joy/deluding his eyes with visions of his own obsession" (52-53). As Boulanger (2007) notes, dissociation "is not a choice; it is imposed by an overwhelmed psyche that is attempting to protect itself from further harm" (p. 82).

While Ajax himself locates his great shame in his inability to follow through with his intent to kill the Greeks, mistaking animals for them, it's also possible to read his slaughtering of the animals as an example of the fundamental inhumanity of war, in which men do indeed, as the My Lai massacre and countless other war atrocities attest, kill in states of catastrophic dissociation brought on by experiences where they have been brought to the brink of either their own or someone else's annihilation. Rage, as Lansky (1996) implies, especially over the loss of comrades, certainly plays a part in this, but it can also be traced back to the amygdala-controlled "fight" response that is initiated when the body is in danger. The overwhelmingness of such experiences is amplified, after the fact, by waves of helplessness—not least of which is the helplessness in attempting to make sense or meaning of the traumatic events and memories. Ajax, certainly, is unable to make meaning from his "divine madness," to fit his former self with his current self; after the bloodbath, Tecmessa says, he begged her to tell him "how he had come to be in such condition" (314). This exchange takes place offstage, before the action of the play has begun, which makes it particularly striking that the first words we hear from Ajax on stage speak directly to his shattered sense of agency in a world he once felt in control of. "Why me? Why me?" (333) and then two lines later, "Why me? Why me?" and again, fifty lines later: "Why me? Why?"

Ajax's violently dissociative experience during his slaughtering spree is also, of course, intertwined with a collapse of his self's physical cohesion and sense of continuity. Independently of his conscious mind, his body registers danger and the neural and chemical signals to fight. His body, in other words, was present, but not his mind, and this rupture of the balance between psyche and soma, as Boulanger (2007) points out, is a rupture of "the body as psychic container, capable of establishing an interior object world inhabited by a benign object and capable of recognizing the separateness of others" (p. 87).

At the same time, Ajax's sense of continuous selfhood is brutally disrupted: he does not know what has happened. The text highlights the difference between his state of madness and his state of sanity, as though they exist in different dimensions of time: "Slowly and painfully he returned to his senses/And when he saw the carnage under his roof/He grasped his head and screamed/Crashing down onto the bloody wreckage/Then just sitting in the slaughter, fists clenched/his nails tearing into his hair" (305-10). During the rampage, time stood still; for both Ajax and the audience, the experience is frozen intact in time, and cannot be processed into a narrative of past, present, or future. Indeed there is no "going on being" (Boulanger, 2007, p. 89) for Ajax in the moment of his traumatic rampage—or after. The Chorus pleads with Ajax to reclaim continuity: "It happened; nothing can change that now—/But don't keep suffering the pain of the past" (377-78). Ajax cannot: "Where could I run? Where could I ever stay? My reputation now lies here/Among these butchered carcasses" (403-06). His sense of a self that exists through time, that has a past and a future, has been obliterated, and he is imprisoned in, as Boulanger puts it, a "meaningless now" (p. 90).

Ajax's traumatized affect is evident in the disembodied quality that overtakes him during the massacre. Indeed, as Boulanger notes, it is often the case that "powerful affect triggers the

dissociative response" (p. 90) and Ajax's profound feeling of betrayal and rage at his dishonoring by the Greek leaders, certainly propel his actions. Both during and after the traumatic slaughtering, it is clear that he has lost the usual range of familiar feelings that ground his core sense of himself. As the Chorus observes, "The mighty warrior/Ares sent out to war/Retreats into lonely despair,/Greatly distressing his friends/Everything he reached for/All his great glories, lost" (611-17). Tecmessa too is shocked by Ajax's weeping presentation—and his inability to locate his former self:

> I told him what I knew
> And he let out such pitiable, mournful cries—
> Sounds I had never thought possible from him
> He had always thought weeping cowardly,
> A sign of weakness in lesser men.
> Before, he would never wail or cry
> But deeply groan and bellow like a bull.
> Now he has been laid low by this evil. (315-21).

As with loss of agency, physical cohesion, and continuity, loss of affect regulation implies a loss of subjectivity; without an "I," with nothing but a "self that exists only as an object," the "subject who makes choices and follows through on them is lost" (Boulanger, 2007, p. 81). Perhaps this loss of subjectivity also explains Ajax's repeated, desperate cry of "Why me?", as though in saying *me* over and over again he might actually come to *feel* a sense of *me.*

The inability to register one's own affect, too control one's own affect, or to "experience feelings in a consistent fashion" (p. 93) destroys not only a sense of an "I" but a sense of an other as well: "With the failure to register one's own feelings comes both the inability to share one's

affective state with an other, and the failure to appreciate the other's affectivity, which is the basis of intersubjective experience" (p. 93). In the case of Ajax, we see this rupture between self and other play out with his wife, Tecmessa, as he urges her to "Get out of my sight! Get away!/Aiai! Aiai!" (369-70).

But I would argue that this rupture of a capacity for intersubjectivity began earlier, before the massacre of livestock, which simply compounded it. For Ajax the death of the "good object" of Achilles, and then Achilles' second death, symbolized by Ajax's loss of his armor, is the tipping point. Sophocles does not describe Ajax's grief around Achilles' actual death, but we can infer how devastating it is from his extreme response to the armor being given to Odysseus. There is obviously the question of honor and respect—and by extension the brutal negation, the betrayal of not being honored. But perhaps the significance of the armor for Ajax also lies in its ability to keep the good object of Achilles, the internalized empathic other, with him; he would have worn the armor, and like a layer of skin it would have served to preserve physical cohesion, the integrity of inside and outside, the internal and the external. Without it, Ajax experiences profound depersonalization, and as Boulanger notes, "[w]hen the significance of external objects is suddenly voided, the internal object world becomes a void" (p. 99). Empathy for the other—an ability to hold onto the presence of Achilles or of Tecmessa's and his son's love—is unattainable in this state. The betrayal of the Greek generals—what Ajax emotionally registers as a desire to destroy him—further corrupts his sense of internalized benign others. He is reduced to the attacked, reactionary object rather than a reflective subject, and is thus left in Klein's (1935, 1986) paranoid schizoid position. From this point of view, the slaughtering of the animals, not to mention the repetition of words like hacking and butchering, can also be read as representations

of Ajax's internal landscape, a world filled with persecutory part objects. As Boulanger says of the paranoid schizoid position brought on by trauma,

> In this world, [he] has no subjectivity, no agency, and no sense of history; object use and mutuality suddenly seem beyond reach, a vague memory of something lost, while others, who once felt important to [him] now feel like shadows with no substance of their own. (p. 101)

Ajax is thrust into a state of traumatic aloneness, and indeed, the only thread of hope that Sophocles holds out for his survival, hinges on interrupting that aloneness, on staying in the company of his family and friends. The Messenger reports back a prophecy given to Ajax's half brother, Teucer: "if he ever wanted to see/Ajax alive again, he must do everything /In his power to keep him inside today" (773-75). (As a side note, it is astonishing to see that Sophocles, over two thousand years ago, was already offering a version of the treatment planning around suicidality that is still in effect today. Again, to draw on my experience as an intern at the VA, although this is true in any crisis of suicidality, when a veteran voiced suicidality, one of the most crucial next steps for the mental health workers was to shore up the veteran's support system, to counter, in effect, that traumatic aloneness.)

But Ajax, of course, cannot be kept inside. He remains in a state of psychic equivalence, whereby his self, shattered as it is, can no longer truly reflect, integrate experience, or recognize others. "In this state," as Boulanger notes, "the self that acts as mediator between words and what they stand for, between symbols and symbolized, between immediate and mediated experience, is no longer accessible" (p. 117). His narrative of experience is lifeless; it is one of deadened repetition, evinced by both the repeated scenes of the slaughter and by his repeated narrative of vengeance. Neither has been detoxified in any measure for him because of his state

of traumatic aloneness. The persecutory part objects that speak to his shattered subjectivity reappear in the form of the Furies he calls out to moments before he kills himself: "Come, Furies, to a feast of vengeance—Feed on the whole army; devour them all!" (844-45). He is calling to them to destroy his enemies, but of course he has not truly projected them outward; they are introjected inward and it is it is *he* who is about to be destroyed:

> This plain of Troy, you nurtured me,
>
> And now I take my leave of you.
>
> These are the last words of Ajax;
>
> Now he speaks in Hades to the dead. (862-865)

Ajax's moral injury, his shattered self, his suicidality are appallingly resonant with the experiences of contemporary service members and veterans. Near the end of the play, Menelaus, a Greek general observes, "And any man, however great he grows/Can always be felled by the slightest blow" (1078-79). This, too, is Boulanger's refrain about the fragility of the self in the face of massive trauma, and it is the refrain of the *New York Times* feature story that I mentioned at the outset of this thesis, which highlighted marine after marine who had been considered to be a "fearsome team leader" or who had returned to the States and been a tireless supporter for fellow veterans in trouble, ultimately succumbing to suicide. In the article, one of the soldiers, Travis Wilkerson, implores the others to maintain solidarity and safety. After the funeral of a platoon member who had committed suicide, he says to his company buddies, "Real talk, guys, let's make a pact, right here . . . I don't want to go to any more funerals. Let's promise to reach out and talk. Get your phones out, put my number in. Call me day or night" (Philipps, 2015). Two years later Wilkerson shot himself to death.

Recognizing this breaking point—the basic shatterability of the human self, no matter how strongly constructed it once was—is the springboard for Boulanger's adult onset trauma theory, and is why she sees it as imperative that mental health workers understand the particular process of catastrophic dissociation in adulthood and the specifics of the ensuing psychic wreckage. In the same article, one man perfectly describes catastrophic dissociation, albeit in his own words:

> "Something happens over there," said Mr. Havniear, whose best friend from the battalion tried suicide by cutting his wrists after returning home, but survived. "You wake up a primal part of your brain you are not supposed to listen to, and it becomes a part of you. I shot an old woman. I shot her on purpose because she was running at us with an RPG. You see someone blown in half, or you carry a foot. You can try, but it is hard to get away from that." (Philipps, 2015)

Boulanger argues that without recognizing how this mode of dissociation differs from developmental trauma, without according value to Lacan's Real—the severed foot in your hand—and without finally privileging narrative over interpretation as a pathway to healing, treatments will dead-end and narratives, like Ajax's—or Mr. Havniear's—will remain lifeless. The subject will not be found.

Strengths and Limitations

Moral injury, as it is currently being constructed, is a complex phenomenon that has implications for veterans on both a societal and personal level. The combined application of White's narrative theory and practice and Boulanger's adult onset trauma theory offer social workers a way to attend to both the socio-cultural and psychodynamic components of moral

injury. As far as I know, this thesis is unique in its application of these two theories to the public health project, Theater of War, and to the text of Sophocles' *Ajax*.

However, there are limitations to this thesis. I have not applied other theoretical constructs like betrayal trauma theory or emotional processing theory, attachment theory, or neurobiology, all of which would have offered compelling lenses and provided additional understanding of the phenomenon of moral injury. My theoretical lenses are also constrained by the fact that I have looked at them exclusively through their founding authors—Michael White and Ghislaine Boulanger. Boulanger, as far I can tell, is the only person who is calling her theory adult onset trauma, and the only one making her particular distinctions about catastrophic dissociation, but with regard to narrative practice, I have not branched out to include the theorizing of the many other writers and practitioners who engage in this framework. I have also chosen to illustrate the social and psychodynamic devastations of moral injury primarily (although not exclusively) through fictional texts, rather than through first hand oral testimonies.

This thesis is also hampered by my personal limitations, primarily the fact that I am a civilian and do not have family members or friends who are in the military. I write from a position of tremendous privilege with regard to veterans and moral injury: my social class, my race, and my gender have all protected me from war experiences, both in terms of actual enlistment as well as in terms of social engagement with veteran causes. I did not grasp the severity of the trauma that veterans experience until a year ago, when I was an intern at the Department of Veterans Affairs. I have therefore lived many years contributing to moral injury by my inability to see it in the first place.

Conclusion

The current moral injury construct is for me, in the end, a signifier of an acute understanding of the catastrophic trauma of war. It is an important step in increasing the visibility of war trauma for social workers, for other mental health workers, and for civilians, and for forcing all of those who have not engaged in our recent wars to look more closely at the shattering psychological impact of killing other human beings—and to look, as well, at the shattering psychological impact of *not recognizing* the shattering psychological impact of killing other human beings. Betrayal, as moral injury illustrates, can take many forms.

I have no illusion that either narrative practice or adult onset trauma theory offer easy fixes for something that, ultimately, can never be entirely fixed. But both seem, as I hope I have demonstrated, to be frameworks that, in their privileging of narrative, fervently wish to restore a measure of richness and meaning to daily experience, even for those who have been near-decimated by annihilation—theirs or someone else's. Social workers need to attend to both components, to work to create more venues for the communalization of war, as Theater of War does so effectively, as well as to comprehend the depths of psychic shattering that occurs, and the long, slow work of rebuilding a self through therapy that recognizes the particularities of adult onset trauma.

"Absorbing, mysterious, of infinite richness, this life," writes Virginia Woolf in *Mrs. Dalloway* (1925). Throughout her novel she holds that sentiment in a dialogic balance with the equally true observation, made by Septimus Warren Smith, the suicidal combat veteran, that "human nature is remorseless" (p. 98). Such is the balance that social workers—that all of us—must reconcile when attending to moral injury. In our interactions with those who are, like Septimus, continually at risk of feeling "as if some horror had almost come to the surface and was about to burst into flames" (p. 15), we must stand alongside them as true witnesses to the

horror that they have experienced, whether that horror has overtaken them from the inside or has surrounded them from the outside, remembering too that the nature of inside and outside, personal and communal, in a moral injury context, is porous indeed. We must recognize the reality of this horror, of this very particular human narrative, and in so doing refuse to leave anyone behind in the flames.

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