Full-Length Article

The Military, Moral Injury, and Music Therapy

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Abstract

Moral injury (MI), described as the consequences of being faced with morally ambiguous situations that can lead to inner conflict and guilt, is still in the beginnings of exploration. The literature states that the diagnosis of Post Traumatic Stress Disorder (PSTD) no longer fully encompasses the experiences or complex symptoms of our military service members and veterans. Thus, implicating the need for treatment interventions that provide specific focus on the symptoms of MI. Music therapy has been shown in the treatment of trauma and PTSD to provide unique access to the inner conflict and guilt of the individual in a non-intimidating and safe environment. Research has indicated a need for interventions for MI to focus on the integration of the traumatic experience and inner conflict/dissonance with the individual's sense of self. Music therapy offers a potential avenue for treatment of MI through its versatile interventions. Increased awareness of this construct with music therapists working within the military milieu provides the potential for the development of MI specific interventions and further study.

Keywords: *Moral Injury (MI), Military, Music Therapy, Post Traumatic Stress Disorder, Trauma, Veterans*

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Introduction

As one of the most underserved populations, understanding the psycho-social needs of veterans and service members has become a central and important issue in healthcare research [1,2]. There were more than 21.2 million military veterans as of 2012, according to the U.S. Census Bureau (2012), and 3.6 million listed with service-connected disabilities. Military veterans have had distinctive issues that compound their often-devastating illnesses and injuries [3,4,5]. The American Music Therapy Association (AMTA) has released a paper [6] focused on music therapy and military populations that included recommendations for further research into the treatment of veterans. The National Endowment for the Arts (NEA) and Department of Defense (DoD) have created a partnership providing for the incorporation of creative arts therapy treatment at Walter Reed Army Medical Center and at the National Intrepid Center of Excellence (NICoE) to explore the potential benefits of creative arts therapy interventions with combat veterans with traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD) [7].

Our society's view of the military has evolved in the 40 years since the Vietnam era. Combat and the military are recognized as complex phenomena, which may require service members to carry out orders and in doing so act in ways that are inconsistent with their personal moral codes.

This moral and ethical dilemma has sparked the development of the concept of moral injury (MI), found in recent research concerning active service members and veterans [8,9]. The development of this construct occurred in response to the belief that the diagnosis of PTSD neither fully explains nor incorporates the wide range of the wartime experiences service members are subjected to throughout the course of their careers [8,9]. PTSD develops as a response to a stressor event that involved or held the threat of death, violence or serious injury that may have been directly or indirectly experienced, witnessed or repeated or extreme indirect exposure to qualifying events. Diagnosis requires meeting eight criteria, of which exposure to the stressor event is one. The symptom clusters include the following: intrusion/re-experiencing, avoidant, negative alterations to cognition or mood, and increased arousal symptoms [10]. Litz [11] differentiates between MI and PTSD by stating that PTSD is a diagnosable disorder while MI is a "dimensional problem…[with] no threshold for establishing the presence of

PRODUCTION NOTES: Address correspondence to:

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moral injury; rather, at a given point in time, a Veteran may have none, or have mild to extreme manifestations" [11, *p. 1*].

The concept of MI was developed to better incorporate a more expansive range of the combat experience [8] MI is defined as the omission or commission of certain actions during war by an individual that abruptly contradicts personally held expectations of one's code of conduct and creates an internal conflict or dissonance due to the violation of deeply held moral and ethical standards [8,9,11,12,13]. Other authors have expanded the definition to include "events, such as perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations that may be deleterious in the long-term, emotionally, psychologically, behaviorally, spiritually, and socially" [12, *p. 695*]. Unlike traditional trauma exposure, whereby an individual is either directly or indirectly the victim of violence and/or witness to the results of that violence, service members are socially and politically authorized and/or ordered to create, inflict, and perpetrate that violence and destruction upon others [8]. Drescher et al [8] also indicates that most trauma research has been focused on the victimization resulting in PTSD, with little to no acknowledgment of the consequences of inflicting it. Maguen et al [14] found that killing was a significant predictor for PTSD in combat veterans.

Researchers [8,11,12,13] created an operational definition of MI in order to accommodate and ultimately properly treat unique aspects of MI in combat veterans. Evidence-based PTSD treatments, Drescher et al [8] argue, are based primarily on fear condition and extinction models that would appear to be less suitable for the treatment of veterans whose post-deployment issues are more highly influenced by moral and ethical conflict rather than fear. Litz et al [12] illuminates the divergent premises by indicating MI as primarily based on other affects and cognitions (i.e., shame). The training of military personnel promotes the understanding that there will be times when the suspension of an individual's ethical code and the commission of acts that would normally be illegal (e.g., killing) would be necessary in order to follow orders [8]. As of recent published studies [9,12,13], research has been confined mostly to surveys or the review and reference of trials where common MI themes are present. Other research [8] focused on semi-structured interviews healthcare and religious professionals with experience working with the military. No randomized-control trials examining MI were found in the search of the databases.

Flipse Vargas et al [9] utilized the National Vietnam Veterans' Readjustment Study (NVVRS) to qualitatively analyze more than 3,000 Vietnam Veteran participants' narratives of traumatic experiences and the psychosocial consequences of those experiences for themes and symptoms that point to/suggest MI (e.g., betrayal, disproportionate violence, incidents involving civilians, and incidents within ranks). Findings [4] suggested that exposure to an MI event was either particular to combat veterans or by noncombat veterans in response to a sense of failure in living up to their own moral codes and standards. Additionally, it was indicated that moral and ethical dilemmas/violations did not fit standard trauma models and can still be detrimental to combat veterans.

Litz et al [12] referenced a study [15] which reported that of the soldiers and Marines polled, 52 percent reported having fired or directed fire at enemy combatants.32 percent were directly responsible for the enemy's death. Increased ambiguity of combat due to unconventional facets (e.g., an enemy who is indistinguishable from or hidden within the civilian population, civilian threats) causes greater chance of negative repercussions for the service member.

In a field survey, researchers [12] found 27 percent of soldiers experienced situations where they were faced with a moral or ethical decision during deployment in which they did not know how to respond. Moreover, the increased number of deployments were shown to lead to compounded feelings of anger and frustration due to being continually exposed to these morally/ethically vague situations. This accumulation of emotions often translated into increased unethical behaviors [12].

Overall, researchers [8,9,12,13] have been working on a way to adequately define the influences of MI as seen in service members and veterans. There are continued debates focused on the naming of the construct, since the term "moral" is viewed as insufficient [8]. Litz et al [12] have thus updated the definition of MI as the "inability to justify or contextualize personal actions or the actions of others and the unsuccessful accommodation of these potentially morally challenging experiences into pre-existing moral schemas, resulting in concomitant emotional responses (e.g., shame and guilt) and dysfunctional behaviors" [12, *p. 705*].

Orientation/Treatment

Cognitive-behavioral therapy (CBT) incorporates techniques provided on a short-term treatment plan that are directive and problem focused, and includes psycho-education on PTSD [16]. The focus of CBT is cognitive restructuring, which is the reworking of the learned instinctive thinking process to a given stressor or situation, allowing for the individual to learn new ways of responding [17]. However, caution is given for interventions such as exposure therapy due to the risk of re-traumatization which increases the chance of ceasing therapy prematurely [18].

Psychodynamic interventions have been shown to provide significant success with long-term outcomes, especially with complex trauma [19]. Concentration is on addressing issues related to trauma and/or PTSD (e.g., developmental, interpersonal, or intrapersonal). Mindfulness builds an awareness of and specific focus on the attention of the present moment while learning a nonjudgmental

acceptance of one's ongoing thoughts, emotions, and/or sensations [20]. Greater awareness of the present-centered state helps clients to accept without judgment trauma-related triggers as well as stressful internal states, while also decreasing the PTSD avoidance symptoms, psychological arousal, and stress reactivity [20].

Litz et al [12] indicated that a more holistic, person-centered understanding of the therapeutic alliance is required when treating MI. The authors [12] indicated the development of a modified CBT program that utilizes some techniques (e.g., looking for multiple perspectives, increasing awareness of triggers) but incorporates present-moment emotion-focused event-processing and experiential strategies to address the inner conflict/dissonance. Additional foci include the unconditional acceptance and benevolent authority provided by the therapist and the examination and understanding of the implications of experience in regards to the self and other schemas [12].

Music Therapy

As the construct of MI is still in the early stages, a review of databases indicated that research into MI and music therapy has not been conducted. However, music therapy research into PTSD and trauma affords one the opportunity to understand the potential for music therapy treatment with MI. As Bensimon [21] described, music has the ability to create a sense of community, an interlocking experience that is not achievable with speaking. The ability to play and communicate simultaneously allows for communication while actively supporting one another through harmony, rhythm, and the blending of ideas. Music therapy approaches the traumatic memory through sensory stimulation, bypassing the logical and verbal approach to bring the memory to consciousness in order for the veterans to integrate them into their sense of self [21,28,29,30,31,32].

Trauma encompasses a variety of experiences that may cause great disruption to an individual's cognitive and social functioning as well as his or her sense of self [22]. Polyvagal theory asserts that an individual has more than one defense system (i.e., mobilized "fight/flight" or immobilized shutdown) that are connected to the nervous system which is constantly monitoring the environment for risk [24]. Activation of the defense system is unconscious. Furthermore, the neuroception of the auditory environment is often unconscious and may trigger a response without actual awareness [24].

Music has the ability to activate all limbic and paralimbic structures of the brain (i.e., emotional processing) promoting neuroplasticity [25]. Emotions that are evoked by trauma, such as fear, have the potential to isolate an individual and disconnect one from the wider society and one's own emotions. Music therapy provides a safe concrete and external transitional space to express and explore one's emotions and memories surrounding the events [26,27,28]. Music gives the traumatic experience a voice in both verbal and non-verbal realms [22,29]. In the case of clinical improvisation, the experience is in the moment and responsive combined with the ability to create simultaneously stability and ambiguity [29]. Amir [29] further describes improvisation as being able to contain and access features of psychological, emotional, and creative expression. Through the present moment of the musical experience, the individual is able to access and give voice to both the conscious and unconscious feelings/thoughts. This is due to music's ability to represent externalized phenomena beyond itself, in essence to give meaning to the expression both musically and non-musically. It provides an opportunity for the individual to redefine/find one's sense of self that may have been lost and reconnect with others [22,30]. Through the music, the individual can access the emotions and use multiple therapeutic interventions to process the aftermath of the traumatic experience.

Bensimon et al [21] researched the impact of drumming within the context of group music therapy for young male veterans. The study [21] found that group music therapy promoted the sense of unity, group cohesion, intimacy and other meaningful aspects of support and relationships, which is often in opposition to trauma and can lead to isolation. The study [21] also demonstrated the process by which music (more specifically, drumming) can offer a non-intimidating avenue to traumatic memories. Burt [33] described the action of controlling and modulating one's muscles when drumming as a metaphor for learning how to modulate one's emotions. The aim in the session was to take control of the instrument as the veterans wished to take control and responsibility of their own actions while providing a vehicle for expression.

Austin [22] utilized vocal improvisation and verbal processing in her work with adults traumatized as children. She spoke of trauma as a sense of "self-loss," [22, *pg. 22*] when the connection to the authentic self or the understanding of self is broken or damaged (e.g., ego-dystonia). The inner dissonance/conflict may splinter within the individual's sense of self but has the potential to be externalized through the transference/counter-transference of the therapeutic relationship [2]. Vocalization provides opportunity for sensory stimulation, which can have influence on pulmonary and cardiac functions through breathing techniques that can lower stress levels, and support the individual in reconnecting with one's inner emotional state [22,28]. Austin [22] developed a method of vocal holding techniques that utilize the voice of the client and therapist to provide a fluid structure that is a stable and safe transitional space. In the musical transitional space, the client has the opportunity to work through his or her memories while reconnecting with another individual. The purpose was to access those dissociated aspects of the individual's self and facilitate the integration of those parts.

Moral Injury and Music Therapy

The common thread between MI and music therapy's approach for trauma and PTSD is the focus on integrating and expressing the many facets of an individual's inner conflict [8,9,12,13,30,31]. In many cases, that inner conflict/dissonance is either unconscious or unable to be interpreted verbally [12,21]. Music provides a modified opportunity, in a non-intimidating and safe environment, to expose one's self to the traumatic experience [21,29,32]. Litz et al [12] developed a conceptual model of treating MI as a process that works to integrate the opposing aspects creating the internal dissonance. The authors [12] illustrate a model based on exposure to the traumatic experience while examining the debilitating beliefs, integrating the opposing views, self-forgiveness, conversation with a benevolent moral authority, reparation, and reconnecting.

The conceptual model [12] indicates the need for connection, a caring and genuine therapeutic relationship. Trust and unconditional acceptance are primary to the role of therapist due to the feelings shame and self-abhorrence that is often a part of MI as well as in traumatized individuals and individuals with PTSD. As stated earlier, it is essential for a person-centered and holistic approach is needed. Austin [20] speaks to the therapists' need to provide the stable musical structure and utilizing transference/counter-transference occurring within the music to provide the client with a supportive connection/relationship. Amir [29] states the role of the therapist is to support the client with empathy and compassion. Music therapy researchers [21,22,29,30,31,33], illustrates that music may function as a safe and secure versatile medium in which to explore one's inner conflict.

Amir [29] states that trauma lives in the unconscious, an aspect of the self that music may access where it can realize and re-image the traumatic experience [26]. Through the musical experience the client has the potential use creativity to transform and alter one's view of self and others- to redefine the narrative of the trauma and to help integrate the opposing elements of the self [21,26]. The versatility of improvisation allows music to serve as a vehicle to elicit emotions, images, memories, and conditions that are connected to his or her inner conflict/dissonance [29]. The strength of the intervention is that the expression of both the psychological and emotional states through music is done in the "here-and-now." Garrison [34] stated, "Of anything you take from this presentation, the most important is for the service members to be in the here and now. To be present." Being in the "here-and-now" is important for veterans when transitioning from combat to civilian life as they relearn what normal life is like [32,33]. Return to civilian life means having time to regret, look back, and ruminate on one's experiences. The veteran must work to no longer be hyper-aware of potential dangers and combatants, that there is time to take in the moment [13]. Music facilitates examination of the multiple characteristic of difficult emotions while remaining linked to the present and promoting connection to others [32,37]. Group music therapy interventions (e.g., improvisation, song recreation) were found to have facilitated expression, interpersonal connections, and awareness of support [21,34]. Nolan [37] identified improvisation's capacity to provide peak experiences, thus decreasing anxiety and influencing mood state [21,31,36]. The veteran may learn tolerance of difficult emotional and inner states, which helps to increase self-regulation and decrease hyper-arousal/hyper-vigilance symptoms [21,22,37,38].

The use of clinical improvisation techniques within the therapeutic relationship allows the music therapist to gain insight into the individual's internal and external organization, interpersonal processes and meaning-making in the musical realm [21]. To provide an example a veteran may choose to replicate the moral injurious event/experience by creating two opposing melodic voices/themes that represent each side of the dilemma (e.g., the voice of conscience vs. voice of authority/command) and then use the improvisation to integrate the voices. Depending on the structure (i.e. individual session or group session) the integration and development of the two voices could be done by the veteran alone or with the help of the therapist and/or group.

Conclusion

Integration of the traumatic experience and the inner dissonance is the goal for treatment of MI. The individual works to learn how to integrate all components of the emotional and psychological repercussions of the traumatic experience. The implementation of music therapy interventions help to bring veterans to the here-and-now but also provide a vehicle to express and explore their trauma and MI through a transitional space and in the case of a group, within the inter-subjective space. They can manipulate the music, change the narrative of their story, and create a new perspective through the musical domain. Through music, they have the ability to give a voice not only to their experience but to untangle, examine, and redefine the narrative in a way that may not be perfect, but is more acceptable to one's sense of his or her moral self [13,22].

MI is a complex issue that still needs to be explored more completely. As Johnson [26] addresses, the creative arts have a unique avenue in which to facilitate the healing of trauma. MI, at its core, is exposure to traumatic experience(s). In combat, our society requires our military service members to face the repercussion of both experiencing and inflicting trauma and violence. Increasing knowledge and awareness of this concept, for music therapists working with veterans, proposes a greater potential of how music therapy may be utilized in addressing and treating MI with our returning veterans.

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