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MORAL INJURY AMONG MILITARY PROFESSIONALS: PSYCHOLOGICAL, SOCIAL, AND ETHICAL DIMENSIONS AND IMPLICATIONS FOR CRISIS INTERVENTION

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Summary. Moral injury refers to persistent distress that can follow experiences perceived to violate deeply held moral expectations. In military settings, potentially morally injurious events (PMIEs) may involve one's own action or omission, witnessing wrongdoing, or betrayal by a trusted authority. This study examines moral injury as a multidimensional phenomenon and considers its implications for crisis intervention. A systematically guided integrative review was conducted for literature published between 2009 and 2026, drawing on a reproducible military evidence synthesis and an update search; 18 core empirical studies were subjected to thematic synthesis and MMAT appraisal. Across the evidence, moral injury was associated with guilt, shame, self-condemnation, anger, loss of trust, disrupted identity and meaning, relational difficulties, and problems with reintegration. Social support, ethical leadership, organisational justice, purpose, and self-forgiveness emerged as potentially protective, although causal evidence remains limited and intervention findings are heterogeneous. The resulting framework positions crisis intervention as an initial stage of care that combines safety and stabilisation with assessment of moral meaning, responsibility, and betrayal, followed by appropriate relational, organisational, and specialist support. Moral injury is therefore best approached as a clinically relevant but non-diagnostic construct whose consequences extend beyond conventional post-traumatic symptom reduction.

Keywords: moral injury, military professionals, potentially morally injurious events, crisis intervention, guilt, shame, PTSD, social support, ethical leadership, reintegration.

Introduction

Military service places demands not only on physical and psychological functioning but also on moral judgement, responsibility, professional identity, and personal values. Operational decisions are often made under threat, uncertainty, time pressure, and hierarchical constraint. Some experiences are therefore distressing less because they involve danger than because they challenge an individual's judgement of what was right, permissible, or just. The concept of moral injury has become increasingly influential in accounting for this form of distress, particularly where conventional threat-based models of traumatic stress provide only a partial explanation (Litz et al., 2009; Litz & Walker, 2025).

The contemporary literature usually begins with potentially morally injurious events (PMIEs): perpetrating, failing to prevent, or witnessing conduct that conflicts with deeply held moral expectations, as well as experiences of betrayal by trusted people or institutions (Litz et al., 2009; Nash et al., 2013). Crucially, a PMIE is an exposure, not an outcome. Moral injury refers to the persistent moral, emotional, cognitive, social, or spiritual disturbance that may follow. This distinction has become more explicit in recent measurement work, including the Moral Injury and Distress Scale, which separates exposure from subsequent distress and functional consequences (Norman et al., 2024).

Moral injury overlaps substantially with PTSD, depression, and anxiety but should not be treated as interchangeable with them. Williamson et al. (2018) reported associations between PMIE exposure and several adverse mental-health outcomes, while also emphasising weaknesses in the evidence base. Norman et al. (2022), using a nationally representative sample of 1,321 U.S. combat veterans, found PMIEs to be common among veterans with probable PTSD or depression but also present in approximately one third of those without either probable disorder. The clinical significance of a morally difficult experience therefore cannot be inferred from psychiatric diagnosis alone.

What appears distinctive is the appraisal of the event in moral terms. Questions of responsibility, preventability, betrayal, loyalty, and personal character may become more salient than fear itself. Guilt may remain focused on an act, whereas shame can generalise from 'I did something wrong' to a judgement

of the whole self. Betrayal may direct distress outward, undermining trust in commanders, peers, or institutions. These pathways are not mutually exclusive, and the literature cautions against a simple dichotomy in which PTSD is equated with fear and moral injury with guilt or shame (Currier et al., 2018; Litz & Walker, 2025).

The consequences also extend beyond individual symptoms. Qualitative work describes changes in worldview, identity, meaning-making, and close relationships (Kalmbach et al., 2024), while longitudinal findings point to the relevance of social support and purpose (Chesnut et al., 2025). Organisational context matters as well: betrayal-related PMIEs have been associated prospectively with later post-traumatic symptoms and reintegration difficulties, albeit with small effects (Sowden et al., 2026). These findings make it difficult to locate moral injury solely within the individual; relational and institutional responses may either compound or buffer distress.

This broader perspective is particularly relevant to crisis intervention. Safety, stabilisation, and assessment of acute psychiatric risk remain essential, but they may not address persistent guilt, shame, betrayal, disrupted identity, or loss of meaning. Veterans themselves have described continuing moral distress after treatment and have highlighted values, significant relationships, and the therapeutic alliance as relevant to recovery (Bonson et al., 2024). At the same time, morally painful reactions should not automatically be pathologised: exposure to a PMIE does not inevitably lead to lasting impairment (Norman et al., 2024; Litz & Walker, 2025). The unresolved issue is therefore how psychological, relational, organisational, ethical, and existential evidence can be integrated into a clinically useful but appropriately cautious framework for crisis and follow-up care.

The aim of the present study is therefore to analyse moral injury among military professionals as a multidimensional psychological, social, relational, and ethical phenomenon and to examine its implications for crisis intervention and multidisciplinary professional support. Using a systematically guided integrative review of the literature, the study seeks to identify the principal manifestations and mechanisms associated with moral injury in military settings, distinguish moral injury from related trauma responses, identify relevant risk and protective factors, and synthesise evidence applicable to crisis-intervention practice. On the basis of this synthesis, a multidimensional conceptual framework for crisis intervention is proposed, integrating psychological stabilisation with moral appraisal, relational and social support, organisational context, reconstruction of meaning, and psychosocial reintegration.

The following research questions were formulated in accordance with the study aim:

RQ1: What psychological, social, relational, ethical, and existential dimensions of moral injury are identified in the literature on military professionals?

RQ2: How can moral injury be conceptually distinguished from PTSD and other trauma-related responses in military populations?

RQ3: Which individual, social, organisational, and leadership-related factors influence the development, severity, or mitigation of moral injury among military professionals?

RQ4: Which principles and components of professional support should be incorporated into crisis intervention for military professionals experiencing moral injury?

1. Methodology

1.1. Study Design

The present study was designed as a systematically guided integrative literature review. An integrative review allows evidence generated through different methodological designs to be synthesised in order to develop a more comprehensive understanding of a phenomenon (Whittemore & Knafl, 2005). This approach was selected because moral injury is multidimensional and has been examined in military populations using quantitative, qualitative, and mixed-methods designs.

The methodological procedure followed the framework proposed by Whittemore and Knafl (2005), comprising five stages: problem identification, literature search, data evaluation, data analysis, and presentation of the resulting synthesis. The purpose of the integrative review was not merely to describe individual studies, but to identify recurring concepts, relationships, differences, and mechanisms and to integrate them into a conceptual account of the phenomenon under investigation.

Transparency in study identification, screening, and selection was supported by the principles of PRISMA 2020 (Page et al., 2021). In the present study, the PRISMA framework was used primarily to document the search process, removal of duplicates, title and abstract screening, full-text assessment, and reasons for excluding publications.

1.2. Research Problem and Analytical Framework

The review examined moral injury among military professionals across psychological, social and relational, ethical and organisational, and existential domains, with particular attention to risk and protective factors and to implications for crisis intervention. The four research questions stated in the Introduction served as the organising framework for data extraction, categorisation, and thematic synthesis.

1.3. Information Sources and Search Strategy

A two-stage evidence-identification strategy was used. The reproducible foundation of the evidence base was the U.S. Department of Veterans Affairs Evidence Synthesis Program review by Beech et al. (2024), in which a research librarian searched MEDLINE (Ovid) and APA PsycINFO from 2009 to February 2024. After language and date restrictions were applied, 775 records were identified in MEDLINE and 711 in APA PsycINFO, yielding 1,486 records; 1,179 remained after deduplication. Following title and abstract screening, 871 publications were assessed as potentially relevant. The broader evidence overview included 282 primary studies and 29 reviews, of which 135 primary studies involved veterans or military personnel (Beech et al., 2024).

To capture more recent publications, an update search was conducted in PubMed/MEDLINE on 11 August 2026, followed by backward and forward citation checking. The update covered publications from March 2024 to August 2026 and targeted studies reporting evidence on the psychological, social and relational, ethical and organisational, existential, or intervention-related dimensions of moral injury. Search terms were combined as follows: ("moral injury" OR "potentially morally injurious event*" OR PMIE*) AND (military OR soldier* OR servicemember* OR veteran* OR "armed forces") AND (relationship* OR "social support" OR leadership OR ethical OR meaning OR spiritual* OR intervention* OR reintegration OR forgiveness).

The present integrative review built on an existing reproducible systematic evidence synthesis rather than conducting a fully de novo search across all commercial databases. Accordingly, unverifiable record counts from Scopus or Web of Science were not incorporated into the PRISMA flow. The PRISMA-informed diagram therefore presents the reproducible MEDLINE/PsycINFO flow from the source synthesis and separately identifies the core analytical set used for detailed thematic synthesis in this review.

1.4. Inclusion Criteria

The following criteria were established for inclusion in the analytical set:

- the publication substantively addressed moral injury or potentially morally injurious events (PMIEs);
- the study population comprised:
 - professional military personnel,
 - members of the armed forces,
 - active-duty military personnel,
 - reservists,
 - war or military veterans;
- the study examined at least one domain relevant to the aim of the review:
 - psychological manifestations and consequences,
 - social or relational consequences,
 - ethical and moral aspects,
 - organisational factors,
 - leadership,
 - social support,
 - spirituality or existential issues,
 - coping, resilience, or protective factors,
 - professional support, treatment, crisis intervention, or reintegration;
- the publication reported an empirical quantitative, qualitative, or mixed-methods study in a peer-reviewed journal;

- the study was published between 2009 and 2026;
- the full text was available in English;
- the study provided sufficient methodological and outcome information to assess its relevance to the research questions.

Seminal conceptual papers and major systematic or theoretical reviews were used to interpret and contextualise the findings, but were not automatically included among the primary empirical studies in the analytical set. This distinction reduced the risk of double-counting findings from primary studies already incorporated into previous reviews.

1.5 Exclusion Criteria

Publications were excluded if they:

- used the term moral injury only marginally without examining it empirically;
- focused exclusively on PTSD, combat stress, or general trauma exposure without explicitly assessing moral injury or PMIEs;
- concerned exclusively civilian occupational groups without a military population;
- were editorials, commentaries, letters to the editor, conference abstracts, or non-peer-reviewed publications;
- did not provide an adequately described methodology or results;
- were not available in English;
- reported duplicate findings without additional analytically relevant data.

Studies of healthcare professionals, police officers, firefighters, and other helping or security professions were not included in the primary synthesis unless results for military participants could be clearly separated.

1.6. Study Selection Process

Evidence selection proceeded at two levels. At the first level, the transparently documented identification and screening flow from the source systematic synthesis by Beech et al. (2024) was adopted. At the second level, a core analytical set of empirical studies was constructed from the military corpus and the update search to ensure representation of different countries, populations, methodological designs, and all dimensions corresponding to the research questions. Where cohorts overlapped, secondary publications were interpreted with recognition of the shared data source and were not treated as independent replications.

Eighteen core empirical studies published between 2013 and 2026 were included in the detailed tabular and thematic synthesis. Seminal conceptual papers, systematic reviews, and additional empirical studies were used for contextualisation and discussion but were not counted as separate studies in the core analytical set. This approach is consistent with the purpose of an integrative review, which is not only to summarise the frequency of findings but also to connect heterogeneous forms of evidence within a multi-dimensional framework relevant to crisis intervention.

1.7. Methodological Quality Appraisal

The methodological quality of the 18 core empirical studies was appraised using the Mixed Methods Appraisal Tool (MMAT), version 2018 (Hong et al., 2018). For each study, the appropriate five-item criterion set was applied according to design: qualitative, randomised, non-randomised, quantitative descriptive, or mixed methods. The appraisal addressed the appropriateness of the research question and design, quality of sampling, adequacy of measurement or data collection, completeness of data, control of confounding in non-randomised studies, and consistency between findings and interpretation.

In accordance with MMAT guidance, the appraisal was not interpreted as a validated overall quality score. For transparency, however, Table 2 reports the number of criteria met (ranging from 3/5 to 5/5) together with the areas in which methodological limitations were identified. Methodological quality was not used as an automatic exclusion criterion; instead, it informed the weight assigned to individual findings in the synthesis.

1.8. Data Extraction

For each core study, data were extracted on author and year, country, sample size and characteristics, research design, instrument used to assess PMIEs or moral injury, type of morally injurious experience, principal findings, and dominant analytical dimension. Particular attention was paid to whether a study

measured exposure to PMIEs or subsequent manifestations of moral injury, because these constructs are not interchangeable. For intervention studies, the type of intervention, control condition, and relevant psychological or functional outcomes were also recorded.

1.9. Analysis and Thematic Synthesis

Given the marked heterogeneity of populations, instruments, and study designs, no pooled quantitative effect estimate was calculated. The evidence was analysed using integrative thematic synthesis. Meaning units were first extracted from the findings of individual studies, then coded and compared across designs. Codes were grouped into higher-order analytical categories and repeatedly examined against the four research questions. Five interconnected domains emerged: psychological; social and relational; ethical and organisational; existential and spiritual; and intervention-related. Risk and protective factors were synthesised separately.

Longitudinal and controlled designs were given greater interpretive weight where available, whereas conclusions based predominantly on cross-sectional associations were formulated in non-causal terms. Qualitative studies were used particularly to capture the meaning of experience, identity, relationships, trust, and mechanisms of reintegration that standardised measures only partially assess.

1.10. Development of the Conceptual Framework

The final analytical stage integrated the identified themes into a multidimensional conceptual framework of moral injury and crisis intervention among military professionals. The framework follows the trajectory: potentially morally injurious event → moral appraisal of the event → emotional and cognitive responses → influence of individual, social, organisational, and existential factors → adaptive or maladaptive course → need for crisis and follow-up professional intervention → psychosocial, professional, and moral reintegration.

The proposed framework is a conceptual synthesis of the available evidence rather than an empirically validated therapeutic protocol. Its purpose is to clarify domains relevant to the early recognition of moral distress, risk assessment, and planning of multidisciplinary support.

2. Results and Thematic Synthesis

The underlying evidence base demonstrates both the rapid growth of moral injury research and substantial methodological heterogeneity. Beech et al. (2024) identified 135 primary studies conducted in military or veteran populations; approximately 80% of studies in the broader corpus used a cross-sectional design. The present review used a core set of 18 empirical studies for detailed integrative synthesis. This set represents psychological, social, ethical-organisational, existential, and intervention-related aspects and also includes studies published after the search cut-off of the source systematic review.

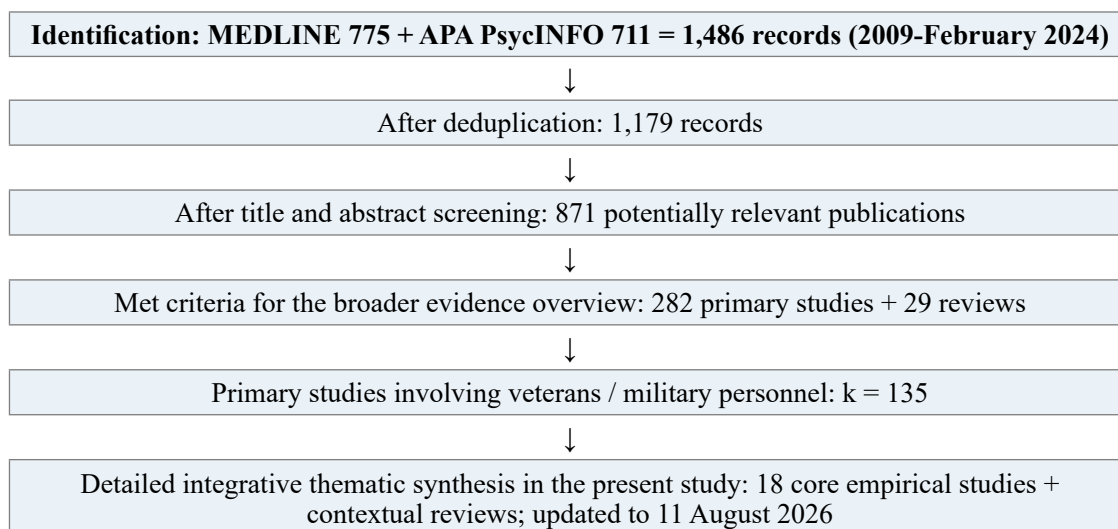


Figure 1. PRISMA-informed flow of evidence identification. Counts through k = 135 are reproduced from Beech et al. (2024); the final box denotes the analytical subset used in the present review

Table 1

Characteristics of studies included in the integrative review

Author, year	Country	N	Population	Design	MI/PMIE measure	Type of PMIE	Main findings	Dimension
Nash et al., 2013	USA	867	active-duty USMC personnel after combat deployment	prospective psychometric validation	MIES	transgression; betrayal	The MIES supported two latent dimensions: perceived transgressions and betrayal, with good stability and convergent validity.	conceptual / psychological
Bryan et al., 2016	USA	151 + 1,086	U.S. Air Force clinical sample; Army National Guard non-clinical sample	cross-sectional psychometric study	MIES	self; other; betrayal	A three-factor model was supported. Self-transgression was most strongly associated with hopelessness, pessimism, and anger; betrayal and transgressions by others were associated with PTSD and anger.	psychological / ethical
Currier et al., 2015	USA	131	Iraq/Afghanistan veterans	cross-sectional, SEM	MIQ-M	various MIEs during deployment	Difficulties in meaning-making partially mediated associations of MIEs with PTSD, depression, and suicide risk.	psychological / existential
Zerach & Levi-Beiz, 2018	Israel	191	combat veterans	cross-sectional mediation analysis	PMIE self/other/ betrayal self-report	primarily betrayal	Betrayal was associated with PTSS through depressive attributions, trauma-related guilt, internal shame, and self-disgust.	psychological / ethical
Williamson et al., 2020	UK	30	male military veterans	qualitative thematic analysis	semi-structured interview; event classification	PMIE; trauma; mixed	PMIEs were associated with moral dissonance and conflict between military and civilian values; psychological impact differed from purely traumatic events.	psychological / ethical
Williamson et al., 2021	UK	204	military veterans	cross-sectional online survey	written event description + independent PMIE classification	PMIE; trauma; mixed	PMIEs were associated with anxiety and suicidal ideation; the highest probability of PTSD was observed in the purely traumatic group.	psychological
Williamson et al., 2023	UK	30 veterans + 15 clinicians	veterans and clinicians	qualitative thematic analysis	semi-structured interview	PMIE vs trauma	Following PMIEs, social withdrawal, aggressive/risk-taking behaviour, family strain, and occupational difficulties were more frequently described.	social / relational
Zerach et al., 2023	Israel	335	active-duty combat soldiers	2.5-year prospective, 3 waves	validated PMIE self/other/ betrayal scales	self; other; betrayal	Ethical preparation predicted fewer PTSD/psychiatric symptoms; with high ethical preparation and leadership, the association between PMIEs and symptoms was markedly attenuated.	ethical / organisational / protective

Table 1 (continuance)

Diekmann et al., 2023	Germany	85 (45+40)	soldiers with chronic PTSD and moral distress	controlled non-randomised intervention	Compass of Shame Scale + clinical MI history	killing; omission; witnessing; betrayal	Values-based group CBT reduced maladaptive shame strategies (attack-self, withdrawal, and attack-others) compared with a wait-list control.	intervention / psychological
Kalmbach et al., 2024	USA	26	post-9/11 combat veterans	qualitative thematic analysis	in-depth interviews	various war-related PMIEs	Twelve themes clustered around changes in worldview, meaning-making, identity, and relationships.	social / existential
Fernandez & Currier, 2024	USA	65	combat veterans participating in a peer-led MI programme	cross-sectional	EMIS-M	self- and other-directed MI	After adjustment for PTSD, moral injury remained uniquely associated with poorer intimate relationship functioning.	social / relational
Litz et al., 2024	USA	174	post-9/11 veterans with PTSD linked to traumatic loss/MI	randomised controlled trial	clinical MI/TL classification; SDS, CAPS-5	transgression; witnessing/ victimisation; loss	AD-E produced greater post-treatment improvement in functioning and PTSD than PCT; between-group differences were not maintained at follow-up.	intervention
Bonson et al., 2024	UK	10	veterans after psychological treatment related to MI	qualitative thematic analysis	semi-structured interview	various PMIEs	Some veterans reported persistent guilt/shame after CBT; they identified values, letter writing, significant others, and the therapeutic relationship as important.	intervention / relational
Levi-Belz et al., 2025	Israel	374	active-duty combat soldiers transitioning to veteran status	longitudinal, 3 assessments	validated PMIE self/other/ betrayal + self-forgiveness	self; other; betrayal	PMIEs predicted later trauma-related guilt and suicide risk; greater self-forgiveness acted as a protective moderator.	risk / protective / psychological
Chesnut et al., 2025	USA	4,784	post-9/11 veterans	longitudinal latent transition analysis	MIES	PMIE exposure/ distress	Higher PTSD and ACEs increased the probability of transition to a high-MI profile; social support and purpose reduced this probability.	risk / protective
Sowden et al., 2026	USA	815	U.S. Army personnel before and after separation from service	prospective, 2 waves	PMIE self/other/ betrayal	self; other; betrayal	Betrayal in particular predicted subsequent PTSS and reintegration difficulties; effects were small but remained after covariate adjustment.	social / reintegration / ethical
Danson et al., 2026	USA	12	post-9/11 veterans with MI	qualitative cognitive interview study	two existing MI scales + cognitive interview	various PMIEs	MI and reintegration influenced one another through moral emotions, trust, disclosure, and meaning-making about military service.	social / existential / reintegration
Purcell et al., 2026	USA	40	veterans after Impact of Killing treatment	qualitative rapid analysis	semi-structured post-treatment interviews	killing-related MI	Veterans described greater self-understanding and self-compassion, improved relationships, and greater engagement in meaningful activities; they requested longer-term follow-up support.	intervention / existential

2.1. Conceptualising Moral Injury and Potentially Morally Injurious Events

Across the reviewed literature, the most stable conceptual distinction was between the morally salient event and the response that follows it. The model proposed by Litz et al. (2009) remains foundational: military personnel may perpetrate, fail to prevent, or witness acts that conflict with deeply held moral expectations, and the enduring difficulty arises through subsequent appraisal of responsibility and meaning rather than through exposure alone. This formulation also accommodates social and spiritual consequences, not only symptoms conventionally associated with trauma.

Four recurrent classes of PMIE were evident: one's own actions, omission or failure to prevent harm, witnessing the transgressions of others, and betrayal by a trusted person or institution. These categories are analytically useful but overlap in practice. A single event can produce guilt about one's own conduct and anger towards a commander or organisation; perceived responsibility can also change after deployment as the event is reinterpreted in a different social and moral context. Qualitative work similarly shows that veterans locate the source of moral injury both in their own behaviour and in the actions of others (Schorr et al., 2018).

Psychometric findings support this differentiation. Nash et al. (2013) identified perceived transgression and betrayal as two dimensions of the MIES, while Bryan et al. (2016) reported a three-factor solution separating self-transgression, transgression by others, and betrayal. The dimensions were not psychologically equivalent: self-transgression showed stronger associations with hopelessness, pessimism, and anger, whereas betrayal and transgression by others were associated with post-traumatic symptoms and anger (Nash et al., 2013; Bryan et al., 2016).

The distinction between exposure and outcome remains methodologically important. Earlier measures frequently assessed whether a PMIE had occurred, whereas newer instruments attempt to capture subsequent moral distress and functional impairment. The Moral Injury and Distress Scale is one example of this shift (Norman et al., 2024). Consequently, prevalence estimates and associations cannot be compared uncritically across studies that use exposure measures and those that assess moral injury symptoms.

Conceptual variation remains substantial. Richardson et al. (2020) identified 12 prominent definitions in 124 publications on military populations, and Nazarov et al. (2024) likewise found marked heterogeneity across measurement instruments. This lack of standardisation is more than terminological: it affects who is classified as having moral injury, which outcomes are attributed to it, and how apparently conflicting findings are interpreted.

Recent formulations therefore place greater emphasis on persistent functional consequences. Litz and Walker (2025) describe moral injury in terms of impairing moral emotions, beliefs, and behaviours, together with negative beliefs about self, others, humanity, meaning, or life direction. This functional emphasis is useful because moral injury is not a standalone psychiatric diagnosis and morally painful reactions can be proportionate and adaptive. The clinically relevant question is not simply whether a PMIE occurred, but whether the resulting appraisals and moral emotions have become persistent, rigid, and disruptive.

For crisis assessment, this distinction shifts attention from event classification alone to the individual's interpretation of responsibility, violated values, betrayal, and consequences for identity, relationships, and meaning. Two superficially similar events may therefore call for different priorities in care. The synthesis supports treating moral injury as a dynamic process arising from the interaction of event, moral appraisal, psychological response, and social-organisational context rather than as a fixed consequence of a particular class of military exposure.

2.2. Psychological Dimension of Moral Injury

The psychological dimension is one of the most prominent domains of moral injury among military professionals. Its core lies not only in the response to objective danger or the traumatic nature of an event, but above all in how the individual interprets their own actions, omissions, the behaviour of others, or an experience of betrayal in relation to their value system. A morally injurious experience can fundamentally disrupt previously held beliefs about one's own moral integrity, the trustworthiness of others, and the meaningfulness of the world. The resulting pattern may include a complex set of emotional and cognitive reactions, among which guilt, shame, self-condemnation, anger, loss of trust, hopelessness,

and identity disruption are particularly salient. The multidimensional nature of these reactions is also reflected in the Moral Injury Symptom Scale – Military Version (MISS-M), which includes not only guilt and shame but also self-condemnation, loss of trust, difficulties with forgiveness, loss of meaning and purpose, and spiritual conflict (Koenig et al., 2018).

2.2.1. *Guilt as a Central Response to Moral Injury*

Guilt is among the most frequently discussed psychological mechanisms of moral injury. In military settings, it may arise from one's own actions, decisions, omissions, or the belief that an adverse outcome could have been prevented. It may concern the death of a comrade, civilian casualties, the use of lethal force, failure to fulfil a perceived duty, or situations in which a military professional judges their behaviour to have been incompatible with personal moral standards.

A systematic review by Nazarov et al. (2015), which included 19 military studies, identified a meaningful association between exposure to, or perceived perpetration of, moral transgression and experiences of guilt and shame. These emotional responses were also associated with adverse mental health outcomes, particularly post-traumatic symptomatology (Nazarov et al., 2015).

Importantly, the intensity of guilt does not necessarily correspond to the individual's objective degree of responsibility for the event. In retrospect, a person may attribute to themselves greater control than they actually had in the operational situation. Their appraisal may therefore involve counterfactual thoughts such as 'I should have done more', 'I should have known what would happen', 'I could have prevented it', or 'I should have decided differently'. Such retrospective re-evaluation may sustain psychological distress, particularly when the event is not interpreted within the information, options, and constraints that were available at the time the decision was made.

The relevance of the type of moral experience is also supported by Bryan et al. (2016). In analyses of the Moral Injury Events Scale across two military samples, self-directed moral transgressions were most strongly associated with hopelessness, pessimism, and anger, whereas transgressions by others and experiences of betrayal showed different profiles of psychological association. These findings suggest that the psychological consequences of moral injury cannot be understood independently of whom the individual regards as responsible for the morally problematic event (Bryan et al., 2016).

2.2.2. *Shame and Self-Condensation*

Although guilt and shame are closely related, they are not psychologically identical processes. Guilt is generally focused on a specific action – 'I did something wrong'. Shame can encompass a broader judgement of the self – 'I am a bad person', 'I am not worthy of respect', or 'I am not the person I believed myself to be'. This shift from a negative evaluation of an act to a negative evaluation of the whole self may be one of the most consequential mechanisms through which moral injury persists.

The importance of shame is supported by both military research and clinical studies. Koenig et al. (2018) treated shame and self-condemnation as distinct components within a multidimensional assessment of moral injury. In their study of 427 veterans and active-duty service members with PTSD symptoms, manifestations of moral injury were also significantly associated with PTSD, depression, and anxiety.

The relevance of shame to intervention is further illustrated by Diekmann et al. (2023) in traumatised German soldiers. The authors evaluated a values-based cognitive-behavioural group intervention focused on war-related shame and moral injury. The intervention was grounded in the recognition that PMIEs may violate a soldier's personal value system and subsequently manifest in combinations of anger, alienation, guilt, and shame. The findings support the need to address these moral emotions explicitly rather than subsuming them automatically under general post-traumatic symptomatology (Diekmann et al., 2023).

For crisis intervention, distinguishing guilt from shame is clinically relevant. When guilt predominates, it may be useful to examine the realistic degree of responsibility, the circumstances surrounding the decision, and possibilities for repair. When shame is dominant, intervention may also need to address a globally negative self-concept, feelings of unworthiness, and disruption of moral identity.

2.2.3. *Anger, Perceived Betrayal, and Loss of Trust*

Moral injury is not necessarily directed only towards the self. When the precipitating experience involves transgression by others or betrayal, anger, moral outrage, or a sense of injustice may become the dominant emotional response. Anger may be directed towards a specific commander, fellow service members, the military organisation, political leadership, or a broader system.

Bryan et al. (2016) found that perceived betrayal was strongly associated with post-traumatic stress and anger, while transgressions by others were also substantially associated with post-traumatic symptomatology. A qualitative analysis of Canadian Armed Forces members and veterans by Houle et al. (2021) identified loss of trust, identity disruption, interpersonal difficulties, spiritual disturbance, rumination, and both internalised and externalised emotional and behavioural responses as major themes following exposure to PMIEs.

Loss of trust may be particularly consequential in the military profession. Trust in peers and command is not merely a social preference; it is a functional requirement of military units. When a military professional interprets an event as betrayal by an authority or organisation, the consequences may extend to professional identity and basic assumptions concerning reciprocity, loyalty, and justice.

2.2.4. *Moral Injury, PTSD, Depressive Symptoms, and Anxiety*

The relationship between moral injury and PTSD remains a central issue. Available evidence supports substantial overlap between the two constructs, but does not justify treating them as identical. In veterans and active-duty military personnel, Koenig et al. (2020) found that overall moral injury scores were most strongly associated with the PTSD cluster of negative alterations in cognitions and mood. Some degree of overlap was also observed with other PTSD symptom clusters (Koenig et al., 2020).

At the population level, Nazarov et al. (2018) examined Canadian Armed Forces personnel deployed to Afghanistan. More than half of the deployed participants reported at least one PMIE, and exposure to such events was associated with a higher likelihood of PTSD and major depressive disorder. A particularly strong association was observed for perceived responsibility for the death of one's own or allied military personnel (Nazarov et al., 2018).

These associations, however, do not establish moral injury as an independent cause of PTSD or depression. Studies differ in how they define and measure PMIEs and moral injury itself, and much of the available evidence is observational. It is therefore more accurate to describe moral distress, post-traumatic symptoms, depressive symptoms, and anxiety as interrelated phenomena whose configuration may vary across individual military professionals.

2.2.5. *Hopelessness and Suicidal Experiences*

In more severe cases, moral distress may be accompanied by hopelessness and suicidal experiences. In a study of U.S. combat veterans, Nichter et al. (2021) found that perceived self-transgressions, transgressions by others, and betrayal were associated with suicidal ideation, planning, or attempts even after adjustment for a range of sociodemographic, trauma-related, and psychiatric characteristics. At the same time, PTSD and depression accounted for substantially more variance in suicidal outcomes than PMIEs, underlining the importance of not interpreting moral injury in isolation from the individual's overall clinical presentation (Nichter et al., 2021).

For crisis intervention, this finding is especially relevant to comprehensive risk assessment. Intense guilt, shame, or self-condemnation should not by themselves be taken as evidence of suicidal risk. However, when these experiences occur alongside hopelessness, depressive symptoms, social withdrawal, and other risk indicators, safety and clinical assessment require heightened attention.

2.2.6. *Identity Disruption and Loss of Meaning*

Moral injury may disrupt not only the individual's current emotional state but also continuity of identity. A military professional may struggle to reconcile an experience from deployment with a previous self-concept as an honourable, competent, and morally responsible person. Such a discrepancy may contribute to repeated rumination about the event, doubts about personal worth, and loss of meaning in professional or personal life.

In a study of 131 veterans of Iraq and Afghanistan, Currier et al. (2015) found that PMIEs were related to mental health difficulties both directly and indirectly through problems in making meaning of stressful experiences. The authors therefore identified meaning-making as one possible mechanism linking morally injurious experiences with difficulties in post-deployment adjustment (Currier et al., 2015).

Similarly, Houle et al. (2021) identified identity disruption, changes in moral attitudes, loss of trust, and difficulties in interpersonal and spiritual functioning among military personnel and veterans following PMIE exposure. Moral injury therefore cannot be reduced to isolated negative emotions. In more severe

cases, it involves a broader disruption in how individuals understand themselves, their past, and their place in the world.

2.2.7. *Self-Forgiveness and Psychological Repair*

Self-forgiveness has received growing attention in contemporary moral injury research. It should not be understood as denial of responsibility or simply as 'getting rid of guilt'. Conceptually, self-forgiveness may involve accepting an appropriate degree of responsibility, willingness to repair the consequences of one's actions where possible, and the capacity not to transform a specific moral failure into enduring global condemnation of the self.

In validating a modified Self-Forgiveness Dual-Process Scale among 924 individuals exposed to PMIEs, including military veterans, Griffin et al. (2024) distinguished two components of self-forgiveness: value affirmation, involving realistic appraisal of personal responsibility and readiness to make amends; and esteem restoration, defined as the capacity to regard oneself as a person of worth and capable of growth despite failures and imperfections. The two dimensions showed different relationships with moral distress, PTSD, depressive symptoms, functional impairment, and post-traumatic growth (Griffin et al., 2024).

This distinction is also relevant to crisis intervention. The aim of support should not be to persuade a military professional that they bear no responsibility when this does not correspond to their experience. A more appropriate direction may be to help differentiate responsibility for a specific action from global condemnation of the self, identify realistic possibilities for repair, and gradually restore continuity in the individual's moral identity.

2.2.8. *Implications of the Psychological Dimension for Crisis Intervention*

For crisis assessment, the psychological evidence favours a focused appraisal of four linked issues: what moral meaning the individual assigns to the event; how responsibility is attributed to self and others; which emotions and beliefs are dominant (particularly guilt, shame, anger, betrayal, hopelessness, and self-condemnation); and whether these reactions are accompanied by functional impairment, social withdrawal, or acute safety concerns. This approach avoids treating PTSD status as a proxy for moral injury and helps distinguish problems that may require different forms of follow-up care.

The strength of evidence also depends on what is measured. The U.S. Department of Veterans Affairs Evidence Synthesis Program judged associations of moral injury symptoms with PTSD, depression, and anxiety to be supported by moderate-strength correlational evidence, whereas evidence was weaker for PMIE exposure itself and for suicidal behaviour, substance use, and social functioning (Beech et al., 2024). This distinction reinforces the need to separate exposure from subsequent moral distress and impairment.

2.3. *Social and Relational Dimension of Moral Injury*

Moral injury is not confined to intrapsychic processes. A substantial proportion of its consequences is expressed in relationships with family members, partners, fellow service members, the military organisation, and wider society. In qualitative studies, veterans describe social withdrawal, difficulties with trust, feeling misunderstood by civilians, limited disclosure of wartime experiences, and problems re-establishing intimacy. Kalmbach et al. (2024) identified relational change as one of four principal domains of moral injury, alongside worldview, meaning-making, and identity. Similarly, Danson et al. (2026) showed that moral emotions, trust, and the ability to discuss PMIEs are closely intertwined with reintegration after leaving military service.

The impact on family and occupational functioning is documented in the UK qualitative study by Williamson et al. (2023). Following PMIEs, veterans more frequently described social withdrawal, aggressive or risk-taking behaviour, tension within the household, and difficulties returning to occupational roles. In intimate relationships, moral injury may manifest as reduced capacity for emotional closeness, difficulty discussing the experience, or difficulty tolerating vulnerability. Fernandez and Currier (2024), in a sample of 65 combat veterans, found that moral injury outcomes were associated with poorer intimate relationship functioning even after PTSD symptoms were taken into account. This finding suggests that relational difficulties should not automatically be attributed solely to post-traumatic symptomatology.

Social support also appears to have a protective role. In a longitudinal analysis of 4,784 U.S. veterans, greater social support together with a stronger sense of purpose was associated with a lower probability

of transitioning from a low to a high moral-injury exposure/distress profile (Chesnut et al., 2025). Within military organisations, unit cohesion, belonging, and the opportunity to discuss morally difficult experiences safely with people who understand the operational context may represent particularly relevant social resources. Conversely, isolation, stigma surrounding help-seeking, and dismissive responses from others may reinforce guilt, shame, and self-condemnation.

The transition from military to civilian life represents a particularly important period. In a prospective study of 815 U.S. Army personnel, Sowden et al. (2026) found that betrayal experiences before separation from service predicted later post-traumatic stress symptoms and reintegration difficulties, although effect sizes were small. Clinically, this finding supports continued attention to moral distress after formal military service has ended. Social reintegration should therefore be understood not merely as a return to employment, but as the restoration of trust, social roles, reciprocity, the capacity to receive support, and a renewed sense of belonging within family and community.

For crisis intervention, these findings indicate the need to assess the quality of the available social network, family conflict, degree of isolation, capacity to discuss the experience, and barriers to help-seeking. Where safe and consistent with the client's preferences, involvement of a significant other, peer support, or a trusted member of the unit may be beneficial. Social support should not replace professional care; rather, its function is to create a context in which moral processing does not have to occur in isolation.

2.4. Ethical and Organisational Dimension of Moral Injury

The ethical dimension of moral injury reflects the fact that military service is structured around norms of duty, obedience, loyalty, protection of comrades, and protection of civilians, while simultaneously exposing individuals to situations in which these norms may conflict. A morally injurious event may be legally or operationally legitimate and yet still be experienced as incompatible with the soldier's personal values and sense of the person they wish to be. Williamson et al. (2020) described this conflict as moral dissonance between concurrently valid normative frameworks, for example between military and civilian values.

Betrayal is a central organisational category. The MIES distinguishes perceived transgression from perceived betrayal (Nash et al., 2013), while the three-factor model reported by Bryan et al. (2016) further differentiates self-transgressions, transgressions by others, and betrayal. In a sample of 191 Israeli combat veterans, betrayal-based experiences were associated with post-traumatic stress symptoms through depressive attributions, trauma-related guilt, internal shame, and self-disgust (Zerach & Levi-Belz, 2018). Thus, a service member may experience moral injury not only because of what they themselves did, but also because a legitimate authority, commander, or organisation is perceived to have failed in protection, fairness, or loyalty.

The organisational environment may also modify risk. In a 2.5-year prospective study of 335 Israeli combat soldiers, Zerach et al. (2023) found that ethical preparation was associated with lower subsequent psychiatric symptomatology and that, under conditions of strong ethical preparation and ethical leadership, the association between PMIEs and post-deployment symptoms was markedly attenuated. The finding does not imply that leadership can eliminate the moral risks of war; rather, it points to the value of preparing personnel for moral complexity, transparent decision-making, and a command climate in which ethical dilemmas can be discussed without humiliation or stigma.

Crisis intervention should therefore distinguish personal guilt from organisational or distributed responsibility. Practitioners should neither automatically absolve the client of responsibility nor reinforce global self-condemnation when the individual's options were constrained by orders, rules of engagement, limited information, or decisions made by higher authority. In practical terms, assessment should explore who made the decision, what information was available, what genuine scope for choice the individual had, which values were in conflict, and how the organisation responded to the event. In betrayal-related cases, support also involves addressing loss of trust and differentiating a specific failure of authority from a global belief that no one can be trusted.

2.5. Existential and Spiritual Dimension of Moral Injury

Moral injury may disrupt the basic narrative through which a person understands their life, military service, and the value of their decisions. The existential dimension includes questions of meaning, identity, forgiveness, justice, and the possibility of continuing one's life after an event perceived as morally

incompatible with one's previous self-concept. Currier et al. (2015) showed that difficulties making meaning of a stressful experience partially mediated the association between morally injurious events and mental health problems. Qualitative findings from Kalmbach et al. (2024) similarly identify disruptions in worldview, identity, and meaning-making as central features of moral injury.

The spiritual dimension is not synonymous with religious belief. It may involve perceived forgiveness, relationships to transcendent values, questions of good and evil, existential guilt, or the belief that one has forfeited the right to acceptance. Multidimensional measures such as the MISS-M therefore include items addressing loss of meaning, forgiveness, trust, and religious or spiritual struggle (Koenig et al., 2018). For some military professionals, discussion with a chaplain or another spiritual authority may be relevant; for others, a secular language of values, meaning, and identity may be more appropriate. Intervention should be guided by the individual's preferences rather than by an assumption that spirituality is inherently necessary.

Self-forgiveness is an important but sensitive mechanism. It does not imply denial of responsibility or moral relativism. Longitudinal findings by Levi-Belz et al. (2025) indicated that lower self-forgiveness strengthened the indirect pathway from PMIE exposure through trauma-related guilt to later suicide risk. A clinical aim may therefore be to move from rigid global self-condemnation towards realistic acceptance of appropriate responsibility, possibilities for repair, and restoration of value-consistent action. Moral repair may include apology or reparative action where possible, service to others, restoration of relationships, acceptance of human limitations, and meaning-making that does not minimise the seriousness of the event.

For crisis intervention, this means that work should not end once acute anxiety has subsided. When a crisis has affected core identity or meaning, stabilisation is only the first phase. Follow-up care should allow space to explore questions such as: What does this experience mean for how I see myself? Which of my values remain intact? What am I responsible for, and what was beyond my responsibility? How can I act again in ways that are consistent with the person I want to be? Understood in this way, restoration of meaning is an important component of psychosocial reintegration.

2.6. Risk and Protective Factors

The synthesis indicates that the relationship between PMIE exposure and persistent moral injury is not simply deterministic. Risk is shaped by the interaction of pre-existing vulnerability, characteristics of the event, moral appraisal, psychological regulatory processes, the social environment, and the organisational response. Recurrently identified risk factors include greater post-traumatic and depressive symptomatology, adverse childhood experiences, poorer emotion regulation, higher aggression, social isolation, low trust, and betrayal-based PMIEs. Williamson et al. (2021) also demonstrated the relevance of adverse childhood experiences and in-service trauma in a clinical UK veteran population, supporting a broader developmental understanding of vulnerability.

Some of the strongest recent longitudinal evidence is provided by Chesnut et al. (2025). Among 4,784 U.S. veterans, higher PTSD symptoms and adverse childhood experiences were associated with a greater probability of transition to a high moral-injury exposure/distress profile, whereas social support and a sense of purpose reduced this probability. In an Israeli prospective study, ethical preparation and ethical leadership attenuated associations between PMIE exposure and subsequent psychiatric symptoms (Zerach et al., 2023). Together, these findings support a multilevel preventive model in which protective factors operate at individual, relational, and organisational levels.

At the individual level, potentially protective factors include psychological flexibility, the ability to differentiate proportionate from disproportionate responsibility, adaptive coping, self-compassion, and self-forgiveness. At the social level, relevant resources include safe close relationships, peer support, cohesion, and opportunities to disclose experiences without moral judgement. At the organisational level, ethical leadership, transparent communication, organisational justice, access to professional support, and a culture that does not penalise help-seeking are particularly important. At the existential level, meaning, continuity of values, and opportunities for moral repair may be protective.

From the perspective of crisis practice, it is important to recognise that no protective factor functions as a universal remedy. Social support, for example, may be helpful only when it is experienced as safe

and non-judgemental; spirituality may be beneficial for some individuals but, in the context of spiritual conflict, may also become an additional source of distress. Assessment of risk and protective resources should therefore be individualised and dynamic, particularly during post-deployment transitions, separation from service, or events that reactivate morally salient memories.

2.7. Implications for Crisis Intervention and Multidisciplinary Professional Support

Crisis intervention for moral injury should retain the core principles used in other acute crises – safety, stabilisation, risk assessment, activation of resources, and linkage to follow-up care – while adding explicit assessment of the moral meaning of the event. Practitioners need to distinguish between exposure to a PMIE without persistent functional impairment and established moral distress characterised by guilt, shame, self-condemnation, anger, betrayal, loss of trust, alienation, and disruption of meaning. The MIES or another exposure measure should therefore not be interpreted as a diagnostic test for moral injury.

The first phase remains safety and clinical assessment. Marked hopelessness, self-condemnation, depressive symptomatology, or suicidal ideation require standard suicide-risk assessment and an appropriate level of healthcare. Moral interpretation must not replace diagnosis and management of acute risk. Once immediate safety has been addressed, assessment may examine the type of PMIE, perceived degree of responsibility, value conflict, experience of betrayal, available social support, and the meaning of the event for identity and life direction.

A second phase involves moral and emotional processing. In cases dominated by guilt, it is useful to distinguish actual responsibility from responsibility exaggerated in hindsight; in cases dominated by shame, the evaluation of a specific act should be separated from global condemnation of the person. In betrayal-based moral injury, it is important to validate the experience of breached trust without reinforcing a total generalisation of mistrust. Subsequent work may involve self-compassion, self-forgiveness, values-based work, reparative action, meaning-making, restoration of relationships, and gradual professional and social reintegration.

The evidence base for specific interventions is growing but does not yet support a single standard protocol for moral injury. The systematic synthesis by Beech et al. (2024) identified several approaches, but only a small proportion had been examined in sufficiently large randomised trials. In an RCT involving 174 veterans, Adaptive Disclosure-Enhanced produced greater post-treatment improvements in functioning and PTSD than present-centred therapy, although between-group differences were not maintained at follow-up (Litz et al., 2024). A controlled German study of values-based group CBT reported reductions in maladaptive shame-related strategies (Diekmann et al., 2023). Qualitative veteran data also support the relevance of values, the therapeutic relationship, involvement of significant others, and longer-term follow-up (Bonson et al., 2024; Purcell et al., 2026).

On the basis of the synthesis, a six-stage framework for crisis and follow-up care can be proposed: (1) safety and stabilisation; (2) identification of the PMIE and its moral meaning; (3) differentiation of guilt, shame, anger, betrayal, and responsibility; (4) mobilisation of relational, peer, and organisational support; (5) meaning-making, moral repair, and restoration of value continuity; and (6) psychosocial and professional reintegration with follow-up monitoring. This framework is not a newly validated therapy, but a practical synthesis of domains that should be assessed deliberately within crisis intervention and, where necessary, referred for specialised follow-up care.

Depending on individual needs, multidisciplinary support may involve a psychologist or psychotherapist, psychiatrist, social worker, crisis-intervention practitioner, military chaplain, and organisational or command support structures. Command involvement may contribute to rebuilding trust, clarity, and perceptions of organisational justice, but should not substitute for confidential professional care. Respect for the military professional's autonomy, protection of confidentiality, and avoidance of moralising by helping professionals are essential.

2.8. Methodological Quality of the Included Studies

The MMAT appraisal indicated generally acceptable to high methodological quality across the core analytical set, while also identifying recurring limitations. The most common limitations of quantitative studies were cross-sectional designs, non-representative or volunteer samples, and limited ability to control all relevant confounding variables. Qualitative studies generally demonstrated good alignment

between the research question, data collection, and thematic interpretation, but often used small purposively selected samples. Intervention evidence was methodologically strongest in the RCT by Litz et al. (2024), whereas the study by Diekmann et al. (2023) was limited by its non-randomised design.

Table 2

MMAT appraisal of the methodological quality of the core studies

Study	MMAT category	C1	C2	C3	C4	C5	Criteria met	Main methodological note
Nash et al., 2013	quantitative descriptive	✓	✓	✓	△	✓	4/5	specific, highly exposed military cohort; limited reporting of attrition
Bryan et al., 2016	quantitative descriptive	✓	△	✓	✓	✓	4/5	two appropriate samples, but limited representativeness
Currier et al., 2015	quantitative non-randomised	△	✓	✓	△	✓	3/5	cross-sectional design limits temporal interpretation of mediation
Zerach & Levi-Belz, 2018	quantitative non-randomised	△	✓	✓	△	✓	3/5	volunteer sample and cross-sectional mediation analysis
Williamson et al., 2020	qualitative	✓	✓	✓	✓	✓	5/5	strong thematic coherence; male purposive sample limits transferability
Williamson et al., 2021	quantitative non-randomised	✓	✓	✓	△	✓	4/5	cross-sectional self-report data; adjustment for selected covariates only
Williamson et al., 2023	qualitative	✓	✓	✓	✓	✓	5/5	detailed functional data; partly shared research context with earlier work
Zerach et al., 2023	quantitative non-randomised	✓	✓	✓	✓	✓	5/5	prospective three-wave design with relevant moderators
Diekmann et al., 2023	quantitative non-randomised	✓	✓	✓	△	✓	4/5	control group, but no randomisation and no longer-term follow-up
Kalmbach et al., 2024	qualitative	✓	✓	✓	✓	✓	5/5	rich data; small purposive veteran sample
Fernandez & Currier, 2024	quantitative non-randomised	△	✓	✓	△	✓	3/5	small convenience sample and cross-sectional association
Litz et al., 2024	randomised	✓	✓	✓	✓	✓	5/5	strong RCT design; between-group effects were not maintained at follow-up
Bonson et al., 2024	qualitative	✓	✓	✓	✓	△	4/5	very small treatment-seeking sample
Levi-Belz et al., 2025	quantitative non-randomised	✓	✓	✓	✓	✓	5/5	longitudinal model with temporal ordering of variables
Chesnut et al., 2025	quantitative non-randomised	✓	✓	✓	✓	✓	5/5	large longitudinal sample; latent profiles are model-dependent
Sowden et al., 2026	quantitative non-randomised	✓	✓	✓	✓	✓	5/5	prospective transition design; small effects
Danson et al., 2026	qualitative	✓	✓	✓	✓	△	4/5	exploratory design and N=12
Purcell et al., 2026	qualitative	✓	✓	✓	✓	△	4/5	post-treatment self-report perspective without a control group

Legend: ✓ = criterion met; △ = partially met or methodological uncertainty. C1-C5 denote the five criteria for the relevant MMAT category; their content varies according to study design. The 3/5-5/5 notation is presented solely for transparent description and should not be interpreted as a validated overall quality score.

3. Discussion

This review brought together evidence that is often discussed in separate clinical, relational, and organisational literatures. The resulting picture is coherent in one respect but less settled in another. Moral injury is consistently described as involving moral appraisal, responsibility, betrayal, identity, and meaning;

however, the empirical literature varies considerably in definitions, measures, populations, and study design. The synthesis therefore supports a multidimensional formulation, but not the claim that moral injury constitutes a discrete disorder with clearly established diagnostic boundaries.

For RQ1, the strongest recurring pattern concerns the interaction between psychological and social processes rather than any single symptom. Guilt, shame, anger, self-condemnation, and hopelessness frequently co-occur with withdrawal, impaired trust, relational strain, and difficulty reintegrating. Ethical and organisational factors are particularly salient when the precipitating experience involves betrayal or constrained responsibility, while existential disruption becomes visible in altered identity, meaning, and forgiveness. These domains should not be read as independent categories: the qualitative literature suggests that they often reinforce one another, although the small and selective samples in many such studies limit claims about prevalence.

RQ2 highlights an unresolved conceptual boundary. Moral injury and PTSD overlap substantially, yet evidence based on moral-injury symptoms is more consistent than evidence based on PMIE exposure alone (Beech et al., 2024). This matters because exposure measures cannot establish that an injury occurred. Conversely, a strict contrast between fear-based PTSD and guilt- or shame-based moral injury is also too simple; fear, guilt, anger, shame, and betrayal can coexist after the same event. The practical value of the construct is therefore less in replacing existing diagnoses than in identifying moral content that may otherwise remain clinically underexplored.

The evidence relevant to RQ3 is suggestive rather than definitive. Longitudinal studies provide better support than cross-sectional work for a multilevel model: social support and purpose were associated with more favourable trajectories (Chesnut et al., 2025), ethical preparation and leadership attenuated later symptoms in one prospective military cohort (Zerach et al., 2023), and self-forgiveness moderated a pathway involving trauma-related guilt and suicide risk (Levi-Belz et al., 2025). These findings are clinically plausible, but they come from different populations and operationalisations and should not be treated as evidence that any one factor is universally protective.

For RQ4, intervention evidence remains the least mature part of the literature. Adaptive Disclosure-Enhanced produced greater short-term improvement in functioning and PTSD than present-centred therapy, but the between-group advantage was not maintained at follow-up (Litz et al., 2024). The German values-based group CBT study reported improvement in shame-related coping but was non-randomised (Diekmann et al., 2023). Qualitative studies add useful information about values, self-compassion, significant relationships, and the therapeutic alliance (Bonson et al., 2024; Purcell et al., 2026), but they do not establish comparative efficacy. Crisis intervention should therefore be framed as assessment, stabilisation, and linkage to appropriately selected follow-up care rather than as a brief treatment for moral injury itself.

The main contribution of the proposed framework is consequently organisational rather than diagnostic or therapeutic. It links the moral appraisal of a PMIE with individual, relational, organisational, and existential contexts and asks clinicians to identify which pathway is most salient in a particular case. Guilt may require careful appraisal of responsibility and possible repair; shame may call for work with global self-condemnation; betrayal may require attention to trust and organisational meaning; and loss of purpose may need longer-term values- and meaning-oriented work. The framework should be regarded as a structured synthesis to guide assessment and referral, not as an empirically validated treatment algorithm.

4. Limitations

Several limitations should be considered when interpreting the findings. First, the broader evidence base remains dominated by U.S. and other Western military populations, and a substantial proportion of the data comes from veterans, limiting generalisability to active-duty personnel in other armed forces. Second, approximately four fifths of the published literature is cross-sectional, which means that most associations cannot establish the causal direction between PMIE exposure, moral distress, and mental health outcomes (Beech et al., 2024).

Third, heterogeneity in definitions and assessment instruments complicates comparison across studies. Some scales primarily assess PMIE exposure, whereas others measure subsequent emotions and beliefs

or broader symptoms of moral injury. Fourth, several publications draw on overlapping cohorts and therefore should not be interpreted as fully independent replications. Fifth, the core set of 18 studies was constructed as an analytical sample from an already systematically mapped military evidence corpus together with an updated PubMed search. Consequently, the present study is not a new *de novo* systematic review based on independently repeated licensed searches across all Scopus and Web of Science records.

Finally, the MMAT appraisal was conducted as a single-reviewer structured appraisal and was used to support interpretation rather than as an exclusion tool; it should not be regarded as an independently replicated quality assessment. The number of criteria met across heterogeneous designs is descriptive rather than a universal quality score. The integrative approach is useful for connecting quantitative, longitudinal, qualitative, and intervention evidence, but it is not designed to estimate a single pooled effect. Future work would benefit from prospective multicentre designs, more consistent separation of PMIE exposure from moral injury outcomes, independent quality appraisal, and longer-term evaluation of both clinical and organisational interventions.

5. Recommendations for Practice

The evidence supports a smaller set of practice priorities rather than a long list of discrete actions. These recommendations should be adapted to the individual's clinical state, operational context, preferences, and available services.

1. Prepare personnel for moral complexity, not only threat. Pre-deployment preparation should include realistic ethical dilemmas, competing duties, limits of personal control, and discussion of PMIEs. The aim is not to normalise harmful conduct, but to give personnel a language for recognising and discussing morally difficult experiences.

2. Treat ethical leadership as part of prevention. Commanders should be trained to recognise moral distress, communicate transparently, acknowledge appropriate responsibility, and create conditions in which ethical concerns can be raised without humiliation or automatic stigma. Organisational fairness and trust are relevant to prevention as well as recovery.

3. Extend post-event assessment beyond PTSD symptoms. After operationally significant events, assessment should include guilt, shame, self-condemnation, moral anger, perceived betrayal, loss of trust, withdrawal, disrupted meaning, and current safety. A PMIE exposure score should not be used as a diagnostic proxy for moral injury.

4. Match intervention to the dominant moral mechanism. Guilt calls for realistic appraisal of responsibility and possible repair; shame requires attention to global self-condemnation and identity; betrayal requires work with breached trust; and loss of meaning may require longer-term values-based or existential work. Trauma-focused treatment may remain appropriate, but moral content should not be assumed to resolve automatically when PTSD symptoms improve.

5. Use social support deliberately and protect help-seeking. Where appropriate and with the individual's consent, partners, family members, trusted peers, or unit-based support can reduce isolation and support reintegration. This requires a command climate in which seeking psychological or psychosocial care is not treated as professional failure.

6. Provide multidisciplinary, confidential, stepped care. Depending on need, care may involve psychology or psychotherapy, psychiatry, crisis intervention, social work, peer support, and, when requested by the individual, chaplaincy or other spiritual support. Command structures can facilitate organisational repair but should not replace confidential clinical care.

7. Plan follow-up around reintegration, not only symptom reduction. Moral distress may change after deployment or during transition to civilian life. Follow-up should therefore consider intimate and family functioning, occupational roles, trust, disclosure, belonging, and the person's ability to integrate the experience into a coherent identity.

8. Make space for moral repair and restoration of meaning. Where clinically appropriate, support may include accepting proportionate responsibility, reparative action where feasible, self-forgiveness, renewed value-consistent behaviour, and reconstruction of personal or professional meaning. These processes should be invited rather than prescribed.

9. Evaluate military-specific interventions and organisational prevention. Research should prioritise prospective follow-up after PMIE exposure, clearer measurement of moral injury outcomes, replication outside predominantly U.S. veteran samples, and evaluation of leadership, organisational justice, relational support, and interventions targeting moral repair and reintegration.

Taken together, these priorities describe a continuum of care: preparation → early recognition → safety and stabilisation → assessment of moral meaning and responsibility → targeted psychological, relational, or organisational support → moral repair and reconstruction of meaning where relevant → psychosocial and professional reintegration with follow-up.

6. Conclusion

Moral injury is best understood as a non-diagnostic, multidimensional response that may follow experiences perceived to violate important moral expectations. Its relevance lies in the combination of moral appraisal and functional consequences: guilt, shame, anger, betrayal, disrupted trust, altered identity, relational withdrawal, and loss of meaning. These reactions frequently overlap with PTSD, depression, and anxiety, but exposure to a PMIE is neither equivalent to moral injury nor sufficient to establish psychopathology.

For crisis intervention, the implication is practical. Safety and stabilisation remain the first priorities, but assessment should also ask what the event means to the individual, how responsibility is understood, whether betrayal is central, and which values or relationships have been disrupted. Where distress persists, crisis intervention should provide a bridge to appropriately matched follow-up care rather than attempt to resolve a complex moral conflict within a brief encounter.

The review also shifts attention from the individual alone to the context in which moral injury develops and is repaired. Social support, ethical leadership, organisational justice, opportunities for confidential help-seeking, and meaningful reintegration may influence outcome. Multidisciplinary care is therefore justified when psychological symptoms intersect with relational, organisational, ethical, or spiritual concerns.

The proposed framework integrates these levels without claiming a new diagnosis or a validated treatment protocol. Given the predominance of cross-sectional studies, heterogeneous measurement, and a still limited intervention literature, its components should be applied cautiously and evaluated prospectively. Its principal value is to make the moral dimension of military crisis visible and to organise assessment, referral, and longer-term support around that dimension.

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