Original Research

Moral Injury and Suicide Ideation Among Combat Veterans: The Role of Trauma-Related Shame and Collective Hatred

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Abstract

Exposure to potentially morally injurious events (PMIEs) among combat veterans has been acknowledged as a significant stressful combat event that may lead to mental health problems, including suicide ideation (SI). Several studies have examined the risk and protective factors that can explain the conditions in which PMIEs may contribute to the development and maintenance of SI. However, the contribution of social-emotional factors has yet to be examined. In the current study, we examined the association between PMIE-Self and SI among combat veterans and explored the mediating role of trauma-related shame and the moderation role of collective hatred in this association. A volunteer sample of 336 Israeli combat veterans was recruited, completing self-report questionnaires in a cross-sectional study. Results indicated that PMIE-Self was positively associated with SI, and trauma-related shame mediated this association. Moreover, collective hatred moderated both their direct (PMIE–SI) and indirect (PMIE–Shame–SI) association. Notably, collective hatred had an inverse role for each of the associations. Thus, collective hatred was found to comprise both a risk and a protective factor for SI following PMIE-Self. The current findings highlight the crucial contribution of trauma-related shame and collective hatred to

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the association between moral injury and suicidality. Moreover, the findings demonstrate that even years after their military service release, combat veterans exposed to PMIEs may still feel consumed by painful memories and maintain premonitions of a foreshortened future. Furthermore, the findings help to better understand the dynamics of collective hatred and the challenge of modifying it.

Keywords

Introduction

During their military service, and especially in times of war, many combat soldiers are subjected to ethical challenges. They may act in ways that transgress deeply held moral beliefs or may experience conflict about the unethical behaviors of others. Combat soldiers may also witness intense human suffering and cruelty that shake their core beliefs of humanity. These events have been recognized as potentially morally injurious events (PMIEs; Litz et al., 2009). PMIEs are commonly defined as the perpetrating, failing to prevent, witnessing, or learning about acts or events that transgress an individual's deeply held moral beliefs. Three categories have been attributed to PMIEs: acts or events performed by the individual (PMIE-Self), by others (PMIE-Other), and betrayal events (PMIE-Betrayal; Drescher et al., 2011; Litz et al., 2009; Maguen & Litz, 2012).

The prevalence of PMIEs tends to vary between eras, geographical areas, branches of military service, and the specific transgressive acts assessed (Frankfurt & Frazier, 2016). One study found that among a population-based sample of US veterans, a total of 10.8% of combat veterans reported personal transgressions, 25.5% endorsed transgressions by others, and 25.5% endorsed betrayal (Wisco et al., 2017). Another report among active-duty Marines deployed to Afghanistan revealed that 24.1% endorsed transgressions by self, and 28.4% endorsed betrayal (Jordan et al., 2017). In research done among Israel Defense Forces (IDF) combat veterans, 21.9% endorsed at least one PMIE-Self, 33.7% of the veterans endorsed at least one PMIE-Other, and 31% endorsed at least one PMIE-Betrayal (Zerach & Levi-Belz, 2018). Considering these numbers, the importance of addressing the issue of PMIEs and their consequences is critical.

Moral injury (MI) is the psychological, biological, spiritual, behavioral, and social impact created by PMIEs (Litz et al., 2009; Zerach & Levi-Belz, 2020). According to Litz et al.'s conceptual model, MI stems from the

dissonance between individuals' moral beliefs and their own or witnessed behavior during the PMIE. If the discrepancy between individuals' moral beliefs and the said behaviors remains unresolved, MI can manifest itself in the form of adverse psychological outcomes (Levi-Belz & Zerach, 2018; Zerach & Levi-Belz, 2018, 2019). A critical potential adverse psychological outcome is suicide ideation (SI; Levi-Belz & Zerach, 2018). Military service members, particularly combat veterans, have become a significant at-risk group for suicide in the last decade, with rates increasing steadily, nearly doubling since 2005 (Levi-Belz & Zerach, 2018; Reger et al., 2015).

Numerous studies have shown a unique influence of PMIE-Self on SI. For example, a recent study found that PMIEs committed by oneself or others were associated with higher SI and suicidal behavior levels than PMIE-Betrayal (Zerach & Levi-Belz, 2019). Other studies have shown that of the three PMIE aspects (Self, Other, and Betrayal), PMIE-Self manifested the strongest association with current SI (Bryan et al., 2014; Wisco et al., 2017). Lastly, PMIE-Self was the only aspect that remained positively associated with SI, even after controlling for depression and feelings of entrapment (Levi-Belz & Zerach, 2018). This strong association between PMIE-Self and SI may be due to PMIE-Self's entailing inner conflict and emotional distress about one's own acts and decisions that are perceived to be immoral. Suicidal individuals have extremely negative self-perceptions and tend to be highly self-critical about perceived defectiveness (Bryan et al., 2012, 2014; Kanzler et al., 2012). Thus, of the three PMIE aspects, PMIE-Self manifests the strongest relationships with hopelessness, guilt, and shame (Bryan et al., 2013). Hence our focus for the current study was on PMIE-Self and its association with SI.

After committing PMIE-Self, moral feelings may arise during the meaning-making process of those events (Farnsworth et al., 2014; Frankfurt & Frazier, 2016; Litz et al., 2009). Years after the event, some combat veterans may attribute their moral transgressions to global, internal, and stable flaws within their personality, and this attribution may lead to feelings of trauma-related guilt and shame (Litz et al., 2009; Zerach & Levi-Belz, 2018).

Shame comprises a negative global evaluation of the core self (Farnsworth et al., 2014; Tangney et al., 2007) and includes behavioral tendencies of avoidance and withdrawal (Litz et al., 2009; Tangney et al., 2007). Moreover, shame comprises the fear of facing rejection and condemnation of others as a consequence of one's actions (Crowder & Kemmelmeier, 2018; Gunnarsson, 2020). Thus, in the context of PMIE-Self, the feeling of trauma-related shame includes the belief that the combat veteran's transgressive acts must be hidden. Concealing these transgressive acts can, at times, result in distancing oneself from others (Øktedalen et al., 2014). Moreover, previous studies have

shown a positive association between shame and SI (Bryan et al., 2013, 2015; Cameron et al., 2020).

As noted, PMIE-Self may generate dissonance between soldiers' ethical beliefs and their behavior at the time of the event. In states of conflict, individuals tend to adjust their attitudes to their reaction at the time, thereby justifying and explaining it. In doing so, they diminish the discrepancy between their moral beliefs and their actions at the event (Gilovich et al., 2016). In the context of moral dissonance, Bandura (1999) introduced the concept of moral disengagement. *Moral disengagements* are performed through various moral justifications that can avert self-condemnation upon performing unethical acts (Bandura, 1999). In this way, individuals can perform actions that contradict their ethical standards without having to experience guilt or shame. Accordingly, it was found that collective hatred toward the out-group helps individuals interpret events and guide their behavior (Halperin, 2008). The process that leads to collective hatred includes a set of cognitive perceptions for which dichotomous thinking is central. Collective haters create an absolute separation between the in-group and the out-group; they believe that the out-group members are evil and identify a profound gap between themselves and the out-groups' values, ideologies, and basic goals (Bartlett, 2005; Elster, 1999; Halperin, 2008). For example, in Halperin's (2008) study on collective hatred, between-group disparity placed the out-group outside the accepted norms (delegitimization) and helped in-group members ascertain their superiority. Collective haters have been described as believing that the out-group members' actions are intentionally evil and emerge from the out-group members' motivation to harm the in-group (Bar-Tal et al., 2007; Elster, 1999; Halperin, 2008). In some situations, collective haters preferred to distance themselves from the out-group, and in others, they strived to harm it (Bar-Tal et al., 2007; Halperin, 2008; White, 1996).

Considering the above, it can be conjectured that collective hatred may provide a reasonable explanation for committing transgressive acts, even if those acts contradict the individual's moral standards. To our knowledge, only two qualitative studies have acknowledged the role of collective hatred in the context of MI (Shatan, 1973; Singer, 2004). In these studies, years after their release from the military service, combat veterans who committed atrocities still showed shame, hatred (toward themselves and others), felt they were unforgivable, and had the urge to self-punish. One manifestation of these self-punishing urges was SI. These studies adopted qualitative methodologies and suggested a theory of associations based on dynamic therapy, which the authors applied among war veterans (Shatan, 1973; Singer, 2004). However, these studies lacked a robust empirical basis for their ideas. Taken together, this qualitative research and the empirical research on collective

hatred (Halperin, 2008) suggest that out-group hatred may help combat veterans resolve their dissonance following PMIE-Self and, in turn, moderate its negative psychological consequences. According to recent theoretical and empirical studies on hatred, this posited effect of out-group hatred may be driven by the fact that hatred is associated with the belief that the "other" is evil or immoral by nature and will not or cannot change their malicious intentions, attitudes, and behavior (Halperin et al., 2012). Such beliefs provide the optimal resolution to the noted dissonance, as it enables one to fully justify militant behavior toward the malevolent other, which otherwise would be seen as immoral. Thus, our goal in this study was to shed light on the contribution of collective hatred on the associations between PMIE-Self, trauma-related shame, and SI.

The Present Study

According to Litz et al. (2009), MI results from the dissonance generated from the conflict between transgressive acts and long-held beliefs about one's basic moral worth and the world's goodness. If this dissonance is left to generate stable, internal, and global negative attributions about the causes and meaning of a transgressive act, then these attributions will lead to long-lasting shame, guilt, and a fear of being judged (Frankfurt & Frazier, 2016; Litz et al., 2009). Several studies have reported evidence of an association between PMIEs and SI, with mediators such as depression, feeling of entrapment, and meaning-making (Currier et al., 2015; Levi-Belz & Zerach, 2018), and moderators such as self-forgiveness and perceived social support (Levi-Belz et al., 2020).

The present study was designed to examine and expand Litz et al.'s (2009) conceptual model through an empirical investigation of the contribution of trauma-related shame and collective hatred to the association between PMIE-Self and SI among Israeli combat veterans. Examining the adverse psychological outcomes following PMIE-Self among Israeli combat veterans poses a unique and valuable opportunity in light of the features of their active duty: first, the veterans had been tasked with securing Israel's borders and participating in traditional armed conflict (including two major military operations that took place in Gaza in the last 10 years; second, veterans had carried out security and policing assignments, such as operating checkpoints, patrols, arrests, and ambush missions in the West Bank—an urban environment with proximity to civilians at varying levels of conflict. More broadly, IDF combat soldiers' activities are rooted in the context of the prolonged Israeli-Palestinian conflict and Israel's long-term occupation of the Palestinian territories. This context offers potentially dissonant circumstances whereby, on the one hand,

all Jewish Israelis are socialized to be part of the Israeli system, adopting the Zionist ethos of conflict (see Bar-Tal, 1998). However, at the same time, the mere act of occupation controverts many of the basic democratic values that most Israelis believe stand at the core of their nation's identity. As such, the microlevel dissonance noted above is further amplified by a more macrolevel dissonance.

This study's main objective was to understand the specific role of trauma-related shame and collective hatred in the linkage between PMIE-Self and SI. Based on our literature review, we focused on PMIE-Self as the primary facilitator of SI. Specifically, we aimed to determine if trauma-related shame has a mediating role in the association between PMIE-Self and SI and if collective hatred moderates this association. Following that, three hypotheses were tested: (H1) A positive and significant association will be found between PMIE-Self and SI; (H2) Trauma-related shame will mediate the positive association between PMIE-Self and SI; (H3) Collective hatred will moderate the direct and indirect associations between PMIE-Self and SI.

Method

Participants

This study is part of broader research regarding distress and growth in the aftermath of PMIEs. The current sample included 336 IDF combat veterans. Inclusion criteria required participants to have served as combatants and released from regular mandatory military service in the previous ten years. Of all participants who gave their consent ($n = 576$), 220 (38.2%) participants submitted incomplete questionnaires, and 20 (4.1%) participants did not meet the inclusion criteria. No significant demographic differences were found between veterans who completed the questionnaires and those who did not. Thus, whereas the drop-out rate proved relatively high, we have reason to believe that the study sample was representative of the IDF's young veteran population.

The combat veterans' demographic and army service characteristics are presented in Table 1. Two hundred eighty-one of the participants were males (84%). Their mean age was 26.16 ($SD = 3.06$). On average, they had completed 13.36 ($SD = 1.89$) years of education. Most of the participants were secular (67.9%), Israel-born (84.6%), and were unmarried (77%). Of the participants, 41.2% worked in part-time jobs and reported having a below-average income (66.9%). The average time since deployment for our sample was 4.21 ($SD = 2.45$) years. The distribution of army units revealed 39.9% in the Infantry, 9.2% in the Armored Corps, 8.3% in the Artillery Corps, and 8% in the Combat

Engineering Corps. In general, these percentages are comparable to other young veteran samples (Zerach & Levi-Belz, 2019; Levi-Belz et al., 2020).

Table 1. Veterans' Sociodemographic and Army Service Characteristics.

Variable		N (%)	M (SD)
Sociodemographic characteristics			
Gender[1]	Male	281 (83.9%)	
	Female	54 (16.1%)	
Age			26.16 (3.06)
Education			13.36 (1.89)
Origin	Israel	281 (84.6%)	
	Europe/North America	26 (7.8%)	
	Asia/Africa	2 (0.6%)	
	FSU	21 (6.3%)	
	South America	2 (0.6%)	
Time since immigration[2]			17.62 (8.24)
Marital status	Single	258 (77%)	
	Married	73 (21.8%)	
	Divorced	1 (0.3%)	
	Other	3 (0.9%)	
Children	Yes	38 (11.5%)	
	No	293 (88.5%)	
Relationship duration[2]			3.5 (2.76)
Working status	Full-time job	136 (40.6%)	
	Half-time job	138 (41.2%)	
	Not working	61 (18.2%)	
Income	Above average	51 (15.6%)	
	Average	57 (17.5%)	
	Below average	218 (66.9%)	
Religiosity	Secular	228 (67.9%)	
	Traditional	60 (17.9%)	
	Orthodox	44 (13.1%)	

Table 1. continued

Variable		N (%)	M (SD)
Ultraorthodox		1 (0.3%)	
Other		3 (0.9%)	
Army service characteristics			
Time since deployment[2]			4.21 (2.45)
Branch of military	Infantry	134 (39.9%)	
	Armored corps	31 (9.2%)	
	Artillery corps	28 (8.3%)	
	Combat engineering	27 (8%)	
	Other	116 (34.6%)	

[1]One missing value in gender, summing to 335; [2]in years.

Procedures

Potential participants were recruited between August and November 2019, using two methods: (1) Invitations to participate were uploaded to Facebook social media groups (e.g., military units, colleges, universities, cities); (2) Using snowball sampling, participants distributed invitations to participate to their colleagues with whom they did their IDF service. The invitation to participate in the trial included a message that explained that the research focused on "military service experiences" and solicited volunteer participants. All potential participants were informed of the risks and compensation procedures before their participation and were promised at the outset that questionnaire data would be completely anonymous, with no personal identifying information collected. They also received an explanation of the study's aims and a link to the related online survey through an online data-gathering website (Qualtrics.com). Combat veterans agreeing to participate were required to affirm their willingness to participate and sign an informed consent form. Following the completion of the online questionnaire, participants were compensated with a voucher for coffee and pastry (approximate value: US$5). Ethical approval for this study was granted by the Ruppin Academic Center's internal ethical boards.

Measures

PMIE-Self was measured using the Moral Injury Event Scale (MIES; Nash et al., 2013). MIES is a self-report 9-statement questionnaire that assesses

exposure to perceived transgressions committed. The MIES scale comprises three subscales: (1) MIES-Self—four items assessing exposure to MI resulting from committing acts or making decisions perceived as morally wrong (e.g., "I acted in ways that violated my moral code or values"); (2) MIES-Other—two items that assess exposure resulting from witnessing or learning about others' actions perceived as morally wrong (e.g., "I am troubled by having witnessed others' immoral acts"); and (3) MIES-Betrayal—three items that assess exposure to MI resulting from perceiving deception or betrayal by others (e.g., "I feel betrayed by fellow service members whom I once trusted"). Veterans were instructed to answer the items regarding their military service. The statements were presented on a 6-point Likert-type scale, ranging from 1 (strongly disagree) to 6 (strongly agree). Following other studies in the MI field, we used the sum of scores for each subscale in our analyses. The MIES has demonstrated good preliminary factor structure and reliability, with only small to moderate correlations with other psychopathology measures, indicating that the MIES comprises a distinct construct (Bryan et al., 2014). In the present sample, the MIES showed good internal consistency among the subscales of Self ($\alpha = .91$), Other ($\alpha = .8$), and Betrayal ($\alpha = .82$). In the present study, we focused on the MIES-Self subscale, with the additional subscales (MIES-Other and MIES-Betrayal) used for further data exploration and substantiation of our findings. The results regarding the MIES-Other and MIES-Betrayal subscales are presented in the appendices.

Trauma-related shame was measured using the Trauma-Related Shame Inventory (TRSI; Øktedalen et al., 2014). The TRSI is a 24-item self-report questionnaire that assesses the subjects' feelings of trauma-related shame. The items included both internal shame (e.g., "As a result of my traumatic experience, I do not like myself") and external shame (e.g., "If others knew what happened to me, they wouldn't like me"). Items were presented on a 4-point Likert-type scale ranging from 0 (not true of me) to 3 (true of me), with the total scale score ranging from 0 to 72. The scale has demonstrated robust construct and content validity (Øktedalen et al., 2014). In the present sample, very good internal consistency was demonstrated for the internal shame ($\alpha = .96$) and external shame ($\alpha = .97$) subscales.

Collective hatred was measured using the Hatred Appraisal Scale (Halperin et al., 2012). It included four items that were part of a longer hate scale originally developed and validated by Halperin et al. (2012). The original scale yielded a solid internal reliability of .71 and has been used in numerous studies in several contexts and regarding various potentially hated groups. The current scale taps the participants' level of collective hatred toward the Palestinian population. The scale's targeting of feelings toward the Palestinian population stems from the frequent friction of IDF soldiers as they encounter

Palestinians in the course of their service. Participants rated their level of agreement with the scale items, presented on a 6-point Likert-type scale ranging from 1 (not at all) to 6 (very much). The subjects rated to what extent they thought that (1) "The Palestinians are evil by nature," (2) "The Palestinians are not moral and will never change," and (3) "The Palestinians are all identical to each other." Moreover, the subjects rated the extent to which they felt that "The Palestinians want to harm us without instrumental goals" (4). For the present sample, the scale presented very good reliability ($\alpha = .90$).

SI was measured using the Suicidal Behaviors Questionnaire-Revised (SBQ-R; Osman et al., 2001). The SBQ-R is used to assess the general suicide risk of SI and behavior. The SBQ-R comprised four items: lifetime suicidal ideation and previous suicide attempts ("Have you ever thought or tried to kill yourself?"); frequency of suicidal ideation over the past 12 months ("How often have you thought about killing yourself over the past year?"); the current threat of making a suicide attempt ("Have you ever told someone you were going to commit suicide or might commit suicide?"); and the likelihood of suicidal behavior in the future ("How likely are you to commit suicide someday?"). For our focus on current SI in the present study, we used Item 2, which taps the participant's frequency of suicidal ideation over the past 12 months. The participants rated their response on a 5-point Likert-type scale, ranging from 1 (never) to 5 (very often). Other studies have used a single item to assess suicidality, and more specifically, Item 2 has been used to assess SI (Levi-Belz & Zerach, 2018; Teismann et al., 2018). Moreover, there is strong evidence for a single item's predictive ability and its relevance for assessing suicidality (Green et al., 2015; Simon et al., 2013).

Sociodemographic measurements were assessed using demographic characteristics of the participants' country of origin, family status, religious orientation, age, gender, income level, educational level, army unit, and year of release from the IDF.

Results

Data Analysis

To examine the role of trauma-related shame and collective hatred on the association of MIES-Self and current SI, we carried out our data analysis in two stages. First, we performed a preliminary Pearson correlation test to examine the associations between the study variables and calculated their prevalence. Second, we performed a mediation-moderation analysis, using PROCESS macro model 8 (Hayes, 2013), using SPSS statistics V. 25 and the extension of PROCESS macro (Hayes, 2013).

Prevalence of PMIEs and Collective Hatred Toward Palestinians

We calculated descriptive statistics and rates of MIES, shame, collective hatred, and current SI. We calculated the percentages of participants who reported that they "slightly agree" or higher with the MIES-Self statements. The most-endorsed MIES-Self item was, "I acted in ways that violated my values or moral code" (24.18%). For the Collective Hatred questionnaire, we calculated the percentages of participants who reported "to a certain extent" or higher to the presented statements. The most commonly endorsed items were, "I think the Palestinians want to hurt us without instrumental goals" (61.68%), and "I think the Palestinians are immoral and will never change" (52.68%). Although most of the participants (79.8%) reported that they had not experienced SI over the past year, the remaining 20.2% reported having at least one thought of committing suicide over the past year; these numbers correspond to previous studies conducted on young veterans in Israel (Levi-Belz & Zerach, 2018).

Relationships Between Sociodemographic Characteristics and Current SI Among Veterans

In preliminary analyses before examining the hypotheses, no significant SI differences were found in ANOVA analysis regarding veterans' gender, family status, religiosity, service branch, IDF military job, performance of reserve duty, and elapsed time since demobilization. SI levels were also not significantly associated with any other demographic variable, including age, income level, and education level. Furthermore, no significant differences or correlations were found upon examining demographic relationships with the three PMIEs subscales.

Intercorrelations Between Study Variables

Confirming our hypothesis, MIES-Self correlated positively and significantly with current SI. Moreover, a positive association was found between MIES-Self and trauma-related shame. Trauma-related shame was also associated positively and significantly with current SI. Whereas collective hatred was not significantly correlated with MIES-Self, collective hatred correlated positively with trauma-related shame and negatively with current SI. Table 2 presents the associations between all study variables. The results regarding MIES-Other and MIES-Betrayal subscales are presented in Table A in the Appendix.

Table 2. Descriptive Statistics and Bivariate Correlations Between Study Variables (*N* = 334).

	1	2	3	4
1. MIES-Self	–			
2. Shame	.44***	–		
3. Collective hatred	.01	.26***	–	
4. Current SI	.33***	.27***	−.16**	–
M	8.46	8.01	12.62	1.37
SD	5.02	13.6	5.82	.86
Range	4–24 (20)	0–67 (67)	4–24 (20)	1–5 (4)

Note. *p < .05, **p < .01, ***p < .001; MIES = Moral Injury Event Scale, SI = suicide ideation.

Mediation-Moderation Model

To examine the model in which the relationship between MIES-Self and current SI is mediated by trauma-related shame and moderated by collective hatred, we employed a mediation-moderation analysis using PROCESS macro macro model 8 (Hayes, 2013). MIES-Self was the independent variable, current SI was the dependent variable, trauma-related shame was the mediating variable, and collective hatred was the moderating variable. The levels of collective hatred were selected in accordance with the PROCESS macro analysis—the mean and ±1 *SD*. We examined two moderations: the moderation of collective hatred on the positive association between MIES-Self and current SI (the direct effect) and the moderation of collective hatred on the positive association between MIES-Self and trauma-related shame (the indirect effect). The analysis revealed that the index of mediation moderation was significant (95% CI [0.01, 0.08]). The results are presented in Table 3.

As seen in Table 3, we found that collective hatred moderated the association between MIES-Self and trauma-related shame. The positive association between MIES-Self and trauma-related shame increased as the levels of collective hatred rose. Moreover, the association between trauma-related shame and current SI was positive and significant. Accordingly, the indirect effect of MIES-Self on current SI through trauma-related shame was significant at all levels of collective hatred.

Furthermore, collective hatred also moderated the direct effect of MIES-Self on current SI. The interaction revealed that the positive effect of MIES-Self on current SI decreased as collective hatred rose. At high collective hatred levels, the direct effect of MIES-Self on current SI disappeared. The mediation–moderation model was confirmed. The results suggest a

Table 3. Results of the Integrative Model.

	B	SE	T	P	Bootstrapped CI 95%		R²
					LL	UL	
Model 1: Mediator variable model				Outcome: Trauma-related shame			
MIES-Self	.24	.30	.79	.43	−.35	.82	.30
Collective hatred	−.11	.23	−.49	.63	−.55	.33	
MIES-Self × collective hatred	.08	.02	3.62	.00	.04	0.12	
The conditional direct effect of MIES-Self on trauma-related shame							
Collective hatred (−1 SD)	.75	.18	4.21	.00	.40	1.11	
Collective hatred (Mean)	1.19	.13	9.26	.00	.94	1.45	
Collective hatred (+1 SD)	1.63	.18	9.32	.00	1.29	1.98	
Model 2: Outcome variable model				Outcome: Current SI			
MIES-Self	.10	.02	4.76	.00	.06	.13	.20
Trauma-related shame	.02	.00	4.26	.00	.01	.02	
Collective hatred	.01	.02	.66	.51	−.02	.04	
MIES-Self × collective hatred	−.01	.00	−3.26	.00	−.01	−.01	
The conditional direct effect of MIES-Self on current SI							
Collective hatred (−1 SD)	.06	.01	5.09	.00	.04	.09	
Collective hatred (Mean)	.04	.01	3.65	.00	.02	.06	

(continued)

Table 3. continued

	B	SE	T	P	LL	UL	R²
				Bootstrapped CI 95%			
Collective hatred (+1 SD)	.01	.01	.65	.52	−.02	.04	
Bootstrapping results for the indirect effect (via trauma-related shame)							
Index of moderated mediation	.00	.00			.01	.08	
The conditional indirect effect of MIES-Self on current SI (via trauma-related shame)							
Collective hatred (−1 SD)	.01	.01			.01	.03	
Collective hatred (Mean)	.02	.01			.01	.04	
Collective hatred (+1 SD)	.03	.01			.01	.05	

Note. MIES = Moral Injury Event Scale, SI = suicide ideation.

$N = 308$. B = unstandardized regression coefficients. Bootstrap sample size = 5,000. *LL* = lower limit. *CI* = confidence interval. *UL* = upper limit.

mediation of trauma-related shame on the association between MIES-Self and current SI. Figure 1 describes the model paths. The results concerning MIES-Other and MIES-Betrayal are presented in Appendices B and C.

Discussion

In this study, we examined the mediating role of trauma-related shame and the moderation of collective hatred in the link between PMIE-Self and SI. We focused specifically on PMIE-Self, as various studies have shown that the association between PMIE-Self and suicidality is particularly strong (e.g., Levi-Belz & Zerach, 2018; Wisco et al., 2017; Zerach & Levi-Belz, 2019). Our findings demonstrated a positive correlation between all three PMIE subscales and SI. As in previous studies, PMIE-Self correlated the strongest with SI compared to PMIE-Other and PMIE-Betrayal. To our knowledge, this is the first study to examine the mediating role of trauma-related shame in the association of PMIE-Self and SI. Moreover, it is the first study to empirically examine the critical contribution of collective hatred in the context of MI in general, specifically in its role in the PMIE–Shame–SI
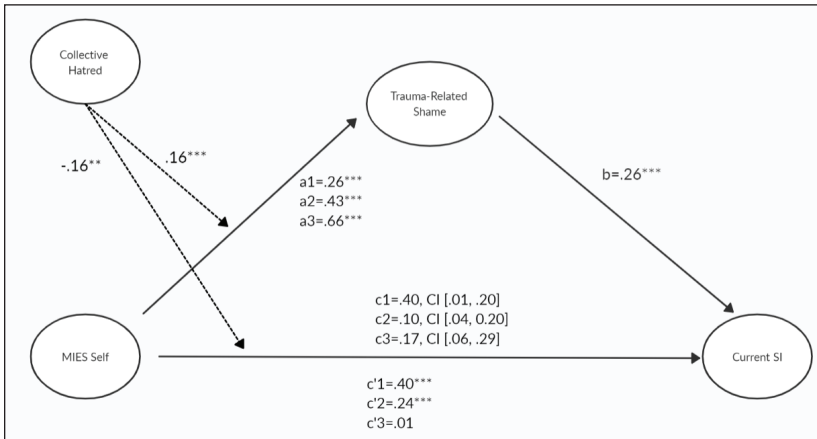

Figure 1. The association between MIES-Self and current SI, as moderated by collective hatred and mediated by trauma-related shame (*N* = 308).

The figure represents the standardized values. *p < .05, **p < .01, ***p < .001; CI = confidence intervals; a = The association between MIES-Self and trauma-related shame, b = The association between trauma-related shame and current SI, c = The indirect association between MIES-Self and current SI, c' = The direct association between MIES-Self and current SI (1 = for low levels of collective hate, 2 = for average levels of collective hate, 3 = for high levels of collective hate); SI = suicide ideation; MIES = Moral Injury Event Scale. The numbers represent the β values.

association. Our findings indicate that transgressive acts performed by one-self (PMIE-Self) contribute to an elevation in SI. These findings align with previous research in the field (Bryan et al., 2014, 2018; Levi-Belz & Zerach, 2018; Levi-Belz et al., 2020).

Importantly, however, it should be noted that as this study is cross-sectional and lacking data regarding prior exposure to trauma, our ability to infer causality from results of the multiple and serial mediation analyses is very limited. This limitation is particularly important in this field, as a systematic review of prospective studies (DiGangi et al., 2013) found that the uses of various coping styles (e.g., rumination, avoidance) that were assessed before the traumatic exposure comprise predisposing risk factors for PTSD or SI and not only the consequences of traumatic exposure or the results of the interaction with it. Thus, the pattern of associations that has been found in this study should be further validated in future prospective studies among more representative samples of veterans.

Our results indicated that PMIE-Self contributed to feelings of trauma-related shame and that feelings of shame contribute to an elevation in SI. These results align with previous studies in the field (Bryan et al., 2013; Cameron et al., 2020; Zerach & Levi-Belz, 2018, 2019). The novelty of our study is the identification of the mediating role of trauma-related shame in the association between PMIE-Self and SI. Our findings reveal two pathways in the PMIE-Self and SI relationship. The first is an indirect path, which includes trauma-related shame as a mediator, and the second is a direct path, not explained by trauma-related shame. Several studies have indicated similar variables as mediating the relationship between PMIEs and psychopathology (Levi-Belz & Zerach, 2018; Zerach & Levi-Belz, 2018, 2019); however, this study is the first to demonstrate the mediating role of trauma-related shame, as suggested in Litz et al.'s (2009) conceptual model.

More central to our study, we found confirmation for a moderation-mediation model, in which collective hatred plays a moderating role, both in the direct path between PMIE-SI and in the indirect route of PMIE–shame–SI. Our findings offer an empirical basis to previous theories that suggested the existence of shame, collective hatred, and the urge to self-punish among combat veterans who committed atrocities (Shatan, 1973; Singer, 2004). Moreover, our findings suggest that when soldiers perform PMIE-Self, collective hatred can serve both as a protective and a risk factor for SI. In the direct path, when collective haters perform PMIE-Self, they report less SI. In contrast, in the indirect route, when collective haters perform transgressive acts, they feel more shame for their actions and, ultimately, experience higher current SI levels.

Elucidating the Role of Collective Hatred in the Mediated Association Between PMIE-Self, Trauma-Related Shame, and SI Among Combat Veterans

An intriguing question that may arise from the study's findings is how can the inverse role of collective hatred as moderating the link between PMIE-Self and SI be explained. One explanation may relate to the definition of PMIE-Self as the level at which combat veterans believe that they committed acts or made decisions they perceive to be morally wrong (Litz et al., 2009). According to this definition, participants reporting high levels of PMIE-Self acknowledged that they had committed an act or made a decision contrary to their moral standards. Thus, participants who reported performing PMIE-Self perceived themselves as having failed to refrain from conduct incongruent with their moral standards. Consequently, they experience distress in the form of trauma-related shame and SI.

Emotion regulation implies an effort to transform an existing emotion into a desired one (Gross, 1998). Thus, when individuals seek to avert such distress, they will seek to regulate their emotions. One way to regulate combat veterans' distress following PMIE-Self is through collective hatred, as it can provide moral justification for their actions. In the direct path, we can see that collective hatred functions as a moral justification for the PMIE-Self and, thus, manages to reduce its contribution to the elevation of SI.

In the indirect path, however, collective hatred appears to have a paradoxical role. Collective haters who report committing PMIE-Self experience relatively more trauma-related shame, and in turn, their current SI levels increase. Typically, individuals' sense of shame stems from violating their moral or social codes of conduct (Crowder & Kemmelmeier, 2018), as occurs in PMIE-Self. When individuals feel shame, they typically sense a threat to their social bond (Gunnarsson, 2020; Retzinger, 2002; Scheff, 2000).

In emotion regulation, individuals are motivated to regulate their emotions in a way that promotes the desired relations between the in-group and the out-group (Porat et al., 2020). Collective hatred provides justification for the PMIE-Self to the individual's in-group (if the out-group is evil and wants to harm the in-group, the group will be unlikely to reject the individual who committed the PMIE-Self). Thus, it can be assumed that combat veterans would have an incentive to adopt this perspective. However, it may be that the effort to regulate the individual's trauma-related shame following PMIE-Self through collective hatred paradoxically leads to the implementation of the threat to the social bond, thus elevating feelings of shame and, ultimately, SI.

Studies have shown that individuals having a liberal ideology subscribe to more (or more intense) moral concerns than conservatives (Emler et al.,

1983; Graham et al., 2009). Also, liberals, compared with conservatives, recorded higher agreement rates with the moral statement, "It can never be right to kill a human being" (Graham et al., 2009). Thus, as PMIE-Self comprises a subjective perception, it is reasonable to assume that those affiliating with a more liberal group would have lower thresholds for reporting PMIE-Self. Consequently, it can be assumed that liberals will score relatively higher on the PMIE-Self scale for identical acts, inducing relatively greater trauma-related shame following the transgressive acts. Hence, it is likely that liberally oriented soldiers would be more motivated to rely upon a sense of collective hatred to justify their deeds to their in-group as a way to regulate their feelings of trauma-related shame. In this manner, liberal soldiers' agreement with statements such as, "It can never be right to kill a human being," is likely to be diminished, and thus, their views will be further distanced from their in-group. Indeed, research has shown that individuals tend to shift to the conservative right when faced with a collective threat (Bonanno & Jost, 2006; Landau et al., 2004; Porat et al., 2019). Hence, tragically, as collective hatred increases in order to justify committing atrocities, the divergence between the combat veterans who performed the PMIE-Self and their in-group increases as well. In this situation, the threat to the social bond becomes more tangible and will likely be expressed in the elevation of trauma-related shame, perhaps leading to an increase in SI.

The second possible explanation of our findings is driven by psychodynamic theories. According to Klein's object relations theory (Klein, 1946, 1988), the infant has two sets of emotional experiences from the earliest stages of life—love and hatred. Klein's theory asserts that we are born into a *paranoid-schizoid* position that preserves the *split* between the good (feelings of love) and the bad (feelings of hatred) into separate objects. Over time, the mental capacity to accommodate complexity matures and develops the *depressive position*, which includes the realization that good and bad can coexist in the same object. Klein's notion of positions differs from other developmental theories in that we do not grow out of, or grow through, this position, but continuously move from one to the other (Clarke, 1999). Thus, in adulthood, *splitting*, which characterizes the *paranoid-schizoid* position, is adopted as a low-order defense mechanism that distorts reality. In certain situations, the regression to splitting is adaptive and helps individuals cope. Given the moderating effect of collective hatred in the direct path between PMIE-Self and SI, it would appear that the splitting defense mechanism operates effectively. Individuals that manage to split and hate the out-group are more shielded from the complexity of the situation and its adverse psychological consequences.

Regarding the findings in the indirect path, shame involves the belief that one is a bad person; notably, shame differs from guilt, which indicates that one had performed a bad deed (Crowder & Kemmelmeier, 2018; Tangney et al., 1996). Thus, it seems that in shame, there is an emotional split similar to that characterizing hatred. Accordingly, Strachey (1961) described suicide as a sadistic act of the superego, which punishes the ego and leads to death. Thus, it can be assumed that when a veteran performs a mental split and senses shame for the actions committed, not only does the PMIE victim become utterly evil, but the veteran also ascribes evil to the veterans themselves. Ultimately, the SI elevation results from the superego's urge to punish the ego for its actions. In both experiences, there is a clear, dichotomous vision of reality that does not accommodate complexity or nuance. The distinction between collective hatred and shame is that whereas the former splits the external object (the out-group), the latter splits the self. Thus, it appears that the splitting defense mechanism becomes ineffective when applied in this case as it does not reduce the elevation of trauma-related shame and SI in the indirect path.

Limitations and Future Studies

Several important limitations of this study warrant mention. First, as noted, given the cross-sectional nature of the data, the directionality and causality of the associations found among the variables remain undetermined. Therefore, the directionality we propose is speculative and is based on Litz et al. (2009) conceptual model. Thus, future longitudinal studies would contribute to a better understanding of the direction of the associations revealed in our findings. Second, the study did not examine prior exposure to trauma, and thus it could not be controlled as a covariate. Moreover, considering the crucial role of collective hatred and trauma-related shame in the linkage between PMIE-Self and SI, future research should examine the associations and contributions of various demographic variables to hatred, shame, and suicide risk.

Third, as the data were derived from self-report measures, a well-acknowledged range of biases may have been introduced, caused by factors such as mood-dependent recall, forgetting, and social desirability. Specifically, assessing PMIE-Self by self-report in the absence of objective assessment may present an estimation bias. However, importantly, self-report questionnaires are prevalent in war-related trauma and suicide studies. The questionnaires' format facilitated our understanding of the combat veterans' subjective and perceived experiences regarding PMIE and SI, as well as the psychological mediators and moderators. Regarding PMIEs, the combat veterans'

perception of the events is the most critical component in how these events evolve to PMIEs and, consequently, to MI processes.

Moreover, it is important to note that the SI and PMIE-Self measurements were assessed using relatively few items (i.e., SI was assessed by a single item and PMIE-Self by four items), which may reduce the validity of the findings. Although previous research exhibits standard practice with good construct validity to those measurements, future research should examine these variables using a mixed-methods approach. A mixed-methods approach enables obtaining information both from questionnaires and from the participants' description of their experience. Furthermore, whereas the TRSI taps participants' reactions during and following a traumatic experience(s), our study did not explicitly ask the respondents if they had experienced trauma during their military service. Although the TRSI instructs the participants to respond based on their military service experiences, we acknowledge the importance of understanding the exposure to and experience of trauma and suggest that future studies examine this specifically and separately when using the TRSI.

Fourth, we capitalized on a nonrepresentative, volunteer sample that may not accurately represent the study variables' rates of occurrence among combat veterans. Participant recruitment for the study relied on the snowball sampling technique with a focus on social media. Thus, the participating veterans may have been more inclined than others to disclose, express, use social media, and participate in surveys, possibly introducing a small sampling bias. Future studies should examine intact groups (e.g., army units) to overcome this limitation. Moreover, 38% of the veterans in the initial sample only partially completed the questionnaires and are thus regarded as missing data. This relatively high percentage of incomplete questionnaires could be related to the questionnaires' length and nature, tapping sensitive and emotional issues such as SI, hate, and PMIEs.

Lastly, we did not query participants regarding their political ideology (liberal or conservative), and we did not examine the sources of their sense of collective hatred. Thus, we were unable to investigate the effect of these factors in the current work. Future studies should examine the specific contribution of ideology and motivation toward feelings of collective hatred on MI experiences.

Theoretical, Clinical and Social Implications

The study findings offer several theoretical, clinical, and social implications. From the theoretical perspective, our work supports Litz et al.'s (2009) conceptual model concerning the role of trauma-related shame, with an

important addition of collective hatred as an essential moderating variable. Understanding the contribution of the various mediating and moderating factors to MI is critical to fully understand this phenomenon, its components, and its contributing features.

Moreover, our study offers several clinical implications. First, the association we found between PMIE-Self and SI highlights the importance of marking PMIE-Self as events that exacerbate suicide risk. Thus, military personnel and clinicians must be skilled in identifying them and performing suicide risk assessment among combat veterans who have endured such events, even years after their military service discharge. Second, following the contribution of trauma-related shame as a mediator of the relationship between PMIE-Self and SI, discussing these feelings and facilitating their emotional expression in the therapeutic process would have particular value. Processing trauma-related shame in a therapeutic framework would help alleviate symptoms, and, as a result, reduce SI (Gilbert & Procter, 2006; Lipsitz & Markowitz, 2013). Third, our clinical work facilitates identifying soldiers at risk for SI and enables a targeted treatment, even before their departure for combat missions.

Moreover, our study also has social implications regarding aspects of group conflict. The high rates of agreement regarding statements on the Collective Hatred Assessments Scale highlight the social relevance of addressing collective hatred in army veteran populations. Through our study, some of the adverse psychological consequences of group conflict on the individual can be observed. Whereas our findings showed that collective hatred comprises, in part, a protective factor for these deleterious psychological consequences, it is critical to remember that collective hatred feeds ongoing conflict between the groups. We emphasize that from a normative perspective, whereas it is important to reveal the potentially seemingly advantageous effects of hatred as a protective factor, we certainly believe that hatred should be diminished, given its nature as being one of the most problematic and destructive emotions in the context of long-term intergroup conflict (see Halperin, 2008). At the same time, however, we believe that our findings help to deepen our understanding of some of the dynamics of collective hatred and the challenge of modifying it, especially among combat veterans. Thus, in the context of racism-reduction programs, it may be appropriate to design tailored intervention programs for combat veterans having experienced PMIE-Self, which would take into account the protective factors of collective hatred.

Declaration of Conflicting Interest

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