



CLINICAL DIAGNOSTIC CHEAT SHEET: PTSD VS. MORAL INJURY

A 4-Page Reference Guide for Specialized Trauma Practitioners and Veteran-Heavy Mental Health Clinics brought to you by: Moral Injury Support Network for Servicewomen, Inc.

CLINICAL FOUNDATIONS & NEUROBIOLOGICAL FRAMEWORK

Understanding the clinical divergence between Post-Traumatic Stress Disorder (PTSD) and Moral Injury (MI) is critical to unlocking recovery for clients who are "stuck" in standard exposure-based trauma protocols. While they frequently co-occur, their etiological roots, core emotions, and neurobiological pathways are distinct.

ETIOLOGICAL PATHWAYS

PTSD: Threat-Based Response (Fear & Safety)

[Life-Threatening Event] → [Amygdala Hyperactivation] → Fight/Flight

MORAL INJURY: Value-Based Response (Ethics & Beliefs)

[Moral Transgression] → [Cognitive Dissonance] → Existential Dissonance

1. Neurobiological Divergence

- **PTSD (Fear-Circuitry Dominant):** Primarily driven by the hyperactivation of the amygdala, hypoactivation of the medial prefrontal cortex (mPFC), and hippocampal dysfunction. The nervous system remains trapped in a persistent state of autonomic hyperarousal (sympathetic nervous system dominant), reacting to environmental cues as active threats to physical survival.
- **Moral Injury (Cognitive-Evaluative Dominant):** Primarily activates the "Default Mode Network" (DMN) and brain regions associated with moral evaluation, social cognition, and self-referential processing (e.g., the anterior cingulate cortex [ACC], orbital frontal cortex [OFC], and insula). Rather than a dysregulated threat-detection system, Moral Injury is an ongoing state of profound cognitive

and existential distress stemming from the rupture of one's global moral belief system.

2. Primary Affective Profiles

- **PTSD:** Fear, terror, horror, helplessness, and physiological vulnerability.
- **Moral Injury:** Guilt, shame, existential betrayal, self-loathing, moral disgust, and profound grief.

3. The Female Servicemember Nuance

Female veterans and servicewomen face a highly intersectional risk profile for Moral Injury. The trauma is often compounded by:

- **Betrayal Trauma:** High incidence of Military Sexual Trauma (MST) or systemic institutional minimization, where the "betrayal by trusted authorities" (leadership, peers, the institution) acts as the primary catalyst for Moral Injury.
- **Gender-Responsive Friction:** The dissonance between societal expectations of femininity/motherhood and the brutal, utilitarian demands of operational military service.

THE DIFFERENTIAL DIAGNOSTIC MATRIX

This matrix maps the diagnostic criteria of DSM-5-TR PTSD against the clinical presentation of Moral Injury to assist in side-by-side differential assessment.

Clinical Dimension	DSM-5-TR PTSD	Moral Injury (Non-DSM Syndrome)
Primary Driver	Threat & Fear (Actual or threatened death, serious injury, or sexual violence).	Moral Transgression / Betrayal (Acts of commission, omission, or betrayal by trusted authorities).
Somatic Markers	Hypervigilance, exaggerated startle response, panic attacks, physiological reactivity to trauma cues.	Chronic fatigue, heavy somatic burden (feeling "weighted down"), somatic symptoms of depression, lack of somatic safety.
Cognitive Alterations	"The world is unsafe." "I cannot protect myself." (Anxiety/survival focus).	"I am a monster." "The system is fundamentally corrupt." "God has abandoned me." (Identity/moral focus).
Avoidance Behavior	Avoidance of external physical triggers (places, sounds, smells, crowds) that mimic the event.	Avoidance of internal moral triggers (intimate relationships, spiritual settings, looking in the mirror).

Social / Relational	Social withdrawal driven by fear of lack of safety or hypervigilance.	Self-isolation driven by the belief that "if people knew what I did/saw, they would despise me."
Treatment Response	Responds well to standard Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT).	Often <i>worsened</i> by PE (exposure without moral processing can cause re-traumatization); requires meaning-making.

CLINICAL ASSESSMENT & INTERVIEW PROTOCOL

When assessing veterans, standard trauma diagnostic tools (such as the CAPS-5) may miss underlying moral injury. Use this semi-structured interview guide to assess the etiology and depth of moral distress.

Semi-Structured Clinical Interview Prompts

Use these targeted, gentle prompts to explore moral landscapes without triggering defensive walls:

- **To Assess Acts of Commission (Doing something that violated moral codes):**

"In high-stakes, operational environments, people are often forced to make decisions where there are no good options. Looking back at your service, do you feel you had to make decisions or take actions that crossed your own personal moral line?"

- **To Assess Acts of Omission (Failing to prevent something that violated moral codes):**

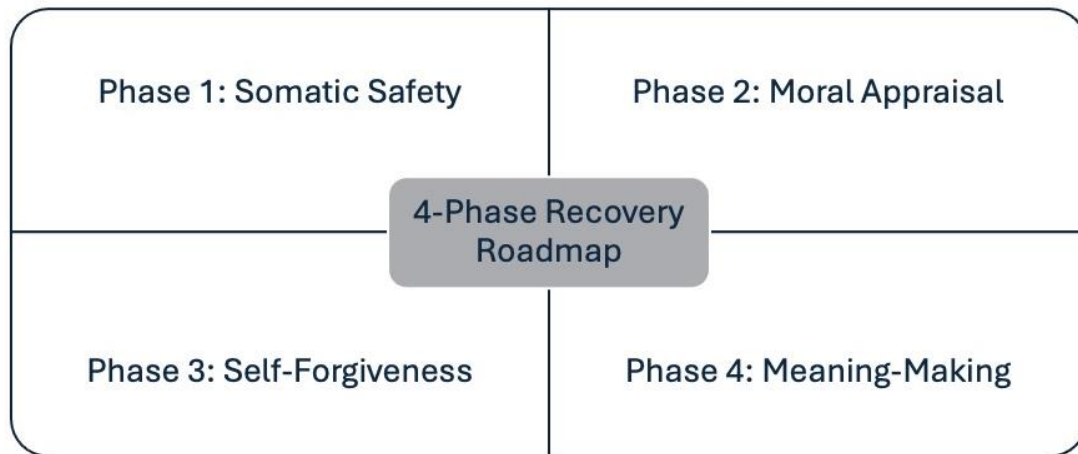
"Sometimes the heaviest burdens we carry are not things we did, but things we felt powerless to stop. Are there moments from your service where you felt you couldn't speak up, intervene, or protect someone else according to your values?"

- **To Assess Betrayal (Being violated by trusted peers or leaders):**

"Military service relies on intense trust in leadership and peers. Did you experience times where people in authority—or the institution itself—acted in ways that deeply betrayed your trust, your safety, or your core values?"

GENDER-RESPONSIVE INTERVENTIONS & CLINICAL RESTORATION

Once a primary or co-occurring diagnosis of Moral Injury is established, the treatment plan must shift from threat-extinction to moral repair, identity integration, and meaning-making.



Phase 1: Establish Somatic Safety (Somatic Resourcing)

Before engaging in moral processing, the client must feel somatically grounded.

- **Technique:** Use bilateral stimulation (EMDR) or somatic experiencing to anchor the client in the physical present. Address the "heavy burden" sensation in the chest or shoulders directly through breathwork.

Phase 2: Cognitive Moral Appraisal & Deconstruction

Explore the rigid, globalized beliefs ("I am unlovable," "All leaders are corrupt") that drive the moral distress.

- **Technique:** Deconstruct "All-or-Nothing" thinking. Help the client separate their *identity* from the *actions* they were forced to take under extreme operational conditions. Transition the client's internal language:
 - *From: "I am a monster because of what I did."*
 - *To: "I did something under immense pressure that conflicted with my deeply held values, which proves my conscience is still intact."*

Phase 3: The Pivot to Self-Forgiveness and Sorrow

Shame is an internalizing, self-destructive emotion ("*I am bad*"). Sorrow is an outward-facing, healing emotion ("*I feel deep pain for what happened*").

- **Technique:** Facilitate a symbolic "Restorative Apology." Have the client write a letter of remorse or acknowledgment to those affected by their action/omission,

or to their younger self. Focus on transitioning internal guilt into active compassion.

Phase 4: Meaning-Making & Purpose-Driven Post-Traumatic Growth

Moral Injury cannot be cured by forgetting; it must be resolved through integration and purposeful living.

- **Technique:** Connect the client with localized service, mentorship, or peer-advocacy. For military women, this often looks like mentoring younger servicewomen or joining veteran advocacy groups. This externalizes their moral energy, turning a past "soul wound" into a profound source of clinical and community authority.

For the complete 12-NBCC credit syllabus and masterclass schedule featuring Dr. Daniel L. Roberts and Gina Hernandez, go to:

<https://misns.org/programs/workshops/>