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REVIEW

Moral Injury Among Youth: Historical Accounts, Current Research and Future Directions

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Abstract
This manuscript explores the definition and historical context of Moral Injury (MI), detailing its psychological and spiritual impact on individuals, including youth populations. Morals are our beliefs and understanding of what is right and wrong. They are often informed by cultural and social norms and typically encompass values and responsibilities that individuals use to judge whether an action is right or wrong. MI is a psychological phenomenon that can unfold when there is a loss of trust in these beliefs or others' ability to keep our shared moral agreements. Traditionally associated with military personnel, MI has evolved to include other populations, including youth and family systems. This piece explores moral development among youth populations and how injuries to moral codes are particularly salient in youth populations and family systems. Special attention is given to MI's unique manifestations and implications in childhood and adolescence. The manuscript concludes with a call to action for further research that prioritizes and integrates youths' own voices in understanding and addressing MI.

Defining Moral Injury

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To understand moral injury (MI), it is important to explore the values and beliefs of an individual. Moral beliefs develop through one's religion, spirituality, events, and interactions with others. MI is the state of loss and trust in these beliefs or others' ability to keep our shared moral agreement [1].

Shay [2, 3] notes that MI is a psychological construct or outcome that can occur when an individual is betrayed by someone who holds authority or power. Shay [2, 3], Nash and Litz [1], and others [4–7] all explain that someone can experience a MI as a result of another person's actions or inaction and features a violation of social contract. Further, both acts of omission (not doing something) or commission (doing something you shouldn't have) can lead to the later development of MI [8].

Tick [9] notes that MI can have a deep, lasting, psychological and spiritual impact and occurs when "damage is done to one's conscience or moral compass when that person perpetrates, witnesses, or fails to prevent acts that transgress one's own moral beliefs, values, or ethical codes of conduct" ([10], para. 1).

MI is a concept often associated with people who are in the armed forces. For example, soldiers in combat experience situations where they may witness or participate in unethical behaviors that go against their moral beliefs and values but are necessary for survival [11]. When describing the construct of MI, the term "inner conflict" is often used when someone acts in a way (or fails to act in a way) that aligns with their personal morals and values system. The Marine Corps document titled *Combat and Operational Stress Control* describes inner conflict as ''stress arising due to moral damage from carrying out or bearing witness to acts or failures to act that violate deeply held belief systems'' [12], pp. 1–11).

Additional circumstances that could lead to MI include child neglect and intimate partner betrayal or violence [13]. In research that examines MI in the context of the child welfare system, professionals who work within the system describe the moral harm that they experienced as a result of working within an adversarial system that is built on unfair policies [14] and perpetuates systemic bias, historical trauma, and racism. Parents involved in the child protective services system have also reported experiencing MI. For example, those who have been threatened with loss of parental rights also note feeling MI (and related shame, guilt, and anger) as a result of their own parenting behaviors, but

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also from the experiences that they had with a social system that is supposed to be helping them [15]. Further, emerging adults (18–25 years old) report experiencing MI as a result of their former involvement with the child welfare system. They describe feeling unprotected and vulnerable (others had failed to protect them or keep them safe) or they failed to keep others safe (observing a peer being sexually abused and not intervening) [13]. Haight et al. [13] note that MI may be a "burden that foster youth carry with them into adulthood. Prior to entering care, children and youth may experience physical, emotional, and sexual abuse, or neglect and abandonment by adults whom they love and who are morally obligated to care for and protect them" (p. 139). Both those who experience MI as a result of someone else's action or inaction or their own action or inaction can potentially experience MI.

Whether it is combat-related or not, MI results from the inability to cope with the emotions associated with the violation of one's moral code. This leads to an inner conflict that can compromise an individual's well-being [13]. In seeking to understand the transgressions of moral beliefs, Litz and colleagues [16] identified key emotions, feelings, and behaviors that were part of MI. They [1, 16] specifically identified that shame and guilt were key aspects of MI as well as an inability to forgive oneself.

Morally Injurious Events and Potentially Morally Injurious Events

Not everyone will develop MI following exposure to the same traumatic events. The extent to which an individual might develop MI after a traumatic event (that involves conflict with moral codes) largely depends on that person's own moral code and value system [17]. A potentially morally injurious event (PMIEs) is something that *could* result in MI for some but perhaps not others [18]. MI would likely only develop after someone is exposed to a PMIE, and the event that happened contradicts their moral expectations of what they perceive *should* have happened. This results in cognitive dissonance or internal discomfort when these things are not in alignment [16]. Further, attempts to resolve the internal discomfort may result in unhelpful cognitions ("I am a fundamentally bad person," "God will not forgive me," or "I should have done more"). The cognitive triad [19] would suggest that the unhelpful thoughts would lead to certain emotions and then certain behaviors. In the case of MI, one might experience complex and often unhelpful emotions like shame, guilt, and disgust [16, 20–24].

Understanding the difference between MI and PMIEs is an issue of gradation. Developing valid and practical tools that help differentiate between MI and potential MI is one important aspect of treatment and intervention. One such scale is the Moral Injury Events Scale (MIES), which was developed by Nash et al. [25] in their work with military veterans. The current iteration of MIES is broken down into three subscales that focus on transgressions by self or others and betrayals. The initial wording of the betrayals component was specifically focused on the military context. Haight and colleagues [14, 15] later modified the MIES so that the questions in the betrayal subsection better fit family systems contexts.

The Relationship Between PTSD and Moral Injury

MI and post-traumatic stress disorder (PTSD) share several related features but are distinctly different. Early theorists even wondered whether the two were, in fact, different or if MI was a feature of combat-related PTSD [11, 16]. Both MI and PTSD occur after a traumatic or stressful event (or series of events) and can result in psychological distress. Both may also involve avoidance symptoms, painful memories, and altered cognitions [11]. In his chapter titled "Military Service, Moral Injury and Spiritual Wounding" [26], Tick [9] notes that,

> Some practitioners contend that moral injury and post-traumatic stress disorder, though manifesting similar symptoms, are actually different animals. Others say that moral injury is at the root of PTSD. And some say that they are different aspects of the wounding of the whole person - moral injury wounds the character and soul, while trauma can also wound us biologically, physiologically, cognitively, and psychologically. It seems to finally be accepted that doing what one judges to be wrong, even in life-threatening combat, harms the inner life, the psyche, and the soul of the actor. (p. 309)

While MI may co-occur with PTSD, the literature increasingly differentiates the two [27, 28]. Unlike PTSD, MI is not a diagnosable condition, according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. PTSD occurs after a traumatic exposure where there is actual or perceived danger [29] and often results in prolonged physiological activation [11]. The physiological response is typically related to inaccurate cognitions and avoidance following the event [30]. In contrast, MI is specifically related to the moral conflict that occurs when actions (self or others) are misaligned with an individual's moral code [11].

"On a conceptual level, MI is different from long-established post-deployment mental health problems. For example, whereas PTSD is a mental disorder that requires a diagnosis, MI is a dimensional problem. There is no threshold for establishing the presence of MI; rather, at a given point in time, a Veteran may have none or have mild to extreme manifestations" [8], p. 1).

What are Morals, and How do They Develop?

Defining Morals and Morality

Understanding MI or potential MI in children and adolescents requires first understanding what morals are and how they develop. Generally speaking, morals refer to standards or principles that tell us what is right and wrong. They are often connected to cultural and social norms, and they guide decisions and interactions [31]. Morals influence our willingness to behave in ways that support the collective interest [32]. Morality refers to the systems or codes of conduct that guide the principles of right and wrong. It typically encompasses values and responsibilities that individuals or groups use to judge whether an action is right or wrong [31, 32]. Ethics, a branch of philosophy that deals with systematizing and codifying morals, is a related concept often associated with morals and morality (Aristotle, 2009/350 B.C.E. Ethics generally encompasses the principles, values, or standards that guide how we think about good and bad behavior or what is right and wrong. Ethics and morals are closely related but different concepts. While morals can be thought of as a person's beliefs about right and wrong, ethics refers to the systematic study and codification of these beliefs. Morals are the actual beliefs that people have, while ethics describes the theoretical study of those beliefs (Aristotle, 2009, Kant, 1993. Aristotle (ca. 350 B.C.E originally discussed these concepts in his work, as did Kant (1785) much later.

How do Morals Develop?

Two of the most influential early thinkers in the world of morality and moral development are Jean Piaget and Lawrence Kohlberg. Piaget was a Swiss psychologist who, in the early twentieth century, significantly contributed to our understanding of moral development in children. In 1932, he published "The Moral Judgment of the Child," which examined how children's thinking about rules, justice, and morals change as they grow up. Piaget was less concerned with whether children broke the rules and more about how they thought about them [33, 34].

Piaget suggested a two-stage model of children's moral reasoning. The first stage is called "Heteronomous Morality" (Morality of Constraint or Moral Realism), and it typically occurs in children between the ages of 5 to approximately 9 or 10 years of age. During this stage, children generally view rules as unchangeable and created by authority figures like parents, teachers, or police officers. Further, children's thinking about doing what is right or wrong is driven by a focus on being obedient and avoiding punishment. They are often aware, during this stage, that doing something wrong could have a consequence [33]. As children grow and their cognitive capacities shift, their understanding of morals and what is right or wrong also change and evolve.

The second stage that Piaget identified is "Autonomous Morality (Morality of Cooperation or Moral Relativism)," which is generally seen in children 9 or 10 years and older. During this stage, there is an increased understanding that right and wrong may not be absolute, and rules may be changed. Here, children also start to understand that what is right or wrong may also be connected to someone's intentions and not just the consequences [35],[33]. Piaget's work builds the foundation of our understanding of how morality develops in children, highlighting that there is a shift or change over time from a more rigid interpretation of right and wrong to a more flexible approach.

In the 1950s and 60 s, American psychologist Lawrence Kohlberg expanded the work of Piaget by conducting research on children who were faced with moral dilemmas. By analyzing their responses to these moral dilemmas, Kohlberg proposed a more nuanced model of moral development that included six distinct stages across three levels [36]. One of the most well-known studies conducted by Kohlberg included the "Heinz Dilemma," where a man must decide whether to steal medications that he cannot afford to save his dying wife. In this research, Kohlberg was most interested in the reasoning *behind* the decisions that the youth in the study made. Analyzing the responses of the participants, Kohlberg was able to identify patterns that changed with the age of the participants, which ultimately led to his developing his own six-stage model of moral development [36–39]. Kohlberg [36] "considered morality or conscience to be the set of cultural rules of social action which have been internalized by the individual" (p. 277). Kohlberg found that younger children's decision-making was guided by the personal consequences they might encounter as a result of their behaviors, whereas older children's decisions were guided by social rules and later by more complex principles like justice. Kohlberg's stages [36] and levels fall into three categories: Level 1 Pre-Conventional Morality, Level 2 Conventional Morality, and Level 3 Post Conventional Morality.

Broadly speaking, Kohlberg's approach showed that, over time, youth developed "an increased sense of moral autonomy and a more adequate conception of justice" [37], p. 54). In Chapter 13 of the Handbook of Child Psychology and Developmental Science, Elliot Turiel notes that moral development (which involves both emotional appraisal and moral reasoning), as articulated by Piaget, Kohlberg, and others, is not just about increasing knowledge of cultural values and ethics. Instead, it is about a transformation that occurs over time in the individual's **structure of thought.** While the content of the thinking may shift across cultures,

the structure of thought around moral judgments is universal and unfolds in a predictable developmental pattern [40]. Turiel [40] notes that various moral philosophers may have different conceptualizations of moral development, but they share in common the idea that to be a human requires thought and reasoning. What then happens when someone's ability to reason, think, and problem solve is negatively impacted by stressors, adversity, and trauma that occurs during development?

Moral Beliefs and Cognitive Schemas

The links between morality and cognitive schemas (broad mental structure or frameworks that help someone organize and interpret information) or cognitive appraisal patterns (the process by which someone evaluates and interprets a situation) are complex, and there is limited research in this area, particularly as it relates to youth populations. Nash and Litz [1] examined MI through the lens of family systems and developmental stages, highlighting the role of beliefs and cognitive schemas. They articulated that moral beliefs and values "develop throughout life through an iterative process of stepwise assimilation and accommodation—through small and palatable alterations of deeply held moral beliefs to incorporate new information obtained from credible sources, and through altering perspectives on events and interactions with others so that they seem to better conform to existing moral expectations" [1], p. 369). When a potential MI occurs to a cognitive schema while the developmental processes are still unfolding (i.e., in childhood), the impact may be particularly damaging, and moral agency may be distorted.

In 2023, Bonson et al. proposed a new conceptualization of MI that centrally features the role of cognitive schemas and views about self, others, and the world. Their social-cognitive model suggests "that central to MI is deterioration in the relationship with self, others, and humanity, leading to global belief and behavioral changes" [41], p. 75). They propose that when a moral injury occurs, there is a cognitive appraisal of that event, which leads to the development of maladaptive beliefs. This in turn, leads to a deterioration in relationships with self, others, and humanity. These authors recognize that individuals' views about self, others, and humanity are shaped by early experiences. This is particularly salient when considering adverse childhood experiences and the later development of MI. They note,

> This definition of MI could explain why individuals who already have maladaptive beliefs may develop MI after exposure to a PMIE and those who do not have maladaptive beliefs do not. For example, a child who witnessed domestic violence may be vulnerable to MI as an adult if they are involved in a later PMIE in which they are unable to prevent violence to others; the PMIE could confirm a maladaptive belief from childhood that they are a weak or bad person for not being able to protect others. (p. 76)

Cognitive schemas and ways of viewing self, others, and the world are also important to examine when considering how MI is maintained and, in turn, treated clinically. Bonson et al. [41] suggest that to truly understand how MI develops and is maintained, we need to understand cognitive appraisal patterns. Rumination, self-blame, and problem-focused thoughts are potentially important mediators between PMIE and later mental health challenges. These authors further discuss treatment implications. For example, an appraisal of a PMIE could include "someone I trust betrayed me," which may be an accurate assessment. That appraisal (despite it being true) could lead to maladaptive beliefs and result in feelings of shame or anger. A clinician would not target that specific appraisal to dispute or challenge because it is accurate and true [41].

Other adjacent research that examines cognitive schemas and emotional processing among adolescents may help understand the intersection of cognitive schemas and moral injury. While not exclusively focused on morality, the work of Calvete and Orue [42] explores how schemas related to the justification of violence and mistrust are important risk factors for later aggression [42, 43]. Calvete and Orue build on the work of Young et al. [44], noting that early maladaptive schemas, which are pervasive, dysfunctional patterns of beliefs about self and others, are developed in childhood, cultivated in adolescents, and expanded on throughout the life course [42, 44]. Of particular interest when considering the role of MI among children and adolescents is the EMS of mistrust. The mistrust schema "consists of the expectation that others will hurt, abuse, humiliate, or take advantage of one, and usually involves the belief that the harm is either intentional or the result of negligence" [42], p. 106). While this literature sits adjacent to the scholarly work on moral injury, multiple studies suggest mistrust may be connected to later aggressive behaviors in adolescent populations [45, 46]. A closer examination of these links between mistrust and aggression, as well as other cognitive schemas, particularly in the context of MI, could be useful.

Attachment Theory, Family Systems and Moral Injury

Attachment Theory and Connection to MI

Bowlby's attachment theory is a psychological framework that describes the dynamics of relationships between children and caregivers and lays the foundation for future

interpersonal relationships. Bowlby's theory, which has its roots in evolutionary biology [47] suggests that infants and young children have an internal drive to build connections with caregivers in order to survive [48, 49]. Creating a relationship with a dependable and reliable caregiver increases the likelihood that basic needs will be met. When this relationship is healthy and secure, it serves as the foundation for the child to explore the world around them [48, 50]. Kochanska [51] and Kidwell & Kerig [17] highlight that healthy caregiver-child relationships feature caregiver responsiveness and directly influence the development of moral thinking and behavior. Thus, the child-caregiver relationship is fundamentally important in helping the child build their mental representations of self and others and governs how they think, act, and behave. When a caregiver acts in responsive and attuned ways, this supports healthy development in multiple domains, including morals.

Later work by Mary Ainsworth [50] expanded on Bowlby's attachment theory and delineated four different types of attachment styles. She noted that a secure attachment style, when the child feels confident that the caregiver can respond to their needs in reliable ways, was the healthiest. A secure attachment would help a child develop positive internal working models (representations of self and the world), resilience, social competence, and the ability to explore the world around them [48, 50, 52]. The more recent literature on neurobiology corroborates the significance of the attachment relationship, as mapped out by early theorists. Porges [53] who is well known for his work on polyvagal theory, notes that secure early attachments are essential in building a healthy nervous system. Evolutionary biologist Robert Sapolsky further articulates the role of early attachment in his work on the neurophysiology of self-regulation [54].

The primary goal of normative moral development is to develop one's own sense of moral agency and internal working model for what is right and wrong. This generally relies on a foundation of healthy attachment, where caregivers are attuned to the child's needs and do not act in hostile or rejecting ways. Disruption or damage to normative moral development can be highly damaging and is closely related to early attachment relationships. Early attachment with a caregiver serves as the foundation for later relationships and how the child experiences, expresses, and modulates their emotions and navigates their world. As such, healthy attachment is a key construct in healthy development in general and moral development in particular.

Understanding the Role of Family Systems in Moral Injury

Like Piaget, Kohlberg, and others who came before them, Nash and Litz [1] suggest that moral development does not happen in isolation,rather, it occurs relative to the systems, relationships, and culture in which someone exists. One critical aspect of these systems is that they are ultimately made up of social relationships, which play an instrumental role in the development of morals. Mead [55] noted that "It is as social beings that we are moral beings" (p. 385).

Moral values and beliefs are shared through social relationships and provide a consistent and predictable way of governing behavior. When upheld, they also provide a foundation of trust and safety [1]. "Morality arises for social beings because it concerns situations in which interests are in conflict" [56], para. 9). This suggests that social relationships are a key part of moral development, and injuries to morals may involve relational elements. Nash and Litz [1] note that,

> MI can be conceptualized as the consequence of a challenge to moral belief systems that exceeds the information-processing capacity of the person at their current stage of development, given available social and spiritual resources. The relative toxicity of [PMIEs] may correlate not only with how violently they appear to contradict existing moral schemas but also the extent to which they compromise the ability of existing social and spiritual supports to maintain a secure holding environment. In this model, one would expect moral injuries resulting from perceived betrayals by those most trusted, such as family members, to be among the most egregious. (p. 370)

Family systems theory [57] provides a way of understanding family dynamics and posits that individual family members' behaviors, actions, needs, and upsets ripple throughout the family system. This would suggest then that breaches of trust within that system can have a profound impact on all members of the family. Nash and Litz [1] connect this to the understanding of MI in youth and families, noting that "to the extent members of families are interdependent, moral injuries resulting from betrayals of trust within the family can be transmitted and retransmitted between family members like waves generated by the fall of a rock in a small pond" (p. 371).

As the impact of MI ripples through the family system, considering the supports for all members of the system is critical. Williamson et al. [58] found that in a sample of 30 male veterans and their families, PMIEs had a negative effect on both the veteran and the family, including an impact on occupational functioning. This work highlighted the need to help spouses of veterans understand and navigate the veterans' needs while also supporting children and other family members. These works provide a useful framework for furthering our consideration of how MI may impact youth and, relatedly, family systems.

Trauma and Moral Injury

Adverse Childhood Experiences and Complex Trauma

Trauma and adversity, particularly those that occur during childhood when rapid developmental processes are unfolding, can have negative impacts. The Adverse Childhood Experiences (ACEs) study, conducted by the CDC and Kaiser Permanente in the late 1990s [59] found a strong correlation between childhood trauma and negative health outcomes in adulthood, including chronic diseases, mental health issues, and impaired cognitive development. ACEs can disrupt neurodevelopment, leading to lifelong challenges such as increased risk of substance abuse, difficulties in learning and memory, and greater susceptibility to chronic illnesses like heart disease and diabetes [59].

The original ACEs study by Felitti and colleagues [59] examined the presence of ten categories of childhood adversity. Participants were asked to place a number 1 next to each ACE category they had experienced before age 18 and then to calculate the total number of categories they had experienced. The categories included experiences like witnessing domestic violence, living with someone who had a drug or alcohol problem, experiencing physical abuse, living with an adult who was mentally ill, and experiencing unwanted sexual contact. The initial study was focused on the extent to which the individual had experienced any of those ten categories with discrete yes or no responses. The original exploratory study focused less on the extent of prolonged or repeated exposure to the types of traumas described in the categories.

The concept of complex trauma expands on what was learned in the ACE study. Both ACEs and complex trauma can significantly disrupt typical developmental processes, but complex trauma has a more central focus on exposure to chronic and prolonged traumatic events, most often within the caregiving system (i.e., abuse or neglect perpetrated by a caregiver). The National Child Traumatic Stress Network [60] describes complex trauma, noting.

> Both children's exposure to multiple traumatic events—often of an invasive, interpersonal nature—and the wide-ranging, long-term effects of this exposure. These events are severe and pervasive, such as abuse or profound neglect. They usually occur early in life and can disrupt many aspects of the child's development and the formation of a sense of self. Since these events often occur with a caregiver, they interfere with the child's ability to form a secure attachment. Many aspects of a child's healthy physical and mental development rely on this primary source of safety and stability. (para. 1)

A key feature of complex trauma is that it often occurs in the context of the caregiving system, where youth experience long-term, chronic trauma, adversity, and stress [60–62]. Unlike a single-incident traumatic event, complex trauma involves repeated, prolonged exposure to traumatic situations. These traumas are generally interpersonal in nature and occur during key developmental periods. Complex trauma can have deleterious impacts on youth, including causing difficulty with emotional regulation, cognition (e.g., memory, problem-solving), self-concept, understanding of healthy relationships, and even the development of morals.

Attachment Trauma and Betrayal Trauma

When there is a disruption or assault to healthy attachment, an "attachment trauma" may occur. When something damaging unfolds (i.e., neglect, abuse, parental mental illness, perceived emotional abandonment, etc.) the caregiver is no longer consistently available or able to keep the child physically or emotionally safe [48, 63]. Trauma, stress, and related disruptions to healthy attachment can fundamentally damage how children process information, regulate emotions, view themselves, and navigate the world [62][64]. These in turn, can have a catastrophic impact on healthy child development and children's sense of right and wrong.

Nash and Litz [1] noted that MI could occur directly (primary exposure) or indirectly (secondary exposure). In the context of military experience, direct exposure could include when a military family member (spouse or child) learns that their parent/spouse engaged in things during wartime that directly violated their moral code [1]. Indirect exposures specifically "constitute betrayals of trust, through actions or failures to act, perceived to be committed by members of one's moral covenant, including family members, teachers, community leaders, a deity, or oneself" [1], p 371).

Emerging research suggests that whether there is an immediate threat of danger (physical abuse) or a perceived threat of danger (separation from caregiver, emotional abandonment), youth can experience both as traumatic [17, 65, 66]. Both of these types of events could be characterized by a threat to the trustworthiness or availability of the attachment figure,either they were unavailable to meet the child's needs and/or the caregiver failed to keep the child safe [62, 65, 67]. Both "may be experienced as a threat to psychological survival through the eyes of children due to their ultimate reliance on that attachment figure for resources and support" [17], p. 462). Given the important role of the caregiver-child relationship in all aspects of development, including moral development, traumas such as those described above could be related to MI in youth [17]. When a caregiver fails to act in ways they are supposed to (based on perceived social

contracts, e.g., the caregiver's responsibility to keep a child safe), the young person may experience a MI.

An additional construct, *betrayal trauma*, was developed by Freyd and others and suggests that interpersonal betrayals (not just those with a caregiver) can result in a trauma response. Betrayal trauma is psychological harm caused when a person's trust or dependency is violated by someone (or something) that they rely on [68] (Freyd 2013) [69, 70]. Such betrayal can result in a trauma response, including a social betrayal, which could include institutions and systems [71–73].

Future Directions

While advances have been made in our understanding of MI in youth populations, there is still work to be done in order to fully understand the construct and how best to support those who experience it.

Advancing Research

From the emerging research in attachment and betrayal trauma, it is clear that there is much to learn about the specific experiences of youth and MI. We suggest here that community-based, participatory research approaches [74] that partner *with youth in the research process* and amplify their voices are essential. Even if children do not fully understand the concept of morality, they do have the ability to determine if someone with authority (parents, teachers, caregivers, caseworkers, etc.) has hurt them. As researchers, we have a responsibility to do research that trusts the experts (those with lived experiences), whether they are children or adults. Ethically working with youth in research involves doing no harm *and* trusting their expertise.

In addition to examining the construct of MI in youth populations, understanding MI in family systems is also important. Our research team (Wycoff, Roberts, Foleno, Bohn, Archer) is currently conducting a qualitative study exploring the experiences of spouses of military veterans. In this study, we seek to understand how a participant is affected by their spouse's MI and how MI impacts others in the family system. Early analysis suggests that this systemic impact may also include aspects of MI experienced by the non-military spouse. We are hoping to understand the lived experiences of the non-military spouse and their children. In this first phase of the study, we are not directly speaking to the youth; however, this is planned for future phases of the work. Finally, we encourage scholars to continue to consider what MI looks like outside of the military system. MI has historically been examined in the context of the military, but Haight et al. [13–15] and others have made it clear that MI exists outside of the military culture as well, and this warrants further exploration. The present authors share the sentiments of Bonson et al. [41], who note, "Although MI research is growing rapidly, most samples are small and largely consist of military or health care populations, highlighting a need for studies with larger, more varied populations to thoroughly conceptualize MI and develop treatments" (p. 78).

Considering the varied and complex nature of moral injury among youth populations and family systems, as well as the clear need for future research in this area, these authors have organized potential areas for future scholarship using various frameworks and theories. We propose that the broad frameworks serve as structures or outlines for organizing concepts or ideas. The frameworks noted below are relatively broad, whereas the theories are a more narrow and systematic set of principles or explanations that seek to explain a phenomenon.

We recognize that frameworks may be *based* on specific theories but are generally broader and more flexible than specific theories. A flexible approach (that considers both broad frameworks and more narrow theories) is a helpful strategy when considering a topic as complex and nuanced as MI. We use the term "theoretical framework" in Table 1 to denote this recommended flexible approach.

Treatment Implications

Treatment options for MI are also an area that warrants further attention. Serfioti and colleagues [75] noted that mental health professionals agreed on the need for improved therapeutic strategies for working with those who have MI. This study also highlighted the importance of increasing the flexibility of treatment approaches to allow a patient and provider to craft a personalized plan that is more likely to be implemented by the patient and their various support systems.

Policy and Practice

Despite the lack of current research on MI in children and youth, the findings described by Haight et al. [13] about MI in CPS systems underscore that policy needs to better center and support those experiencing MI. Additional research [76] suggests that teachers and other K-12 professionals are also experiencing MI as well. Teachers often experience moral dilemmas, which arise from conflicts between laws and professional commitments; overload, frustration, and guilt result in unresolved dilemmas [76]. Examining MI in systems and institutions may allow us to improve policy and practice and ensure we are truly

Table 1 Recommended Areas for Future Research

Theoretical Framework	Potential Areas of Inquiry
Complex Trauma Theory, Adverse Childhood Experiences Framework	What is the intersection of ACEs and MI in youth populations?
Systems Theory, Educational Theory, School Psychology Frameworks	What is the role of MI among youth in educational systems?
Systems Theory, Life-Course Theory	What is the role of MI among youth in judicial systems?
Systems Theory, Life-Course Theory	What is the role of MI among youth in child protective systems?
Family Systems Theory, Social Learning Theory, Attachment Theory	How does MI show up in family systems? What is the relationship between MI and intergenerational transmission processes?
Intersectionality Theory, Critical Race Theory, Cultural Ecological Theory, Racial Identity Development Theory	How do identity and positionality intersect with the experience of MI, particularly in youth populations?
Cognitive Behavioral Frameworks, Social Cognitive Theory, Constructivist Learning Theory	What are the cognitive schemas/mechanisms involved in MI among youth populations?
Kohlberg's Moral Development Theory, Piaget's Theory of Cognitive Development, Attachment Theory, Bandura's Social Learning Theory	'Does MI look different in youth and adults?' 'Does the fact that children and youth are still developing their morals impact how they experience MI?' 'Is there a difference in the resulting MI, based on the age or developmental stage that the PMIE occurred?'
Multiple intersecting theories and frameworks noted above would support the exploration of these research questions	How do we reliably assess and identify MI among youth populations? What treatments are most appropriate / well suited / impactful for youth populations experiencing MI?

ACE is the abbreviation for Adverse Childhood Experiences. MI is the abbreviation for Moral Injury. PMIE is the abbreviation for Potentially Morally Injurious Events

helping and not adding additional pain and suffering to those experiencing moral injury.

Conclusion

Knowing what is right and wrong is an essential element of the human experience. Morals and injuries to them emerge from an individual's diverse life experiences, and there is an increased need to understand both. In this perspectives piece, we suggest that there is a growing body of evidence to suggest that MI is a construct that extends to youth populations. There is a critical need for future research that explores the specific manifestations and interventions relevant to youth populations. Addressing these gaps in the literature is of utmost importance to enhance our understanding of MI. By doing so, we can develop more effective ways to support youth and their families in coping with the significant impacts that may result from moral and ethical transgressions.

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Data Availability No datasets were generated or analysed during the current study.

Declarations

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