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Session: Moral Injury and Killing in Combat Veterans: Research & Clinical Implications
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Unidentified Male: She’s mental health director of the OEF/OIF integrated care clinic in San Francisco VA. She’s a staff psychologist on PTSD team and associate professor at the University of California in San Francisco. Her wide range in research interests include PTSD, suicide, a recurrent topic, moral injury, risk and resilience in service people. She has a particular interest in women veterans. Thank you Shira. We look forward to this presentation.

Shira Maguen: Thank you so much for the introduction. It's such a pleasure to be here today. I’m really looking forward to presenting to all of you and also really looking forward to being able to have some discussion at the end. So please do feel free to send in any questions or discussion topics and we can make sure to get to those at the end. So I wanted to start out by saying that a lot of the questions that I get asked is how did you get interested in this or where did you start with this. And as was mentioned, I wear several hats in the work that I do. So I’m a clinician. I’m a clinical psychologist. I’m also doing a lot of research and training as well. And so I think a lot of the interest in this topic really grew out of my own clinical work. I’ve been working within PTSD clinics first at the Boston VA and now here at the San Francisco VA. And so a lot of my interest in this research area grew out of finding that I wanted to do more for veterans who were struggling with these issues. And really even after engaging in evidence-based care or PTSD a lot of veterans were still struggling with issues that were related to either killing in war, which I’ll focus on specifically, or moral injury. So we’re going to define all of those terms in today’s talk. But I wanted to give you a little bit of background about how I started out studying this topic area.

So great. So before we begin I just wanted to ask just so I have a good sense of what everyone’s primary role in the VA is. And you can see some options here. So please feel free to enter your answers and we can see those on the screen so I can get a better sense of who’s on the call today.

Operator: Thank you. Give me one second and I will put that up on our attendees’ screens. So for our attendees you do have that up on your screen at this time. So once again, we want to get an idea of who’s joining us. So what is your primary role in VA? We do understand that many of you do wear many different hats in the organization but please select just one. So the answer options are student training or fellow, researcher, clinician, manager or policy maker, or other. And if you are selecting other, feel free to wait until the end of the presentation when we put up our feedback survey. There will be a more extensive list of job titles and you may find your specific one there to select. But at this time we have 85 percent response rate so that’s great. Thank you. I’m going to go ahead and close the pole now and share those results. So as you can see Shira, we have 14 percent student training or fellow, 15 percent researchers, 38 percent clinicians, 9 percent manager, or policy maker, and 24 percent responded as other. So once again, thank you to our respondents. And Dr. Maguen, I will turn it back over to you now.

Shira Maguen: Great! Thank you so much and thanks for responding to that. That’s very helpful. So I wanted to start out with some brief background about particularly the issue of killing in war. And I wanted to show you just some statistics from the current conflicts of Operation Iraqi Freedom, about 77 to 87 percent reported directing fire at the enemy with about half of those reported being responsible for the death of an enemy combatant and about 14 – 28 percent reported being responsible for the death of a non-combatant. So I think those are just some important statistics to keep in mind as we move through this. So the other thing that we know is that veterans for multiple areas who kill in war are at increased risk for PTSD, alcohol abuse, suicide, and functional difficulties after they return home. So really as I mentioned, I’m going to focus on killing in particular and then expand the lens out to moral injury. I’m going to talk about some focus groups that we did with veterans to learn more about killing and than about killing and their experienced killing. Then I’m going to specifically focus on a randomized controlled trial that we did with the treatment that focuses on the impact of killing for people after they’re involved in some trauma-based evidence-based treatment.

So that’s going to be the agenda for today. But I wanted to kind of really start out by focusing a little bit more on killing and then we’ll broaden the lens. So we do know that veterans who kill are at risk of a number of different mental health issues and also functional difficulties. Yet, we also know that killing is not routinely assessed by the VA and DOD. And there’s not a clear treatment trajectory after evidence-based treatment for those who continue to be impaired by killing. And really that is a part that really drew my interest in when I was first starting to study this. So if anyone is interested in any of these citations below please contact me and I’m happy to send you the more detailed papers. We were able to look at some of these questions in Vietnam veterans, Iraq and Afghanistan veterans, Gulf War veterans, and as well as large databases of those veterans. So I’m happy to share any of that work with anyone who is interested.

I wanted to show you here. We wanted to answer the questions in particular, are those who kill in war, do they have worse PTSD symptoms? So this is Iraq and Afghanistan veterans. And what we did here was we looked at latent class trajectories, latent classes of people who had PTSD, who were diagnosed with PTSD, and you can see here that there are really four different groups. So there is a group that is reporting across the board a high level of PTSD symptoms, much lower PTSD symptoms. And then the middle two groups, one group really tends to be lower on detachment-restricted affects, diminished interest, and the other group tends to be much higher on that. So what we wanted to see is among those who killed you can see here that for the class one is the worst off symptoms. And then if you look at the bottom right hand corner, those are the percentage of subjects who killed in each class. So you can see that about 75 percent of those who killed were in the two worst off PTSD classes. So I think that was also important for us to kind of keep in mind. So these are really people that even sometimes after evidence-based care could still use more treatment in many cases. And that’s where we wanted to intervene.

So I’m now going to turn to focus groups. So when we were first starting to do this work we really wanted to find out from the veterans in their own words who this would focus on veterans who would kill in particular. We wanted to find out what were the things that they continue to struggle with even after PTSD treatment had been done and just to get a general sense of where were they getting stuck in moving forward with their own recovery. So as you can imagine, there’s a lot of information that we gleaned from these focus groups. These were veterans of all eras. But I wanted to just give you a very small sampling of what we found to give you a sense of how we then led to doing the trial that we did. So a big theme that emerged was the dark side of the self. So veterans talked about how when they killed in war they really got to see a dark side of the self, feeling like a monster, what I’m capable of doing is what scared me. So it kind of brings into your mind a question of who you are as a person and what you’re capable of. It brings a lot of insecurities. So again, this idea that you get to see this part of yourself that you might not have seen before and that can be a very scary experience and something that you carry with you into civilian life and how does that impact you later on.

So secrecy and stigma was a huge issue. A lot of times people felt like even though killing in war was very bothersome to them, they didn’t feel like they could talk about it. They felt like it would be seen as crazy. And they felt like that was really reinforced because of all the media especially with the Vietnam veterans being called baby killers. There was really a sense that how would people if they knew that the person killed in war, how would they see them? So there was a sense of withdrawal and shutting down and a lot of secrecy for many years for a lot of veterans. In fact, one of the issues that came up in the groups, in the focus groups, was that for many veterans even though they had been in treatment for a while, they were very hesitant to bring it up, or for many the focus group was the first time that they had actually disclosed killing someone. So I think that that’s important to note how important the secrecy really is.

Issues of morality came up. So your morality gets tossed out the window. It's the same thing with religion because I think once he’s thinking about it, “Boy, I can’t do this because it goes against everything I’ve been taught or believed in since I was a young person.” When you start thinking about the moral issue, you’d be dead. You don’t have time to think about those things. You just do it. But then you have to come back and you have to think about that later on and what you’re responsible for. And that’s very hard. That comes back to haunt me all the time. Those are all different participants actually. So the sense that people really struggle with the morality of it particularly when they get back and how do you reconcile what you did for many people becomes a big issue. So I think the spirituality is a whole other area that came up that unfortunately I’m not going to have time to present here but really having a very serious impact on spirituality and that whole aspect of the self as well.

So I want to present here next a conceptual model of PTSD-based trauma and killing trauma and how those might be different. And so I think this can really help guide us in terms of why we might need additional treatment. So as many of you know a lot of this PTSD based treatments were originally designed to be focused on a fear-based response to trauma. So now within in UDSM that’s certainly changing in terms of how we do the diagnosis but still the treatment that we have, CPT causing \_\_\_\_\_\_ [00:12:00] and prolonged exposure therapy, which are excellent treatments also are based on models of fear-based response to trauma.

So with killing trauma, the response can be quite complex. So certainly fear-based responses can be very present and you fear for your life. You feel like you have to defend yourself. But oftentimes too, killing trauma can occur in the context of law. So it's losing someone who was very close to you, someone who you care deeply about, and also you’re very angry that this loss occurred or you’re angry that you’ve been in war for many people. When they kill they’ve been in conflict for a while and in war for a while. And so you saw on the prior slides it kind of wears at you and wears you down. And pretty much, the focus is on staying on alive. So I think that I want to just kind of highlight how those traumas might be different. With PTSD trauma oftentimes it's the violence from the other that’s directed at the self. And with killing trauma, violence from the self is really directed at the other. With killing trauma, there’s a lot more focus on being a participant in the trauma whereas with PTSD trauma it's much more of a focus of being a recipient of the trauma. So clearly there’s a lot of areas of overlap with arousal, with numbing, dissociation. So I wanted to highlight those areas as well. So hopefully that’s helpful in helping us think some of these issues through.

Okay. So let’s broaden the lens now and kind of think about defining moral injury more generally. So killing is one particular instance of moral injury but there are a lot of other instances that can fit under the umbrella of moral injury. So I wanted to kind of put the definitions up. So moral injury can be defined as perpetrating, failing to prevent, bearing witness to, or learning about access, transgression, deeply held moral beliefs and expectations. And I think the important thing with moral injuries is there has to be some kind of act of transgression that’s perceived. So I get asked oftentimes, what about people who kill in war but don’t feel that transgression, etc.? And I think really what we’re talking about here is people who kill and who have moral injury. Those are the people who feel like there was a transgression. And that’s an important part of the definition that we have to really keep in mind. So just because you had an exposure in war doesn’t mean that you necessarily have moral injury.

So here is a causal framework. This is from a paper that we published in 2009. And this is a lot of the model that drove the treatment or the impact of killing treatment that I’m going to talk about more specifically today. So as we talked about in the beginning is really the transgression that occurs, which can be a killing which can also for some people be witnessing something or feeling like they weren’t able to help in a situation, feeling like betrayal also fits under the umbrella of moral injury too. So, as I mentioned, there’s a particular treatment that I’m going to be focused on today. We focus on killing in particular. So there is some kind of global attribution. So those are oftentimes cognitions. So if we’re thinking about this from a cognitive, behavioral perspective oftentimes there are specific causations related to the killing that people carry with them afterward. So many of the veterans in the focus groups they felt like I can’t. Because I killed in war, I can’t have a family. I don’t deserve to have children. I deserve to kind of suffer myself because of what I did.

And so as you can imagine having some of those attributions or cognitions really keeps people stuck and not able to move forward with their lives. And so that’s a lot of what we wanted to focus on in the treatment. There’s shame and guilt as a result of that, withdrawal that we already talked about. This is where the treatment that I’m going to talk about deviates significantly from other treatments. So not only are we focusing specifically on killing cognitions but we’re also focused on self-forgiveness. So we felt that self-forgiveness and exploring that was very tied to spirituality for some people but just self-forgiveness in general was an important focus for the treatment that I’m going to tell you about. And so that is an area. And with moral injury there can be traditional PTSD symptoms but there can also be a lot of self-harming behaviors, self-handicapping behaviors like self-sabotaging relationships, and those types of issues as well, and that sense of demoralization because of what happened. So this is just a preliminary working model that can really help guide our thinking.

So the killing treatment that we designed was called the *Impact of Killing Module*. It's designed to be a treatment module that comes after some trauma-based work. So the way that we conceptualize this is the CBT treatments provide a very helpful base for killing, exploring the killing treatment module and being able to move forward with doing the killing treatment module particularly if debilitating cognitions exist. So one of the things that we did from the focus groups is we developed something called the killing cognition scale. And so it was a scale that really drew out the areas in which people were expressing the struggles. So as I mentioned, issues with impairment with families and relationships, shame, guilt, spirituality, which were some of the areas in which we focused on for the killing cognition scale? So we really wanted to focus on those cognitions as a part of the treatment. And as I mentioned, we wanted to have veterans with some preliminary work before they got to us for this module from trauma-focused work.

So in this treatment study, our goal was to test feasibility, acceptability, and efficacy of a treatment module that addresses the mental health and functional impact of killing in the war zone. And what we did is we assigned people to treatment or to a wait-listed condition. We offered everyone who’s in the wait lists of treatment after that. It was six to eight sessions of individual therapy, 60 – 90 minutes each week. And participants were also asked to complete assessment measures and provide feedback about the treatment afterwards.

So we had veterans who spanned 18 – 80-years of age. So our oldest veteran was a Korean War vet. And we had younger veterans as well. They completed some trauma-focused treatment. They had to be impacted by killing in combat or feeling responsible for the death of someone else. So for example, officers or medics we also enrolled. So as long as they felt like they had killed someone by either directly or indirectly because they weren’t able to save them in the case of medics or in the case of officers, they ordered people to do things that resulted in killing. So the bottom line is that they felt responsible for killing and they had long-term ramifications because of that. So we ideally had people abstain but then we also engaged in the harm reduction for those who were not able to abstain. And they couldn’t be currently engaging in any self-harming behaviors.

So here is a very broad sketch of the treatment overview. Session four and five are often extended. And so oftentimes the session ends up being the bottom, the lowest session in six sessions but oftentimes we do up to eight sessions with people. So the first session is really focused on a pretreatment evaluation where we look at barriers to treatment, making sure that they have adequate coping to engage in this type of treatment, and really understanding where they’re getting stuck in moving forward with their moral injury or their killing-specific trauma. So in the second session we have a much more focused session on killing, the common responses to killing. So we talk about the physiology of what happens in your body when you kill as well as the cognitions and emotions. So as I mentioned, the killing cognition scale is used to really understand what areas are people kind of getting most stuck in moving forward. And so we use the killing cognition scale for that.

Then we continue in session three to really take a deep look at some of those cognitions. We also have them. I’m going to talk about the assignments that we do in the next couple of slides, the added session assignment. And I think that will flesh this out a little bit. But we have them think about the meaning of killing in particular. So what does it mean that they killed someone and how did that affect their life. And then that continues into session four. Then in session five, marked here at five we really focus on self-forgiveness. So this is a whole generally two sessions that we focus on defining self-forgiveness and barriers to self-forgiveness. So we want to understand where there are ideas about self-forgiveness come from, and we want to understand what have been the barriers for them moving forward with forgiving themselves. One of the things that we do is also have them write a forgiveness letter. So oftentimes, they will write a letter to the person who they killed or a younger version of themselves. And so that’s really something that can be quite powerful. As you can see, we really worked up to that so that’s not done as a standalone intervention. But I think what’s really been important is that we work up to that forgiveness letter which can be very, very intense. And then the last sessions are really focused on taking the next steps, how to make amends, and how to maintain game.

So just to give you a sense of the homework assignments here, I’m not going to go into this in great detail, but for that first meaning statement what does it mean to you that you killed. A lot of the themes that come up are alienation, anger, fear, loss, and feeling they’re damaged somehow or toxic or evil or unforgiveable. So that assignment after session two is very important in helping us understand what are some of the themes that come up for them and how we can deal with that. So this is how we identify themes to work on in future sessions in conjunction with the killing cognition scale. So the worksheets that we do after session two are specifically focused on killing-related cognitions, as I mentioned. We wanted to put some examples here so you can get a sense of some of the ones that have come up in session for people. I’m forever tainted because of killing. I have feelings I should not have had when I killed. I’m afraid of what I’m capable of and where was God when the killing happens. And those are some of the things that we have come up when we do the worksheets.

I also want to say at this point is that something that’s really important that I haven’t mentioned previously is that this treatment really does an important role in that a lot of times veterans will come to us and say, “I know what I did was wrong and I don’t want anyone to tell me otherwise.” And that’s not really what we see as our role at all. And in fact, we really try to balance that, the acceptance piece of meeting the veterans where they’re at and yet still trying to figure out how they can move forward. So I think that’s a really important point that we want people to take home with them. Part of this is really understanding that a lot of people come to us with a lot of shame and guilt. And we acknowledge that they might have done something that they really feel goes against their morals and values. And so that’s a starting place for us rather than trying to challenge any of that. So that’s been a very important part of the treatment that I just don’t want to get lost in the mix.

So after session four there’s a forgiveness plan and I wanted to kind of focus a little bit on that and talking about here we really focus on the pros and cons of self-forgiveness and why they might be stuck in moving forward with that. And then of course, there’s the forgiveness letters, some to the individuals that they killed or injured, some from the present day self to a younger self, which can also be very powerful. So we really tailor it depending it on what information has been covered thus far. The Amends Plan after session is an action plan that really honors the veterans’ values. So it’s spending time with family with veteran self-care, spiritual practice. Those are the kinds of things that we often see in the Amends Plan. And the treatment really balances looking back but also moving forward.

So just to kind of go through some of the information that we collected from people, we looked at a whole host of demographics, PTSD symptoms, more global psychiatric symptoms. We used the killing cognition scale. We also looked at acceptability and feasibility as well as a measure that we designed to index some of the changes that we thought we would see in people post treatment. So I’ll present some of that data as well. So we had 30 completers. We had a couple of dropouts in each group, one in the control group and one in the active group just due to life circumstances. But most people who started finished. And I’ll present, again, when I look at some of the intent to treat analyses. I’ll go over this in more detail. So you can see here that definitely most of our veterans were Vietnam era, Vietnam age. We had male participants. We tried to recruit women as well who had killed in war. I had hoped to enroll more in the future but for this particular sample it was an all-male sample. And you can see the raised and relationship status breakdown here. You can see the service-branch operation breakdown as well. So we definitely had representation of about 15 percent from Iraq, about 6 percent from Afghanistan, 3 percent from Gulf War, and 9 percent from other with the majority being Vietnam veterans.

So as I mentioned, we conduct intent to treat analyses. So I’m going to present the outcomes from several of our measures. This is the PTSD symptom measure in particular. So you can see the dotted line is the wait list group. The dark blue line is the treatment group. And you can see here improvement for the PTSD. So when we do intent to treat and compare treatment to wait list, there is a significant difference with those in the treatment group improving more than those in the wait list group. It's the same.

So now I’m going to present from the brief symptom inventory a number of sub scales. So we saw that obsessive-compulsive symptoms also went down. That was significant. We’ve compared the treatment in the wait list group. And I should also say that, the intent to treat is what you’ll see above is the intent to treat and then you’ll also see numbers for analyses we adjusted for baseline differences here. So here is interpersonal sensitivity. It's also a very similar pattern. And from the previous slide here with the treatment group going down and the wait list actually increasing symptoms similar to anxiety as well. We saw a reduction, a significant reduction, in anxiety symptoms with the treatment. And the wait list group went up a little bit. And it's the same with depression. We saw a reduction, a significant reduction in depression symptoms with the control group increasing their symptoms slightly at follow-up. This is just some phobia symptoms so fear of different things. Again, it's definitely a pattern to go down for the treatment group and up for the wait list group.

Okay. So in terms of this the acceptability and feasibility questionnaire, we wanted to make sure that not only are people getting better but that they find the treatment acceptable and feasible since we’re asking them to really disclose a lot. And it was a very moving experience to have them involved. I did some of the therapy for the study as well in addition to doing some of the feedback sessions. And so we had three excellent therapists in addition to myself that were working on this study, which I’ll acknowledge. But we wanted to really get a good feeling about did people find the treatment acceptable and feasible? And overall, the answer was yes. So some of the highest rated items were I would recommend this treatment to a friend. I feel like I benefitted from the treatment. The treatment provided new information. The treatment taught me new skills and provided new ways of approaching problems or struggles. Definitely people felt that they wish the treatment had been longer. We see this treatment as a springboard to continuing to deal with some of these issues but by no means do we expect that all of the issues will be resolved at the end of this treatment. But we talked to people about starting to make some changes in their lives that they can continue to carry out. And that self-forgiveness is definitely a process. So I think that that’s important that most people felt that they wished the treatment happened longer.

So then we wanted to look at some of the outcomes for areas in which we thought people would improve in particularly areas that are difficult to measure. So you can see here that some of the most highly rated items were I’m more accepting of different aspects of myself. I feel that there are specific things that I can do to continue healing. I have a better understanding of what self-forgiveness means to me. And I’m more self-forgiving I think was also something and feeling closer to family members, etc. is something that people endorsed as well. So I wanted to give you a sense of what were some of the killing cognition scale items that people showed changes on. So this is the killing cognition scale that’s quite a long scale but I wanted to sort of draw out some of how people say that they changed, again, from base line to post treatment. So those in the treatment group improved significantly compared to the wait list on the items of I deserve to suffer for killing. I feel betrayed by my superiors who ordered me to kill against my own beliefs. I can no longer be intimate with a partner after killing. I believe I was justified in killing and I wish I did not have to kill as many people as I did. So again, I think that there is a lot if we focus on functional differences here and feeling like there are some changes in intimacy and suffering as well. So I think that that’s important.

So in terms of how do we summarize all this? I know I talked a lot about a lot of information and moved through it pretty quickly. So I think that the take home messages here are that after six to eight sessions of the impact of killing treatment that addresses the impact of killing in war, we saw improvements in PTSD symptoms. We also saw shifts in killing related causative domains including self-concepts, spirituality, and self-forgiveness. We also saw a lot of improvement in general psychiatric symptoms such as depression and anxiety. And so one of the things that I think is really important to think about too is that we’ve done a couple of studies. I didn’t present them here today but we’ve done a couple of studies that have really found that those who kill are at much higher risk of suicide and suicidal ideation. In fact, in one study we found that Vietnam veterans who killed in war even after adjusting for general combat and PTSD and depression and substance use, even after adjusting for all those things, those who killed were actually two times more likely to report suicidal ideation.

And so I think that we’re always in the back of our minds too. And so if we can bring down the PTSD symptoms, if we can bring down depression and anxiety, I think that goes a long way in thinking about suicide and how to reduce some of those terrible outcomes that we’ve seen as well that this group is particularly at risk. So I think that that treatment focused on the impact of killing is really conceptualized. We don’t conceptualize it here as a standalone treatment but we conceptualize it as something that can be added onto many of the options that we do have for veterans who are struggling with PTSD and other functional issues. So by no means is this a replacement but really a supplementary treatment. I think that that’s a really important point that I wouldn’t want missed.

So I wanted to also just focus on the take home for the veterans self-assessment areas of their own growth. So they acknowledged that healing is an ongoing process, that they have a greater self-acceptance and self-integration, and self-forgiveness. One of the things that’s been really neat in this study is that we got veterans from so many different backgrounds and so many different types of spirituality. So some people were not religious at all but considered themselves spiritual. Some people came from Native American cultures where their ideas about self-forgiveness were really important. And they integrated their own rituals from their own communities in their healing. We had some people from Christian-Judao backgrounds. And so we really tried to tailor it to the individual and bring in how they were doing in particular with sort of how they’re conceptualizing self-forgiveness. And so that was very, very important so greater self-acceptance, increased understanding of killing events in the past. So veterans reported that they felt that this six to eight session treatment was acceptable and feasible in many domains as we went over. I wanted to also mention that these were veterans that were included. We did not rule people out for TBI [ph]. The participants that we had that were in the study had mild TBI. So we didn’t get referrals that were more severe. But I think similar to other cognitive behavioral treatments we definitely had people who had mild TBI and they seem to do well with this treatment as well.

So finally because it always takes a village to do this kind of work, there were so many people that first of all, the veterans that participated in this research, both of the focus groups of the trials were just incredible in opening themselves up to us and really trusting us. And so a huge thank you first and foremost to them. There are a lot of people including the study therapists and a huge team that was incredibly helpful in making this research happen. And then I want to just acknowledge my funding sources as well. So this research was funded both by the VA as well as UCSF. And in addition, I had a career development award that allowed me to really focus on some of this work that I talked about today, so.

So I will mention that I know that we’re going to have ample time today to talk about questions and comments that people have and I’m really looking forward to that. If we don’t get to any of your questions, please feel free to email me. I’m on Outlook. Feel free to email me with any questions. If you want any of the articles that I talked about, I’m very happy to do that and send you those as well. I will say that we’re literally in our very final phases of writing the trial that I talked about up today. So we’re really going to be sending that out soon for review. And so if anyone is interested in kind of the full paper I’m happy to send that out to you as well. And that hopefully will get accepted. And so I also should say that the treatment itself is not in a place where we’re able to send it out to people yet but we’re hoping to get there soon. So we also, in addition, I did not get to talk about this today just in the interest of time. But we did feedback with providers about the treatment and also with veterans about the treatment. And there’s some tweaks that we want to make to the treatment. So I’m not quite ready to send those out yet but I’m very happy to keep people’s names if you’re interested in the future when that’s ready to go. I’m happy to send that out as well. So thanks so much for being part of this call and I’m really looking forward to some of the discussion that comes afterwards, so.

Operator: Thank you so very much. That was an excellent presentation. We do have lots of great pending questions. So without further adieux or actually I do want to make one quick announcement. For those of you that joined us after the top of the hour if you want to submit a question or a comment for Dr. Maguen just please use the control panel on the right hand side of your screen. You can expand the question section by clicking the plus sign next to the word questions and then type your question or comment in there and press send. And we’re going to go ahead and get to those straightaway. First off, thank you for this important presentation. Regarding different behavioral health therapy options, please speak about the pros and cons of using CBT versus more mindful approaches such as ACT, acceptance and commitment therapy, or MBSR for interventions for veterans with moral injury.

Shira Maguen: Great! Yes. I love that question. And I think that we’re starting to see more work as people are getting more interested in the topic of moral injury. I think we’re starting to see more work that looks at people with moral injury in those different treatments. I am a big fan of mindfulness-based strategies. And I think what we have learned over time is that not every veteran is going to do well in a CBT framework. And so we need to really expand the options of what is available. So there was recently actually a paper on ACT and moral injury that I would encourage you to look up because I think that people are starting. It was more of a conceptual paper. But I think people are really starting to write more and more about it. and I think I’m personally a big advocate of as many options as possible for people because I think that is a complicated topic and that some people are going to do better in \_\_\_\_\_\_ [00:41:28] based treatments. And some people are going to do better in CBT-based treatments. So I think really what I encourage people to do is spend a lot of time in asking also about patient preferences with this topic and also really thinking about what is the best match for the person in front of you and using a treatment where it can really be tailored if you know that the person is not going to be a good fit for one treatment or another.

So that’s really what we try to do in the IOK treatment that I talked about today is for some people we were able to kind of focus more on the cognitive pieces. For some people the self-forgiveness piece was just so key that we tried to kind of move to that as well within this six to eight session framework as well. So I think without a doubt depending on the type of trauma, different people are going to be a better match with different kinds of treatments. And I’m really hoping that this presentation and other presentations that we’ve seen on moral injuries can kind of spur more research so we can better answer those questions. I think there’s a lot of exciting research that’s coming out nowadays on trauma type. So people are focusing a lot more on what was the trauma type and can there be different treatment trajectories based on individuals’ trauma type. And so I think we’ll be seeing a lot more of that too in some upcoming studies. And so I want to just alert people that that’s coming down the pipeline and just pay attention to that because I think that’s a really neat way to think about things. And if people have different traumas then we can sort of think about treatment trajectories that might be different for different people. That can be really helpful in helping us conceptualize the best match for people.

Operator: Thank you for that reply. Let me see. Sorry. I’m scrolling through. Thank you for trying to tease out moral injury diagnosis and treatment from PTSD as a whole. From focus groups, could it be helpful to distinguish moral injury of commission omission from that of betrayal for instance let down by God or commanders?

Shira Maguen: Yes, definitely. So I think the betrayal question is a really important one and definitely under the umbrella of moral injury. So I presented today the killing specific focus groups that we did. We actually did a whole other set of focus groups that were held both in Boston and in San Francisco. And we looked at larger questions of moral injury. And that’s something that we’re starting to write up as well. Betrayal was a big issue. So in the focus groups that I presented today we really did hone in on killing in particular. And in these more general focus groups, we focused a lot more generally on active omission and commission as we were saying. And actually the question is a perfect fit for some of the things that we’re finding that betrayal really is it's own category and maybe needs to be considered separately. So hopefully we’ll be able to get some of those findings out too. And if that particular person wants to email me I’ll be sure to get them a manuscript when it does come out.

Operator: Thank you for that reply. Another person writes in, excellent presentation. Is there a moral element where veterans find that there wasn’t meaning for existential absurdity?

Shira Maguen: Right. So this is kind of like more at the philosophical level. I mean I think it's an excellent point that a lot of veterans when they get back do struggle with some of the moral implications on some level. And I think that that’s also something that comes up in treatment in general for sure. So there’s kind of under that, there is the umbrella of some of the more specific moral injury acts that we talked about. But the larger picture is, is there some struggle that happens, some existential struggle that happens when people get back? And I know that that’s certainly true in terms of the whole process of reintegration. And that’s so much of what we could be focusing on too. I think that interestingly with a lot of the younger vets what we see is that when people get back, as you all know, we’re sort of primed to meet basic needs. And oftentimes for some people that is first and foremost right away. But for other people that really emerges with time. So I think the other important piece with that is just the developmental perspective of when some of these issues might emerge and how we can match treatment to sort of deal with the larger picture of what people are struggle with in their reintegration.

Operator: Thank you for that reply. We do have an attendee that has very graciously offered their services and resources available to anyone on the call. This varies from everything like virtual training to help prepare soldiers getting ready to be deployed to interact with a virtual officer training and put them through moral dilemma scenarios. She’s also offering up books, three part essays on moral injury, and many items. So if you are interested in any of those resources, please do write into the question box and I will happily provide her contact info, which she has approved, for me to give out. And she would be very happy to connect with a lot of you. And Shira, she has mentioned you personally as one of the reasons why she attended this presentation, you and your work.

Shira Maguen: Great! Well, thank you. It's always I think one of the things that’s most exciting to me is to hear about the work that other people are doing in this area. I think there is more and more work coming out. So it's wonderful to hear about resources that are coming out for people. And I just encourage that work for people who are interested in this topic area. Our team here is very open to collaboration. So it's wonderful to hear that that work is happening and continuing to happen. I think that that’s so much of an inspiration for me to continue doing this work, those colleagues who are doing some amazing work in this area.

Operator: Excellent! It is an incredibly important topic. The next person writes in, compared to mild TDI and PTSD, what is the relative frequency of moral injury alone?

Shira Maguen: Yeah. So that’s definitely the question that we all are struggling with. I think one of the things that is really tricky is that there is no epi-study. So there’s no epi-study that really kind of gives us a good sense of what are the rates of moral injury. We know there have been sort of smaller studies done in different samples. And now there’s better measures. I think that part of the issue has been is there weren’t good measures. I mean we’re still I think struggling with developing good measures to really capture measuring something that can be really complex. And so I think epi-studies are definitely the next step but for now what we have is more within certain contexts what percentage of people say that they struggle with moral injury. And I think what we’ll find is what we’re finding is that it's comparable to rates of PTSD. But the important thing is moral injury is not in the DSM and there’s a lot of controversy about whether it should be in the DSM or not or whether it's a diagnosable condition or a dimensional issue. And so I think that this is really the take home message in many ways that we’re really in our infancy of studying moral injury. And we don’t have a good grasp of the prevalence rates or how the overlap with PTSD is also. We know that there is some overlap but that certainly moral injury is distinct in many ways. And so I think that this is a lot of the research that needs to happen over the next few years to really get clear.

Operator: Thank you. Okay. The next question we have, I’m having to dig through because there’s so many people just writing in. Thank you. This is a wonderful presentation. So just know that there are lots of those and I’m trying to get to the questions. Okay. How do you understand the importance of spirituality in recovery from combat related moral injury?

Shira Maguen: Oh, that’s such an important question. Yeah. I feel like there can be a whole talk just on spirituality actually. And one of the exciting things about this study and this work is that we have worked pretty closely with the spiritual community and people who are doing spirituality research as well because it is such a critical piece. There’s so much overlap I think with moral injury. And so one of the things that we have really done is tried to understand and be able to connect with spiritual community so that there can be a bridge for people who are doing this work to also be involved in it or more involved in their spiritual communities and have kind of a common umbrella or common definition of the moral injury that they have been through. So we’ve been really lucky to connect with some great people. So there’s people in San Diego doing some great work, people here locally. I know in the south there’s some great people doing some moral injury work in the spiritual community as well. And so I think part of it really is acknowledging that we can collaborate together with those communities and that there’s a lot of work that can be done together. But I think that without exception it's something that for some people it's a bigger issue with the moral injury and with some people who weren’t connected to spiritual communities in the beginning. It's not as big of an issue. But I think that across the board it comes up in the discussion of morals and values and what it means to the person. So I think it's almost impossible to talk about moral injury without talking about spirituality on some level. And so I think that more research in this area is going to be really helpful but just building those bridges. So for example here I know that we’re connected with our chaplains and we’re connected with people in that community so that we can facilitate future work in that area. And I think that continuing to really understand how integratively those things are tied is very, very important. So I think that to continue to do that, build those bridges, and do that work is really important.

Operator: Thank you. The next question we have is have you encountered vets who still desire to kill, who intensely miss killing, and are deeply ashamed? How have you handled those clients?

Shira Maguen: Yes. Great question! So I will say that the folks whole come to us worry about their anger and worry about the reaction that they might have to certain things. But we haven’t had anyone who has come to us per se and said I miss killing or I really want to kill. In fact, it's quite the opposite. They’re worried that they’ll get angry and act on that. But I think also we have vets who have fantasies of angry, etc. but no one who has really said to us we want to act on killing, etc. That being said, I think it's still very, very important to address the anger, the fear of anger that comes up. In fact, we see quite the opposite that people who have killed and are deeply ashamed worry a lot more but have not acted out some of those fears. So I think that that’s a really important thing that we address in treatment. And kind of going back to the dark side of the self-slide that I showed earlier. There’s a piece of themselves that we haven’t dealt with that issue in particular of someone who’s really kind of missing that. I think interestingly our younger veterans we see a lot of folks doing and engaging in video games that are very oriented towards it and very realistic these days too. So I think that we do see some of that but no one who is saying I miss it and I want to go out there and do it. So if anything it's the flip side.

Operator: How is it addressed when clients are hesitant to write out or will not write out the assignments?

Shira Maguen: Yeah. so that’s something that we talk about very early on that in order to engage in the treatment, this is a piece of it. And so in that very first session when we talk about barriers to treatment, we make sure that that’s something that they’re willing to engage in. and if they feel like they’re not then maybe this treatment isn’t the best match for them. And so I think we haven’t had as much of an issue because we address it right up front and make it clear that that’s something that’s really going to be integral and a part of the healing. So I can’t imagine someone going through this treatment without writing what does it mean to you that you killed or some of the forgiveness letters. And I think veterans who are willing to engage in this really understand that that’s a critical part of the work. So I think just like anything else, talking about early and often. And when it comes up what we have seen is veterans who will come to us and say, “This is really hard or I’m really struggling with doing this assignment.” And then we tackle that directly but there’s no one who has just flat out refused to do the assignment. So if there are barriers coming up we address those directly in the treatment. And generally we’ll continue moving forward with the assignments.

Operator: Thank you. Do clients write all three of the forgiveness letters or just one or two?

Shira Maguen: So it varies. For some people it's really only one. And for some people they can write up to three. I mean there’s also been other versions. Those were just three examples but there’s been other versions of the letter. And we really work with them really closely to figure out the best match or matches for them. So I think that the tailoring is really done. And for a lot of veterans they feel like it's such an important part of their healing that they will actually say I think I need to do one more letter. I actually just finished treatment with a veteran who we used this treatment protocol on. Towards the end he was almost assigning himself letters to write because there was still another piece that he needed to address. And so it varies tremendously I think in terms of what the person needs and then we try to tailor that.

Operator: Thank you. Another person writes this work with individualized therapy seems to be making important impact on veterans’ lives. Do you have any thoughts about whether this could be done via phone weekly calls versus in person?

Shira Maguen: Yeah. You know, I’m a big advocate of doing things over the phone. It's a great question, which I don’t really know the answer to. I think that oftentimes a mix is nice. And so there’s a piece of this treatment that is so intimate especially when you get to the letter writing. And I think it's possible. I just think that also there’s a piece of this that I will say that I think some of the healing actually happens by having someone there to read the letter to, for example, or to read the killing meaning statement too so that a part of it is about having someone there to actually witness something that you’ve been ashamed or too afraid to tell to another person. And so certainly that can also happen over the phone. But I think there is some anonymity to the phone or less of kind of there’s a person there to hear this, and a little bit more of kind of a distance when it's on the phone. So I think that it can be done but I think we would have to think really carefully about sort of a mix of sessions and which sessions would be best in person, which might be able to be done over the phone. I’m so aware of the fact that we have a lot of rules that are written that are struggling or really alone with this. And so I want to sort of be mindful and thoughtful about answering that kind of question because ultimately I think that we can still accommodate those veterans but maybe eventually have something where it's a mix of over the phone and in-person. It was interesting. We actually had veterans come from quite far away in some cases to do this treatment. But over time it would be nice to be able to have part of that done in a more convenient way.

So that’s a very good question. I mean the other question that comes up actually is in terms of treatment modalities about groups. And I think we chose to do this individually but I think that that’s an open question too about can some of this healing happen in the context of a group?

Operator: Thank you. I do recognize that we’re at the top of the hour Shira. Are you able to stay on so we can capture the remaining Q&A in the recording?

Shira Maguen: You know, unfortunately I have a meeting that I need to go to. I can maybe stay for like one or two more questions. But I should really wrap up.

Operator: No problem. If it would be alright with you, could I email you the remaining questions and get written responses that we can post with the archive?

Shira Maguen: Absolutely!

Operator: Okay. So for those of you still on the call that didn’t get your question answered, have no fear, we will followthrough with it and you will receive a follow-up email two days from now with a link leading to the recording. And sooner or later depending on our schedules, we will get the remaining Q&A text up there as well with the handouts that we’ll post. So rather than try and squeeze in one more question, I will just ask if there’s any concluding comments that you’d like to make.

Shira Maguen: Well, I just want to thank everyone who is on the call for really great discussion and really great questions just around some of these complex topics. And I look forward to the other ones. And we’ll definitely make sure we get to answer those. And thanks again for organizing and to Dr. DePalma [ph] for organizing as well. I really appreciate the opportunity to get to have this discussion and look forward to the future questions.

Operator: Excellent! Well, we can’t thank you enough for lending your expertise to the field especially for such a valuable topic. And thank you of course to our attendees for attending and for your interest in this topic and for your great questions. And I’m going to close out this session momentarily. And when I do a feedback survey will populate on your screen so please take just a moment to answer those questions as we do look very carefully at your responses and it helps guide our program on what future topics to help facilitate. So thank you again Dr. Maguen and thank you to our attendees. And this does conclude today’s HSR&D Cyber Seminar. Have a great day everyone.