

Humanness and Self-Dehumanization in the Context of Combat-Related Moral

Injury: A Pilot Study

By

Olivia A. Kostreva

A Thesis Submitted in
Partial Fulfillment of the
Requirements for the Degree of

Master of Science in Clinical Mental Health Counseling

At

The University of Wisconsin-Whitewater

July 2022

Approval

The members of the Committee approve the thesis of
Olivia Kostreva presented on August 08, 2022

Dr. Cindy Anderton, Chair

Dr. Carrie Merino

Dr. Amy Barth

Humanness and Self-Dehumanization in the Context of Combat-Related Moral Injury: A Pilot Study

By

Olivia A. Kostreva

The University of Wisconsin Whitewater, 2022
Under the Supervision of Dr. Cindy Anderton

Moral injury (MI) is a relatively new concept that describes negative mental health outcomes resulting from past wrongdoing or the perception of wrongdoing. It emerged in work with military veterans as a counterpoint to Post-Traumatic Stress Disorder (PTSD), which historically describes negative mental health outcomes resulting from past threats-to-life or physical integrity. There are several frameworks that outline the causes and symptoms of moral injury. One potentially relevant framework is one of humanness, self-dehumanization and re-humanization in response to a harming event. These concepts were developed in the fields of moral and social psychology and have yet to be applied to cases of combat-related moral injury. This pilot study focused on the relationship between symptoms of moral injury and measures of humanness. Forty-nine combat veterans completed an online survey to include the Expressions of Moral Injury Scale - Military Version (EMIS-M), and a measure of humanness based on a 2006 integrated model of humanness (Haslam, 2006). Findings suggest that EMIS scores - particularly self-directed EMIS scores - are moderately, negatively correlated with humanness scores

Table of Contents

CHAPTER ONE: Self-Dehumanization in Combat-Related Moral Injury.....	1
Statement of the Problem.....	2
Purpose of the Study.....	3
Research Questions.....	3
Significance of the Study.....	3
CHAPTER TWO: Review of the literature on Moral Injury.....	4
Overview of Moral Injury.....	4
Veterans' Perspectives on Moral Injury.....	10
PTSD treatments for Moral Injury.....	11
Themes in the Literature.....	16
A Model of Humanness.....	17
Dehumanization and Re-humanization.....	17
The Current Study.....	19
CHAPTER THREE: Method.....	20
Participants and Procedure.....	21
Instrumentation.....	22
CHAPTER FOUR: Results.....	24
Descriptive statistics.....	24
Reliability of the Humanness Scales.....	25
Correlations.....	25
CHAPTER FIVE: Discussion.....	30
Hypotheses.....	30
Additional Considerations.....	34
Limitations.....	36
Recommendations for Future Research.....	36
Conclusion.....	37
References.....	39

List of Tables and Figures

Table 1: Descriptive Statistics for EMIS and Humanness Scores.....	24
Table 2: Internal Consistency of the Humanness Scales.....	25
Table 3: Intercorrelations.....	26
Figure 1: Potential Moderators of Humanness Scores.....	27
Table 4: Hierarchical Regression Analysis Summary for Volunteering Frequency as a Moderator.....	28
Table 5: Hierarchical Regression Analysis Summary for Relationship Satisfaction as a Moderator.....	29
Tables 6: Hierarchical Regression Analysis Summary for Era of Service as a Moderator.....	30

CHAPTER ONE: Self-Dehumanization in Combat-Related Moral Injury

Since the 1980s, the field of military psychology has relied on the Post-Traumatic Stress Disorder (PTSD) diagnosis to describe the psychological consequences of war. Historically, PTSD was thought to result from a fear response to one or more traumatic experiences. These traumatic experiences include “actual or threatened death, serious injury, or sexual violence” (American Psychological Association [APA], 2022, p. 301). Those suffering from PTSD experience a wide range of symptoms that include intrusive memories, distressing dreams, flashbacks, avoidance of trauma-related stimuli, negative alterations in cognition or mood and/or hyperarousal symptoms such as hyper-vigilance and aggression (APA, 2022). The PTSD diagnosis represented a major step in normalizing mental health concerns resulting from traumatic experiences. It laid the foundation for VA support to hundreds of thousands of veterans with PTSD symptoms.

Over the past 10 years, PTSD has come to share the stage with the concept of moral injury (MI). Moral injury attempts to distinguish fear-based trauma responses (i.e. PTSD) from a pattern of lasting distress resulting from moral conflict (i.e. MI). Definitions of moral injury are typically broad, and encompass “the psychological, biological, spiritual, behavioral and social impact of perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs” (Litz et al., 2009, p.697).

As the study of moral injury took flight, so did the development of the ideas of humanness and self-dehumanization within the field of social psychology. Researchers created an integrated model of humanness (Haslam, 2006), describing what are commonly perceived to be “human traits.” Future studies applying this model found that people tend to perceive themselves as “less human” after they have done something harmful or wrong. Studies further

found that self-dehumanization occurs for both the harming and harmed parties. Because moral conflict in many cases involves perceived harm and wrongdoing, the concepts of humanness and self-dehumanization may be relevant to the study and treatment of moral injury.

It should be noted that the current study takes a view of the self that is borrowed from third-wave cognitive therapies like *Acceptance and Commitment Therapy*. More traditional cognitive behavioral therapies favor the importance of schema: Schema are patterns of thought and understanding that help us interpret our world and our place in it. Self-concept in these therapies is a set of conscious, largely static understandings of the question “who am I?” Saying “I am a warm person,” is a simplistic example of this. Third-wave cognitive behavioral therapies, meanwhile, take a view of the self called *self-as-context*. In this framework, the self is simply consciousness: Our thoughts, feelings and patterns of behavior are experiences that the self has, but they do not define the self. Saying “I am feeling warmth,” or even “I tend to feel warmth,” instead of “I am a warm person,” is more indicative of the third-wave perspective of self. By extension, the focus of humanness in this study was on an experience of humanness rather than the attribution of human traits to static self-concept. This will be discussed in greater detail in Chapter 4.

Statement of the Problem

Though evidence suggests that moral injury is distinct from PTSD, we are only beginning to develop therapeutic interventions designed for moral injury specifically. Several evidence-based treatments for PTSD have been applied to moral injury, with mixed results. Three more programs - namely, the *Impact of Killing*, *Adaptive Disclosure*, and *Acceptance and Commitment Therapy for Moral Injury* - are being developed. However, research on the treatment of moral injury is still in its infancy.

Purpose of the Study

The purpose of this study is to determine whether humanness and self-dehumanization are concepts relevant to the understanding and treatment of moral injury. We expect that higher scores on measures of moral injury will correlate with lower scores for “humanness,” suggesting self-dehumanization. We further predict that prosocial relationships and activities, as well as time, will moderate the relationship between moral injury scores and humanness scores.

Research Questions

Research questions for the current study are as follows:

1. Is there a specific, negative correlational relationship between EMIS Total score and Humanness Total scores in the current sample of veterans?
2. Is there a specific, negative correlational relationship between Self-Directed EMIS scores and Humanness Total scores in the current sample of veterans?
3. Does frequency of volunteering in the community post-deployment moderate the relationship between EMIS Total and Humanness Total scores in the current sample of veterans?
4. Does current relationship satisfaction moderate the relationship between EMIS Total and Humanness Total scores in the current sample of veterans?
5. Does era of service moderate the relationship between EMIS Total and Humanness Total scores in the current sample of veterans?

Significance of the Study

Statistically significant, negative correlations between measures of moral injury and humanness would indicate that self-dehumanization is relevant to our understanding of moral injury. Strong correlations could support future studies investigating whether or not

self-dehumanization may be a mechanism through which moral injury develops. Moderate correlations between moral injury and aspects of humanness could suggest specific treatment interventions and goals when working with veterans experiencing moral injury. As previously mentioned, humanness is conceptualized in this study as being an experience (i.e. *how often do you feel warm, rational, open-minded, etc?*) rather than relating to a static self-concept (i.e. *do you think that you are a warm, rational, open-minded person?*)

CHAPTER 2: Review of Literature on Moral Injury

The previous section introduced PTSD, moral injury, self-dehumanization and the potential relationships between them. Below is a review of the literature on the development, measurement and treatment of moral injury. This is followed by an overview of studies of humanness and self-dehumanization within the field of social psychology.

An Overview of Moral Injury

The term moral injury was coined by Dr. Jonathan Shay in his 1994 work, *Achilles in Vietnam*. According to Dr. Shay, leadership functions as a group's default moral authority. When leaders betray what is right, they create a moral injury that is felt among those they lead. The idea has since expanded and is defined in research literature as the "psychological, biological, spiritual, behavioral and social impact of perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs" (Litz et al., 2009, p.697). VA chaplains and clinicians understand moral injury to be the psychological consequence of an action or inaction that runs contrary to a servicemember's moral code (Drescher et al., 2018).

As noted above, PTSD results from a fear response to an actual or threatened death, serious injury, or sexual violence. Thus, moral injury is distinct from PTSD, and though it may

involve fear, it is the sense of wrongdoing rather than an immediate threat to self or close others that creates the conditions for moral injury.

Potentially Morally Injurious Events

Of the existing instruments designed to measure moral injury, one measures exposure to the (egregiously named) potentially morally injurious events (pMIEs) alone. That is the *Moral Injury Questionnaire* (MIQ) which lists 20 experiences that might arise during combat (Currier et al., 2015). These include the harsh treatment of civilians, friendly fire incidents, acts of revenge, and a sense of coming to enjoy violence, among others.

The 9-item *Moral Injury Events Scale - Military Version* (MIES-M) measures both exposure to morally challenging events and reactions to those events (Nash et al., 2013). It pairs statements like “I acted in ways that violated my own moral code and values” with “I am troubled by having acted in ways that violated my own moral code and values” (Nash et al., 2013, p.651). Subsequent validation studies suggest that these items may be split into combinations of the following categories - transgression by self, transgression by others, and/or betrayal (Nash et al., 2013; Bryan et al., 2015; Richardson et al., 2020)

Symptoms of Moral Injury

Two instruments have been designed to define and measure the symptoms of moral injury: The *Moral Injury Symptom Scale - Military Version* (MISS-M) and the *Expressions of Moral Injury Scale - Military Version* (EMIS). The MISS-M drew from existing assessments to measure their 10-subscales (“guilt, shame, moral concerns, religious struggles, loss of religious faith/hope, loss of meaning/purpose, difficulty forgiving, loss of trust, and self-condemnation”) (Koenig et al., 2018). These were compiled into a 45-item measure of moral injury.

The *Expressions of Moral Injury Scale - Military Version (EMIS)* “[captures] possible cognitive and emotional consequences of moral injury events as well as maladaptive behaviors that often follow such moral reactions” (Currier et al., 2018, p. 476). Symptoms in this model are either self-directed (expressed as guilt, shame, self-loathing, and self-devaluation) or other-directed (expressed as anger, mistrust, contempt, and resentment). They include resultant behaviors like social withdrawal, self-sabotage, self-punishment and lashing out. Findings from the scale’s validation study indicated that both self-directed and other-directed expressions of moral injury were positively correlated with depression, substance use and PTSD.

It is important to note that many of the symptoms listed above are described by PTSD’s Criterion D - negative alterations in cognition and mood. It follows that elevated moral injury symptomatology is associated with greater symptoms of PTSD (Koenig et al., 2020). However, PTSD and moral injury have been validated as independent constructs with different origins (Litz et al., 2018). Though there is certainly overlap, studies have shown that moral injury and PTSD display distinct neural underpinnings (Sun et al., 2019).

Development of Moral Injury

In tandem with an effort to understand what events may cause moral injury and how it manifests, researchers put forth several models describing how it might develop. What follows is a brief discussion of these models.

Models of Moral Emotions. Moral emotions form the basis for several models of moral injury and may be understood in terms of “other-condemning” and “self-condemning” emotions (Haidt, 2003). Among other-condemning emotions are: anger, disgust and contempt. Anger is a response to a perceived injustice and motivates redress of that injustice. Disgust arises when something calls into question the boundary between humanity and animality (Haidt, 2003); it

motivates expelling the contaminated person, place or thing from the self and/or the group.

Contempt involves a sense of moral superiority.

Self-condemning emotions include guilt, which comes from a conviction that we have acted in a way that is harmful or wrong. Shame is more global; it is a sense we are wholly bad, wrong, or defective. It motivates social withdrawal, possibly in an attempt to avoid the judgment and rejection of the social group. It has also been proposed that shame resulting in social withdrawal is an attempt by the individual to “protect the social group from being contaminated by moral violations” (Currier et al., 2018, p. 476). This view of moral emotions informs the separation of categories “self-directed” and “other-directed” symptoms on both the MIES and EMIS.

Jinkerson (2016) identified four core symptoms of moral injury (guilt, shame, loss of trust and loss of meaning), which “influence the development of secondary symptomatic features” to include depression, anxiety, anger, reexperiencing the conflict, self-harm thoughts and behaviors, and social problems (p. 126). A follow-up study confirmed that higher levels of guilt were strongly correlated with increased symptoms of depression and anxiety in combat-veterans exposed to moral conflict (Jinkerson & Battles, 2016). Higher guilt scores were also correlated with re-experiencing and avoidance, supporting the claim that guilt may be a mediating factor in the development of secondary moral injury symptoms. Similarly, individuals with less sense of meaning in life tended to experience greater PTSD symptomatology and secondary symptoms of moral injury.

Stress-injury Model. The stress-injury model speaks of moral injury in terms of organisms, stressors and performance. It was developed in 2004 to suit the needs of a military culture with little tolerance for discussions of emotional and mental health. According to this

model, stressors cause stress responses designed to help us overcome the challenge or threat at hand (Nash, 2019). Exhaustion occurs either when the stressor abates, or when the body fatigues in the face of a constant stressor. During the exhaustion phase of stress response, “performance drops below the original baseline as internal resources are replenished” (Nash, 2013 p.467). This model argues that, in cases where “the appearance of distress or alterations in functioning...persist despite adequate rest,” a literal injury occurs (p. 468). This literal injury can be both physical, as seen in studies tying significant stress with physical ailments, and neuron and gray matter loss in the brain. The injury can be to “intrapsychic structures, such as internalized representations of the self and the world” (Nash, 2019, p. 468). The example given is that of a servicemember who loses a friend or family member and is unable to call on that person for the connection, security and affirmation they once provided. This ultimately diminishes the individual’s internal resources and alters their sense of self and world.

Cognitive Model. The cognitive model has its roots in schema therapy. When an event is in some way contrary to what a servicemember believes about themselves or the world, this creates cognitive dissonance. Cognitive dissonance is at best uncomfortable and at worst, overwhelmingly painful and confusing as the brain attempts to integrate old ways of understanding and new information.

Farnsworth breaks the thought processes involved into descriptive and prescriptive cognitions (2019). Descriptive cognitions are beliefs about the nature of an event, for example, “I could have done more.” Trauma-related, descriptive cognitions are oftentimes patently false, and may be evaluated for accuracy by examining and clarifying facts around the event. In the above example, it might be possible to walk through alternative courses of action to determine whether or not there was anything more that might have been done. Farnsworth suggests that descriptive

cognitions can and should be evaluated in the course of therapy, and that they may naturally alter or soften prescriptive cognitions.

Prescriptive cognitions are beliefs about how things should be, speaking in terms of morality. For example, “I had a responsibility to step in.” These are rooted in highly individualized, subjective moral judgements. It is difficult and oftentimes inappropriate to evaluate prescriptive cognitions for “accuracy.” Unlike descriptive judgements, interventions aimed at prescriptive judgements should not attempt to challenge as a matter of course. Instead, they should focus on clarifying values and beliefs, on understanding how the moral injury impacts values and beliefs, and vice-versa. Farnsworth suggests that the cultivation of self-compassion, making amends, forgiveness of self and others, acceptance, and values-driven action are alternatives to challenging prescriptive cognitions.

In summary, moral injury may manifest psychologically, physically, socially, behaviorally or spiritually. Symptoms of moral injury include both self-directed (guilt and shame) and other-directed (anger, contempt, and disgust) moral emotions. These emotions likely serve an evolutionary purpose and may motivate a range of behaviors, from prosocial acts like making amends to social withdrawal.

Moral injury may be considered a stress injury with a physical impact. It may be conceptualized according to the schema theory of trauma, in which core beliefs about the self and world are shattered in the aftermath of a traumatic (or morally injurious) event. Within the sphere of moral injury-related cognitions are both descriptive and prescriptive beliefs. Descriptive beliefs represent a factual understanding of the event, and can and should be clarified in order to ensure that it is an accurate understanding of reality. Prescriptive beliefs are a moral understanding of what should be or should have been. These beliefs should be discussed to

clarify and explore a servicemember's moral judgements and values. Understanding how the event impacted these beliefs and vice-versa is similarly important.

Veterans' Perspectives on Moral Injury

A narrative thematic analysis of interviews with eight Vietnam veterans revealed five moral injury-related themes (Held et al., 2019): Timing was the first. For most participants, a sense of wrongdoing was immediate. However for many, the emotional impact of an event didn't hit until after they returned home. The second theme was context. Many participants talked about being in chaotic situations that did not allow for deliberate problem solving. They discussed the need to follow orders and to protect themselves and those in their charge. For veterans who were part of units with a more aggressive culture, fitting in could be a motivating factor. The third theme was reactions to the event. Participants described the emotional impact of moral injury, including rumination, social withdrawal, guilt and shame. The fourth theme was search for purpose and meaning. Some of the participants spoke to a feeling of lost humanity: "Specifically, in attempts to comprehend what they had done, many of the veterans described that they could only explain what they did by comparing themselves with a monster or animal" (Held et al., 2019, p. 402). The last theme was opening up. Some found that speaking to friends and family gave them perspectives on their experience that they had missed. Many of the participants agreed that although speaking with loved ones could be helpful, fear of judgment prevented them from doing so. Most agreed that speaking with other veterans about their experience was both helpful, and easier.

A minimally-structured, focus-group interview of 26 combat veterans of the Vietnam war investigated the impact of killing in war specifically. Experiences varied greatly, with some common themes. Some participants reported immediate feelings of nausea and disgust after the

event, while others described desensitization, rage, euphoria and a sense of “god-like” power (Purcell et al., 2016). As in the previous study, many participants did not feel the effects of their wartime experience until they were home again. Of the individuals who described a “power trip,” one remarked that the sense of power and “not caring” abated with time - in his words, “you have to come back and you have to think about that later on” (Purcell et al., 2016, p. 1076).

About half of the participants described having to confront a side of themselves they didn’t know existed. This dark side was universally disturbing and disorienting. It was described by different participants as being a beast, savage, monster or animal, which they dealt with by compartmentalizing this aspect of themselves. This was effective to varying degrees, with one participant saying “there’s always someone knocking on the door, ‘let me out, let me out,’” (Purcell et al., 2016, p. 1081). Many were afraid that this dark side might take over and cause harm, motivating further social withdrawal, substance use or overworking. Fear of judgment and rejection made opening up to friends and family challenging. At the same time, some veterans reported that not sharing these aspects of themselves and their experience made them feel unseen; that their everyday interactions were a facade, and that no one truly *knew* them.

The experience of moral injury can be an intense - and intensely isolating - one. This should reinforce the necessity of creating safe, welcoming and supportive spaces in which veterans can be seen and heard. It should reinforce the necessity of well-considered, therapeutic interventions.

PTSD Treatments for Moral Injury

Few treatments exist to target moral injury specifically. Many studies have shown a tendency for providers to gloss over moral injury-related concerns, such as feelings of wrongdoing and guilt, in favor of addressing fear-based trauma (Burkman et al., 2019). In a

2014, semi-structured interview, veterans agreed that “moral injury was either not discussed or...did not receive sufficient attention in therapy” (Borges et al., 2020, p. 385), and at least one participant heard the term for the first time during the study.

A handful of studies have attempted to tailor existing VA-endorsed, PTSD treatments to moral injury, most commonly Prolonged Exposure therapy (PE) and Cognitive Processing therapy (CPT). Discussions of these treatment approaches for moral injury and veterans perspectives on these treatments are discussed below.

Cognitive Processing Therapy

Cognitive processing therapy (CPT) is based in the social-cognitive and schema theories of PTSD. Underlying beliefs about the self and world, called schema, may change after a traumatic experience. There are three ways schema and traumatic memories may be integrated. *Accommodation* is a balanced integration of the two. After a car accident, the belief “the world is entirely safe” may become “the world is relatively safe.” *Assimilation* is understanding a traumatic experience in a way that matches existing schema. The *Just World* schema - the idea that good things happen to good people, and bad things happen to bad people - is often implicated here. People who hold this schema may conclude in the wake of a traumatic experience that *they* are bad, rather than revising their belief that the world is always a just place. *Over-accommodation* is changing schema to match the traumatic experience alone. Concluding that the world is entirely dangerous after a traumatic event is one example of this. According to CPT, both assimilation and over-accommodation give rise to erroneous beliefs that can be challenged by examining contrary evidence. This is typically done through a technique called *socratic questioning* (USDVA, n.d.)

Therapeutic work in a 2018 case study of moral injury and CPT revolved around the question - “was there anything else you could have realistically done” to address impairing guilt, shame and anger experienced by one OIF veteran (Held et al., 2018, p. 16). The clinician in this study did not pose this question head-on. Instead, the clinician and veteran collaboratively identified three beliefs about what he felt he should and should not have done (I should have checked my weapon; I should not have taken the shot; I should not have laughed). Investigating the details of each event led the veteran to conclude that there was nothing else he could have done, given the situation. He concluded that his reactions were specific to a certain time, place, and situation rather than indicative of a deep and abiding character flaw.

The investigators suggested that many of their veteran clients knew they made the best choice they could given the circumstances and still felt immense guilt. They argued that this discrepancy is often “due to unchallenged and inaccurate information the clients use to support their guilt” (p.16). Clarifying details of the event may lead to revising inaccurate beliefs, resulting in a decrease of guilt, shame, etc. In this case study, the veteran’s scores on the *Post-Traumatic Stress Checklist - 5* dropped below the clinically significant range. His scores on the *Patient Health Questionnaire - 9*, measuring depressive symptoms, dropped from the “moderately severe” to low “moderate” range. CPT treatment loosened his conviction “I am a monster,” which was thought to be an over-accommodated belief resulting from an inaccurate understanding of the event (Held et al., 2018).

A veteran who underwent CPT treatment in 2020 had a different experience: “...the way the doctor said you were in war. You weren’t thinking straight. So according to that therapy, everything that I did was justified. And for me it wasn’t and it still isn’t” (Borges et al., 2020, p 384). This is consistent with criticisms of CPT that argue elimination of guilt through

challenging, often by emphasizing the context of combat, can be inappropriate and harmful (Gray et al., 2017); In cases of harming or seeing harm done, guilt, shame and anger may be expressions of an intact moral compass. When a clinician questions moral convictions relating to an event, this may be “confusing, invalidating, and ultimately condescending for the patient” (Finlay, 2015, p. 223).

Prolonged Exposure Therapy

Prolonged Exposure therapy (PE) was designed to treat trauma within the emotional processing theory of PTSD (USDVA, n.d.). It asks people to rate a series of trauma-related triggers, (to include external situations and internal thoughts/feelings/memories) according to *subjective units of distress*. Distress in PTSD treatment typically describes fear and anxiety. The individual is then exposed to these triggers in a safe and supportive context. Although this unfortunately creates an expected fear response, “sitting with it” teaches the brain that the trigger is not indicative of present danger. Over time this leads to “extinguishing” of the fear response, as the brain creates competing pathways representing neutral or positive interactions with the trigger. There are a few case studies investigating the use of PE for moral injury, which come to similar conclusions:

One (Paul, et al., 2014) case study followed a veteran who identified three events causing significant feelings of guilt and shame. He listed these as nearly shooting a child, clearing a convoy that then drove over an IED, his wife’s affair and the subsequent end of their marriage. During treatment, the working definition of subjective units of distress was expanded to account for guilt and shame as well as fear. Symptoms of PTSD, depression and anxiety decreased during the course of treatment, and all were in the subclinical range by the end of treatment (Paul et al., 2014).

In a second case study, a veteran recounted being ordered to shoot a child who had been sent toward his unit carrying an IED (Held et al., 2018). He and the child had a friendly relationship. The veteran yelled at her to stop walking toward them. When she did not, he attempted to shoot at her legs, but missed and fatally shot her. He remembered becoming very upset, being relieved of duty, taking a hot shower, and waking up thinking it had been a bad dream.

After returning home, he struggled to hold down regular jobs, maintain loving romantic relationships, and frequently used cannabis to help him cope with his symptoms. He struggled with the belief “I am a monster.” His exposures during PE included looking at himself in the mirror, which caused him feelings of self-hatred and disgust, and later, taking his young nieces to a park. Being around children triggered intense guilt, and he reported “I destroy everything I touch...I’m scared of what could happen to them” (p. 9).

After PE, this individual determined that he was not to blame in spite of the all-consuming guilt he had been grappling with. Exposures aimed at providing corrective experiences helped him feel capable of closeness with family, his nieces and his girlfriend.. They decreased the guilt and shame he felt, as well as the loosening of the conviction “I am a monster,” when confronted with potential reminders of the trauma.

While the veteran in the study above came to a conclusion that his guilt was unwarranted, a 2021 case-study concluded that the elimination of guilt and shame were not necessarily a goal of treatment. “That is, for as long as that important value (e.g., caring, compassion) remains in place, the memory of the transgression *cannot* be presented without the cognitive (and emotional) acknowledgment of that violation” (Evans et al., p.12). Instead, the treatment team

hoped that the servicemember would have a greater range of behavioral and cognitive responses to moral emotions and related memories.

The veteran in this study identified three events; the death of his teenage friend, firing a missile during a deployment that killed a civilian family, and being unable to rescue an Iraqi child during a firefight, as causing lasting moral pain. In addition to identifying painful triggers for exposure exercises, he identified values such as cultivating his faith, and related actions (attending church) as potential positive exposure exercises. During therapy, he defined forgiveness as something that may be achieved by acting on values that were violated. To this end, he and his wife began donating soccer gear to children in Iraq. This was especially meaningful to him because he had regularly played soccer with the children who died in the missile strike.

This veteran had recently completed CPT treatment, and felt it invalidated the guilt, disgust and anger he felt about his time in the military. In his words, not feeling these emotions “would make me even more of a monster than I already am” (Evants et al., 2021, p.20). By the end of treatment, he made a shift from “struggling” to “hurting but not struggling” (Evans et al., 2021, p.28). Post-treatment, he was heavily involved in his church community, in volunteering, and spending time with his family. He reported “I know this is the way out [of PTSD/moral injury] and I can tell that everyday I do it” (Evans et al., 2021, p.28). T

Themes in the Literature

One of the striking aspects of these studies is the intensity of people comparing themselves to monsters or animals. This was a theme among the narrative interviews listed above. It features in CPT case studies, where the beliefs “I am bad” or “I am a monster” are

explicitly identified as beliefs that should be challenged (Held et al., 2018). These beliefs feature in case studies of PE, where they activate threatening and overwhelming emotion.

The opposite of this experience would seem to be not goodness, but humanness. Each of us knows in our bones what it is to be human. It is an idea more suited to poetry than to data collection. Though ample research hinges on the idea of humanness and dehumanization - within the medical system, in the criminal justice system, during ethnic conflicts, in the treatment of women in media, to name a few - there are few research tools that attempt to pin down how we might collectively define humanness.

A Model of Humanness

In 2006, Dr. Nick Haslam proposed a model that identifies “human uniqueness” and “human nature” as two distinct facets of humanness. Human uniqueness is the set of traits that differentiate us from animals. They include civility, refinement, moral sensibility, rationality/logic and maturity. They look different between cultures and are socially acquired. Human nature traits differentiate us from objects. They include emotional responsiveness, interpersonal warmth, cognitive openness, agency/individuality, and depth. Per this model, those that perceive others to be lacking in human uniqueness are likely to view themselves as superior. They perceive their social relationship to be one of superior - inferior. Those that perceive others to be lacking in human nature traits, by contrast, view those others as a nonentity. From the perspective of the person making that judgment, no social relationship exists whatsoever.

Dehumanization and Re-humanization

Much of the research literature views “dehumanization as an important precondition or consequence of violence” (Haslam, 2006, p. 255), and several studies show a self-dehumanization tendency after harming. In one study, students who were asked to play

violent video games ($n = 106$) attributed fewer human traits to themselves when compared with those playing sports video games (Bastian et al., 2012). This pattern held after controlling for enjoyment of the game, frustration, excitement, self-esteem and overall mood. Other studies have shown similar patterns of self-dehumanization in instances of interpersonal harm that do not involve violence.

A study of 53 undergraduates determined that students rated themselves as lower on human nature and human uniqueness scales after narrating a time they socially excluded someone (Bastian et al., 2013). Participants were also asked whether they felt their behavior had been immoral, and analyses indicated that conscious perception of wrongdoing significantly mediated the relationship between social exclusion and self-dehumanization. Greater moral engagement led to greater self-dehumanization.

In a 2018 study, those who recalled unethical acts reported marginally lower human capabilities (in this case, sense of agency and capacity for feeling) when compared with those who recalled morally neutral or ethical acts (Kouchaki et al., 2018). People felt “less human” after reading a first-person narrative of cheating on a test, compared with those who read about failing the test.

Perhaps the most comprehensive of these studies is the *Tethered Humanity Hypothesis*, which supported many of the findings and hypotheses above (Vaes & Bastian, 2021). It concluded that people rate friends “more human” than enemies; that we are more likely to aggress against an enemy than a friend. It found that people rate themselves as less human after an instance of harm, when compared with before the event. This was true for both “perpetrator” and “victim.” Aggression led to significantly more self-dehumanization than other kinds of offenses.

“Re-humanization” after a harming event seemed to be a motivating factor in subsequent decision-making, and was achieved both independently, and in collaboration with the harmed party. Imagining a friend or enemy in a prosocial situation supported the re-humanizing effect; thinking of helping the harmed party or being sympathetic to their distress was correlated with higher attributions of humanness to both the self and the other after a harming event.

Re-humanization occurred for both the self and the harmed party when victims - in the context of the study, those who were socially excluded from an online game - demonstrated forgiveness toward the harming party. According to the authors, the potential clinical utility of these findings may be summarized accordingly: “one way for perpetrators or victims to reclaim their full human status is to re-establish or at least increase the perceived humanity of the opposing party” (p. 378)

The Current Study

The spirit of the tethered humanity hypothesis revolves around the delivery and/or acceptance of an apology, or engagement with the humanness of harmed others. Though the former in particular may not be feasible in cases of combat-related moral injury, the framework of humanness and self-dehumanization may be useful concepts. To that end, we asked the following research questions to guide the study:

1. Is there a specific, negative correlational relationship between EMIS Total score and Humanness Total scores in the current sample of veterans?
2. Is there a specific, negative correlational relationship between the Self-Directed EMIS scale and Humanness Total scores in the current sample of veterans?

3. Does frequency of volunteering in the community post-deployment moderate the relationship between EMIS Total and Humanness Total scores in the current sample of veterans?
4. Does current relationship satisfaction moderate the relationship between EMIS Total and Humanness Total scores in the current sample of veterans?
5. Does era of service moderate the relationship between EMIS Total and Humanness Total scores in the current sample of veterans?

We proposed the following hypotheses for each specific research question:

1. There will be a statistically significant negative correlational relationship between EMIS Total score and Humanness Total scores in the current sample of veterans.
2. There will be a statistically significant negative correlational relationship between the Self-Directed EMIS score and Humanness Total scores in the current sample of veterans.
3. Frequency of volunteering will act as a statistically significant moderator of the relationship between EMIS Total scores and Humanness Total scores in the current sample of veterans.
4. Degree of relationship satisfaction will be a statistically significant moderator of the relationship between EMIS Total scores and Humanness Total scores in the current sample of veterans.
5. Era of service will act as a statistically significant moderator of the relationship between EMIS Total scores and Humanness Total scores in the current sample of veterans.

CHAPTER 3: Method

What follows is a brief summary of recruitment procedures, participant demographics, and instruments used for the current study.

Participants and Procedures

Participants were recruited online through local and national veterans' groups that included: local American Legion posts, the American GI-Forum, the University of Wisconsin-Whitewater Veterans Services Office, and the anti-war advocacy groups Veterans for Peace and About Face. Information about the study was disseminated over email, as well as the instructions for the anonymous Qualtrics survey. The survey included demographic questions, the *Expressions of Moral Injury Scale- Military Version*, and the *Human Nature and Human Uniqueness* scales.

Participant Demographics

A total of 61 participants submitted information via Qualtrics. Of those, 44 submissions were complete. Five participants omitted two or less items of demographic information or two or less items from the humanness scales, and were included in the final data set ($n=49$). Participants overwhelmingly identified as White ($n=44$). One respondent identified as Hispanic/Latino, and three declined to report ethnic background. The majority of participants self-identified as male ($n = 44$). Four participants self-identified as female and one participant self-identified as nonbinary/nonconforming.

Approximately 10.20% of participants were between the ages of 18-29 ($n=5$). 30.61% were between the ages 30-49 ($n=15$). 14.28% were between 50-69 ($n=7$), and 44.89% were between 70-89 ($n=22$). Participants were also asked to identify their era of service: 46.93% were veterans of the Vietnam war ($n=23$), 4.08% were veterans of the Persian Gulf War ($n=2$), 38.77% were veterans of Operation Iraqi Freedom/Operation Enduring Freedom/Operation New Dawn or other post-9/11 campaigns ($n=19$): 8.16% ($n=4$) were veterans of other/unlisted campaigns.

Volunteerism and Relationship Satisfaction

In addition to race/ethnic background, gender, age and era of service, participants were asked to report frequency of volunteerism on a scale of *never*, *rarely*, *sometimes*, and *often*. A total of 34.69% (n=17) selected *often*. 38.78% (n=19) selected *sometimes*. 24.49% (n=12) selected *rarely* and 2.04% (n=1) selected *never*. Participants were also asked to report their level of satisfaction with close relationships on a scale of *extremely satisfied* to *extremely dissatisfied*. Approximately, 26.53% selected *extremely satisfied* (n=13). 36.73% selected *somewhat satisfied* (n=18). 10.20% were *neutral* (n=5). 22.45% selected *somewhat dissatisfied* (n=11) and 4.08% selected *extremely dissatisfied* (n=2). These two items were included so that volunteerism and relationship satisfaction might be evaluated as potential moderators in the relationship between EMIS and humanness scores.

Instrumentation

In addition to demographic information, volunteering, and relationship satisfaction participants completed two assessments: the Expressions of Moral Injury Scale – Military Version (EMIS-M), and a scale evaluating humanness. Further information on these assessments are detailed below.

Expressions of Moral Injury Scale

Participants were asked to complete the 17-item, likert-type *Expressions of Moral Injury Scale - Military Version*, an instrument designed to measure symptoms of moral injury (Currier et al., 2018). Items are divided across two subscales; self-directed moral injury and other-directed moral injury. Unlike the *Moral Injury Events Scale*, the EMIS-M does not attempt to measure exposure to events with the potential for moral conflict (“I saw things that were morally wrong” (Nash et al., 2013). Instead, it measures responses to them (“I am ashamed because of things I saw/did while in the military” (Currier et al., 2018). Because the purpose of

this study is to investigate the relationship between the experience of moral injury and humanness, it was determined that measuring the severity of symptoms was more important than isolating the events that caused them. Consequently, the EMIS-M was chosen as a measure of moral injury over the MIES.

In an initial sample of 286 war-zone veterans, the EMIS-M demonstrated convergent validity with a number of like instruments; with correlation coefficients of .57 to .62 when measured against the *Moral Injury Events Scale*, self-directed and other-directed, respectively. It is strongly correlated with the *PTSD Checklist - 5* (.73), measures of guilt (PFQ-2; .69), shame (PFQ-2; .6), and anger (DAR-5; .64). It demonstrated excellent test-retest reliability ($r = .80$) for overall EMIS-M score, as well as excellent internal consistency ($\alpha = .94$). The instrument was further validated in a second study of 624 war-zone veterans: Through confirmatory factor analysis of this sample, researchers determined that the instrument is best conceptualized as a two-factor model of moral injury (self and other directed). This sample similarly demonstrated excellent internal consistency ($\alpha = .95$).

Human Nature and Human Uniqueness Scales

Participants were also asked to complete a scale of “humanness.” In this study, humanness is conceptualized according to Dr. Nick Haslam’s 2006 integrated review of self-dehumanization. Human nature represents human characteristics as compared to objects (emotional responsiveness, interpersonal warmth, agency, depth, and open-mindedness). Human uniqueness represents human characteristics as compared to animals (civility, refinement, moral sensibility, rationality, maturity.) These concepts were operationalized in a 2010 study of social ostracism, and included 12 items rated on a likert-type scale (Bastian & Haslam, 2010). In the 2010 study, internal consistency for the human uniqueness scale was lower than desired at α

=.59. The human nature subscale demonstrated good internal consistency at $\alpha = .78$. The original scale was rated on a 7-point scale, 1 - *not at all like me* to 7- *very much like me*, and was adapted into a 5-point response scale (*never, rarely, sometimes, often, always*) for the purpose of this study. This is discussed in more detail under the discussion section.

CHAPTER FOUR: Results

Descriptive Statistics

Descriptive statistics were calculated and evaluated for both the EMIS and humanness scales. The lowest possible score on the EMIS, indicating an absence of moral injury symptoms, is 17. The highest is 85. Total EMIS scores for this sample ranged from 17 to 79 (SD=13.61). Subscale scores for self-directed expressions of moral injury and other-directed expressions of moral injury are reported in the Table 1 below.

Scores on the humanness scale may range from 12 to 60. For this sample, the minimum score was 24 and the maximum was 52 (SD=5.73). Subscale scores for human nature and human uniqueness are reported in the Tale 1 below. Data across all scales demonstrated values of skewness between -2 and +2 and kurtosis between -7 to +7, proving normal distribution (George & Mallery, 2010), (Byrne, 2010).

Table 1

Descriptive Statistics for EMIS and Humanness Scores.

Scale	n	Mean Score	Std. Dev	Kurtosis	Skewness	Min Score	Max Score
EMIS Total	49	51.37	13.61	0.02	-0.28	17	79
EMIS Self	49	24.37	8.15	-0.63	0.15	9	42
EMIS Other	49	27.00	6.83	0.77	-0.85	8	37
Humanness Total	49	41.88	5.73	0.86	-0.87	24	52

Human Nature	49	20.98	3.17	1.06	-0.88	11	27
Human Uniqueness	49	20.90	3.31	0.24	-0.94	13	26

Reliability of the Humanness Scales

Because the humanness scales have not been independently evaluated for reliability and validity, Cronbach's alpha was calculated for each. Internal consistency for the human nature and total humanness scales were on the low end of acceptable range at $\alpha=.61$ and $\alpha=.73$ respectively. Internal consistency was low for the human uniqueness scale at $\alpha = .52$.

Table 2

Internal Consistency of the Humanness Scales

Scale	n	Items	α
Humanness Total	46	12	0.729
Human Nature	48	6	0.612
Human Uniqueness	47	6	0.521

*Note: Listwise deletion was employed for two responses on the human uniqueness scale, one response on the human nature scale, for a total of three deletions when evaluating the composite scale

Research Question #1: Is there a specific, negative correlational relationship between Moral Injury Total score and Humanness Total scores in the current sample of veterans?

To explore relationships among the variables, Pearson product moment correlation coefficients were computed. Prior to calculating correlations, categorical variables were re-coded as dummy variables. Dummy variables allow the use of categorical data in both correlation and regression, and are linear. Due to the nature of the research questions in the current study, utilizing dummy variables was determined to be statistically appropriate. Preliminary analyses were performed to ensure no violation of the assumptions of normality, linearity and homoscedasticity for non-dummy variables. No abnormalities were present, indicating the

appropriateness of variables for correlation. When considering EMIS Total score and Humanness Total score, a significant negative correlation was found ($r = -.515$, $p < .001$). This indicates that, as EMIS Total score increased, Humanness Total score decreased. This correlational relationship, based on Cohen's (1988) interpretation model, is considered a large effect size (.50 and above for Pearson's r), accounting for 26% of the variance seen in this sample of veterans. Table 3 below includes all correlation results for the study.

Research Question #2: Is there a specific, negative correlational relationship between the Self-Directed Moral Injury scale and Humanness Total scores in the current sample of veterans?

Similar to research question 1, Pearson product moment correlation coefficients were computed for the Self-Directed EMIS scale and the Humanness Total score. For these variables, a statistically significant negative correlational relationship was found ($r = -.595$, $p < .001$) which is also considered a large effect size, accounting for 35% of the variance in the current sample of veterans. In other words, as Self-Directed EMIS scores increased, Humanness Total scores decreased. See Table 3 below.

Table 3

Intercorrelations

	1	2	3	4	5	6
EMIS Total	-					
EMIS Self	.92**	-				
EMIS Other	.89**	-.64**	-			
Humanness Total	-.51**	-.59**	-.31*	-		
Human Uniqueness	-.51**	-.59**	-.31*	1.0**	-	
Human Nature	-.58**	-.68**	-.64**	.56**	.56**	-

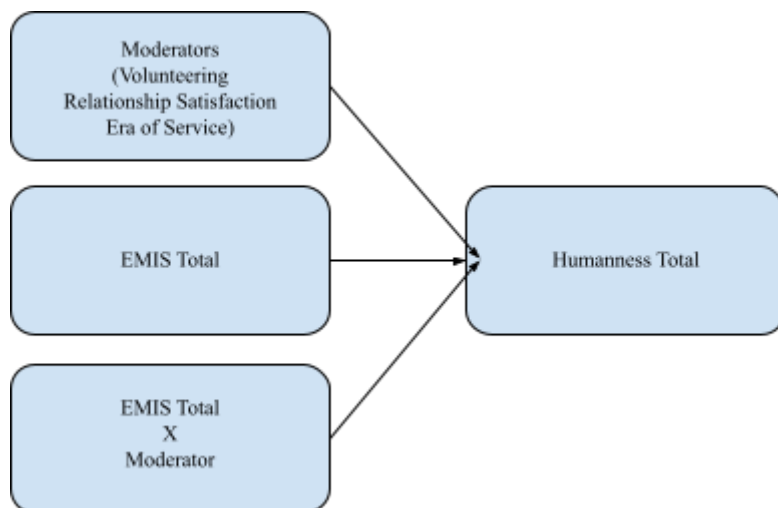
Note: * $p < .05$ (two-tailed); ** $p < .001$ (two-tailed)

Research Question #3: Does frequency of volunteering in the community post-deployment moderate the relationship between Moral Injury Total and Humanness Total scores in the current sample of veterans?

In considering moral injury and “humanness” for veterans in the United States, understanding what can help to moderate distress is clinically important. Based on a review of current literature, the current study identified several variables which could act as moderators. These include era of service, relationship satisfaction, and frequency of volunteering in the community post-deployment. Each may influence the relationships between Moral Injury scores and Humanness scores. Figure 1 presents a graphic of the moderation hypothesis for the current study.

Figure 1

Potential Moderators of Humanness Scores



The current research question examines the frequency of volunteering. Hierarchical multiple regression was utilized to assess the validity of the moderation hypothesis for hours of volunteering and EMIS Total scores along with Humanness Total scores. Dummy variables

created previously for volunteer frequency were utilized in the regression. Preliminary analyses were conducted to ensure no violation of the assumptions of normality, linearity, multicollinearity and homoscedasticity for Humanness Total scores and EMIS Total scores, with no violations found. In Step 1, EMIS Total score was entered into the model, accounting for 26% of the variance, which is statistically significant. In Step 2, frequency of volunteering variables were entered into the model along with EMIS Total score, accounting for a total of 31% of the variance. This change in R² was statistically significant ($F[1,47]= 5.011, p=.002$). “Volunteer Sometimes” was excluded by the analysis. In order to determine specifically if frequency of volunteering acts as a moderator in this model, the t-test statistics included as part of the regression were observed. Specifically, only the EMIS Total was statistically significant in the model. Therefore, the frequency of volunteering did not operate as a moderator in the current sample. Table 3 shows the results of this regression analysis.

Table 4

Hierarchical Regression Analysis Summary for Volunteering Frequency as a Moderator

Step and Predictor Variable	<i>B</i>	<i>SE B</i>	β	<i>R</i> ²	ΔR^2
Step 1				.265**	.250
Moral Injury Total	-.125	0.30	-.515		
Step 2				.313	.251
Moral Injury Total	-.123	.031	-.507**		
Volunteer Often	-.855	.960	-.124		
Volunteer Rarely	-1.55	1.06	-.204		
Volunteer Never	1.89	2.97	.082		

** $p < .001$ Outcome Variable: Humanness Total Score

Research Question #4: Does current relationship satisfaction moderate the relationship

between Moral Injury Total and Humanness Total scores in the current sample of veterans?

Hierarchical multiple regression was utilized to assess the validity of the moderation hypothesis for relationship satisfaction and EMIS Total with Humanness Total scores. In Step 1, EMIS Total score was entered into the model, accounting for 26% of the variance. In Step 2, EMIS and all five levels of Relationship Satisfaction were included in the model and accounted for 47% of the variance. The change in R² was statistically significant ($F[1,47]= 7.722, p<.001$). “Extremely Satisfied” was excluded by the regression model. Based on t-test comparisons, only a relationship satisfaction of “Neutral” is statistically significant, accounting for the variance seen in the model. The Neutral rating for relationship satisfaction operates as the only moderator variable in this sample. This indicates that those with higher EMIS Total scores who rated their relationships as “Neutral” are more likely to have lower Humanness Total scores. Table 4 below presents regression statistics.

Table 5

Hierarchical Regression Analysis Summary for Relationship Satisfaction as a Moderator

Step and Predictor Variable	<i>B</i>	<i>SE B</i>	β	<i>R</i> ²	ΔR^2
Step 1				.265**	.250
Moral Injury Total	-.125	0.30	-.515		
Step 2				.473**	.412
Moral Injury Total	-.075	.032	-.309		
Extremely Dissatisfied	.151	1.97	.009		
Somewhat Dissatisfied	-2.64	1.22	-.336		
Neutral	-4.95	1.45	-.458*		
Somewhat Satisfied	-.257	.972	-.038		

**p<.001 Outcome Variable: Humanness Total Score

Research Question #5: Does era of service moderate the relationship between Moral

Injury Total and Humanness Total scores in the current sample of veterans?

Finally, hierarchical multiple regression was utilized to assess the validity of the moderation hypothesis for era of service, and EMIS Total scores with Humanness Total scores. In Step 1, EMIS Total score was entered into the model, accounting for 26% of the variance. In Step 2, EMIS and all five Eras of Service were entered into the model, which account for 37% of the variance. The overall model was significant ($F[1,47]= 6.415, p<.001$). Both Korean and Vietnam Era were excluded by the model. Based on t-test comparisons, only the OEF/OIF/OND or other Post-9/11 era was statistically significant. In other words, veterans with a higher EMIS Total score who identified their era of service as OIF/OEF/OND or other Post-9/11 were more likely to have a lower Humanness score. Table 5 presents the findings from this regression analysis.

Table 6

Hierarchical Regression Analysis Summary for Era of Service as a Moderator

Step and Predictor Variable	<i>B</i>	<i>SE B</i>	β	R^2	ΔR^2
Step 1				.265**	.250
Moral Injury Total	-.125	0.30	-.515		
Step 2				.371**	.315
Moral Injury Total	-.121	.031	-.479		
Persian Gulf	-.638	2.04	.039		
OIF/OEF/OND/Post-9/11	-2.33	.859	-.345*		
Other/Unlisted	-1.790	1.496	-1.50		

** $p<.001$ Outcome Variable: Humanness Total Score

CHAPTER FIVE: Discussion

Hypothesis 1: There will be a statistically significant negative correlational relationship between EMIS Total score and Humanness Total scores in the current sample of veterans.

As hypothesized, individuals with higher total moral injury scores (EMIS Total) tended to endorse feeling “less human” (Humanness Total): They felt less warm, less emotionally responsive, etc., than those with lower moral injury scores. This mirrors previous studies on social ostracism, imaginal exercises of aggression, and violent video games. These studies unanimously tie interpersonal harm to self-dehumanization.

In studies of self-dehumanization, moral engagement - the degree to which someone is aware of moral considerations at play - was a mediator in the relationship between harmful behavior and self-dehumanization. The EMIS partly accounts for this, in that symptoms inherently demonstrate moral engagement. Someone who is aware of harm, and evaluates that harm as wrong, is much more likely to identify with symptoms of moral injury than someone who is either unaware of the harm or who feels that harm was justified.

This finding suggests that humanness is a clinically useful concept in the expression and treatment of moral injury. As in all therapy, exploring a veteran’s unique meaning-making around the ideas of humanness should take priority over endorsing any particular model. A veteran's experience of the humanness - whether defined by the individual, or the subfactors discussed in this study, (again, warmth, emotional responsiveness, cognitive openness, agency, depth, maturity, self-restraint, refinement, moral sensibility, refinement, and civility), may function as a starting point for generating therapeutic goals.

Hypothesis 2: There will be a statistically significant negative correlational relationship between the Self-Directed EMIS scale and Humanness Total scores in the current sample of veterans.

Humanness scores demonstrated stronger relationships with self-directed EMIS scores than other-directed and EMIS Total scores. Existing studies on self-dehumanization and re-humanization focus on the relationship between a harming party and a harmed party. Other-directed moral injury represents a type of harm involving a third party who is at fault. Though self-directed and other-directed moral injury are not mutually exclusive, they are largely differentiated by who is seen to be responsible for an event. It is therefore likely that other-directed moral injury, which does not implicate the self, does not represent a challenge to one's sense of humanness. Because other-directed moral injury scores are included in the composite EMIS Total score, it follows that the relationship between EMIS Total scores and Humanness Total scores is dampened by the inclusion of other-directed EMIS scores.

Hypothesis 3: Frequency of volunteering will act as a statistically significant moderator of the relationship between EMIS Total scores and Humanness Total scores in the current sample of veterans.

Because empathizing with and acting kindly towards others has shown a rehumanizing effect in previous studies, it was hypothesized that more frequent volunteering would moderate the relationship between EMIS Total and Humanness Total scores. The more often one volunteered, the higher Humanness Total scores would be. This was not the case for the current sample. This could be because the majority of study participants were recruited through volunteer organizations. The effect of volunteering may have been greater when compared with a group of non-volunteers. Because participants in this study were overwhelmingly involved in volunteering, data analysis became a question of parsing through degrees of volunteerism instead.

Hypothesis 4: Degree of relationship satisfaction will be a statistically significant moderator of the relationship between EMIS Total scores and Humanness Total scores in the current sample of veterans.

Rating ones' relationship satisfaction as "neutral" seemed to moderate the relationship between EMIS Total scores and Total Humanness scores: Those who selected "neutral" were more likely to endorse feeling "less human" than those who selected other categories of relationship satisfaction. This was very much contrary to expectation.

In the tethered humanity hypothesis, one's own sense of humanness is tied to the perceived humanness of a harming or harmed party and vice versa. Again, these studies focused on interactions and outcomes between those two parties alone. Nevertheless, we predicted that close, supportive, interpersonal relationships would support the re-humanizing effect. It is possible - and perhaps likely - that more extensive measures of "relationship satisfaction," and greater specificity in the kinds of relationships (familial, romantic, social, etc.) would bear this out.

Hypothesis 5: Era of service will act as a statistically significant moderator of the relationship between EMIS Total scores and Humanness Total scores in the current sample of veterans.

Era of service was a statistically significant moderator for Post-9/11 veterans: Those with higher EMIS Total scores felt "less human" overall than those with similar scores in other groups. While there may be other factors impacting this distinction, the most obvious is time. Post-9/11 veterans were the most recently exposed to combat. Their experience of moral injury likely differs from that of veterans who have lived with moral injury for decades. Studies measuring perceptions of humanness and social harm tend to focus on the immediate before and

after of an event. That being the case, this finding is encouraging. It suggests a re-humanizing tendency with the passage of time.

Additional Considerations for the Humanness Scales

Given the low measures of internal consistency for the humanness scales, some discussion of these scales is merited. It was clear that items in the humanness scales were more or less measuring a single concept (the idea of humanness). Even so, internal consistency of the human nature and even composite humanness scales were on the lower end of acceptable range. The human uniqueness subscale exhibited especially low internal consistency. Their low reliability scores match those of similar scales in other studies (Bastian et al., 2010). They suggest a need for reevaluation of the subfactors of humanness and perhaps a revision of the scales.

It feels important to acknowledge that establishing any measure of humanness entails the very dicey territory of trying to define what is characteristic of humanity, and what is not. This lends itself to writing off those with divergent experiences of being a person. Studies of harm and wrongdoing offer a unique context in which to discuss this. They assume shared humanity among all people; assume that it is the recognition of shared humanity in harm or wrongdoing that causes distress.

Informed by third-wave cognitive behavioral therapies, the current study took a view of the self that is experiential (self-as-context). The self in these theories is simply consciousness: That consciousness provides the blank canvas on which our thoughts, feelings and inner worlds are brought to life. This can be contrasted with a view of the self employed in second-wave cognitive behavioral therapies, which is more static and which can be defined as one trait or another. The idea of self-as-context acknowledges that someone may have a tendency to act

kindly. It would stop short of saying “Person X is kind.” Always? In all contexts? Under all circumstances? What is *kind*? This may seem like a trivial distinction but it has implications for clinical work.

The response options on the humanness scales were adapted to focus more on an experience of “humanness,” rather than attribution of human characteristics to one’s self-concept. The original response options *not at all like me - very like me* (reflecting static self-concept), were changed in this study to measures of frequency *never, rarely, sometimes, often, always* (reflecting experiences of being a human).

In addition to reflecting self-as-context, this was informed by aspects of some trauma theories - the Polyvagal theory of trauma for one - that say that there is a sub-verbal component to trauma response. That is, the body recognizes and responds to traumatic events even when the individual can’t consciously and verbally evaluate the event. In these theories, that sub-verbal response is at least partly responsible for PTSD symptomatology. It therefore alters the experience of self, if not a person’s consciously-held self-concept, by increasing the intensity and frequency of these negative emotional states.

In the same way we considered that positive experiences of self/humanness would be restricted by moral injury, and that negative experiences of the self (e.g. feeling unable to exercise self control, feeling cold or robot-like, etc.) may have been exacerbated by moral injury. These experiences would be influenced by, but would not be dependent on, what someone consciously thinks about themselves.

It is possible that relationships between EMIS scores and humanness scores would have been stronger had the response options been left on their original scale (*not at all like me to very like me*). If this study were replicated with the original response options, and relationships

between EMIS and humanness scores were stronger, that would support theories suggesting that cognitive dissonance is the crux of moral injury.

Limitations

There were several limitations to the current study. The sample size for this study was relatively small (n=49) and may not be representative of the wider population of combat veterans in the United States. It is important to note that the bulk of respondents accessed the survey through the anti-war advocacy groups Veterans for Peace and About Face. This may indicate shared attitudes, values and/or life experiences with the potential to affect trends in the data.

Lastly, because of the interpersonal nature of dehumanization and re-humanization studies, it could have been beneficial to ask respondents to fill out humanness scales for the perceived harmed party. In cases of other-directed moral injury, this could have been extended to third-party “perpetrators.” The additional data may have revealed relationships between perceptions of human qualities in the harmed party/third-party perpetrators, and human qualities in the self.

Recommendations for Future Research

To further determine whether humanness, dehumanization and re-humanization are relevant concepts in the treatment of moral injury, it will first be necessary to build on or tailor humanness scales so that they demonstrate good reliability and validity, both within and outside our current community of veterans. This measurement tool might take into account humanness in terms of static self concept, humanness in terms of an experience, or both. Further work on the idea of shared humanness within the context of moral injury may benefit from measuring perceptions of humanness for other parties. They might additionally account for time passed between the event and study participation.

Conclusion

Critiques of moral injury as a clinical concept assert that by speaking of moral injury in terms of moderating variables, by comparing and contrasting it with PTSD, by attempting to identify treatment objectives, we are “pathologizing negative feelings about war” (Finlay, 2015, p. 225). This paper does all of these things. It uses language like “symptomatology” to describe the feelings of guilt, shame, anger, distress, etc. resulting from perceived wrongdoing. This language *does* contradict the consensus among moral injury researchers that many “symptoms” of MI are normal and natural under the circumstances. The language of research psychology is the language of the medical model. While it is useful to access shared language on the subject, we would like to acknowledge that it does not translate well into what is ideally highly individualized, relational, and wellness-based approaches to therapeutic work.

Moral injury is not a problem to be fixed. It is, however, a pattern of experience that may be resolved or intensified, that may be limiting or motivating. Clinicians can create space for discussions around what an event means to someone, about themselves and their world. They can facilitate awareness of the patterns of thinking and feeling that lead to those conclusions. Clinicians can offer resources and strategies, so that veterans suffering from moral injury may live healthy, fulfilling lives.

While this is an experience that has been brought into the clinical space (and into clinical language) it is as fundamental to being a person as any of the characteristics discussed above. We are all imperfect. We are all harmful. We are all harmed. It would be dismissive to suggest that all harms are equal - they are not, or that context doesn't matter - it does. And still, the core of moral injury is wrongdoing, particularly in cases of harming and seeing harm done. It almost exclusively involves another person.

So one more framework for understanding moral injury may be that of shared humanness. This study attempted to determine whether there is a relationship between moral injury and humanness, or self-dehumanization. Moderate correlations suggest that there is a relationship between self-directed moral injury and self-dehumanization in particular. By extension, conclusions drawn around self-dehumanization and re-humanization in the context of other studies have immediate, practical implications for working with moral injury. The framework of humanness utilized here may serve as a jumping off point for generating counseling goals. Or it may simply support a discussion of what humanness, and perhaps shared humanness, means to individuals experiencing moral injury.

References

- Bastian, B., & Haslam, N. (2010). Excluded from humanity: The dehumanizing effects of social ostracism. *Journal of experimental social psychology, 46*(1), 107-113.
- Bastian, B., Jetten, J., & Radke, H. (2012). Cyber-dehumanization: Violent video game play diminishes our humanity. *Journal of Experimental Social Psychology, 48*, 486– 491.
<https://doi-org.libproxy.uww.edu:9443/10.1016/j.jesp.2011.10.009>
- Bastian, B., Jetten, J., Chen, H., Radke, H., Harding, J. F., & Fasoli, F. (2013). Losing our humanity: The self-dehumanizing consequences of social ostracism. *Personality and Social Psychology Bulletin, 39*, 156– 169. <https://doi-org.libproxy.uww.edu:9443/10.1177/0146167212471205>
- Bastian, B., & Loughnan, S. (2017). Resolving the meat-paradox: A motivational account of morally troublesome behavior and its maintenance. *Personality and Psychology Review, 21*, 278– 299.
<https://doi-org.libproxy.uww.edu:9443/10.1177/1088868316647562>
- Bryan, C. J., Bryan, A. O., Anestis, M. D., Anestis, J. C., Green, B. A., Etienne, N., Morrow, C.E, & Ray-Sannerud, B. (2016). Measuring moral injury: Psychometric properties of the moral injury events scale in two military samples. *Assessment, 23*(5), 557-570.
- Byrne, B. M. (2010). Structural equation modeling with AMOS: Basic concepts, applications, and programming. New York: Routledge.
- Currier, J. M., Holland, J. M., Drescher, K., & Foy, D. (2015). Initial psychometric evaluation of the Moral Injury Questionnaire—Military version. *Clinical psychology & psychotherapy, 22*(1), 54-63.
- Currier, J. M., Farnsworth, J. K., Drescher, K. D., McDermott, R. C., Sims, B. M., & Albright, D. L. (2018). Development and evaluation of the Expressions of Moral Injury Scale—Military Version. *Clinical Psychology & Psychotherapy, 25*(3), 474-488.
- Department of Veterans Affairs and Department of Defense. (2017). *VA/DoD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder*. Author. Retrieved from: <https://www.healthquality.va.gov/guidelines/MH/ptsd/>
- Evans, W. R., Russell, L. H., Hall-Clark, B. N., Fina, B. A., Brown, L. A., Foa, E. B., & Peterson, A. L. (2021).

Moral Injury and Moral Healing in Prolonged Exposure for Combat-Related PTSD: A Case Study.

Cognitive and Behavioral Practice, 28(2), 210-2

Farnsworth, J. K. (2019). Is and ought: Descriptive and prescriptive cognitions in military-based moral injury.

Journal of Traumatic Stress, 32, 373–381.

Finlay, L. D. (2015). Evidence-based trauma treatment: Problems with a cognitive reappraisal of guilt.

Journal of Theoretical and Philosophical Psychology, 35(4), 225

Forkus, S. R., Breines, J. G., & Weiss, N. H. (2019). Morally injurious experiences and mental health: The moderating role of self-compassion. *Psychological trauma: theory, research, practice, and policy*,

11(6), 630

Friedman, M. J., Keane, T. M., & Resick, P. A. (Eds.). (2007). *Handbook of PTSD: Science and practice*.

Guilford Press.

George, D. & Mallery, M. (2010). *SPSS for Windows Step by Step: A Simple Guide and*

Reference, 17.0 update (10a ed.) Boston: Pearson.

Gnoulati, E. (2019). Potential ethical pitfalls and dilemmas in the promotion and use of American

Psychological Association-recommended treatments for posttraumatic stress disorder.

Psychotherapy, 56(3), 374.

Gray, M. J., Nash, W. P., & Litz, B. T. (2017). When self-blame is rational and appropriate: The limited utility

of Socratic questioning in the context of moral injury: Commentary on Wachen et al.(2016).

Cognitive and Behavioral Practice, 24(4), 383-387.

Haidt, J. (2003). The moral emotions.

Haslam, N. (2006). Dehumanization: An integrative review. *Personality and social psychology review*, 10(3),

252-264.

Held, P., Klassen, B. J., Brennan, M. B., & Zalta, A. K. (2018). Using prolonged exposure and cognitive

processing therapy to treat veterans with moral injury-based PTSD: Two case examples.
Cognitive

and behavioral practice, 25(3), 377-390.

Held, P., Klassen, B. J., Hall, J. M., Friese, T. R., Bertsch-Gout, M. M., Zalta, A. K., & Pollack, M. H. (2019).

"I knew it was wrong the moment I got the order": A narrative thematic analysis of moral injury in combat veterans. *Psychological Trauma: Theory, Research, Practice, and Policy*, 11(4), 396.

Jinkerson, J. D. (2016). Defining and assessing moral injury: A syndrome perspective. *Traumatology*, 22(2),

122.

Jinkerson, J. D., & Battles, A. R. (2019). Relationships between moral injury syndrome model variables in combat veterans. *Traumatology*, 25(1), 3

Kelley, M. L., Bravo, A. J., Davies, R. L., Hamrick, H. C., Vinci, C., & Redman, J. C. (2019). Moral injury and

suicidality among combat-wounded veterans: The moderating effects of social connectedness and

self-compassion. *Psychological trauma: theory, research, practice, and policy*, 11(6), 621.

Koenig, H. G., Ames, D., Youssef, N. A., Oliver, J. P., Volk, F., Teng, E. J., Haynes, K., Erickson, Z. D.,

Arnold, I., O'Garro, K. & Pearce, M. (2018). The moral injury symptom scale-military version. *Journal*

of religion and health, 57(1), 249-265.

Koenig, H. G., Youssef, N. A., & Pearce, M. (2019). Assessment of moral injury in veterans and active duty

military personnel with PTSD: A review. *Frontiers in psychiatry*, 10, 443.

Koenig, H. G., Youssef, N. A., Ames, D., Teng, E. J., & Hill, T. D. (2020). Examining the overlap between

moral injury and PTSD in US veterans and active duty military. *The Journal of nervous and mental*

disease, 208(1), 7-12.

Kouchaki, M., Dobson, K. S., Waytz, A., & Kteily, N. S. (2018). The link between self-dehumanization and

- immoral behavior. *Psychological science*, 29(8), 1234-1246
- Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C., & Maguen, S. (2009). Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical psychology review*, 29(8), 695-706.
- Litz, B. T., Contractor, A. A., Rhodes, C., Dondanville, K. A., Jordan, A. H., Resick, P. A., ... & Strong Star Consortium. (2018). Distinct trauma types in military service members seeking treatment for posttraumatic stress disorder. *Journal of Traumatic Stress*, 31(2), 286-295.
- Management of Post-Traumatic Stress Working Group. (2010). VA/DoD clinical practice guideline for management of post-traumatic stress. *Washington (DC): Veterans Health Administration, Department of Defense*, 1-251
- Nash, W. P. (2019). Commentary on the special issue on moral injury: unpacking two models for understanding moral injury. *Journal of traumatic stress*, 32(3), 465-470.
- Nash, W. P., Marino Carper, T. L., Mills, M. A., Au, T., Goldsmith, A., & Litz, B. T. (2013). Psychometric evaluation of the moral injury events scale. *Military medicine*, 178(6), 646-652
- Paul, L. A., Gros, D. F., Strachan, M., Worsham, G., Foa, E. B., & Acierno, R. (2014). Prolonged exposure for guilt and shame in a veteran of Operation Iraqi Freedom. *American journal of psychotherapy*, 68(3), 277-286.
- Purcell, N., Koenig, C. J., Bosch, J., & Maguen, S. (2016). Veterans' perspectives on the psychosocial impact of killing in war. *The Counseling Psychologist*, 44(7), 1062-1099.
- Richardson, C. B., Chesnut, R. P., Morgan, N. R., Bleser, J. A., Perkins, D. F., Vogt, D., Copeland, L., & Finley, E. (2020). Examining the factor structure of the moral injury events scale in a veteran sample. *Military medicine*, 185(1-2), e75-e83
- Rosen, G. M., & Lilienfeld, S. O. (2008). Posttraumatic stress disorder: An empirical evaluation of core assumptions. *Clinical psychology review*, 28(5), 837-868.
- Sun, D., Phillips, R. D., Mulready, H. L., Zablonski, S. T., Turner, J. A., Turner, M. D., McClymond, K.,

Nieuwsma, J.A., & Morey, R. A. (2019). Resting-state brain fluctuation and functional connectivity dissociate moral injury from posttraumatic stress disorder. *Depression and anxiety*, 36(5), 442-452.

Vaes, J., & Bastian, B. (2021). Tethered humanity: Humanizing self and others in response to interpersonal

harm. *European Journal of Social Psychology*

Wachen, J. S., Dondanville, K. A., & Resick, P. A. (2017). Correcting misperceptions about cognitive processing therapy to treat moral injury: A response to gray and colleagues (this issue). *Cognitive and behavioral practice*, 24(4), 388-392