Between Moral Injury and Moral Agency

Exploring Treatment for Men with Histories of Military Sexual Trauma

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Abstract

This Research Article deploys the frameworks of moral injury and moral agency to explore the experiences of veteran men who completed group therapy for military sexual trauma (MST). The article analyses ethnographically how veteran men with MST experience psychological growth via a replenishment of their sense of moral agency, thereby blending psychological theory about moral injury with anthropological theory about moral agency. It highlights how broader cultural experience can intersect and contribute to shame around MST, then depicts the ways that veterans recovered from a life characterised by pervasive shame, isolation, and compromised identity—psychological signs of moral injury—and made gains toward a life characterised by greater self-acceptance, an ability to tell one's own story, and intimacy with others—signs of moral agency. In so doing, the article highlights the social and moral dimensions that can constitute psychological injury, and the way that addressing these dimensions can promote moral agency and thus mental health recovery.

Keywords

Introduction

'I only want to have sex when I am high on coke or drunk', shared Donnie[1], a 71-year-old African American veteran man at the beginning of a group psychotherapy session. 'I need help coming to grip with what happened to me many, many years ago'. When he was in his twenties, Donnie was raped by a White military peer while serving in the US Navy. After decades of substance abuse, failed relationships, and emotionally avoidant sexual encounters, he was seeking treatment with hopes for a 'normal sex life'. Donnie described feeling strikingly isolated by his military sexual trauma, and thought he avoided people in his life as a result. He also felt that—given his age—his time to develop more fulfilling relations was limited: 'I have been very sick this past year and I feel the end may be near. I've got to deal with this'.

In this research article we, as a collective of psychologists and anthropologists, focus on men with histories of military sexual trauma (MST) to understand some of the social and moral dimensions of the shame and moral injury associated with these experiences. To shed light on this topic, we draw on ethnographic reflections on the clinical work of the first author, Jonathan Yahalom, a US Department of Veterans Affairs (VA) psychologist-anthropologist who has treated MST survivors for over four years. In addition, two leaders in the field co-author this article: Sheila Frankfurt, VA psychologist with expertise in the moral dimensions that underlie psychological trauma, and Alison Hamilton, VA psychological anthropologist and gender studies specialist.

In his work with veteran men, Yahalom et al. (2022) found that MST involves a great deal more than living with trauma. Men described the impact of MST as distinct to Post-Traumatic Stress Disorder (PTSD), for example, as suffering heightened feelings of shame. Such shame seemed to indicate victims' sense of moral rupture, marked by compromised identity, lack of belongingness, and entrenched intra- and interpersonal avoidance (see also Monteith et al. 2016; O'Brien et al. 2015). Drawing on theory from psychology and anthropology, the authors view these features of shame as *moral* insofar as these feelings are deeply relational, responding to military cultures and reflecting distress about their social standing and security in that cultural world. In so doing, this current article describes how MST-related distress is situated in a specific cultural orientation related to military life and how recovery can be achieved through providing a culturally relevant clinical response that moves a veteran from moral injury to agency.

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1   This name and other identifiers have been modified. All efforts have been made to protect the anonymity of veterans presented in this study.

The idea of 'moral injury', initially proposed by US psychologists and psychiatrists working with combat veterans, conceptualises the psychosocial suffering that may result from events in which one participates via acts of commission or omission, or from others' acts of betrayal, that '[…] transgress [the Veterans'] deeply held moral beliefs and expectations' (Litz et al. 2009, 295; see also: Shay 2014).[2] Moral injury is characterised by significant shame, guilt, and anger, as well as prototypical traumatic symptoms such as reexperiencing, numbing, and avoidance symptoms (Griffin et al., 2019) as well as disrupting core sense of relatedness and social connectedness, identity and self-perception, and moral thinking (Yeterian et al., 2019).

Although the novelty of the moral injury concept is that it provided a framework for describing a complex trauma syndrome in response to transgression, it also can be applied to describe the impact of moral victimisation: doing so foregrounds the distress that arises when moral expectations fail to be upheld by others, which can lead to victims' distrust and disconnect from self and others (Molendijk et al. 2022; Molendijk 2021; see also: Herman [1992] 2015). In this sense, MST may also be experienced as a transgression of institutional values of care and protection of service members, and of justice, both in the failure of military institutions to protect service members from assault and from organisational failures to prosecute perpetrators of MST (Frankfurt et al. 2019).

In conceptualising MST as an instance of moral transgression, the experience of overwhelming shame is foregrounded as a key affective response to trauma (see also Herman, 2011). Survivors exhibit shame regarding their victimisation and their sense of not upholding gendered, military norms about masculinity, as well as its possible intersection with other factors such as race. As we will come to describe, survivors of MST believe that 'real men' cannot get raped. This view informs much of the shame we will describe in this article and accounts for survivors' attempts to manage it, including their avoidance of relationships and manifestations of irritability. However, in general, psychological research on moral injury has not tracked individual differences in personally salient morals or people's 'local moral worlds' (see Kleinman 1999; MacLeish 2021; Mattingly 2014; Molendijk, Kramer, and Verwiej 2018). It thus risks overlooking the intersectional, culturally distinct factors that constitute shame, such as the particular factors that inform veteran men's experience of masculinity as well as the lived experience of identifying and being seen as culturally, ethnically, or racially different. Moreover, psychotherapeutic approaches to moral injury generally do not attend to how

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2   Moral injury is often contrasted with the definition of trauma in the DSM-5 Posttraumatic Stress Disorder Criteria (PTSD) (APA 2013, Criterion A) which attends to trauma in terms of threatened death, serious injury, or sexual transgression. However, some types of trauma (including sexual trauma) that would meet Criteria A of DSM-5, may also be injurious due to violations of implicit understandings of right and wrong behaviour.

morals shape a therapeutic exchange that is inherently interpersonal, which we will come to defend as critical to promote healing from shame in the case of MST. Thus, we propose that psychological research on MST can benefit from the theory and methods of anthropology.

Anthropological research on 'moral agency' defines it as the ability to recognise and pursue a good life through developing and sustaining intimate relationships (Blacksher 2002; Myers 2016, 2019). This line of research attends to the surrounding social circumstances that are necessary for agentive and social wellbeing— how a sense of trust, safety, and belonging in the world are premised on social exchange. It simultaneously attends to how the restoration of moral agency involves the ability to tell (and experience agency through the experimentation of telling) one's personal life story (Myers and Ziv 2016; see also Mattingly 2014). The anthropological framing of moral agency foregrounds how morals are socially constituted, and the way in which varying identity-based factors can be drawn upon to promote healing of shame in the context of men's MST.

In what follows, we deploy the frameworks of moral injury and moral agency to explore the experiences of 24 veteran men who completed a group therapy for MST over three months, attending treatment once a week. The group was facilitated by the first author, a White VA psychologist without first-hand personal military experience. The goal of this research is to blend psychological theory on moral injury with anthropological theory on moral agency in order to propose how group therapy helps veterans with MST experience psychological growth via a replenishment of their sense of moral agency. To do so, we explore how military culture can contribute to shame around MST, then depict the ways that veterans recovered from a life characterised by pervasive shame, isolation, and compromised identity—psychological signs of moral injury—and made gains toward a life characterised by greater self-acceptance, an ability to tell one's own story, and intimacy with others—signs of moral agency.

We thus make two sequential arguments. Firstly, as exemplified by the heightened shame, men experience MST within a continuum of moral experience, situated between the poles of moral injury and moral agency. By framing the veteran's MST in this way, we underpin the value of group therapy to support their sensitivity to the impact of moral transgression and recovery via social connection. In so doing, we call for an interdisciplinary approach to understanding trauma that blends the clinical and the ethnographic method, as well as the psychological and anthropological theory. Secondly, insofar as moral injury is rooted in one's sense of right and wrong in a broader social world, this article suggests that healing from moral injury can occur through treatment that directly addresses social experience. We highlight the social and moral dimensions that can constitute psychological

injury, and the way that addressing these dimensions through therapeutic social exchange can promote moral agency and thus mental health recovery.

The clinic as field site

Group therapy offers intimate access to the experience of shame among men MST survivors. Group therapy is here understood as a type of ethnographic method, akin to conducting focus groups that elicit opinions within a social setting to explore the dynamics of meaning, experience, and understanding— including of trauma (Krueger 2009). Although perhaps underutilised, this clinical-ethnographic approach has precedent and facilitates the researcher's 'experiencing in a raw, direct way' the nuances and broader context of lived experience that all ethnographic inquiry seeks to disclose (Lester 2009, 286; see also: Farmer 2000; Garcia 2010; Havens 1976; Kleinman 1988; Schein 1987; Calabrese 2013). In this research, we integrated an analysis of responses from 24 veterans to questionnaires collected pre- and post-treatment. These questionnaires included queries on aspects such as symptoms, perceptions of treatment, and general concerns, with ethnographic insights gained from the first-author's four years of experience conducting men's MST groups (for description of the intervention, see Yahalom et al. 2022).

The first-author's experiences were documented through process notes, a form of notetaking meant solely for the treating clinician's reflection, and distinguished from progress notes, which are submitted in the patient medical record (DeLettre and Sobell 2010). Sustained participant observation—a hallmark of ethnography— was gained through delivery of and collaboration in therapy, and with the collection of personal notes and reflections about this experience, resulting in a culturally grounded understanding of psychological phenomena. As we shall illustrate, this approach provides an intimate, person-centred perspective on men's MST experience, meaning-making and social process by blending veterans' responses with ethnographic insight, which can serve as a model for clinician-ethnographers.

Whereas this article draws on the positionality of a clinician to inform insights as an ethnographer, and though these positions overlap in their shared aim to incorporate an understanding of the role of culture when conceptualising MST, each has a distinct objective. The ethnographer seeks to understand a phenomenon (e.g., the experience of MST and how that experience is culturally constituted); the clinician seeks to intervene upon the distress inherent to that experience (see also: Schein 1987). To the extent that therapy alters experience, it may be considered problematic from an ethnographic perspective if the clinician and researcher are one and the same. Yet there are many examples of activist ethnographers who promote intervention on the field under study (see Fine and

Weis 2002; De León 2015; Scheper-Hughes 1993) which points to a current reappraisal of this standpoint. In presenting data in this article, we attempt to acknowledge the distinction between the clinical and ethnographic while also making use of the unique access to data that clinical experience has afforded to help improve clinical support for veterans in the future.

Unless otherwise noted, all veteran quotations come from pre- and post-treatment questionnaires. The exceptions to this will either be clarified, or are presented in the form of a composite case study. Composite case presentations have been used as a narrative tactic by anthropologists who may present sensitive details on vulnerable populations and seek to maintain participant confidentiality (e.g., Luhrmann 2011; Reyes-Foster 2018; see also Gibbert et al. 2008). In this article, all data that inform the composite case study derive from actual clinical encounters and feature real statements which were combined and de-identified to maintain patient confidentiality while illustrating the overall therapeutic process.

These observations, we will argue, align with established literature on military cultural orientations to masculinity, sexuality, selfhood and race. Extending this literature, this article indicates the usefulness of an anthropological approach to understanding the way these implicit social norms and values can contribute to moral injury and shame (its syndrome and product) in the case of men's MST. Insofar as shame involves appraisal of how one is viewed in context to broader military culture, it signals an instance of a moral failure within a military setting—not within the veteran (although it will be experienced that way by them), but in a cultural world that promotes a specific understanding of morality and selfhood that has become compromised through MST victimisation. For these veterans, MST is experienced as morally wrong through multiple cultural vantage points, including: institutional betrayal, violations of gender and sexual norms, as well as racialised violence. Appreciating moral injury's relation to shame through anthropological theorising can inform therapeutic strategies to promote moral agency and, therefore, recovery.

'Men don't get raped': The moral injury experienced by men with MST

During an early session of treatment, one veteran contested the use of the word 'rape': 'Men can get sexually assaulted, or even victimized', he said, 'but men don't get raped. I can't use that word'. Most of his group peers were in agreement with him. In conducting multiple group cohorts, the first author observed that veterans not only avoided using words that were descriptive of their trauma, but became emotionally overwhelmed when such words were used by providers. Veterans' reactions varied, but often involved growing silent and still, or tearful and angry.

Some would get up from their chairs and pace. Others appeared to lose their capacity to answer questions. In consideration of how MST can be viewed as a morally injurious event (i.e., a transgression of morally sanctioned behaviour), veterans showed tremendous concern for how they would be judged by others and whether they would be subject to peer ridicule. The idea that they had been raped was deeply shameful for men and defied multiple cultural military norms. Thus, while most MST Group participants were traumatised by rape, they worked hard to conceal their shame.

In this vein, veterans were acutely aware of the impact MST had had on their capacity to hold relationships. Before treatment, one veteran noted, 'My family has noticed me [as] not the same loveable, happy go lucky person I used to be. I know I feel self-conscious, reserved, scared, ashamed. Why did this happen to me?' Notably, nearly all the men in this cohort were either single or divorced (see Table 1). Veterans often described their lives as socially broken due to their distrust of others and showed tremendous difficulty overcoming this when starting group therapy. Recruitment for therapy was a challenge, often involving multiple phone calls or in-person meetings to develop trust and willingness. Veterans initially needed to be reminded of group sessions through phone calls a day prior to scheduled sessions, citing forgetfulness, but later acknowledging fear of others' judgement as a primary reason for having initial difficulty engaging in treatment.

Age	
< 60	6 (25%)
> 60	18 (75 %)
Race/Ethnicity	
Asian	2 (8.33 %)
Black or African American	16 (66.67 %)
White/Caucasian	4 (16.67 %)
Hispanic/Latino	2 (8.33 %)
Marital status	
Single	14 (58.33 %)
Divorced	7 (29.17 %)
Married	3 (12.50 %)
Total	24

Table 1. Demographic characteristics of participants in the MST Group (n=24).

Veterans appeared to exhibit other symptoms that pointed to preoccupation with their shame. For example, veterans were noticeably alert and distressed when in the same room with other men: some perspired through clothing, others continually looked around the room for possible threats. For cohorts that met in-person, the seats closest to the door (that provided quickest access to exit) were the most

popular. Men were not only worried about revictimisation, but also preoccupied with whether they could trust others.

One veteran noted prior to beginning therapy, 'I'm always looking behind my back and am nervous around groups'. Another veteran said, 'I [suffer from] anxiety, sleeplessness, stress, [especially] in situations with males who are in a position of authority over me, and [I experience a general] lack of trust'. In such descriptions, it was clear that the veterans were aware their lives had been impacted by trauma, as they mentioned the presence of intrusive thoughts and haunting nightmares, attempts to avoid thoughts or situations that might evoke MST memories, noticed changes in how they thought about themselves and the safety of the world, as well as experiencing hyperarousal and discomfort with others. Although these symptoms may be central to the DSM-5 diagnostic criteria for PTSD, they also foreground *moral* concerns about revictimisation and social ridicule.

Hence, the above descriptions which describe 'typical' PTSD also point to the way in which distress caused by MST is primarily concerned about feelings of being morally 'wrong'—both regarding others and oneself. 'Wrongness', here was often indicated by overwhelming feelings of anger and resentment. One veteran said before beginning treatment: 'Prior to entering the military, I wasn't an aggressive and thoughtless man. After my experience, I became hostile towards authority figures and ended up doing decades in prison.' Another reflected, 'I experience anger and [I try] not being around people', suggesting that he often found himself getting into altercations.

These statements reveal veterans' significant distrust towards others and their loss of moral security. Veteran participants also noted how they tended to negatively judge themselves, another facet of perceiving themselves as morally wrong. One veteran said, 'I'm tired of living with all the [thoughts] that make me feel bad about myself'. Another shared, 'I feel depressed all the time. I hope I can find a way to just get back my self-confidence and be able to react to my wife in a better way. We're separated, and I can't find my confidence'. This preoccupation with feeling 'bad' illustrates the veterans' orientations to shame, moral standing among peers, and the inability to feel safe among the veterans' broader community.

Like Donnie, many veterans also described significant anxiety around coming to therapy, concerns that involved worries about privacy and confidentiality that seemed to stem from shame. Prior to beginning therapy, one veteran said, 'I'm nervous about someone knowing me', and another similarly stated, '[I'm concerned about] confidentiality [and] not telling others about my story'. These statements suggest survivors' broader effort that they not be seen or 'known' for having their trauma. They express distrust in others and self-consciousness about their MST history. Veterans also expressed shame and their efforts at self-concealment in

more explicit terms. One veteran observed, '[I've] never talked to anybody about this... [and I'm] worried about sharing it with others'. Another said, '[I'm concerned about] someone else knowing my business. I'm ashamed about this incident'. Veterans needed reassurance about confidentiality and showed entrenched doubt about whether others could be morally dependable. Veterans' shame, preoccupation with belongingness, and distrust of others reveal the profound moral injury sustained through MST victimisation.

The social context of MST for veterans: MST, shame and moral experience

Group therapy for MST revealed how most men experienced tremendous reluctance to engage with treatment primarily due to difficulty with social interactions. This highlighted the central role of shame among men MST survivors, and the important way shame is socially and morally constituted, as well as the impact moral injury-related shame has on veteran wellness.

For most men with a history of MST, gender-specific shame was a major component of distress. As anthropologists have long noted, shame is experienced on a personal level, but it is also culturally embedded, grounded within 'external sanctions of control' that are oriented toward one's broader standing in the social world (Benedict [1946] 2006). Shame involves awareness of the inadequacy or incongruence with a desired self-image, with how a given individual aspires (but fails) to be perceived by their surrounding community (Creighton 1990). Thus, shame is at once a personal and interpersonal phenomenon: insofar as it is premised on cultural norms, values, and orientations, it is steeped in cultural meaning, and experienced through social relationships. As such, our clinical experience and previous research suggests that shame is also both a product and symptom of moral injury (Frankfurt et al. 2019; Litz et al. 2009; Shay 2014).

For veteran men, shame about MST seemed to be driven by a military cultural assumption that instances of MST among men are rare or simply do not happen. Like Donnie, who waited decades to seek treatment due to pervasive shame, veteran men who were assaulted or raped by other men often hold beliefs that men do not (or cannot) get raped, that rape undermines masculinity, or that rape compromises one's sexual orientation (Turchik and Edwards 2012; see also Lees 1997). For veterans who were assaulted or raped by women (also typically military peers and superiors), other types of gender-based beliefs that 'a man can't be raped by a woman' appeared to contribute to shame, stigma, and confusion (O'Brien et al. 2015).

Despite growing recognition that underrepresented racial and ethnic groups can disproportionally be targeted through sexual harassment and sexual violence,

many Black, Indigenous, and people of color (BIPOC) veteran men seemed to hold broader beliefs that racialised violence directed toward men did not involve sexual violence (Barth et al. 2016; Bovin et al. 2019; Yahalom et al. 2022). Like Donnie, for BIPOC victims of MST, such beliefs appear to be internalised as an instance of racialised trauma and lead to profound isolation and shame. That is because some MST incidents were inflicted by White offenders toward victims of colour (Yahalom et al. 2022; see also Foster 2011). In these cases, subsequent experiences of racism then invoked distressing memories that compounded MST-related distress.

Other forms of social identity—such as gender, sexual orientation, religion, disability, socioeconomic status, and military rank—at times intersected with the experience of MST to exacerbate distress. Veterans thought that the reason they had been targeted had to do with forms of social identity that they were already ashamed of, compounding the problem.

For most survivors, and across socio-cultural identity, men's experience of shame was informed by military cultural norms concerning masculinity, military belongingness and self-sufficiency. Service members are trained to depend on the military institution for basic life survival: the military is often experienced as a 'second family', and military training encourages dependency, trust, and fraternity (Hall 2012). The military promotes a particular vision of selfhood premised on 'selfless service', fostering belief that personal wellbeing is subordinate to group-level success (Meyer 2015). Moreover, service members are trained to prepare for war by being 'a good machine' (MacLeish 2015), to be fortified against biological and psychological impairment (Bickford 2020), and to embrace psychological self-sufficiency (Wertsch 1991; see also Hall and Moore 2008). Perceptions about race and racism are similarly shaped within this context, where service members are encouraged to hold beliefs pertaining to meritocracy and 'colorblindness' (Hunt, Lim, and Williams 2022) which can, in turn, contribute to overlooking instances of racism.

Many men noted that the distress they experienced due to MST contrasted sharply with the gender norms promoted in this cultural military context. Men often noted that military culture was 'a test of manhood' that prioritised strength and the larger military unit (see Nash 2007). These gendered norms were at odds with the personal vulnerabilities and needs exposed by MST victimisation. Moreover, in the context of men viewing heterosexuality as a cultural military norm, and considering the fact that many of men's MST experiences involve same-sex assaults, men MST survivors recounted how making formal reports about MST incidents were difficult and contributed to further stigma (see Monteith et al. 2016). Men thus described their victimisation as an instance of failing to uphold cultural norms, leading to social disconnect and moral injury.

Joe's story

It can be instructive to reflect on a composite case study about an individual participant to contextualise the experience of therapy and veterans' recovery from moral injury and shame. The details of this story draw from many group participants, and all details are grounded in clinical encounters that have been significantly altered to protect individual confidentiality. 'Joe' was a 53-year-old African American veteran who initiated treatment with significant hesitation. When asked to introduce himself to peers at the beginning of the 12-week treatment, Joe said he was 'curious' to see what therapy could offer yet showed hesitancy to speak. For the first three weeks, Joe appeared to participate in mindfulness practices and was attentive, yet non-responsive, to what his peers said in group discussions. These discussions, largely focused on participants' acknowledging the impact of MST and their desire to improve quality of life, were intended to promote greater trust and participation among group peers and therapist.

Joe was asked about his experience each week, but it was only during the third week that he shared with the group the way in which for decades he had been profoundly isolated. Joe was 15-years sober from alcohol and crack cocaine, addictions he had developed upon discharge from military service. Yet, years prior, he had ceased attending twelve-step recovery groups for addiction and avoided speaking to his sponsor. He shared that people knew him as having problems with anger, and he had concluded it would be better to avoid interactions than to risk further manifestations of anger. He lived alone, and while he listened to other group participants talk about their partners, he disclosed that he never had a romantic relationship after the military. He also had no close friends.

After the first month of treatment, Joe heard another Black participant describe what transpired during his MST. Upon being invited to share his reaction and express compassion for this peer, Joe reflected that this was the first time he had heard a story so similar to his own. He said he wished he had been able to protect his peer to prevent what transpired. 'No one should have to go through that', he said to the peer, and added: 'You're not alone'. Yet Joe continued to describe feeling alone himself. He shared that he did not trust people. And while he was participating more in group discussions, each week when group members were asked whether they felt ready to share their MST event, Joe did not respond and looked away.

Toward the end of our MST group therapy, Joe indicated he was ready. 'Everyone else's shared their story', he said recounting the previous weeks, 'and so I think it's time that I share mine'. He said he had not disclosed his MST to anyone other than a doctor before. Joe shared that he grew up in a religious household, and that he was a star football athlete. He described what happened during his MST while

at basic training, as well as his feeling he was targeted due to his athleticism. 'They mocked me for being the fastest runner', he said, 'and they called me [racist names] while they said they were giving me "a lesson to remember"'.

He said he'd never felt more alone than immediately after the event: 'They said they'd kill me if I told anyone'. So, he kept silent, developed a dependency on alcohol, and subsequently was dishonourably discharged. He had wanted to make a career out of military, reflecting on his father's pride upon him enlisting, yet said he was robbed of that opportunity. He reflected on his having grown up with affection and dignity as a child, and the dissonance of being subject to rape and racism in the military. He said through choked words and tearfulness, 'I was on top of the world in high school football – how could this have happened to me?'

Upon completing his account of MST, the group leader acknowledged the painful juxtaposition between Joe's childhood and his military experience. Joe was appreciated for his courage to speak after having internalised for decades his perpetrator's demand that he remain silent. Joe had been confused between being situated in a worldview distinguished by safety and athleticism, and another that robbed him of those virtues.

Being able share that discrepancy among his peers helped Joe acknowledge and process the pain of his history. Group participants, in turn, said they heard their own stories echoed in Joe's experience: they understood his anger, and that they felt more connected to him than before. One participant said to Joe: 'You are a man for having the courage to share your story'. For the first time, Joe said he was able to acknowledge that beneath his anger there was a profound sense of vulnerability, loss, and pain. In so doing, he acknowledged his feeling separate from social life and pointed to the broader impact of moral injury—a loss of intimate relations and an underlying belief about being socially unaccepted. He had lost a sense of moral agency.

While he felt overwhelmed at having spoken, he reflected in the final week of therapy that he felt hopeful. 'I think I'm ready to go back to the [Alcoholics Anonymous] Program', he said, 'and I think I'm ready to tell my sponsor why I've avoided him for all these years'.

'I can say the word 'rape' without shame': Moral agency fostered through group therapy

Like Joe, over the course of treatment many group members appeared to make significant steps toward recovery by developing their sense of moral agency: they gained an ability to confront shame through recounting their MST history, to experience respect among peers, and participate in meaningful relationships

(Myers 2016; also see Blacksher 2002; Myers 2019). As the course of treatment progressed, the men appeared to walk through the hallway to sessions with greater levity, and many even acknowledged looking forward to group meetings. Group members were often overheard engaging others and clinic admin staff in conversation. After the group concluded, Yahalom had multiple encounters with veterans on campus who warmly greeted him and provided updates about life developments since ending treatment. Indeed, in contrast to the avoidance on display at the beginning of group, one man shared: 'I can say the word "rape" without shame'.

Many veterans needed support to disclose their MST event, and the first author often helped through asking guided questions to structure their thinking when they expressed distress. Participants reported relief in doing so, noting that they were able to engage in treatment, and even be more vocal with other providers about other aspects of their medical care. Veterans noted that, for the first time, they were able to address MST, despite how shameful and distressing the process was.

One veteran shared upon his completion of therapy, 'I have a better understanding on how to process what happened to me and tools to deal with my thought process on the event which happened to me'. Another Veteran echoed: 'I'm more able to face the stress of this problem. I'm [still] not ready to address the anger and shame, [but] I see a light at the end of the tunnel'. One observed, 'In some ways I feel stronger than before. Time will have to reveal just what it really is'. These statements illustrate the veterans' regained sense of moral agency: they demonstrate growth in being able to confront stressors and in feeling morally accepted among their peers.

Like Joe, other group members also had the experience of being recognised and affirmed by peers. One veteran noted the group was effective due to 'the bonding with other Vets who had suffered the same experience, [and] the openness of others about their problems.' Another veteran said he felt he had grown by, 'confronting this daemon, telling someone else I had this tragic, tragic experience happen to me. Also listening to the other guys in the group, that really gave me hope that maybe, with time, things might get better'. Another shared that, 'I will always have effects from what happened, I just don't feel so much alone, so I can deal with it'. These statements further illustrate a sense of belongingness and moral acceptance among peers.

To this last point, a shared racial identity also seemed to foster moral support for some veterans of colour. Often in tears, these veterans recounted how during their MST incidents they were called racial slurs and targeted because of their race. They reflected how subsequent microaggressions and more explicit racist acts experienced after military service created a further sense of vulnerability that was

linked to their understanding of why they were originally targeted by MST perpetrators. To this end, being in a group with other men of colour helped one veteran who said that knowing 'we were all African' helped him achieve a shared sense of understanding and healing.

Lastly, group participants also reported improvements in their ability to connect with and maintain meaningful relationships, an integral feature of moral agency. Like Joe, and in contrast to the avoidance and distress that marked initial stages of treatment, toward the end many Veterans noted a sense of solidarity and care. Many exchanged phone numbers to keep in touch in between sessions, and once treatment ended. 'The biggest surprise [of this group] was that some of the same things happened to others', one veteran said. Another veteran observed, with surprise, that he healed in treatment because 'we shared a lot in and out of group, and just listening [to each other] with compassion and kindness'.

For some veterans, these gains appeared to extend beyond the group to personal relationships with trusted others. One veteran noted how the positive experience he had with his peers gave him courage to speak with his family: 'I have come honest with my ex-wife and now she can understand why I sometimes act weird. I told my children I see a psychiatrist, now they know why I sometimes act weird or distrustful'. Another group member observed, '[I feel] open to try to be around others and participate in things'. Lastly, a veteran noted how his improved relationships with others paralleled his improved sense of peace within himself: 'I sleep better. No one is chasing me in my dreams. I can talk with other people now'.

Reflections on recovering moral agency from injury

In exploring the experience of treatment for men's MST, this article brings together theory (on moral dimensions of injury and agency), method (ethnographic-oriented reflections on group therapy), and culture (of veteran belongingness, masculinity, and ethno-racial experience). This approach allows for a reconceptualisation of trauma and the therapeutic process. In addition to intrapsychic symptoms of distress, trauma is viewed interpersonally, with consideration for moral appraisal. This helps account for the experience of shame and profound avoidance that marked many of the veteran lives presented in this article. In regards to treatment, beyond focusing on symptom reduction (relying on a deficits-based model of psychology that would focus on amelioration of injury), the approach adopted in this article facilitates appreciation of empowerment, resiliency and agency. This latter, strengths-based perspective understands that patients participate in a therapeutic process not merely for the purposes of reducing distress, but rather in pursuit of a more meaningful, pleasurable, and dignified life. The veterans' growing ability to take ownership of their personal history, experience respect among peers,

and participate in meaningful relationships are expressive of treatment that exceeds symptom-reduction and captures the larger cultivation of moral agency (Myers 2016; also see Blacksher 2002; Myers 2019).

Trauma survivors often initiate therapy with basic acknowledgment of their trauma, but face difficulty confronting its details, either privately to themselves or socially with others. As psychologists have long noted, being able to name traumas like sexual assault as 'rape' and confront associated feelings are important milestones in sexual trauma recovery—expressive of self-acceptance, distress tolerance, and self-compassion (Herman [1992] 2015). These gains serve to interrupt what Herman refers to as the 'dialectic of trauma': an interplay between the will to deny horrible events and the will to proclaim, in an emotionally dysregulated way, what transpired. Such a dialectic was observed among MST survivors' expressions of their avoidance of trauma and of their being haunted by intrusive memories and nightmares.

In this group therapy, veteran men with a history of MST recognised their sexual trauma in the company of peers who understood military culture in addition to experiences of racialised trauma as primarily African American veterans, and could therefore validate and understand their shame and lived experience. In so doing, they were able to confront the truth about what had happened with greater tolerance and compassion. Initiating each group cohort entailed difficulties in establishing trust and veteran confidence. While trust is often challenging for most survivors of sexual violence, it is likely that an African American veteran clinician, perhaps with a personal history of MST, could have been better situated to address provider mistrust. However, having a primarily minoritised group of men in the group allowed a space for the sharing of shame and racialised trauma that may have otherwise not been possible. This may have helped bypass cultural differences between patients and provider. Moreover, directly addressing cultural experience—about masculinity, veteran belongingness, and for many, the experience of being victimised through racialised violence—facilitated self-reflexive discussion about culture and shame among group participants and with the group therapist, and represented the veterans' growing ability to feel resilient in the context of cultural difference. In the process of engaging with treatment, the veterans appeared to move from a life characterised by shame and avoidance, toward one that was distinguished by greater social interaction and self-acceptance. The poles of this trajectory can be conceptualised through the notions of moral injury and moral agency, respectively, and help put into focus the underlying importance of social interaction more generally.

We propose, then, that moral injury and moral agency comprise a continuum of psychological functioning. Viewing men's experience of a history of MST as

situated within a continuum—that is to say, a spectrum of moral experience with poles defined by morally constituted distress and well-being—helps further conceptualise MST beyond a standard psychiatric taxonomy that emphasises individual, intrapsychic distress toward appreciation of the way distress occurs interpersonally, in context, and grounded in specific moral expectations and social experience. A moral continuum also helps revise and put into focus treatment goals, demonstrating the importance of moral restoration through social exchange. Findings of this study indicate that men survivors of MST can find treatment impactful not simply due to the alleviation of PTSD symptoms alone, but also for attending to broader facets of social and moral experience, that is to say, for their recovery of moral agency.

Through this interdisciplinary approach, we gain interpretive depth about the moral dimensions of MST-related distress. Moral injury (via psychological theorising) provides an approach to categorising and conceptualising the symptoms of traumatic distress and the moral factors of some traumas that have historically been overlooked in standardised, intrapersonal psychiatric definitions. Moral agency (via anthropological theorising) offers complementary focus through its attention to the co-constitutive nature of morals, as well as to how moral experience is affirmed through social interaction. Through the intersection of the two disciplines, we achieve appreciation not only of the underlying role of morals in the case of men's sexual trauma, but also the function of morals in sustaining social exchange and promoting psychotherapeutic healing.

Authorship statement

The first author Jonathan Yahalom is responsible for the conceptualisation and design of the study, for conducting the research and clinical therapy, for carrying out formal analysis, and for leading the writing of the publication. Sheila Frankfurt is responsible for formulations regarding moral injury, and Alison Hamilton is responsible for conceptualising treatment gains and their relevance to moral agency. All authors contributed to the manuscript and reviewed the final version.

Ethics statement

The VA Greater Los Angeles Institutional Review Board exempted this project (2020-000087) from review as part of standard clinical care. Names and other identifiers have been modified and all efforts have been made to protect the anonymity of veterans presented in this study.

Acknowledgements

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