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MORAL INJURY

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The term *moral injury* has recently begun to circulate in the literature on psychological trauma. It has been used in two related, but distinct, senses; differing mainly in the "who" of moral agency. Moral injury is present when there has been (a) a betrayal of "what's right"; (b) either by a person in legitimate authority (my definition), or by one's self—"I did it" (Litz, Maguen, Nash, et al.); (c) in a high stakes situation. Both forms of moral injury impair the capacity for trust and elevate despair, suicidality, and interpersonal violence. They deteriorate character. Clinical challenges in working with moral injury include coping with [1] being made witness to atrocities and depravity through repeated exposure to trauma narratives, [2] characteristic assignment of survivor's transference roles to clinicians, and [3] the clinicians' countertransference emotions and judgments of self and others. A trustworthy clinical community and, particularly, a well-functioning clinical team provide protection for clinicians and are a major factor in successful outcomes with morally injured combat veterans.

Keywords: veterans, moral injury, trust, character, Homeric epics

For 20 years, I was the sole psychiatrist for a small U.S. Department of Veterans Affairs (VA) Boston Outpatient Clinic component known as the Veterans Improvement Program (VIP). It had been founded 10 years before my arrival to cope with the most troubled and troubling Vietnam veterans. Over time, it morphed from a partial hospitalization program to an intensive long-term outpatient program, narrowly specializing in psychologically and morally injured combat veterans. Its concepts, practices, and location in the institutional ecology are fully described in a chapter that one of the founders of VIP and I contributed to the Saigh and Bremner text *Posttraumatic Stress Disorder: A Comprehensive Text* (Shay & Munroe, 1999). The present piece is in the personal voice I developed while there; my patients did not trust me when I spoke in the unlocated, God-speaking-from-the-edge-of-of-the-universe voice of the expert. I can no longer inhabit that voice.

Starting sometime after 1995 (I can't date it more precisely without mining old hard drives), but continuing after retirement from the VA and clinical work, I have also worked

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with active military services, not as a clinician, but as an advocate for changes in policy, practice, and culture aimed at preventing psychological and moral injury. Dialogues with active military people have partly been in a paid capacity—such as performing the Commandant of the Marine Corps Trust Study for General Jim Jones, or in serving as Chair of Ethics, Leadership, and Personnel Policy in the Office of the Army Deputy Chief of Staff for Personnel or as the 2009 Omar Bradley Chair at the Army War College—and partly as an unpaid missionary from the veterans I served as a psychiatrist. I have also spoken with Canadian, British, and German forces. I spoke in my own voice to these audiences, and I shall do so here, with all its wake-you-up bumps from one level of diction to another. I speak to all these audiences for the veterans I have served; they do not want other young kids wrecked the way they were wrecked in Vietnam.

That's where I'm coming from and what I've been up to. The topic at hand is moral injury—a term that apparently I coined in mental health—and its treatment. I will offer some thoughts about the clinical resources and the conditions I believe are needed to address it successfully.

My version of moral injury is something we can do something about. It is, to a degree, within our control. When I do my full military prevention riff on Cohesion/Leadership/Training, I spell out the need for leadership to be *expert, ethical, and properly supported*. These three aspects are very sensitive to policy and practice, and thus offer opportunities to lift the average level of ethical performance of military leaders, but this is not the place to go into that further.

Here's my version of moral injury, derived from my patients' narratives and from Homer's narrative of Achilles in the *Iliad*. Moral injury is:

- A betrayal of what's right.
- by someone who holds legitimate authority (e.g., in the military—a leader).
- in a high stakes situation.

All three.

The nature and importance of moral injury first crystallized for me from Homer's *Iliad,* resulting in a little didactic article on taking a decent combat history that appeared in the *Journal of Traumatic Stress* (Shay, 1991). This then evolved into the book *Achilles in Vietnam* (Shay, 1994). The narrative of Achilles in this poem is a story of moral injury. Homer scholar Johannes Haubold shows that the relationship of leader to his people is a crucial theme linking the *Iliad* and *Odyssey*—two poems that are otherwise famously dissimilar; *people* here refers to the key term λαός (*laos*). Haubold (2000) says in the book's conclusion:

> Early Greek epic sings about the incurably vulnerable nature of the *laoi.* Their defining structure [the leader]. . .fails. [It is] encapsulated in the metaphor of "the shepherd of the people" (ποιμήν λαων). . . . The leaders are said to have "destroyed the people." (p. 195)

The Iliadic troops are almost always the *laos,* for which the leaders Agamemnon, Achilles, Odysseus, and Hector have a shepherd's fiduciary responsibility, and all four fail catastrophically in their separate ways and for their separate reasons. The *Odyssey* uses the word *laos* only rarely outside Books 2–4, referring instead to Odysseus' Ithacan troops/crews as "companions" and to the Ithacans remaining behind as "suitors." Tellingly, the suitor Eurymachus pleads for the lives of the remaining suitors, using the word *laos* in the moment after Odysseus puts an arrow through the neck of Antinous, the most villainous suitor. Eurymachus says, "Then spare your people (λαων), your own ones" (*Od.* 22.54 as

cited in Haubold, 2000, p. 119). And just before the brief final battle of the *Odyssey,* in Book 24, Eupeithes, the father of the same Antinous, whips up his lynch posse with the words, "First he [the leader] took many excellent men away in the vessels with him [to Troy], and lost the hollow ships and destroyed the people (λαούς)" (*Od.* 24.427 ff. as cited in Haubold, 2000, p. 108).

A number of clinician-researchers, among them Brett Litz, Shira Maguen, and William Nash, have done an excellent job of describing an equally devastating second form of moral injury that arises when a service member does something in war that violates their own ideals, ethics, or attachments (See Figure 1.). The DSM diagnosis, Posttraumatic Stress Disorder (PTSD), does not capture either form of moral injury. PTSD nicely describes the persistence into life after mortal danger of the valid adaptations to the real situation of other people trying to kill you. However, pure PTSD, as officially defined, with no complications, such as substance abuse or danger seeking, is rarely what wrecks veterans' lives, crushes them to suicide, or promotes domestic and/or criminal violence. Moral injury—both flavors—does.

We have been carefully taught to believe that good character cannot change in adulthood. This belief has a brilliant pedigree. It starts with Plato and runs through the Stoics, Kant, and Freud. It says, if you make it out of childhood with "good breeding" (Plato's term; today we would say "good genes") and good upbringing, then your good character is set by the end of childhood. No bad experience can break it. The trouble with this lovely idea is that it is bunk. The classic [pun intended] discussion of this by a philosopher is Martha Nussbaum's (1986) *The Fragility of Goodness*.[1]

Over the years, the American Psychiatric Association (APA) has rejected every diagnostic concept that even hints at the possibility that bad experience in adulthood can damage good character. It has rejected what numerous clinicians following Judith Herman, MD and Mary Harvey, PhD call "Complex PTSD," but which the APA atrociously named in its field trials, "Disorders of Extreme Stress Not Otherwise Specified (DESNOS)." It has rejected "Enduring Personality Change after Catastrophic Experience," which is a current diagnosis in the WHO International Classification of Diseases, and "Post Traumatic Embitterment Disorder." The latter diagnostic construct is the work of Professor Michael Linden's group at the Free University of Berlin and Charité in Berlin. He and his colleagues have a vast body of clinical and research data on the often devastating psychological consequences of having one's honorable and respect-worthy life trajectory shot out of the sky, such as was nonviolently inflicted on hundreds of thousands in the former German East zone upon reunification. I do not refer to the Stasi here, but to sanitary engineers, fine optics makers, and so forth. I believe the stubborn APA opposition comes from American attachment to this old philosophic position with its brilliant pedigree, not from empirical facts, which abundantly show the opposite.

Like physical injuries, moral injuries of the kind described by Litz, Nash, Maguen, and others in their now numerous publications on moral injury strike in every war. I discussed this in *Achilles in Vietnam: Combat Trauma and the Undoing of Character* (Shay, 2002) under the heading "moral luck," a term used by ethical philosophers such as Bernard Williams and Martha Nussbaum.

What I have to say complements what Litz, et al. (2009) have described, differing primarily in the "who" of the violator. In their definition the violator is the self, whereas in mine the violator is a powerholder. To date, the only symptomatic difference between

[1] See particularly the last chapter, "Hecuba."

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

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

Figure 1. What is missed by current conceptions of PTSD?

the syndromes arising from moral injury as I define it and that of Litz, et al. is that they report that physiological arousal is not part of moral injury. From my observation, where leadership malpractice inflicts moral injury, the body codes it as physical attack, mobilizes for danger and counterattack, and lastingly imprints the physiology every bit as much as if it had been a physical attack. Nevertheless, both are important; both can coexist; and one can lead to the other in any order. Think of a situation where an infantry Marine is ordered to leave behind a wounded buddy and the Marine obeys the order; or think of sexual coercion by your rating senior in the chain of command targeting one of your subordinates, and you fail to protect her or him.

By contrast, here is a combat incident alone that might cause moral injury as Litz, et al. define it. This was told to me at a Marine Corps Combat and Operational Stress Control conference in San Diego as an incident that happened at Fallujah. A Marine scout-sniper team was supporting a Marine infantry unit that had taken several casualties from a well-hidden and effective enemy sniper. My understanding is that the typical Marine team is two: the shooter and the spotter; they have different roles at given moments of engagement, but both Marines are trained to perform both functions, and often swap. The Marine sniper eventually found and identified the enemy sniper in his scope and could see that he had a baby strapped to his front in a sling we would call a Snuggly. The Marine believed that the enemy was using this baby as a "human shield," although other interpretations were possible [for example, "I want my son to join me in Paradise," that is, martyr thinking, or "If I am dead, there will be nobody to protect and look after him—if I die, he will die" (cf. Hector/Astyanax in the *Iliad* or Odysseus/Telemachus in the *Odyssey*)]. However, the point here is not the enemy sniper's thinking, but the Marine's. The Marine sniper's understanding of the then-current Rules of Engagement and of the

Law of Land Warfare was that shooting the enemy sniper was permissible, even if the baby could be foreseen to die unintentionally in the process. His understanding of his job description and his duty to the Marines he was supporting was to make the shot, which he did. He saw the round land, and will probably live with that memory the rest of his life.

How does moral injury change someone? It deteriorates their character; their ideals, ambitions, and attachments begin to change and shrink. Both flavors of moral injury impair and sometimes destroy the capacity for trust. When social trust is destroyed, it is replaced by the settled expectancy of harm, exploitation, and humiliation from others. With this expectancy, there are few options: strike first; withdraw and isolate oneself from others (e.g., Achilles); or create deceptions, distractions, false identities, and narratives to spoil the aim of what is expected (e.g., Odysseus).[2]

In *The Mourner's Song: War and Remembrance from the* Iliad *to Vietnam*, James Tatum (2003) offers the novel argument that the *Iliad*'s point of view is that of the excellent leader, compared to whom Agamemnon, Achilles, and Hector all fall short. I was not convinced of his thesis until rereading Haubold's (2000) *Homer's People* in preparation for this piece. The key is the fiduciary duty embodied in the expression "shepherd of the people." Anticipating the cry, "Anachronism!," that my argument may call forth when I attribute a fiduciary duty to the Homeric military leaders, I note that Haubold meticulously documents textual evidence that the moral world of the Homeric poems held leaders to obligations that today we would recognize as the duties of a fiduciary: to take care attentively ("duty of care"), and to subordinate their own interests to those of the person or persons in their care should they conflict ("duty of loyalty").

The *Iliad* and Demodokos' first song in *Odyssey* 8 show Agamemnon as an almost perfectly bad leader—with one important exception, that he was personally brave and shared the lethal risks of combat with the rest of his forces. He did not orbit in his helicopter at 6,000 feet, yelling instructions into the radio for his people down in the mud as some higher commanders did in Vietnam. Otherwise, the whole tragedy of the *Iliad* had been kicked off in Book 1, by Agamemnon's breathtaking twin violations of his army's moral order. First, he impiously—and with disgusting crudity—rebuffed ransom for the captive girl, Chryseis, from her father, the priest of Apollo. Then, he publicly dishonored his most esteemed, most effective subordinate commander, Achilles, in front of the troops by seizing Briseis, Achilles' *geras,* his "Medal of Honor." What Agamemnon did to Achilles was no private wrong. There are no private wrongs in the use of military power. All people watch the trustworthiness of those who wield power over them—all the time.

Odysseus, in contrast, displays a mixture of both good and bad leadership in the *Iliad.* Odysseus is, as Homer says, *polytropos,* many-sided, mixed, multicolored, and piebald. He is a mixture of outstandingly good and outstandingly bad military traits. His night reconnaissance with Diomedes behind Trojan lines in Book 10 of the *Iliad* condenses, in a single episode, Odysseus' contradictory blend of brilliance and failure. During this exceedingly dangerous mission, Odysseus and Diomedes discover the Trojan order of battle and learn that Hector and his top commanders are conferring unguarded by the tomb of Ilos. We know that Odysseus is armed with a bow and that he is capable of very rapid, accurate fire. So why do Odysseus and Diomedes not decapitate the Trojan leadership or

[2] I do not imply that all of Odysseus's off-color character formation comes from moral injury in war. In *Odysseus in America (*Shay, 2002, pp. 140-144), I discuss the textual evidence that Odysseus also carried a pathogenic load of childhood trauma, particularly the episode in puberty when his career-criminal grandfather, Autolycus, almost gets him killed in a boar hunt, scarring him for life, physically and perhaps psychologically.

even try? Greed gets in the way. Diomedes wants to go after the tired and newly arrived Thracians for their booty, and Odysseus, famous for greed, never says, "Whoa! Let's keep our eye on the ball." He is the senior man of this duo, and without hesitation wholeheartedly goes for the loot. He has lost sight of the military purpose of the night reconnaissance. He puts self before mission, forgetting that there is a good chance that the next morning the Greeks will be thrown out of their beachhead and all slaughtered—as Nestor had earlier warned, when he asked for volunteers to do this night's reconnaissance.

Odysseus and Diomedes find the Thracian bivouac, kill the Thracian king and some of his sleeping soldiers, and race away with the king's glorious team and chariot, outrunning the hue and cry. They drive into the Greek beachhead. Amid all the crowing and congratulations on their flashy prize and the relief that both Odysseus and Diomedes have returned safely, nobody debriefs them for the intelligence needed for the next day's fight. Remember, the whole army is in danger of being thrown into the sea and annihilated. Book 10 ends with the two warriors having a hot bath and a stiff drink. The next day, on the verge of disaster, the Greeks are saved, not by intelligence from the night reconnaissance, but by Achilles' release of fresh troops under Patroclus, who take the Trojans by surprise on the flank.

The figure of Odysseus is a troubling and multifaceted example of leadership malpractice from modern American military officers' perspective. It would be less troubling if he were not so brilliantly gifted in several areas of military functioning. You can look at a "Summary of the Charges against Captain Odysseus" in *Odysseus in America,* a mock charge sheet for his court martial, which also summarizes the mitigating examples of his outstanding contributions to the cause (Shay, 2002, p. 236). But, Odysseus might be even more troubling to enlisted ranks who pay the butcher's bill for military malpractice of the sorts that Homer portrays.

The Homeric texts permit us to learn new things about modern veterans who have physically survived their Odysseus and, going the other way, to learn about the Homeric texts and their ancient reception. I believe, for example, that the portrayal of Odysseus as a "stage villain" (Stanford, 1968, p. 102–117) by the Athenian tragic poets reflects the war veteran origins of the Athenian poets, actors, and audience (Shay, 1995). Similarly, the reception of Achilles throughout classical Greece, including Athens, as an object of grieving veneration taps into other aspects of military experience; namely, the grief and sense of vulnerability that grips a unit when its most effective leader and fighter is killed. Harvard Professor Gregory Nagy (1979) writes:

> We know from ancient sources that the traditional ceremony inaugurating . . . [the Olympic Games] centers on Akhilleus: on the day before the Games are to begin, the local women of Elis, the place where the Olympics were held, fix their gaze on the sun as it sets into the Western horizon—and begin ceremonially to weep for the hero (p. 114).

Whereas in *Odysseus in America* I summarized the case for Odysseus' court martial using data derived from both epics. In *Achilles in Vietnam,* I summarized the abundant data scattered throughout the *Iliad* that Achilles had been an exemplary soldier and leader prior to our first sight of him during Book 1, in which he was so publicly dishonored by Agamemnon and deserted, rather than kill Agamemnon as "payback" for the dishonor.

The experiences of real soldiers and real veterans have greatly heightened our ability to hear what musicians call the "inner voices" in the complex music of these compositions. In the *Odyssey,* the in-your-face theme in the brass is, "Odysseus is not to blame—his people brought destruction upon themselves." Only by consciously attending to the other

instruments do you hear, "He destroyed the people!" In the *Iliad,* the announced theme is, "Achilles brought pain, suffering, and death on the people," but a second theme in another key weeps, "This was the tragedy of Achilles at the hands of the leader Agamemnon."

Now I put on my clinician hat: What are the take-home messages for clinicians regarding moral injury? I cannot hope to say everything that needs to be said here and, instead, refer the reader to the long clinical chapter in the Saigh and Bremner textbook on PTSD (Shay & Munroe, 1999). What is most meritorious in this chapter was either invented or rediscovered by Jim Munroe, the late Lillian Rodriguez, Lisa Fisher, and Michelle Klopper in the 10 years before I came to the VA. I mainly deserve credit for not destroying it, as the psychiatrist replacing Dr. Rodriguez after her death. I realized that something amazing was going on in that grubby VA day treatment center, and that I wanted to learn it. Other than that, I just added some intellectual lip-gloss. But I do want to touch on a few highlights here.

First, last, and always, the question of trust is on the table, regardless of what forms of moral injury are in play. "Why should I trust *you*?" is a question asked, both verbally and behaviorally, a thousand times in the course of clinical work with every morally injured veteran. This often creates major problems for clinicians. Psychoanalytically minded, and for sure, psychoanalytically trained, clinicians think a lot about transference and countertransference. Anyone doing clinical work with morally injured combat veterans better think about it. Every such veteran has three questions he or she urgently needs answered:

1. What's your game? (i.e., What do YOU get out of this?)
2. Do you know your ass from a hole in the ground?
3. Will you respect me, my experience, and the questions I ask?

These questions together ask, "Who are you?"

1. Are you another *perpetrator*?
2. Are you a *victim* like me? (If so, what the hell good are you?)
3. Are you a self-serving *bystander* who enables or turns a blind eye to the perpetrator?
4. Are you a *rescuer*? (Heaven help the clinician who becomes hooked in this transference/countertransference trap.)

You can think of these—perpetrator, bystander, victim, and rescuer—as the only personae that Central Casting has to send into the life of a survivor of moral injury. Once the survivor can even imagine the clinician as a freely cooperating *partner,* the survivor's recovery is well advanced.[3] This all makes sense when you recall what fills the vacuum when trust is destroyed: expectancy of harm, exploitation, and humiliation. No wonder the bearer of moral injury looks for such personae.

Bombarded with invidious "Who are you?" questions—whether put directly, suspiciously, hostilely, sideways, or behaviorally in scenarios scripted by the veteran to test the

[3] I firmly believe I heard this from Mary Harvey, PhD and/or Judith Herman, MD almost two decades ago when I attended (and occasionally presented at) the weekly Victims of Violence clinical conferences at Cambridge Hospital (Cambridge, MA). When I fact-checked this with Dr. Harvey, she said, "No." It may be my "preconscious elaboration" of a part of her very important article (Harvey, 1996), which appeared during that period.

trustworthiness of the clinician, it is no wonder the clinician could find the veteran hateful and react with countertransference aversion, anger, or lofty detachment. Some of the veterans in VIP were referred to us from other VA clinicians with words like, "Get this guy the f**k away from me!"

Here we encounter one of many places that the group—a social nexus in the clinical setting greater than the dyad of the clinician and the patient alone in the latter's office—proves indispensable in this work. Much of the heavy lifting in the VIP program was done in the group therapies and when veterans were hanging out together in the milieu. The group is necessary not only for morally injured veterans, but for the clinicians working with them as well.

From the veteran's side, having social support and recognition from brother veterans in the clinic is an essential empowerment. As Drs. Herman and Harvey have said repeatedly, these kinds of trauma arise from an ecology of power. Empowering survivors of moral injury by supporting and fostering the development of veteran bonds enormously strengthens the hand of clinicians who work with them, rather than seeing these bonds as a danger.

Some clinicians, but particularly clinician-administrators and lay administrators alike, seemed nervous about clinician support for veteran cohesion, responding as a mill owner might to one of his foremen promoting a union: fear and rage. Their fears are not entirely baseless. Whenever we witness social solidarity and support develop among formerly unconnected people, we witness the development of social power where none had existed before. However, support and recognition by peers is an essential ingredient of recovery from moral injury. You don't get recovery without social connection. "Recovery happens only in community" was our slogan at VIP, where community was initially the community of other veterans in the program.

Administrators also loathe clinicians' need for the time-consuming meetings of a treatment team. The number of clinician hours necessary for a clinical team to do this work safely for the veterans and for themselves is high, given the need for a rather intensive schedule of team meetings at which every member of the clinical team must attend and engage faithfully and fully, including the highest cost "help," the psychiatrist and the doctoral-level clinical psychologist. To function safely and effectively, a clinical team must be much more than a list of names on a paper and a mechanism of social control for the institution to enforce its "business model" and other norms and decisions. The institutional leadership in turn needs some tranquility about the social power created *ex nihilo* by this cohesive clinical team within the institution.

If all of this sounds expensive, it is. But so is suicide and incarceration; so is crime itself, if only the losses and injuries to the victims, not to speak of policing, courts, and incarceration; so is domestic political terrorism—all some of the devastating consequences of unhealed moral injury. (Every administrator can say, sotto voce, "but not out of MY budget!") Adequate institutional support for effective team functioning is not only a success factor in working with such patients, but also an "occupational health and safety" issue. This comes from two facts about this work:

- A diet of horrific trauma survivor narratives can damage the mental health of the clinicians who work with them.

- "Splitting" and other adaptive strategies employed in the clinical setting and elsewhere by survivors of "conditions of coercive control" (Judith Herman's term) or moral injury can pit the clinician against some other—sometimes another clinician, sometimes an administrator, or sometimes outsiders such as the press, a Congressman, or the veteran's spouse or parents. If

not worked out by team process, such as comparing notes on what a veteran said and how he said it, splitting can damage clinicians and their clinical work.

I shall discuss the first more briefly than the second, as the consequences of working with trauma have been so widely discussed over the years, both in the context of countertransference and in such terms as *vicarious trauma* or *secondary traumatic stress*.

Clinicians' emotional and behavioral reactions to trauma survivors' narratives are best handled within the clinical team, functioning here as peer supervision. Good team functioning is occupational health and safety in the mental health workplace, not group therapy. However, essential materials and energies of our work are personal and not reliably embodied in formal credentials and institutional position. The usual attitude of institutional administrations is to say, "You have the MD and psych specialty training or other clinical credentials in psychology or social work: There are the veterans, go to work." I submit that we are very poor at predicting how effectively a clinician can do this work from how this clinician looks on paper beforehand.

In a well-functioning team, all members have a well-founded confidence that they can safely own feelings and projections about each other for the work to succeed. In general, morally injured veterans only trust clinicians one-by-one, and can tentatively extend trust to the whole team if it is functioning well. Generalization beyond that to the clinical service, to the whole medical center, or to the whole VA is sometimes "a bridge too far."

A key team quality is a culture of *safe struggle,* with equal emphasis on both words. There is an infinity of real differences among members of a clinical team: age, gender, race, religion, clinical discipline, income, wealth/financial stress, marital status, parental status, history of military service, exposure to traumatic experience, and kinds and degrees of institutional power and prestige within which the clinical activity takes place. Team members must be able to do their interpersonal and emotional work safely with each other, for patients split us along fissures that we pretend do not exist. I have witnessed long-time colleagues who love and respect each other flare in naked hatred when a veteran has successfully split them. Our view was that this veteran is not evil or being difficult, but simply using survival strategies that served them under earlier, traumatic conditions of coercive control to test our trustworthiness and, failing that, to open a tiny incremental space of autonomy for himself. Everyone on a prison tier and in a badly led military unit learns this strategy either by observation or his own invention, as do children in domestic battering and incest-bound families.

Well-practiced, the clinical team model described here thus covers two generic mental health threats to clinicians doing this work: (a) the cumulative or acute toxic effects of hearing trauma narratives of horror, cruelty, mayhem, and depravity and (b) the destructive impact of being assigned roles in the veterans' emotional worlds and of their behavioral tests of trust. Good social functioning in the clinical microcommunity is occupational health and safety in the mental health workplace.[4]

As has been evident in my work with veterans and in my reading of Homeric texts, moral injury as I have defined it is a byproduct of war as long as war has existed. We can conjecture that the same is true of moral injury as Litz, et al. (2009) have defined it, but the literary, and thus historic, footprints are not as easily discernable. As I define it, failures in leadership lead to catastrophic, long-lasting outcomes in which trust in others is destroyed and encoded in the body. This not only haunts the affected soldiers but also the clinicians and systems that

[4] For further detail please see Shay and Munroe (1999).

ultimately treat them. As I see it, the potential for successful treatment lies in recognizing moral injury, empowering veterans, and creating and supporting well-functioning treatment teams. Period.

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