**The Role of Compassion in Moral Injury among Military Veterans: Implications for Treatment**

**Abstract**

**Objectives:** The study investigated the relationship between psychological distress, alcohol use, and the fears, facilitators and inhibitors of compassion, as well as the three flows of compassion on moral injury (MI) in veterans. **Methods:** A total of 127 participants (81.9% male, *Mage*= 51.24, *SD* = 13.98) completed measures of MI, psychological distress, alcohol use, shame, fears of compassion, self-criticising and self-reassurance, and the three flows of compassion. Bivariate correlations and a hierarchical multiple regression were conducted to determine relationships between psychological distress, alcohol use, and the facets of compassion and MI, and whether psychological distress, alcohol use, and the facets of compassion predicted MI among veterans. **Results:** Demographic variables of younger age and lower rank alongside psychological distress, alcohol use, and the facets of compassion were all significantly related to MI in veterans. Age, rank, psychological distress, alcohol use, and the facets of compassion did not predict MI in veterans. However, shame was found to be the biggest predictor of MI in veterans, followed by lower rank. **Conclusions:** The study supports prior research indicating MI as a shame-based presentation with younger age and lower rank posing as risk factors for MI in veterans. Additionally, the findings indicate strong relationships between the facets of compassion and MI in veterans, highlighting the potential clinical utility of including compassion within MI-based interventions.

*Keywords:* Military, veterans, moral injury, compassion, shame

**Clinical Impact Statement:**

MI has been recognised as a shame-based disorder where compassion-focused treatments may be theoretically suitable to treat MI in veterans. MI has been associated with increased psychological distress, alcohol use, shame, fears of compassion to self, others, and from others, and has been linked to decreased self-reassurance, self-compassion, and compassion to others, supporting the use of trialling compassion-focused treatments for moral injury among veterans in clinical settings. In addition, lower age and rank have been identified as risk factors for developing moral injury among veterans.

**Introduction**

**Moral Injury**

Moral injury (MI) describes the intense feelings of guilt and shame experienced by military veterans after combat exposure (Frankfurt & Frazier, 2016). MI has been proposed to occur when one “acts in ways that transgress deeply held moral beliefs and expectations” (Litz et al., 2009, p.697). Although MI is yet to be classified as a mental health disorder, it is widely recognised as a syndrome related to increased shame, guilt, anger, self-injurious behaviours, and loss of trust in self and others (Frankfurt & Frazier, 2016; Koenig et al., 2017; Litz et al., 2009).

MI has been theoretically related to post-traumatic stress disorder (PTSD) (Koenig & Al Zaben, 2021; Litz et al., 2009) and shares characteristics with PTSD limited to the affective domain within the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) criteria for PTSD (American Psychiatric Association [APA], 2013; Koenig & Al Zaben, 2021). PTSD is a fear-based disorder characterised by hyperarousal and avoidance following exposure to traumatic events (APA, 2013), whereas MI is characterised by guilt and shame resulting from exposure to morally injurious events (MIE). The distinct differences (i.e., guilt and shame) between PTSD and MI are supported by research revealing differences in neuropsychological mechanisms (Barnes et al., 2019), and the development of questionnaires measuring each construct separately (Currier et al., 2017).

**Moral Injury and Veterans**

MI research is rooted within the military due to the large number of MIEs military personnel experience (Litz et al., 2009). MIEs within this context include failures of leadership, killing/injuring in combat, betrayal by others, and witnessing mistreatment of civilians (Bryan et al., 2014; Currier et al., 2015; Shay et al., 2002; Williamson et al., 2019). Consequently, veterans are at high-risk for developing MI (Hamrick et al., 2020). Maguen et al. (2020) found 27.9% of 7200 post 9/11 veterans witnessed MIE’s, 18.8% perpetrated MIE’s, and 41.1% experienced MIE-related betrayal.

Research investigating MI in veterans has consistently revealed adverse mental health outcomes including increased PTSD symptoms (Bryan et al., 2016; Koenig et al., 2019), suicidal ideation (Ames et al., 2018; Hamrick et al., 2019), depression (Currier et al., 2014), and alcohol misuse (Davies et al., 2019). Interestingly, Nieuwsma et al. (2021) evaluated different MI measures revealing that MI robustly correlated with increased PTSD, depression, suicidality, and alcohol abuse. From this, research recommendations were made to investigate MI as a distinct presentation from PTSD (Nieuwsma et al., 2021).

**Treatment for Moral Injury**

Research has focused on applying evidence-based treatments for PTSD, including cognitive processing therapy and prolonged exposure to the treatment of MI, revealing reductions in trauma-related guilt (Held et al., 2018; Paul et al., 2014). However, these findings are limited due to methodological issues, leaving debate as to the appropriateness of PTSD treatments for MI (Maguen & Burkman, 2013). Furthermore, it has been argued that fear-based models of PTSD do not sufficiently address MI-related processes and emotions (e.g., guilt, shame) (Griffin et al., 2019; Litz et al., 2017). Therefore, research investigating alternative treatments focusing on the distinctly different characteristics of MI (e.g., shame and guilt) from the fear-based aspects of PTSD is required (Frankfurt & Frazier, 2016; Griffin et al., 2019).

Emerging research indicates that Adaptive Disclosure (Litz et al., 2017), Acceptance and Commitment Therapy (Hayes et al., 1999), spiritual groups (Cenkner et al., 2021), and Cognitive Behavioural-based interventions (e.g., Impact of Killing treatment) (Purcell et al., 2018) may be beneficial for MI among veterans. Of interest, these alternative treatments share a focus on targeting guilt and shame via compassion (Griffin et al., 2019; Koenig & Al Zaben, 2021).

**Compassion Theory: Three Flows and Inhibitors and Facilitators of Compassion**

Gilbert (2014) defines compassion as “a sensitivity to the suffering in self and others, with a commitment to try and alleviate and prevent it” (Gilbert, 2014, p.19). Gilbert et al. (2017) propose compassion as an evolved care-based motivational process of stimulus detection and behavioural response to alleviate suffering. This is depicted within a three-system model consisting of a threat system, a drive system, and a soothing system (Gilbert, 2009). According to Gilbert’s (2014) theory, compassion can be understood as an integrated tri-directional flow of compassion to self (SC), to others (CtO), and from others (CfO). Gilbert et al. (2017) suggests the three compassionate flows function distinctly differently, yet all influence one another.

Gilbert (2011) proposes attachment insecurities and early abuse from significant others activates fear responses to compassion, resulting in inhibition of the three compassionate flows. Consequently, fears of compassion (FoC) inhibit the ability for effective engagement in compassion-focused treatment (Gilbert, 2010). Contrastingly, self-reassurance (SR) has been linked with warmth and safeness, helpfully activating the soothe system, and acting as a facilitator of compassion (Gilbert, 2009).

Kirby et al.’s (2019) meta-analysis exploring the three FoC (fears of compassion to self [FCTS], fears of compassion to others [FCTO], and fears of compassion from others [FCFO]) and psychological functioning found FCTS, FCTO, and FCFO were related to depression, shame, and self-criticism. Interestingly, Forkus et al. (2019) found FCTS mediated the association between PTSD symptoms and alcohol misuse in veterans. However, only one study to date has researched the three FoC in veterans, and no research thus far has explored this in relation to MI.

Derived from evolutionary psychology (Darwin, 1872), neurophysiology (Porges, 2007), attachment theory (Bowlby, 1982), and Buddhist traditions (Gilbert, 2009), Gilbert (2020) developed Compassion Focused Therapy (CFT) to support individuals with shame and self-criticism. CFT adopts a transdiagnostic approach to reduce threat-based responses, address emotional dysregulation, and promote soothing behaviours (Gilbert, 2014; Leaviss & Uttley, 2015). Numerous reviews have supported the use of CFT for self-criticism, shame, psychosis, and trauma (Craig et al., 2020; Leaviss & Uttley, 2015).

**Applying Compassion to Moral Injury**

Compassion has consistently been associated with reduced features related to MI including shame, self-criticism, and alcohol use (Irons & Lad, 2017; Phelps et al., 2018; Zhang et al., 2017). Given this, compassion-based therapies have been proposed for treating MI in veterans (Farnsworth et al., 2014; Williamson et al., 2019). Emerging evidence has demonstrated efficacy of using SC interventions for PTSD in veterans (Eaton et al., 2020). For example, Held and Owens (2015) revealed a SC workbook increased levels of SC and decreased trauma-related guilt, Hiraoka et al. (2015) found SC was negatively associated with PTSD symptoms among U.S. veterans, and Steen et al.’s (2021) recent review revealed SC reduced PTSD symptoms and trauma-related guilt in veterans.

A promising body of research has explored the use of CFT for veterans (Grodin et al., 2019; Lang et al., 2019). Grodin et al. (2019) investigated the feasibility and effectiveness of group CFT for veterans with PTSD and anger, revealing reductions in PTSD symptoms, anger, and FoC. Moreover, a Cognitively Based Compassion Training programme focusing on developing SC and CtO found reductions in PTSD symptoms, depression, and anxiety among veterans (Lang et al., 2019). However, research is lacking into exploring how CfO may present in a veteran population.

Due to theoretical underpinnings of CFT in targeting shame, alongside the promising emerging evidence investigating compassion-focused interventions for veterans, it may be beneficial to explore the different facets of compassion and their relationship to MI in veterans. One preliminary study exploring MIEs, mental health, and SC in veterans revealed SC moderated relations between MIE’s, PTSD, depression, and self-harm (Forkus et al., 2019). In contrast, Kelley et al. (2019) found no moderating effects of SC on MI and suicidality in veterans, highlighting the need for future research to explore the varying facets of compassion for MI in veterans, whilst considering confounders such as fears of compassion.

**The Present Study**

The current study therefore aims to investigate the association between psychological distress, alcohol use, the inhibitors of compassion (shame, FCTS, FCTO, FCFO, self-criticism), facilitators of compassion (SR), and the three flows of compassion (SC, CtO, and CfO) on MI among veterans. The study hypothesises that (1) Psychological distress, alcohol use, and the inhibitors of compassion (shame, FCTS, FCTO, FCFO, and self-criticism) will be positively related to MI; (2) The facilitators of compassion (SR) will be negatively related to MI; (3) Lower levels of SC and CtO will be associated with increased MI; (4) SC and CtO will predict MI after accounting for the contributions of psychological distress, alcohol use, and the inhibitors (shame, FCTS, FCTO, FCFO, and self-criticism) and facilitators (SR) of compassion.Due to scarcity of evidence in the literature, no directional hypothesis could be made for CfO and MI.

**Materials & Methodology**

**Design**

A correlational design using internet-mediated research was used to quantitatively explore the research hypotheses. A G\*power (Faul et al., 2009) calculation was conducted to determine the sample size and power with an alpha value of 0.05 and power of 0.80, indicating a total of 103 participants were required for the study.

**Participants**

Participants included 127 military veterans who met the study inclusion criteria (see Table 1). The sample comprised 81.9% males and 17.3% females with a mean age of 51.24 years (*SD* = 13.98), ranging from 25-84 years. Most participants identified as White British/Scottish/Irish/Gypsy, or Irish Traveller (92.9%), with the remaining identifying as Black (1.6%), Asian (1.6%), or Mixed (2.4%) ethnicities. Most participants were in full-time employment (52.8%), followed by retired (26%), part-time employed (15%), in volunteer work (3.1%), or not stated (3.1%).

Participants were predominantly in non-commissioned ranks (lower rank) (78.0%) compared to commissioned ranks (higher rank) (18.9%). Most participants had been deployed (86.6%), 51.2% spent 0-10 years in service, and 48.8% spent 11 or more years in service. Most participants had experienced past or current physical and mental health problems (35.4%), with 32.3% of participants receiving past psychological and medical treatment, and 17.3% receiving current psychological and medical treatment. Demographic information is presented in Table 2.

**Measures**

***Demographics***

Demographic characteristics included age, gender, ethnicity, employment, relationship status, and military service. Risk factors associated with MI were assessed including rank, deployment, length of service, discharge reason, past or current physical and/or mental health problems, and past or current psychological and/or pharmacological treatment.

***Moral Injury***

The Expressions of Moral Injury Scale-Military Version (EMIS-M; Currier et al., 2017 is a self-report 17 item questionnaire assessing MI in military populations. The EMIS-M assesses self-directed and other-directed MI. Items are rated on a 5-point scale ranging from 1 (strongly disagree) to 5 (strongly agree). An example item is “I am an unforgivable person because of things that I did/saw in the military”. There are no clinical cut-offs for the EMIS-M, although higher scores indicate increased levels of MI. The EMIS‐M has demonstrated strong internal consistency, Cronbach α = .95 (Currier et al., 2017). The total score was used to capture MI as an overall factor (Currier et al., 2017; Currier et al., 2019).

***Shame***

The External and Internal Shame Scale (EISS; Ferreira et al., 2020) is an 8-item self-report measure assessing global shame and the external and internal dimensions of shame (e.g., “I am isolated” and “Other people see me as uninteresting”). Each item is rated on a 5-point Likert scale ranging from 0 (never) to 4 (always). Scores vary between 0 and 32 points, with higher values indicating higher levels of shame. The EISS has demonstrated good internal consistency, Cronbach α =.89 (Ferreira et al., 2020).

***Self-criticising and self-reassuring***

The forms of self-criticising/attacking, and self-reassuring scale **(**FSCRS; Gilbert et al., 2004) is a 44 item self-report measure assessing self-criticism (e.g., “I am easily disappointed with myself”) and SR (e.g., “I find it easy to forgive myself”). The questionnaire is split into two sub-scales (self-criticism and SR). The self-criticism subscale measures two forms of self-criticism: inadequate self (IS) and hated self (HS). Items are scored on a 5-point Likert scale ranging from 0 (not at all like me) to 4 (extremely like me). Scores are summed on three subscales (inadequate self, hated self and self-reassurance) with higher scores indicating worse outcomes. The FSCRS demonstrated good internal consistency, with Cronbach α =.91 for inadequate self, Cronbach α =.87 for hated self, and .85 for reassured self (Gilbert et al., 2014).

***Alcohol Use***

The Alcohol Use Disorders Identification Test (AUDIT; Saunders et al., 1993) is a 10-item self-report questionnaire assessing alcohol consumption, drinking behaviour, and alcohol related problems. An example item is “How often do you have a drink containing alcohol?”. Items are scored on a 0–4-point scoring system. Scores are summed and range from 0-40. Scores of 8 or more indicate harmful alcohol use. The measure has been validated across numerous studies demonstrating good internal consistency with a Cronbach α score falling in the =.80s (Reinert & Allen, 2002).

***Psychological Distress***

The Clinical Outcomes in Routine Evaluation (CORE-10; Barkham et al., 2013) 10-item self-report questionnaire screened for anxiety, depression, trauma, physical problems, general functioning, and risk to self. An example item is “I have felt unhappy”. Each item is rated on a 5-point Likert scale ranging from 0 (not at all) to 4 (most or all the time). Higher scores indicate greater mental distress. A clinical cut off score of 11 is indicative of requiring mental health support (Barkham et al., 2013). The CORE-10 has demonstrated good psychometric properties and good internal consistency, Cronbach α = .90 (Barkham et al., 2013).

***Fears of Compassion***

FoC was assessed using the Fears of Compassion Scale (FCS; Gilbert et al., 2011) measure. The FCS measures comprises of three subscales measuring three different FoC: fear of compassion for self, for others, and from others. Participants respond to each item (e.g., “I fear that being too compassionate makes people an easy target”) on a 5-point Likert scale ranging from 1 (don’t agree at all) to 5 (completely agree). Scores for each subscale are summed with higher scores indicating greater fears of compassion. The FCS has demonstrated good internal consistency, Cronbach α = .79 (Asano et al., 2017).

***Three Flows of Compassion***

Gilbert et al’s (2017)Compassionate Engagement and Action Scales (CEAS) questionnaire assessed SC (e.g., “I toleratethe various feelings that are part of my distress”), CtO (e.g., “I notice and am sensitive to distress in others when it arises”), and CfO (e.g., “Others are emotionally moved by my distressed feelings”). The three respective scales comprise of 13 items on a 10-point Likert scale ranging from 1 (never) to 7 (always). For each three scales, two subscales can be calculated (engagement and actions) by summing items related to each subscale. A total scale score for each scale is derived from the sum of scale items. Reverse items are not included in the scoring. Higher scores represent higher levels of compassion. The CEAS has demonstrated good internal reliability, Cronbach α from .67 to .94 (Murfield et al., 2020).

**Procedure**

The study was approved by the University of Southampton Ethics and Research Governance board (ERGO number 69915) on 01/06/2022. Participants were recruited via an anonymous survey link that was shared on social media platforms including Facebook, Twitter, and online military-based groups (e.g., Veterans UK).

All participants were required to provide informed consent via the online consent form within the survey. Participants completed demographic questions followed by the EMIS-M, EISS, FSCRS, CORE-10, FCS, AUDIT, and CEAS. Participants were provided with online links and telephone numbers to NHS and military based support services at the beginning and end of the survey. Participants were debriefed at the end. Upon survey completion, participants had the opportunity of entering a prize draw to win one of four £50 Amazon vouchers.

**Data Analysis**

Analyses were performed using SPSS (Version 29) and statistical significance was set at *p* = .05. Data were screened for missing values, outliers, and unusual values. A total of 239 participants completed a minimum of 5% of the measures. Those who completed <86% of the full set of measures were removed as this resulted in zero CEAS data. This resulted in the removal of 40.6% of data. Participants who completed at least one of the three parts of the CEAS were included in the analyses. This resulted in 93.7% (*n* = 119) of the sample with full data sets, 2.4% (*n* = 3) of the sample with CtO missing, and 3.9% (*n* = 5) with CfO missing. Histograms, scatterplots, and boxplots indicated the assumptions of homoscedasticity, normality, and linearity were met.

**Results**

**Hypothesis 1: Psychological distress, alcohol use, and the inhibitors of compassion (shame, FCTS, FCTO, FCFO, and self-criticism) will be positively related to MI**

All correlations and descriptive statistics are reported in Table 3. As depicted in Table 3, bivariate analyses indicated strong significant positive correlations between psychological distress (*r* = .737), alcohol use (*r* = .337), shame (*r* = .765), FCS (*r* = .702), FCTO (*r* = .548), FCFO (*r* = .704), and self-criticism as indicated by IS (*r* = .712) and HS (*r* = .759), and MI. Interestingly, age (*r* = -.327) and commissioned ranks (*r* = -.226) were also significantly correlated to MI, indicating veterans younger in age and lower in rank are likely to experience increased MI (see Table 3).

**Hypothesis 2: The facilitators of compassion (SR) will be negatively related to MI**

In support of hypothesis two, SR was found to be significantly negatively associated with MI (*r* = -.474) indicating that veterans who are higher in SR are likely to experience lower MI symptoms (see Table 3).

**Hypothesis 3: Lower levels of SC and CtO will be associated with increased MI**

Bivariate correlations revealed SC (*r* = -.347) and CtO (*r* = -.204) was significantly associated with increased MI, indicating veterans who are lower in SC and CtO experience increased MI symptoms. Interestingly, CfO was not significantly correlated with MI (*r* = -.115) supporting the proposed null hypothesis (see Table 3).

**Hypothesis 4: SC and CtO will predict MI after accounting for the contributions of psychological distress, alcohol use, and the inhibitors (shame, FCTS, FCTO, FCFO, and self-criticism) and facilitators (SR) of compassion**

A hierarchical multiple linear regression examined the role of the three flows of compassion (SC, CtO, CfO) on MI symptoms whilst controlling for age, rank, psychological distress, alcohol use, and the inhibitors (shame, FCTS FCTO, FCFO, and self-criticism) and facilitators (SR) of compassion. Overall, the model was found significant (*F* (14,118) = 19.12, *p* < .001), accounting for 72% of the variance of MI. The model indicated SC [*β =*.090], CtO [*β =*-.121], CfO [*β =*.083] did not significantly predict MI in veterans after accounting for age (*β =* .023), rank (*β =* -.112), psychological distress (*β =* .116), alcohol use (*β =*.071), and the inhibitors (shame [*β =* .425] FCTS [*β =* .050], FCTO [*β =* .064], FCFO [*β =* -.017], and self-criticism as indicated by IS [*β =* .093] and HS [*β =* .166]) and facilitators (SR [*β =* -.052) of compassion.

However, upon closer inspection of the individual predictors (age, rank, psychological distress, shame, alcohol use, FCS, FCTO, FCFO, SR, SC, CtO, and CfO), only shame and rank remained significant predictors of MI (see Table 4). The analysis revealed shame as the most prominent predictor of MI (*β* = .425), followed by rank (*β* = -.112).

**Discussion**

**Findings in Context**

The current study investigated the association between MI, psychological distress, alcohol use and the various facets of compassion as proposed by Gilbert (2020) among veterans. The results are discussed in consideration of research and theories.

**Inhibitors and Facilitators of Compassion and MI**

The current study found shame and self-criticism were positively associated with MI among veterans, with shame as the primary predictor of MI. This supported Litz et al. (2009) who propose MI results in feelings of shame and self-loathing. Additionally, FCTS, FCTO, and FCFO were all strongly related to increased MI. Shame is associated with a perceived negative evaluation from others and the self, resulting in high self-criticism and increased psychological distress (Litz et al., 2009; Gilbert & Irons, 2008). Consequently, individuals experiencing shame and self-criticism can withdrawal from others due believing they are undeserving of compassion, leading to the development of FoC (Gilbert, 2009; Litz et al., 2009; Naismith et al., 2017). Subsequently, this avoidance maintains MI-related shame and the three FoC (Litz et al., 2009). Alternatively, SR has been proposed as an antidote to self-criticism, acting as a protective factor against psychopathology, and may explain the current significant relationship between increased SR and reduced MI in veterans (Gilbert, 2006).

**Psychological Distress, Alcohol Use, Military Characteristics and MI**

This study partially replicated prior research revealing increased psychological distress and alcohol use were significantly associated with MI (Ames et al., 2018; Bryan et al., 2016; Williamson et al., 2021). Furthermore, increased alcohol use has historically served as a coping strategy within the military and has more recently been linked to MI-related self-harming behaviours (Murphy & Turgoose, 2019). The current finding further evidences the prevalence of alcohol use in military population.

Interestingly, the study revealed veterans younger in age and lower in rank are at increased likelihood of experiencing MI symptoms. Moreover, findings from the current regression analysis revealed rank as the second biggest predictor of MI among veterans. This supports prior research demonstrating links between MI and less social empowerment (e.g., younger age), highlighting these as risk factors for MI among veterans (Nieuwsma et al., 2022).

**The Three Flows of Compassion and MI**

MI within the military has been proposed to develop by either acts committed by oneself, or acts committed by others (including betrayals) (Currier et al., 2014; Litz et al., 2009; Shay, 2014). Based on this, the SC and CtO flows may relate to the two respective forms of MIE that occur in the military. If one experiences shame and distrust resulting from transgressive acts committed by oneself or others, then resistances and FCTS and FCTO may arise (Gilbert et al., 2017; Kirby et al., 2019; Litz et al., 2009). These resistances may include shame, avoidance, and reduced empathy for others, potentially explaining the current association between reduced SC and CtO and increased MI among veterans.

Interestingly, CfO was not related to increased MI among veterans. CfO has been linked to the quality of care received during early life, with increased CfO relating to positive and caring relationships, and reduced CfO relating to a lack of social support and neglectful relationships during early childhood (Gilbert et al., 2017). Early life experiences such as adverse childhood experiences (ACE’s) were not measured in the current study, therefore, factors such as access to support during early life may contribute to the understanding of the current finding. Moreover, research suggests each flow of compassion can differ in relation to different mental health presentations (Kirby et al., 2019). Given the novelty of these findings, further research is required to establish how CfO relates to MI, a veteran population, or whether this finding is idiosyncratic to MI in veterans.

Of note, SC, CtO and CfO did not predict MI after accounting for the effects of age, rank, psychological distress, alcohol use, and the inhibitors (shame, FCTS, FCTO, FCFO, and self-criticism), and facilitators (SR) of compassion. However, the findings from the regression analysis revealed that together, age, rank, psychological distress, alcohol use, and the facets of compassion (Gilbert, 2020) play a large role in MI among veterans, potentially indicating the clinical utility of using CFT within the treatment for veterans experiencing MI (Gilbert, 2009).

**Strengths, Limitations and Suggestions for Future Research**

This is the first study exploring the facets of compassion and MI among veterans, contributing to the novel emerging evidence-base (Kelley et al., 2019). The study included a large sample with a diverse range of characteristics, enhancing generalisability of the findings (Fox et al., 2009). Additionally, the study employed standardised validated measures to enhance the reliability and validity of the findings (Fox et al., 2009). The study provides further evidence for the conceptual understanding of MI as a predominantly shame-based presentation, supporting evidence that PTSD interventions using fear-based models may not appropriately target shame-based processes relating to MI among veterans (Griffin et al., 2019; Litz et al., 2009).

In consideration of the limitations, the cross-sectional and correlational nature of the data limits the ability to draw causal inferences (Kesmodel, 2018). Future research adopting longitudinal designs are required to determine causal inferences. Moreover, the findings tentatively indicate the need for future research to start exploring the utility of CFT for MI in veterans, adopting randomised controlled trial (RCT) designs to establish its effectiveness. Furthermore, more research is needed into whether compassion differs in relation to the two different forms of MI among veterans to further guide treatment.

The participants comprised mainly White males who had been deployed at least once. Therefore, these findings may not generalise to female veterans, and those from other cultures and ethnic backgrounds. Future research should aim to investigate these variables to develop a deeper understanding in this area. Additionally, factors which impact shame, FoC, and the three flows of compassion (e.g., ACEs) were not accounted for in the study (Gilbert, 2014; Lucre & Clapton, 2021), which is another potential avenue for future research.

**Clinical Implications**

The findings tentatively support the clinical utility of using CFT for MI among veterans, which adopts a transdiagnostic approach to increase compassion, reduce shame and self-criticism, and address FoC (Gilbert, 2009). Therefore, services should routinely screen for MI in veterans, start trialling the use of CFT for MI among veterans, and evaluate the effectiveness of this. Furthermore, services should routinely consider rank and age as risk factors when assessing veterans experiencing MI.

**Conclusions**  
 The current study indicates MI as a shame-based presentation among veterans and provides an initial insight into the complex relationships between the various facets of compassion and MI in veterans. The findings highlight age and rank as potential risk factors for MI, and alcohol use and psychological distress as MI-related comorbidities. The findings tentatively support the potential value of utilising CFT for veterans with MI, highlighting the need for future research in this area. The non-significant finding between CfO and MI in veterans needs further consideration to explore whether this is idiosyncratic to this study, to MI and/or the veteran population. Clinical services should aim to routinely assess for MI, shame, compassion, inhibitors and facilitators of compassion, and consider age and rank as risk factors.

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