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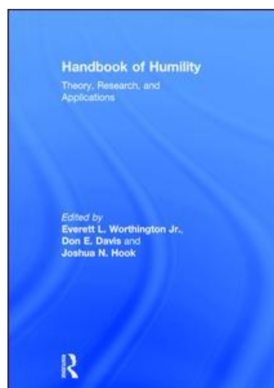

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Theory, Research, and Applications
Everett L. Worthington, Don E. Davis, Joshua N. Hook

The Clinical Application of Humility to Moral Injury

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23

THE CLINICAL APPLICATION OF HUMILITY TO MORAL INJURY

An Exemplar of Positive Military Psychology

Brandon J. Griffin, Everett L. Worthington, Jr., Robert F. Dees, Laurel Shaler, John Benesek, Treven Pickett, Joshua N. Hook, and Don E. Davis[1]

Military service in general, and combat in particular, can present a wide variety of scenarios to service members that pose ethical challenges and in some circumstances violate personal values. Although exposure alone does not necessarily lead to clinically significant levels of distress, *moral injury* can occur when service members witness or perpetrate an act that violates their sociomoral values and impairs their perceptions of self-worth and social connection. In the current chapter, we develop a sociocognitive framework to guide efforts intended to alleviate the problem of service-related moral injury, and we introduce *humility*—that is, a dispositional tendency to form accurate self-appraisals, behave in other-orientated ways, and present oneself modestly—as a component of prevention and intervention efforts that target moral injury.

Humility

The field of positive psychology complements a historical focus among social scientists on disorder by investigating character strength, virtue, and well-being. In fact, positive psychological emphases on resilience, values-based living, and leadership have even given rise to a positive military psychology (Matthews et al., 2008). Nevertheless, humility is one of the latest positive psychological constructs to debut and has yet to be integrated into military healthcare settings (Worthington et al., 2015).

Scholars conceptualize humility to have three components. First, humility entails having an accurate view of oneself (Davis, Worthington, & Hook, 2010). It is neither self-enhancing nor self-depreciating. Humble individuals are aware of their limitations as well as secure in the value of their accomplishments.

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Second, humility is characterized by a benevolent orientation toward others (Davis et al., 2011). Humble people are attentive to others' needs, empathic, and prioritize shared outcomes above their own self-focused gain. Third, humility is expressed behaviorally in modest self-presentation (Davis et al., 2016), which contrasts with perfectionistic self-presentation of one's abilities, moral character, or social influence.

A Sociocognitive Model of Moral Injury

The concept of moral injury has only recently received attention from military health professionals. Shay (2014, p. 182) initially described moral injury as "(a) a betrayal of 'what's right;' (b) either by a person in legitimate authority or by oneself; (c) in a high stakes situation." Although this definition and its revisions were a seminal step forward that increased awareness of moral injury, its anecdotal heritage inspired little confidence among professionals in a military healthcare system informed by a promulgation of evidence-based practice. For this reason, diverse theoretical perspectives continue to proliferate. From their collective clinical expertise, Litz and colleagues (2009) define moral injury as "perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations" (p. 697). Likewise, based on interviews with military health and religious professionals, Drescher et al. (2011, p. 8) described moral injury as a "disruption in an individual's sense of personal morality and capacity to behave in a just manner." And, Nash and Litz (2013, p. 368) framed moral injury as a developmentally inappropriate challenge to moral cognition that precipitates "a state of loss of trust in previously deeply held beliefs about one's own or others' ability to keep our shared moral covenant." We focus the current analysis on what is common across these definitions—that is, threatened trust.

We first establish a model of moral injury. According to social cognitive theory, *moral self-regulation* occurs as individuals monitor their planned behavior for morally relevant information, judge their planned behavior in relation to internalized sociomoral values and perceived situational constraints, and decide to act in order to maximize their sense of self-worth and social connection (Bandura, 1986, 1991). Yet, perpetration of behavior judged as morally unacceptable inevitably occurs and might result in condemnation from oneself and others (Bandura, 1999). Importantly, these violations can occur in situations wherein service members have limited time and information to make difficult decisions, or as a product of situational pressures, and not solely for reasons such as a premeditated perpetration of an atrocity (Zimbardo, 2008). For example, service members may be involved in firefights in which innocent civilians are inadvertently harmed in the context of chaotic urban warzones, or a service member

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might engage in the excessive use of violence toward enemy combatants to retaliate for the demise of a compatriot if personal responsibility is diffused among others in a unit. In situations where sociomoral violations occur that an individual later perceives as morally reprehensible, *moral self-reparation* is the process through which an individual's sense of self-worth and social connection can be restored.

We adapt a sociocognitive model of moral injury by theorizing that exposure to a potentially morally injurious event affects self-worth (i.e., intrapersonal outcomes) and social connection (i.e., interpersonal outcomes) via mechanisms including self-condemnation, threat to meaning, traumatic grief, and sacred desecration. In the current chapter, each aspect of the model will be reviewed; then, applications of humility that are proposed to assuage the problem of moral injury by resolving mechanisms that link exposure to impairment will be discussed.

Exposure to Potentially Morally Injurious Events

Potentially morally injurious events saturate the military environment, but exposure looks different at various levels of the command hierarchy. For enlisted ranks, exposure to potentially morally injurious events may include killing an enemy combatant, injury or death of a fellow soldier, and injury or death of innocent civilians. Combat-related killing has been consistently associated with higher levels of posttraumatic stress when statistically controlling for common predictors of distress such as combat exposure (e.g., Maguen et al., 2010), and the moral struggle that ensues when a service member kills an enemy combatant may be one explanation of the exaggerated traumatic response to killing. Next, military officers and leaders might experience moral injury when they make decisions that have high human costs (e.g., injury or death) for those under their command, and support personnel who adhere to morally salient professional ethics codes, such as combat medics or chaplains, may experience a moral injury if they feel unable to adequately serve those under their professional care. Although the prevalence of moral injury in military personal at any level of the command hierarchy is not well established, Stein et al. and the STRONG STAR Consortium (2012) found evidence to suggest that, among active duty personnel in treatment for posttraumatic stress disorder (PTSD), 12 percent perpetrated a morally injurious event and 22 percent witnessed a morally injurious event.

Impairments Associated with Moral Injury

For service members who sustain moral injuries, the emotional, relational, and quality of life tolls may be long lasting irrespective of the time since the morally injurious event. We classify impairments as (a) psychological and behavioral

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problems *within* the individual and (b) relational problems *between* the individual and others.

Intrapersonal Problems

First, moral injury has been associated with psychological problems including depression, anxiety, and hostility, as well as behavioral problems including social withdrawal, substance abuse, and risk-taking behaviors (Litz et al., 2009). In fact, some scholars have suggested that emotional distress secondary to moral injury may be one explanation for the alarming rates of self-harm and suicidal behavior among service members (Bryan, Theriault, & Bryan, 2015). These intrapersonal problems often manifest in conjunction with persistent offense-related cognitions (e.g., blame appraisals) and emotions (e.g., guilt and shame).

Interpersonal Problems

Interpersonal problems occur *between* service members and others. For example, evidence suggests that one's own self-condemnation threatens the relationship satisfaction of both partners in a romantic dyad (Pelucchi, Paleari, Regalia, & Fincham, 2010). Perhaps due to difficulty trusting others, service members who sustain moral injuries frequently report conflicts with others such as romantic partners and coworkers. If service members labor to withhold information about their morally injurious experience from others, the individuals may serve as triggers that perpetuate rumination in the mind of the service member. For example, exposure to a potentially morally injurious event may lead to chronic sleep disruption due to nightmares if a service member chooses to protect their spouse by not sharing their experiences but simultaneously re-experiences a traumatic event while lying next to their uninformed spouse in bed.

Furthermore, evidence has suggested that individuals relate to whatever they hold to be sacred (e.g., God, nature, humanity, etc.) in a similar way that they relate to others (Davis, Worthington, Hook, & Van Tongeren, 2009). These sacred relationships may also be affected by the presence of moral injury. Moral injuries may cause religious/spiritual struggles, including feelings of anger, alienation, and betrayal, which characterize one's relationship with whatever one holds to be sacred (Exline, Pargament, Grubbs, & Yali, 2014). Exposure to a morally injurious event may also precipitate disengagement from stable beliefs and practices, which might impel people who were not religious toward religion or, alternatively, steer people who were once religious away from religion. Wuthnow (1998) has described this as disrupting spiritual dwelling and resulting in spiritual seeking (see Worthington & Sandage, 2015).

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Potential Mechanisms that Lead to Distress

Not every service member exposed to a potentially morally injurious event will experience clinical levels of distress. Individual differences exist in service members' reactions to traumatic events; therefore, we seek to understand how service members who sustain moral injuries might react differently to exposure than those who do not sustain moral injuries. We focus our analysis on four mechanisms hypothesized to link exposure to a potentially morally injurious event to individual and relational problems. These include self-condemnation, threat to meaning, grief, and experiences of sacred desecration.

Self-Condemnation

Service members may experience recurrent intermittent or chronic self-condemnation if they engage in, fail to prevent, or witness actions that violate their values (Worthington & Langberg, 2012). Self-condemnation has been associated with traumatic stress, depression, and anxiety among veterans (Witvliet, Phipps, Feldman, & Beckham, 2004), and condemnation toward oneself may be perpetuated or exacerbated by actual or perceived judgment of others. Although research suggests that negative emotion is not necessarily maladaptive, given its positive association with amend-making behavior in the aftermath of perpetrating an interpersonal offense (Tangney, Stuewig, & Mashek, 2007), negative emotions like shame and guilt are maladaptive when they persist long after an event occurs. Thus, persistence of negative emotions is the problem. Oftentimes, service members condemn themselves for their role in events for which they find it difficult to exercise direct amend-making behavior such as apologizing to, offering restitution to, or seeking forgiveness from those affected by the event (Gausel & Leach, 2011). Instead, service members and veterans may use avoidant ways to cope with self-condemnation such as seeking sexual pleasure, focusing on career, or abusing substances. Coping strategies associated with meaningful interpretation and healthy resolution of negative emotions, such as engaging in amend-making behaviors, tend to be more adaptive than strategies characterized by avoidance.

Threat to Meaning

Service members who experience moral injuries have difficulty making meaning out of their traumatic experiences. "Meaning-making" is the process through which individuals strive to achieve an understanding of the meaning of previously experienced stressful events (Park, 2010). Currier, Holland, and Malott (2015) demonstrated that exposure to a morally injurious event was related to traumatic stress, depressive symptoms, and suicide risk after warzone service,

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in part because service members struggle to make meaning out of their experiences. We speculate that the violation of trust that is characteristic of moral injury shatters people's foundational beliefs about themselves and the world to the extent that there is little foundation for the critical reparative process of cognitive restructuring to occur (Janoff-Bullman, 2010).

Grief

War will always cause loss, and grief is the human response to loss. Stein and colleagues (2012) found that 30 percent of post-9/11 veterans from the U.S. military conflicts in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) reported traumatic losses, such as the death of a fellow soldier. Also, Toblin and colleagues (2012) found that grief was associated with physical and occupational problems among service members after controlling for demographics, combat experiences, injuries, and mental health variables. Moreover, Boss (1999) expanded conceptualizations of what service members lose in war, noting that some report ambiguous losses such as loss of innocence, a sense of self, or feelings of intimacy resulting from morally injurious experiences.

Although the losses of close others can be extremely challenging, cultural and religious rituals provide people with permission to grieve these losses. For service members who experience ambiguous losses, such as loss of trust, control, or compassion, there are no instructions or protocols about how to grieve. Consequently, service members may neither recognize their distress as grief, nor engage in the grieving process to integrate the loss experience into a new healthy lifestyle.

Experiences of Sacred Desecration

Service members may view some moral injuries as sacred desecrations to the extent that they perceive that their sacred values were somehow violated by the event (Exline, Pargament, Grubbs, & Yali, 2014; Witvliet et al., 2004; Worthington & Sandage, 2015). Violating sacred values tends to amplify distressing emotions (Pargament, Magyar, Benore, & Mahoney, 2005; Wortmann, Park, & Edmondson, 2011), which often causes religious/spiritual struggles such as feeling alienated from or betrayed by whatever one holds to be sacred. Sacred desecration, however, does not require affiliation with a specific religious group that coheres around belief in a supreme being. Even nonreligious individuals may experience spiritual struggle when their cherished values (e.g., patriotism, a family legacy of military service, or commitment to military values that transcend the individual) are offended by encountering a potentially morally injurious event.

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Practical Lessons in the Clinical Application of Humility to Moral Injury

In summary, exposure to a potentially morally injurious event may lead to psychological, behavioral, relational, and spiritual problems insofar as service members' responses to exposure are characterized by self-condemnation, threat to meaning, unresolved grief, and sacred desecration. It is in the intersection of these mechanisms that trust is ruptured, distorting perceptions of self and others, and it is here where we propose that clinical application of humility has an important role in shaping prevention and intervention efforts intended to alleviate symptoms of moral injury. We organize our analysis of the practical lessons in the clinical application of humility according to three propositions: (a) As a component of prevention, humility buffers the association between exposure to a potentially morally injurious event and mechanisms of distress that link exposure to impairment; (b) as a component of intervention, humility facilitates meaningful interpretation and healthy resolution of mechanisms of distress that otherwise persist chronically and lead to impairment; and (c) humility is a critical component of the provider–patient relationship that enhances therapeutic outcomes among individuals seeking treatment for moral injury.

Practical Lesson 1: Humility Buffers the Association between Traumatic Exposure and Mechanisms of Distress

Efforts to prevent moral injury must begin before service members ever enter a war zone. Although the training received by U.S. military service members reduces the likelihood of moral injuries by promoting adherence to the rules-of-engagement and escalation-of-force guidelines, many service members report that the ethical aspects of training are insufficient and most often eclipsed by the technical component of training. Thus, our first proposition is that incorporation of humility into predeployment training would help weaken the links between exposures to potentially morally injurious events from the hypothesized mechanisms of distress.

A growing body of evidence supports our first proposition that humility buffers the association between exposure to a potentially morally injurious event and mechanisms of distress (e.g., self-condemnation, threat to meaning, loss and grief, and sacred desecration). For example, demonstrating the intersection of humility with grief, Kesebir (2014) found that when reminded of one's own mortality, individuals high in trait humility are less likely to morally disengage. Those low in trait humility appeared to inflate self-esteem, exaggerate the level of intimacy in their relationships, rigidly defend beliefs about the world, and distance themselves from authority figures. Thus, in response to mortality cues such as the death of a battle buddy, we suggest that humble individuals might better tolerate challenges to their beliefs by demonstrating cognitive

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flexibility. Humility may facilitate processing of traumatic events that otherwise challenge foundational assumptions about personal invulnerability and belief in a just world, which ultimately may result in greater unit cohesion, trust in command, and ethical-decision making.

In addition, Krause and Hayward (2012) found evidence to suggest that the strength of the association between lifetime trauma and doubt weakened at high levels of humility. We suggest that exposure to potentially morally injurious events challenges service members' foundational beliefs about themselves (e.g., I am a good person) and others (e.g., Other people are generally trustworthy), which ultimately may result in loss of trust in one's own or others' abilities to live in a morally responsible way. Humble individuals appear to negotiate these challenges to foundational beliefs with less trouble, perhaps because they are less defensive of their worldview, accepting failures in their belief system and leaving open the possibility for continued growth (Grubbs & Exline, 2014). This theorizing aligns with Van Tongeren et al.'s (2014) findings that humility promotes recollection of important interpersonal relationships to reduce distress caused by challenges to one's foundational beliefs.

Practical Lesson 2: Humility Facilitates Meaningful Interpretation and Healthy Resolution of Mechanisms of Distress

Humility facilitates meaningful interpretation and healthy resolution of mechanisms of distress, thereby preventing mechanisms of distress from producing intrapersonal and interpersonal problems. For example, regarding self-condemnation, we argued that condemning feelings of guilt and shame in response to exposure to a morally injurious event are common, though offense-related emotions become problematic when they are chronic. Given the accurate self-appraisal and other-oriented components of the construct of humility, people who are dispositionally humble may be more likely to accept themselves as flawed and be more apt to exercise amend-making behavior, ultimately leading to the resolution of offense-related negative emotions in response to self-perceived violation of a moral value. Thus, humility may facilitate forgiveness of oneself by catalyzing a decision to accept responsibility for an offense and make amends as well as by evoking replacement of self-condemning emotions with self-affirming emotions (Bryan, Theriault, & Bryan, 2015; Dees, 2011; Griffin et al., 2015).

In addition to the recovery-oriented model whereby individuals are theorized to return to a pre-event level of functioning, growth-oriented models suggest that exposure to stressors sometimes promotes positive changes that enhance one's functioning beyond the pre-event level (e.g., reorganization of priorities, increased focus on intimate relationships, greater appreciation of beauty, etc.). Calhoun, Cann, Tedeschi, & McMillan (2000) conceptualize this

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posttraumatic growth as "the experience of significant positive change arising from the struggle with a major life crisis" (p. 521). A variety of predictors of posttraumatic growth have been identified and incorporated into clinical interventions including openness to new experience, sense of coherence, optimism, internal locus of control, benefit-finding, and acceptance coping (Zoellner & Maercker, 2006).

We hypothesize that a humble disposition provides fertile grounds for these seeds of stressor-related growth. That is, humility interventions are beginning to proliferate (Lavelock et al., Chapter 19, this volume), and humility may be an upstream target of intervention that promotes generative change in known predictors of posttraumatic growth. For example, the accurate self-appraisal that is characteristic of humble character may enhance the internal locus of control by facilitating use of problem-focused coping in controllable situations and acceptance coping in uncontrollable situations. Humility may also promote a sense of coherence, such that individuals might make meaning out of encounters with adversity as a form of character development and personal growth. Although these hypotheses have yet to be empirically tested, theory suggests that future investigations may observe positive associations between dispositional humility and predictors of posttraumatic growth such as openness to experience, internal locus of control, benefit finding and acceptance coping, and other predictors of growth among trauma survivors.

Practical Lesson 3: Humility Builds Trust in the Provider–Patient Relationship

Humility among providers is a critical component of the provider–patient relationship that enhances therapeutic outcomes. Support for this exists in psychotherapy research (see Mosher et al., Chapter 6, this volume; Drinane et al., Chapter 22, this volume; Sandage et al., Chapter 21, this volume), particularly when providers address aspects of identity valued by patients. However, this might be especially true for providers treating service members who seek help for problems related to moral injury, given that moral injury is rooted in the violation of trust. Individuals who have sustained moral injuries may be acutely aware of situations in which they are vulnerable to betrayal by another (e.g., treatment providers, family members, government officials, etc.). They know that entering into a relationship with an imperfect individual makes them vulnerable, and they may engage in avoidance behaviors overtly (e.g., by delaying seeking treatment) and/or covertly (e.g., by discounting the recommendations of a civilian provider). Providers can help facilitate recovery from moral injury by modeling humility to provide opportunities to build and repair trust in a safe environment that will increase service members' confidence that they can

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negotiate feelings of vulnerability that deter them from maintaining close relationships and sequester them from aspects of their lives that they say they value most (e.g., family).

Future Research Directions

Although we have adduced evidence demonstrating how humility interacts with each of the hypothesized mechanisms of distress that are known to link exposure to a potentially morally injurious event to intrapersonal and interpersonal impairments, much empirical work remains to be done. Empirical studies could add to the literature by assessing the stress-buffering functions of humility, especially as it is associated with self-condemnation, threat to meaning, traumatic grief, and sacred desecration. Furthermore, applied studies of humility are only beginning to emerge (Lavelock, et al., Chapter 19, this volume), and the characteristic features of moral injury, as well as the organizational framework of the military, provide an excellent platform for humility intervention design and development.

There will be challenges weaving humility into the fabric of military culture. Some authors purport that military service members rarely value temperance-based virtues (e.g., forgiveness, mercy, and humility; Matthews, 2006), as such values may be viewed as signs of personal weakness. Awareness-raising campaigns that emphasize the importance of humility in a military setting may therefore be most effective if humility is framed as a principal component of leadership, promoting a sense of mission accomplishment, unit cohesion and cooperation, and ethical decision making (Owens, Rowatt, & Wilkins, 2011; van Dierendonck, 2011). Additionally, interventionists might draw on Worthington et al.'s (2015) claim that humility involves other-orientedness that reflects power under control to maximize benefits for others rather than self-serving ends.

Next, scholars have investigated methods through which individuals develop humility such as dealing with difficult life transitions and stressors (Krause & Hayward, 2012); engaging in community and religious activities (Krause, 2014); observing inspirational heroically humble models (Worthington & Allison, 2016); practicing other-oriented virtues like gratitude, altruism, and forgiveness (Ruberton et al., Chapter 18, this volume); and even participating in psychological interventions (Lavelock et al., Chapter 19, this volume). We hypothesize that humility might not only be a value component of resilience to and recovery from trauma, but also that traumatic experience may facilitate the development of humility. Trauma challenges foundational assumptions, such as perceptions of personal invulnerability, and humility may be one possible outcome of the meaning-making process by which some individuals positively reframe their

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negative experiences to achieve posttraumatic growth (Tedeschi & McNally, 2011). Further empirical investigation is needed to test this hypothesis.

Finally, although PTSD may be seen as a result of threat to safety and moral injury seen as a threat to trust, at least one model of PTSD conceptualization and treatment (cognitive processing therapy and the theory behind this specific evidence-based treatment) associates both threat to safety and trust with PTSD. In fact, cognitive processing therapy (CPT) helps individuals with PTSD challenge "overgeneralized beliefs about oneself and the world" related not only to safety and trust, but as related to control, esteem, and intimacy as well (Resick, Monson, & Chard, 2008, p. 3). It may be that moral injury and PTSD represent different patterns of response and are unique stressor-related disorders, though this is an empirical question. Furthermore, future applied investigations are needed to determine if individuals who sustain moral injuries, when it does not co-occur with PTSD, might respond differently to evidence-based treatments typically used to treat service members who report exposure to traumatic events. All of these questions coalesce around evidence-based practice for assessing and treating moral injury that has yet to develop.

Conclusion

In conclusion, we adapted a sociocognitive model to conceptualize the experience of exposure to potentially morally injurious events, intrapersonal and interpersonal problems that sometimes result from exposure, and mechanisms of distress that link exposure to impairments. Violation of trust was identified as an essential feature of the construct of moral injury, and humility was hypothesized to buffer the association between exposure and mechanisms of distress, facilitate meaningful interpretation and healthy resolution of mechanisms of distress when they occur, and enhance therapeutic outcomes by fostering trust in the provider–patient relationship. We hope that this theoretical framework provides a firm foundation for the expansion of humility into prevention and intervention efforts that target service-related moral injury.

Note

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