Moral Injury and Harm: An Inevitable Human Experience of War

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Abstract

This qualitative Interpretive Phenomenology (IP) research study examines the first-hand experience of moral harm described by 299 military nurses and 67 Wounded Service Members (WSMs) deployed to Iraq and/or Afghanistan. Distinctions between Post Traumatic Stress Disorder (PTSD) and Moral Harm are delineated. Moral harm includes but goes beyond violation of one's moral norms and integrity, to include an ontological level of harm created by war's destruction of lives, human worlds, and environment. Moral harm is described and interpreted: 1) Examples of moral harm and its symptoms; 2) Unrecognized and stigmatized symptoms of moral harm; 3) Moral harm, caused by war's assault on embodied, interdependent social lives and world; 4) Extreme life saving measures and irreparable injuries; 5) Misallocation of resources and futile care; 6) Bearing Witness to War's Devastation on a War-Torn Society.

These six interconnected causes of moral harm provide direction for diminishing moral harm and preventing untenable modern wars. A call is made for more engagement with and responsibility for wars by leaders and citizens.

Keywords: moral harm, PTSD, Middle East wars, military

Introduction

In the beginning of this research, the investigators did not make clear distinctions between Post Traumatic Stress Disorders (PTSD) and moral harm. But it became clear in the interview data, that though often co-occurring, moral harm and PTSD were distinct in their origins, meaning, and responses. Moral harm, as described by military nurses and WSMs disrupts sense of moral integrity and radically alters one's pre-war identity and world. Moral harm goes beyond an extended response extreme danger, such as, the explosions, physical injuries, dangers, death of buddies, and emotional scars common in PTSD. Moral harm pertains to one's sense of integrity and self-understanding, as a result of guilt, shame, or remorse for what one did or observed, and a sense of one's complicity in the large-scale destructiveness of war itself. The interventions that create recovery and healing differ for PTSD and moral harm. Moral harm is much broader than PTSD and more intensely related to self-understanding and personal appraisals of one's complicity and responsibility in war. Moral harm alters one's ways of being in the world and prior taken-for-grantedness of one's self and world.

Human beings typically give an account of themselves, for actions, and ways of being in the world (Taylor, 1997; Dreyfus, 1991; Butler, 2005). Giving an account of oneself involves taking a stand on the kind of being or person one is and on what kind of life one is living. Giving an account of oneself occurs in the context of one's actions, particular history, meanings, and one's life. Moral harm responds to therapies that help articulate the sources of the moral harm and its accompanying meanings such as feelings of shame, guilt, and remorse.

Moral harm disrupts the ontological level of dwelling in the world (Dreyfus, 1991; Dreyfus, 2012). A Moral harm at the ontological level, results in an altered sense of self and world that changes what is noticed, what shows up as salient, and what is experienced first-hand because the taken-for-granted background meanings of the world are radically altered and change perception and perspectives. Moral harm includes assaults on strongly held moral beliefs, identity, and alterations in one's understanding of the world itself.

Collective, shared responsibility exists between leaders, citizens and WSMs for initiating and carrying out wars. Service members act as citizens, on behalf of all citizens. Junger (2016) notes that the current Middle East wars have not enlisted the involvement of U.S. citizens. Moon (2019, p. 1) notes that war remains "undeclared" in the longest war in U.S. history, with the lowest percentage of the population fighting this war than any previous war, 1 percent compared to 14 percent in World War II and 7 percent in Vietnam. These small percentages have required multiple deployments by most service members. The small percentages of the population involved in war and the current all-volunteer military force restricts the awareness of the war by the general citizenry and consequently, accountability by government and military leaders directing the war.

Military nurses and WSMs were interviewed about their experience of war and the distress and anxiety experienced both during and afterwards. Accounts of the horrors or "hell" of war and specific violations of moral norms and a diminished sense of personal integrity accompanied by ongoing anger, guilt, remorse, shame, insomnia, nightmares, and social isolation were identified in the interview data. War is incommensurable with ordinary civilian life, making conversations difficult, if not impossible with those who have not been to war (Sites, 2013). Typically, servicemembers preferred to talk with those who had experienced war:

Some of the guys are ready to talk about issues, mental health issues, mainly, some of the depression, some of the PTSD, whatever you want to label it, doesn't matter. Some of the guys aren't ready to talk and they'll just hold it in. Where do you find the balance? How do you reach out to those patients? The best therapy I got in the military, was with the guys [who had been in war], the best therapy that I have now is with the guys...I talked to a social worker once when I was still active duty, and, he annoyed me, so I never went back. (Wounded Service Member)

Jonathan Shay (1994) claims that moral injury is an inevitable wound from war. How could it be otherwise in modern warfare, where there are no clear front lines or safe zones, where children and civilians are injured and killed, and not readily separated from military personnel? Zachary Moon (2019) points out that the definition of moral harm is evolving. Wood defines moral harm in relation to the nature of modern wars:

> The old signposts of morally acceptable behavior, the laws of war, the Geneva Conventions, the just war doctrine, seem increasingly irrelevant in a world of drone killings, the beheading of hostages, and the deliberate massacre of schoolchildren by Islamist extremists. Traditional ideas about "victory" over these groups are obsolete, battered relics of a bygone age, given their ability to inspire disaffected youth and the wildfire spread of weapons and technology that has enabled them to armor their utter ruthlessness with the killing power once reserved for nations (Wood, 2016, p.12).

Many military nurses noted the urgent need for mental health and spiritual resources before, during and after war. Many military traditions, particularly Native American traditions, have rituals of entering battles, fighting, and returning to civilian life (Wood, 2016; Sherman, 2015; Moon, 2019). Such rituals acknowledge the altered realities of war, along with the altered demands of killing, and risking one's own life that require for preparation and dealing with the inevitable remorse caused by violence to others, the self, and society.

The U.S. Military currently offers pre and post-war screening with little or no education or treatment offered, encouraged, or requested. No war entry or exit rituals, and little or no acknowledgement of the personal and moral risks in war are offered prior to going to war. Wood, (2016) notes that though some classes, or even cohorts of troops are exposed to lectures on the theory of a just war (Sherman 2015), there is little anticipatory guidance or preparation for the conflicts and tragedies inevitable in war. Moon and others (2019; Litz, et. al. 2009; Meagher and Pryer, 2018) note that military mental health services and the chaplaincy owe service members entering and exiting rituals, along with guidance and support during and after deployment. As Litz, et. al. (2009) note:

> Many service members may mistakenly take the life of a civilian they believed to be an insurgent, be directly responsible for the death of enemy combatants, unexpectedly see dead

> bodies or human remains, or see ill/wounded women and children who they are unable to help. We are doing a disservice to our service members and veterans if we fail to conceptualize and address the lasting psychological, biological, spiritual, behavioral, and social impact of perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and moral expectations, that is, moral injury (Litz, et. al, 2009, p. 697).

Meagher and Pryer (2019, p.2) describe symptoms of Moral Injury as follows:

> ...Guilt, shame, a loss of trust (in yourself, others or God), feelings of powerlessness or hopelessness, depression, anxiety, anger, re-experience of the moral conflict, and self-destructive behaviors (suicidal ideation, substance abuse, high-risk behavior, the sabotaging of close relationships) (Meagher & Pryer, 2018, p.2).

"Moral Injury" is not a good candidate for specific diagnostic criteria that measures the extent and nature of moral harm, as have been developed for PTSD. Another reflective wounded service member in this study explains:

It frustrated me because, it wasn't until later that I was more open, and I was able to talk and kind of understood. Because there are a lot of things involved. You're getting out of the military, your stress with that. You lost the leg, you are not the same, you're stressed with that. Is it really that you're having problems with [those things], or is it your experiences seeing everything that people shouldn't have to ever see? I mean, it's tough, it's a combination of things. (Wounded Service Member)

Diagnostic criteria related brain alterations from PTSD have been focused on magnetic resonance imaging (MRI) findings (Benner, et. al, 2017). Ignoring the social, lived history that created PTSD by excessive focus on brain tracings impedes developing therapeutic interventions related to the social causation of the original injury (Benner et. al., 2017). Most likely, there are few "pure cases" of only PTSD or moral harm since they can co-occur and be inter-related within the same event. Even so, the two distinct kinds of injury should not be conflated. With or without the diagnosis of PTSD, few study participants escaped moral harm, generated by killing, witnessing death, witnessing and/or causing extreme wounds, seeing the injustices and atrocities of war, witnessing the devastation of the war on society and the threat to the sustainability of societies, and the environment, and the world itself. Precise delineation of moral infractions and physiological causes for moral harm will fail, because the social, moral, and ontological assaults in war are located in and vary with individual shared group experiences. Moral harm, while reflected in the physiological embodied experiences of anxiety, fear, vigilance, and in changes in brain functioning, are first and foremost lived personal and social experiences in specific war contexts (Benner, et. al., 2017) and must be treated at the social and personal levels. While moral harm cannot be exhaustively categorized nor generalized, since it is tied to specific instances and meanings of moral harm by the one harmed, this interpretive analysis uncovered several distinct kinds of moral harm related to commonly held moral concerns and strong shared experiences of war.

Methods

Interpretive Phenomenology (IP) guided the design and conduct of this study (Benner, 1984; 1994; Chan, et. al. 2010, Geertz, 1977; Benner et. al., 2017; Benner, et. al., in review, 2020). The team interviewed 299 military nurses and 67 WSMs. Military nurses' and WSMs'

experience of moral harm as a result of actual first-person narrative accounts of actual events in war were examined.

IP addresses ways of being in the world, ontological concerns and perceptual grasp that generate the conditions of possibility that allow meanings, events, and concerns to show up--to be noticed. IP is designed to examine more than explicit beliefs, norms, at the epistemological levels (issues and conditions of knowing) through uncovering taken-for-granted meanings, concerns, habits, and practices that shape one's self and world. This is why narrative accounts of first-person experience near events are used, rather than opinions, generalizations, or beliefs about experiences (Geertz, 1977). First-person experience-near narrative accounts (Geertz 1977) given in either small group (2-6 persons) or individual interviews provide data sources for this study. Where agreed to by participants and feasible, the team used small group interviews. Interviewees typically preferred to talk with those who had also been in war, because they shared understandings gained in war improved communication. Small groups created a communicative, conversational context with service members who had experienced war. Participants could listen, ask questions, and clarify issues and their war memories that would have been impossible for the uninitiated. The investigators sought to understand participants' immersion in specific situations and therefore asked for first person, experience-near accounts of embodied, embedded experiences of war (Geertz, 1977).

IP provides a critique of and an alternative to a representational (Cartesian) view of the mind. As Dreyfus and Taylor (2015) point out, Cartesianism posits that mental schema, concepts, ideas determine all perception. IP studies perception and learning from immersion in the real world by embodied, embedded, engaged persons (Dreyfus & Taylor, 2015; Dreyfus, 2012) rather than beliefs, concepts opinions and abstract ideas that might be held by those persons. Interpretation and descriptions of first person-experience-near narratives are the primary sources of data for IP (Geertz,1977; Benner, 1994).

Volunteer participants were recruited through posted fliers or information sessions at seven military medical treatment facilities (MTFs) and two Veterans Administration Medical Centers (VAMC) overseas and within the United States. Human Subject Institutional Review Board approval was obtained from all recruitment sites. Interested nurse and wounded service member volunteers were screened for the eligibility criteria of having been deployed to combat zones in the Iraq and Afghanistan Wars and being cognitively and physically able to participate in the study. Given the sensitivity of the topic, the institutional review board protocol required that one of the investigators accompany any interviewee directly to an appropriate mental health service should they become upset or anxious during the actual interview. This occurred twice, and both participants agreed to be accompanied to a mental health professional immediately. All participants were given printed referrals to mental health services in case they were needed later.

Two hundred ninety-nine military nurses who were deployed in the Middle Eastern wars signed written informed consent before participating in one-time small group (2-6 participants each) or individual interviews. Military nurses were asked to give first person narrative accounts of experiences both during their deployment and afterwards during assignments in Landstuhl, Germany or in U.S. MTFs or VAMCs interviewers asked the participants to avoid "opinions" or generalizations, so that the narrative accounts gave feelings, concerns, and actual experiences lived through by the participants. Interviews were recorded, transcribed

verbatim, and checked for accuracy. Names, ages, and particularities that would give away an interviewee's identity were changed.

Data were entered into the Atlas.ti Qualitative Analysis Software, Version 7, for retrieval and comparisons of topics and themes between research team members (2014). Two members of the research team experienced in IP read the military nurse transcripts and articulated 25 themes. All WSMs' transcripts were read and coded by the entire research team, and 38 themes were identified and coded. The findings from this study of moral harm are based on reading and interpreting all WSMs' complete transcripts and three of the original 25 themes for military nurses indexed as "PTSD;" "Anger" and "Moral, Ethical and Political Issues" by the first author and then all selected themes for military nurses and WSMs were read by both authors.

Findings

The following research themes were identified and interpreted: 1) Specific examples and symptoms of moral harm; 2) Stigmatization and denial of moral harm; 3) Moral harm caused by war's assault on embodied, interdependent social lives and world; 4) Extreme life saving measures and irreparable injuries; 5) Moral harm created by misallocation of resources, and futile care; and 6) Bearing Witness to the Devastation of a War-Torn Society. These moral harms have much in common with other wars but are writ large in the current Middle East wars.

Examples and Symptoms of Moral Harm

Moral harm is difficult for service members to voice and articulate, not just because of the stigmatization and lack of legitimacy for all psycho-social war related issues, but also because moral harm is caused by disruptions to hidden taken-for-granted meanings that constitute one's world itself, the taken-for-granted background habits, practices and meanings in one's world, in addition to violations to explicit beliefs and thoughts. What one signs on for and expects in war do not match up with war's inevitable losses and horrors. Service members cannot know, in advance, what aspects of deeply held taken for granted meanings about self and world will be violated. Violations of taken-for-granted meanings, such as the impact of taking another human being's life, a taken-for-granted expectation and necessity of war, are felt at visceral level, and not easily spoken about. In the following combat zone experience, the wounded service member had been thoroughly examined, including X-rays, but kept returning to the E.R. for unrelieved pain. As the attending military nurse relayed:

He ended up coming back to the ER, saying that his whole body hurt. And somebody finally sat him down and asked him what happened, and he said that he was going into a building, and an Iraqi came out with a gun, he shot him first, and he just could not get over that. And that's what was going on. But he didn't tell anybody that he was with because he didn't want to seem weak. (Wounded Service Member)

Deeply held meanings of direct killing of another human being are not easily described, nor the implications easily grasped at a personal level. The shared, taken-for-granted meaning that life is sacred covered over in preparation for war that makes the enemy despised and wholly "other." This service member was still trying to understand his first experience of killing another. His sense of trepidation and self-examination were felt more than thought. He did what he was

trained to do in war, what is necessary in war, without anticipating the emotional and moral impact of killing another human being. Meagher (2014, Loc. 219-224) and Litz, et. al. (2009) have described the moral impact of killing on one's sense of humanity and moral integrity. This example reveals an inchoate awareness of the human significance of killing another human being. Many service members noted that the impact of killing and experiencing other kinds of moral harm were not reflected upon until after leaving the battlefield, noting that war "leaves little time for thinking."

The following wounded service member describes distress and "survivor's guilt" caused by being assigned to "funeral detail." This example illustrates the co-occurrence and inter-relatedness of events causing PTSD and moral harm:

I was doing too many funeral details, and I just --brought back a lot of memories, and--tried to commit suicide, and--due to the PTSD, and I also had the survivor's guilt, and then I was sent for care at Military Health Care Center, and I got some care there. I was drinking a lot, and I got some alcohol care there, and I did well, moved on, and then it just came back. so, I was sent here with PTSD. (Wounded Service Member)

Survivor's guilt probably does not fully express the sorrow experienced over repeated losses and the distress of handling the bodies of so many slain fellow service members. The following nurse describes the toll of repeated exposure to death and the difficulty of caring for injured children:

The worst part about it, when I was in Iraq, the worst part about it was picking up bodies, when I had to assist with the Mortuary Affairs Department. And the babies, would be ranked second in my list of the bad, the worst things I dealt with over there. The children that had the shrapnel wounds and, you know, at that time, we didn't have any idea what to do with the children, once we gave them care, because their parents were either deceased from the bombings, or shrapnel wounds, or whatever. We had one particular baby, we called her baby girl, and she stayed with us on the ship for, I think, about four months. We didn't know what to do with her, they finally got ahold of, what would be social worker, equivalent in Iraq, I don't know, but that young baby stays with me. (Military Nurse)

Experiences or moral harm are often captured by "lingering memories" --memories that will not go away. In a study of PTSD (Benner, et. al., 2017), one of the participants who attempted suicide almost resulting in death, could not rid himself of the memory of a young boy, about the age of his son, throwing a grenade into the front vehicle of a military convoy, killing all occupants including a visiting officer. That officer had insisted on riding in the first vehicle against the pleas of the above officer in charge of the convoy. The service member who later attempted suicide had great remorse and guilt for not preventing the deaths of those in the first vehicle:

One of my biggest problems was that I pushed everybody away. I'm married with three kids, and--I mean, I pushed everybody away. And anyway, it got to the point to where I didn't do anything with my kids, because, when I saw my two sons, I was seeing that kid throwing that grenade [that killed the officer]. I'd say [to my sons]: "Go, get outta here, go play somewhere else!" And it tore up my marriage big-time, to where--my wife's not even here with me. (Wounded Service Member)

Being able to articulate the connection between the strong memory of the young boy throwing a grenade and the death of all those in the first vehicle, took time and counseling. Linking this powerful memory to his current anguish and separation with his sons was accompanied by healing and a reconnection with his sons. This powerful visual memory spreads out before him, altering his perception of the present, an example of breadth psychology rather than Freudian Depth Psychology based upon development issues (Benner, et. al., 2017; Dreyfus, & Wakefield, 1988):

> [With a traumatic experience,] Time and its passage does not carry away with it these impossible projects, it does not close up on traumatic experience; the subject remains open to the same impossible future, if not in his explicit thought, at any rate in his actual being. One present among all presents thus acquires an exceptional value; it displaces the others and deprives them of their value as authentic presents (Merleau-Ponty 2012, p. 66).

Altered sense of time is inevitable in the wake of the war. The past permeates the present. This is not surprising because the experience of time is always shaped by context. People do not experience time as a linear succession of moments (Benner, et. al, 2017). Because memories linger and alter perception, recounting them and gaining understanding of their impact on one's current perceptions and distress is therapeutic and healing. In moral harm, where taken-for-granted meanings are often hidden and less accessible, narrating memories to others is central for recovery and healing.

Another moral harm of the Middle East wars had to do with ambiguities of fighting alongside an Iraqi volunteer army who might have divided loyalties. A wounded service member describes his experience of hypervigilance, distrust, and unease due to the lack of loyalty of conscripted Iraqi soldiers:

The exposure to war, you know, seeing what I saw over there and then coming back over here. We were 50 or 100 yards away from Iraqi Army and 20percent of the Iraqi Army is sympathetic to the Insurgents. And if somebody looks at you strange, you don't know whether this person is going to attack you or not... And they're [Iraqi Army] under stress too, you know, and they're freaking out, they have PTSD as well. And the detention camps [where service member was located] are the front lines, because they get mortared all the time, they get rocketed almost every day... It's not great, but it is what it is. It's war... You don't know who to trust, whether your buddy next to you, is there for you, or whether anyone with the uniform on is there for you, but, if they're not wearing a uniform, you watch out. (Wounded Service Member)

Not knowing who to trust was a source of fear and anxiety that lingered with this service member after the war.

Medicalization of moral harm, and PTSD are prevalent in military health care (Benner, et. al, 2017). Medicating symptoms seems more expedient, even though medications are less effective without concomitant talk therapies that address the lived experiences of war. As another wounded service member commented:

My experience with the VA psychiatrists and psychologists that they're just quick to give meds . . . I just hate the meds, I don't like taking them, but if they are, I believe, if they are a good tool, use them. But a lot of people that I've seen and a lot of the experience I've had with the guys here,

sometimes when it comes to the mental health issues, zombies they'll just issue the meds and then they're not really working on the problems. They're not talking, they're not working and fixing that... (Wounded Service Member)

Another wounded service member with an interviewer describes his experience with taking multiple medications for mental health symptoms as follows:

Interviewer:

And has the treatment for that [mental health issues] been helpful, things working, or?

Wounded Service Member:

Not really. That's the main reason I'm getting out. I've had a ridiculous amount of treatment for it, it just never really took effect. I'm on medication for suppression of nightmares, mood stabilizers, all that fun stuff, but nothing really ever took hold. I haven't had more than four hours of sleep in the past two years. I'd say I ended up just staying here [rather than returning to war] because, my, I mean, my burns got better because that's natural, but my head really never straightened back out, so, I ended up staying here.

Interviewer:

Would you say that it's the same or it's improving?

Wounded Service Member:

I'd say it's the same.

One wounded service member described the military health care as an "apothecary system of giving medications for symptoms because it was quicker and easier." He too wanted a more "holistic approach" that included talking and working through wartime experiences.

Resorting to medications for symptom management as the major approach to treatment ignores the need to come to grips with the moral harm and radical alterations in sense of self and world caused by war. Use of medications for symptom management alone, may delay recovery and healing. An "apothecary" approach also reveals a system of covering over the social, lived, embodied histories that caused moral harm and its symptoms. Until mental health interventions, prior, during, and after war address moral harm, service members will continue to feel anger, shame, social isolation, and be at risk for substance abuse and suicide. Use of medicalized interventions without talk/and listening therapies will continue to contribute to silence and numbing.

As noted above, war experiences are incommensurable for the uninitiated. Many participants preferred to speak of their war experiences only with others who had experienced war:

I'm still a Marine, and I did my service as a Marine. I went out, I deployed, I've done things that most people, heck in the Navy, have never even seen. Navy people don't go to war, except for Corpsmen. The lieutenant commander, who's the case manager, never killed people, you know, she's never seen her friends laying there dying right beside them. (Wounded Service Member)

People who have been there, that's one thing. But I feel more comfortable with people in my job description, so to speak... Because those who have never been through it and could not relate, so I was not ready to talk to somebody who hadn't experienced war... One of my good friends that I met out there, infantry as well, [has] been through the same stuff, and it was just easier to relate because we can talk about it, and we know exactly what we are talking about. (Wounded Service Member)

Talking with other service members about war experiences revealed shared experiences and meanings impossible to access with civilians. Planning for conversations about shared experiences in the extremes of war offers healing, diminishing the social isolation caused by moral harm. Research has shown that social isolation and lack of communication are frequently associated with shame. Moon (2019) notes that:

> Shame is likely to cause some form of withdrawal and hiding, further entrenching the disconnection in valued relationships with others... All too often, shame perpetuates social isolation and relational discord, as well as high-risk, self-harming, or parasuicidal behaviors (Moon, 2919, p. 12).

Often sources of shame and self-blame can be lessened by hearing of another's similar situation and experience.

Unrecognized and Stigmatized Symptoms of Moral Harm

While PTSD is often stigmatized within military culture, moral harm is also stigmatized, and even less recognized by the military than PTSD. Recognizing that war does moral harm to WSMs opens the possibility of questioning the conduct of war, including episodes of violating international law, torture, and the large-scale devastation, killing, and destruction of societies in modern war (Butler, 2016). Acknowledging and preparing for moral harm prior to entering battle conflicts with the military and societal framing of war as necessary, that lives lost or damaged in war are expendable, and non-grievable (Butler, 2016). This is what makes preparing service members for moral harm prior to entering battle so difficult and seldom is done. Raising the specter of moral harm conflicts with the goal of changing of one's moral orientation that occurs in boot camp where one's identity as a civilian is transformed into that of a fighting service member (Moon, 2019, pp, 3-4). Despite these impediments, the avoidance of preparing service members for the moral harm of war, causes further moral harm. Without realistic preparation for moral harm incurred in war, it will be difficult for service members to adequately prepare for war, articulate the nature of damage to self and world by war, will delay counseling, healing, and prevent removing acutely distressed service members from battle:

I worked directly under the psychiatrist, and I saw patients, one on one, with supervision. This was this wounded service member's third deployment and he just recalled having to do some horrible acts against mankind. Commit some killings, and so on, that he truly didn't want to do, but he was ordered to do it, and it just went against his conscience and his beliefs. He was having nightmares, he had terrible outrage, bursts of anger. He would have flashbacks, reactions to noises that he attributed to certain experiences that he had in the field... His superiors didn't believe that his problems were real. And he experienced taunting, being made fun of. He also experienced, [comments] like, "Man, suck it up."...Well, over time, at one point, he seemed to be getting better, and then he just started getting more and more frustrated, more and more angry, to the point where he felt homicidal towards some of the people in his chain of command. He had an officer in his chain *of command*

who went out of his way to make this guy miserable. Eventually, after I talked to the psychiatrist, we decided that this young man needed to be sent back to the States so that they could do an evaluation on him, to see if they needed to do medical board on him. (Military Nurse)

This nurse and her supervisor went out of their way to intervene on behalf of this service member, averting further deterioration of his mental health, and the threat of his endangering others. Persistence was necessary to overcome the resistance of commanding officers, who did not believe that his problems "were real." Initially, even extreme distress and medical advice were insufficient reasons for removing this service member from the field. Despite extensive evidence of real mental health issues, officers' suspicions of this WSMs' malingering to get out of battle, over-rode strong professional documentation of mental illness. Commanding officers' first priority is to have a full complement of able-bodied service members available for duty. They do not want it to be "easy" for a wounded service member to "shirk" his or her duty, but military health care policy dictates that military officers defer to mental health workers and physicians to make battle-ready decisions.

The lack of acknowledgement of the suffering incurred as a result of moral harm makes it more difficult to develop preventive mental health programs prior to deployment, treatment in the field, and afterwards. PTSD (Benner, et. al., 2017) and moral harm are both stigmatized because both are associated with a mental illness. This stigmatization causes avoidance in seeking help to avoid jeopardizing their career during and after war:

A big thing that scares people about talking also is that if you get labeled with PTSD, what happens with jobs later? Well, in the Marines, security forces are what they know how to do, so they get jobs as either firefighters or cops. How are you going to do that if you have PTSD? And so, people are scared, and so they're not telling the truth... I may not have been completely truthful. So, I acknowledged that [his symptoms] and eventually someone convinced me to go back and describe my symptoms and treatment for PTSD, so I got that rating fixed. (Wounded Service Member)

Many military nurses called for more availability, and acceptability of mental health care prior to going to battle, on the battlefield, and upon coming home:

I think there is a movement towards more mental health and casualty training or the type of stress training for out in the field... We need to have more mental health professionals out there. It doesn't necessarily have to be psychiatrists, but either clinical nurse specialists or certified psych military nurses need to be out there to help take care of these people, or at least be there to prevent some of this distress, anxiety, and depression afterwards. I think there should be some prevention training prior to going over. That was something that nobody received either, I'm not aware of any kind of training. They had some combat stress teams out there. The Air Force had a few that would make the rounds at some of the camps in Iraq and northern Kuwait looking for referrals for people or patients that needed to see them... Still, in all, there is no pre-intervention that I'm aware of. (Military Nurse)

Lack of recognition, denial, and stigmatization of moral harm prevents timely interventions and protection from battle when service members are incapacitated. As Butler (2016) notes, preparing for and warning service members about the moral harm of war conflicts with both the deliberate and tacit framing of war, that make war show up as legitimate, socially necessary and acceptable:

> ...A certain reality is being built through our very act of passive reception, since what we are being recruited into is a certain framing of reality, both its constriction and its interpretation (Butler, 2016, Loc. 99-100)... the frame does not simply exhibit reality, but it actively participates in a strategy of containment, selectively producing and enforcing what will count as reality [the ontological level of moral harm] ...Although framing cannot always contain what it seeks to make visible or readable, it remains structured by the aim of instrumentalizing certain versions of reality, discarded negatives of the official version... When versions of reality are excluded or jettisoned to a domain of unreality then specters are produced that haunt the ratified version of reality, animated and de-ratifying traces. In this sense frame seeks to institute an interdiction on mourning: there is no destruction, and there is no loss. (Butler, 2016, Loc. 108-114).

Butler's (2016) interpretation of the ontological nature of the framing of war, explains why openly addressing moral harm before entering war creates cognitive dissonance for military trainers, who are engaged in the instrumentalization and negation of the human costs of war. Warning about probable moral harm of war creates cognitive dissonance by those making "going to war" seem necessary, courageous, and heroic. Yet, service members do encounter direct moral harm from war, and their responses of outrage, sense of betrayal over the lack of honest warnings about the moral costs of war provide a strong case for advance preparation for the moral harm of war, despite the cognitive dissonance.

Moral Harm, Caused by War's Assault on Embodied, Interdependent Social Lives and World

There were many examples of the tragedy and injustices of war breaking through to a personal level where framing of war, along with its protective coping and denial, fall away, leaving the service member defenseless against moral infractions, the tragic injuries and death of children, and civilians, and outright criminality of war, such as torture. In the following interview excerpt, the nurse describes breaking down and railing against the tragedy and injustice of the death of a two-year-old child who died as a result of drinking kerosene in a war zone:

The one time I felt totally inadequate in my sense of knowing about other cultures was when we knew we were getting a baby in that was coding [being resuscitated] who we were receiving from the British [medical team]. We didn't know what had happened. The Brits brought him in. He was a [beautiful boy] [crying]--not a mark on him and he'd swallowed kerosene. My staff did a wonderful job. The Brits had done a wonderful job. He had every line, every drip he would have gotten here at Walter Reed. The only thing I could walk away from that thinking was that I teach parents about safety every day in my clinic. And this one little, beautiful little boy couldn't be saved because we had blown up this country, and for no reason, because we can't find any weapons of mass destruction. This was very close to us coming back stateside. (Military Nurse)

Interviewer:

Were you not able to save this little one?

Military Nurse:

No. This two-year-old child "rigored" [already had rigor mortis, evidence of death] coming off the helo[copter]. The pediatrician looked at me and he said, "We can't stop this [code]." He

said, "They [the parents] just got here. We have to run it for at least 45 minutes." Of course, my thought being a mother of two...and the parents were there. They were standing off to the side. I went in because they needed help and I did chest compressions on him. But I couldn't get the mom to sit in a chair. I wanted her to sit in a chair. [choking up] She wouldn't. It finally dawned on me, "Ann, you really don't know how these people mourn. You're totally inadequate." Once he died you heard that animalistic parental cry from both the parents.

By this time, I had seen so many people shot to hell for what I considered to be politically no reason. Of course, I can't say that in public because I'm an officer. I can't question the Commander-in-Chief, but I can certainly come to those conclusions in my own mind. That [sic] was the one most difficult times. One of my male military nurses, who dealt with death often, also fell apart. He just fell apart. I had to leave. I kept it together enough to teach the corpsmen about the morgue care....

I'm still not clear about how the Muslims handle this. We need to talk to one of the Saudi translators... I called the psychologist at about 5 A.M. and asked for him to come right before we went off shift, so we can do a debriefing about this child. I said, "He died and everybody was there." He was our only death while I was there, as I recall. Everybody else had made it out alive. I'm sure many of them were brain dead and they just hadn't taken them off the monitors yet.

Interviewer:

That's very hard. What were the kinds of things that you take home from that deployment experience?

Life is very short, and you cannot wait for anything. You have to do what you want to do right now within the confines of your own morals. I always thought I wouldn't mind going to war, to take care of folks, for what my country thought was a just cause. But you really have to be careful whose hands you put your life in. Many of us have been in [the military] for so long that there's no getting out... It was war; but you don't have to lose your humanity, your basic people skills. There were many things I didn't particularly care for during the war in terms of how things were led. (Military Nurse)

In this tragic instance, the distancing and depersonalization of war recede, and the tragic loss of a child touches all those involved. For this nurse it became a moment of taking stock of the horror and immeasurable damage of war on everyone's world. Describing moral injury in terms of violation of the individual's wounded service member's moral norms is too narrow, failing to capture the threat of war to human worlds, and to humanity itself. Such a close personal confrontation with war's extreme destructiveness and threats to livable lives and a sustainable world, became clearer to service members, making war itself untenable. The common humanity of the "enemy" was felt and the life of this child was grieved.

The interview data contained many instances of moral harm that went beyond violation of specific moral norms. Participants described experiences where leading the kind of life the service member wanted to live was ruptured, if not, destroyed. The moral harm caused by the disruption of one's world occurs at the ontological level that determines what a person can notice, experience, and can "think" about explicitly. It is this taken-for-granted background of the world where individuals dwell and their lives and meanings are constituted that makes perception, noticing, and foreground possible (Dreyfus, 2012; 2009).

Many participants also experienced close at hand moral harm that resulted from the destructiveness of modern war itself, and felt shame, guilt, and remorse over their own complicity in war itself. Experiences of personal complicity in war altered the service member's sense of his or her life. War caused many service members to question the kind of life that they were leading (Taylor, 1997). This question was usually at odds with the framing of war they received as recruits.

The confrontation with the extremities and suffering of war is not usually realized fully in the moment, but continues to recur in memories, nightmares, anxiety, and depression. These memories of remorse and guilt differ from the flashbacks of danger and trauma in PTSD. At issue for these service members is that their stance on the "kind of person they are" (Dreyfus, 1991; Taylor, 1997; Butler, 2005;) has been radically assaulted and is at stake. Moral harm is rooted, in part, by this common human practice of giving an account of oneself, taking a stance on the kind of person one is as evident in the life one leads (Dreyfus, 1991; Taylor, 1997; Butler, 2005). The war experience creates an internal dialogue that generates efforts at ridding oneself of the memory or some reckoning, in order to not be overwhelmed by remorse, shame, and guilt. When an innocent child dies as a result of war, or as exemplified by the next WSM's experience of extreme repeated dangers of IEDs (improvised explosive devices), extreme injuries, mass casualties, and more, the taken-for-granted framing and justification of war break down and are questioned. The veil is lifted and unredeemable tragedies are re-evaluated in terms humaneness and moral integrity, and the war's destructiveness. War's threats to human life, the human world, and environment become overwhelmingly evident. The military nurse warns: "You really have to be careful whose hands you put your life in.

Nurses and WSMs told horror stories of encountering only fragments of persons killed by an improvised explosive device (IEDs) leaving only limited remains of their bodies. It is known from past studies of moral harm (Moon, 2019; Sites, 2013; Meagher, 2014; Meagher, & Pryer, 2018) and from nurses' and WSMs' accounts that disposing of amputated body parts and handling human remains causes moral harm, a kind of lasting revulsion and horror over the killing and shattering of human life. IED blasts created an ongoing sense of danger and threat:

We had one patrol, one time that lasted 18 hours. We went out and found so many IEDs And it was like, every time you found an IED, you called the OD [Ordinance Detonators], they come, blow it, leave, and then two hundred meters later you find another IED, you have to call them back. That was a miserable time. All our GPS's died that night, and we were just calling back to base, and they shoot only rounds up in open air, and we were just walking towards the sounds. It was pretty bad. That was crazy. We had a guy, from another unit, he blew up, and we went up to the area where the explosion was, and all we found [were] his leg and side. That was all that was left of him. (Wounded Service Member)

Improvised explosive device blasts came from trees, from ditches, and were an ever-present threat that caused death and extreme injuries. The investigators were moved by the grief and continuing remorse over the extreme injuries of war, and the shattering experience of finding only body fragments of fellow service members.

Bearing witness to a painfully altered life of a fellow service member is a frequent moral harm reported by military nurses and WSMs interviewees:

Ever since we had taken care of this one Marine that had an IED go off between his legs. And he had massive facial injuries. He was with us about eight or nine weeks before we could get him back home. He was really sick. His friends brought in pictures. He was a really good-looking guy, apparently the life of the party. One of my friends also knew about him. And I guess apparently a few times he tried to take his own life because he lost his vision. Literally his whole face was gone. He's had multiple surgeries, but he was still pretty disfigured and lost a couple of limbs. That was hard. You can put so much work and you think you're healing their body, but you still have to think about their emotions. (Military Nurse)

This tragic loss reaches this nurse at a personal level. Few military nurses and WSMs escape war without a personal confrontation of such extreme injury. Another nurse describes the personal grief incurred by witnessing a difficult death of a young wounded service member. This young man was injured beyond recognition and fought strenuously against his imminent death. The pathos and tragedy of his fighting death, against all odds, lingers with this nurse after returning from war:

I just felt like he did not want to go. I don't know. I just felt like he had a wedding ring on, and he was not really young but in his 30s probably, and I just felt that there were children. I don't know. I just felt like it was a sudden thing, he wasn't expecting to die, he didn't want to go, and it disturbed me so much, and so I mean, I was just trying. . . I would say kind things and stroke him and just pray for him and I mean, I really felt so upset about that, I really did. And when he finally expired, he just groaned out so loud, and I was like--he is just not at peace about dying. You know what I mean? And during that time, his commander would come in, but he couldn't recognize him due to the extent of his blast injuries... I didn't think about it much until a couple months after I got home. And I was so upset about him, and so I bought some flowers for him... And it's nothing you can tell anybody because no one in my unit deployed with me... I think that it was war. (Military Nurse)

The tragedy of war is instantiated in the life of an unrecognizable but memorable wounded service member. The memory evokes awareness that this tragedy is a repeated one. Confrontations with the tragedies of war incurred at particular points in time are typically remembered later as the nurse or wounded service member takes up life after war. Intrusive or disruptive repetitive thoughts and feelings of remorse and shame intrude in the midst of caring for one's own children and family, and as military nurses care for the wounded and as WSMs and military nurses take up their usual peacetime moral practices, codes, and beliefs.

The risk and tragedies suffered by interpreters, and even family members of civilian or enemy combatants treated by Americans (Benner, et. al., in review), inevitably made the tragedies and risks of war, personal and the lives of others grievable (Butler, 2016). Military nurses felt morally responsible for harm incurred by those who were targeted as a result of helping or being helped by Americans. Lives and injuries of interpreters and civilians injured or killed because of their contact with Americans were grieved by Americans who felt responsible and complicit.

Extreme Life Saving Measures and Irreparable Injuries.

A major source of moral harm described by military nurses was the extreme life-saving surgeries to save badly WSMs, enemy combatants, and civilians. The above examples of extreme injuries demonstrate the long-term moral harm of experiencing and bearing witness to these

tragedies. The Middle-East wars have created massive injuries, especially to the head, and extremities, due to IEDs and improved body armor that protected the body core. Part of the moral harm of these wars is the extreme suffering of the wounded, and the horror of bearing witness to such extreme injuries. As one military nurse recounted:

We had a hemi corpectomy, a guy cut in half by a mortar round. Two medics - one on each side--what used to be his leg, just trying to tamp off his blood flow. One arm gone, this one splayed, and he was still conscious. ...at one time we had 16 folks working on him... And as coincidence would have it, our orthopedic surgeon that worked on this kid was from Military Hospital. And when he went back to Military Hospital, this kid was there, He survived. So, the [same orthopedic surgeon] did some of the revision surgery, to try and outfit him with prostheses and things like this. I'll never forget that... So, he lived, and then we took his legs next-door and we took the skin, to graft another patient. Which is something else I'd never seen or done before. (Military Nurse)

This is a horrifying unforgettable injury to live through and witness. The wounded service member's body is dismembered and shattered. Those who heroically saved his life are left with devastating memories. This young service member is left with unimaginable physical loss and disability. Documented in the interviews are other accounts of triple amputations and other torso level injuries due to blasts. The following nurse's story captures this agony:

Oh my God. I don't know whoever said it first, that war is hell, but it's true. There's still no reason for it. We're putting ourselves--this 20-year-old kid, he gets himself blown up. This guy was in vehicle number two, his vehicle "one" got blown up so they push it out of the way because you heard someone screaming in it. [There is no possibility for rescue for a man being burned up in the first vehicle.] His vehicle takes a hit, he loses both his arms and legs. And while he was in the ER, he said, "don't take my legs because my wife will divorce me." And he had come to us with no legs. Gee! What do you tell him? He's partially awake but he's still chewing on the plastic of his tube. It's so suffering, so suffering. (Military Nurse)

Witnessing a buddy trapped alive in the first burning vehicle without being able to rescue him, creates a sense of helplessness and intense grief for the wounded service member. The horror of witnessing a buddy being burned alive is then interrupted by the explosion of his own vehicle. In the emergency room this wounded service member, unaware, that he has lost both his legs, fears losing his wife if he loses one of his limbs. As the nurse says, "So suffering, so suffering." The particular and collective experience of the tragic loss of life and extreme injuries caused moral harm for military nurses and WSMs.

Wartime, unfortunately, and in ad hoc ways, gave surgeons informal, and ill-considered permission to try to repair extreme injuries that were, in the long-run, inhumane:

They tried to save everybody. And so, we had the craziest--we had like--just insane things, like bilateral frontal lobectomies [both frontal lobes of the brain removed]. I mean, what kind of life is that poor guy going to have? And we had this Iraqi guy who had his entire trachea blown out. They brought the trachea through his chest. So, he was going to spend his life. . . and actually, we discharged him, we called him "Stomeophegus," because it was just a lot of crude joking. But I guess a fly went in there or something. It's a hole. A hole right here for him to breathe out of, and what kind of quality of life is that? I don't know. But the surgeons just tried to save everybody. (Military Nurse)

This nurse is incredulous and cannot imagine the suffering involved in surviving such a devastating injury. Such extreme surgeries are beyond the pale of humane, civil care in ordinary health care settings. The crude jokes uncover the dehumanization that often occurs in such extreme circumstances. This unexamined and perhaps unethical form of wartime surgical intervention would never be approved in stateside hospitals. It is not acceptable, humane health care to try to repair unspeakable, horrendous injuries without getting consent or approval that takes into consideration the long-term outcomes and patient preferences. It is as if the extremity of the war, and war injuries themselves, allow surgeons to abandon their usual prudence about considering the costs of extreme and often futile heroic care. The initial injury becomes compounded by the continued demands of living with extensive physical disabilities.

Interviewer:

And that's really a new level of injury. "Lethality" was your term. With the blasting, the loss of limbs, injuries are really, really extensive in this war. (Interviewer)

Military Nurse:

Oh yeah, very much so. You see the mangled bodies and trying to attach everything as the litter is coming into the ER [in the combat zone]. We saw some horribly wounded people. I know it's not for us to decide, but were we really doing them any favors, [saving their lives] with such massive injuries? Maybe we should have let some of them go. I mean, I had one guy who had two drains in his head, an ICP (intracranial pressure) monitor and half his skull was out. I don't know how he did but the long-term prognosis--like I say, we don't know how they end up doing. Or they're missing both their legs and one arm... In the long-term, are we really doing them any favors?

We need to see them down the line [earlier], because we don't talk to our young troops. In the event this happens to you, nobody signs living wills, nobody signs advance directives, nobody. We ought to be doing it. When they come back home and they're depressed, and kill themselves, because everything is so bad... They could suffer a catastrophic injury, and then they come back and it's like, what did we do for them over there? Is that what they wanted?

Military nurses' and WSMs' questions about what kind of life is bearable and livable, are valid and need to be studied. The military ethos, shared by many WSMs, is that if the wounded service member is badly injured, the military medical system will "fix" the injuries. They are promised that all extreme measures to save their lives and put their bodies back together will be taken. The emergency and rescue possibilities offered by new embedded ICU capabilities in the battlefield, and quick transport from the field, and in-field hospitals resulted in "unprecedented survival rates (as high as 98 percent) for casualties arriving alive to a combat hospital (Mabry, 2015, p. 78):

We saw American soldiers come in that were basically just a torso. Sometimes we saved them. Most of the time we did actually. We had approximately a 96 percent save rate [survival statistic for this particular infield MCF]. If you made it alive coming through the ER door, 96 percent of them went out. But the burns were the worst, and the Iraqis have no capability for taking care of burns. At first, we had burn surgeons there. And we tried to take care of everybody [including enemy combatants and civilians]. And that was very, very difficult, because they'd [enemy combatants and civilians] be there for two, three months. And then we'd get ready to transfer them, and on the

way to the battalion burn hospital, the ambulance crew stole his [enemy combatant's] ventilator, so when he got there, he died 40 minutes later, when he needed his ventilator. We kept this guy [enemy combatant] alive, he was already 75 percent burned or so, but we kept him alive, kept him grafted, and he was--all he needed was rehab and ventilator support occasionally. He died for lack of a ventilator. Things like that. (Military Nurse)

The ethics and tragedy of limited ventilators plagued most military nurses caring for enemy combatants and civilians (Benner, et. al. in review, 2020). The persistent gaps between what American health care provided, and the health care and rehabilitation that could be sustained in the Middle East, created an ongoing sense of moral injustice and harm for American military nurses. Eventually, American health care personnel did manage to procure ventilators for use of enemy combatants after discharge, but they could not be assured that they could be effectively used.

As noted by the nurse above, the rescue of injured WSMs far surpasses any prior war. As military nurses point out, this raises new questions about the humaneness and wisdom of the general practice and culture of rescuing all patients regardless of the extremity of their injuries. WSMs and military nurses alike spoke of the commonly accepted military promise of providing all heroic effort to save everyone who was injured. This unexamined promise, which may seem reassuring upon entering battle, prevents questions about which "extreme measures" are actually acceptable to the WSMs themselves. Extreme medical rescue was experienced as a moral harm by WSMs who found the consequences of living with extreme disabilities unbearable. Military nurses who bore witness to the struggles of extremely injured WSMs felt remorse as illustrated by the above nurse's plea to have advanced directives and discussions about what level of permanent injury the wounded service member is willing to endure. Advanced directives may later be revoked by the person, but at least the person will have considered options and thought about the consequences of living with extreme injuries.

Moral Harm Created by Misallocation of Resources, and Futile Care

Military nurses reported that continuity and passing on experiential learning from one deployment group to the next had little overlap time, was highly variable, and often ineffective. Consequently, poor practices and error of judgment went uncorrected. The following issues of poor practices were frequently mentioned: The need to reserve limited supplies in case of a mass casualty; treatment for non-war related health care problems for civilians that used scarce medical supplies and personnel; and the risk of enemy attacks incurred by allowing civilians onto the base for treatment were commonly expressed by military nurses.

Military nurses reported that needed resources for "our own troops were always available." Inadequate resources may have occurred, but it is doubtful that it happened often, if at all. Yet, with ever-present possibility of mass casualties, concern over conserving resources was an ongoing and legitimate concern of military nurses. Despite the risk of running out of essential supplies, health care providers felt compelled to treat enemy combatants and civilians needing immediate rescue and care, often citing what they as professional nurses are committed to do, and as they are mandated to do by the Geneva Conventions (Benner, et. al., in review).

Other questions of equity had to do with allocation of resources without assurance of a reasonable chance for good outcomes. Providing futile heroic care was a constant source of moral conflict, and was considered "poor practice" as reflected by military nurses:

We had a guy who had a mortar through his head, and he literally had the U [U shaped entry of a mortar] in his head. He had come into ER and he was still talking. His helmet had fallen off; he was still talking. They took him to surgery. The decision was made that they were going to try and keep him alive, so that his family could still see him alive instead of letting him die in theater...And I walked into the OR, they had the guy's head open and he had this big black hole, literally, where his brain had been singed...We wanted the C-CAT (Critical Care Air Transport] team to keep him alive, and he's on all the drips and all that type of stuff. [This was against protocol, which was explained by the nurse. But the surgeons and nurse prevailed, and the futile treatment continued]. Well, we got him on an aircraft, but we had to manipulate it, but [the air-transport team] didn't want [us to transport] the expectant/urgent so that the family could say goodbye while he was still on vent. (Military Nurse)

It is not clear that it is actually more reassuring to see one's family member, unconscious and close to death, rather than seeing them after they have died. It is an unexamined wartime logic and practice, that seeing a loved one after death is more distressing than being with an unconscious wounded service member, unable to speak and hovering near death. Perhaps wishful thinking about salvaging as much as possible out of a tragedy is an unexamined motivation for this practice. This unexamined practice needs to be studied and more informed policies based on preferences of WSMs and their families need to be established.

A recurring ethical conflict and tension also surrounded using scarce medical resources for the care of civilians. Using scarce resources was only one part of the problem. Allowing Iraqi or Afghan national civilians and their families into the health care unit created security risks:

We did not follow our own policies as far as who they treat, why, and what. We opened a can of worms that we can't close. When you let a civilian in, like if you let a child in, you're going to let the family in. Well, you don't know who they are! When I was there, we got mortared 168 times. Not 168 rockets; 168 times! And Iraqis would come along, and they'd have GPSs. Once they get your grid coordinates--we got there a couple weeks after the PX got hit. And it was an inside job. The whole country's been in disarray for ten years. There's no shortage of patients that would have just ripped your heart out. But our group didn't care for very many civilians. Their group did [former military unit]. But the group behind them cut it off again. Our unit did a few. This colonel did a few. He took a nasal tumor out of some girl that was huge. And those are all "feel-good" cases. (Military Nurse)

As illustrated above, military nurses valued humanitarian care to Iraqi or Afghan national civilians, but understandably worried about providing needed ordinary health care of civilians, incurring security risks, and depleting resources for those injured in battle. Providing needed unavailable health care to civilians "felt good," a spark of humanitarian concern in the midst of war. Nevertheless, health care provided outside of formal policy guidelines, created ethical demands and dilemmas. Providing civilian health care with scarce medical resources, in facilities already close to capacity, troubled military nurses. Their second major concern was the real possibility of an incoming enemy attack on the health care facility, because of a breach of security from patients and their family members.

Bearing Witness to the Devastation of a War-Torn Society

As noted earlier, modern wars are not confined to armies, or even clearly demarcated areas of fighting. Civilians suffer injury, death, and the deprivations of war such as hunger, malnutrition poverty, and ever-present risks of injury and death from war. The evidence of children deaths in Ballad was visible in the shoes left behind. A military nurse describes seeing a whole hallway lined with shoes. She had to escape, noting that she had never seen children in Ballad. The killing of children in war is against International Law, a heinous war crime, and a "freaky" intrusion of the horror of war:

> The international law that prohibits crimes against civilians [and international laws against killing women and children] presupposes there could be a war without such crimes, reproduced the idea that there could be a clean war whose destruction has perfect aim. Only on such a condition can we distinguish between a war and crimes of war. But if there is no distinguishable way to distinguish between permissible collateral damage from the destruction of civilian life, then such crimes are inevitable, and then there can be no non-criminal war (Butler, 2016, Loc. 183-186).

The killing of children makes living in a safe inclusive, egalitarian world impossible. In the Middle East wars, children were conscripted into the war to plant bombs and toss hand-grenades, usurping their rights to live a life free from being instruments of war. Conscripting children to be instruments of war and killing children were both heinous war crimes and demonstrate that war itself is often criminal.

Other pervasive signs of devastation of a society due to long-term wars were evident to military nurses and WSMs:

When you see these starving people, who are in such need, your heart goes out to them and you think, "well, somebody has to help." What are you going to do? These people are starving, and it's not just because of the two years of war. And then when you have people who've never had calcium in their diets, so their bones are osteoporotic at 40 [and] their wound healing is terrible. You have 90-pound men as an average. And the men walk down the hallway and you can see every bone. They look like they belong in a concentration camp and it breaks your heart to see human beings in such need, and you struggle with how to take care of them, but that wasn't ... -our job is to provide long-term care, so it was really hard ethically. Where do you draw the line in saying, okay, we're going to send you home now? We're going to send you to an Iraqi hospital after we did all this work to save your life, and now you may die in an Iraqi hospital. But we're not a long-term rehab center. What do we do? (Military Nurse)

Another nurse told of the devastation of the large and constant vehicle traffic on the crops of people living nearby:

The convoys were creating all this dust, and so the government--our government--went to them, and because their small plot of land wouldn't grow any vegetables, they were starving, and so we paid them whatever they would have made, if they had been able to grow food, because the convoy dust was ruining their garden. (Military Nurse)

This begs the question of whether neighbors could find food to purchase. There were many examples of military nurses becoming involved in the lives of injured children. In the following example, nurses became involved with one child who had been badly burned, and whose parents couldn't care for him, so the uncle offered to sell the child to a nurse:

He was there for a couple of months, and he was an amazing child. I found out later that his name means "prayer answered." And I really thought he filled a huge need for so many people who had left their children at home. I mean, he was just the "Hit Parade." Everyone would come see him and hold him and. he was completely spoiled. His family was very poor. So, his uncle offered to sell this child for [a sum of money]. I took him up on it, and I talked with our powers that be around the base. And then someone actually was contacting the Pentagon, because you have to go through those channels. Through an interpreter, I asked the uncle to ask the family if they were serious about this, [and explained] that I would be willing to take him and give him a good life. So, the interpreter asked this family if they were willing to adopt this child out to an American. The family said, "We'd rather see him dead than adopted by an American." And so, they came and got him the very next day. It was really devastating. That was one of the most painful experiences I had there. (Military Nurse)

The interviews contain many stories of military nurses getting close to children, civilians, and more rarely, even with enemy combatants. These connections brought the tragedies and suffering of human beings living in an impoverished war-torn society close personally. The connection and tragedy of this young child was painful for this and other military nurses caring for him. Part of the moral harm stems from the impotence to prevent and alleviate suffering of women and children. It is paradoxical that while using extremely powerful weapons, which cause death and destruction, service members often felt powerless to control their own actions and behaviors. War necessitated killing and following orders. Once decided upon, the use of power could neither be avoided nor managed. Killing is necessary in war (Kudo, 2018). Paradoxically, while wielding great power, while being prepared and socialized to exert power over others, many service members experienced powerlessness in war.

Large-scale harm and devastation to a whole society, is an inevitable consequence of modern war, and causes inescapable moral harm to that society and to those who bear witness to the suffering. Not only do those in battle feel complicit and guilty, they are left with images of how bad daily life can be in a war-torn country.

Military nurses talked about the stark contrast and the inequity they felt when returning to a wealthy, consumer-oriented, market-driven culture (Benner, et. al., 2017). The injustices, poverty, and suffering of those in a war-torn society made the wealth and excesses in their own culture stand out (Benner, et. al., 2017). Many WSMs and military nurses found it impossible to justify causing more deprivation and suffering in a society so damaged by long-term wars.

Discussion and Conclusions

Military nurses recommended that prior to going to war, all service members be prepared for the world-altering moral confrontations and moral harm inevitably encountered in war. Realistic preparation and inoculation can better prepare service members and decrease service members' sense of betrayal, social isolation, individual blame, shame, and denial during and after the war (Moon, 2019). Self-forgiveness and compassion, in the midst of extreme circumstances, provided as preventive measures, can limit surprise and helplessness and provide language and

understanding of what happens when taken-for-granted moral assumptions and norms are violated. No individual can avoid the tragedies, nor come out of war entirely without regrets and remorse, but self-compassion, shared war experiences, and healing social practices can lessen the burden of moral harm (Moon, 2019).

A heroic, "just war framing" for going to war, is central to convincing society that war is justified, and for recruiting, and preparing the WSMs to fight, yet it impedes realistic preparation for going to war. The persuasive framing of the necessity of war works against preparing service members for tragedies, collateral damages, and inevitable moral harm. Until mental health interventions, prior, during, and after war address the realities of war, including moral harm, service members will continue to experience moral harm, resulting in anger, shame, social isolation, and be at risk for substance abuse and suicide. Use of medicalized interventions without talk/and listening therapies will continue to contribute to silence, numbing, and delay of healing.

In addition to advanced preparation for the moral injuries of war, immediate debriefing and counseling needs to be available near the battlefield and upon returning home. Many bear witness to atrocities and extreme injustices in the thick of war. All are exposed to the inhumane damages to any war-torn country; and all are directly exposed to the damages of war, to shared humanity, to a more equitable human world, and to the protection of the environment. Citizens, government, and military leaders, as well as service members, need to address the full scope of moral harm, violations of moral norms, and damage to one's sense of moral integrity, as well as moral harm at the ontological level to one's world and environment. This must be done before, during, and after war.

Moral harm created by excessive and futile surgeries, as described by military nurses and WSMs, can and should be prevented. Follow-up research studies of veterans living with extreme injuries and disabilities are essential to assess the quality and livability of irreparable injuries and the consequences of futile treatments. Research to develop more humane guidelines for interventions associated with more acceptable long-term outcomes is needed. Ultimately, the individual service member must be given as much say in these decisions as possible. There is extensive civilian ethical literature and research that can guide more livable and humane care of the extremely injured.

Provision of extreme futile health care to WSMs should be guided by similar measures used in the United States such as advanced directives, durable power of attorney options, as well as options for appointing battle buddies to provide guidance as directed by the service member. All these well-developed approaches to planning for preferred health care options and the avoidance of futile care, would allow WSMs more control over their infield military health care and advanced planning for future surgeries and rehabilitation. All service members deserve advanced coaching about possible injuries from health care professionals and from veterans and service members living with extreme war injuries. Wise care of injured service members can facilitate much more prudent, ethical, humane, and participatory decisions than the current unexamined, "no holds barred" approach of extreme surgeries permitted in war zones.

Clearer guidelines and policies about the allocation of scarce resources and provision of medical care treatment for civilians needing health care unavailable in their own country should be developed, based upon the current failures, and a need for optimal allocation of scarce resources.

Judith Butler (2016) calls for a larger, more urgent and radical solution to the problems of moral harm. She (Butler, 2016, Loc. 235-237) seeks more than a resistance to the current framing of war, and to the destructive paths of making war. She calls for a more "radical and effective egalitarianism," an interdependent world where all lives count, are respected, and grievable (Butler, 2016, Loc. 235-237). This more interdependent vision broke through to wounded service members and military nurses when they experienced the tragedies of the lethal, unlivable, and unsustainable consequences of war.

The extreme abuses in Abu Ghraib, in Iraq occurred early in the war. Consequently, participants in this study were not directly involved at the time of the abuses. In studying care of enemy combatants and civilians, the team found that the abusive tortures at Abu Ghraib Prison were generally known by both military nurses, WSMs, and Iraqi enemy combatants (Benner, et. al. in review). Some military guards threatened unruly enemy combatants with transfer to Abu Ghraib, if they did not change their behavior, terrifying enemy combatants (Benner, et. al. in review). The torture and abuses at Abu Ghraib were generally known by American service members, violated the Geneva Convention, and weighed on many American service members not involved in the torture themselves. The extreme torture at Abu Ghraib should be essential education to prevent, and inoculate against torture in the future. Accounts of remorse and moral harm experienced by Americans who participated or failed to intervene in the acts of torture, provide realistic warnings about the torture and excessive abuse of power that occurred in Abu Ghraib (Fair, 2016). Presentation of these realistic threats can better prepare service members to prevent and intervene in torture, while preparing service members for the possible atrocities of war.

World War II is cited as a necessary and just war because of the despotism and unspeakable genocide, harm, and conquest that were unavoidable without war. But how many modern wars could be avoided if all efforts at peaceful solutions were given higher priority and international arbitration, and planned preventive efforts were marshalled against war by international bodies? How can a collective consciousness be developed and upraised concerning the extreme costs of war that include extreme suffering and damages to war-torn societies, to humanity, and to the physical environment? Preventing war will require engaged citizens and leaders who are trustworthy and judicious about going to war, and who will commit to prevent modern wars when at all possible. With a clearer and better documented evidence of the global impact of war, prevention of war could become a top national and international priority, ushering in new strategies, policies, and negotiation strategies to prevent war.

Prevention of war is the most effective way to prevent moral harm. Every service member deserves preparation for the inevitable moral harm of going to war, along with programs that repair and offer compassion and healing for those returning from war. Government and military leaders, service members, and citizens share the responsibilities, burdens, suffering, and environmental costs of war. Sharing responsibility with service members means that citizens must be more aware of the service members' actual war experiences, as well as the damage of modern war on humanity, shared human worlds, and protection of the environment.

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