Moral Injury & Suicide
Assessment and Treatment For Veterans with Invisible Wounds
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The Fall issue of *Combat Stress* represents the voices of moral injury from wartime and military service, including my own below. In addition, we have highlighted critical concerns regarding the issue of military and Veteran suicides, which continue to exceed that of the civilian sector of the American population. Moral injury may be considered a rather enormous factor in the taking of one’s life, when despair and the lack of belongingness suffocate the diminishing soul of the Service Member and the Veteran.

We have included a summary of recent assessment and intervention initiatives from some of our nation’s premier authors, as well as Veterans who have taken this agonizing walk and survived the journey, and leading national experts who have ministered so brilliantly to those whose cries have not fallen on deaf ears.

The toll of war and military service is staggering. It is the taking of lives and the killing of souls that follows that have become the other signature wounds of war. It comes in the form of nightmares and flashbacks and intrusive memories, as we are forced to bear the burdens of reliving the sights and sounds and smells of the bodies of children piling up in the streets of remote villages, soaked in excrement and carpeted with burned tires, all because they fired upon American troops and you had no choice but to “take them out” to spare their lives or their own. It is an “us versus them” kind of thing. Dreadful, horrible things happen in the fog of war. They erupt in the most unexpected of moments and it is those of us who have worn the uniform who are forced to live with the recklessness of war, cast upon us without any say in the matter, only because we swore to protect and defend. Scores of the 2.6 million of us who have served in the combat theaters of Iraq and Afghanistan are now returning home, profoundly impacted by the mind deafening quagmire of an adrenalin rich and rapturous frenzy, pride for having served and made it home alive and with a couple of medals to prove it, and a steaming brew of moral confusion, survivor guilt, and a mind that has failed to be bulletproof to the experiences of war that live in the shadows and the darkest recesses of our minds. This is what fractures our moral grounding and forces us to confront a horde of vague and uncertain moral and ethical dilemmas that may never be reconciled (Wood, 2014).

And just exactly who is it that we hold accountable for this? Is it the all-volunteer Army that was borne of the end of the draft in 1973 that resulted in the excusal from 99 percent of all Americans from military service and guaranteed that the fewer of 1 percent of us remaining poor suckers would have to carry the load. There is a virtual guarantee that the remaining skeleton force will be forced to bear the highest human toll, deploying over and over again until their initial euphoria about joining up and going off to war has turned to dust. It is the moral outrage and revulsion that slams us back into the ground when we sweat and toil and bleed in 130-degree heat, exposed to UCMJ (Uniformed Code of Military Justice) action if we fire upon the enemy implanting IED’s in the ground if they are not facing us, the Rules of
Engagement designed to protect those we are trained to kill and instead spill our entrails in the sand. And the final assault is when high ranking officers receive far less than a hand slap for the crimes of adultery and repetitive sexual assault against subordinates, another stellar example of the moral degradation of the military, broken trust, and a laughable mockery of military justice that is grossly out of proportion to the offenses committed. They might as well have pinned another medal on the bastards for getting away with felony offenses against humanity.

Appalling things happen in war. These are not just the distinguishing and traumatic war wounds that become the curse that haunts the spirit and the soul: the traumatic amputations, traumatic brain injuries, and Post-Traumatic Stress Injuries; the latter ripe with a revival of horrors and the endless nightmares and years of sleepless nights and the reliving of all things vile and repulsive in living color, right down your best friends’ death at the hands of the enemy and his or her blood curdling screams as they lay dying; the rush of adrenalin that ignites in firefights and ambushes on the battlefields of urban warfare, the exaggerated hyper-startle response set in motion in response to any unexpected sounds, by crowds, by bright lights, by any degree of surprise, by arguments, by any unsettling event; the uncontrollable anxiety and anger and rage that detonate in the face of a home and a land that we no longer trust.

In reality, the situation is far worse than that. It is the massive ignorance we face when we come marching home from war that not only diminishes what our country has asked us to do for them, but the terrible shame that this has brought upon us for having done so (Wood, 2014). What percentage of the American populace is unaware of the fact that we were at war for 13 years? Perhaps what we need to consider is that the most injurious wounds of war are not those suffered on the battlefield, but at the hands of a society and a culture devoid of any interest in the subject matter or any degree of compassion or awareness (Wood, 2014). It’s this simple; if it doesn’t affect us directly, it doesn’t exist. When the flag waving has ceased and the ticker tape has been swept up, what’s left? A carbon footprint?

We return to a homeland that too often demonstrates complete disregard, disdain, and disrespect for and towards our military service and the psychological injuries that we carry home in our duffel bags and ruck sacks. To have served has come to be discounted. Come home to homelessness and joblessness and assault and battery on the psyche by the very establishment that sent us headlong into combat by presidential call up in the first place. The onslaught of grief that invades our every breath for losing comrades and for failing to save them despite mortal wounds, not to mention the wrath for the unsound decision making that placed troops in the wrong place at the wrong time, is just the beginning of the rationale for rage and loss of faith in humanity. The toll of such unconscionable treatment is immeasurable, as it evokes an inability to trust and to react without anger and outrage. It is the ethics and moral belief systems that we took to war and that collide directly with the revolting realities of not only war, by the battleground of the home front that rejects us, dismisses us, and ultimately, forgets us (Scurfield, 2006). We swore
to protect and defend, but apparently, this courtesy has not been extended to us.

This is a toxic stew that simmers with the maiming and dismemberment of the psyche and the soul with survivor guilt, with moral outrage and indignation, with grief of unequalled proportions for those we could not save, and for witnessing the perpetration of evil that we are powerless to prevent. **It is this brokenness and despair that too often steer those struggling with such unbearable anguish to the taking of what have become such futile and barren lives.** Fellow countrymen and women of all ages, do not allow this to become the totality of our military service.

This issue offers initial responses from military research and both military and civilian clinical communities, offering the great hope that collectively, we may all begin to work towards a lessening of the suffering among those with moral injury stemming from military service. They are the voices that should inspire us to rise to the challenge of changing the course of individual Service Members’ and Veterans’ isolation and acts of despair; those morally compromised by our military service. No one should walk this alone.

**REFERENCES**


A documentary film to revolutionize the way we think about health and the human body

The American Institute of Stress is an executive producer of Body Electric: Electroceuticals and the Future of Medicine, a documentary film aimed to revolutionize the way we think about health and the human body. This 68 minute movie, by British producer/director/writer Justin Smith, is available online and on DVD for purchase through AIS.

Members stream for free at stress.org
Click here to buy the DVD for $29.95
Military moral injury has been examined for more than two decades by military, clergy, and clinical scholars and researchers in a variety of ways (e.g., Amidon, 2016; Litz, Stein, Delaney et al., 2009; Maguen & Litz, 2014; Scurfield, 2006; Shay, 1994; Sherman, 2015). To summarize, moral injury is a betrayal of or damage to the core values of Service Members (and Veterans) who have experienced one or more significant events that present a “violent contradiction to their moral code or expectations” (Nash, 2017). This can happen either through an act (perpetrator, whether intentionally or unintentionally causing harm) or failure to act (silent witness) in war or garrison incidents, and/or can result from abuse, threats, or betrayal (victimization, e.g., by peers or chain of command) while serving in the military.

Military Sexual Trauma (MST), for example, can result in deep moral injury, with wounds of betrayal by peers who may remain silent, and/or a chain of command that may undermine an investigation and expedite the transfer or discharge of the survivor, further aggravating the wounds of a sexual act committed against the victim. The victim’s moral injury may exhibit as intense anger toward all involved, and perhaps shame and grief. Meanwhile, a peer who may have witnessed military sexual assault but said nothing at the time or during an investigation, may experience moral injury as intense guilt over betrayal of one’s comrade.

Other examples of moral injury include decisions that result in catastrophic loss, such as warriors’ guilt at having led or left teammates (intentionally or unintentionally) in harm’s way, or torturing/killing the enemy, civilians, or children; being a survivor when others have died can leave lifelong scars.

Any such event can result in betrayal of Service Member values, self, justice, and/or loyalty to peers, command, and ultimately to all leaders. These assaults can result from one’s own choices to act or the failure to act, both toward peers or enemies (e.g., revenge killing, rape, harassment, or war and peer-on-peer crimes, either as perpetrators or witnesses who do not report or take action), and from the actions or failure to act justly by peers or leaders (e.g., decisions by peers, commanders, and government leaders causing injury, death, or other losses to self, comrades, civilians, children).

Moral injury contributes to a sense of powerlessness, futility, anger/grief/shame/guilt (depending on incident), alienation, diminished honor, and disillusionment in oneself, one’s peers, one’s leaders, one’s government, in authority figures, and in one’s higher power. Its impact can change the trajectory of relationships and of one’s behavior, work, and community adjustment. These can become lifelong changes and lead to a significant compromising or questioning of one’s character and worth. In some cases, these can become substantial factors leading to suicidal thoughts and behavior.

While most definitions and discussion on moral injury relate to combat and war experiences, moral injury also occurs in garrison conditions, such as situations in which actions result in deep violations of trust (e.g., assault or abuse by a peer or leader). Such incidents violate one’s core beliefs and triggers guilt or shame (Zalenski, 2015).
Regrettably, and not discussed in the literature, secondary moral injury may be perpetrated by the actions or failure to act by clinicians who fail to assess and treat this condition, and by government agencies, including the Department of Defense (DoD) and the Veterans Administration (VA). We may delay evaluation of moral and physical injury claims (e.g., military assault), delay assessment and treatment due to backlog of appointments, misdiagnose or neglect to acknowledge, assess, and/or treat these wounds, or dismiss or avoid correcting errors made related to the original cause of the moral injury. In this regard, civilian, military, and Veteran communities and clinicians have a responsibility to provide both adequate assessment and treatment, and to correct those mistakes, where possible, as related to the original moral injury.

This article:
• identifies selected literature, films, and types of moral injury, including those not related to combat;
• summarizes research, assessment, and treatment protocols; and
• challenges those working on behalf of Service Members and Veterans to collaborate in expanding assessment, treatment protocols and accessibility, and to increase awareness of this injury across generations of Veterans and civilians, past, present, and future.

Literature, Prayers, Films, and Experiences of Moral Injury

Ancient Themes of Moral Injury

The Greeks fought the Trojan Wars for decades, and their leaders recognized and wrote about the acts perpetrated by their warriors and leaders that led to warriors’ moral injuries. In a powerfully worded example of perpetrator moral injury, Euripides’ (424 BC) character Heracles laments his shame and avoidance of his community and his gods after killing:

“What can I do? Where can I hide from all this and not be found? ...How deep a hole would I have to dig? My shame for the evil I have done consumes me... I am soaked in blood-guilt, polluted, contagious.”

The Greek General/playwright Sophocles also described war-related moral injury through his characters’ words and actions. In his play about the heroic warrior, Ajax (440 BC), the moral injury perpetrated by an act of injustice by government is illustrated in two kings’ choice to give the armor of Achilles, the greatest warrior leader who had been killed in battle, to another warrior (Odysseus), who was a brilliant but poor leader who had made costly mistakes, costing many lives. Achilles’ armor should have by all rights gone to Ajax, second only to Achilles as a warrior leader. Ajax’s fury at this decision led to a psychotic break in which he slaughtered animals. His subsequent shame and grief upon recognizing his actions ultimately led him to fall on his own sword.

Ancient Spiritual Themes of Transgression and Forgiveness

While the Greeks used stories and literature to illustrate moral injuries to warriors, the Christian tradition had, by the 8th century, adopted a prayer of penitence. The Confiteor, in acknowledgement that all humanity transgresses and is in need of forgiveness, includes specific acknowledgment of two types of sin, omission and commission:
I confess to almighty God and to you, my brothers and sisters, that I have greatly sinned, in my thoughts and in my words, in what I have done and in what I have failed to do, through my fault, through my fault, through my most grievous fault…

(St. Joseph Sunday Missal, 2018)

This prayer continues to be said aloud by all participants in the Rite of the Catholic Mass and in some other Christian rites. It is recited by all present; it serves to teach and to reinforce a core belief system that all humans sin by action and failure to act, to take public ownership of this belief and to acknowledge that we all are in need of forgiveness. This religious code, including the power invoked in the sacrament of Confession, also teaches that we can be forgiven. This is also reinforced in the petition within The Lord’s Prayer (Ibid.):

…Forgive us our trespasses as we forgive those who trespass against us…

These prayers, said from childhood, are integrated into Christian belief systems long before military service. They illustrate, as does the early memorizing by Jews and Christians of the Old Testament Commandment of “Thou shalt not kill”, how core beliefs are internalized as part of Judeo-Christian character development, and how warriors’ errors of commission or omission during their service, including war, can result in direct conflict with their moral code. This conflict can contribute to shame and guilt at violating the code, withdrawal from religious beliefs and practices (which may have been a source of solace and comfort prior to the transgression) and a supportive spiritual community, and feelings of being unworthy of forgiveness (by self, others, God). The spiritual and soul repair work needed in recovery from shame and self-blame (e.g., Adsit, 2007, Brock & Lettini, 2012, MacLeish, 2017) will be discussed further below.

Literature, Film, and the Arts

Throughout the past two centuries, American writers and poets (including Veterans) have explored the effects of moral injury from military service and war. Similarly, film-makers in the twentieth century have examined this theme, allowing civilians to witness such injuries in ways previously limited to those in direct contact with soul-wounded warriors. For example, Wings (1927) features a World War I pilot who has erroneously shot down his friend, is bereft, but receives a hero’s welcome as he has to face his friend’s family. Saving Private Ryan (1999) demonstrates the lifetime effects of a Soldier rescued in World War II living with survivor guilt. Platoon (1986) and Full Metal Jacket (1987) illustrate the moral injuries sustained by soldiers participating in atrocities in Vietnam, and Marine trainees harassed in boot camp respectively, while Casualties of War (1989) depicts the true story of a squad of five soldiers, four of whom rape and kill a young Vietnamese woman, the fifth who reports them and is told by superiors to “let it go”. Such films serve to educate the civilian community about moral injuries and prepare those who watch them to participate in community efforts to help Service Members reintegrate, find absolution, treatment, and/or justice as may be needed, and to feel heard and welcomed home.

Veterans of recent wars have been...
encouraged and coached to use the expressive arts as a way to purge, process, and heal. Military and Veteran personal stories, both autobiographical and fictionalized, are poignant in illustrating all types of moral injury (e.g., Edmonds, 2015; McCoy, 2016; Self, 2008). Groups of Veteran artists representing all genres of the arts support expression of closely held emotional responses to their Service as a way to manage/educate and purge their moral injuries. Examples of publications by and for Veterans include the Military Experience in the Arts community which began at the University of Eastern Kentucky (Martin et al., 2012; O’Hara & Martin, 2014), the Veterans Writing Project out of Silver Spring, MD (Capps, 2011), and an invitation to women Veterans to write their stories (Doyle, 2016). Veterans have also been invited to compose, sing about, and record their military experiences (e.g., Veteran Jason Moon’s non-profit Warrior Songs).

Experiences of Moral Injury

Moral injury is unique to the Service Member who experiences it. It includes the degree to which one has internalized personal and military codes of honor, the degree to which either or both are broken, the circumstances and level of ambiguity of the offensive act(s), the relationship of the perpetrator to the witness and to the victim(s), and the portion of blame or guilt the Service Member assigns to him/herself or others. Therefore, sociopathic pathology minimizes one’s experience of moral wounding and negates one’s personal responsibility, while emotional and spiritual strength and living by the military Code of Honor can cripple a Service Member experiencing the same circumstances. Similarly, killing enemies during battle while following orders may lead to little or no guilt or shame, while witnessing the rape of a battle buddy, turning a blind eye, and remaining silent during an investigation may lead to lifetime guilt and shame. The individual’s participation and set of circumstances can affect moral outcome.

Examples of events that can have debilitating moral, spiritual, and relational effects include:

- Perpetrating atrocities of war, intentional or unintentional, including killing, maiming, torture, pillaging, out of revenge, vengeance, sport, or team collusion
- Perpetrating rape, assault, harassment, destruction of evidence, fraud
- Being assaulted, raped (MST), humiliated, harassed, or ostracized by peers or commanders; failure to obtain justice for the perpetrators; being transferred, demoted, or discharged from military service after such incidents
- Following orders that are immoral, illegal, or against the Rules of Engagement
- Failing to respond, or report those who fail to respond, to those in need of help/aid, including witnessing any of the above without taking action
- Making a forced decision in war where there is no clear "right way", e.g., where death or injury of others is likely, where a choice means sacrificing life, where innocents/children are at risk
- Survivor guilt
- Disillusionment with leaders/command in situations of dishonesty, favoritism, catastrophic decisions (e.g., in war), failure to take corrective action (especially when corrective action is moral, just, and possible), toxic commanders.
While most discussions focus on errors of commission and omission in warzones, many of the above examples occur during training, transitions, and in garrison. Service Members who experience moral injury under these conditions are often discounted or these events go unreported; but they need support as much as those who have been on the battlefield; indeed, many have experienced moral injury in both circumstances.

Service Members who have been harassed, abused, threatened, raped, or experienced near-death experiences during training or in garrison may have additional moral injury, suggested here as an example of secondary moral injury, when their reports and petitions for justice are ignored, denied, and even worse, when their perpetrators go unpunished or promoted. This additional loss reinforces their powerlessness, anger, and questioning of the Military Code of Conduct (i.e., disillusionment), as well as their own moral codes. Regrettably, the military culture allows such heinous betrayal by peers and commanders to continue, when there have been calls for and options proposed to correct it (McLendon, 2016; Platoni, 2016; Zalenski, 2015).

Research, Assessment, and Treatment
Moral Injury is not PTSD

Moral injury represents a miniscule portion of research currently funded by the Department of Defense (DoD) and Veterans Administration (VA). At the time of this article, there is a description of moral injury, one assessment tool, and two treatment interventions listed on the VA website under the National Center for PTSD (Maguen & Litz, 2016). No VA research-funded studies are listed.

Similarly, the Center for Deployment Psychology website has limited descriptions and trainings on moral injury. There are three free webinars offered on moral injury (Domenici & Copland, 2015; Nash, 2017; Cantrell & Nieuwsma, 2018) and several Staff and Guest Perspectives, but no overview of assessment and treatment protocols, no listing of resources for further clinical training, no ongoing (or calls for) collaborative research listed, nor any indication of the need for DoD funded research on this subject. The options for collaborative work cannot move forward without a commitment to a national repository of resources and more trainings readily available to clinicians, researchers, Veterans, and community leaders.

Jonathan Shay re-introduced the presence of moral injury in relation to modern warfare over two decades ago (specifically, Achilles in Vietnam, 1994). Numerous authors since then have emphasized the injurious effects of war on combatants (e.g., Grossman, 1995; Hoban, 2012; Lettini & Brock, 2012; Matsakis, 2007; Meagher, 2014; Scourfield, 2006; Scourfield & Platoni, 2013; Tick, 2013) as well as injurious effects of other moral injuries such as Military Sexual Trauma (e.g., Holly, 2018; McCoy, 2016; O’Hara, 2016; Zalenski, 2015).

Given this plethora of writing and awareness, it seems that the limited research and treatment protocols for moral injury, relative to PTSD and traumatic brain injury, serves to reinforce the sense of betrayal of Veterans with moral injury, further alienating them from the clinical community to whom they have turned for help. As a national community, we have to own that we have allowed
this to happen. Where did we get off track? We, as clinicians, researchers, and a national community, must take corrective action.

Of note, moral injury is not addressed in evidence-based treatment interventions endorsed by the DoD and VA, including Cognitive Processing Therapy (CPT) and Prolonged Exposure Therapy (PET). A Veteran/Military version of the CPT Therapist’s Manual (Resick, Monson, & Chard, 2014) has been developed, in which Veterans with killing-based moral injury work toward adjusting their perceived culpability, but the effect to which these strategies alleviate this specific type of moral injury is not known.

Also of note, the comprehensive RAND study (2008) identified PTSD, major depression, and traumatic brain injury as the three invisible wounds of the Iraq and Afghanistan wars. While significant funding went into analyzing the consequences of these wounds, services available, and gaps in treatment and services, moral injury was not mentioned. The focus on PTSD and mild traumatic brain injury as the signature wounds of these wars had already taken hold. Moral injury, perhaps in its messy and difficult varieties, perhaps in an assumption that spiritual or soul wounds would not fit quantification and cognitive-behavioral approaches, was omitted in the DoD and VA research trajectories. In reality, moral injury is the signature injury of all wars, and as such should be included in every discussion, research publication, screening, and treatment intervention targeting the effects of military service.

However, in the past decade, research protocols and treatment interventions for PTSD and traumatic brain injury have been heavily emphasized. Meanwhile, suicide rates have skyrocketed, protocols have been implemented both in active duty and Veteran populations to be watchful for signs of suicidality, Veterans in mental distress have long waits for treatment, thousands of nonprofits have been established to help Veterans, and still moral injury remains under-assessed and largely untreated.

Moral injury has some features that parallel Post-Traumatic Stress Disorder (PTSD), but there are features that distinguish it from PTSD (Nash, 2017; Bryan et al., 2018). When Veterans show evidence of both, research indicates they can have more significant likelihood of suicidal thinking and behavior. Bryan et al. (2018) studied a group of 930 National Guard Personnel and concluded that:

PTSD and moral injury represent separate constructs with unique signs and symptoms. The combination of PTSD and moral injury confers increased risk for suicidal thoughts and behaviors, and differentiates between military personnel who have attempted suicide and those who have only thought about suicide. (p.36)

This represents a significant and alarming finding. It supports the need for immediate re-screening of Service Members and Veterans already diagnosed with PTSD for symptoms of moral injury. It also supports the need for immediate wide dissemination of this information at the highest levels of the military, government and nongovernmental agencies supporting Veterans, and to clergy and police (the latter of whom are often first responders to suicidal Veterans).

Assessment Instruments

Fortunately, there are a small number of researchers/clinicians working collaboratively in military/Veteran settings who
have been researching moral injury for the past decade and developing long-awaited assessment instruments. These include Brett Litz, PhD and his colleagues at Boston University, the Boston and San Francisco VAMCs, and William Nash MD, Director of Psychological Health at United States Marine Corps; Joseph Currier PhD at University of South Alabama and colleagues Jason Holland PhD at LifeSparkweekly.com, Kent Drescher PhD at the National Center for PTSD, and David Foy PhD at Pepperdine University; Harold Koenig MD at Duke University Medical Center and colleagues from several VAMCs, Duke, Baylor, and Liberty Universities.

Their work includes the standardization and publication of four instruments to date:

- the Moral Injury Events Scale (Bryan et al., 2014; Bryan et al., 2016; Nash et al., 2013),
- the Moral Injury Questionnaire – Military Version (Currier, 2015; Currier et al., 2015),
- the Moral Injury Symptom Scale – Military Version (MISS-M) (Koenig, 2018; Koenig et al., 2018), and
- the Moral Injury Symptom Scale – Military Version Short Form (MISS-M-SF) (Koenig et al., 2018).

The first, the Moral Injury Events Scale (Exhibit 1), is a 9 item self-rating with items assigned to three subscales: Perpetration Other (witness), Perpetration Self (participant), and Betrayal. The Service Member/Veteran rates him/herself on each statement on a 6-point Likert Scale ranging from score of 1, “I strongly agree” to 6, “I strongly disagree”, with a higher score indicating greater moral injury (see exhibit 1). Discriminant and internal validity were established, and differences in experiences between Perpetrator, Witness, and Betrayal were identified over a large cohort of more than 1,000 Marines (Bryan et al., 2014; Bryan et al., 2016; Nash et al., 2013). This scale is very easy to administer and score, giving immediate information on which moral injury subscale the respondent loads.

The second is the Moral Injury Questionnaire – Military version (MIQ-M), developed by Currier et al. (2015). This is a 20-item self-report measure (Exhibit 2). Results on a small sample size (N=211) demonstrated “significantly higher scores on MIQ-M items in the clinical sample when controlling for demographics, deployment-related factors and exposure to life threat stressors associated with combat” (p.54). Of note, incremental validity testing indicated that MIQ-M scores were uniquely linked with
suicide risk and other mental health outcomes, a finding that matches other data (Bryan et al., 2018) on moral injury and suicidal behavior. The authors noted the need for further research on this instrument.

The third and fourth screening instruments were developed by another collaborative group of researchers (Koenig, 2018; Koenig et al., 2018). Their Moral Injury Symptom Scale—Military (MISS-M) is comprised of 45 items. Its short form, the Moral Injury Symptom Scale—Military-Short Form (MISS-M-SF; Exhibit 3) screens for responses loading on the following 10 items: guilt, shame, moral concerns, loss of meaning, difficulty forgiving, loss of trust, self-condemnation, religious struggle, and loss of religious faith. A group of 427 Veterans and active duty military with symptoms of PTSD were recruited from five VAMCs and two universities to test the validity and reliability of the Short Form. Results suggested that the MISS-M-SF is a reliable and valid measure of symptoms of moral injury that can be used to screen for moral injury.

These instruments represent ways to conduct a short, simple screen for moral injury that can be used in military, VA, and private clinical settings. The authors are to be collectively applauded for this seminal work that can help identify not only the potential for moral injury, but the loading factors (perpetration, witness, betrayal) that can help direct treatment.

A fifth instrument, the Flourishing Scale (Diener et al., 2010), was developed for assessment of Veterans in a retreat setting, the Walking with St. Francis Retreats program (MacLeish, 2017) near Scottsdale, Arizona. Administered prior to and following
Exhibit 3  Moral Injury Symptom Scale – Military Version Short Form\(^1\)

Instructions: Please circle the number that most accurately indicates how you are feeling now:

1. I feel betrayed by leaders who I once trusted.

<table>
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<tr>
<th>Strongly disagree</th>
<th>Mildly disagree</th>
<th>Neutral</th>
<th>Mildly agree</th>
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2. I feel guilt over failing to save the life of someone in war.

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<th>Mildly agree</th>
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3. I feel ashamed about what I did or did not do during this time.

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4. I am troubled by having acted in ways that violated my own morals or values.

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5. Most people are trustworthy.

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Mildly disagree</th>
<th>Neutral</th>
<th>Mildly agree</th>
<th>Strongly agree</th>
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6. I have a good sense of what makes my life meaningful.

<table>
<thead>
<tr>
<th>Absolutely untrue</th>
<th>Mostly untrue</th>
<th>Somewhat untrue</th>
<th>Can’t say true or false</th>
<th>Somewhat true</th>
<th>Mostly true</th>
<th>Absolutely true</th>
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7. I have forgiven myself for what happened to me or others during combat.

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<tr>
<th>Strongly disagree</th>
<th>Mildly disagree</th>
<th>Neutral</th>
<th>Mildly agree</th>
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8. All in all, I am inclined to feel that I am a failure.

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<tr>
<th>Strongly disagree</th>
<th>Mildly disagree</th>
<th>Neutral</th>
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9. I wondered what I did for God to punish me.

<table>
<thead>
<tr>
<th>A great deal (very true)</th>
<th>Quite a bit</th>
<th>Somewhat</th>
<th>Not at all (very untrue)</th>
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10. Compared to when you first went into the military has your religious faith since then...

<table>
<thead>
<tr>
<th>Weakened a lot</th>
<th>Weakened a little</th>
<th>Strengthened a little</th>
<th>Strengthened a lot</th>
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Scoring: Reverse score items 5, 6, 7, 9, and 10, and then sum all items to produce a total score indicating moral injury severity (possible range 10-100)


participation in an immersive healing retreat for Veterans, The Flourishing Scale (Exhibit 4) is an 8-item summary measure of the respondent’s self-perceived success in areas such as relationships, self-esteem, purpose, and optimism. The Scale provides a single psychological well-being score and was chosen as its language is neutral (non-religious). This Scale is copyrighted, but the authors have made it available at no cost to researchers and practitioners under condition of crediting authors using the citation listed in for individual or group administration. They serve as quick screens of moral injury, stuck points, and identification of mind, body, heart, and spirit balance/imbalance. In group administration, as appropriate, they can serve as prompts for voluntary group discussion. These assessment tools were developed with and administered to over 100 active duty Military Personnel seen in a brain injury/PTSD clinic in a military hospital over several years. Neither has been validated, and a fifth element (Shame) has been recently added

References below.

Results of the 2017 retreat participant Flourishing Scale well-being scores demonstrate an average increase of 8.15 from pre- to post-retreat scores. As this represents a very small sample size, data is being collected in future retreats to determine statistical significance across a larger pool of participants. Follow-up data will be collected to determine if these scores are durable over time.

O’Hara (2018), co-author of this article, offers two additional assessment tools, the F4G4S2, and the Circle of Balance, developed
to represent a dimension previously unaddressed in the original F4G4.

Both the Circle of Balance and the F4G4S2 are offered for potential further research and/or clinical use with author’s permission given going forward with appropriate citation. These tools have also been presented to several large groups (20-100 per group) of clinicians for self-assessment and to demonstrate the immediate self-assessment and discrimination of their emotions, their “stuck points”, and their self-awareness of where they are in/out of balance.

The first, the F4G4S2 (Exhibit 5) assesses five emotions Veterans with moral injury, PTSD, traumatic brain injury, and other service-related traumas, often hold: Fear, Fury, Guilt, Grief, and Shame (O’Hara, 2018). This instrument is a 6-point Likert Scale on which the Service Member rates each of 5 continuums of emotion. The forced choice asks the respondent to estimate his/her current valence on continuums of Fear vs. Faith/Trust; Fury/Anger vs. Forgiveness of Others; Grief vs. Gratitude/Solace; Guilt vs. Grace/ Self-Forgiveness, and Shame vs. Serenity/Honor. Respondents have been able to immediately recognize the emotions with which they struggle (lower scores toward left of continuum).

In clinical practice, scores are not shared in group settings unless they are volunteered during discussion. Rather, group members are invited to silently identify which one(s) represents a “stuck” point, to identify what is keeping them stuck, and to consider how they might move forward (toward the right side of the continuum). In a group setting, this exercise allows individuals to recognize that they are not alone in their struggles, to generate possibilities for letting go of fear, fury, guilt, grief, and shame, and to take risks in sharing how they are stuck (and sometimes, why).

While data has not been collected and Shame has recently been added, Service
Members who completed the scale responded that they struggled with Fury/Anger and Guilt far more than Fear. Based on the literature reviewed here, it is hypothesized that a low score on the Fear continuum is more likely to represent symptoms of PTSD, the Shame and Guilt continuums more likely to represent symptoms of Perpetrator or Witness moral injury (with some PTSD overlap), and the Fury continuum, of Betrayal. This tool could be used, similarly to the Flourishing Scale, as a measure of pre-post treatment to assess movement away from self-perceived internal conflict.

The second tool, the Circle of Balance (O’Hara, 2018), is more complex in its assessment of strengths and weaknesses in each of four internal domains. Veterans are given a circle divided into four quadrants representing Mind, Body, Heart, and Spirit (see exhibit 6). They are asked to list two strengths and two areas in need of improvement for each of the four domains, and to work in silence. Several minutes are typically needed to complete this task, but Veterans are often unable to complete each quadrant. Among respondents, more questions are asked before writing about the meaning of Heart and Spirit than Mind and Body. Heart is described as encompassing emotions and relationships, while Spirit is described as representing beliefs, faith, and hope. Mind is described as thinking, memory, judgment, while Body is described as physical health, strength, conditioning, and systems.

The Circle of Balance challenges Veterans to recognize that they are neither a diagnosis, one-dimensional, nor locked into their current state of (dys)function. Upon completion of their responses, they are encouraged to identify which quadrant was the easiest and which the most difficult to complete, whether they focused on strengths or problems first, and in which quadrant(s) they are stuck in generating responses. When administered in a small group setting, they are invited to voluntarily talk about their responses and in which quadrants they perceive themselves to be in or out of balance.

This tool gives both Veterans and clinicians rapid insight into Veteran self-awareness, capacity to complete a complex task, and in what aspects a Veteran may be out of balance. It also gives the clinician insight into the domain(s) in which the Veteran primarily processes information (e.g., cognitive vs. emotional vs. spiritual constructs) and his/her capacity to identify strengths and weaknesses. Indicators such as the Veteran’s preferred channel of therapeutic communication (e.g. use of cognitive vs. emotional constructs), cultural clues (e.g., on spirituality), and insight into perceived strengths vs. weaknesses may help in selection/direction
of treatment. For example, physically injured Veterans can frequently list their problems ("areas in need of work") in the Body quadrant, while Veterans with brain injury can list problems in the Mind quadrant; they and their treatment providers often focus on physical pain and on cognitive and physical deficits and pain. The Circle of Balance introduces two additional quadrants that may otherwise go unaddressed in treatment, when one or both may represent the most pressing needs and/or areas of untapped strengths needed to maintain balance during and after treatment.

The Circle of Balance can be repeated over the course of treatment (or over life), with comparison of responses over time, to determine increased capacity to assess relative strengths and weaknesses, to set targets for treatment (or personal) goal setting, and for mindfulness/self-awareness of one’s life balance.

Of note, disclosure of responses on these two tools when used in a group setting should be limited by the leader when trust has not been established.

In summary, there are now four research-based screening instruments for moral injury, and others that could be considered for research development. It is imperative that clinicians working with Veterans be made aware of these, add them to their screening tools for accurate assessment and treatment planning, and consider collaborating with researchers in developing these and other instruments to assess moral, spiritual, and emotional well-being.

### Treatment Protocols

In the third volume of his insightful Vietnam Trilogy, War Trauma: Lessons Unlearned from Vietnam to Iraq (2006), author Ray Scurfield, DSW, LCSW warns that “Manual-Based Treatment” avoids some of the core aspects of war trauma and readjustment. These include: "damaged, self-denigrated, disordered and fragmented identity, self-hatred; existential

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**Exhibit 6** O’Hara, 2018

Instructions:
List 2 strengths in each quadrant and 2 of your needs for each.

Mind (thoughts, memory, ideas):
Body (health, physical systems):
Heart (relationships and feelings):
Spirit (beliefs, hope):
malaise… a sense that one’s life is out of orbit; disconnections between cognitions, affect, physiological responses and environmental cues; pre-occupation with blame…;… loss of control over affect and behaviors; the central role of rage, grief, and terror/fear.” (p.167)

Scurfield also voices concern that individual treatment interventions limit the Veteran from processing his trauma with his peer group; as other Service Members represent a major contextual aspect of all war trauma, small group work (replicating a squad) may be necessary for contextual healing (p.169). Most of the treatment interventions described below, unlike evidence-based CPT and PET protocols, acknowledge the ethos and context of wounding, and address these directly in group settings.

Scurfield also notes the importance of two cognitive reframing interventions: a) examining and owning the paradox of war, i.e. for every negative aspect of trauma, there is a positive to be identified (pp. 194-197); and b) determining the Percentages of Responsibility for acts of war (pp. 215-219). The first, reframing, offers a way to shift from thinking in universal negatives to generating alternate views, helping to move Veterans out of “being stuck”. The second, which can be done using a pie chart, helps Veterans reframe what percentage of responsibility they hold for their actions and atrocities, and what percentages they assign to each of the others present at the time, each up the chain of command, media, government, citizens, etc.

These two interventions are, regrettably, not integrated into any of the treatment interventions described below. This article hopes to bring together disparate and perhaps forgotten/unlearned lessons and interventions used by seasoned Veteran clinicians from earlier eras that can be integrated into protocols to maximize healing. Healing requires a canvas with depth, breadth, and lessons/wisdom from the past.

Scurfield, along with others addressing the ultimate issue of the morality of war (e.g. Meagher, 2014; Meagher & Pryer, 2018; Shay, 1994, 2002; Tick, 2014) speak to the need for expanding the circle of community responsibility for individual acts of war as well as waging war, and for Veterans finding ways to contribute to the community and “live well” after war; finding forgiveness, acceptance, and doing acts of reparation may be integrated into this work. These themes are seen in some current retreat and community-based treatment interventions, such as the OASIS treatment program at the Naval Medical Center at San Diego (Gray et al., 2012). Scurfield notes that when Veterans reach a plateau in their isolation or limited pool of relationships, both Veterans and their advocates/companions need to identify and reach out to whom the Veteran most needs in his/her “circle of healing to reclaim a more peaceful existence” (p.178). The emphasis on embracing healthy relationships, and on the community’s participation both individually and collectively in owning their part of war and in healing, is central to Veterans’ healing process (2006; Scurfield & Platoni, 2013; Caplan, 2011).

Treatment protocols for moral injury include:

• **Adaptive Disclosure** (Gray et al., 2012; Litz et al., 2009, 2017; Steenkamp et al., 2011)
• **Impact of Killing in War** (IOK), (Maguen & Litz, 2016; Maguen et al., 2017)
• **Immersive Healing Retreats** (Bruner, 2017; Ford, 2017; Kip et al., 2017; MacLeish, 2017; OHara & Vicars, 2017).
• **Expressive Arts** (Capps, 2011; Carey 2006; Morley, Anderson & OHara, 2013; Martin et al, 2012, Scurfield and Platoni, 2013)

• **Faith-based Interventions** (Adsit 2007; Brock & Lettini, 2012; Carey et al., 2016; MacLeish, 2017)

• **Community-based Interventions** (The Syracuse Project; The Listening Project)

  **Adaptive Disclosure** (Gray et al., 2012, Litz et al., 2009, 2017) is a treatment intervention developed for active duty Service Members and Veterans experiencing moral injury from atrocities and killing. It is a “hybrid” of CPT and exposure therapy (incorporating emotional processing of a specific event), with the goal of achieving balance through coming to terms with the traumatizing event(s), owning responsibility and reducing self-blame, and working toward reclamation of one’s goodness and the capacity to move forward living well (Litz et al., 2017).

  In its eight 90-minute sessions, the Veteran identified the event(s) and processes/shares the details and meaning of corresponding memory(s) causing guilt/grief/shame/anger. To shift from self-blame and suffering, s/he is asked to “dialogue with an imagined benevolent moral authority or provide advice to a hypothetical Service Member who is similarly stuck” (Litz et al., 2009, p.701) about forgiveness and one’s capacity to do good going forward. Steps include connection, education, modified exposure, examination and integration, dialogue with imagined figure, reparation and forgiveness, fostering reconnection, and long-term planning. This intervention is used at the NMCSD in both inpatient and outpatient treatment settings. The authors describe the research on which Adaptive Processing is based, the need for clinicians to be fully educated in military culture in order to use this intervention, and assessment and treatment planning strategies in their recent book (Litz et al., 2017).

  **Impact of Killing in War** (IOK) is a cognitive behavioral short-term individual treatment intervention developed by Maguen et al. (2017) to augment evidence-based treatments for PTSD. IOK is a 6 session, weekly individual psychotherapeutic intervention using cognitive behavioral therapy (CBT) to reduce symptoms of moral injury. 60 to 90-minute sessions focus on themes that include physiology of killing responses, self-forgiveness, spirituality, making amends, and improved functioning. Pilot testing with a small sample size demonstrates significant reduction in mental health symptoms, more capacity to share feelings and thoughts with others, and more community engagement when compared to controls (Maguen & Litz, 2016).

  **Immersive Healing Retreats** are described in detail in two issues of Combat Stress Magazine, published online for clinicians and researchers working with Service Members and Veterans, and for Veterans (Bruner, 2017; Ford, 2017; Hejmanowski and Johnson, 2017; Kip et al., 2017; MacLeish, 2017; McCoy, B., 2017; O’Hara & Vicars, 2017, and others). Each article describes a military and Veteran immersive healing retreat model, including participant selection criteria, interventions, staffing, impact, and for some, research protocols. These retreats are typically long weekend to week-long intensive healing experiences led by clinicians and clergy (often Veterans) with extensive experience working with military trauma.

  Participants attending retreats may include male or female Service Members and Veterans only, mixed groups of Veterans (gender,
intergenerational), military/Veteran couples or families, and trauma-specific Veterans (e.g., combat; military sexual trauma). Most are held in remote natural settings and/or retreat centers. These retreats are considered to be complementary to other standardized treatment interventions, and not a replacement. Referrals often come from treating clinicians and chaplains in active duty and VA mental health settings.

The immersive experience offers those attending safety, the opportunity to relax, learn new skills (including meditation, expressive arts, communication, reframing, animal assisted therapies, adaptive recreation, etc.), take risks (in self-disclosure, trying new activities), and strengthen relationships, grounded in nature. They offer Veterans a non-hospital setting without diagnostic labels, and offer partners/caregivers/children an opportunity to connect with/see their Veterans in a different perspective. They lend hope and experiential evidence to participants that “I/we can heal. We are not alone. We can have fun. We can connect and share.”

Some retreat models focus on faith-based sessions (such as the Army Strong Bonds Couples Retreats (Allen et al., 2015) and the Walking with Saint Francis Retreats (MacLeish, 2017). These models acknowledge the moral and spiritual cost of war on individuals and on relationships, the need for self-forgiveness and healing, and a safe space to connect with other Veterans in a small group. It is common across retreat models for one or more participants, most of whom have been or are in mental health treatment, to comment that the weekend has been “transformative... been worth years in counseling... (or)... has changed me/my family” (O’Hara & Vicars, 2017). Such qualitative data needs to be analyzed in a qualitative study to capture the impact that current standardized self-report questionnaires are not able to capture.

Many retreat models are offered to Veterans through non-profits funded by private grants (e.g., the generous $10 million grant awarded to Boulder Crest Retreat in Virginia for programs and expansion in July 2017) and individual donations; most retreats are free. For many civilians, donating is a way to “give back” to Veterans and acknowledge that the community cares and wants to help them and their families heal. Civilians are at times also offered the opportunity to volunteer at retreats in supportive roles (e.g., serving meals, helping with recreational activities, etc.).

The Department of Defense and the VA fund primarily chaplain-led Strong Bond Retreats, but to date have not provided large scale funding for research or retreat models other than Strong Bonds. Of note, the VA website lists a women Veteran retreat that one upstate New York VAMC has hosted for 2 summers, but it is funded by donations (Goodman, 2017), and the report did not include whether data was collected.

A review of research studies on selected retreat models demonstrates a growing body of evidence that immersive Veteran, Veteran Couple, and Veteran Family retreats benefit participants. Specifically:

- In a study of the Integrative Intensive Retreats Model, offering 4-day retreats including psycho-educational, group and conjoint therapeutic sessions, and recreational activities for dyads/couples, 76 dyads (N=152) of Veterans and Support Person-Partners (SPPs)
demonstrated a reduction on standardized measures of trauma symptoms. SPPs reported experiencing a significant increase in a measure of post-traumatic growth from pre-retreat to post-retreat although Veterans’ increase did not reach significance. However, both groups reported an increase in relationship adjustment (Bruner, 2017; Monk, Ogolsky & Bruner, 2015; Monk et al., 2017).

- Before and after completing a 3-day Lone Survivor Foundation (LSF) therapeutic retreat program, 167 Veterans/family members provided self-report data on symptoms of PTSD, global psychopathology, anxiety, and pain. The model included psycho-education, equine-assisted learning, behavioral consultation, and brief trauma-focused psychotherapy. Pre-retreat, 90 percent of participants screened positive for PTSD and 66 percent screened positive for depression. Post-retreat, mean reduction on the PTSD Checklist was 24.1 +/- 16.8 points (p<0.0001); 77 percent reported a reduction of 10 points or more. Similar strong benefits were reported on measures of global psychopathology, anxiety, and pain, and were reported across type of retreat conducted (Individual, Group, or Military Sexual Trauma). (Kip et al., 2017).

- The Walking with Saint Francis Retreat model encourages Veteran participants to examine their “wounds of war from various perspectives, in the light of a saint who rose out of the ashes of combat to become an icon of peace” (MacLeish 2017). Joseph Campbell’s Hero’s Journey and Ron Moody’s Five Stages of the Soul are presented for Veterans to integrate how St. Francis moved through The Call, Responding to the Call, The Struggle, The Breakthrough or Transformation, and the Return into their personal experiences in each area (Ibid.). The Model uses the Flourishing Scale (Diener et al., 2009, 2010, see Exhibit 4) pre- and post-retreat to assess change over the 3-day retreat. Initial research demonstrated an average increase of 8.15 in scores on Well-being from pre- to post-retreat, with significant shifts identified in pre-post measures of self-perceived success (MacLeish, 2017). Additional data is being added to the pilot study for further evaluation of the model.

Retreat models represent a promising alternative for Veterans with moral injury, as they offer a variety of choices both in content, geographic location, leadership, and group composition. They also can be a starting point for Veterans whom have had no clinical treatment/are aversive to hospital settings, and for those who need adjunctive support. Finally, they offer
an opportunity for relationship enhancement between partners, among families, and as support for caretakers. It is recommended that one or more of the Moral Injury Assessment screens be included in all retreat models to identify whether there is change on any of the scales from pre- to post-retreat and on follow up, as no retreat model has integrated these tools to date.

The Expressive Arts represent another avenue of healing from moral injury for those Veterans who are willing to risk trying an expressive arts experience. These include visual arts (e.g., painting, drawing, sculpture, photography), drama (e.g., masks, puppets, role play, writing/performing plays), music (e.g., instrumental, voice, songwriting, e.g. Jason Moon’s nonprofit, Warrior Songs), movement/dance, and writing (biography, fiction, poetry, journaling) (Capps, 2012, Martin et al., 2012; Doyle, 2016). A chapter of moral injury poetry is chosen to open the recent inclusive and noteworthy text, War and Moral Injury: A Reader, edited by Meagher & Pryer (2018).

Theory and treatments for Veterans have emerged largely by adapting findings from the field of expressive arts therapies with other populations (e.g., Carey, 2006; Serlin 2009, O’Hara and Martin, 2013). Grassroots Veteran arts networks have expanded across the country in each of these areas (O’Hara & Martin, 2013). Scurfield and Platoni (2013), both Veterans and clinicians, have edited an entire handbook on creative therapies with Veterans. The ArtReach Foundation, Inc., a nonprofit that staged a five year Project America offering expressive therapies free-standing workshops and workshops embedded within military retreats for active duty, Veterans, and families (Morley, Anderson, & O’Hara), was unable to continue the Project for lack of funding. We need to identify funding for such efforts from both private and government sources, similar to the scale of funding described earlier for retreats.

The DoD has some expressive arts inpatient and outpatient treatment programs in place, with research to date largely limited to active duty Service Members’ art and mask-making (e.g., Jones et al, 2018; Walker et al., 2017). The VA offers some art and music therapy treatment interventions, and hosts an annual national arts competition for Veterans (summarized in O’Hara & Martin, 2013). Most of the language describing such DoD and VA therapeutic interventions recognizes the need for healing from war trauma; research populations are primarily drawn from inpatients with diagnoses of PTSD and TBI. If we can collaborate among disciplines, in theory and in writing expressive arts research and program descriptions for those with moral injury, we may be better able to build meaningful, replicable interventions for our wounded warriors.

Faith-Based Interventions can be helpful to Service Members who struggle with loss of pre-service beliefs and spiritual practices.
following incidents or situations that may have triggered deep guilt, shame, or intense anger for self-labelled “unforgiveable” acts done by them or to them. An assessment of cultural and spiritual beliefs is an important aspect of determining whether these emotions are blocking forgiveness or contributing to despair (i.e., I cannot forgive/be forgiven, I should be punished by a just God, I want to die).

A separation from one’s previous supportive spiritual beliefs plunges Veterans into the darkness and away from the healing light, a healing community, and an epiphanic moment of serenity/reclamation. Faith can be both personal and community based; therefore private confession of “sins” within a penitential rite may be insufficient. Public penance (e.g., recounting the details of one’s perceived transgressions to a faith group or community group, and asking them for forgiveness), offering restitution in some form within the community, and the perceived support of/forgiveness by a faith community may ease one’s conscience far more than participation in a cognitive behavioral protocol. The personal meaning of any military trauma is unique to the individual’s history, experience, and beliefs; therefore, clergy and clinician’s own responsibility for careful assessment and referral to expedite healing in the domain (cognitive, emotional, spiritual) in which the injury is most deeply embedded.

**Faith-based Interventions** and guides for the spiritual repair of moral injury have been written by and for military chaplains and congregations (e.g., Adsit 2007; Brock & Lettini, 2012; Carey et al., 2016). Such interventions focus on the spirit and soul wounds of war and other military-related moral injuries including Military Sexual Trauma. Other moral injuries that are rarely discussed are those faced by combat medics, trauma surgical teams, and nurses whom have made life and death decisions for Service Members with no time to process (before or after) the moral impact of their most difficult choices. Similarly, recovery teams, mortuary affairs, and death notification teams struggle with the deeply embedded sensory memories of handling fellow Service Members’ remains, as well as witnessing the grief responses of families and comrades. Guilt over forgetting to be reverential enough, shame over having said or done “the wrong thing” to a grieving spouse or parent, and one’s own cumulative grief can haunt a lifetime if left unaddressed.

The Chaplain Corps of the DoD and the VA have a great responsibility in meeting the needs of our morally wounded warriors. In a review of over 400 articles on the relationship of chaplains and moral injury (not specifically Veteran moral injury), Carey et al. (2016) identified 60 that discussed the role of chaplains in relation to moral injury. Their role was described in the majority of articles as a positive one, but the need for research in chaplain-assisted healing from moral injury was strongly recommended. Military Chaplains are limited by budgetary restrictions, few or no staff to assist in research design and data collection, a pool of rapidly moving subjects, and conflicts of interest in recruiting subjects as controls from Service Members who may be in need of immediate counsel.

Chaplains have, however, implemented and collected data on couples attending Strong Bonds Retreats which are structured as couples’ small group, faith-based sessions. A review of the data from 662 Army couples participating
in Prevention & Relationship Enhancement Program (PREP) Strong Bonds retreats over one and two year follow-up showed a significant reduction on divorce effects, modest effects on marital quality post-sessions, but greater long-term marital quality outcomes for couples with historical risk factors of infidelity and cohabitation (Allen et al., 2015). One issue facing military chaplains is the extension and adaptation of Strong Bonds programs to couples of all faiths or no faith, same sex couples, and cohabiting couples who would not fit elements of Christian-based Strong Bonds programs.

An example of another Christian-centered approach to moral injury is Reverend Chris Adsit’s book, The Combat Trauma Healing Manual (2007). This Veteran-centered workbook includes assignments for the reader in each section. Many themes parallel those incorporated into other treatment interventions, including topics on being forgiven and forgiving others, finding bridges back to one’s belief system, finding a supportive community, and rebuilding healthy relationships. For those seeking faith-based recovery or attempting to reclaim shattered Christian beliefs, this workbook could be used alone or in a group. A second book for spouses of Veterans has a similar approach (Adsit, 2008). As there is no research on its effectiveness, other than testimonials, research protocols would lend evidence that this approach is effective.

Since 2012, Brite Divinity School has developed materials for congregations on moral injury (https://www.brite.edu/programs/soul-repair/) in recognition that faith communities may be the first or last resort for Veterans seeking forgiveness, restoration, and healing from moral injury. A study guide has been developed with the authors of a book on Soul Repair (Brock & Lettini, 2012).

Another faith-centric intervention, described earlier, is the Walking with Saint Francis Retreat model. This model welcomes Veterans of all faiths, embracing Saint Francis as a role model of a spiritually wounded warrior whose path toward recovery embraced nature in solace. He went on to found the Order of Franciscan Monks (MacLeish, 2017).

Only one publication was identified that reviews Christian, Jewish, and Islamic faiths and their relationships to moral injury (Kopatz et al., 2017). This article discusses the etiology of moral injury and represents a comparative discussion of how understanding the tenets of different faiths can contribute to effective intervention. Such discussions are critical to developing culturally specific assessment and treatment interventions for Veterans going forward.

For those Veterans who have no faith connections, deep moral injury can be framed within discussion of the Military Code of Honor and the respective Branch Values, both of which are internalized during basic training and reinforced throughout military service. When this
code or one of its inherent values is perceived to have been irreparably broken, the moral injury may be embedded in deep betrayal of military brotherhood, loyalty, and/or honor. The military, at the highest levels, needs to constantly be vigilant about policies to prevent or limit such trauma, including screening out recruits with histories of abuse toward others, criminal activity, and sociopathic personalities who can taint all whom they touch. Military leaders must be held accountable for all chain of command decisions allowing a culture of harassment, including Military Sexual Trauma, and poor leadership, in which perpetrators go largely unpunished, to continue. Similarly, military leaders must remain vigilant for acts of vengeance and atrocities of war that contribute to Service Member moral injuries.

Similarly, Service Members who commit acts against the Military Code of Honor should be punished and removed from military service. Failure to take action against perpetrators in the Corps allows for immoral acts against peers or enemies, causing more moral injuries. The military community must take more responsibility to prevent internal acts of moral injury, including Military Sexual Trauma, assault, abuse, and other acts of individual and team wounding; provision of sexual assault teams to assess damage after the fact is woefully insufficient.

Community-based Interventions are a necessary element of Veteran and civilian reconnections, yet they are poorly developed, coordinated, or researched. This is despite a call almost 25 years ago by Jonathan Shay (1994) to take ownership in healing moral injury:

“We must create our own new models of healing which emphasize communalization of the trauma. 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. We need a modern equivalent of Athenian tragedy. Tragedy inclines us to prefer attachment to fragile mortals whom we love, like Odysseus returning from war to his aging wife, Penelope, and to refuse promised immortality”. (Shay, 1994)

As the calls to serve continue, the civilian community must own its part in engaging in war and addressing the moral injuries of its warriors (Caplan, 2011; Shay, 2002; Sherman, 2015). Two such efforts are the Moral Injury Project at Syracuse University (http://moralinjuryproject.syr.edu/) and The Listening Project (https://whenjohnnyandjanecomemarching.weebly.com/).

The Moral Injury Project (Johnson, 2018) illustrates the impact of an entire university campus community’s willingness to embrace their responsibility for war and its impact on Veterans. The initiative reaches out to Veterans to offer opportunities to engage with civilians on campus about their service experiences, provide resources to them, and foster public discussion about moral injury. Their website includes references for further reading.

The Listening Project was launched by Paula Caplan, PhD, following publication of her book, When Johnnie and Jane Come Marching Home (2006). The website gives information about how and why listening sessions can be held in any community for Veterans to tell their stories, and for civilians to respectfully listen. Listening circles are held around the United States by those civilians who care enough to take the time to invite Veterans and civilians to come together
for what are designed to be open-ended
sessions. Intergenerational and cross-cultural
listening is an opportunity for individual and
collective healing.

Challenges
The Need for Collaborative Integration

Research, assessment, and treatment
protocols regarding moral injury
are moving forward, with significant
progress in the development of assessment
screens, and treatment interventions. Training
protocols for clinicians, chaplains, and clergy
in screening for and treating moral injury lags
behind. One promising development: the
National Association of VA Chaplains (NAVAC)
has instituted a new Board Certification for
Chaplaincy in Moral Injury (https://www.navac.
net/copy-of-mental-health), requiring extensive
initial documentation of literature review and
clinical experience, and ongoing continuing
education.

One major challenge will be the
agreement by the DoD and VA to begin
universal screening for moral injury, and to
collect/share data with research designers
for continued development.

Other challenges include the need for
leaders in research and interventions within the
field to initiate communication to move forward
in a more coordinated approach, including:
• becoming familiar with one another’s
  language/definitions, protocols, research,
  challenges, strengths, and needs;
• identifying collaborative initiatives in
  assessment, treatment, and distribution of
  information on moral injury;
• discussing a body of language and definitions
  for moral injury;
• generating pathways for training and use
  of assessment instruments and treatment
  interventions;
• developing a repository of research incorpo-
  rating bodies of research on related topics,
  including shame, grief, guilt, faith-based
  tenets of moral injury, and research with other
  populations;
• developing a public repository of resources
  for Veterans and family members to find
  points of entry for treatment and community
  engagement/support;
• developing a mobile app similar to those
developed by the National Center for
Telehealth & Technology (T2) for other military
mental health needs (http://t2health.dcoe.mil/
products/mobile-apps);
• discussing and revising the diagnostic nomen-
  clature for PTSD and MST, with consideration
  of an “umbrella” of moral injury under which
  PTSD, MST, and other subtypes of moral injury
  are described;
• identifying funding sources and how to submit
  persuasive and collaborative grant proposals;
• identifying how to disseminate information to
  clinicians and clergy treating Veterans.

We must bring together those using
Adaptive Disclosure, IOK, faith-based models,
community-based programs, arts-based
protocols, and immersive healing retreat models.
Such collaborative discussion and integration can
help identify multiple interventions to best serve
our warriors suffering from moral injury. Such
collaboration could include a series of on-line
and live regional and national round tables
hosted by leaders in the field and sponsored by
government and non-government agencies.

To omit initiating this collaboration, expansion of assessment, and development of clinical training protocols would be an error of commission, i.e., a national failure to integrate and disseminate a body of work in the best interest of our veterans. To do none of the above would be a further betrayal of our Veterans. We cannot delay, as to do so is to drive more Veterans into despair, alienation, and potential suicide.

Ultimately, a thirteenth century warrior who suffered as a prisoner of war before returning home to change his world (through founding of the Franciscan Order) challenges all of us, with or without moral injury, to become instruments for peace. While the Peace Prayer is anonymous, it reflects his vision to shift from an instrument of war to one of peace. Ironically, it is embraced by warriors struggling with addictions often related to their military service.

Lord, make me an instrument of your peace: where there is hatred, let me sow love; where there is injury, pardon; where there is doubt, faith; where there is despair, hope; where there is darkness, light; where there is sadness, joy.

O divine Master, grant that I may not so much seek to be consoled as to console, to be understood as to understand, to be loved as to love.

For it is in giving that we receive, it is in pardoning that we are pardoned, and it is in dying that we are born to eternal life.

Anonymous Prayer for Peace, 1912 (Loyola Press)

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Christiane O’Hara, PhD served as a volunteer Psychologist at the Functional Recovery Program, TBI Clinic, Dwight David Eisenhower Army Medical Center for 9 years. She has served as a Retreat Leader for Gratitude America; Advisor and Retreats Coordinator for Women Veteran Social Justice Network; and a Retreat leader for warrior, couple, and family retreats through Fort Gordon Warrior Transition Battalion. She is co-author of Rehabilitation with Brain Injury Survivors: An Empowerment Approach (1991); “ArtReach Project America and other Innovative Civilian-Military Partnering” chapter in War Trauma and its Wake: Expanding the Circle of Healing (2012); “Veterans and the Arts as Healing Interventions” (2014), “Sleep Assessment and Interventions for Service Members and Veterans” (2017); and edited double issues on Women Veterans (2016) and Veteran Retreats (2017) in Combat Stress. She is a military daughter, served as an Army spouse, and is the mother of a Soldier.

CH (LTC) Cliff Vicars, D. Min

Chaplain Cliff Vicars serves as the Deputy Command Chaplain for the 108th Training Command (IET) in Charlotte, N.C. He is also the Chief of Chaplain Services at the James H. Quillen VA Medical Center in Mountain Home, TN. He has served as an Army Chaplain for nearly twenty-three years and has a passion for working with Service Members and Veterans across all military components who have been injured due to military service. His work developing retreat models that focus on holistic care and healing have been a benchmark used to inform and guide the provision of ministry used by non-profits and military caregivers who use retreats to enhance healing. He sees the healing of Wounded Warriors as a responsibility of the entire community and works to build bridges between military and civilian providers, affording all an opportunity to contribute to the Warrior/Veteran journey towards recovery. As a Chaplain trained in clinical pastoral care, he has spent several years working in both Army and Veterans Administration hospitals. He is married to Sharon, who grew up in an Army household. They have two sons, Will (28), an Army combat Veteran, and Charlie (19).
Can I get 100% of your attention for the next 120 seconds?

I hope so, because you could help save a Veteran from suicide. Please continue reading.

STEP ONE

This article addresses SUICIDE and specifically to bring focus on Veteran suicide. Plain and simple. This is my priority here, and I pray that it sparks you into some positive direction and commitment to purpose.

Think about this… good and honorable men and women join our United States Armed Services and commit their lives to protect our great country and way of life. Many are sent to combat war zones. Some don’t return. Some come back with various injuries. One major and current statistic entwined in this reality, is that we are sadly losing 20 Veterans a day to suicide. Everyone shudders at the thought of suicide, and we should. It’s pandemic. Realizing that the World Health Organization has revealed that ‘worldwide’ 1,000,000 humans annually commit suicide! Why? Why? Why? That’s a major question and missing piece to the human puzzle. As a United States of America Veteran, myself, I’m compelled to find some answers and HELP my fellow Veteran where needed to turn this negative reality around!

BTW: While you read this article, statistically ONE Veteran will commit suicide. Hold that thought... I’m wondering, how many intelligent people realize the depth of that gross feeling of wanting to commit suicide? Do you?

In the next couple of minutes, I’m going to try to describe for you what the threshold of contemplating suicide feels like. You see, I personally experienced that state-of-mind some 50 odd years ago after my service in the US Navy. And for the record... once you experience the dreadful consideration of suicide, it’s with you for the rest of your life; kind of like learning to ride a bicycle, you don’t forget it.

I’m sincerely hoping this testimony will stir compassion in your heart for all those that go through this hell-like emotion every day of their life, and that this ‘brief’, gives you the sense of ‘we have to help them’! You see, my motivation is to help end the ‘suicide plague’!

Thanks for reading this far...

“What if we could save just ONE? What price can you put on that life?”

Imagine if you will, being so alone that all you want to do is cry. You cry, but that doesn’t help. You cry out to God... ‘where are you God?’ No answer. Never an answer. You feel that weird lonely pain again. It’s like a ball drops from your heart to your stomach. It inflates and goes back to your heart and pounds away trying to jump out of your chest. You attempt to cry again. No tears. You can’t figure out what the feeling is or...
how to deal with it, but deep down inside with your eyes bulging out of your head and your stomach wanting to dry heave, you just want your life to end. It’s that painful! It’s so damn lonely, you cry out to God. Is there a God? You feel nothing but despair and hopelessness. Absolutely no light at the end of the tunnel. Imagine having no hope! Unfortunately, that’s a small glimpse of why suicide looks attractive. Please, keep reading this paragraph over and over until you’re nauseous, then read on.

Many Veterans and other sufferers have real physical pain, and some have mental anguish that brings them to the point of suicide. So, what do we do? Seriously, what can we do? Nobody, and I mean nobody, seems to know how to solve it. Theorize, philosophize, discuss and discuss, but no solid answer. There are some glimmers of light and hope out there. And I can tell you from personal experience the best way to reach a person in that state-of-mind is to embrace them. Hug them. Stay in constant contact with them 24/7. Talk with them. Assure them. Love them. Don’t leave their side.

I’ll give you more of my personal experience at the end of this article. What I want you to realize and imagine is how important hearing the voice of a loved one is, someone who cares, someone that reach’s out and says, “how are you doing? I’m with you.” “Tell me what you need. I’ll get it for you.” Now if that sounds like being rocked in a cradle, it is. Like many people over the past few years, hearing the drumbeat in the media of how we are losing 20+ Veterans a day to suicide, moved this man (me) back to the emotions I long ago buried and how I dealt with it.

**STEP TWO**

So, like many of you, I prayed and I prayed some more and prayed for deliverance from the reality that many people, not just Veterans, suffer with thoughts of suicide, and what I have to share, can help them all. After all, I was once a suicidal Veteran!

When this idea came to me it was a true “ah ha” moment! Like sitting straight up in bed from a deep sleep and seeing the bright light of Jesus. ‘Here’s how I can help these Veterans!’ I know that with today’s technology, we as a human race can unravel and hopefully solve this dilemma. We’ve all seen the technology, push a button and call for help. So simple, right? Well, when this idea came to me, I felt it was an answer to a prayer. I came up with P.U.S.H., Patriot’s United for Suicide Help; PushUpVets.org is the birth of a global Web presence for this new tool to aid in the struggle. I knew what the product was going to be, I gave it a name, created a website and started to get the word out before I even had the actual product in hand. This is God inspired to me friend, (my answered prayer) and it all came together in literally, just a few days in 2016. I started calling all the big-name companies out there to introduce this idea, thinking for sure they would
jump in and want to take this project on. But it was a big fat NO from everybody, until I had a lead from someone that said you might try calling RescueTouch.com. This is a small company run by two Veterans. They became very sympathetic to my idea to the point they wanted to consider it.

So, I got excited and decided to pursue P.U.S.H., (Patriot’s United for Suicide Help) i.e. ‘Push Up Vets’ further, but lo and behold, after a couple of months of research, they decided there wasn’t a large enough market and a ‘market’ means making money from it. It was too small of a niche. After the floor fell out from under me, I thought, oh my goodness, this is going to have to be treated like a business. They put it on hold for several months, but I continued to search around and to be honest with you, I could not grasp the idea of creating this into a business. It was not my motivation. I already have a business and I didn’t want another one, but I still wanted to help Veterans. When I could find a little spare time, I kept digging around, talking to people, researching on the internet and quite frankly, after a while I gave up. And then, ding, ding, ding, after about six months, I got a phone call from Scott, one of the owners from RescueTouch. The idea sat on their hearts and minds long enough for them to say, “Yes, let’s give it a try!” Not for the money now, they also wanted to help save Veterans. Hurray!

We joined forces, dug in a trench and starting to pursue it. To date, there is a website that needs rebuilding, but it shows the device. I thought if we could save just ONE, hopefully we could save many others from this tragedy of suicide. Go there, it’s PushUpVets.org. I didn’t invent the device, someone else did that years ago. It’s a handheld panic button if you will. If you fall and press the button, they will come to your aid. The difference with the ‘Push Up’ or ‘Buddy Check’ as it’s called on the website: rescuetouch.com, is that you can hold it in your hand. It’s about the size of an automobile key fob. It has one button on it, with a built-in microphone and speaker that stays active for approximately one month before it needs recharging. It is cellular activated. If a Veteran is depressed to the point of having the button in one hand, and a gun in the other, my prayer is that he/she pushes the button.

Here’s what will happen next:

That small device sends out up to five text messages to the individuals that have been pre-selected, to talk with the Veteran. When these five individuals receive the text message, they simply respond back from their phone and that call goes directly to the device held by the Veteran wherever they are within ‘cellular’ tower range. The device acts like a two-way radio, so it’s instant communication. The device also has GPS capable technology which doesn’t have to be activated if one feels it’s not necessary. This is 2018 technology being utilized to its finest!

STEP THREE

Go to sleep, wake up, go to sleep… So much happens in between the lines of our waking day, do we even have time to deal with ‘stress’? Well, life is stressful. So, let’s just face it head on and take the positive juncture that is in front of us right now. Life is this moment. Yesterday is gone and there’s no guarantee that your next step or decision will ever be there to take. You could be gone from this life in the snap of a finger… and that’s a whole lot to consider. Right?

Now on to my story so you can better understand why I’m so passionate about
helping our suicidal Veterans.

I am a Veteran who was a U.S. Navy Photographer aboard the USS Pine Island, a Sea Plane Tender, where I served two tours to South Vietnam 1964-1966. We anchored in Cam Rahn Bay and DaNang. Our mission was photo intelligence and I spent 24/7 in the dark room breathing very toxic photo chemicals. That’s my claim to the onset of mental issues including the considering of suicide… So, I do feel I can speak from the ‘edge of a cliff or with a finger on a trigger’... so to speak.

Stress at it’s worst state, taxes and harms the body causing it to breakdown. Physical and mental breakdowns are tied together. Several years after release from active military duty and during the onset of my full nervous breakdown, I was arrested for bazaar behavior and disturbing the peace. I was subsequently institutionalized and just plain driven crazier in behavior than one would imagine. The movie “One Flew Over the Cuckoo’s Nest” was a very accurate presentation of what the mental asylum experiences were like for me “locked away” in the 1970’s. Pure horror movie stuff! I last wound up at a VA hospital in Coatsville, PA where my loving family actually believed I would be rehabilitated and brought back into normal society. (After all, there was absolutely NO family history for that condition). Well, that didn’t go as hoped, and things just got worse. I last wound up in a double lock down cell block (30’ x 60’ approx.) with about two dozen or so other helpless Veterans. I honestly felt that society and the VA were throwing away the key on me. And don’t think for a second that ‘society hasn’t thrown away the key’ of freedom of many suffering Veterans and other souls experiencing ‘mental’ illness. At the VA hospital, I befriended a Veteran in that concrete block cell that had been kept in and out of this ‘treatment’ facility for 15-20 years after he served in the Korean conflict. Sad to say this, but to this day, I’m not too friendly with medical doctors or www types and I hope you will understand why as my story continues.

I’m time tested you see. Two and half years of agonizing mental hell and torture through the doors of five separate ‘mental health’ facilities, the last one being the VA. It took that final VA ‘treatment’ and exposure to what seemed to be hundreds of drugs pumped into me and which literally brought me to my knees and the point that I could not even pick my head up from a table top on most days. Luckily, I avoided getting ‘electric shock therapy’, which is still administered today at VA hospitals. Nothing better than burning brain cells to make your day brighter... And yes, I remember seeing men and women transformed into zombies and met people that had had lobotomies performed on them!

Very scary stuff to experience as a young naive and trusting man.

Getting back to my new Korean War Veteran friend…. we spent our days in this concrete room sitting on the floor or pacing in front of windows (as there was no furniture). This is when I had this great spiritual awakening that society was ‘throwing away the key’ on me and I’d better come up with my own plan. So, I ‘faked’ being normal, hid the pills in my mouth and flushed them down toilets, which (in my opinion) is where they belong. I must have fooled the doctors in charge, as my new ‘faked’ behavior got me ground privileges. (I actually hate the fact that all those horrible experiences are so vivid in my mind still, and more pleasant and recent ones fade so quickly). Well onward with ‘ground
privileges... I didn’t waste a minute. I packed up my trusty guitar with a few underwear changes and headed out to the VA grounds. I kept walking and walking, all the time talking with Jesus, and how I’m not going down this road again! No sir, I kept going, and by sunset, I was over 100 miles away. Free at last!

My life story from here was sketchy, as I hitchhiked and stayed at various missions and crash houses until I eventually reconnected with some past friends that ultimately guided me into the world of natural health. At the time (mid 1970’s), this was considered ‘far out.’ This period became much more positive and enlightening. I learned enough about personal health and nutrition to ‘reverse engineer’ my last medical diagnosis of paranoid schizophrenia. Wow, now that’s still a mouthful to spit out almost 50 years later. (Just imagine carrying that baggage title through life) 50 years? Yes sir, I’ll turn 74 this year, 2018. By the grace of God and the understanding love I have from my wife of 43 years, I’ve raised a solid family, built a small business and stayed relatively healthy. How you ask? Reverse engineering of the body through detoxification, fasting, eating whole natural foods, plenty of fresh organic vegetables, sprouts and calculated vitamin supplements that’s how. And all it took was 3-5 years of concerted effort and determination to never go back to that hell I was in.

**STEP FOUR** This is where you come in. We, together, can make a huge dent in the suicide plague. P.U.S.H. / PushUpVets is now a 501c-3 Non-Profit. The significance of this is that we can attract the funding to conduct a ‘clinical or similar study’. Our plan is to use the funding to purchase and provide the devices for Veterans in the study, as well as providing the cellphone service required.

This study would show the potential benefit for a suicidal Veteran to conquer their inner demons with having possession of the PUSH device and being intimately connected to those who care the most about them. One PUSH will bring the first positive step in saving them from making a bad choice and having the opportunity to change their life.

No one should be left alone in this state. You don’t need special training to tell someone you love them. When you hear stories of individuals being put on hold or disconnected from ‘suicide hotlines’, as helpful as they may be, this PUSH device opens the door for a more personal connection. That’s where P.U.S.H. can become a household term.

Give due credit to those that manage ‘suicide hotlines’ and serve through mental health counseling. Their effort is honorable and should definitely continue. **We just have to keep trying new ideas until we break the web around this subject.**

Holistic clinics should become the norm. Teach proper nutrition and the physical results of ‘good vs bad’ lifestyles. It’s not taught in our schools and many families lack this knowledge. So, I’m appealing to your higher self to get involved. Learn more on this subject. Learn the benefits of holistic/natural living.

**STEP FIVE** While you’re in this mode of consideration, ask yourself what you can do to help! Get involved at whatever level of compassion and love you can handle. No time to devote but want to contribute, then pull out your checkbook or credit card and donate to P.U.S.H. Inc. (501-C3)

Write us a letter or call. Share whatever
is on your mind. We want to hear from you. Be candid, it’s okay. While life keeps moving forward, we will now be working together to bring about the potential GOOD from this effort. Do you have a clearer concept of Suicide now? Will you Help? You’re needed. HELP us please, so we can HELP STOP VETERAN SUICIDE!!! PushUpVets@gMail.com What if we could save just one? What value would you put on that life?

PUSH (Patriots United for Suicide Help) seeks to provide a two-way, push-button communication device to at-risk Veterans. This is pre-programmed with the phone numbers of family, friends, mental health providers and even suicide hotlines to quickly (with one-touch) connect the suicidal Veteran to a person who can help in a time of crisis. The device can be worn or carried by the Veteran, as it easily fits in a pocket and is the similar size of most automobile key-fobs. It is similar to the devices marketed to the elderly, worn around the neck and used to call for help if they fall or become incapacitated. The basic premise is simply, to have the Veteran push the button on the device, not the trigger of a weapon or take some other deadly action. In addition to providing the two-way communication devices, PUSH has considered utilizing other programming or support groups for suicidal Veterans, such as the use of social media closed groups and partnering with “like-minded” Veteran service-related organizations. All services strictly follow a peer support model and none of the board members or volunteers at PUSH hold any mental health or counseling degrees.

The PUSH devices are provided to the Veterans absolutely free of charge. PUSH seeks to pay for the costs of the devices and to cover the monthly wireless charges through charitable donations to PUSH. The cost of each device is $100 (a one-time fee for 100% ownership of device). Wireless charges are $19. to $24 per month (depending upon the level of service selected) or $390 for the first year of ownership of the device, $168 per year for service there-after.

The selection criteria used to identify the at-risk Veteran will involve interviews with a PUSH board member or volunteer to personally assess if, in their reasonable opinion, that Veteran would benefit from use of the PUSH device.

PUSH will cover the costs for the device and for the monthly wireless charges associated with it for first year of use. This will assure that funds are utilized for their intended purpose.

ABOUT THE AUTHOR

George Schmall

George Schmall, is a Navy Veteran who served in the Vietnam war effort as a US Navy photographer, handling photography support to intelligence efforts. He personally struggled with depression and suicidal ideation when he returned from active service in Vietnam. George’s mission is now to help Veterans like himself who are struggling with suicide by providing suicide prevention services to at-risk Veterans. He is the founder of Veterans PUSH (Patriots United for Suicide Help, Inc.).
Almost Sunrise (Directed by Michael Collins) tells the inspiring story of two young men, Tom Voss and Anthony Anderson, who, in an attempt to put their haunting Iraq combat experiences behind them, embark on an extraordinary journey – a 2,700-mile trek on foot across America. While the film exposes some of the brutality of war, it does not dwell there. It’s ultimately a story of hope and potential solutions. Most importantly, the film reveals the promise of holistic practices for healing. When Tom signs up for a special breathing workshop for Veterans, he must confront his deepest spiritual identity. He encounters Father Thomas Keating, a renowned Trappist monk who has counseled Veterans for decades, which gently illuminates the need to turn inward to achieve real peace – and gives guidance that culminates in a remarkable inner transformation rarely depicted on screen.

Where the stereotypes of “the broken Veteran” or “homecoming hero” leave off, the film continues onward, offering an unprecedented portrait of those who return from war; rich, complex, far more hopeful. Almost Sunrise allows us to connect with a universal human aspiration for happiness and through Tom and Anthony’s natural search for it, be reminded of our common soaring possibilities.

The film also acts as an urgent call for communities to better understand these deep-seated psychic wounds, and for the government to acknowledge and finally treat moral pain by using methods other than pills. Almost Sunrise deftly and movingly demonstrates the promise of holistic healing practices is on the horizon in a way that we cannot afford to ignore.

It’s a staggering statistic. Twenty or more U.S. Veterans take their own lives every day, which means, we lose more Soldiers to suicide than to combat. Despite billions of dollars spent on Veterans’ mental health, the national crisis rages unabated. Almost Sunrise is a timely and groundbreaking look at what could be a missing piece of the puzzle – the true nature of the psychological wounds of returning soldiers known as “moral injury,” and the undeniable potential power of meditation and nature therapy in helping Veterans to reclaim their lives.

Almost Sunrise premiered as the opening film at Telluride Mountainfilm in 2016, where it won the top Moving Mountains Award. It has had more than 500 screenings across the U.S., winning 6 major awards including the Cine Golden Eagle Award. In recognition of the positive impact the film has had in society, it has been honored with media awards from SAMHSA and the National Association of Social Workers. Almost Sunrise premiered on PBS in November 2017 and was recently nominated for an Emmy® Award for Outstanding Current Affairs Documentary.

Almost Sunrise is available for educational and intuitional licensing through New Days Films: https://www.newday.com/film/almost-sunrise Educational screening kits include discussion guides and lessons plans about ‘moral injury’, as well as 2 hours of bonus videos and other resources. For any questions, please contact: screenalmostsunrise@gmail.com or visit http://sunrisedocumentary.com/

For individual use, Almost Sunrise can be found on iTunes and Amazon.
Moral Injury Defined

While serving in combat zones, Service Members may engage in a range of ethical and moral challenges. To successfully circumnavigate these challenges, military personnel often reflect on their training, leaders, tactics, and rules of engagement. Despite effective training and operational experience, some individuals may inevitably encounter experiences that challenge their belief systems. When individuals experience an inner conflict that is at odds with their fundamental moral and ethical beliefs, this defines “moral injury.”

Currently, diagnostic tools to qualify signs and symptoms of moral injury are limited. The moral injury events scale (MIES) has been developed and provides clinicians with a “tool” to measure exposure to events in a military context, with the potential to contradict deeply held moral beliefs [Nash et al, 2013]. MIES is based on eleven items that address perceived violations of moral beliefs or betrayal by self or others, as well as perceptions of trust.

This article deliberates how one Service Member, after a combat deployment to Iraq in 2006, crossed this bridge of morality and landed in the zone of moral injury.

Generations of Selfless Service

Tom Voss joined the United States Army at the age of nineteen. His grandfather, Clair Voss, served in the United States Marine Corps, which had a significant impact on Tom’s
decision to join the military. His grandfather’s life was an embodiment of selfless service. He almost did not make it home from his time fighting on Iwo Jima.

On February 19–20, after just three days of U.S. naval shelling, Marine Commander, General H. M. Smith, had requested three reinforced divisions totaling 75,000 Marines landing on Iwo Jima. Among them was Clair Voss, a 24-year-old former Marquette University football player from Antigo, Wisconsin. He commanded a platoon of 58 Marines, 55 of whom would be killed or wounded on Iwo Jima. The savage struggle for control of the strategic island would be the only World War II battle in which U.S. casualties (22,000) outnumbered those of the enemy. A week after landing, Voss’s unit (A Company, 1st Battalion, 27th Marines) was ordered to assault Hill 222, directly forward of its position. Previous attempts at taking the key vantage point had been stalled by a heavy volume of enemy mortar and machine-gunned fire; yet the obstacle had to be taken.

Clair Voss grabbed his work tools: a satchel of grenades and plastic explosives. Under cover of suppressive fire provided by his own men, he slowly crawled forward and around to the rear of the Japanese position. The lieutenant expertly pitched grenades to silence an enemy machine-gun nest, but his success drew hostile fire from nearby “spider holes.” Voss then crawled toward the Japanese pillbox, climbed onto its roof, and tossed demolition charges into the fortification. The resultant explosions wiped out the position.

Voss later wrote: “I was frightened, scared, and apprehensive about everything connected with being shot at on Iwo Jima; however, the training the Marines gave me overcame any fears that I had about what had to be done.” Voss’s exceptional valor at Hill 222 would result in the awarding of the Navy Cross.

More immediately, it also freed up his company to take its next objective. After he moved out with his men, a Japanese mortar round exploded next to Voss. Multiple shards of shrapnel lacerated his arms and legs, severed his nose, “tore up” his skull, and pierced his lung. Voss blacked out, but a Navy corpsman wrapped a body bandage over his sucking chest wound and tagged him for emergency medical evacuation.

He was placed on a stretcher, carried to a battalion aid station, and given several transfusions. From there, Voss was transported by jeep under continuous enemy fire to the beach and placed with a stack of dead bodies. A Higgins boat conveyed Voss to a hospital ship filled with wounded and dying Marines. Navy physicians, including George E. Collentine, a former Marquette University basketball player and an alumnus of the medical school, began stabilizing Voss by draining blood from his lung cavity.

The Marine lieutenant slowly came back from the near dead. A long convalescence followed at a naval hospital on Guam, where physicians began the delicate process of removing shrapnel from Voss’s skull. Due to the difficulty of extraction, surgeons had to leave many bits of metal inside their patient’s arms, legs, and face. Voss was transported to naval hospitals in Honolulu, San Francisco, and Naval Station Great Lakes (north of Chicago) for six months of additional treatment and rehabilitation. Upon discharge from the Marines, he decided to enter law school at Marquette

Clair Voss had a profound influence on his grandson, Tom, in his formative years and taught him a great deal about selfless service. Tom’s father, Patrick Voss, was a social worker, and his mother, Margret Voss, a special-education teacher. From a very young age, it was clear to Tom that his family’s business was service to the community and the nation.

When Tom walked into the recruiting station in Brookfield, Wisconsin, he immediately sat down and requested a slot in the infantry. The Army recruiter did his best to sway him in a different direction with more massive signing bonuses. However, he was not interested. Tom followed in his grandfather’s footsteps and served on the front lines.

Tom received his orders and was whisked away from his parents in the dead of night by a recruiter in January of 2003. From there, he made his way to Fort Benning, Georgia, Home of the Infantry. After graduation from infantry school, he was stationed to Fort Lewis, Washington and attached to 3rd Battalion, 21st Infantry Regiment, an element of the 1st Brigade, 25th Infantry Division, one of the Army’s first Stryker infantry brigades. More specifically, Tom reported to the headquarters company as part of the Battalion Scout-Sniper Platoon, where he assumed the role of infantry scout/reconnaissance for his Battalion Commander.

After a year of training, the battalion received orders to deploy to Mosul, Iraq. Tom did not know too much about Mosul or what was in store for him there. Unannounced to him, they would spend the next twelve months in heavy combat. The first time they made contact, a young Iraqi boy, not older than the age of ten or twelve, had thrown a Molotov cocktail; a glass bottle with a rag shoved in the neck of the container. This is by design and will set on fire to anything it encounters.

From that point on, they were frequently attacked by car bombs, improvised explosive devises, small arms fire, indirect mortar fire, and suicide car bombers. In the beginning months, they remained terrified. The fear was almost paralyzing, until one day, a massive car bomb rocked their platoon. It then dawned on them that they were going to die. Tom was twenty years old when he accepted the possible reality of death in combat. After that event, he became free and a more effective Soldier. He had developed an entirely new mentality, believing that since there was a strong likelihood that he was going to die, he was going to “take out” as many of these insurgents as he could before that possibility became a reality.” It was not long after this paradigm shift that they lost one of their teammates, their Platoon Sergeant. Not only did they lose the leader of their platoon, but each of them lost a piece of their souls and wondered whether or not the rest of the platoon would return to the United States alive.

Tom and a few members of his platoon were given the day off, this was a routine practice to avoid burnout on noncritical missions. It was getting later in the day and his platoon still hadn’t returned from their intended mission. The mission was to provide a newly deployed unit
a tour of Mosul. This was nothing particularly challenging but was supposed to be a quick “out-and-back” type of a task. When they finally returned, their squad leader told them the horrible news. The members of the platoon that were given the day off, including Tom, were devastated that they were not there to assist with the mission.

Tom questioned what could have been different if he had been there. “Why is he dead and I’m not? He had a wife and kids, and I didn’t. It should have been me.”

Shortly after this earth-shattering event, they lost a second platoon member: the team three squad leader, another pillar of the platoon. This time Tom was on scene and the events of that day remain with him to this day. The platoon was ambushed from the rooftop after being blown up by an improvised explosive device (IED) or roadside bomb. His team leader suffered a fatal gunshot wound to the head. When they had transported him back to the medical unit, it was already too late. Tom’s platoon-mates who were in the vehicle with the casualty emerged from the depths of their Stryker combat vehicle, covered in blood. What many people were unaware of is that the scout-sniper platoon of HHC 3/21 were responsible for cleaning out the vehicle after catastrophic events such as this. It is unimaginably impactful it is to be placed in the role of washing your friend’s blood and brain matter out of your vehicle.

Shortly after the loss of their friends, they received a new Platoon Sergeant. During the very first mission out of the gates, about a mile down the road from their Forward Operating Base (FOB), they were rocked by a massive car bomb – an explosion that engulfed a four-lane highway. We heard that familiar call over our platoon radio that the platoon had sustained another casualty. It was their new Platoon Sergeant. He had been struck in the head by a piece of shrapnel, which had lodged itself in his eye. They turned around immediately and headed to the medical treatment facility. The platoons brand new Platoon Sergeant ended up losing his eye and had an abrupt departure to Germany for medical treatment.

**Transition to PTSD and Moral Injury**

The twelve months that Tom spent in Mosul was overrun with fatalities, lost friends, civilian casualties, suicide car-bombs, decapitations, explosions, gunfire, and the forever-lasting impact of all of this on his soul. Tom separated from the military shortly after returning from the deployment in January of 2006. He was 21 years old. He felt guilty for leaving his friends who were getting ready to go back to Iraq. He thought he was letting them down. He was not sure that he would be able to live with himself if the unit endured another casualty. Most of his friends that he deployed with were “stop-lossed;” a “pause” in their military service contract so they could deploy once again. This usually meant that their term of military service had come to an end, but that their service was still needed.

Tom returned to his parents’ home in Wauwatosa, Wisconsin. From there, he did not know what to do with himself after all that he had just experienced. He had no one in his immediate network to connect with, because no one knew or understood what he had experienced, except my grandfather, who had long passed away. Most of Tom’s friends from high school were gearing up for college graduation.
Tom did what he thought was best and started using his GI Bill benefits to go to attend school to become a firefighter. It was not long after being hired as an on-call fire fighter that Tom realized that he was no longer in a place to effectively deal with trauma anymore.

Tom was diagnosed with Post-Traumatic Stress Disorder in 2008. From there, he was put on a cocktail of medications to address depression, anxiety, and insomnia. The combination of all these medications made him feel less than human. He was completely numb to everything and everyone around him. Moreover and in addition to that, he was still self-medicating with alcohol. Every night that he made the choice to drink, (he would usually drink five or six nights a week), Tom would roll the dice and leave to fate, what would happen when combining Ambien with alcohol.

His life would move in perpetual cycles of being okay, able to function day-to-day, to completely crashing and burning. He would shut everyone out and drop out of school, destroy relationships and push people away. He just wanted just to die. Every single day, Tom would think of new and innovative ways to take his own life. “Maybe I could find a nice sturdy Wisconsin Oak tree on a country highway to wrap my car around?” Maybe he could take enough of those prescribed medications and not wake up. His mind would drift from fantasy to fantasy to find the means to end the suffering he was enduring on a day-to-day basis.

Tom spent about ten years in this cycle – being okay for a month or two and then, “full on the crash and burn.” One day, in 2013, Tom was at his sister’s apartment when his suicidal fantasies became more present in his reality. He thought that if he was going to go through with taking his own life that, he needed to give an honest effort to address his many underlying issues. There was no way, however, that he would ever be able to address the traumas of his past with everything else going on in his life. Tom needed to indeed focus on himself, with himself, and by himself.

To accomplish this, Tom would walk. He would walk from Wisconsin to California to see his friend Emmet, who was in his platoon when they deployed together to Mosul. Walking across part of America would give him enough time to address the traumas of his deployment. After running the idea past a few family members and friends, Tom received overwhelming support for this idea. Within three months, he would be on the road, with good friend, Anthony Anderson. Anthony did not serve with Tom in Mosul, but he was deployed to Baghdad, Iraq, from 2004-2005, at the same time Tom was in Mosul. Together they would confront their war traumas. Tom had no idea how to accomplish this or how to obtain the results he desired, but he knew he had to move. He just had to keep moving.

Tom and Anthony realized that they would have to fundraise to cover the cost of their bills while on the road. Because they put out a call to action, they were able to connect with some independent documentary filmmakers, who thought what we were doing would make a compelling documentary. Tom and Anthony agreed to allow them to document their experience on the road. This film would later become the Emmy-nominated documentary, Almost Sunrise.

Not long after connecting with the filmmakers, Tom and Anthony were exposed to...
the concept of Moral Injury - a wound to the soul caused by the participation in or witnessing of, actions that transgress one’s deeply held sense of right and wrong or their moral belief system. After learning about this concept, they both explored it at length and in great depth. Tom looked at his diagnosis of Post-Traumatic Stress Disorder versus Moral Injury, realizing that there were many commonalities, but that they were distinctly separate, but parallel entities.

For Tom, PTSD manifested with the physical manifestations having served in a hazardous environment for an extended period which made perfect sense to him. When he returned home from Iraq, he would react to cars parked on I-94 West the same way that he had in Mosul. He would move as far as he could from these vehicles, as any one of them might readily be a car bomb. Sounds, smells, and people, would trigger memories of the most perilous time in Tom’s life, where they were being watched and hunted daily. Moral Injury, on the other hand, set in a little later down the road. When enough time away from the military and the military culture had passed, he had to ask himself the very toughest of questions: “Was I justified in my actions? Could I have done something differently to have saved the lives of my friends? Would my community accept me if they knew what I participated in? Was the war I took part in justified? Was all the killing and death justified?”

Some of the symptoms Tom experienced were grief, guilt, shame, depression, and sorrow; thoughts that could not be easily medicated away in any case. He believed that it is essential to arrive at the cause of these emotions in order for them to be successfully treated. After exploring this concept more deeply, Tom realized that he was living his life with both PTSD and Moral Injury. The deaths of his friends and fellow Soldiers, witnessing all the civilian casualties, and not having a solid understanding or foundation of why we were fighting in the first place, all contributed to the experience of Moral Injury.

The men left on their trek in late August of 2013 on the hottest day of the year. Their bags were overpacked and they set the ambitious goal of walking twenty miles a day. They made it as far as ten miles on the first day. Devastated and uncertain of their life choices, they pushed on to grind through the state of Wisconsin. From there, the Veteran pair walked through the great states of Iowa, Nebraska, Colorado, New Mexico, Arizona, and California. The trek took five months to complete. At the end of 2,700-miles, Tom realized how much more work he had yet to undertake in order to resolve the traumas of his past that stemmed from his wartime service. “I didn’t feel completely healed by any means, but rather, I understood that I had taken the first steps to my personal healing.”

On the last day of the trek, Tom was invited to a breath-based meditation retreat for Veterans and their families in Aspen, Colorado. He knew that the old Tom would have shut down this opportunity immediately, so he reluctantly boarded a plane to Colorado where he would participate in a meditation workshop and master Power-Breath Meditation over the course of a five-day experience. Through this process, Tom was able to unload and unpack a lot of his past traumas through the power of breath. He participated in some light yoga, pranayama’s or yogic breathing, and SKY meditation (Sudarshan Kriya Yoga) - a rhythmic breathing technique
with roots in India as described below. There was now a separation, a space, between Tom and his emotional self. He was able to view his past traumas subjectively, “but without getting sucked back into a black hole of depression or anxiety”. For the first time in over ten years, Tom could breathe.

Tom has been practicing these breath-based meditation techniques for the past four years. He is no longer on any medications, does not consume alcohol, and he is on the way to becoming a certified yoga instructor. He volunteers his time to help Veterans who have participated in the Power Breath Meditation Workshop (PBMW) by Project Welcome Home Troops http://www.projectwelcomehometroops.org/. Sudarshan Kriya Yoga (SKY) Practice is a set of breathing techniques is the cornerstone technique learned in the PBMW. Through rhythmic breathing patterns, the SKY Practice brings deep mental and physical relaxation which can reduce symptoms of anxiety, anger, insomnia, and depression. Through interactive discussions, the PBMW builds a framework for resilience and empowerment and develops self-awareness, connectedness and community, and a positive outlook.

Physiological Mechanisms of SKY Breathing

The physiological responses to physical stress (i.e., blood loss) or cognitive stress (i.e., moral injury or PTSD) consist of adjustments in metabolism, cardiovascular function, and the autonomic nervous system. Each of these mechanisms contributes to the physiological reserve of an individual and is specific to the genetic make-up, non-genetic factors, and
event dependent (i.e., the level of stress) [Carter et al., 2014]. In nature, the breathing patterns of animals reflect the presence of environmental stressors (i.e., predators, drought) and the level of physical activity. However, it is unknown whether or not non-humans can experience “morality.” While humans are presented with numerous internal and external stressors on a daily basis, the consequences of these insults on short and long-term human performance, health, well-being and “morality” are not always considered.

We previously investigated neurophysiological mechanisms underlying yogic breathing and demonstrated a concomitant temporary state of alertness and calmness, resulting in spontaneous activation of the autonomic nervous system. Breath-based meditation seems to modulate metabolism and cardiovascular function through neural pathways and structures within the brain [Carter et al., 2018]. However, precisely how these physiological responses contribute to potential acute and long-term improvements in human performance and well-being are unknown.

We postulate, however, based on existing evidence that Sudarshan Kriya Yoga (SKY) meditation and associated sequence of breathing patterns and durations likely simulate various peripheral and central sensory pathways related compensatory mechanisms that govern balancing metabolism, cardiovascular and nerve function.

If you dissect what holistic healing modalities Tom experienced over the duration of the trek, you will find peer support, nature immersion (nature-based therapy), community engagement and support, meditation, yoga, and SKY breathing techniques. This combination set him on the path to healing the unseen wounds to the soul.

REFERENCES
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LTC Robert Carter III, PhD, MPH, FACSM, FAIS is the Product Manager for Medical Simulation, Program Executive Office of Simulation, Training and Instrumentation (PEO STRI), Orlando, FL. He is a graduate of the Army Medical Department Officer Basic and Advanced Courses and is a member of U.S. Army War College, Class of 2020. Dr. Carter completed postdoctoral training at Harvard School of Public Health in Boston, Massachusetts, holds a Doctor of Philosophy (Ph.D.) in Integrative Physiology & Biophysics, a Master of Public Health (MPH) in Biostatistics and Epidemiology. His military awards and decorations include the Meritorious Service Medals, OEF and NATO Campaign Medals, Combat Action Badge, the Order of Military Medical Merit, Order of Saint Maurice (Legionnaire) by the National Infantry Association, and the Army Surgeon General’s 9A Proficiency Designator. He is a fellow of American Institute of Stress (FAIS). He has published over 100 peer reviewed articles, abstracts and book chapters. Dr. Carter has a book in press (Harper Collins Leadership, Scheduled Release December 2018) entitled, The Morning Mind: Use your Brain to Master Your Day and Supercharge Your Life.

Tom Voss

Tom Voss served on active duty in the United States Army for three years, from 2003 to 2006. Tom served with the 3rd Battalion, 21st Infantry Regiment, an element of the 1st Brigade 25th Infantry Division, one of the Army’s first Stryker Infantry Brigades. He served as an infantry scout in the battalion scout-sniper platoon. In October of 2004, after 20 months of training with his unit, Tom was deployed to Mosul, Iraq to support Operation Iraqi Freedom. In 2013, he teamed up with fellow combat Veteran Anthony Anderson to plan and execute a 2,700-mile trek from Milwaukee, Wisconsin to Los Angeles, California. For his work empowering veterans to overcome moral injury, Tom has been featured in the New York Times, Newsweek, National Geographic Adventure, Men’s Health, USA Today, Fox News, the Chicago Tribune, Epoch Times, and the Hollywood Reporter.

Michael Collins

Michael Collins is an Emmy nominated filmmaker and founder of Thoughtful Robot Productions. In 2011, his first feature documentary “Give Up Tomorrow,” premiered at the Tribeca Film Festival and won the Audience Award and a Special Jury Prize for Best New Director. The film went on to screen in over 75 festivals in more than 40 countries, winning 18 major awards, including seven Audience Awards, four Human Rights Awards and the Activism Award at Michael Moore’s Traverse City Film Festival. This documentary was Emmy-nominated for Best Investigative Journalism and nominated for a Grierson Award in the UK. Michael’s most recent feature, Almost Sunrise, is the first film to directly address “moral injury.” The film premiered at Telluride Mountainfilm in 2016 and has had more than 500 screenings across the U.S., winning 6 major awards including media awards from government organization SAMSHA and the National Association of Social Workers. It opened theatrically in select US cities, followed by a PBS national broadcast in November 2017. “Almost Sunrise” was nominated for an Emmy® Award in 2018 for Outstanding Current Affairs Documentary.

Fall 2018 AIS Combat Stress www.stress.org
A conversation between Lila, a Marine fighting for her life, and RJ, her therapist friend who herself has struggled and recovered from suicidality, reveals the promise of holistic practices for healing.

Lila: “Knowing your life has no meaning... how do you function?”

RJ: “Well, basically you continue on because you don’t really know why you’re here, what’s in store for you or why you’re in so much inescapable pain and it’s damn hard to kill yourself even though you can’t stop thinking about relief. What you don’t realize is the Lord or Universe or whatever you want to call it has given us an undeniable, inexorable, undefinable, biological predisposition to live at any cost. It is the constant battle between these two, living and dying, that causes more anguish than anyone can imagine... day after interminable day... night after exhausting night.”

Lila: “But I know things are a bit more complicated than that, for sure.”

RJ: “It’s not unusual to feel like you’re the only one feeling this way, like you want to just dissolve into nothingness, just disappear. You watch others continuing on, doing their jobs, going about their business, living their lives with their families, loving their spouses, playing with their dogs, all the while appearing very normal and usual. It is natural to feel less than. It’s only reasonable to feel like the odd man out.”

Lila: “I feel that way. But it helps very little knowing that I’m not the only one who has experienced that. It’s like finding out you are not the only one in hell... how is that helpful? That’s supposed to make me feel better somehow? It’s like being told, “Don’t worry about being suicidal, because it’s only mental illness.” Huh? How does being told that I have a mental illness help make me feel better? So now I’m crazy?”

RJ: “Yup, I understand why that would not automatically make anyone want to come forward and talk about how crappy EVERY DAY feels!”

Lila: “Not me, I’m not saying a word, not one word ever again.”

RJ: “I’m glad you told me, Lila. You know I only realized my own pain as ‘suicidality’ when I was 13 at my first attempt – which, by the way, was never discovered by anyone. It wasn’t until through my clear and crystal understanding in sobriety that my psyche finally deemed me ready to remember the childhood sexual abuse perpetrated by our babysitter’s boyfriend. It was that memory that allowed me to start my
research into the naissance of my own suicidality. I dove into the neurology of thought and the psychology of trauma. Since then I’ve been able to unravel the psychobiology of suicide which I outlined in my book, ‘Just because you’re suicidal doesn’t mean you’re crazy: The psychobiology of suicide.’ Since the very first day a patient revealed their suicidality to me, I’ve been keeping statistics and the similarities in their mutual experiences are astounding.”

Lila: “So what happened when I told you that I knew I wasn’t the only one in the military who was suicidal? I mean I suspect a lot are.”

RJ: “The first report that military suicide had superseded the civilian rates created an urgency in me to try harder to protect innocent lives. Research into how military personnel might become suicidal fell to those professionals who seemed to look only outward when the problem was inward. Epidemiological researchers seeking roots of suicidality appeared to be focused on stressful telltale events underpinning combat or a combat support role. Only in 2014 did three different articles in the Journal of the American Medical Association discuss the possibility that military personnel might have had emotional issues before entering the military.”

Lila: “My recruiter told me to keep quiet about any emotional stuff if I wanted to be a Marine.”

RJ: “It occurred to me that you were not the only one who might have been encouraged by their recruiter to overlook mentioning that you have struggled with suicidal thought. No one who signed their original paperwork knowing that they were omitting that information felt like it would come back to bite them later on. After all, there was no diagnosis. No one ever knew about it. You, like many others, never told their doctor or anyone else of responsibility in their lives. After signing on the dotted line, getting sworn in, you have a tendency not to look back. However, making that mistake in times of war and learning that there might be probative evidence to the contrary could be considered treasonous.

Many potential Service Members don’t really understand that suicidality morphs over time and can start merely as thoughts of not wanting to be here. Those thoughts can deepen and strengthen without a person realizing it.”

Lila: “Yeah, but are you suicidal if you just wish you were dead a lot?”

RJ: “Well, what does that really mean? Many people don’t identify those thoughts as potentially dangerous. However, if you look closely at the trauma driving those thoughts, it doesn’t take much scrutiny to conclude that wishing you were dead with frequency are thoughts commensurate with precursors to suicide.

Lila: “I really felt like I had to assure the recruiter that I’d never had any mental health issues.”

RJ: “There are numerous reasons a person would not reveal any emotional problems to a recruiter if he or she wanted desperately to be in the armed services. And almost every male member of your family had been a Marine. And you were an exemplary Marine.”

Lila: “Unfortunately in Iraq I was stupid enough to admit that I was feeling like nothing mattered (having suicidal thoughts). That’s when all hell broke loose.”
RJ: “That was unconscionable, the abuse you suffered from your own commanding officer! You told me he accused you of being selfish, unpatriotic, a failure, a nuisance, and worse – a danger to your unit. When you came home you told me the abuse continued and even got worse broadening to serious and deadly sabotage of your equipment. I didn’t know what to say to you; I felt so badly for you. I told you I believed you and still do but understood why no one else wanted to listen nor would your complaints, I feared, land anywhere near receptive ears. I’m so sorry that you continue to be the target of cruel and criminal intentions making you feel more suicidal than ever before. The men who were supposed to have your back had summarily stabbed you squarely between the shoulders. That betrayal had to be more devastating than any other fatal festering wound could possibly be. How could you be expected to continue on, feeling like this... like a coward... worthless and so full of contempt for yourself and for the treachery of your abusers - the very members of your unit. This was worse than any trauma or abuse you could have ever endured as a child or even in battle - and there was no escape.”

Lila: “All I know is I wish I’d never reached out, never said a word.”

RJ: “I work with individuals from 12 years old to 70 plus, civilians and military alike. All of these individuals are in some stage of suicidality and all of their suicidal ideation began as a result of untenable, inescapable childhood or adolescent trauma. It all began with the thought of “not wanting to be here” as a way to save their lives and get them through otherwise unbearable trauma. I explain to my patients it’s not their fault. This unavoidable, unchangeable situation began an unconscious default thought pattern meant to save their lives. They begin to understand that their suicidality began as a coping mechanism to deal with this trauma. Their thoughts of not wanting to be here, like many coping mechanisms, were emotionally reinforced forging stronger and stronger neural pathways each time life presented them with stress or difficulty. And it certainly wasn’t their fault that their brilliant brains successfully careened down well-worn wired default neural pathways to the familiar result. It remains only reasonable to sit in deep reverie of a refuge free of pain, free of frustration, free of the angst and anguish of life’s seemingly dire and endless entangled complications.

Coming to realize that our brains have implemented an ideal and efficient way to save our lives and that the unconscious mechanism over time has turned on us is NOT our fault. However, after learning and understanding this process, it is our fault if we continue to do nothing to take charge of our lives. The dreadful realization that too many people don’t know this and are relegated to ending their lives before they have a chance to is beyond disgusting and painful to me.

I need to make one very clear distinction. I am referring to one kind of suicidality - chronic suicidality - in my experience the most prevalent type. There are other forms of suicidality. Situational suicidality is temporary caused by unfortunate circumstances happening in one’s life that cause great consternation, often feelings of self-blame, loss and grief. Antepartum and Post-Partum Depression are examples of situational suicidality. This type can be treated with a short term of anti-depressant and/or some concerted counseling. Another more
treatment-resistant form of suicidality stems from a psychotic break or the onset of schizophrenia hallmarked by delusions and/or hallucinations.

**Lila:** “They gave me an anti-depressant and said everything would be better in a few weeks.”

**RJ:** “I’m sorry, Lila, it’s not that easy or simple. I wish it was. But many people take that medication and if things don’t get better they often don’t seek any other possible remedy. Things can continue to get worse for them. By far the most hidden and stigmatizing type of suicidality is the chronic form. It can last for decades with individuals holding on to tenuous life by clinging to family, or religion or job obligation. Unfortunately, without full recovery, an individual beset with chronic suicidality will sooner or later be confronted with weakening inhibition and overwhelming pain or loss. This occurring to such a degree that the individual cannot hold on to the mainstay that has since been their anchor to life.”

**Lila:** “I know I said I could never do it to my son and new granddaughter.”

**RJ:** “But what happens to that resolve if something dreadful and final happens to them? What then? What will hold you together and what will hold off your impending suicidality. The next serious problem will test your lost resolve and tempt you once again. The anguish will start again charging you with the reactivation of that subconscious neural pathway that originally brought you relief with thoughts of “not being here.” Without ongoing vigilance to your recovery from suicidality, you’ll quickly be back in the deep pain of suicidal contemplation. Along with recognizing the vexing toxicity in your life and being willing to face it down and deal with it, there is another mechanism that builds over time when you’re not paying attention. It is the selective attention we pay to the seemingly dreadful and odious state routinely being reported in this world. Because we love to be right, we’d often rather be right than happy. We constantly and intently, yet subconsciously, absorb those abhorrent, loathsome, detestable and repellant aspects of life and hold them as proof of our core belief. Confirmation bias proves to us without a doubt that our belief that life on earth is painful at best... and not worth living one moment longer. Each moment of endurance pushes us closer to the inexorable edge of life itself. And that penchant for looking at life not worth living makes it possible to overlook the redemptive meaning of relationship. Somewhere along with the abominations in life we include ourselves. It’s possible then for us to prove to ourselves and others that the world is permanently impaired and thus further poisoned by our presence in it. Without specific and pointed intervention for resolution of ambivalence, no external enticement can change that sure juggernaut.”

**Lila:** “But my psychiatrist said that when a person’s life becomes unbearable they turn to suicide.”

**RJ:** “That tunnel vision and incredibly simplistic opinion outrages those of us who have struggled so magnificently to stay alive beyond untold daily difficulties. Because what those individuals don’t know is we strive mightily not to kill ourselves but instead to STAY ALIVE! We do everything and anything to keep going. You know we all will employ as many coping mechanisms as we can. Each one works for a while - then over time, not
so much. This becomes a ubiquitous abiding effort lasting year upon year that no one with that tunnel vision has the perception to authenticate. Realizing recovery means concerted effort towards specific goals. Those goals must be underpinned by renewed almost daily conviction towards putting one foot in front of the other. One must remember giving up means a return to anguish. That anguish is an undulating negative feedback loop alternating between relief from thoughts of ending life and deeper pain resulting from the battle to achieve that elusive end.

You know I was careful to give my readers and my patients the benefit of my research and my lived experience in establishing my own recovery.”

Lila: “Don’t you ever worry if it was so easy to fall into this thought pattern and behavior and so difficult and challenging to get out, aren’t you afraid of it just being postponed and not really being removed? I find times when I once again have let the demon of perfection tie me up and lay me sweetly across the railroad tracks. I feel like I’ve fallen down the rabbit hole again. Why? What happened to me?”

RJ: “I can tell you that I firmly believe in the AA (Alcoholics Anonymous) saying that ‘When you are not paying attention to working your recovery, you can be assured that your disease is doing pushups in the closet.’ That is so true. I’ve had patients call me months and years after they have quit seeing me regularly. They are distressed because their thought patterns have risen again. It isn’t very long before they realize they have stopped working their recovery. They’ve started hanging around negative, toxic people instead of their understanding supportive friends. Or they have let themselves neglect good sleep hygiene, focus on every negative happening in the world, stop a balance diet, quit their routine of mindfulness, binge watch true crime dramas, or simply given up on their daily commitment to gratefulness. Everyone’s recovery is different, and everyone must build their recovery as a basis for future daily living. When you stop being vigilant and stop being rigorous about doing those identified things, you can be assured your brain will return to that well-worn pathway at the first sign of stress. That indelible neural pathway will never go away but it can be purposely atrophied through vigilance. The neural pathway that allows you to still remember how to tie your shoes will not disappear just because you’ve worn Velcro closing shoes for decades and can’t remember the last time you tied your shoes.”

Lila: “So full recovery is definitely possible?”

RJ: “Successful recovery relies on never giving up. Educated and dedicated social support is vital. Like the Twelve Step movement, it will obviously take years before the world sees that chronic suicidality must be treated in a different way than other types of suicidality. In the same way that stigma has been somewhat removed from alcoholism as we learned that it is a neurobiological adaptation not a matter of willpower, I look to the same course of events for chronic suicidality. Likely it will not happen in my lifetime. But I see that as no reason to stop my efforts towards enlightenment not only for those who suffer but also for those in relationship to those suffering.”
Lila: “I remember our agreement: say hello to everyone, smile at everyone even if they flip me the bird. You never know who might be thinking they’re invisible and no one cares they’re alive. You could be an angel unaware and the one that breaks the bind of suicidal rumination.”

RJ: “I hope that this ‘over the top’ explanation helps you understand the vagaries of suicidality and recovery in a new and different way. You can do it. Anyone can. It’s all about vigilance and not having to do it all alone.”

ABOUT THE AUTHOR

Randi Jensen

Randi Jensen is a Licensed Mental Health Counselor, Chemical Dependency Professional, former Director of The Soldiers Project Washington, and Founder/Director of Jensen Suicide Prevention, Inc. Randi is currently in private practice in Shoreline, WA, specializing in treatment for chronic suicidality, substance abuse, and trauma. Author of “Just Because You’re Suicidal Doesn’t Mean You’re Crazy: The Psychobiology of Suicide, 2012” and chapter “Military Suicidality” (“Trauma and its Wake”, Routledge, 2012). R. Jensen is an accomplished conference speaker and trainer in Chronic Suicidality, Motivational Interviewing, Current Trends in Drug Use, Gambling and Suicide, PTSD and Suicide.
Anyone interested in more information about this film and scheduling possible screenings may contact the filmmaker through isaacpopefilm.com. The trailer for this film may also be viewed on this website.
Fed the daily diet of horror and toxicity within leadership and confronting the very worst that humanity has to offer, defying words and violating all that is right and good and decent, has come to capture the other signature wounds of war – moral injury and the 10,000 miles of bumpy road that far too often, lead to a bottomless void and a life devoid of meaning. The next fork in the path may be the one that leads to suicidal intent, with shattered beliefs that the world, once thought to be a benign and benevolent place, is quite the contemptible dwelling for the realities once held dear. This issue of Combat Stress should serve as an alarming wakeup call to arms for clinicians to avail themselves to the critical awareness and the multitude of treatment interventions that confront the tragic nature of wartime service and its longstanding, life-nullifying impact. We can ill afford to look the other way at that which results in such damage to the psyche and the soul.
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