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How meaningful is meaning-making?

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ABSTRACT

The aim of this paper is to develop understandings of how meaning-making processes apply to moral injury in military populations. Moral injury is an emerging clinical construct recognized as a source of mental health morbidity. Meaning-making processes, especially following highly stressful events, have far-reaching applicability to ensuring favorable mental health outcomes. This paper examines meaning-making processes in the context of moral injury: meaning and morality in times of war, morally injurious experiences, moral emotions and cognitions, the importance of meaning-making in general mental health, and how meaning-making plays into the expressions and/or symptoms of MI. We apply these understandings in a case vignette of a Veteran affected by moral injury. We end by offering suggestions on how meaning-making can be applied in the development of clinical support strategies in cases of moral injury.

1. Introduction

An emerging literature has examined the issue of moral injury (MI), sometimes also referred to as “inner conflict” in the U.S. Armed Forces, among military Service members and Veterans. While there is a lack of consensus on the definition and definitive features of this condition, MI has become recognized as a source of mental health morbidity in these populations. The development of MI represents a process that starts with being party – in an active or passive role – to potentially morally injurious events (PMIE; Shay, 2007), described as a “transgression that severely and abruptly contradicts an individual's personal or shared expectation about the rules or the code of conduct, either during the event or at some point afterwards” (p. 700, Litz et al., 2009). Yet not everybody who experiences a PMIE goes on to become morally injured (i.e., develop expressions/manifestations of MI; Jordan, Eisen, Bolton, Nash, & Litz, 2017).

Empirical understandings of MI have only begun to emerge in recent years and several working definitions presently exist to describe MI (Hodgson & Carey, 2017). The underlying common element shared across these definitions is a sense of harm following a PMIE (e.g., Masick, 2016). This sense of harm can extend across psychological, biological, spiritual, behavioral, and/or social domains (Hodgson & Carey, 2017). Some definitions of MI also apply understandings of interpersonal and institutional betrayal-related events (e.g., Shay, 2014) as well as religiosity (e.g., Brock & Lettini, 2011). Ultimately, being morally injured reflects a clinically significant constellation of negative affect (Bryan, Bryan, Roberge, Leifker, & Rozek, 2018; Gray et al., 2012; Jinkerson, 2016). For example, transgressions actively committed against others might give way to feelings of pervasive shame and guilt, beliefs/attitudes about being unlovable, or difficulty with forgiveness (Currier, McDermott, Farnsworth, & Borges, in press). Assuming a passive role in a PMIE (e.g., witnessing others' transgressions), can also give way to feelings of anger and moral disgust, beliefs/attitudes related to mistrust of others, and revenge fantasies (Currier et al., in press).

At present, most of the MI literature has focused on military populations, though understandings of MI can and have been applied to other populations as well (e.g., Hoffman, Liddell, Bryant, & Nickerson,

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2018). The dynamics of military service, including but not limited to combat and warfare, frequently push deeply held core personal beliefs, ethical values, and moral norms to the forefront. The literature, however, is limited in developing understandings of how Service members and Veterans reconcile their military experiences with their own beliefs, values, and norms. Developing such conceptual understandings could inform and impel knowledge on how some go on to develop MI, the potential for having one's beliefs, values, and norms violated, reducing unnecessary suffering, and fostering a renewed sense of meaning and purpose as a means for supporting those affected by MI (Farnsworth, Drescher, Evans, & Walser, 2017).

In this discussion paper, we use meaning-making to propose a framework for the processes which lead to MI in military populations. In so doing, the aim of this paper is to present MI as a psychological wound which gives way to the basic human need of making meaning from stressful or traumatic life events. Meaning-making is defined as "retaining, reaffirming, revising, or replacing elements of [one's] orienting system to develop more nuanced, complex and useful systems" (p. 208, Gillies, Neimeyer, & Milman, 2014). We contend that meaning-making is uniquely suited to inform the processes underlying the development of MI. Meaning-making, especially following highly stressful encounters (e.g., PMIEs), is recognized as having far-reaching applicability to mental health (Park, 2010; Park & Folkman, 1997). Accordingly, this paper is designed to inform such understandings as related to MI. We end by illustrating how meaning-making applies in the case vignette of a Veteran experiencing MI.

2. Morally injurious events

The morally injurious potential of military service is thought to be vested in the sometimes moral and/or ethical ambiguity of wartime and military settings. Anecdotal understandings of military conflict draw attention to how such ambiguity has existed since time immemorial. Using the example of contemporary military conflicts, most notably beginning with the Vietnam War (1955), such ambiguity has manifested itself as unconventional models of warfare, threats posed to noncombat troops, and the risk of harming civilians/noncombatants (Litz et al., 2009). Some authors have also posited "ambiguous, inconsistent, or unacceptable rules of engagement, lack of clarity about the goals of the mission itself, […] and inherently contradictory experiences of the mission as both humanitarian and dangerous" (Wood, 2016). When faced with such ambiguity, Service members and Veterans are forced to process new schema related to warfare, changing roles, and sensorial experiences (Litz et al., 2009).

Military personnel are, by definition, disciplined and proficient in combat operational skills. Military training is intended to habituate military members to fear. Service members typically expect to feel fear, are taught how to cope with fear, and have had practice acting in contexts of fear. Military cultural norms and values emphasize the necessity for peak performance and excellence in war. Military culture may also play a formative role in shaping how global meaning systems – composed of content (i.e., beliefs, identity, goals, values) and judgment (i.e., comprehensibility, sense of mattering and purpose) – are used to assess highly impactful life events (Park, 2017). In military settings, this manifests as a strict system of belief and practice, unambiguous and clear rules for living, closeness with like-minded individuals, and a collective sense of identity and belonging. Most military settings further apply strict rules of engagement for delineating right from wrong.

Yet military training does not routinely empower Service members with the knowledge, skills, or abilities to cope with sadness, guilt, shame or experiences of moral violation and/or betrayal, such as that associated with PMIEs (Litz, Lebowitz, Gray, & Nash, 2015). If such skills should be imparted during military training remains a topic for discussion and debate. For example, while most individuals are taught by their family and culture "Thou shalt not kill," the military conditions Service members to enact lethal harm on others (Grossman, 1995). What follows is that killing the "wrong person" may leave individuals even more vulnerable to MI. Killing in war, especially in the context of anger/revenge or a noncombatant, has been associated with more frequent and severe PTSD symptoms (Maguen et al., 2013). Veterans' experiences of killing others and failing to prevent death has also been linked with a reported weakening of religious faith, both directly and as mediated by feelings of guilt (Fontana & Rosenheck, 2004).

As a potentially traumatic event, PMIEs will usually fall under one or more of the following domains: acts of betrayal, acts of disproportionate violence inflicted on others, incidents involving death or harm to civilians, violence within military ranks, inability to prevent death or suffering, and ethical dilemmas/moral conflicts (Currier, Holland, Drescher, & Foy, 2015). For some, PMIEs do not appear to have lasting effects. For others, however, PMIEs represent a source of lasting moral pain: a painful discrepancy between aspects of their global meaning system and the situational appraisal of the exposure, increasing proneness to dysphoric moral emotions and cognitions (Farnsworth et al., 2017; Park, 2010; Park, Currier, Harris, & Slattery, 2017). This discrepancy represents a gap between "what happened" and "what should have happened." The challenge of reconciling any such discrepancies may present in the short-term following a PMIE (e.g., still in active duty settings) or in the long-term (e.g., following discharge from military service). For example, some Veterans may find it exceedingly difficult to re-accustom themselves to the "new normal" of interpreting past and present experiences through non-military beliefs or norms (Caddick, Smith, & Pho, 2015).

The negative affect which follows a PMIE may represent a vicious circle of psychache avoidance, where each stage feeds on the one preceding it. Psychache is defined as "the hurt, anguish, soreness, aching, psychological *pain* in the psyche, the mind" (original author's emphasis, p. 145, Shneidman, 1993). This vicious circle could start with experiences of self-hatred, regret, and self-criticism, followed by guilt/shame related to the experience and failure to live up to "code," unhelpful stories about why code was violated and what this means, ruminating on past, regretting, worrying about the future, loss of contact with what matters, culminating in self-destructive survival strategies. Such avoidant behavior has the effect of "limit[ing] reparative experiences and social connection" (p. 11, Delima-Tokarz, 2017). This leaves the individual incapable of healing their moral wounds and processing their experiences (Litz et al., 2015; Papazoglou & Chopko, 2017).

3. Moral injury

To the degree that a PMIE is experienced as violating deeply held beliefs and goals regarding social norms and one's desire to adhere to them, coupled with maladaptive coping strategies (e.g., psychache avoidance, isolation, substance abuse), psychological trauma is experienced and the individual is recognized as morally injured (Farnsworth et al., 2017; Nash et al., 2013). Such individuals will experience intense distress, including the emergence of painful moral emotions (e.g., shame, anger and disgust; Farnsworth, Drescher, Nieuwsma, Walser, & Currier, 2014). This distress will invariably impel them to try to make sense or meaning of their morally injurious experiences. In the context of MI, meaning-making involves working through moral emotions and cognitions (appraisals, attributions), which can either lead towards recovery, a sense of being "stuck," or even exacerbate and extend the sense of MI (Kopacz et al., 2016).

The expressions/manifestations of MI have been associated with a variety of negative health outcomes. For example, in a sample of 103 men with a history of interpersonal trauma, trait shame (but not guilt) accounted for the association between post-traumatic stress disorder (PTSD) and both physically and psychologically aggressive behavior, as well as frequency of physical aggression (Schoenleber, Sippel, Jakupcak, & Tull, 2015). After controlling for demographic and combat factors, difficulty in self-forgiveness or forgiveness of others was also related to depression, anxiety, and PTSD symptom severity in Veterans

seeking VA healthcare (Witvliet, Phipps, Feldman, & Beckham, 2004). Conversely, the ability to forgive has been associated with less cynicism and less psychache (Dangel, Webb, & Hirsch, 2018).

In extreme cases of MI, another negative health outcome might include suicidal behavior, best conceptualized as a means of avoiding the emotional pain and suffering associated with MI (Li, Fu, Zou, & Cui, 2017). In a sample of National Guard members, PTSD symptom severity was associated with higher risk of a suicide attempt among participants with high moral injury and MI complaints were positively associated with suicidal ideation regardless of the level of PTSD symptoms (Bryan et al., 2018). MI has also been associated with suicide attempts, where transgressions committed by self were associated with significantly more suicidal ideation (Bryan, Bryan, Morrow, Etienne, & Ray-Sannerud, 2014). Similarly, transgressions by self and feelings of betrayal have been associated with suicidal behavior (Wisco et al., 2017).

4. Meaning-making

The MI literature has consistently drawn attention to the importance of meaning-making (Currier, Holland, & Neimeyer, 2009; Gillies & Neimeyer, 2006; Holland, Currier, Coleman, & Neimeyer, 2010; Litz et al., 2009). For example, difficulties with meaning-making have been found to mediate how PMIEs increase the probability of psychological problems in some Veterans (Currier, Holland, & Malott, 2015). Meaning-making is a process which looks to increase one's ability to describe how an adverse life event occurred and attributing causality to the event, thereby helping integrate it into one's global meaning system. The process of meaning-making includes two keys stages. Firstly, individuals work to reconcile their appraisals or understandings about specific stressful life events (i.e., situational meaning) with their core beliefs about the world, the self, and others (i.e., their global beliefs; Park, 2010). Secondly, individuals construct meaning by interpreting stressful life events in ways that are congruent with their pre-existing global beliefs (i.e., assimilation) or by changing their global beliefs to make sense of stressful life events (i.e., accommodation; Janoff-Bullman, 1992; Park & Folkman, 1997; Piaget, 1953).

Meaning-making processes are adaptive when violations of global meaning are reduced through meaning-making efforts, producing outcomes called meanings made. These meanings made can include a new understanding of the world, a new view of the stressful encounter more compatible with global meaning, new life goals, or a new or reformed aspect of identity. These meanings made are related to better psychological adjustment following traumatic events. For example, meaning made following the death of someone close has been negatively associated with facets of complicated grief (Currier et al., 2009; Neimeyer, 2001; Neimeyer, Baldwin, & Gillies, 2006). Similarly, meaning made of stress has been negatively associated with suicidal ideation in both veteran and civilian college students (Holland, Malott, & Currier, 2014; Lockman & Servaty-Seib, 2016).

Meaning-making processes encompass such elements as sense-making, benefit-finding, and identity change. For example, individuals may clarify or markedly change their global beliefs to make sense of adverse life events (i.e., accommodation; Park & Folkman, 1997; Piaget, 1953). Benefit-finding involves re-appraising adverse life event(s) in ways that individuals make positive attributions about the specific gains associated with the event (Gillies & Neimeyer, 2006). Identity change involves recognizing specific ways in which one's core sense of self has changed in response to adverse life events (Holland et al., 2010; Neimeyer, Baldwin et al., 2006; Neimeyer, Herrero, & Botella, 2006). Identity-change may be experienced as adaptive (e.g., increased wisdom, emotional strength, autonomy) and/or maladaptive (e.g., decreased interpersonal trust).

Meaning-making processes are important to ensuring favorable mental health outcomes. The desire to persist in pursuing one's life goals requires reconciling challenges to global beliefs (e.g., the world is a safe place, people are inherently good) in ways that allow people to maintain an identity and life story that makes sense across time (Neimeyer, Herrero et al., 2006). This is a critical and multifaceted process that allows individuals to thrive while maintaining a cohesive life narrative (Neimeyer, Burke, Mackay, & van Dyke Stringer, 2010; Neimeyer, 2001). Yet meaning-making process are exceptionally nuanced, reinforcing the importance of recognizing and appropriately attending to these processes in clinical settings. For example, in processing a PMIE, the individual might take on excessive amounts of responsibility or blame (e.g., maladaptive identity change), impeding the pursuit of life goals and a cohesive life narrative.

5. Moral injury vs. post-traumatic stress disorder

MI and PTSD are both recognized as post-traumatic clinical states. Overlap in the clinical manifestations of MI and PTSD has been proposed at the level of anger, depression, anxiety, substance abuse, insomnia, and nightmares (American Psychiatric Association, 2013; Bryan et al., 2018). Overlap in terms of symptomatic reexperiencing of the traumatic event as well as avoidance or numbing has also been posited (Litz et al., 2009; Shay, 2014). Still, the expressions/manifestations of MI are largely recognized as conceptually distinct from, and not fully captured by, a diagnosis of PTSD (Dombo, Gray, & Early, 2013; Drescher & Foy, 2008; Drescher et al., 2011; Maguen & Litz, 2012; Nash et al., 2010). Further, unlike PTSD, there is no clear diagnostic threshold for identifying cases of MI (Drescher & Foy, 2008; Maguen & Litz, 2015; Shay, 2011).

To the extent that similarities exist between MI and PTSD, certain assumptions about MI have been extrapolated from the PTSD literature, underscoring the utility of applying meaning-making to understanding the development of MI.

Meanings made of a life-stressor have been negatively and uniquely associated with severity of PTSD and depressive symptomatology among treatment-seeking Veterans who served in Iraq and Afghanistan (Currier, Holland, Christy, & Allen, 2011; Yan, 2016). Meanings made also partially mediated the associations among PMIEs and clinically-significant mental health symptoms (i.e., PTSD, depression, suicidal ideation; Currier, Holland et al., 2015). Among Veterans affected by PTSD, meaning-making may figure prominently as a motivating factor for remaining engaged in clinical services, even more so than a desire for symptomatic relief (Fontana & Rosenheck, 2004, 2005).

Research has found that some Service members and Veterans affected by PTSD continue to experience symptoms even after receiving front-line therapies (e.g., prolonged exposure, cognitive processing therapy; Steenkamp, Litz, Hoge, & Marmar, 2015). This has been interpreted as highlighting the presence of co-morbidities heretofore not addressed by such therapies (Delima-Tokarz, 2017). For some Service members and Veterans affected by PTSD, this may include the expressions/manifestations of MI (Currier et al., in press). Posttraumatic embitterment disorder (PTED) has been proposed as a diagnosable disorder which appears to encapsulate many of the expressions/manifestations of MI. Core diagnostic criteria proposed for PTED include a negative life event, perceiving this event as “unjust,” intrusive memories, and unimpaired emotional modulation (Linden, 2003). PTED is thought to be clinically distinct from PTSD (Linden, Baumann, Rotter, & Schippan, 2008).

In terms of treatment, front-line therapies for PTSD distinguish between “what happened” and “what should have happened.” The latter of these two perspectives — “what should have happened” — taps into moral beliefs, expectations, and assumptions about one's own actions (e.g., “I should have done something different”), the actions of others (e.g., “They shouldn't have done this”), and/or, in some cases, the actions of a higher power (e.g., “God shouldn't have let this happen”). The end product of these therapies is that the individual acquires an alternative perspective of situational context, which often entails the acquisition of perspectives that preferred options were not available at the time of the event. By facilitating change in how

someone views "what happened," these treatments can also change how the person views "what should have happened." Key to this shift is understanding the values, religious traditions, personal code, military code, and/or sociocultural code that contributes to the Service member or Veteran's understanding of "what should have happened." In this way, trauma-focused therapies can narrow the gap between "what happened" and "what should have happened."

6. Clinical vignette

We present the case of Ed (all vital details changed to ensure anonymity) which illustrates how meaning-making processes may apply to the development of MI following a PMIE. Ed was a Special Reaction Team leader deployed four times to Iraq and Afghanistan during the period 2003–2005. He reported having experienced heavy combat during these deployments. Since being discharged, he experienced chronic and unremitting psychiatric symptoms and moderate to severe dissociative symptoms related to his intensive combat experiences. He has engaged in front line treatments for PTSD for the past 10 years and reports only mild therapeutic benefits.

During his clinical interview, Ed indicated military experiences that could be considered PMIEs. These included an incident involving a dying girl and providing – what he believed was – subpar training to comrades who replaced him at the end of his tour. Firstly, during a house raid, a young girl was accidentally fatally wounded by one of his team. The intensity of the raid did not allow the opportunity to close this young girl's eyes, an issue which continues to cause Ed considerable distress. Secondly, exhausted by his military service, Ed reported not having provided quality training to his comrades. While those under Ed's command suffered no fatalities, he later learned that several individuals from the replacement team were fatally wounded during operations. He attributed these deaths to the self-described subpar training he provided to the team which replaced his.

Chronic and unremittent psychiatric symptoms continue to impair his daily functioning and relationships. He attributes his chronic feelings of shame, guilt, defeatedness, and demoralization to his PMIEs. Clinical encounters further uncovered the presence of moderate to severe dissociation. Dissociation is an alteration of consciousness of time, place, or one's sense of self to accommodate overwhelming experiences, allowing the reduction of the emotional experience so that a person could function under extremely stressful conditions. He would often dissociate during therapy sessions. At one point, Ed even boasted about not needing to continue therapy anymore because he could dissociate on command to cope with intolerable affect and memories.

Ed often wondered how he went from being voted the "friendliest guy" by his senior class to his present state. He reflected on whether his life could have been different if he had closed the girl's eyes or trained his comrades better. He often compared his life to the lives of the people who were deployed with him. He also fixated on the difference between his decision to "do whatever it takes to come home" to his service buddies who made similar decisions, yet took the time to show compassion. Though having served on the same missions, he found these buddies to be better off after separating from the military. According to Ed, they were thriving (e.g., able to maintain jobs and happy, intact marriages) while he struggled with feelings of worthlessness and deflated confidence. Ed reported self-medicating in an effort to regulate emotions and avoid painful memories related to his PMIEs. He actively engages in avoidant behaviors, such as taking multiple vacations and visiting his son out-of-state.

7. Ed: moving from PMIEs to MI

In the case vignette of Ed, one can observe some of the moral ambiguity encountered in wartime experiences. The accidental death of innocent civilians and the combat casualties experienced by the team which replaced his have forced Ed to integrate these events into his global meaning system. Ed is having to evaluate his beliefs on military service, his identity and role in these tragic events, the goals he set for himself as a team leader and trainer, as well as his values related, among others, to death rituals (i.e., closing the girl's eyes) and work ethic (i.e., providing self-described subpar training to his replacement team).

Ed appears to actively engage in a vicious circle of psychache avoidance, unable to reconcile the discrepancy between his personal beliefs, values, and goals and the situational appraisal of his PMIEs. This is evident in his assuming disproportionate responsibility and blame for his role in these PMIEs, his inability to reconcile situational meaning with his core beliefs (e.g., being a friendly individual), and his continued difficulty in aligning these PMIEs with his global belief system. His dissociative behaviors and self-medication are further evidence of psychache avoidance, drawing greater attention to the mental health morbidity associated with his moral emotions and cognitions.

His continued lamenting on life, living, and differences between him and his comrades appears to be evidence of how Ed is "stuck" in attempting to make meaning of his PMIEs and reclaim a cohesive life story. He fails to make any positive attributions related to his self-appraisals or core sense of self-identify. Survival at all costs (i.e., doing "whatever it takes to come home") appears to have shaken his deep-seeded global belief in exhibiting compassion. This violation in global meaning has given way to a yet unclarified sense of identity change, as evidenced by his dissociative practices, which he applies as a coping mechanism for dealing with painful emotions and memories.

Therapeutic goals for Ed included applying sense-making, benefit-finding, and identity change strategies to restore his sense of a cohesive life story. For example, sense-making could be used to reinforce the evolution of his global beliefs and accommodating these beliefs to his wartime experiences. Benefit-finding could serve to identify lessons learned, giving voice to and facilitating engagement with heretofore unarticulated core beliefs and/or ethical or moral norms. When framed in a language of growth, identity-change allows for personalizing the dynamic nature of human experience. Despite earnest therapeutic efforts, Ed remained unable to fully engage in therapy.

8. Discussion

In this paper, we highlighted the importance of meaning-making processes to the development of MI following a PMIE. Recognizing meaning-making as a developmental process is likely to foster an environment where MI is viewed as a normative response to extraordinarily traumatic events and circumstances. Supportive services should focus on creating an emotionally safe environment for validating the difficulty sometimes associated with achieving meanings made, identifying associations with deeply held values and/or beliefs, and facilitating meaning-making processes.

We posit the potential for enhancing the supportive services provided to military personnel affected by MI. First, in cases suggestive of MI, clinicians can provide psychoeducation on the role of meaning-making in MI and the individual uniqueness of meaning-making processes. Second, clinicians can offer validation statements indicating that Veterans are not "less moral" if distress related to a PMIE is not experienced. Rather, lack of distress indicates meaning reconstruction has likely already taken place. Third, when working with Veterans affected by MI, clinicians may also benefit from describing meaning-making as an iterative process that can be experienced during many transitions across the lifespan. For example, the experience of killing during war may be processed in the course of combat, then again differently after one returns home. Such an approach recognizes that the capacity for meaning-making changes with age. Relatedly, clinicians may benefit from asking specific questions about clients' age when PMIEs occurred (McRae et al., 2012; Williams et al., 2006). For example, emerging adult Veterans may still be developing cognitive frameworks for meaning-making, whereas middle-aged and older adult Veterans may

struggle to adapt more fixed global beliefs to developmental transitions (e.g., physical health decline, loss of relationships due to age, death losses).

It is worth noting that each of these strategies are elements of front-line therapies recommended for PTSD. Both therapies begin with psychoeducation about trauma and posttraumatic reactions with a specific focus on how negative thoughts, perceptions, and beliefs, to include maladaptive or stalled meaning-making, can maintain PTSD symptoms over time. Both therapies also emphasize the importance of validating the Service member or Veteran's emotional experiences and conceptualizing meaning-making as a process that evolves during and after treatment. The inclusion of these strategies may explain, at least in part, the observed effects of these treatments on reducing outcomes associated with "what should have happened" such as global guilt, hindsight bias, perceived lack of justification, and perceived wrongdoing (Resick, Nishith, Weaver, Astin, & Feuer, 2002). Additional research with Service members and Veterans is needed to further investigate the possibilities of applying and/or adapting these treatments for MI. Such research could provide critical information about why and how trauma-focused therapies do (or do not) impact the symptoms and sequelae associated with PMIEs.

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