

**Exploring the Emerging Themes of Moral Injury in War Veteran Populations and the
Healing Potential of Art Therapy**

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Abstract

In this capstone project I explore the emerging themes of Moral Injury (MI) in war veteran populations and the potential of art therapy to address these themes. I examine the perspectives on MI from clinical psychology, clerical traditions and traumatology and investigate why a clear definition of MI continues to elude researchers. Although MI is a veritable condition with deleterious effects on all aspects of bio-psycho-social-spiritual function in veteran populations, most clinicians are unfamiliar with it and MI is often classified as post-traumatic stress disorder (PTSD). Treatments for PTSD are ineffective for MI and often can worsen the suffering of the veteran. MI results from the disruption of moral schemas following atrocities of wartime experience with spiritual and existential themes being integral to the healing process – areas often overlooked in clinical practice. Art therapy integrates neuroscience and existentialism through non-verbal approaches and offers veterans an indirect yet powerful way to process MI related to wartime trauma. Research shows that art therapy has been clinically proven to increase function across all bio-psycho-social-spiritual domains in veteran populations. I conclude with recommendations ranging from policy changes, education initiatives and research to support art therapy for veterans. In this capstone I emphasize the urgent need to address MI in war veterans and highlight art therapy's potential to fill these gaps.

Keywords: Moral injury, veterans, art therapy, spirituality

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I wish to acknowledge my internship supervisor, Dr. Amanda de Guerre. As a result of her suggestion to research moral injury I have gained a depth of knowledge in a field previously entirely unknown to me. This knowledge proved extremely applicable in my internship work with veterans and, in addition, brought to my awareness the urgent need for treatments to address moral injury in veteran populations.

I wish to acknowledge the veterans whom I have worked with and met throughout the course of my internship, community and research. My heart goes out to you for your service, sacrifice and courage.

I thank my beloved family for their support and understanding as I put on my headphones, chewed packs of bubble gum and shut myself in my room to write.

To my dearest husband, thank you for your endless stream of positivity, your steady, grounding presence and your help with cars, chicken, dogs, and your listening, listening, listening.

Lastly, I am deeply appreciative of the creative spirit for the healing presence and flow state spaces that I could sink into and uncover a more complete awareness of me.

Dedication

This capstone research project is dedicated to the veterans of war suffering from moral injury. May you find hope and healing to rewrite your stories.

For the purposes of this study, the terms "psychologist," "therapist," and "counsellor" are used interchangeably to refer to professionals who provide therapeutic services aimed at supporting mental health and addressing emotional or psychological challenges. This includes those with various levels of formal training and licensure, such as psychologists with both master and doctoral degrees, counsellors, and therapists from different disciplines.

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“There’s pretty rules of engagement, and then there’s reality ...”

(Molendijk et al., 2022, p. 742)

Exploring the Emerging Themes of Moral Injury in War Veteran Populations and the Healing Potential of Art Therapy

Chapter One: Introduction

What is right and wrong in the context of war is unclear (Molendijk et al., 2022). Warriors are often exposed to overwhelming human suffering which can threaten their fundamental beliefs regarding humanity (Cohen & McClymond, 2024; Dokoupil, 2012; Grossman, 2009; Hodgson & Carey, 2017; Litz et al., 2009). Civilian codes of *thou shall not kill* are shattered by the sounds, sights and scents of gun fire, corpses and screams, replaced with the non-civilian morality of *kill or be killed*; these experiences permanently alter the psyche, soul, morality, faith, mind, emotions and behaviour of the warrior (Cohen & McClymond, 2024; Dokoupil, 2012; Grossman, 2009; Hodgson & Carey, 2017; Molendijk et al., 2022; Litz et al., 2009; Richardson et al., 2022). Military culture engenders a deep obedience to this new moral code and during deployment, military morals govern; killing is normal and witnessing violence is to be expected (Litz et al., 2009). In Canada, the Canadian Armed Forces (CAF) military ethos demands conformity to one's superior, mission before all else, deontological ethics before relational ethics and placing duty before emotion (Defence, 2022). Molendijk et al. (2022) emphasise that moral betrayal may stem from this conflict between one's personal ethics and duty ethics because in war there are no rules of engagement. Transgressions to the strict military ethos are bound to occur when guerilla warfare creates chaos, prompting service members to abandon their training and resort to primary survival responses rooted in fear and anger, leading to inappropriate acts of aggression to non-combatants and civilians (Drescher et al., 2011).

The re-entry to civilian morality is jarring. Service members return from war and are confronted with ambiguity, haunted by ghosts of consciousness, faced with disintegrating moral

compasses and dissociated from their self-perception of their humanity (Richardson et al., 2022). They are prone to experiencing intense anger, shame and grief (Cohen & McClymond, 2024; Dokoupil, 2012; Grossman, 2009; Hodgson & Carey, 2017; Litz et al., 2009; Richardson et al., 2022) which often results in an existential crisis of moral deterioration; the soldier no longer knows what is right and wrong (Abbott, 2020; Litz et al., 2009; Mims, 2022). The assault on morality, ethics and consciousness through military experiences, and the resulting effects on service members, is beginning to be called moral injury (MI). Figure 1 presents a veteran's artistic depiction of MI (Psychotherapy Networker, 2023).

Figure 1

Veteran's depiction of moral injury



What is Moral Injury

Clinical perspectives vary widely with regards to an official definition of MI (Abbott, 2020; Levi-Belz & Zerach, 2023; Litz et al., 2009; Litz et al., 2024; Mims, 2022; Richardson et al., 2022). Some argue that MI treatment necessitates spiritual perspectives (Cohen & McClymond, 2024; Drescher et al., 2011; Hodgson & Carey, 2017; Mims, 2022; Richardson et al., 2022) while clinical psychology researchers emphasize cognitive models (Borges et al., 2020; Litz et al., 2009; Litz et al., 2024; Richardson et al., 2022; Smith-MacDonald et al., 2023). The lack of a clear definition means there are limited treatment options to address MI (Levi-Belz & Zerach, 2023). This absence of definition risks confusing clinicians and those veterans who experience MI (Levi-Belz & Zerach, 2023).

MI creates an upheaval in one's existing moral compass; it attacks known dualities of right and wrong, fostering an existential crisis within the veteran and leading to dysfunction in all bio-psycho-social-spiritual domains (Abbott, 2020; Levi-Belz & Zerach, 2023; Litz et al., 2009; Mims, 2022; Richardson et al., 2022). Traditional verbal based therapies are poorly suited to address the non-binary nature of MI (Kelly, 2021; Ritchie, 2015; Levi-Belz & Zerach, 2023; Litz et al., 2016; Litz et al., 2024). However, creative psychotherapy approaches embrace contradiction and can aid in restructuring cognitive dissonance into a cohesive form, thereby allowing the client to make sense of their MI experience (Allen, 2005; Estrada Gonzalez et al., 2024; Malchiodi, 2014; Mims, 2022; Rogers et al., 2012; Schnitzer et al., 2021).

Chapter 1 provides my research question and approach, a detailed description of why this topic is critical for the discipline of counselling psychology, my positionality as a researcher and definitions of terms. In Chapter 2, the literature review, I examine the subtle facets of MI, the role of spirituality in treatment of MI, the liminal space of moral conflict, how art can weave

opposing realities and aid in meaning making, the role of arts in healing trauma and the impact of making art on veterans of war. In Chapter 3, I conclude this paper with insights into gaps and address recommendations for application of this research and changes to the practice and study of counselling psychology.

Purpose Statement

The purpose of this narrative capstone literature review is to explore the emerging themes on MI in veterans from clinical psychology, clerical and art therapy perspectives. A tentative working definition of MI at this time is the trauma resulting from a violation of a military service member's moral code as a result of wartime experiences. This definition is not to be confused with the detailed definition of terms outlined below. My main research question is two-fold: what are the emerging themes in the literature on MI in veteran populations and how can art therapy contribute to addressing these themes in the healing process?

Theoretical Model /Methodology

The goal of this research is to provide a comprehensive understanding of the role of arts in healing MI. When I first began researching MI it was an entirely new concept to me. My primary research is based on a narrative review, guided by intuitive inquiry. As I began to summarize and synthesize studies, my understanding of the topic deepened; I intuitively explored themes as they arose throughout my literature search. The literature on MI in general is vast, so it was imperative for me to draw boundaries in my preliminary searches. MI exists in first responders, medical professionals, veterans, teachers and civilian populations (Čartolovni et al., 2021). For the purpose of this literature review, I narrowed my focus to be solely on research in military populations and the effects of war trauma. At the start, I did not have a clear framework for inclusion/exclusion of studies. Throughout the research process it became evident

to me that analyzing a blend of qualitative, quantitative and mixed method studies would be most appropriate, and so as not to limit the broad overview of emergent themes on MI in veteran populations. This intuitive approach allowed for flexibility to guide my process and naturally uncovered existing gaps in the literature.

The direction of my research was non-linear. Through the application of an iterative process, I identified the debate surrounding the definition of MI, the integration of spiritual and philosophical approaches to healing, the want of treatment strategies, lack of education for clinicians and the discomfort of clinical psychologists when treating war perpetrated moral crisis in session. Throughout this process I maintained a focus on how arts-based approaches could contribute to addressing the challenge of MI in veteran populations. This hybrid model of narrative inquiry combined with intuitive insights provided a balance of structure and flexibility as I allowed my research to evolve organically. I knew I wanted to address art therapy, but the nature in which arts can address MI emerged throughout the study.

My philosophical framework is guided by pragmatism. This approach emerged intuitively through the process of research. As I learned of the gaps in knowledge and treatment surrounding MI in veteran populations, it became apparent to me how critical it was to contribute to practical solutions for veterans suffering from MI. My goal was not to construct a new theory, but rather, to explore and gather insights into how art can be applied in real-world contexts to support veterans suffering from MI.

Contribution to the Field

It is important to research and explore the experience, treatments and definitions of MI. Currently no best-practices exist for treating MI in veteran populations (Abbott, 2020; Cohen & McClymond, 2024; Drescher et al., 2011; Hodgson & Carey, 2017; Levi-Belz & Zerach, 2023;

Litz et al., 2009; Litz et al., 2024; Richardson et al., 2022; Shay, 2003). It is important to note that a consistent definition of MI is still being formed as society and researchers learn more about the phenomenology of MI. Post traumatic stress disorder (PTSD) symptoms may overlap with MI and clinicians are not trained to distinguish between them (Levi-Belz & Zerach, 2023). In addition, MI integrates spiritual themes whilst the majority of psychologists avoiding these topics in treatment (Cohen & McClymond, 2024; Drescher et al., 2011; Hathaway et al., 2004). Psychologists have an ethical duty to provide best practice; by learning about MI, its treatments and the integration of spiritually focused psychotherapy, counsellors are better prepared to fulfill the Canadian Psychological Association's (CPA's) ethical requirements (2017).

Due to the absence of definition, MI is often masked by a PTSD diagnosis (Levi-Belz & Zerach, 2023; Litz et al., 2009; Litz et al., 2016); however, traditional therapeutic approaches to treat PTSD are inappropriate to address MI (Litz et al., 2009; Litz et al., 2016) and in some cases they can cause greater suffering in the veteran (Levi-Belz & Zerach, 2023). Traditional understandings of PTSD offer limited awareness of guilt and shame with counsellors treating these feelings as forms of irrational thinking rather than an existential crisis of conscious (Molendijk et al., 2022). Existential crisis is connected to spiritual struggles in combat veterans experiencing MI (Cohen & McClymond, 2024; Drescher et al., 2011). Clinical psychology tends to discount and minimize the role of spirituality in counselling (Cohen & McClymond, 2024; Drescher et al., 2011; Hathaway et al., 2004; Hodgson & Carey, 2017; Pargament, 2007).

Spiritual Considerations

Hathaway et al. (2004) explain that clinicians regularly omit addressing spiritual domains of clients in initial intake sessions. According to the CPA (2017), Principle I directs psychologists to acknowledge the full life contexts of their clients, including religion and cultural contexts.

When psychologists neglect to address client's spiritual beliefs in session, the counsellor risks inadvertently inserting their own bias against spirituality into the dynamics with the client, non-verbally communicating that spiritual beliefs are irrelevant to the client's challenge and therefore unconnected to solutions. Moreover, Principle II (CPA, 2017) guides psychologist to work towards the maximum benefit and minimal harm to their clients. By drawing upon clients' spiritual frameworks, clinicians can offer internal and external supports to their clients and contribute to advancing the fulfillment of maximizing benefit.

Spiritually integrated psychotherapy approaches argue strongly for consideration of the inseparable intersections between counselling and spirituality (Pargament, 2007). The role of the spiritually integrated psychotherapist, as opposed to a pastoral counsellor, is to help the client be guided by their own truth, versus the belief system of an established religion (Pargament, 2007). Throughout my research into MI, I learned that the experience of MI integrates existential and spiritual themes, and hence training for new clinicians in spiritual domains is essential to address MI appropriately in therapeutic contexts.

Spirituality connects the entire human experience: mind, body, heart and soul (Paintner, 2007). Art therapy integrates spiritual themes as a foundational approach (Allen, 2005; Rogers et al., 2012; Rubin, 2016). Historically, the arts were used to address societal war trauma in Europe through the Dada art movement throughout WW1 (Richter, 1997). Rogers et al. (2012) express how the arts open new parts of the human experience to conscious knowledge, and Malchiodi (2012) adds that the arts integrate cognitive, emotional, intuitive and somatic awareness.

Ethical Considerations

As a neophyte clinician approaching the end of my graduate studies in counselling, I am concerned that there was no mention of MI in our program. If this material is not addressed in

school, clinicians may be unable to identify MI when it shows up in the counselling room and are ill-equipped to support the sufferer, potentially causing further injury through clinical ignorance (Litz et al., 2009). Ethically, it is our duty to provide care that maximizes benefit to our clients (CPA, 2017), but in the case of MI, unaware clinicians may often be doing more harm than good. The Canadian Code of Ethics for Psychologists (CPA, 2017) emphasizes the Respect and Dignity of Persons and Peoples, and moral rights form the basis of this first principle. When treating clients with MI therapists at times steer clear of the revulsions of war, preferring to remain on the established foundation of civilian morals (Litz et al., 2009). However, therapists must recognize that no matter what morally questionable atrocities the client may have witnessed or directed, the client is nonetheless worthy of respect and deserves fair and dignified counselling (CPA, 2017). A sophisticated understanding of MI is critical to fulfilling one's duty as an ethical counsellor. Hence, this research review contributes much needed knowledge to new students in the field of counselling psychology.

This review points out gaps in existing research literature regarding the connection between spirituality, MI and creativity, and provides evidence for how art therapy may be applied to address these gaps. Given these interconnections, the material conveyed in this literature review is highly applicable to the field of psychology in general and specifically contributes to the study of MI in veteran populations. This research is critical and has the potential to advance treatment options, thereby contributing to increased functionality, well-being, financial success, relationships stability, quality of life, occupational health, mental wellness and overall capacity building in military veteran populations suffering from MI.

Positionality Statement

I never imagined that I would study war. However, in my internship experience I worked with a veteran and my supervisor suggested I research MI. I was surprised at my fascination with the effects of war on soldiers, the types of weapons used, history of war, inoculation to killing procedures for soldiers, details of training, the distance to a kill and the leadership characteristics which inform the severity of emotional trauma endured by the warrior. In addition, the existential themes connected to healing from the trauma of wartime killing, atrocities and moral betrayals attracted my contemplative nature. I have always been deeply reflective and interested in spiritual themes and their impact on the advancement of human consciousness. As a young adult I became a member of the Baha'i Faith which channeled my natural inclination into practical awareness of spiritual frameworks present in the development of individuals and communities. Weaving existential approaches into the counselling room was a natural movement for me as I become interested in the soul wound of MI and how to heal it.

My Artistic Identity

My background as a lifelong artist, proficient professional artist, trained art therapist and experienced arts-based learning and mental wellness through arts facilitator inform my interest in exploring how art and creative approaches can help heal the wounds of MI. I am an intuitive artist, guided by the unseen realm in the creation of my work. Like many art therapists (Allen, 2015; Malchiodi, 2014; Rogers, 2016; Rubin, 2016) I view creativity as a powerful medium of healing and spiritual connection. Art makes manifest the unseen world, inspires new perspectives and integrates exiled parts (Malchiodi, 2014). Humanity is all a part of an interconnected union; when individuals engage their recovery capacities, they heal themselves and by extension their families, communities, societal systems, ancestors and descendants (Wolynn, 2016).

My personal arts practise aligns with the scientific research on the right brain's relationship to creativity (Malchiodi, 2014; Sagan, 2019). My life experience provides evidence that creativity can hold conflicting realities and oppositional concepts in the space of the abstract realm, uniting and transcending linear, simplistic and dualistic thought; art accesses concepts too vast to be expressed in words. Art takes a holistic approach to reality (Allen, 2005), and anything which approaches life holistically is spiritual (Sheldrake, 2012). Veterans experiencing MI are plagued with the burdens of their outdated ideas of right and wrong (Richardson et al., 2022). The union of creativity and spirituality and its application to the treatment of MI compelled me to explore this topic. I became interested in how questions of complex morality could be held within the space of the creative matrix.

My Cultural Identity

In addition to my positionality as an artist and spiritually minded individual, my social identities inform my research and treatment approaches to MI. As a White woman of Polish descent, second generation Canadian, empath, third culture kid (TCK) (Pollock et al., 2017) and former Israel inhabitant, there are some experiences which allow me to relate to veterans suffering from MI and others which limit me. My family history and my personal experience in war provide me a base of relationship to veterans, whereas my strong objection to war and lack of military experience are areas where I lack the ability to draw upon my lived experience. In addition, my experiences as a TCK have sculpted an open-mindedness and adaptability within me and allow me to find points of fast relationship building with others (Pollock et al., 2017).

Poland's history is fraught with wars, occupation, oppression, betrayal, liberation and resistance. My grandparents all experienced WWII and my paternal grandmother is a national Polish hero for her integral participation in the Warsaw Uprising. According to Wolynn (2016)

the visceral experiences of war live in my somatic system. I avoid WWII movies as they result in feelings of betrayal associated with the British disloyalty to Poland upon the German invasion. I also experienced war as a civilian. I lived in Israel for three years and my oldest daughter was born there. In 2006 when she was only six months old, the war with the Hezbollah broke out. We lived in the North and I was suddenly surrounded by air raid sirens, rocket attacks and sights of buildings crumbling due to these attacks. I was terrified. I returned to Canada and the experience left me with an indelible sense of empathy and deep respect for civilians who experience their countries at war. These aspects of my identity allow me to relate to veterans, however, there are many ways in which I cannot relate and draw instead upon my empathy, theoretical knowledge and counselling skills.

I have never served in the military, and I detest war and killing. I have never been in a physical fight or witnessed killing. I judge harshly the amounts of money we spend on defense and am vehemently opposed to killing as a solution to problems. I do not identify with the Warrior archetype, instead I draw upon the Sage energy of guidance and meaning making (Pearson, 1991). My skills are in intuition, perception, compassion and empathy, rather than protection, direction, action and physicality. In addition, most service members in Canada and the US are White males (Army DCS, G1, 2022; Coniconde, 2021). My lived experience as a White female allows me to understand some of the experience of power positions of Whiteness in society (DiAngelo, 2018); but also, as a female, second-generation Canadian, I do not understand the full context of male, White, Anglo-normative Canadian culture.

Definition of Terms

Art Therapy / Arts-based interventions / Creative Therapy: Art therapy is an experiential and systematized approach to the precise application of art media with the goals of affecting specific

brain regions, enhancing conscious awareness, at times inviting mysterious unconscious processes and new connections (Hinz, 2019). It aims to support treatment goals by achieving somatic, mental, behavioural, and emotional responses in the client to enhance increasing manifestations of health and function in all bio-psycho-social-spiritual domains (Allen, 2005; Hinz, 2019; Malchiodi, 2014; Rogers et al., 2012; Schnitzer et al., 2021).

Creativity: The capacity of human beings to use their faculties of imagination to produce new works for art, experiences and inventions (Allen, 2005; Hinz, 2019; Painter, 2007; Rubin, 2016). Creativity integrates emotional, cognitive, intuitive and spiritual faculties and defines the nature of humanity (Allen, 2005; Gates, 2017, McLean, 1994; Rogers et al., 2012). Further, creativity unites dual hemispheric brain function and has applications for treatment of trauma resulting from military experiences (Estrada Gonzalez et al., 2024; Jones et al., 2019; Malchiodi, 2014; Mims, 2022; Perryman et al., 2019; Rapport, 2009; Sagan, 2019; Schnitzer et al., 2021; Winter & Coles, 2021).

Moral Injury (MI): A deep soul wrenching trauma resulting from acts undertaken, witnessed or omitted during wartime experiences which shatters one's moral framework, creating dissonance within oneself and resulting in deleterious effects in all areas of bio-psycho-social-spiritual function (Abbott, 2020; Cohen & McClymond, 2024; Dokoupil, 2012; Grossman, 2009; Hodgson & Carey, 2017; Levi-Belz & Zerach, 2023; Litz et al., 2009; Litz et al., 2024; Mims, 2022; Richardson et al., 2022; Shay, 2003). For the purpose of this paper, moral injury distress (MID) is identified with the above definition.

Morals: A set of deeply held beliefs that govern an individual's attitude towards right and wrong, influencing their decision-making and behaviour. Morals can be dependent on culture,

personal values and religious upbringing. Morals are distinct from ethics, as they are personal, whereas ethics are a community set of practices (Harper, 2009).

Posttraumatic stress disorder (PTSD): Persistent and debilitating mental health disorder rooted in fear responses, which individuals may experience after exposure to a traumatic event, such as war, military combat, witnessing violence, sexual violence, natural disasters (Watkins et al., 2018).

Service members / Veterans / Soldiers / Warriors: A member of the military who has served in combat capacity, such as with the Canadian Armed Forces, and has been positioned in operational theatres, such as combat zones or other mission specific deployments (Grossman, 2019). Although the term military personnel includes persons of all genders, for the purpose of this literature review male pronouns are used to reference veterans for consistency and recognition that the majority of combat veterans in the US and Canada are male (Army DCS, G1, 2022; Coniconde, 2021).

Spiritually Integrated Psychotherapy: Any counselling approach which integrates a client's spiritual or religious context into treatment. This approach is not limited to specific religions or cultural backgrounds and allows for a holistic attitude to healing while recognizing the impact of spiritual beliefs on client well-being (Pargament, 2007).

Spirituality / Spiritual: Refers to anything that concerns the experience of wholeness and offers a pathway to a more authentic relationship with oneself, the sacred, physical reality, relationships, community and the cosmos. It often involves engagement with mystery and unseen forces (Sheldrake, 2012).

Trauma: A stressful event too overwhelming for the body's resources to contain, understand and process resulting in fragmented memories and sensations within the nervous system. Traumatic

experiences shatter one's sense of self and disrupt what one has previously held to be true (Tedeschi and Moore, 2020).

Chapter Two: Literature Review

In this chapter I provide a detailed account of the literature surrounding emerging themes of MI and the role of art in the treatment of MI. I begin with an overview of MI including elements of betrayal, spirituality, types of MI, a context of statistics and the effects of war on soldiers. Ethical, cultural, gender and religious considerations are examined. In the second section I evaluate treatments and assessments for MI and synthesize the supports, challenges, risk factors and protective factors when treating MI. This is followed by an overview of art therapy, including its foundational principles, the process of art therapy, the neurobiological mechanisms of art therapy and the connection between the therapist and client. In the last section I explore the effects of art therapy when applied with war veteran populations and conclude by assessing the impact of art therapy in treating MI and providing healing to this vulnerable population.

An Evolving Definition of Moral Injury

MI first appears in the extant literature approximately two decades ago (Cohen & McClymond, 2024; Hodgson & Carey, 2017; Shay, 2003), however, ancient Greek and Biblical texts provide accounts of Cain, Achilles, Euripides and others experiencing feelings of brokenness, shame and rage following acts of violence or witnessing violence. These examples demonstrate the long-standing nature of MI (Cohen & McClymond, 2024; Shay, 2003). Contemporary research suggests that although MI is not yet a diagnosis, it is a veritable condition experienced by veterans causing significant long term negative effects on service members' bio-psycho-social-spiritual dimensions of life (Abbott, 2020; Levi-Belz & Zerach, 2023; Litz et al., 2009; Mims, 2022; Richardson et al., 2022). Like the morals of war, MI remains ambiguous as it falls between the various disciplines of psychology, traumatology and

theology, and each branch of knowledge has a slightly different perspective (Levi-Belz & Zerach, 2023; Richardson et al., 2022). Those researching the domains of psychology tend to classify MI as resulting from an individual's own failure to perform moral actions, or witnessing others performing immoral actions and failing to prevent them (Cohen & McClymond, 2024; Litz et al., 2009; Richardson et al., 2022). Researchers from clerical traditions insist that spiritual wounding and heart-wrenching betrayal, which shatters the self, be added to the construct of MI (Andrews et al., 2023; Cohen & McClymond, 2024; Dokoupil, 2012; Hodgson & Carey, 2017). However, clinical psychology research is beginning to close the gap; Peris et al.'s (2024) research advances the discussion and knowledge surrounding betrayal-based MI.

For instance, Cohen and McClymond (2024) explain that MI can occur when an individual witnesses an immoral action or fails to prevent an immoral action from occurring, such as death, suffering or human cruelty and depravity. Mims (2022) adds that MI can result from: harming civilians and/or failing to prevent harm; causing harm through death or injury in battle; taking part in vengeful expressions of violence or witnessing these acts by others; betrayal by one's team or government; and learning about vengeful actions. However, Litz et al. (2009) propose the most widely accepted definition of MI, which centers around transgressions against one's own moral code or witnessing transgressions by others. This is known as perpetration-based MI, deemed insufficient by Peris et al. (2024), Richardson et al. (2022) and others. However, Litz et al. (2009) propose that perpetration-based MI leads to increased dysfunction when compared to witnessing brutalities by others.

Betrayal

Richardson et al. (2022)'s critique Litz et al. (2009) for being too broad in their conception of MI. In contrast, Richardson et al. (2022) identify four primary themes that are further subdivided: betrayal, moral ambivalence, soul wounds, and lack of reconciliation. Betrayal includes self-betrayal, betrayal from or unto others and systemic betrayal. Moral ambivalence includes questioning of purpose, shifts in worldview and moral ambiguities. Soul wounds include guilt, demoralization and isolation. Lack of reconciliation includes a sense of duty first and a shame-focus. The research shows that Litz et al.'s (2009) definition is lacking in face validity and reliability, and that the working definition of MI needs to be strengthened. In attempts to clarify the experience of MI, Richardson et al. (2022) propose extending the common concept of trauma existing in the present moment lodged in the *somatic* experience and nervous system of an individual, to comprise a trauma that is lodged in the *soul* of an individual. According to Richardson et al. (2022) and Hodgson and Carey (2017), Litz et al.'s (2009) definition omits the primary construct of betrayal which was the most prominent description from their study across participants. Betrayal is the category most often noted by veterans and is most often associated with higher rates of post-deployment suicide attempts (Mims, 2022). Peris et al. (2024) argue for more research delineating betrayal-based MI and perpetrator-based MI.

Spiritual Wounding

Hodgson and Carey (2017) agree with Richardson et al. (2022) and elaborate that many researchers fail to acknowledge that MI encompasses betrayal *and* spirituality rather than just acts which violate one's morals. They blame psychological researchers for insufficient comprehensive treatment approaches due to the lack of integration of spirituality into counselling theories and approaches. Molendijk et al. (2022) note that the US Marine Corp rejects the term

MI and prefers to use the term *inner* conflict. The researchers confirm that clinical psychology avoids morals and ethical quandaries in treatment and that existential and spiritual approaches are necessary.

Hodgson and Carey (2017) further support Richardson et al. (2022) in stating that MI is connected to an existential sorrow resulting from the dissection of one's morals through the devastating effects of war as a result of witnessing or perpetrating moral transgressions. The researchers boldly suggest that this omission is a *deliberate* attempt to protect clinical psychology from the necessity to consider spirituality. Levi-Belz and Zerach (2023) and Hodgson and Carey (2017) suggest that clinicians do not treat MI as there is a significant gap in knowledge, and because clinicians lack awareness of the spiritual elements and are unwilling to tolerate the distressing traumatic material of wartime experiences leading to MI.

Types of MI

There are two types of MI defined in the literature: MI-self and MI-other (Kelly, 2021; Litz et al., 2024). Broadly, the former corresponds to acts an individual perpetrates against his own morals, and the latter entails acts others commit against an individual's moral code (Kelly, 2021). An individual with MI can internalize the harm, seeing himself as immoral and broken, or he can externalize it and believe the world to be flawed and unjust (Litz et al., 2009). MI-self manifests in the emotion of shame, whereas MI-other manifests as betrayal and anger towards the injustice of the world (Kelly, 2021). Due to the global violation of trust, MI-other presents with more challenges to treat than treatment for MI-self because the client is experiencing a world of complete distrust (Litz et al., 2024).

Advancing Litz et al.'s (2009) research, Fleming (2022) differentiates between standard moral injury (S-MI) and complex moral injury (C-MI). The authors propose that S-MI involves a

moral understanding which remains intact following a morally injurious event, however C-MI originates from an absolute destruction of one's moral foundations, leading to existential anguish, loss of faith in the goodness of life and a disintegration of one's moral compass. Whereas S-MI results in shame, guilt, anger and disgust, C-MI creates a moral malfunction, ethical erasure, cynicism and persistent moral paradox manifested by non-culpable guilt, pervasive hopelessness, futility, absurdity and existential questioning (Fleming, 2022). Standard approaches to MI that facilitate moral repair are ineffective for treating C-MI and Fleming (2022) suggests that it is necessary to address existential and spiritual themes for reconstruction of meaning to occur.

Context of War

Research shows that killing, in itself, is morally injurious and is the worst trauma a person can endure (Grossman, 2009; Mims, 2022). Drescher et al. (2011) suggests a strong causation between perpetrating military sanctioned violence and vigilante violence towards non-combatants. There is a significant and positive correlation between higher rates of combat and deployment and violence towards non-combatants (Drescher et al., 2011). Almost 30 percent of soldiers experience confusing moral paradoxes which offer no simple response solution (Borges et al., 2020; Mental Health Advisory Team MHAT-V, 2008). In addition, Borges et al. (2020) and Molendijk et al. (2022) provide evidence that 11 percent of surveyed war veterans admitted to participating in activities which breached their own moral codes and 26 percent described witnessing the immoral actions of their fellow service members and experiencing feelings of betrayal as a result of war experiences. Over one third of military members with combat involvement acknowledge experiencing potentially morally injurious events (PMIEs) such as

killing a non-combatant, witnessing harm to a civilian by a service member or feeling betrayed by their commanding officers (Weiss et al., 2023).

Deaths by suicide continue to impact service members and their families (Richardson et al., 2022) with suicide rates doubling since 2004 (Dokoupil, 2012). Self-harm is positioned as the leading cause of death amongst US Army service members with an average estimate of three suicide attempts per minute, and more than one third of these attempts resulting in completed suicides (Dokoupil, 2012). Ames et al. (2019) provide evidence that MI is strongly positively associated with increased suicide risk amongst US V/ADM. Further studies are necessary to research applications for treatment of MI.

Interpersonal trauma and violence coincide with more than double the rates of PTSD when compared to trauma from natural disasters (Ritchie, 2015). PMIEs are positively correlated with exacerbated mental health conditions and suicidality (Mims, 2022). Killing while deployed predicts challenges with relationships, substance use and higher rates of PTSD (Ritchie, 2015) and is associated with moral dilemmas leading to increased suicidality (Ames et al., 2019). The order to take another life, or inflict injury on a fellow being, is associated with higher rates of PTSD. Wartime killing is the best predictor of chronic PTSD symptoms leading to issues with substance abuse, dissociation symptoms, functional impairment, attacks of rage and relationship problems (Litz et al., 2009).

The visceral experiences of war pose greater risk for lasting distress than does direct life threat (Litz et al., 2009). In a 2003 study of soldiers who served in Iraq or Afghanistan 52 percent of soldiers reported firing at the enemy, while 32 percent indicated they were directly responsible for the death of an enemy soldier. Of note, 65 percent of soldiers reported seeing human corpses or remains, with 31 percent having handled or uncovered them. Furthermore, 60 percent

witnessed ill or wounded women and children whom they were unable to assist (Litz et al., 2009). Evidence proves that for those who are not accustomed to it, exposure to human remains is a stable predictor for poorer long-term outcomes (Litz et al., 2009). These same service members are at risk for experiencing anguish and shame associated with these perpetrations, and their team members who witnessed these acts are at risk of experiencing anger and betrayal as a result of violations of trust and military procedure (Ames et al., 2019; Drescher et al., 2011).

Psychosocial Impacts of Moral Injury

MI leads to challenges with employment and intimate relationships, crushes assumptions of a safe, just and good world, impacts relationships with self, others and spirit and channels individuals into guilt, anger or shame (Mims, 2022; Ritchie, 2015). MI symptoms can be surmised with social problems such as withdrawal, sociopathy, legal problems, family estrangement and alienation, spiritual or existential struggles including spiritual conflict, depths of sorrow, existential crisis, apathy, and a feeling of being haunted presenting as depression, anxiety, anger, suicidality, addiction, re-enactment, loss of self-worth, occupational dysfunction and exacerbation of existing mental health concerns (Cohen & McClymond, 2024; Drescher et al., 2011; Levi-Belz & Zerach, 2023). In addition, MI predicts guilt and reexperiencing symptoms, negatively impacts mental and physical health, calls into question divine and spiritual authority, as well as raises questions about one's basic sense of goodness. MI also creates anxieties surrounding the re-emergence of aggressive behaviors exhibited during war and presents challenges with establishing a core sense of identity following deployment (Mims, 2022).

How to Assess and Treat Moral Injury

Despite a clear definition, clinical assessment tools for MI are being developed and researched. Preliminary studies provide validity for the Moral Injury Questionnaire -Military Version (MIQ-M), a 19-item self-reporting measure assessing causes and effects of PMIEs (Mims, 2022). The Moral Injury Symptoms Scale, Military Version (MISS-M) measures existential, faith, and religious challenges associated with MI symptoms over time, including shame, betrayal, moral concerns, loss of faith and hope, existential challenges, challenges with forgiveness, guilt, self-blame, and loss of trust (Mims, 2022). The MISS-M is reliable and valid and can be used to assess treatment outcomes for veterans. Lastly, the Expressions of Moral Injury Scale, Military Version (EMIS-M) detects the possibility of MI in military populations and encompasses MI-self and MI-other (Mims, 2022). The EMIS-M has strong convergent and divergent validity and is appropriate for clinicians to determine course of treatment dependent on which type of MI the client is experiencing (Mims, 2022).

Research shows that there are not enough evidence-based interventions for MI (Ritchie, 2015). However, promising approaches are currently being developed. Litz et al. (2024) provide evidence for adaptive disclosure (AD), Purcell et al. (2020) provide research into the impact on killing protocol and Borges et al.'s (2020) research on acceptance and commitment therapy shows positive results. To heal from MI the sufferer must reprocess the traumatic memory emotionally and psychologically, explore its significance and engage in life experiences which highlight the goodness in society, self and others (Litz et al., 2009). Fleming (2022) asserts that healing MI lies in the ability of the counsellor to embrace opposite truths. Spiritual and creative approaches are well suited in this regard by harnessing paradoxical logical absurdities as avenues for growth and healing (Allen, 2005).

Mims (2022) suggests that in treating MI the veteran may need to process self-hatred, remorse, and guilt. Notwithstanding limited studies in the field of MI, expressive therapies have a profound effect on enabling individuals to be aware of their feelings and particularly on helping them integrate their darker emotions (Rogers et al., 2012). The violations inherent in MI create an internal dissonance within the veteran where the personal perception of one's values is questioned (Litz et al., 2009). The degree to which one is able to reconcile this dissonance into a cohesive sense of self determines the extent to which one experiences negatively altered self-schemas of safety, trust, confidence, intimacy, independence and control, all of which impact quality and functions of daily life (Litz et al., 2009). Individuals who are unsuccessful at assimilating morally injurious events experience intrusion, shame, anxiety and avoidance, thereby creating a feedback loop and limiting their own ability to reintegrate parts of self (Litz et al., 2009).

Clinicians who wish to address MI in practice are often without resources because the concept of MI is not captured yet clinically. As a result, there exist few evidence-based treatment models for MI and current conceptualizations of trauma are not sufficient to address MI (Levi-Belz & Zerach, 2023; Litz et al., 2009; Litz et al., 2016). It is necessary to delineate between other trauma related disorders and MI to provide targeted strategies best suited to treat MI (Litz et al., 2009; Litz et al., 2016; Richardson et al., 2022). Richardson et al. (2022) and Levi-Belz and Zerach (2023) point out a gap in literature regarding a clear construct of MI, resulting in part from MI being masked by PTSD diagnoses. Those who suffer from MI are less likely than those experiencing PTSD to reach out for social supports and are more likely to be shamed for their actions, which only exacerbates the degree of suffering (Litz et al., 2009; Litz et al., 2016). Levi-Belz and Zerach (2023) add that in some cases a veteran suffering from MI would not meet

diagnostic criteria for PTSD, hence a clear clinical construct is imperative. They note that although there is overlap between PTSD and MI, the mechanisms and effects differ. Their study highlights the need for mental health professionals to be better equipped to assess MI in practice and for the development of evidence-based methods to treat MI.

Challenges and Supports in Treatments

The risk of reexperiencing MI through interacting with reminders of wartime causes veterans to distance and isolate themselves, thereby perpetuating the shame-spiral and increasing their suffering (Litz et al., 2009). Verbal interactions can cause damaging results. Andrews et al. (2023) provide evidence of decreased social skills after recalling traumatic war memories verbally. Veterans in this study experienced more activation in the right temporoparietal junction, the brain region responsible for empathic understanding (Andrews et al., 2023). For this reason, MI talk therapy groups, often based on PTSD approaches (Levi-Belz & Zerach, 2023), have higher rates of drop out. Veterans report feeling ashamed and embarrassed to share their combat stories and want to avoid reminders; veterans may go through several talk therapists before finding one they feel they can trust (Ritchie, 2015). Moreover, traditional talk therapy treatments, such as CBT and exposure therapy, are questioned because of their primarily verbal nature; trauma experiences disrupt verbal processing and there are often no words (Kelly, 2021; Levi-Belz & Zerach, 2023; Litz et al., 2016; Litz et al., 2024; Ritchie, 2015).

A non-judgmental approach full of positive regard by the therapist is necessary to support the process towards self-forgiveness (Mims, 2022; Litz et al., 2016; Tedeschi & Moore, 2020). Forgiveness must happen organically and intuitively, growing holistically from within the client as the client engages in atonement activities to integrate restorative justice (Kelly, 2021; Mims, 2022). Levi-Belz et al. (2022) and Tedeschi and Moore (2020) provide evidence that

interventions that promote self-disclosure have positive mental health effects and reduce suicidality in veterans suffering from MI. Finally, clients should be supported to reconnect with their families and communities and their pre/post war identities and lost parts of self (Mims, 2022). Risk factors for MI include higher neuroticism, shame proneness, negative attributional style and rumination whereas internal protective factors such as self-esteem, goal-orientation, personal agency and self-worth mediate the relationship between belief in a morally just world and the capacity for self-forgiveness (Ames et al., 2019; Litz et al., 2009). Richardson et al. (2022) add that protective factors against MI include spirituality. In contrast, Ames et al. (2019) note that religiosity does not moderate the relationship between suicidality and MI; however, veterans with strong religious moral codes prior to war experiences are susceptible to increased risk for MI.

Intersectional Considerations

Elbasheir et al. (2024) show that race related stress (RRS) exacerbates existing mental health considerations. This finding is further supported by Liu et al. (2023) who note that racial intersectionalities and systemic issues stemming from exposure to racism increase one's vulnerability to experiencing mental health challenges. In their study on RRS and MID amongst Black Americans, Elbasheir et al. (2024) found that RRS was significantly and positively correlated with rates of MID among male and female Black Americans. Furthermore, the correlation existed with cultural, individual and institutional forms of RRS. In addition, the authors note that socioeconomic status moderates the degree of MI and that White veterans experience lower rates of MI in response to the same stimuli when compared to their Black peers. Liu et al. (2023) show that socioeconomic and education status affect one's risk for mental illness, where lower socioeconomic status is associated with greater risk for mental illness.

When exploring treatment options for male veterans, it is important to consider that they are less likely than their female peers to access mental health supports. Additionally, most MI research has been conducted with male veterans (Silvestrini & Chen, 2023). Silvestrini and Chen (2023) show that male veterans avoid seeking help for mental health struggles and require greater supports to access treatment, in part due to military norms generating standards of help-seeking as unmasculine. Weiss et al. (2023) note that MI has mostly been studied in male populations and focus on the experiences of female service members. They note that female service members experience higher rates of military sexual trauma which places them at higher risk of experiencing MI due to the combined effects of sexual trauma and experiences in combat. Future studies are necessary. Furthermore, Tedeschi and Moore (2020) write that culture impacts gender norms in response to help-seeking. The authors explain that for men in Japan, growing one's capacity to be compassionate is an indicator of success, whereas in the USA a man's level of accomplishment is measured by handling challenges independently.

MI affects individuals irrespective of religious background and leads to increased suicidality (Ames et al., 2019). Ames et al. (2019) examined over 500 veterans and active-duty military personnel (V/ADM) with religious beliefs encompassing Christianity, Buddhism, Hinduism, Judaism, Islam, no affiliations, agnostic and atheistic. Ames et al. (2019) found that MI was significantly associated with increased risk of suicide irrespective of participants' religious beliefs. Further, increased risk for suicide could not be explained by other factors such as PTSD, depression, demographics, military characteristics or religion. Shame was a strong predictor of suicide risk, a finding also supported by Litz et al. (2024). Ames et al. (2019) acknowledge the limitations of their study in terms of finding a causal link between MI and increased suicidality and note that further research is necessary to examine causation and to

develop treatments. In addition, the researchers note that they examined religiosity and not spirituality or faith. Future studies addressing these domains will reveal further aspects of MI. In addition to Ames et al.'s 2019 study, an earlier study found religiosity to be a moderating factor in suicide *attempts* amongst veterans (Lawrence et al., 2016); however, Lawrence et al. (2016) demonstrated no moderation with increased *risk* for suicide irrespective of religious background. Daniels et al. (2023) state that religiosity had no moderation on suicidality in the general population; however, they note that those with greater denial of divinity were at greater risk for suicidality.

Religiosity is significantly and positively correlated with an individual's ability to experience post traumatic growth (PTG) (Tedeschi & Moore, 2020). Although MI affects followers of every religion (Ames et al., 2019), a belief in Divine Law is a potent contributor to the resiliency a soldier may access to make sense of challenging moral experiences (Tedeschi & Moore, 2020). The Baha'i Faith, Islam, Judaism, Christianity and Buddhism provide a framework for understanding that difficult experiences are to be expected, cherished and applied to increase one's spiritual perception and capacities (Cohen, 2004; Tedeschi & Moore, 2020). Counsellors would do well to include clients' religious domains of function in their intake assessments as potent sources of support when treating trauma in general and MI specifically (Hathaway et al., 2004; Hodgson & Carey, 2017).

The Role of Spirituality in Treating Moral Injury

Openness to spirituality is positively correlated with better therapeutic outcomes in treating MI (Hodgson & Carey, 2017). Spiritual people are happier and less prone to addiction (Hathaway et al., 2004). Religion and spiritual functioning positively correlate with an individual's sense of purpose, meaning in life, positivity, healthy diet, resilience, balancing of

transitions to aging life stages and negatively correlate to substance use disorders. Clients' religious and spiritual dimensions are important aspects of a comprehensive assessment; however, the majority of psychologists do not address these domains in their case conceptualizations (Hathaway et al., 2004). Pargament (2007) asserts that spirituality is intimately linked to psychotherapy but in clinical surveys of psychologists, researchers find that when compared to the rest of the population, psychologists are less spiritual and have lower levels of life function in domains of spirituality and religion (Hathaway et al., 2004).

Fleming (2022) surmises the effects of MI include “intense guilt, shame, anger, remorse, spiritual conflict, demoralization, a loss of trust, hope, faith and meaning, as well as self-harming behaviors, difficulty forgiving oneself, social withdrawal, and an increased risk for suicide ideation and attempts” (p. 1027). These factors lead to existential and spiritual anguish. This link to spiritual themes causes MI to exceed existing constructs of mental illness and requires a deliberate cross-disciplinary approach (Molendijk et al., 2022). Historically, scant attention has been paid to spirituality throughout the discipline of psychology, but MI, encompassing a series of multiple nesting symptoms, lies at the cusp of these spheres (Cohen & McClymond, 2024; Richardson et al., 2022). Ideas of right and wrong, sin and forgiveness and divinity are beyond the scope of dominant psychological approaches (Hodgson & Carey, 2017). The authors suggest that the research surrounding MI may need to transcend traditional paradigms of the medical/psychological model if it is to adequately address deep constructs such as morality. In addition, Fleming (2022) stresses the need for spiritual approaches to address the defining features of MI such as loss of faith, meaning and hope.

Some clinical psychology researchers agree that MI treatments need to draw upon spiritual and moral themes (Litz et al., 2009; Mims, 2022). Litz et al.'s (2009) review provides

evidence that clinical psychologists are uncomfortable discussing moral ambiguity in session and most often prefer to focus on instances where warriors were exposed to life threat. This fear-based treatment model, which includes exposure therapy and cognitive trauma processing, offers limited attention to moral emotions such as shame and guilt, and thus the veteran suffering from MI is unlikely to be treated appropriately. At worst, treatments may lead to increased feelings of shame, guilt and isolation (Levi-Belz & Zerach, 2023; Litz et al., 2009). Litz and colleagues (2009) elaborate that some clinicians may avoid discussion of morals as they fear that treatment may condone the atrocities of war. The service member reads the clinician's discomfort as condemnation which further exacerbates the service member's despair (Litz et al., 2009). Mims (2020) adds that clinicians must become morally competent in supporting existential crises by adopting an attitude of non-judgement; anything less risks a further acceleration of maladaptive beliefs in the client.

Spiritually Integrated Counselling Methods

When providing counselling to clients experiencing MI, researchers invite therapists to consider drawing upon spiritual perspectives in counselling, thereby welcoming clients to integrate experiences and connections which transcend the self (Hodgson & Carey, 2017; Litz et al., 2009). They add that by integrating theological perspectives, MI can be understood and healed in a more holistic manner (Hodgson & Carey, 2017; Pargament, 2007). MI never goes away; it evolves with an individual's growth and self-knowledge. Moral philosophers can aid clients to be guided through healing after MI (Cohen & McClymond, 2024). Using this framework of moral philosophy, Drescher et al. (2011) integrate interventions such as spiritually integrated psychotherapy, forgiveness, community engagement and family support, expressing one's feelings, reframing, and rethinking and mentalizing from the victim's perspective.

Promoting the goal of spiritual integration, MI is often addressed through chaplains (Cohen & McClymond, 2024) while AD integrates elements of spirituality through loving kindness meditation (Litz et al., 2016). The integration of creative therapies addresses this integration as they support an individuals' own spiritual wisdom and meaning-making abilities (Allen, 2005; Rogers et al., 2012). Creative expression can shine a light on a truer nature of reality, on its interconnectedness, and can amplify awareness of subtle and spiritual relationships (Rubin, 2017). Creativity is a "truth telling [tool] for discovering what is out of alignment" (S. Sophia, personal communication, June 28, 2018). Connection to culture and groups can also transcend the self, and Litz et al. (2009) provide evidence that engaging with spiritually based communities can be effective to lighten feelings of shame and guilt associated with MI as well as cultivating an increased capacity and awareness of self-forgiveness and forgiveness of others.

Studies indicate that the ability to forgive oneself and others is closely connected to healing from trauma endured as a result of wartime experiences (Tedeschi & Moore, 2020). The spiritual concepts of forgiveness and self-compassion are an essential ingredient to healing from MI (Litz et al., 2024). Litz et al. (2009) assert that veterans who believe they are being punished for their wrongs experience worse mental health outcomes. According to Maté (2018) compassionate curiosity is an effective method to treat mental health struggles. Compassionate approaches to MI also include conversations with compassionate and forgiving moral authorities, and treatments for MI draw upon compassion to build capacity for forgiveness (Litz et al., 2024). Sometimes simply being with someone in an authentic and compassionate way can stimulate transformation (Yalom, 2002). Thich Nhat Hanh (2011), the renowned Buddhist teacher, explains that any therapy which increases love and compassion, creates lasting change in the individual and more peace in the world.

The Role of Creativity in Treating Moral Injury

Creativity is a divine right which fosters the way to healing (Bahá'í International Community [BIC], n.d.; Hinz, 2019; Paintner, 2007). Creative experiences amalgamate intelligence from both hemispheres of the brain (Hinz, 2019; Jung & Haier, 2013; Malchiodi, 2004; Malchiodi, 2014; Sagan, 2019), are inherently spiritual (BIC, n.d.), and draw upon the powers of our higher intelligence (Abdu'l-Baha, 1917). Anthropologists agree that creativity is what delineates the origins of what we know as human life, with the earliest signs of intentional artmaking found in the Blombos Caves in South Africa (Gates, 2017). Closely connected to creativity, the imaginative faculty is considered the greatest divine gift (McLean, 1994), enabling new discoveries, serving as a powerful tool for self-knowledge and meaning making, and functioning as the central faculty of creativity (Painter, 2007). Thanks to the power of imagination, something new is created and brought into being in this world (McLean, 1994). Imagination not only facilitates new inventions, but it also serves as a midwife in birthing better versions of oneself.

Service members face devastating moral challenges in war and emerge from wartime experiences unable to contextualize or integrate their experiences into a congruent conception of self. The arts offer a space where contrasting realities can exist, forming a holistic expression of what it is to be human (Mims, 2022). Imagination is a powerful human capacity which can be used for healing as well as wounding (Grossman, 2009, Malchiodi, 2014; McLean, 1994). With this in mind, artistic interventions lend themselves easily to addressing the spiritual, psychological, emotional and mental wounding that occurs during MI (Allen, 2005; Jones et al., 2019; Malchiodi, 2014; Mims, 2022). PTG theory posits that the deepest wounding can also serve as the most valuable asset for the development of human consciousness, awareness and

self-empowerment (Rothschild, 2017). Therapists eager to treat those who suffer from MI must be willing to enter into the quagmire of competing moral matrices (Fleming, 2022) that threaten to tear the veteran apart worse than anything he experienced in combat (Abbott, 2020).

Therapists must meet warriors in the liminal purgatory they inhabit (Fleming, 2022; Hodgson & Carey, 2017).

Liminality

Rumi writes, "Beyond ideas of wrongdoing and rightdoing there is a field, I'll meet you there" (Barks, 1995, p. 36). Rumi describes a liminal space where ideas transcend duality (Larson, 2014; Marzieh, 2024). Liminality is literally the threshold between spaces where boundaries and borders break down and contrasting possibilities take shape (Larson, 2014). Akin to dream states, liminality invites a myriad of seemingly incongruent concepts to be simultaneously and eternally true (Johnson, 1986). Art exists in liminal space and although meanings may be ascribed to it, art resides in the space beyond cognition, linear thinking and linguistic description (Allen, 2015; Johnson, 1986). Art needs no explanation, accepts no responsibility for its existence and demands no meaning, yet it invites exploration of non-dualism in both the creator and viewer (Allen, 2015; Rogers et al., 2012).

MI exists because the acts undertaken in war do not conform to ideas of right and wrong (Cohen & McClymond, 2024; Dokoupil, 2012; Grossman, 2009; Hodgson & Carey, 2017; Litz et al., 2009). To heal MI, one must step into this liminal space which Rumi describes and accept contradiction (Hodgson & Carey, 2017; Litz et al., 2016). Creative therapies are inherently liminal; they are positioned to offer a healing avenue for MI (Abbott, 2020; Fleming, 2022). Akin to a dream state, symbols and opposing realities coexist in the space of art (Hinz et al., 2022; Johnson, 1986). The arts access possibility, they allow participants to move between

dimensions of perception, they are stories told and retold, emotions and traumas assembled, disassembled and reassembled; intersecting and contradictory ideas emerge into a cohesive whole through the liminal and accepting space of the creative matrix (Jones et al., 2019; O'Connor & Fellow, n.d.).

Healing Through Liminality

Traditional therapeutic approaches are ill suited to treat MI as the left-brain cannot make sense of the contradictions inherent to MI. Taylor (2008) offers subjective experience providing evidence that the left-brain is the space of dualism, category and separation, whereas the right-brain embraces unity of contradiction, accepts ambiguity and absurdity and generates creative concepts. The arts are the doorway between our right and left hemispheres (Malchiodi, 2014; Mims, 2022; Sagan, 2019) and offer a space where opposing realities coexist (Schnitzer et al., 2021). Litz et al.'s (2024) research on AD suggests that creative approaches may also be particularly suited to MI, where the core sense of self has been destroyed and an individual attempts to re-create meaning in their life. Mims (2022) affirms that art therapy provides a space for contrasting impressions of traumatic memories and inner resiliency to be integrated into a cohesive creation, rebuilding an individual's sense of self and resulting in higher efficacy, self-confidence and promoting self-care and play.

Neuroscience research shows that creative approaches invite the play state, activating the parasympathetic nervous system's natural inclination for hope, healing and wellness, engendering attunement and safety in the therapeutic alliance (Haeyen et al. 2018; Hinz, 2019; Mims, 2022; Rogers et al., 2012). The military world exists in harsh contrast. It is the opposite of play; the military world upholds severe constructs of right and wrong where errors in judgement carry dangerous consequences such as death, mission failure, betrayal or injury (Defence, 2022;

Grossman, 2009). Yet, in the world of creativity mistakes do not exist; creativity only offers new possible directions for growth (Haeyen et al. 2018; Mims, 2022). This perspective offers hope and healing to those military service members who believe they are broken (Jones et al., 2019; Mims, 2022; Schnitzer et al., 2021).

Art and Art Therapy

Researchers such as Malchiodi (2014) and Hinz et al. (2022) have explored the effects of art therapy. They draw a distinction between artmaking and art therapy. Whereas any creative endeavor enhances well-being (Hinz, 2019; Rubin, 2016) art therapy is a formal, systematic and theoretical approach to the intentional use of specific art media to achieve somatic, emotional, and cognitive responses in the client. Art therapy thereby assists in a comprehensive actualization of the goals and needs of the treatment plan, and brings the client to further degrees of health (Hinz et al., 2022, Malchiodi, 2014; Rapport, 2009). Through their non-verbal approaches, creative therapies forge new neural pathways and emotional memories (Perryman et al., 2019; Sagan, 2019; Schnitzer et al., 2021). The creative expression allows paradoxical and dissociated unconscious elements and emotions to emerge, to be experienced and to be made explicit (Perryman et al., 2019; Schnitzer et al., 2021).

As far back as 1951, Cane suggested that art integrated body, emotion and thought allowing individuals to glimpse the fourth dimension of spirit (Hinz, 2019). In 1966, Naumburg proposed that art accessed unconscious wisdom that could only be expressed in images rather than words (Hinz, 2019). Rogers et al. (2012) explain that linking art modalities to explore singular themes offers deeper insights with each iteration. Allen (2005), Hinz (2019) and Perryman et al. (2019) remind therapists that images often hold truth, apparent only to the client themselves; individuals engaged in the arts communicate in their own perfect symbolic

languages that are highly subjective and tailored to the unique expression of the creator. Understanding the images clients create must be guided by their own inner wisdom.

Process of Art Therapy

Creative processes balance the left and right hemispheres of the brain, encourage innovative thinking and increase cognitive flexibility and perspective taking (Lusebrink, 2010; Rogers et al., 2012; Sagan, 2019). Movement, colour and sound act as catalysts to activate the sensory and visceral nature of the right hemisphere of the brain (Hinz, 2019; Lusebrink, 2010; Perryman et al., 2019; Sagan, 2019). For optimal learning to occur, information gleaned from diverse sources must be integrated. Creative therapies channel and integrate information from many pathways and thus stream-line growth (Hinz, 2019). Evidence shows that after engaging in creative interventions, individuals have access to new insights and possibilities; solutions to problems emerge spontaneously, fostering an integrated evolution of mind, body, and spirit towards growth (Rogers et al., 2012).

Hinz (2019) explains that creative work leads to flow state and has the same effects on brain wave patterns as mindfulness. When individuals are engaged in creative expression, they often enter a flow state: time and space become suspended, extended or amplified (Kagin & Lusebrink, 1978). A single art therapy intervention, such as painting, integrates, visual, sensory, auditory, cognitive, symbolic, perceptive and affective processes, uniting, body, mind, emotion and spirit in a holistic process of integration. Engaging in art therapy brings new information to the conscious mind of the individual, which can then be reframed through narrative and cognitive left brained processes (Hinz, 2019; Kagin & Lusebrink, 1978; Malchiodi, 2014; Sagan, 2019; Schore, 2009). Hinz (2019) provides evidence of EEG studies measuring the effects of art interventions on brain regions. This research shows that when compared to the control group, art

making increased memory, meditative states and reduced anxiety through impacting gamma and theta activity.

One art form can provide meaning to the next. As individuals move from one medium of expression to another, they gain deeper insights into themselves with each iteration and work with distinct hemispheres and brain regions depending on the medium chosen (Rogers et al., 2012 & Hinz, 2019). The skilled art therapist can guide clients to process trauma memories specific to brain stem, limbic or prefrontal cortex regions (Hinz et al., 2022; Lusebrink, 2010). Through the use of sensory and kinesthetic art mediums the client can experience soothing and release of tension and emotional processing. New understandings emerge from use of colour and fluid media combined with defined forms, and synthesizing the mental and symbolic interpretations of the art promotes cognitive awareness and higher brain function (Hinz, 2019). Each art forms stimulates new discoveries of meaning, accessing deeper states of self-knowing (Rogers et al., 2012). Individuals often experience a feeling of completion, wholeness, elation, and contentment upon viewing the product of their creative endeavors, which precludes the necessity of verbalizing their process because the artmaking itself is inherently meaningful (Allen, 2005; Kagin & Lusebrink, 1978). Due to the experiential nature of creative therapies, this feeling of elation can be captured and reintegrated into the body's core sense of self and be drawn upon as a resource in future times of difficulty (Kagin & Lusebrink, 1978).

Creative art therapies are especially powerful tools for accessing trauma and healing the brain to bring it into a greater state of wholeness (Lusebrink, 2010; Perryman et al., 2019, Sagan, 2019). The International Society for the Study of Trauma and Dissociation (2011) explains that with recent advances in neuroscience, psychology, biology, developmental theories, psychobiology, and psychodynamic knowledge, the treatment of trauma through expressive art

therapies is gaining increasing interest. Further, clinical research into creativity suggests that creative work enhances cognitive processes such as memory, emotional regulation, sustained attention, mental organization, planning and fluid reasoning (Hinz, 2019). This literature affirms the role of arts as vehicle to access right-brain, pre-verbal, non-verbal, traumatic memories of war (Mims, 2022). Hinz (2019) elaborates that the flow state generated through creative experiences significantly enhances one's ability to experience PTG.

Attuned Connection

When working with creative therapies, therapeutic rapport and unconditional positive regard are paramount. Arts bypasses the language centres and promotes relational, right-brain to right-brain attuned attachment processes between therapist and client (Malchiodi, 2014; Perryman & Moss, 2019; Rapport, 2009; Sagan, 2019; Schore, 2014; Winter & Coles, 2021). The degree to which there is a strong therapeutic relationship is the degree to which the emotional right hemisphere of the brain opens up and allows expression (Perryman et al., 2019). Schore (2009) adds that working with creative therapies is a conversation between two right brains. Research shows that attuned states of right-brain therapist-client dyads show synchronized brain and biomarker patterns (Tschacher & Meier, 2020; Schore, 2022). Art therapy allows the client the freedom to simply 'be' in the presence of the attuned therapist, thereby mimicking the experience of an infant being in the presence of an attuned mother (Malchiodi, 2014; Schore, 2022).

After a client has created art, the therapist helps the client to cognitively process their creation, consequently integrating the creative right-brain and the thinking left-brain and promoting trauma recovery (Malchiodi, 2014; Sagan, 2019; Schore, 2020). Creative processes engender new states of consciousness and shifts in perspectives and perceptions, enabling the

client to externalize their experience, witness it, and ultimately speak about it (Allen, 2005; Malchiodi, 2014; Rogers et al., 2012). Malchiodi (2014) explains that art expresses unknown realities and frees the thinking mind from making sense of the traumatic experiences.

Art, Neuroscience and Trauma

Trauma memories are stored nonverbally as sensory based information associated with the amygdala (Campbell et al., 2016; Mims, 2024; Perryman et al., 2019). They cannot be intentionally recalled but are instead evoked involuntarily through reminders of the trauma, making it difficult for individuals to retrieve and process traumatic material verbally (Baranowsky, 2023; Bowen et al., 2024; Sagan, 2019). Broca's area in the brain is responsible for the production of verbal language. When an individual experiences trauma this part of the brain disengages and the amygdala overtakes the primary processing; as a result specifics of the traumatic event are contained in bodily sensations (Mims, 2024). There are literally no words to describe the trauma due to this disengagement (Sagan, 2019). Schore (2022) asserts that most communication connections are rooted in a complex, evolving, dynamic flux of affect, too rapid for conscious assessment and verbal exchange. Creative therapies offer a nonverbal route to address these memories (Perryman et al., 2019; Schnitzer et al., 2021).

Perry (cited in Malchiodi, 2012) highlights how traditional talk therapies often fall short for trauma survivors because trauma primarily affects the parts of the brain that are non-verbal and sensory based. The left hemisphere is generally responsible for logical thought, categorizing, labelling organization and synchronizing thoughts into linear steps; whereas, the right hemisphere is where a significant amount of emotional, somatic and abstract information is processed, and where spiritual insights occur (Hinz, 2019; Malchiodi, 2014; Taylor, 2008). Traditional forms of verbal therapy work from the left-brain, the highly conceptualized, analytic,

language based, reasoning and detached part which insists on what it knows being the limits of knowledge (Malchiodi, 2014; Schore, 2022; Taylor, 2008). When therapists utilize cognitive forms of therapy, they engage with the information clients have direct conscious access to, working with what the client ‘knows they know’ (Perry, cited in Malchiodi, 2012). Nevertheless, the left-brain can easily be misled.

Magsamen and Ross (2023) provide evidence of a dissonance between biodata and cognition. Schore (2022) explains that each hemisphere of the brain holds divergent concepts of self. Experiential therapies such as somatic, mindfulness and expressive arts engage the right-brain, associated with non-verbal, pre-verbal, sensory, emotional, intuitive, unconscious, creative, holistic and fully present processes (Malchiodi, 2014, Sagan, 2019; Schore, 2022; Taylor, 2008). The right-brain recognizes no barriers and conceives of no limits (Taylor, 2008), offering a tremendously powerful portal to transformation and recreation (Schore, 2022). However, the right-brain does not process in language; it understands in abstraction (Taylor, 2008). Accessing this loadstone of unconscious truth requires non-verbal methods (Perry, 2012, as cited in Malchiodi, 2012; Sagan, 2019). When therapists invite clients to access their right-brain in psychotherapy, they encourage them to engage with what ‘they don’t know they know’ (Malchiodi, 2014; Sagan, 2019). This embodied intelligence is a profound source of wisdom in contrast to more common notions of the mind and verbal processing that are considered more knowledgeable (Hinz, 2019; Schore, 2009).

Neuroprocessing of Safety

Most counsellors still prefer to practice using more cognitive forms of therapy, although recent advances in neuroscience suggest that experiential therapies may be better suited for trauma work (Malchiodi, 2014; Perryman et al., 2019; Sagan, 2019). Trauma memories are non-

verbal; they are stored in the right hemisphere of the brain and several barriers exist to relaying somatic information to conscious awareness (Sagan, 2019). By the time information from the brainstem reaches the talkative left-brain, it has been digested and reprocessed three times: from the brainstem to the limbic system, limbic to right-brain, and right-brain to left-brain (Schoore, 2022). Many clients who dissociate experience words as a way to connect to false senses of self and disengage from nonverbal traumatic memories (Sagan, 2019). Verbal therapies for trauma can, at best, offer a third-degree copy of the client's experiences (Sagan, 2019; Schoore, 2022) and at worst increase clients' activation and trauma (Winter & Coles, 2021). The left hemisphere may struggle in attempts to process traumatic memories into logical and sequential thought, which may lead individuals to shut down emotionality, or act out in aggression. With the support of creative therapies, the right hemisphere can provide an alternate channel to process traumatic experiences that were not previously accessible (Perryman et al., 2019, Schoore, 2009). Alpha and beta waves associated with feelings of well-being, trust, connection and focus, are known to increase in the brain when making art (Perryman et al., 2019).

Safety and Art

Creative therapies access several streams of information processing simultaneously; this information is not readily accessible in traditional talk therapy (Perryman et al., 2019; Malchiodi, 2012). Veterans reported increased regulation, awareness of physiological reactions and improved self-esteem resulting in greater confidence to engage with social supports following art therapy interventions (Schnitzer et al., 2021). Tedeschi and Moore (2020) and Malchiodi (2014) explain that throughout eons of history, humans have evolved to use community, spirituality, touch, ritual, and art to generate safety, heal from traumas and experience PTG. Oehen and Gasser (2022) affirm that calming and pleasing sensory input cultivates an environment of trust

and care. The arts affect us in holistic ways that the conscious mind fails to understand and are integral to creating a neuroception of embodied safety (Magsamen & Ross, 2023).

Art therapy offers a compassionate place for wartime memories and potentially triggering symbols to be created and accepted in a titrating cycle of safety, exposure and integration (Baranowsky 2023; Mims, 2022). Veterans comment that the art therapy studio feels warm and inviting, a place full of creative energy and vibrant possibility (Mims, 2022). One combat veteran mused that artmaking offered a myriad of choices to participants, and that this simple approach already fostered an atmosphere of healing and wellness. Other group members reflected that the art therapy group was the safest group they had attended and offered a beacon of hope to their lives (Mims, 2022). When making art, individuals can access traumatic material stored as sensation and categorize it to promote safety, choice and healing (Malchiodi, 2014; Rapport, 2009; Sagan, 2019). Creative focused therapies often begin with a bottom-up approach, integrating the body and somatic sensations into cognitive awareness, and contributing to a sense of security in clients (Malchiodi, 2014; Tedeschi & Moore, 2020).

Therapists may sometimes struggle to keep clients within an ideal range of activation for trauma processing, but creative therapies provide a method to remain in an optimum range of tolerance for a longer period (Baranowsky, 2023; Perryman et al., 2019). Creative approaches provide a non-threatening invitation for self-discovery and the processing of deeply embedded traumatic material, helping to minimize the effects of trauma through corrective experiences, thereby enhancing clients' quality of life (Baranowsky, 2023; Perryman et al., 2019; Sagan, 2019). Art therapy provides a sense of mastery and control over the processing of the traumatic material; the individual can engage or disengage with the meaning-making to the extent that it is

safe. This is evident in service members who report experiencing more mastery and self-control in their lives following art therapy interventions (Schnitzer et al., 2021).

Art Therapy with Veterans

Veterans experience shame and shame is associated with lower well-being (Litz et al., 2024). Art therapy interventions foster a holistic sense of self and integrate aspects of self that are shamed, unacknowledged or exiled (Rogers et al., 2012; Schnitzer et al., 2021). Art therapy is well positioned to provide healing for MI as it supports veterans to express powerful emotions (including shame) that are often challenging to articulate using verbal language (Estrada Gonzalez et al., 2024). Traditional forms of therapy are shown to create feelings of judgement in the veteran suffering from MI, but through the use of arts, judgement may be lessened or removed as the artwork never judges the client (Allen, 2005; Estrada Gonzalez et al., 2024; Mims, 2022). Veterans note that creativity allows them to transform war stories into works of art, something inaccessible to them through talk therapies (Jones et al., 2019). Rogers et al. (2012) explain that a client can dance their rage or paint their guilt. This gentle approach aids clients to become more fully aware of feelings within them, bringing them into a more complete sense of spiritual and holistic self (Allen, 2005; Estrada Gonzalez et al., 2024; Malchiodi, 2012; Rogers et al., 2012). Creative therapies increase compassion, support access to independent thinking, foster hope, build resiliency, strengthen the innate positive traits within each individual and touch upon the spiritual; through engaging in creative processes, internal fortitude heals and radiates in concentric circles, healing the veteran, their families, and their communities (Mims, 2022; Rogers et al., 2012). As veterans become more interested in their internal worlds, the energy of their internal struggles are released and they become more interested in their external world and connected to others. Family members, community members and social supports act as protective

factors against mental illness, traumatic experiences, and MI (Drescher et al., 2011; Mims, 2022; Rogers et al., 2012).

Effectiveness of Art Therapy in PTSD Treatment

Recent studies emphasize the contribution of art therapy to veteran mental health, although sample sizes are limited in diversity and scope (Bowen et al., 2024; Campbell et al., 2016; Estrada Gonzalez et al., 2024; Spiegel et al., 2006). Furthermore, the quality of art therapy interventions can vary widely, hence research is difficult to validate and replicate (Bowen et al., 2024). Spiegel et al. (2006) provide evidence that art therapy was the only effective intervention in reducing PTSD symptoms; veterans can tolerate traumatic war content while engaged in artmaking but cannot during other therapy sessions. Campbell et al. (2016) suggest that art therapy treatment, combined with cognitive processing therapy (CPT) for veterans with PTSD, is more effective than only CPT. Spiegel et al. (2006) further assert that it is crucial for veterans to have freedom to self-direct with art materials as this creates conditions for safety and control during emotional processing. Moreover, veterans engaging in art therapy groups have a higher retention rate than those who engage in verbal therapies alone (Spiegel et al., 2006).

Participants in art therapy research gain efficacy, access an awareness of their own feelings and develop a more complete understanding of self (Schnitzer et al., 2021). Estrada Gonzalez et al.'s (2024) research advances this concept. The researchers conducted an eight-week arts-based intervention with veterans who were experiencing post-traumatic stress symptoms (PTSS). The participants created masks at the start and end of the eight weeks. The sequence of mask creation was withheld from evaluators. Evaluators who subsequently rated the masks identified stronger negative emotions in the masks created at the beginning of the intervention and stronger positive emotions, such as pleasure, in the masks created at the end of

the intervention. Estrada Gonzalez et al.'s (2024) suggest that art therapy with veterans experiencing PTSS is able to transform aggressive behavior, negative mood and distressing memories into more positive expressions. In studying art therapy treatment and CPT, Campbell et al.'s (2016) mixed methods study showed a 40 percent dropout rate from the CPT group, and participants expressed surprise at how much healing the art provided. Enhanced memory retrieval accessed through the art aided their trauma processing. Litz et al.'s (2024) research into AD supports and affirms that non-linear interventions convey deeper levels of expression than simply talking, advocating for the inclusion of imaginative conversations as part of interventions.

Social and Community Impact of Art Therapy

Soldiers often struggle with the civilian world's inability to understand wartime experiences. When civilians misunderstand their experiences, this has subsequent negative effects on veterans' emotional and mental health (Richardson et al., 2022). Estrada Gonzalez et al.'s (2024) show that veterans' art expression increased perspective taking for non-military populations. The masks created by veterans served as a vehicle for communicating the distress of the veterans and allowed viewers to connect to the experience of trauma and stress on a deeper level, fostering empathy where words alone fail (Estrada Gonzalez et al., 2024). O'Connor & Fellow (n.d.) show that MI is healed through the witnessing of artist expression. Increased isolation is strongly correlated with higher rates of distress, shame, guilt, depression and suicidality (Litz et al., 2024; Maté, 2018). If veterans can communicate their experiences to their communities more effectively, this can decrease isolation and increase social supports, thereby mitigating the traumatic effects of warzone experiences by fostering connection (Drescher et al.; 2011; Maté, 2018; O'Connor & Fellow, n.d.).

Art therapy is established as a frontline treatment for military personnel and veterans in the US, and Australia is positioned to direct major funding towards similar programs (Bowen et al., 2024). Bowen et al. (2024) suggest that art therapy interventions for military populations are valuable investments. Researchers provides evidence that art therapy provides a positive social return in treating post-traumatic stress in veterans (Bowen et al., 2024). Results indicate improvement in emotional, physical, relational, occupational, societal and psychological wellbeing, and reduction in mental health hospitalizations and risk-taking behaviours (Bowen et al., 2024). However, the sample size was small in the study. Bowen et al. (2024) propose that more research is needed with specific protocols and larger sample sizes.

Veterans use a myriad of materials when making art to make the invisible visible (Abbott, 2020). Art therapy offers veterans a pathway to transform and reintegrate traumatic material and warzone content into creative expression (Mims, 2022). In combat veterans experiencing PTSD, art therapy intervention has been shown to decrease nervous system activation, increase self-awareness, improve communication skills and emotional expression and increase resiliency to distressing memories (Mims, 2022). Art therapy allows veterans to reengage with their communities and decrease avoidance and seclusion; it allows a non-threatening method to heal and visit disturbing images in the safe context of a therapeutic presence (Mims, 2022). Drescher et al. (2011) strongly advocate for community engagement as a path to heal MI because community supports enhance the possibility of male veterans seeking therapy (Silvestrini & Chen, 2023).

Art Therapy and Moral Injury

Art therapist and artist, Pat Allen, founder of the *Open Studio Process*, focuses on the union of creativity, spirituality and healing (2005). MI is a spiritual wound and impacts the core identity of individuals, thus necessitating holistic remedies (Hodgson & Carey, 2017). Creating art in a consciously spiritual way allows space for awareness to develop and awareness is the first step to growth (Allen, 2015; Rogers et al., 2012). Creative therapies seem like a natural match to heal MI as creativity is a spiritual path and MI is a spiritual wound (Allen, 2015; BIC, n.d.; Hodgson & Carey, 2017; Winter & Coles, 2021).

Spiritual wounding entails a loss of hope (Richardson et al., 2022.) Hope is a crucial ingredient to heal soul wounds sustained as a result of MI (Jones et al., 2019). War veterans express how the creative process provides hope (Jones et al., 2019; Mims, 2022; Schnitzer et al., 2021). They note that art heals the soul wound of war trauma and transcends the limits of words (Jones et al., 2019; Mims, 2022). Veterans explain how rendering their feelings and somatic sensations into artistic expression followed by verbal expression allows them to better understand their inner experience and discover a renewed and positive perception of themselves (Schnitzer et al., 2021). The arts offer a non-judgemental method, independent of psychology or religion, to explore existential themes and integrate spiritual concepts of forgiveness, compassion, atonement, struggle and meaning-making (O'Connor & Fellow, n.d.). Whereas isolation increases despair, community and connection increases hope (Maté, 2018). Veterans can share their stories, be witnessed, and allow their inner worlds to be communicated through metaphor, symbol, texture and form, thereby allowing expression of complexities which are beyond the ability of words to convey (Fleming, 2022; Jones et al., 2019; O'Connor & Fellow, n.d.).

The arts present a healing space of reconnection with other people. Working alongside other individuals in a creative process, whether in group therapy or with an individual counsellor, enables safe expression in contrast to the despair and isolation which the soldier experiences internally. Art making invites physical, emotional, and social relationships (O'Connor & Fellow, n.d.). Society desperately needs treatments to support the healing of veterans suffering from MI (O'Connor & Fellow, n.d.). Talk therapies risk exposing soldiers to more suffering (Andrews et al., 2023; Levi-Belz & Zerach, 2023; Ritchie, 2015); however, expressive arts interventions offer a way to revisit traumatic material from a different angle and present a softer approach (O'Connor & Fellow, n.d.).

Conclusion

In this chapter I provided a comprehensive overview of the complexities of MI and the role of art therapy as a potential treatment, highlighting the gaps in existing research and the significance of this topic for further research. This review of MI provided a nuanced understanding of the challenges associated with defining and treating it. MI encompasses betrayal, soul wounding, moral disintegration, loss of hope and has devastating bio-psycho-social-spiritual impacts on war veterans. Traditional therapeutic treatments for MI are insufficient because they do not address the deeper existential themes necessary for healing.

This literature review provided evidence that art therapy is a well-suited intervention, offering non-verbal, titrated, safe, creative and holistic methods for treating MI. The research affirms art therapy's ability to increase well-being, emotional regulation, to development of social connection, decrease isolation, increase positive senses of self, integrate conflicting ideas and unite opposing concepts of right and wrong. The research regarding the inclusion of spiritual themes into art therapy emphasizes the unique role art therapy can play in treating MI. The final

chapter addresses implications for further study, discusses the application of this review in more detail, explores limitations and proposes recommendations. The results of this literature review emphasize the potential of creative therapies as methods to address the wounds of MI.

Chapter Three: Discussion and Applied Practices

Discussion

As outlined in Chapter 1, the purpose of this capstone research project was to examine the contemporary themes, treatments and perspectives on MI in war veteran populations and to consider how art therapy can contribute to addressing these themes in clinical counselling. In Chapter 2, I summarized current conceptions of MI, including challenges with defining it, the lack of established treatment protocols and the nesting domains contributing to the study and solutions of MI such as philosophy, theology, spirituality, traumatology and psychology. I also explored how spirituality is integral to a comprehensive understanding of MI and how art therapy approaches integrate spiritual perspectives. Lastly, I provided an overview of the efficacy of art therapy to address trauma, its impact on brain function and evidence supporting the role of art in healing trauma in war veterans. Chapter 2 concluded with a discussion of the practical implications of art therapy with veterans. In Chapter 3 I summarize the main discoveries from this literature review, critically examine the research on art therapy with war veteran populations and offer directions for future study and treatment models. As noted in Chapter 1, my main research question is two-fold: What are the emerging themes in the literature on MI in war veteran populations and how can art therapy contribute to addressing these themes in the healing process? I provide an answer to these questions and propose recommendations for future research and treatment of MI in veterans.

Emerging Themes of Moral Injury

MI exists in the liminal space between trauma, existentialism, spirituality and psychology (Levi-Belz & Zerach, 2023; Richardson et al., 2022). MI stems from a soldier's conflict and disorientation due to the competition between two equally powerful systems of ethics and

morality – civilian and martial (Fleming, 2022). It affects the core essence of an individual and creates chaos in the soldier's comprehension of his own moral compass which is no longer adequate to explain his experience in war (Fleming, 2022). Previously upheld civilian morals and codes of ethics are not applicable to wartime contexts and no amount of training can prepare the warrior for the irresolvable moral dilemmas of wartime decision making (Grossman, 2009). His morality is no longer dualistic but requires a refined update (Fleming, 2022). Soldiers report themes of being haunted, feeling inhuman and questioning the goodness in the world (Richardson et al., 2022). Fleming (2022) and Richardson et al. (2022) assert that spiritual approaches are necessary to reassess and recalibrate the soldier's moral compass.

Clinical psychology is poorly prepared to address spirituality in practice because clinicians avoid discussion of morals and prefer to rely on cognitive methods (Litz et al., 2009). Judgments associated with cognitive models of treatment may serve to exacerbate the suffering of the soldier experiencing MI (Mims, 2022). Furthermore, many clinicians fail to include the construct of betrayal which is integral to the soul wound that occurs in MI (Richardson et al., 2022). Therapists prefer to evade discussion of morally questionable behaviour in session due to personal discomfort with such topics and the atrocities of war (Litz et al., 2009). This undermines the purpose of psychotherapy which is to hold clients in empathic and positive regard (Mims, 2022). The therapist's role is not to provide judgement of the client, but rather to support the client to compose a new moral framework which integrates the experiences of betrayal-by-self and betrayal-by-other during war (Mims, 2022; Litz et al., 2016). Therapists integrating traditional PTSD therapies often challenge veterans' beliefs by attempting to contextualize wartime experiences and separate them from the civilian world. This practice is an attempt to help the veteran accept that his actions were justified (Peris et al., 2024). However,

this approach often serves to alienate the veteran further from therapy as it fails to address the deeper issue of goodness stemming from MI (Fleming, 2020; Peris et al., 2024).

Clinical counselling methods are beginning to address spiritual concepts such as forgiveness and compassion in the treatment of MI (Litz et al., 2024). Artistic elements such as active imagination and expressive writing are successfully being employed in evidence-based treatments for MI (Mims, 2022). Creative approaches are naturally positioned to hold contrasting views and offer invitations to consider these views holistically (Rogers et al., 2012). Expressive art therapies integrate multiple perspectives and provide veterans with a platform to explore meaning which facilitates PTG (Hinz, 2019).

PTG theory suggests that the shaping of new possibilities and spiritual meaning-making are necessary components to healing (Rothschild, 2017). Art therapy generates symbols of hope, renewal and fresh perspectives for veterans (Mims, 2022). Symbols of light, growth, renewal, pathways, seeds, transformation and rebirth are effective at reframing veterans' experiences as growth-generating beginnings rather than final destinations of pain (Fleming, 2022). One important reason why artistic interventions may be helpful is that they offer veterans safe vehicles to express themselves and support self-disclosure in veterans experiencing MI. These outcomes are shown to decrease suicidality and increase connection (Levi-Belz et al., 2022).

Contribution of Art Therapy for Treating Moral Injury

The use of arts to heal MI is not without precedent. In Europe, Dadaism emerged as a response to trauma following World War I (Richter, 1997). Dada artists utilized the liminal space of art to create competing images through collage, positioning their works as revolutionary acts against the absurdity of war. Through these artistic expressions, profound methods of healing were accessed, offering a form of meaning-making in the face of the senselessness of war. In this

way, Dada can be seen as a response to the absurdity of the war, using art as a tool to address MI personally and collectively (Richter, 1997). While Dadaism provided an early response to war through art, modern approaches are continuing to offer meaningful ways for veterans to use creative methods for healing.

Literature and research provide general support for utilizing creative arts in trauma work, and specifically with veterans. Veterans indicate that artmaking allows them to safely express their feelings, thoughts, memories, and experiences and is superior to any other therapy, medication or activity at providing healing and support (Abbott, 2020). Artmaking allows veterans to communicate their internal worlds, fears, emotions, hopes and dreams with family and community members, thereby increasing connection, quality of life, mental wellness and emotional regulation (Estrada Gonzalez et al., 2024). Veterans note that art does not judge them for being weak (Abbott, 2020). When considering the research regarding male veterans' avoidance of treatment for fear of being judged, this point is crucial (Silvestrini & Chen, 2023). Art making offers a pathway to healing for male veterans which can bypasses their shame regarding help-seeking behaviour (Estrada Gonzalez et al., 2024; Mims, 2022).

Limitations

There is a lack of empirical research regarding art therapy interventions and frequently the research is prone to small sample sizes and is not easily replicated (Tjasink et al., 2023). Slayton et al. (2010) note that art therapy research often includes art therapy interventions as adjuncts to other treatments, thus more studies isolating art therapy as a treatment approach are needed. However, art therapy has been widely researched with regards to PTSD treatments for veterans (Bowen et al., 2024; Estrada Gonzalez et al., 2024; Mims, 2022; Schnitzer et al., 2021). Art therapy interventions are effective for treatment of PTSD in cases where guilt and shame are

barriers to more traditional talk therapy approaches, as is the case with MI (Schnitzer et al., 2021). Nevertheless, as noted by Tjasink et al. (2023) and Estrada Gonzalez et al. (2024), these studies can be criticized for their small sample sizes and homogeneity.

Given the more recent construct of MI, there is less research surrounding evidence-based treatments for MI in general, and specifically focused on creative therapy approaches (Mims, 2022). However, researchers have found that creative approaches are successful in treating MI, including creative acts such as writing narratives and poetry, sharing stories, and groups creating masks of their internal and external selves, drama therapy, mandala work and open studio groups (Mims, 2022). Creating art work symbolically enables veterans' moral disorientation to be transformed into new moral frameworks (Abbott, 2020). Metaphor is commonly employed to facilitate meaning-making and draws upon the power of the imagination and visual imagery to blend conflicting experiences (Fleming, 2022). Creative therapies may be particularly suited to addressing moral emotions such as betrayal, guilt and shame (Schnitzer et al., 2021).

A further limitation of providing art therapy treatment is that therapists do not receive training in creative intervention in counselling psychology programs unless a student chooses to specialize in an art therapy stream. A review of counselling programs through their official websites indicates that creative therapy approaches are typically offered in specialised program content. Without training in expressive arts therapies, counsellors are not adequately prepared to offer arts interventions.

Recommendations

The results of this literature review show that art therapy interventions are a promising area for treating MI in war veteran populations. However, there is a lack of studies to assess this claim. My recommendation is that future researchers prioritize rigorous, large-scale empirical

studies to evaluate the effectiveness of art therapy practices, specifically for MI. Studies should include standardized measures and structured treatment protocols to increase their reliability and replicability. For instance, suicidality can be assessed. As more evidence-based studies on art therapy are published, more therapists can begin to utilize the models proposed through research and apply them when treating veteran clients experiencing MI.

The CPA Code of Ethics (2017) requires psychologists to be culturally aware. Art practices vary across cultures (Nand et al., 2014; Rubin, 2016). Any research into art therapy should also encompass diverse participants in terms of gender, culture, race and religious orientation. Art therapists should be informed about cultural attitudes, preferences, symbols and historical contexts of art expression and media to provide culturally competent care to their clients (Malchiodi, 2014).

Art therapy research shows its clinical effectiveness in treating trauma and PTSD, yet graduates from counselling programs are poorly informed of this fact. My recommendation is that graduate counselling programs integrate course work regarding creative therapy interventions, the neurobiology of arts interventions and the holistic treatment approaches they provide. From my own experience with art, one does not need to be a trained artist to provide art therapy. The Expressive Therapies Continuum (ETC) (Hinz, 2019) is a scientific, evidence-based, manualized and structured approach to using art materials which can be easily facilitated, replicated and taught. Despite strong historical and contemporary research into the expressive arts as powerful vehicles for healing, (Bowen et al., 2024; Campbell et al., 2019; Hinz, 2019; Jones et al., 2019; Lusebrink, 2010; Malchiodi, 2014; O'Connor & Fellow, n.d.; Perryman et al., 2019; Rogers et al., 2012; Sagan, 2019; Schnitzer et al., 2021; Spiegel et al., 2006), in my City University Master of Counselling program, I referenced the ETC (Hinz, 2019) regularly, and

found that some professionals in the field of counselling had no knowledge of it. Research is clear that somatic and creative therapies are more beneficial than cognitive methods to address trauma, yet this fact is repeatedly ignored by psychologists who profess adherence to evidence-based methods (Luscombe, 2024). If therapists are trained in art therapy interventions, they will be able to provide a higher value of care to clients and fulfill their ethical responsibilities (CPA, 2017).

Clinical psychology programs must also address spiritually integrated psychotherapy to prepare students to assess and treat MI. In this review, I focused on MI in war veteran populations, however, MI is apparent in many areas of human affairs, including, but not limited to those employed to do legal work, provide health care, and serve as first responders (Čartolovni et al., 2021). Therapists are potentially better equipped to provide ethical care (CPA, 2017) to their clients with the addition of spiritually integrated psychotherapy into their course work. In addition, these same graduate programs in psychology should provide education regarding MI.

A clear working definition of MI should be formed. To ensure a robust and multifaceted understanding, this process should include collaboration between psychologists, moral philosophers, theologians, traumatologists, military experts and veterans. The current lack of definition of MI prohibits treatments being more fully explored, thereby prolonging the suffering of veterans, their families and the communities to which they belong. Developing treatments for MI is paramount to address the correlations between suicidality and MI (Ames et al., 2019).

Insurance policies need to be restructured to integrate awareness of creative approaches to treating MI. Creative therapies should be recognized as evidence-based methods and covered under existing health insurance programs. Researchers, insurance providers, therapists and

government agencies should collaborate to develop formal policies indicating the types of expressive arts therapies to be included.

Rubin (2016) explains how the act of creating is healing. Veteran organizations should provide more opportunities for service members to engage with the arts, and they should provide education for all military personnel regarding the therapeutic use of arts to heal trauma from war. A review of available grants for combat veterans who wish to pursue creating art indicates that there are no grants available for individual veterans in Canada. Organizations serving veterans can apply for grants to provide arts related programming, however, the lack of individual grants is surprising and problematic.

Conclusion

This capstone research provides evidence of the gap in existing literature regarding a clear definition of MI and the effect of art therapy interventions to address MI in combat veteran populations. The review highlights the need for spiritual integration in MI treatments and the necessity for psychologists to receive training in recognizing MI. Further, this review emphasizes the obligation of clinical psychology to expand its scope of treatment and utilize more creative therapies in trauma treatments. The research provided several recommendations including policy changes, education initiatives and research to support art therapy for veterans experiencing MI as a result of wartime experiences. In addition, the literature showed that art therapy is an evidence-based treatment for PTSD in combat veteran populations, provides a safe and accessible space for expression, and is able to integrate complex and conflicting challenges into holistic perspectives. Veterans experience art interventions as helpful for emotional regulation, and more specifically to address moral emotions such as shame and guilt. Although PTSD is often treated with art therapy groups, the concept of MI is relatively new and undefined, hence creative groups

targeting the treatment of MI are not common. Art therapy interventions are uniquely suited to address the complex moral questions germane to MI.

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