



Moral Injury and Resilience in Military Personnel: An Integrative Review

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Abstract

Military service exposes personnel not only to life threat but also to events that violate deeply held moral beliefs, such as killing, failing to prevent harm, or being betrayed by trusted leaders. The psychological aftermath of such events has been termed moral injury, a construct that overlaps with, but is distinct from, posttraumatic stress disorder (PTSD). In parallel, military organizations have invested heavily in resilience programs intended to protect service members from adverse psychological outcomes. This integrative review synthesizes conceptual, epidemiological, and intervention research on moral injury and resilience in military populations. Evidence indicates that potentially morally injurious events are common among combat veterans, that exposure is associated with PTSD, depression, and suicidality independent of fear-based trauma, and that guilt, shame, and loss of trust are central mechanisms. Resilience, defined as a stable trajectory of healthy functioning after adversity, is the modal response to deployment, yet most resilience training targets fear and stress appraisals rather than moral meaning. We propose an integrative model in which individual, social, and organizational resources moderate the pathway from morally injurious events to moral injury, and outline implications for assessment, training, leadership, and treatment. We conclude that resilience programming should be expanded to include moral preparation and organizational accountability, and that rigorous longitudinal and intervention research is needed.

Keywords: moral injury, resilience, military psychology, PTSD, guilt and shame, veterans.

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1. Introduction

The psychological costs of war have been documented for as long as wars have been recorded, from descriptions of “soldier’s heart” in the American Civil War to “shell shock” in the First World War and “combat fatigue” in the Second. The formal recognition of posttraumatic stress disorder in 1980 provided a common diagnostic language for these reactions, and PTSD has since

dominated research on the mental health of service members and veterans. The large-scale deployments to Iraq and Afghanistan after 2001 produced an unprecedented body of evidence on combat-related mental health problems, documenting elevated rates of PTSD, depression, and alcohol misuse after deployment, as well as persistent barriers to care (Hoge et al., 2004; Tanielian & Jaycox, 2008).

Yet clinicians working with veterans increasingly observed that the PTSD framework did not capture everything their patients suffered. PTSD is anchored in fear: the defining event is a threat to life or physical integrity, and the core symptoms (intrusions, avoidance, hyperarousal) reflect a fear-conditioning process. Many veterans, however, described suffering that centred not on what was done to them but on what they did, failed to prevent, or witnessed others do. Their distress was dominated by guilt, shame, anger, and a loss of faith in themselves, their leaders, or their moral worldview. Shay (1994), working with Vietnam veterans, described this as a betrayal of “what’s right” by a person in legitimate authority. Litz et al. (2009) broadened the concept, defining moral injury as the lasting psychological, biological, spiritual, behavioural, and social impact of “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations” (p. 697).

At the same time, research on human responses to adversity has shifted attention from pathology toward resilience. Prospective studies show that most people exposed to potentially traumatic events, including combat, do not develop lasting disorder (Bonanno, 2004; Bonanno et al., 2012). Military organizations have embraced this perspective. The U.S. Army’s Comprehensive Soldier Fitness program, launched in 2009, sought to train resilience across the entire force (Cornum et al., 2011), and comparable initiatives exist in the armed forces of the United Kingdom, Canada, Australia, and other nations.

These two literatures have developed largely in parallel. Resilience programs have been designed primarily around stress and fear responses, while moral injury research has focused on clinical populations who are already suffering. This review brings them together. Its aims are to (a) clarify the concept of moral injury and its relationship to PTSD, (b) summarize evidence on its prevalence, correlates, and outcomes in military populations, (c) review the conceptualization and promotion of resilience in military contexts, and (d) propose an

integrative model that identifies where resilience resources may buffer the impact of morally injurious events, with implications for practice and research.

2. Method of Review

This paper is an integrative narrative review rather than a systematic review or meta-analysis. Integrative reviews are suited to emerging constructs where definitions, measures, and study designs remain heterogeneous, because they allow conceptual and empirical sources to be synthesized together.

Sources were identified through the major databases in psychology and medicine (PsycINFO, PubMed/MEDLINE, and Google Scholar) using combinations of the terms moral injury, potentially morally injurious events, resilience, military, veterans, service members, PTSD, guilt, and shame, supplemented by backward searching of reference lists in key reviews (Griffin et al., 2019; Litz et al., 2009; Williamson et al., 2018). Priority was given to peer-reviewed empirical studies with military or veteran samples, validated measurement studies, systematic reviews and meta-analyses, and randomized trials of resilience or treatment interventions. Seminal theoretical works were included where they shaped the field.

The synthesis was organized thematically around four questions: how moral injury is defined and distinguished from PTSD; how common it is and what outcomes it predicts; how resilience is conceptualized and trained in military settings; and how the two bodies of evidence can be integrated. Because the review is narrative, it does not provide pooled effect sizes, and the selection of studies, while guided by explicit criteria, is not exhaustive.

3. Conceptual Foundations of Moral Injury

3.1 Events and outcomes

A key distinction in the literature separates the event from the outcome. Potentially morally injurious events (PMIEs) are experiences that may transgress an individual’s moral code; moral injury is the lasting psychological harm that may follow

(Litz et al., 2009; Griffin et al., 2019). This parallels the distinction between a potentially traumatic event and PTSD, and it matters because exposure does not inevitably produce injury.

PMIEs are commonly grouped into three categories. Perpetration involves acts the person committed, such as killing, harming civilians, or mistreating detainees. Omission involves failing to act, for example being unable to save a comrade or to stop wrongdoing by others. Betrayal involves violations by trusted others, particularly leaders or institutions, such as orders perceived as unjust or abandonment after injury (Nash et al., 2013; Shay, 1994). Witnessing the transgressions of others is sometimes treated as a fourth category.

3.2 The core psychological process

Litz et al. (2009) proposed that moral injury arises when a person cannot assimilate a transgressive experience into existing moral schemas. A soldier who believes “I am a good person who protects the innocent” and then kills a child in a split-second decision faces a profound dissonance. When the event is appraised as reflecting a stable, global flaw in the self (“I am a monster”) rather than as a contextually bounded act, the result is persistent shame. Shame motivates hiding and withdrawal, which prevents the corrective experiences of forgiveness and acceptance that could repair the schema. Over time, this cycle produces self-condemnation, social isolation, demoralization, and self-harm.

Moral emotions are therefore central. Guilt (“I did a bad thing”) is focused on a behaviour and can motivate reparative action, whereas shame (“I am bad”) is focused on the self and tends to drive concealment (Farnsworth et al., 2014). Betrayal-based injuries are characterized more by anger, resentment, and loss of trust in authority. Jinkerson (2016) proposed a syndrome model with core features of guilt, shame, spiritual or existential conflict, and loss of trust, plus secondary features such as depression, anxiety, anger, re-experiencing, social problems, and self-harm.

3.3 Relationship to PTSD

Moral injury and PTSD frequently co-occur, and the DSM-5 revision of PTSD added symptoms such as persistent negative beliefs about oneself, distorted blame, and persistent guilt and shame, bringing the two constructs closer (American Psychiatric Association, 2013). Nevertheless, theorists maintain that they are distinguishable on several dimensions, summarized in Table 1. Empirically, factor-analytic and correlational studies show that PMIE exposure predicts distress over and above life-threat exposure, supporting the view that moral injury is not simply a subtype of PTSD (Bryan et al., 2016; Williamson et al., 2018).

Table 1. Theoretical distinctions between PTSD and moral injury

Dimension	PTSD	Moral injury
Precipitating event	Threat to life or physical integrity	Transgression of deeply held moral beliefs
Role of the person	Usually victim or witness	Often agent (perpetrator) or betrayed party
Dominant emotion	Fear, horror	Guilt, shame, anger, disgust
Core mechanism	Fear conditioning and failed extinction	Moral dissonance and self-condemnation
Characteristic cognitions	“The world is dangerous”	“I am bad” or “No one can be trusted”
Diagnostic status	Formal DSM-5 and ICD-11 diagnosis	Not a formal diagnosis
Treatment emphasis	Exposure and cognitive processing of threat	Self-forgiveness, repair, meaning, reconnection

Note. Adapted from distinctions discussed by Litz et al. (2009), Farnsworth et al. (2014), and Jinkerson (2016). In practice the two conditions frequently co-occur.

4. Prevalence, Correlates, and Outcomes

4.1 Prevalence of exposure

Estimates of PMIE exposure vary with the measure used and the population sampled, but they

consistently indicate that such events are common in combat cohorts. In a nationally representative sample of U.S. combat veterans, Wisco et al. (2017) found that roughly one in ten endorsed

transgressions by themselves, and about one quarter endorsed transgressions by others and betrayal. Studies using the Moral Injury Events Scale (Nash et al., 2013; Bryan et al., 2016) and the Moral Injury Questionnaire–Military Version (Currier et al., 2015) report similar patterns, with betrayal and witnessing typically more frequently endorsed than perpetration. Exposure to killing is itself common among combat-deployed infantry and is a well-documented risk factor (Maguen et al., 2009).

For comparison, estimates of probable PTSD after deployment to Iraq or Afghanistan range from low single digits in some cohorts, such as the UK armed forces (Fear et al., 2010), to roughly one in five in heavily exposed U.S. ground combat units, with differences largely explained by combat intensity, timing of assessment, and case definitions (Kok et al., 2012; Hoge et al., 2004). The gap between the relatively high frequency of PMIE exposure and the lower prevalence of clinical disorder underlines that exposure is not destiny.

4.2 Mental health outcomes

PMIE exposure is associated with a broad range of adverse outcomes. A systematic review and meta-analysis of occupational moral injury found that exposure was associated with PTSD, depression, and suicidality across military and other high-risk occupations (Williamson et al., 2018). In military samples, the association with depression is often as strong as, or stronger than, the association with PTSD, consistent with the self-condemning and demoralizing character of moral injury (Griffin et al., 2019).

The link with suicide is of particular concern. Military suicide rates in several countries rose during and after the post-2001 conflicts, and moral injury has emerged as a plausible contributor. Bryan et al. (2014) found that self-directed moral injury, especially guilt and shame related to one's own actions, was associated with suicidal ideation and attempts in a military sample. Maguen et al. (2009) reported that killing in combat predicted PTSD symptoms, alcohol misuse, anger, and

relationship problems even after controlling for general combat exposure.

4.3 Correlates and risk factors

Several factors appear to increase the likelihood that exposure will develop into lasting injury. Perpetration-based events are more strongly linked to guilt, shame, and suicidality, whereas betrayal-based events are more strongly linked to anger and mistrust (Bryan et al., 2016; Griffin et al., 2019). Younger age, lower rank, and greater combat intensity are associated with higher exposure. Pre-existing mental health problems and childhood adversity are well-established predictors of PTSD after trauma (Brewin et al., 2000) and likely operate similarly for moral injury. Social and organizational factors are also important: low unit cohesion, perceived poor leadership, and lack of acknowledgement after return are associated with worse outcomes.

A recurring barrier is stigma. Hoge et al. (2004) found that service members who screened positive for mental disorders were more likely than others to fear being seen as weak or treated differently by leaders, and only a minority sought professional help. A later systematic review confirmed that stigma and related concerns remain persistent barriers to care in military populations (Sharp et al., 2015). Because shame, by its nature, motivates concealment, morally injured service members may be especially unlikely to disclose their experiences.

5. Resilience in Military Contexts

5.1 Defining resilience

Resilience has been defined in many ways: as a trait, a process, and an outcome. Contemporary research increasingly treats it as an outcome trajectory, namely the maintenance of relatively stable, healthy functioning across time following exposure to adversity (Bonanno, 2004). Masten (2001) described resilience as “ordinary magic”: it arises from common adaptive systems such as secure relationships, self-regulation, and meaning, rather than from rare personal qualities.

The trajectory approach has been applied to military populations with striking results. In a large prospective cohort of U.S. service members assessed before and after deployment, Bonanno et al. (2012) identified distinct trajectories of PTSD symptoms. More than four in five participants followed a stable, low-symptom resilient trajectory, while smaller groups showed chronic, new-onset, or improving patterns. Resilience, in other words, is the norm rather than the exception, even under combat conditions.

5.2 Protective factors

Research has identified protective factors at several levels. At the individual level, these include active coping, cognitive flexibility, optimism, purpose and meaning, and physical fitness (Southwick & Charney, 2012). At the interpersonal level, social support is among the most robust predictors: Pietrzak et al. (2009) found that psychological resilience and post-deployment social support each protected against traumatic stress and depressive symptoms among returning soldiers. At the unit level, cohesion and trusted, competent leadership buffer the effects of combat stress. At the organizational level, policies that reduce stigma, provide accessible care, and recognize service contribute to recovery.

5.3 Resilience training programs

Military resilience training programs aim to strengthen these factors before and after deployment. Battlemind training, developed by the Walter Reed Army Institute of Research, provided soldiers with information about common post-deployment reactions and framed combat skills as needing adaptation at home. A randomized trial by platoon found modest benefits for soldiers with high combat exposure compared with standard stress education (Adler et al., 2009).

The most ambitious initiative is the U.S. Army's Comprehensive Soldier Fitness program, which combined a global self-assessment of emotional, social, family, and spiritual fitness with Master Resilience Training. In Master Resilience Training, sergeants are trained to teach skills drawn from cognitive-behavioural and positive psychology,

including identifying thinking traps, challenging catastrophic beliefs, and cultivating gratitude and strengths (Reivich et al., 2011; Cornum et al., 2011).

The program has attracted significant criticism. Reviewers have argued that it was implemented force-wide before adequate pilot testing, that the internal evaluations relied on non-randomized designs with small effects, and that its evidence base was drawn largely from civilian school-based programs with mixed results (Steenkamp et al., 2013). Others raised ethical concerns about mandatory psychological training and about whether resilience framing could shift responsibility for war's harms onto individual soldiers (Eidelson et al., 2011). Taken together, the evidence suggests that resilience training can produce small benefits on self-reported outcomes but that its capacity to prevent PTSD and related disorders remains unproven.

5.4 A gap: moral content

A notable feature of most resilience programs is that their core content addresses stress appraisal, emotion regulation, and threat-related thinking. Spiritual fitness components exist, but programs give limited attention to the moral dimension of combat: how to anticipate morally ambiguous situations, how to process actions that violate one's values, and how to respond to perceived betrayal by leaders. Cognitive reappraisal techniques designed for catastrophizing may be poorly suited, or even counterproductive, when guilt is partly warranted. This gap motivates the integrative model proposed next.

6. An Integrative Model Linking Moral Injury and Resilience

We propose that moral injury is best understood not as the inevitable consequence of a morally injurious event but as one of two broad trajectories that follow it, with resilience resources determining which path a service member takes (Figure 1). The model combines the moral-dissonance account of Litz et al. (2009) with the multilevel view of resilience described above.

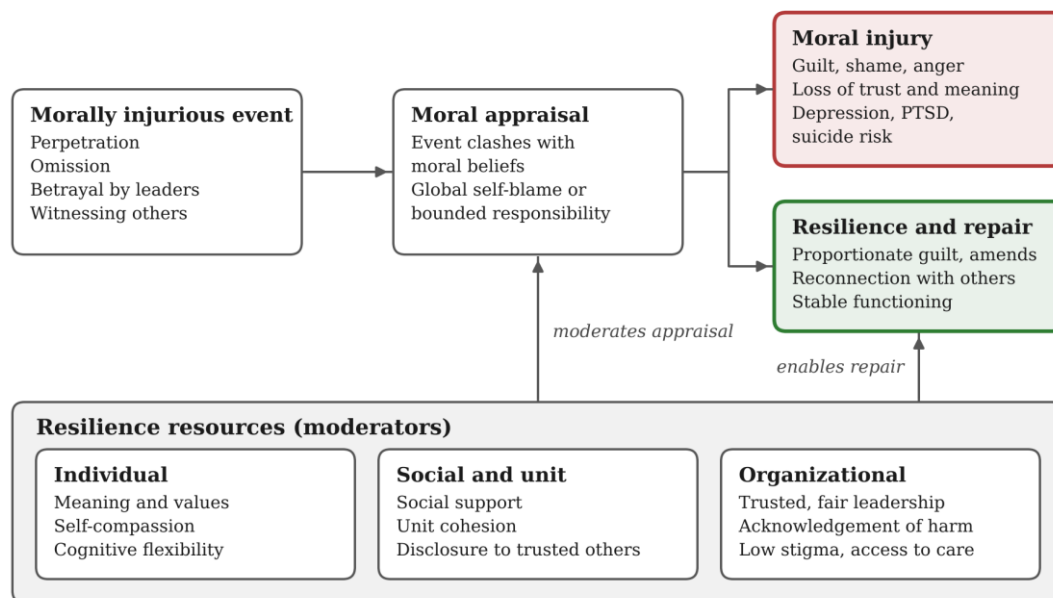


Figure 1. Integrative model of moral injury and resilience. The pathway runs from event to appraisal to outcome; individual, social, and organizational resources act on the appraisal and on the opportunity for repair.

Event and appraisal. The starting point is exposure to a PMIE involving perpetration, omission, betrayal, or witnessing. Whether this exposure becomes injurious depends on how the event is appraised. Appraisals that attribute the event to a global, stable flaw in the self (“I am evil”) or in all authority (“No one can be trusted”) lead toward moral injury. Appraisals that recognize the constraints of the situation, such as incomplete information, split-second decisions, and lawful orders, while still accepting appropriate responsibility, lead toward proportionate guilt and the possibility of repair.

Two outcome trajectories. The injury trajectory is characterized by persistent shame, anger, and loss of meaning, sustained by concealment and withdrawal, and is expressed clinically as depression, PTSD, substance misuse, and suicidality. The resilience trajectory does not imply the absence of moral pain. Instead, it involves processing the experience, making amends where possible, reconnecting with others, and integrating the event into a coherent life narrative. For some, this may include what has been described as posttraumatic or moral growth.

Resources as moderators. Resilience resources act at two points. First, they shape appraisal.

Individuals with flexible thinking, clear values, and self-compassion may be better able to hold themselves accountable without global self-condemnation. Second, they shape the opportunity for repair. Social support and unit cohesion provide safe contexts for disclosure, which counters the concealment that shame motivates. Organizational factors are especially important for betrayal-based events: when leaders and institutions acknowledge harm, act fairly, and reduce stigma, they directly address the source of the injury rather than leaving the individual to resolve it alone.

The model makes several testable predictions. It predicts that resilience resources will moderate, rather than merely add to, the association between PMIE exposure and outcomes. It predicts that self-compassion and social support will be particularly protective for perpetration-based events, whereas leadership quality and institutional acknowledgement will be particularly protective for betrayal. Finally, it predicts that resilience training focused only on threat appraisal will have limited effect on moral injury outcomes, a prediction consistent with the modest effects of existing programs (Steenkamp et al., 2013).

7. Implications for Assessment, Training, and Treatment

7.1 Assessment

Routine military mental health screening focuses on PTSD, depression, and alcohol use, and therefore may miss moral injury. Validated instruments now exist for both exposure and outcome. The Moral Injury Events Scale assesses exposure to transgressions and betrayal (Nash et al., 2013; Bryan et al., 2016), and the Moral Injury Symptom Scale–Military Version assesses symptoms such as guilt, shame, loss of meaning, and loss of trust (Koenig et al., 2018). Incorporating brief versions of such measures into post-deployment health assessments would help identify at-risk personnel. Clinicians should also ask directly about guilt and shame, since service members are unlikely to volunteer such material.

7.2 Moral preparation and resilience training

The model implies that resilience training should be extended to include moral preparation. Possible components include:

- 1) **Ethical decision-making under pressure**, using realistic scenarios that rehearse rules of engagement, civilian protection, and the limits of control in combat.
- 2) **Normalization of moral distress**, teaching that guilt and grief after hard decisions are signs of moral integrity, not weakness or disorder.
- 3) **Accurate responsibility appraisal**, distinguishing warranted guilt from hindsight bias and from the global self-condemnation of shame.
- 4) **Pathways to repair**, including acknowledgement, making amends, service to others, and spiritual or chaplaincy support where it fits the person's values.

Such content should complement, not replace, existing stress-management skills, and it must be evaluated with rigorous designs before force-wide adoption, a lesson from the experience of Comprehensive Soldier Fitness (Steenkamp et al., 2013).

7.3 Leadership and organizational responsibility

Because betrayal is one of the most frequently endorsed categories of PMIE, leaders and institutions are not only potential buffers but also potential sources of injury. Leadership development should emphasize transparency about decisions, fairness, care for subordinates after critical incidents, and willingness to acknowledge institutional mistakes. Structured after-action reviews that address the moral as well as the tactical dimensions of an incident may reduce isolation and self-blame. Organizational policies that reduce stigma and protect careers when personnel seek help are a precondition for any individual-level intervention to work (Sharp et al., 2015).

7.4 Treatment

The first-line trauma-focused therapies, prolonged exposure and cognitive processing therapy, are effective for many veterans with PTSD, but response rates in military samples are lower than in civilian samples and many patients retain a diagnosis after treatment (Steenkamp et al., 2015). Exposure-based approaches that rely on fear extinction may not address guilt and shame directly. Cognitive processing therapy, which targets distorted beliefs about blame, may be better suited, but it can be difficult to apply when guilt is in part accurate.

Interventions designed specifically for moral injury are emerging. Adaptive Disclosure, developed for active-duty Marines, combines emotion-focused processing with an imaginal dialogue with a compassionate moral authority, as well as planning for reparative behaviour (Litz et al., 2016). Other approaches draw on acceptance and commitment therapy, compassion-focused therapy, and structured spiritual care. Early studies are promising but generally small and uncontrolled, and controlled trials comparing these approaches with standard trauma-focused care are needed.

8. Limitations and Future Directions

Several limitations of the current evidence base, and of this review, should be acknowledged. First, there is still no consensus definition of moral injury, and studies operationalize it inconsistently, sometimes as exposure, sometimes as symptoms, and sometimes as both. This makes prevalence estimates difficult to compare and complicates the question of whether moral injury should become a formal diagnosis. Second, most studies are cross-sectional and rely on retrospective self-report, which limits causal inference and is vulnerable to recall bias, particularly for emotionally charged events. Third, the literature is dominated by U.S. samples, mostly male and from ground combat roles. Moral codes are shaped by culture, religion, and military tradition, so findings may not generalize to other armed forces, to women in service, or to roles such as drone operators, medical personnel, and military leaders responsible for life-and-death decisions. Finally, as a narrative review, this paper did not follow a systematic search protocol and cannot rule out selection bias.

Future research should prioritize:

- **Prospective longitudinal designs** that measure moral beliefs, resilience resources, and PMIE exposure before deployment and track trajectories afterward, mirroring the trajectory research on PTSD (Bonanno et al., 2012).
- **Tests of moderation**, examining whether social support, unit cohesion, leadership quality, and self-compassion buffer the association between PMIE exposure and outcomes.
- **Randomized evaluations** of moral preparation modules and of moral injury-specific treatments against established trauma-focused therapies.
- **Cross-cultural and diverse samples**, including non-Western militaries, women, and non-combat roles.
- **Organizational-level** research on how institutional practices, such as acknowledgement, accountability, and

transitions to civilian life, affect betrayal-based injury.

9. Conclusion

Modern military psychology has learned that war wounds the conscience as well as the nervous system. Moral injury describes the lasting guilt, shame, anger, and loss of trust that can follow acts of perpetration, omission, and betrayal, and the evidence shows that such experiences are common among combat personnel and are associated with depression, PTSD, and suicidality beyond the effects of life threat alone. Resilience, by contrast, is the most common response to military adversity, supported by individual, social, and organizational resources. Yet resilience programs have so far concentrated on fear and stress while largely overlooking the moral dimension of soldiering.

Integrating the two literatures suggests that the same resources that protect against stress-related disorders, particularly social connection, trusted leadership, flexible meaning-making, and institutional acknowledgement, may also determine whether morally injurious events become lasting injuries. Expanding resilience efforts to include moral preparation, holding organizations accountable for their role in betrayal, and developing and rigorously testing targeted treatments are priorities for military psychology. Protecting the moral integrity of those who serve is not only a clinical obligation but an ethical one for the institutions that send them into harm's way.

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