Moral injury as a war syndrome: an historical approach

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Abstract

The paper locates moral injury into its historical context as the latest of a long line of war syndromes since 1900. It is argued that merely psychological, psychiatric, and biomedical (PPB) approaches that currently dominate moral injury research and discussions are manifestly inadequate. PPB language and vocabulary are unable to engage fully the moral aspect of the injury, while the inherent individualism has difficulties relating and understanding individual morality with, and within, their respective social contexts. The paper advocates a broadening of moral injury discussions, especially to include reflections on ontology and anthropology of human existence though interdisciplinary contributions.

Introduction

Moral injury is approached in this paper from the historical experiences of war syndromes associated with the major wars since before 1900.[1] This differs from other explorations of moral injury, from psychological, psychiatric, and biomedical perspectives (PPB). I argue that when moral injury is explored in its historical biopsychosocial context, aspects of this complex and debilitating human experience emerge with greater clarity, providing a clear sense of direction for ongoing explorations.

Table 1 below lists some of the war syndromes as identified by Jones.

Table 1: War syndromes since 1850s

pre-1914	Wind contusion, Nostalgia neurasthenia**,** Disordered action of the heart (DAH) also known as - Palpitations (Crimean War 1853-1856), Da Costa's Syndrome (American Civil War 1861-1865*),* Soldier's heart

[1] Edgar Jones et al., "Post-Combat Syndromes From The Boer War To The Gulf War: A Cluster Analysis Of Their Nature And Attribution," *BMJ: British Medical Journal* 324, no. 7333 (2002). Edgar Jones, "Historical Approaches to Post-Combat Disorders," *Philosophical Transactions: Bilological Sciences* 361, no. 1468 (2006).

	(Boer Wars 1880-1881, 1899-1902), Cardiac neurosis, Psychogenic rheumatism.
World War I	Shell shock, Neurasthenia, DAH, Effort syndrome, Neurocirculatory asthenia (NCA), Gas hysteria, Aero-neurosis.
World War II	Psychoneurosis, War neurosis, Non-ulcer dyspepsia, Cardiac neurosis, Effort syndrome, Old sergeant syndrome, Flying stress, Battle exhaustion, Combat fatigue
Korean War	Psychoneurosis, War neurosis, Non-ulcer dyspepsia, Effort syndrome, Combat fatigue
Vietnam War	Effects of Agent Orange, Post-Vietnam syndrome, Delayed stress response syndrome, Acute stress disorder, Acute stress reaction, Battle shock, Combat stress reaction (CSR)
post-1980 to first and second Gulf War	Post-traumatic stress disorder (PTSD), Desert Syndrome, Gulf War Syndrome, Gulf-related illness
Iraq and Afghanistan	Moral injury

Adapted from Edgar Jones, "Historical Approaches to Post-Combat Disorders," *Philosophical Transactions: Biological Sciences* 361, no. 1468 (2006) 534.

The paper consists of three parts.

1. How war syndromes have evolved over time: leading into moral injury.
2. Common features in war syndromes.
3. Moral injury beyond PPB – psychology, psychiatry and biomedicine.

1. How war syndromes have evolved over time

Attributed causes

There is a noticeable pattern of development in the supposed attributable causes of war syndromes, in line with growing medical knowledge. Faced with a new difficult experience in war, physicians and military authorities typically went looking first, for physical causes: so, equipment got the blame initially for disordered actions of the heart (DAH) in 1876. If physical causes were lacking, the focus shifted to physiological and other medical possibilities. When no conclusive physical or physiological causes could be found, as with shell shock for example, the focus moved to possible psychological causes – a field of medicine in its infancy at the time. By the end of WW2, and the Vietnam war, psychological trauma arising from the inhumanity of war itself came to be seen as central.

So, the historical pattern is – physical, physiological, then psychological.

Moral injury was identified as the signature war syndrome of the Iraq and Afghanistan wars, and what is significant is that the attributed cause moves beyond psychological, and now to *moral* trauma.

Who gets the blame?

Likewise, moral injury provides an unexpected twist when it comes to considering who gets "blamed" for the suffering involved.

In the early 1900s, the sufferers themselves were blamed. Authorities first focused on the social class or the lack of "breeding" of individuals. The focus then moved on to suppositions about individuals' lack of courage, toughness, training, or self-discipline – sufferers were cowards or malingerers.

In WW1, the medical and military consensus was that combat experience merely triggered, rather than caused, mental health issues for personnel already predisposed to them.[2] This changed subtly but significantly with non-ulcer dyspepsia in WW2: individuals were no longer blamed for existing "wilful" weakness, yet the focus remained on the factors *internal*

[2] This was the case for the British, German and also among Australian medical establishments. British: Jones, "Historical Approaches."" 537; German: Stefanie C. Linden, Volker Hess, and Edgar Jones, "The nuerological manifesttions of trauma: lessons from World War I," *European Archives of Psyhciatry and Clinical Nueroscience* 262 (2012), https://doi.org/10.1007/s00406-011-0272-9." 253; Australian: Ruth Rae, "An historical account of shell shock during the First World War and reforms in mental health in Australia 1914 – 1939," *International Journal of Mental Health Nursing* 16 (2007), https://doi.org/10.1111/j.1447-0349.2007.00476.x." 268.

to individuals. "Ulcer type" was identified as a pre-existing condition, and it was understood that this was then *triggered* by the war. Later in WW2, with the acknowledgement that "every man has his breaking point," 'war *neurosis*' became the less stigmatising 'combat *fatigue*'. The "problem" is now at least partially externalised.[3]

This evolution was complete in "post-Vietnam syndrome". Lifton's theory of psychohistory argued that "long-term psychiatric casualties were no longer the fault of genes or upbringing, but the insanity of war itself". The injury was caused by external factors alone.[4]

Moral injury provides an unexpected twist to this evolving pattern. While moral injury arising from being betrayed (Shay) maintains the pattern of external cause, moral injury arising from perpetrating harm (Litz) returns to internal causes: sufferers are again blamed as having caused their own injury.

Moral injury thus brings some unexpected developments.

- The focus on attributable causes moves from physical, to physiological, psychological, onto *morality.*
- While "blame" has trended away from sufferers toward the inhumanity of war itself, but in perpetration linked moral injury, this swings back to *sufferers themselves.*

2. Common factors in war syndromes

Discussion now turns towards how moral injury is usefully analysed through common biopsychosocial factors that have shaped war syndromes.

They are:

[3] By latter part of World War II, military psychiatrists came to believed that even the bravest and fittest soldier could endure only so much. Katherine Boone comments: "By making psychiatric symptoms normal, the combat fatigue diagnosis freed soldiers from the stigma of neurosis. The flip side of this reclassification, however, was that it risked minimizing soldiers' very real psychic pain. Whatever its strengths and flaws, combat fatigue was the dominant paradigm in 20th-century military psychiatry until the advent of PTSD." Katherine N Boone, "The Paradox of PTSD," *The Wilson Quarterly* 35, no. 4 (2011)." 20. For more detailed description of the work by Spiegel and Kardiner see G. C. Lasiuk and K. M. Hegadoren, "Posttraumatic stress disorder part I: historical development of the concept," *Perspectives in Psychiatric Care* 42, no. 1 (2006)." 18.

[4] Lenny Grant, "Post-Vietnam Syndrome: Psychiatry, Anti-War Politics, and the Reconstitution of the Vietnam Veteran," *Rhetoric of Health & Medicine* 3, no. 2 (2020)." 192, 199.Bessel Kolk and Lisa M. Najavits, "Interview: What is PTSD Really? Surprises, Twists of History, and the Politics of Diagnosis and Treatment," Article, *Journal of Clinical Psychology* 69, no. 5 (2013), https://doi.org/10.1002/jclp.21992. 516. See also Simon Wessely, "Twentieth-Century Theories on Combat Motivation and Breakdown," *Journal of Contemporary History* 41, no. 2 (2006)." 281.

- new types of warfare;
- the culture of the time; and
- war syndromes testing advances in medical science, and its diagnostic acuity.[5]

New types of warfare

Changes in technology and military strategies are reflected in the suffering of combatants in successive wars. The changes that saw the emergence of moral injury arise from combatants' increased personal participation in more 'efficient' killing and violence.

In WW1, with artillery ranging over 8,000 metres, trench warfare became the norm.[6] Three times as many combatants were killed by shells than by bullets, shell shock was their signature war syndrome.[7]

The changes behind moral injury started a long time before Iraq and Afghanistan. 90% of muskets retrieved from the site of the Battle of Gettysburg (1863) were still loaded: Grossman argues that most soldiers were not trying to kill the enemy.[8] The firing rate of individual soldiers in WW2 was estimated as 15%; 55% in the Korean War; and 90 to 95% in Vietnam.[9] The dramatic change is attributed to the reflexive shooting methods that began to be taught after WW2. Brock and Littini observe how this training suppressed combatants' ability to exercise moral judgement, and so repeatedly exposed them to morally compromising situations.[10] As William Wold, an US Iraq veteran remembers:

> You burst into a house… I had people pointing AKs at me.
> And I was thinkin', "I have to shoot them."
> I shot six people in less than ten seconds.[11]

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[5] Jones, "Historical Approaches." 540.

[6] Howard, 42.

[7] 59% of British casualties were caused by artillery fire. Jones, "Historical Approaches."" 540. See also Stefanie C. Linden and Edgar Jones, "'Shell Shock' Revisited: An Examination of the Case Records of the National Hospital in London," *Medical History* 58, no. 04 (2014), https://doi.org/10.1017/mdh.2014.51." Cited in Jones, "Historical Approaches," 534.

[8] LTCOL Dave Grossman, *On Killing: The psychological cost of learning to kill in war and society*, June 2009 ed. (New York, NY: Back Bay Books, 2009). 25.

[9] Grossman, *On Killing*. 36-37.

[10] Rita Nakashima Brock and Gabriella Lettini, *Soul Repair: Recovering from Moral Injury after war* (Boston, USQ: Beacon Press, 2012). xvii.

[11] Kevin Sites, *The things they cannot say: stories soldiers won't tell you about what they've seen, done or failed to do in war* (New York, NY: Harper Perennial, 2013). 37. There is no shortage of personal accounts of moral injury, attributed to this type of experience from Iraq and Afghanistan. For example, David Wood, *What have we done: the Moral Injury of our longest wars* (New York, USA: Little, Brown and Company, Hachette Book Group, 2016). Robert Emmet Meagher and Douglas A. Pryer, eds., *War and Moral Injury: A Reader* (Eugene, OR: Cascade Books, 2018). There are also other factors, such as guerrilla (Vietnam), and insurgency warfare

The experience of war fighting is significantly altered again, from that of sitting in the trenches, to combatants firing reflexively, only to realise that they have killed civilians, women and children.[12]

The culture of the time

The second of Jones' common biopsychosocial factors is the close relationship of each war syndrome to "the culture of the time" - concerns and preoccupations common to both civilian and military communities.[13] Thus "Non-ulcer dyspepsia" as a war syndrome emerged in the UK against a background of more patients being admitted to hospital with peptic ulcer than any other diagnosis by 1944.[14] Again, Gulf War Syndrome (GWS) and Agent Orange emerged against heightened public awareness of environmental toxins.[15]

Similarly, societal awareness of *trauma* is the background for moral injury. Since its inclusion in DSM-III (1980), PTSD has become the fifth most prevalent disorder in the USA, and "PTSD" and "trauma" have become everyday public vocabulary.[16] It is estimated that 60-90% of US adults experience potentially traumatic events in their lifetime, and 29% of these

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(Iraq and Afghanistan) where the distinction between the civilian population and combatants also become extremely blurred.

[12] The use of UAVs for targeted killing has also been cited as a cause for moral injury among operators who have not even set a foot into the warzone. Yet, they see clearly the devastation and killing they unleashed through the camera on the drones they unleashed. Nicola Abé "Dreams in Infrared: The Woes of an American Drone Operator," *Spiegel Online*, no. December 14 (2012).

[13] Jones, "Historical Approaches." 540.

[14] Gastric and duodenal ulcers were the principal health concern in British civilian community and both physicians and patients were on the lookout for any likely symptoms as well as seeking to prevent the disease. Edgar Jones, "'The gut war': Functional somatic disorders in the UK during the Second World War," *History of Human Sciences* 25, no. 5 (2012), https://doi.org/10.1177/0952695112466515." 4. Ian Miller, "The Mind and Stomach at War: Stress and Abdominal Illness in Britain c.1939–1945," *Medical History* 54, no. 1 (2010), https://www.ncbi.nlm.nih.gov/pubmed. 109.

[15] Minamata disease (1969-1973): M. Harada, "Minamata disease: methylmercury poisoning in Japan caused by environmental pollution," *Crit Rev Toxicol* 25, no. 1 (1995), https://doi.org/10.3109/10408449509089885. Bhopal accident (1984 – 500,000 people exposed to methyl isocyanate gas): Edward Broughton, "The Bhopal disaster and its aftermath: a review," *Environmental Health* 4, no. 1 (2005), https://doi.org/10.1186/1476-069X-4-6, https://doi.org/10.1186/1476-069X-4-6. Chernobyl accident (1986): Jacob I. Fabrikant, "The Chernobyl Disaster: An International Perspective," *Industrial Crisis Quarterly* 1, no. 4 (1987), https://doi.org/10.1177/108602668700100401.

[16] 1984 conceptualisation of PTSD for DSD-III brought together growing research on several different trauma experiences such as those of "battered women, rape victims, and abused children". Shoshana Ringel and Jerrold Brandell, *Trauma: Contemporary directions in theory, practice, and research* (SAGE Publications, Inc., May 31, 2012, 2012). 5. The current iteration, DSM-5TR (2022) is supported by a vast body of research that continues to evolve and grow. Furthermore, Wessely calculated that DSM-5 offers 636,120 possible combinations of symptom presentations for PTSD: that DSM-5 groups together an unusually wide variety of presentations leads to this astonishing statistic. In DSM-IV there were 79,794 possible symptom presentations. Charles B. Nemeroff et al., "DSM-5: a collection of psychiatrist views on the changes, controversies, and future directions," Article, *BMC Medicine* 11, no. 1 (2013), https://doi.org/10.1186/1741-7015-11-202." 6.

suffering from PTSD.[17] But the concept of trauma has now moved beyond the fear and anxiety-based trauma of PTSD. The new trauma is *moral* trauma: of being betrayed (Shay), and of those who perpetrate, acquiesce in, or witness violence in war (Litz).

Testing medical science

Thirdly, war syndromes are often found at the advancing edge of medical science, testing existing diagnostic acuity .[18] When shell shock was observed, no medical imaging was available to find supposed lesion(s) in the spine as the possible cause, for example.[19] When DAH was a problem, portable electrocardiogram (ECG) equipment did not exist.[20] Again, a commercially available flexible endoscope to differentiate gastric/duodenal ulcers from non-ulcer dyspepsia was not produced until 1960, far too late for WW2.[21]

This is also the case with moral injury. Even though, it was the psychologists and psychiatrists who first identified moral injury, it quickly became obvious that the suffering could not be classified as a psychological disorder, because it involved morality, beliefs and values.[22] Moral injury was seen to lie off the edge of the fields of psychology and

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[17] Even the availability of statistics like these is an indication of how trauma has become an important part of public awareness in the USA, and supposedly also in countries like Australia, the UK and Canada. Research into trauma has been steadily growing since the time of Freud and Breuer in the era of shell shock. M. M Rigoli et al., "The role of memory in posttraumatic stress disorder: Implications for clinical practice," *Trends in Psychiatry and Psychotherapy* 38, no. 3 (2016), https://doi.org/http://dx.doi.org/10.1590/2237-6089-2014-0063. Ringel and Brandell, *Trauma*. 2.

[18] Jones, "Historical Approaches." 540.

[19] The discussion eventually moved on to psychological explorations initiated by researchers such as Jean-Martin Charcot, a neurologist, who in1882 suggested new diagnostic terms such as “névrose traumatique” and “hystérie traumatique”. Charcot argued that railway accident or war could serve as a trigger (“agent provocateur”) in individuals with an inherited disposition or “diathése”. Even there, however, while theories and experiments multiplied, no decisive evidence could be found. See detailed discussion in Edgar Jones and Simon Wessely, "A paradigm shift in the conceptualization of psychological trauma in the 20th century," *Journal of Anxiety Disorders* 21 (2007), https://doi.org/10.1016/j.janxdis.2006.09.009. 165-6. The debate on shell shock in the UK continued without any resolution, and the British Government’s novel solution in 1922 was to discontinue the use of the term, to eliminate “shell shock” from official nomenclature! Southborough Commission report, 1922. Jones, "Historical Approaches." 537

[20] An experimental ECG machine was produced towards the latter period of World War I. Its inventor, Willem Einthoven, won a Nobel prize in 1924, yet it weighed 275 kg and required five technicians to operate it. Salvatore Emma Jr, "A Brief Look at ECG Sensor Technology," Article, *Medical Design Technology* 15, no. 6 (2011).

[21] Various attempts were made as early as 1809 in developing equipment for this purpose. C. B. Morgenthal et al., "The role of the surgeon in the evolution of flexible endoscopy," *Surg Endosc* 21, no. 6 (Jun 2007), https://doi.org/10.1007/s00464-006-9109-4.

[22] Some, however, argue for moral injury to be conceptualised as a psychological disorder. Griffin et al., “Moral injury – An Integrated Review,” 357.

psychiatry.[23] While reliable diagnostic tools were quickly produced, PPB vocabulary and language remain inadequate to fully engage in discussing beliefs and values.[24]

3. Moral injury: beyond PPB

The last part of this paper offers some specific examples of the inadequacies of PPB, especially in relationship to moral repair.

First, while using the terms guilt and shame, PPB language does not make a clear distinction between the *status* and *emotions* of guilt. Furthermore, PPB strategies towards moral repair are often limited to addressing the latter, emotions of guilt even seeking to numb or eliminate them, but without engaging the question of guilt as a status.[25] The serious difficulty here is that even though morality lies just beyond the field of PPB, it yet has inseparable connections with them. Powers' monograph, *Full Darkness* offers an extensive treatment on this point.[26]

Secondly, in common usage, Shay's seeing moral injury as a betrayal of *"what's right"* needs care, that is to say that the meaning and nature of "what's right" is rarely explored in typical discussions of moral injury - but assumed to be obvious.[27] Yet, the work

[23] "Psychological theories of moral injury such as that of Litz and colleagues can be insightful and clinically useful, but on their own terms they cannot treat moral injury as anything other than an imminent, psychological phenomenon involving not a fragmentation of an ideological whole but transgression of a soldier's own internalized rules and assumptions. Because their empirical suppositions do not allow them to pass moral judgment on these rules and assumptions or to speak directly about teleology, they are unable to distinguish between meaningful and nonmeaningful moral suffering, so reduction of self-described suffering, measured empirically, becomes the primary goal of the clinical encounter." Warren Kinghorn, "Combat trauma and moral fragmentation: a theological account of moral injury," *Journal of the Society of Christian Ethics* (2012). 67,

[24] An eleven item Moral Injury Event Scale (MIES) was developed by William Nash et al., and a twenty item self-reporting instrument, Moral Injury Questionnaire – Military version (MIQ-M) by Joseph Currier et al. The latter also developed a 45 item self-reporting inventory for use for veterans with PTSD symptoms, the Expressions of Moral Injury Scale—Military Version (EMIS-M). W. P. Nash et al., "Psychometric evaluation of the Moral Injury Events Scale," *Mil Med* 178, no. 6 (Jun 2013), https://doi.org/10.7205/MILMED-D-13-00017; J. M. Currier et al., "Initial Psychometric Evaluation of the Moral Injury Questionnaire-Military Version," *Clinical Psychology & Psychotherapy* 22, no. 1 (2013), https://doi.org/10.1002/cpp.1866; Joseph M. Currier et al., "Development and evaluation of the Expressions of Moral Injury Scale—Military Version," *Clinical Psychology & Psychotherapy* (2017), https://doi.org/doi:10.1002/cpp.2170, https://onlinelibrary.wiley.com/doi/abs/10.1002/cpp.2170.

[25] An empty chair conversation with a "benevolent moral authority" in Adaptive disclosure therapy seeks to address this issue of the status of guilt. Brett T. Litz et al., *Adaptive Disclosure: A new treatment for military trauma, loss and moral injury* (New York, USA: The Guilford Press, 2016). 126.

[26] Brian S. Powers, *Full Darkness: Original Sin, Moral Injury, and Wartime Violence* (Grand Rapids, MI.: Wm. B. Eerdmans Publishing Co., 2019).

[27] In the original context of Shay's usage in 1994, "what's right" was understood in the very specific context of US military. These related to US military ethos and training, both stated and unspoken. Shay indicates what he considers "what's right" as he offers and proposes concrete and specific policy changes. Taken out of its original context, however, the term loses its original clarity. Jonathan Shay, *Odysseus in America: Combat Trauma and the Trials of Homecoming* (New York: Scribner, 2002). 263.

of an anthropologist Tine Molendjiik shows that this is far from the case - individuals often hold sets of internally contradictory moral values formed at distinct levels and different contexts of their lives.[28] Moral values must be thought of, beyond the binary – the *either or thinking* - of “what’s right” and “what’s wrong”. The reality is much more complex.

Thirdly, inherent in PPB perspective is individualism, reflective of the patient/doctor relationship as its primary context. Moral injury is then understood, primarily, in terms of the individual’s morality: therefore, when seeking to address betrayal-based moral injury, this often takes the shape of *my* moral standard, against *their* lack of morality. External causes are then blamed for the injury: “it’s their fault”. Thus, it is maintained that the institutions and cultures that did them harm, must be reformed as a way of preventing future injuries, and also make restitution to those who are injured. While these observations are generally helpful, perspectives beyond the individualism of PPB show that individuals must be understood as intimately linked to their social contexts:

> Individuals are formed/deformed by their context, but they also participate in forming/deforming the very environment that form/deform – and perhaps - injure them.

Carefully considered ontology and sociology beyond PPB are needed if moral repair is to begin.

Conclusion

Historical approaches highlight the importance and primacy of the *moral* aspect of moral injury.

The challenge is that moral injury shares with the rest of war syndromes, one of their most frustrating features, that the core of the injury – the moral part – remains out of reach, when PPB vocabulary and language alone is used, thus limiting the capacity of PPB approaches to engage fully with the suffering involved, and further moral repair.

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[28] “[Morality] is not only an intra-individual matter, it is also present in different social levels (groups, organisation, nation) and in different social contexts (ethnic cultures, social and professional subcultures). An individual lives and acts on a daily basis within a range of these - often overlapping and sometimes opposing - social levels and contexts. As a result, an individual incorporates multiple sets of values and norms, which may correspond but also contradict one another.” Tine Molendijk, Eric-Hans Kramer, and Désirée Verweij, "Moral Aspects of 'Moral Injury': Analysing Conceptualizations on the Role of Morality in Military Trauma," Journal Article, *Journal of Military Ethics* 17, no. 1 (2018). 41.

Beyond language, historical analysis also shows that inter and multi-disciplinary approaches are essential in moving research and practice forward.

And as a post-script, I would add that theological understanding of human brokenness, and biblical exploration of God's grace has so much more to contribute to Christian exploration of moral injury.

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