

RIGHT ON CRIME

MORAL INJURY IN THE TEXAS FIRST RESPONDER WORKFORCE:

Findings and Policy Recommendations

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KEY POINTS

- **62.6% of Texas first responders** surveyed had experienced a morally injurious event; half of those screened positive for probable PTSD.
- **More than half reported** numbness or detachment from people and surroundings, which is an established risk factor for suicide.
- **The newest responders**, in their first three years on the job, showed the highest distress of any tenure cohort.

EXECUTIVE SUMMARY

Moral injury (MI) is the psychological injury that follows perpetrating, witnessing, or failing to prevent acts that violate one's deepest moral beliefs. It is widespread, debilitating, and under-recognized among Texas first responders. It frequently is comorbid with post-traumatic stress disorder (PTSD) but is rooted in shame, guilt, and betrayal of trust rather than fear, and requires a different response.

These 2024-2025 findings are based on 157 survey responses from 103 Texas first responders, predominantly active-duty officers and firefighters from the Fort Worth Police and Fire Departments, Dallas Police and Fire Rescue, and the DFW Airport Department of Public Safety. Responses were collected before and after participation in the American Warrior Association's R3 (Respond, Restore, Resolve) Training Program, using the Moral Injury Outcome Scale (MIOS), the Primary Care PTSD Screen (PC-PTSD-5), and the Brief Inventory of Psychosocial Functioning (B-IPF).

Five Key Findings:

- **Moral injury is common.** 62.6% of Texas first responders surveyed pre-training reported a morally injurious event, close to the 57.6% national firefighter benchmark from the Firefighter Behavioral Health Alliance.
- **Half of those exposed screen positive for probable PTSD.** Among MI-exposed Texas responders, 49.5% met the PC-PTSD-5 threshold. More than half endorsed avoidance (55%) and numbness or detachment (55%), the latter a known and serious risk factor for suicide.

- **The wounds are recent.** A majority of dated events (53 of 97) occurred in 2020 or later. Current operational conditions, not historical trauma, are driving moral injury in this workforce.
- **The pattern of harm is concrete and recurring.** The most frequently cited events were the death or harm of a child (19%), the suicide of a colleague or family member (19%), officer-involved shootings or use of force (15%), sudden cardiac arrest and pediatric CPR calls (15%), and organizational betrayal (10%).
- **Intervention works for the responders who need it most.** Among participants with elevated baseline distress, R3 produced clinically meaningful gains on the MIOS Total Score (-4.6 points, $p = .010$) and the Shame subscale (-3.0 points, $p = .006$). Among those with high baseline functional impairment, MIOS Total scores dropped 5.4 points ($p = .014$). These are the responders at highest risk for crisis, attrition, and suicide.

Intervention works when it reaches the right people. First, screening and identification are prerequisites for effective treatment: without routine, validated assessment, Texas departments cannot direct scarce intervention resources to the responders most likely to benefit, and the MIOS and PC-PTSD-5 are brief, free, and validated. Second, blanket wellness programming is inefficient: low-distress responders gain little, while high-distress responders gain substantially. A tiered model (universal screening, targeted intensive support) is both more efficient and more clinically defensible than ad hoc referrals after a crisis.

DEFINING MORAL INJURY AND ITS CONSEQUENCES

Moral injury describes the lasting psychological, emotional, social, behavioral, and spiritual damage that occurs when a person perpetrates, witnesses, or fails to prevent acts that violate their deeply held moral beliefs. The concept emerged from clinical work with Vietnam veterans and was formalized in a 2009 paper by Brett Litz and colleagues at the National Center for PTSD, who described it as the result of “an act of transgression that creates dissonance and conflict because it violates assumptions and beliefs about right and wrong and personal goodness” (Litz et al., 2009, p. 698).

For first responders, the morally injurious event is rarely abstract. It’s the child who couldn’t be saved. The order that conflicted with conscience. The fellow officer who stood by during a fight. The patient was transported by a colleague using a method the medic believed was wrong. The supervisor who covered for misconduct. The civilian shot in a justified use of force, who, on closer reflection, may not have intended harm. These aren’t failures of bravery or competence. They are events in which duty, training, and values collided with reality in ways that cannot be cleanly reconciled afterward.

Distinguishing MI from PTSD is pivotal, as failing to do so leads to ineffective care. PTSD is a clinical diagnosis defined by the American Psychiatric Association’s Diagnostic and Statistical Manual (American Psychiatric Association, 2013), grounded in fear-based exposure to actual or threatened death, serious injury, or sexual violence. Moral injury is not a DSM diagnosis. It’s grounded in guilt, shame, and betrayal of trust rather than fear. PTSD relates more strongly to self-directed shame (Dill et al., 2023), whereas MI relates more strongly to perceived betrayal of trust by others (Currier et al., 2019). A responder can have either MI or PTSD without necessarily having the other. Many have both.

Moral injury manifests across emotional, cognitive, behavioral, and spiritual domains. The clinical literature consistently identifies guilt and shame disproportionate to actual responsibility, as well as loss of trust in

oneself and/or in others, in institutions, or in a higher power. It includes self-destructive behavior, such as substance misuse and parasuicidal acts, social withdrawal, loss of meaning or purpose, anger and cynicism directed at leadership, spiritual distress, loss of faith or a sense of being beyond redemption, and functional impairment across relationships and work (Drescher et al., 2011; Litz et al., 2009; Nash & Litz, 2013). It is associated with elevated rates of depression, anxiety, PTSD, substance use disorders, and suicide (Papazoglou et al., 2019). Further, the damage doesn't stop at the individual. The cynicism and withdrawal it produces strain families, erode unit cohesion, and degrade the quality of public service the responder delivers.

Between 2014 and 2020, more firefighters died by suicide than in the line of duty in the United States (Dill et al., 2023). Research on police officers has documented suicidal behavior at rates that exceed those of the general adult population (Violante & Steege, 2021), and analyses of first responder suicides consistently identify relationship problems, organizational stressors, and unaddressed moral conflict as contributing factors (Papazoglou et al., 2019). Among Texas responders surveyed for this report, 55% of those who experienced a morally injurious event endorsed feelings of numbness or detachment.

The Firefighter Behavioral Health Alliance (FBHA) has identified relationship problems (marital strain, divorce, estrangement from children) as one of the leading factors in first responder suicides (Dill et al., 2023). Moral injury frequently erupts at home long before it's recognized at work. Children of first responders feel the ripple effects in ways that affect school performance, mental health, and the next generation's willingness to enter public service.

Moral injury compromises judgment, emotional regulation, and decision-making on the job. A police psychologist quoted in the FBI Law Enforcement Bulletin described it as leaving the officer "struggling with feelings of rejection, guilt, shame, and emotional paralysis, all detrimental to mental functioning and job performance" (Papazoglou et al., 2019).

Moral injury rooted in leadership failure or toxic culture is corrosive in ways that individual treatment cannot fully repair. The FBHA found that 44% of firefighters who described a morally injurious event identified leadership actions as a direct contributor (Dill et al., 2023). The Texas survey echoes this: responders described mandatory overtime that destroyed family life, supervisors who undermined officers attempting to do the right thing, and administrative cultures perceived as prioritizing liability over personnel welfare.

WHY MORAL INJURY MATTERS FOR TEXAS FIRST RESPONDERS

Texas employs one of the largest first responder workforces in the country. Its law enforcement, fire, and EMS personnel respond to millions of calls annually across urban, suburban, and rural jurisdictions. Each call carries the possibility—and over a career, the near certainty—of exposure to a morally injurious event.

Research on first responders has consistently documented higher rates of MI exposure than in civilian populations. The FBHA's 2023 pilot study of 479 firefighters across nine departments found that 57.6% reported a morally injurious event (Dill et al., 2023). A review of MI among firefighters, paramedics, and police officers concluded that the operational demands of first response place these workers at a substantially elevated risk relative to the general population (Lentz et al., 2021). The Texas data align with this national pattern: 62.6% of responders surveyed pre-training reported a morally injurious event, slightly above the national firefighter benchmark.

THE AMERICAN WARRIOR ASSOCIATION SURVEY

The American Warrior Association administered a MI survey to Texas first responders attending its R3 Training Program between 2024 and late 2025. The survey was designed to: 1) document the prevalence and severity of MI and related symptoms in a Texas sample, 2) characterize the events producing MI in this population, and 3) evaluate whether R3 produces measurable change. Respondents completed the survey before attending and after attending. The survey was anchored by the MIOS, the first psychometrically validated measure of MI, developed by the Litz Consortium and published in 2022 (Litz et al., 2022).

A gatekeeper item asked whether the respondent had experienced an event in which they (a) did something or failed to do something that went against their moral code, (b) saw someone else do or fail to do something against their moral code, or (c) were directly affected by someone else doing or failing to do something against their moral code.

A five-item screen for PTSD symptoms draws from the Primary Care PTSD Screen for DSM-5 (Prins et al., 2016), assessing nightmares and intrusive thoughts, avoidance, hypervigilance, numbness and detachment, and guilt or self-blame in the past month. Three or more affirmative responses indicate probable PTSD.

Fourteen Likert-scale statements assess two subscales: a seven-item “Shame”-related Outcomes subscale and a seven-item “Trust Violation”-related Outcomes subscale. The MIOS Total Score sums all 14 items (ranging from 0 to 56).

Nine items assess functional impairment in domains including romantic relationships, relationships with children, family, friendships, work, hobbies, religious or spiritual life, and daily activities (Kleiman et al., 2020). Each item was scored 0–6; the total was normed to 0–60 by averaging the answered items and multiplying by 10.

The survey received 157 responses from 103 unique respondents (99 pre, 58 post-wave). Fifty-four respondents completed both waves, providing matched pairs. Composition is summarized in Appendix 1.

DATA ANALYSIS

Among the 99 Texas first responders who completed the pre-wave survey, 62 (62.6%) affirmed having experienced an event that violated their moral code. This closely tracks the 57.6% prevalence in the FBHA national pilot (Dill et al., 2023) and is consistent with broader research suggesting that as many as 45% of those exposed to morally injurious experiences develop lasting symptoms (Papazoglou et al., 2019).

The MIOS Total Score quantifies current symptom intensity on a 0–56 scale. The pre-training mean was $M = 20.3$ ($SD = 10.1, n = 76$), with substantial variation across respondents.

Table 1
Baseline Moral Injury Severity Among Texas First Responders

Measure	Range	M	SD	Interpretation
MIOS Total Score	0–56	20.3	10.1	Substantial current moral injury
Shame-related subscale	0–28	9.3		Self-directed distress
Trust Violation subscale	0–28	11.0		Other-directed distress

The slightly higher mean on Trust Violation than on Shame is consistent with research distinguishing MI from PTSD: where PTSD relates more strongly to self-directed shame, MI relates more strongly to perceived betrayal of trust by others (Currier et al., 2019). Forty-five percent of MIOS-scored respondents had a Total Score of 20 or higher, indicating clinically substantial MI; 11% scored 30 or higher. Individual scores ranged up to 48 of 56.

The PC-PTSD-5 assesses five core post-traumatic stress symptoms in the past month. Three or more affirmative responses indicate probable PTSD.

Table 2
PC-PTSD-5 Symptom Endorsement Among Texas First Responders

Symptom	n endorsing	%
Avoidance of reminders	58	55.2
Numbness or detachment	58	55.2
Hypervigilance	50	47.6
Guilt or self-blame	48	45.7
Nightmares or intrusive thoughts	40	38.1
Probable PTSD (≥ 3 of 5 symptoms)	52	49.5

The 55.2% endorsement of numbness or detachment warrants particular attention. The FBHA reported a comparable rate in its pilot study, calling the finding “disturbing given that social isolation is a known risk factor for suicide” (Dill et al., 2023, p. 12). Nearly half (49.5%) of MI-exposed Texas respondents met the standard screening threshold for probable PTSD. Given that this sample was drawn from responders already actively engaged in seeking peer-supported intervention, the true prevalence among Texas first responders not attending such programming is likely higher, not lower.

The B-IPF assesses impairment across nine life domains. The pre-wave mean was $M = 22.6$ ($n = 71$) on a 0–60 scale, showing meaningful impairment across multiple domains, with individual scores ranging from 0 to 60. Comparing years of service among pre-wave MI-exposed respondents revealed a counterintuitive pattern.

Table 3
Baseline Outcomes by Years of Service

Years of Service	n	Mean MIOS Total	Mean B-IPF	Probable PTSD (%)
1–3 years	6	29.2	31.5	83.3
4–10 years	16	19.1	26.1	62.5
11–20 years	19	20.1	21.5	57.9
20+ years	21	20.3	25.1	29.0

Several explanations are plausible and not mutually exclusive: self-selection, in which the most affected responders exit the profession before reaching 20 years; generational differences in willingness to acknowledge distress; cumulative coping skills and post-traumatic growth among more tenured responders; and survivor bias, in which the most affected responders die, retire on disability, or leave the workforce before accumulating decades of service.

Among Pre-wave MI-exposed respondents, firefighters reported moderately higher symptom burden than law enforcement officers across all measures.

Table 4
Pre-Wave Baseline Outcomes by Occupation (MI-Exposed Respondents)

Outcome	Firefighters (n = 29)	Law Enforcement (n = 31)
Mean MIOS Total Score	22.0	18.8
Mean B-IPF Functional Impairment	25.8	23.7
Probable PTSD (%)	55.2	48.4
Numbness/detachment endorsement (%)	62.1	54.8

Differences are modest but consistent in direction. The pattern aligns with literature suggesting firefighters and EMS providers face particularly high cumulative pediatric and mass-casualty exposure, while law enforcement officers face distinctive exposures tied to use of force and direct interpersonal violence. The implication is that effective intervention models likely require occupation-specific design.

Fifty-two respondents provided substantive narrative descriptions of their worst event. Thematic coding produced the categories in **Table 5**.

Table 5
Categories of Morally Injurious Events Described by Texas First Responders

Theme	n	%
Child or infant death or serious harm	10	19.2
Suicide (self, colleague, or family member)	10	19.2
Officer-involved shooting or use of force	8	15.4
Sudden cardiac arrest or CPR call	8	15.4
Vehicle accident or mass-casualty crash	6	11.5
Organizational betrayal or leadership failure	5	9.6
Sexual assault (personal experience)	4	7.7
Mass casualty or mass-shooting event	3	5.8
Witnessed domestic violence	2	3.8

The events that Texas first responders carry are not abstract. The following anonymized excerpts illustrate the range and texture of what the standardized measures are quantifying:

- “About 20 feet away from 2 vehicles colliding head on at 80mph each way. Cut on[e] of the people in half.”
- “Being hit by a truck while on the scene of an MVA”
- “This was a murder /suicide of a married couple.”
- “As a fire crew we were dispatched to the scene of a 2 year old who was ran over by car in the family’s driveway.”

- “Father trying to beat his baby mama and she held her 6 week old up to shield herself and the baby was beaten to death.”
- “While working on patrol, another officer and I got into a fight with a suspect. The other officer stood by watching me fight the suspect for about 15 minutes by myself. He did not help me. I was injured from head to toe.”
- “I arrested a mother who birthed her baby and put him in a suitcase and left him in a closet for a week. She then dumped him in a dumpster. I watched the autopsy of the rotten child. I found her and arrested her. She has 6 other children.”

In the reported narratives, three patterns are discernible. First, the catalysts for MI are diverse. Some responders report a single, catastrophic event; others describe an accumulated burden of exposure to tragic incidents over the years; and some identify organizational or management failures related to their employment but not to the central mission itself. Second, MI can be experienced external to the job, but has the same effect nonetheless (e.g., the suicide of a spouse or a family member’s overdose). Finally, responders perceive the layers as cumulative, identifying that the absence of structural support makes MI chronic and not resolvable.

EVIDENCE THAT INTERVENTION WORKS

Of the 103 unique respondents, 54 completed both pre- and post- waves. The matched sample is broadly comparable to the full sample in occupational composition and department, though it skews toward respondents with somewhat higher baseline distress.

Finding 1: Treatment Provided No Significant Change Across the Entire Sample

Across all matched pairs, changes in the primary outcomes are small and not statistically significant. Taken alone, **Table 6** would not support a strong claim that R3 produces measurable change. The point estimates trend in the expected direction, but the differences are within measurement noise, and the effect sizes are negligible. If the analysis stopped here, the appropriate conclusion would be that R3 does not produce a detectable population-level benefit. However, like nearly all successful treatments in medicine, criminology, and dozens of other fields, *success is largely based on the appropriate targeting of the intervention.*

Table 6

Pre/Post Change on Primary Outcomes, All Matched Respondents

Outcome Measure	n pairs	Pre M	Post M	Δ	p	Cohen’s d
MIOS Total Score	44	19.34	18.66	-0.68	.576	0.08
MIOS Shame subscale	44	8.93	8.30	-0.64	.378	0.13
MIOS Trust Violation subscale	44	10.41	10.36	-0.05	.939	0.01
PC-PTSD-5 sum	54	1.63	1.83	+0.20	.330	-0.13
B-IPF Functional Impairment	40	20.90	19.36	-1.53	.460	0.12

A parallel example from criminology exists within the correctional treatment. Imagine two individuals entering a probation program following property offenses. The first presents with multiple criminogenic needs (such as antisocial attitudes), a peer network of offenders, unstable employment, and a substance use disorder. The second has stable employment, prosocial family ties, and a single isolated offense. Under the Risk-Need-Responsivity framework (Andrews & Bonta, 2017), these cases warrant different responses. The first

should receive an intensive cognitive-behavioral program targeting his antisocial cognitions and peers. The second should receive minimal intervention, as subjecting a low-risk individual to intensive treatment risks disrupting the prosocial ties that protect against reoffending and may expose him to higher-risk peers within the program itself. Applied correctly, the same system (using different approaches) reduces recidivism in the high-risk case while avoiding harm in the low-risk one. Applied indiscriminately, it would likely worsen outcomes for both.

Finding 2: Treatment DOES Work for Those for Whom It Is Intended

When the matched sample is stratified by baseline severity, a different, substantial pattern emerges. Among respondents who arrived already at elevated levels of moral injury or functional impairment, R3 produced clinically meaningful improvements, meeting conventional thresholds for both statistical significance and effect size.

Table 7

Pre/Post Change on Primary Outcomes Among Matched Respondents With Elevated Baseline Distress

Subgroup / Outcome	n	Pre M	Post M	Δ	p	Cohen's d
High baseline MIOS (Pre Total ≥ 20)						
MIOS Total	19	28.00	23.42	-4.58	.010	0.66
MIOS Shame	19	14.05	11.05	-3.00	.006	0.71
MIOS Trust Violation	19	13.95	12.37	-1.58	.048	0.49
Probable PTSD at baseline (PC-PTSD-5 ≥ 3)						
MIOS Total	19	24.21	20.32	-3.89	.039	0.51
MIOS Shame	19	11.37	8.74	-2.63	.019	0.59
High baseline impairment (B-IPF ≥ 25)						
MIOS Total	15	26.80	21.40	-5.40	.014	0.73
MIOS Shame	15	13.00	9.40	-3.60	.008	0.81
B-IPF Functional Impairment	15	38.68	31.80	-6.88	.058	0.53

Among respondents who arrived with clinically substantial moral injury (MIOS Total ≥ 20), scores dropped 4.6 points on average ($p = .010$, $d = 0.66$), a medium-to-large effect. The strongest effect is on the Shame subscale, where respondents with high baseline impairment saw a 3.6-point reduction. Shame is the dimension most closely linked to suicide risk in the research literature (Litz et al., 2009, 2022), and the dimension conventional PTSD treatments often fail to address. Respondents who screened positive for probable PTSD at baseline also showed a significant reduction in moral injury symptoms, suggesting that R3 reaches even those with substantial comorbid post-traumatic symptoms, a population traditionally considered difficult to treat in brief intervention formats.

Additionally, while the data discussed above does validate the success of AWA's R3 therapeutic framework, it is important to note that R3 specifically is designed as a *proactive* intervention rather than a *reactive* intervention. A holistic approach would include detecting first responders who are not yet in crisis and intervening early, before cumulative stressors begin to affect job performance or worse. A system that relies solely on

clinical entry points is likely to intervene too late (i.e., the accumulation of moral injury may have progressed to a stage where improvement is far more difficult) or miss a pre-crisis first responder entirely.

RECOMMENDATIONS FOR TEXAS POLICY MAKERS

These three recommendations share a common premise: Texas has already done the hard part. Texas Law Enforcement Peer Network (TLEPN) gives every peace officer in the state 24-hour anonymous peer support. HB 35 (2025) is building a parallel network for firefighters and EMS. The First Responder Mental Health Program is moving grant dollars to departments every year. None of what follows asks the Legislature to invent something new or to find money it has not already appropriated. The survey data make clear that the system has a targeting problem, not a capacity problem. That is, the intervention reaches the responders who happen to seek it out, rather than those most likely to benefit. Screening closes that gap on the front end. Statutory confidentiality closes it on the side, where fear of professional consequence keeps responders from raising their hands. Weighting grant criteria toward early-career and high-distress populations closes the door on the back end, where public investment in training is most vulnerable to being walked out the door.

1. Add Validated Moral Injury Screening to Existing Peer Support and Grant Programs

The MIOS and the PC-PTSD-5 are quick, validated, and free. Together, they take less than 10 minutes to administer. The Governor's Public Safety Office, in coordination with TCOLE and the new HB 35 firefighter and EMS peer network, could establish brief MI screening as an expected component of intake and follow-up protocols for the TLEPN and the newly developed HB 35 firefighter/EMS peer network. Further, baseline and outcomes assessment within programs funded under the Governor's First Responder Mental Health Program grants. Screening would generate aggregate, de-identified outcome data, allowing the state to evaluate which programs are most effective for which populations.

2. Strengthen Confidentiality and Career-Protection Statutes

The confidentiality and anonymity protections the Legislature codified for TLEPN should be reviewed for potential extension to other state-funded first responder mental health programs, including the HB 35 peer network and grantee programs under the Governor's First Responder Mental Health Program. For example: prohibition on use of program contact records in disciplinary, fitness-for-duty, or licensing actions absent specific statutory exceptions; protections against discovery in civil proceedings, and explicit non-retaliation protections for responders who self-refer or are identified through screening. These can be modeled on the existing TLEPN framework.

3. Direct Existing Grant Funding Toward Newer Responders and High-Distress Populations

Within the existing eligibility and scoring framework of the Governor's First Responder Mental Health Program, additional weight could be given to applications that include systematic early-career screening and intervention components; targeting academy graduates and first-three-year responders for intensive resilience and moral injury education; and integrating with TCOLE's mandated training framework for peace officers and the equivalent for firefighters and EMS. The administrative adjustment is small; the targeting effect could be substantial.

CONCLUSION

Moral injury in the Texas first responder workforce is neither hypothetical nor exotic. It is present at rates comparable to national benchmarks, is concentrated among responders most likely to leave the profession or die by their own hand, and is driven in significant part by operational conditions the state has both the standing and the authority to influence. The survey data are limited (a single sample drawn from a handful of North Texas departments, without a control group), but they are illustrative, consistent with the broader literature's findings over the past decade, and point in a single direction. Responders who need help can be identified through a 10-minute screen. The intervention that helps them already exists. It is just a matter of making policy choices to address the need. ■

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APPENDIX 1: RESPONDENT CHARACTERISTICS

Characteristic	n	%
Occupation		
Law Enforcement Officer	75	47.8
Firefighter	73	46.5
Administrative Staff	4	2.5
Sworn Staff	1	0.6
Not reported	4	2.5
Department		
Fort Worth Police Department	70	44.6
Fort Worth Fire Department	68	43.3
Dallas Police Department	6	3.8
Dallas Fire Rescue	4	2.5
DFW Airport DPS (Police, Fire, Aviation Security)	5	3.2
Not reported	4	2.5
Occupational Status		
Active duty	147	93.6
Retiree	6	3.8
Not reported	4	2.5
Years of Service		
1–3 years	17	10.8
4–10 years	48	30.6
11–20 years	44	28.0
20+ years	44	28.0
Not reported	4	2.5

ABOUT THE AUTHOR



Derek M. Cohen, Ph.D., is the Foundation's Chief Policy & Research Officer and Right on Crime Senior Fellow. Previously the Vice President of Policy and Director of Right on Crime, the Foundation's criminal justice reform initiative, Cohen was instrumental in the passage of the First Step Act, federal legislation that borrowed from successful changes to prisons and sentencing that he had helped pass in conservative states. In addition to leading the Foundation's work on

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Cohen currently serves as a commissioner on the State Commission on Judicial Conduct and as a member of the Judicial Advisory Council, both terms expiring in late 2029.

Prior to joining the Foundation, Cohen worked as a researcher with the University of Cincinnati's Institute of Crime Science and completed three advanced statistical trainings at the Inter-university Consortium for Political and Social Research (ICPSR) at the University of Michigan. He also taught classes in statistics, research methods, criminal procedure, courts, and corrections.

Cohen's academic work can be found in *Criminology and Public Policy*, *Victims and Offenders*, the *Oxford Handbook on Police and Policing*, and many other academic outlets. He has presented several papers to the American Society of Criminology, the Academy of Criminal Justice Sciences, and the American Evaluation Association.

Cohen graduated with a BS in criminal justice from Bowling Green State University and earned his M.S. and Ph.D. in criminal justice from the University of Cincinnati.

