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**AN EXPLORATION OF MORAL INJURY AS
EXPERIENCED BY COMBAT VETERANS**

A dissertation presented to the faculty of
ANTIOCH UNIVERSITY SANTA BARBARA

in partial fulfillment of
the requirements for the
degree of

DOCTOR OF PSYCHOLOGY
in
CLINICAL PSYCHOLOGY

by
Marjorie M. McCarthy, J.D., M.A.

2016

ProQuest page....

**AN EXPLORATION OF MORAL INJURY AS
EXPERIENCED BY COMBAT VETERANS**

This dissertation, by Marjorie M. McCarthy, has been approved by the committee members signed below who recommend that it be accepted by the faculty of Antioch University Santa Barbara in partial fulfillment of requirements for the degree of

DOCTOR OF PSYCHOLOGY
in
CLINICAL PSYCHOLOGY

Dissertation Committee:

Ron Pilato, Psy.D.
Dissertation Chair

Sharleen O'Brien, Psy.D.
Second Faculty

CAPT William P. Nash, M.D., MC USN (Ret.)
External Expert

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Abstract

War-zone stressors among Service members can lead to adverse psychological consequences that fall outside the scope of post-traumatic stress disorder. Combat stressors can also result in moral injury. Moral injury is an emerging psychological construct. One proposed definition of moral injury is the perpetration of, failure to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations. The current study used this proposed definition to conduct a qualitative phenomenological investigation of the lived experience of moral injury among combat Veterans of the wars in Iraq and/or Afghanistan. Eight male combat Veterans who self-identified as having the experience of moral injury as put forth in the proposed definition, were individually interviewed. Qualitative analysis was utilized to uncover themes related to morally injurious events and psychological sequela. The findings revealed support for the proposed definition of moral injury as well as six themes describing morally injurious experiences: shame, guilt, and feeling unforgivable connected to the involvement of children in war; shame, guilt, and anger for taking part in killing others; shame, guilt, anger, and feeling unforgivable when they did not speak-out regarding morally injurious events they were a part of as a group; no longer holding the same religious/spiritual beliefs; a loss of meaning in life after viewing death and a sense that they deserved to be disgraced after the way they handled the human remains of the enemy and witnessing others disgrace human remains of the enemy; and difficulty reconnecting emotionally with loved ones after their morally injurious experiences in combat. The most endorsed theme by the Veterans related to morally injurious experiences with children in war. Results suggest an important area for future research could help to define ways to prepare Service members for encountering child soldiers as well as potential ways to manage witnessing the suffering of children in war. The electronic version of the dissertation is accessible at the Ohiolink ETD center <http://www.ohiolink.edu/etd>.

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“...[t]he soldier above all other people prays for peace, for he must suffer and bear the deepest wounds and scars of war.”
-General Douglas MacArthur

Chapter I: Introduction

The United States (U.S.) has been continuously engaged in war over the last 13 years: Operation Iraqi Freedom (OIF) in Iraq and Operation Enduring Freedom (OEF) in Afghanistan. The Veterans of these wars are being diagnosed with posttraumatic stress disorder (PTSD) at an alarming rate. In spite of over 30 years of research and billions of dollars spent on devising preventions and treatments for PTSD, since 9/11 approximately 30% of Iraq and Afghanistan Veterans have been diagnosed with PTSD (Epidemiology Program, 2012). In preliminary findings the Department of Veterans Affairs (VA) identified approximately 1,000 suicide attempts every month among discharged Veterans (The truth about veteran suicides, Hearing, 2008). Every 65 minutes one of them is successful (Kemp & Bossarte, 2013). In February 2013 the VA released its 2012, Suicide Data Report (Kemp & Bossarte, 2013). The VA utilized their internal records as well as death records from 21 U.S. states from the years 1999 through 2011. Those 21 states represented approximately 40% of the U.S. population (Basu, 2013). The remaining 29 states, including the two largest, California and Texas both with the largest veteran populations, and the fifth largest state, Illinois, did not report data in time to be considered in the 2012 report. While the VA cautioned about the limitations of the study, they projected a national figure of 22 veteran suicides a day. However, 34,027 of the reported suicides from the 21 states were discarded because the veteran status was unknown or not recorded. This number amounted to 23% of the suicides from the 21 reporting states. Therefore, the VA report looked at 77% of the recorded suicides in 40%

of the U.S. population (Basu, 2013; Kemp & Bossarte, 2013). It is a disturbing possibility that when data from all 50 states are analyzed the number of daily veteran suicides may be much greater than 22. It is hoped that the number is less. In 2012, Secretary of Defense, Leon Panetta (Ret.) addressed the House of Representatives Armed Services Committee and the Committee of Veterans Affairs regarding military suicides. He said, "It's an epidemic," and "Something is wrong" (Miller, 2012).

The "something" that is wrong may be a known form of psychological suffering, but a type of psychological suffering that is rarely asked about or talked about and is only just beginning to be seriously researched. This type of suffering has the working title of "moral injury." Moral injury has been defined as an act of serious transgression that brings about serious inner conflict because the experience is at odds with deeply held moral and ethical beliefs (Maguen & Litz, 2012). More specifically, moral injury has been defined as perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs (Litz et al., 2009). In particular the actions can be immoral, inhumane, cruel, depraved or violent, which bring about the pain, suffering, or death of others (Drescher et al., 2011).

If a soldier is driving a truck down a desert road in Afghanistan, and what looks like a woman holding what looks like a baby steps into the middle of the road, the soldier is trained to keep driving. The woman may be a decoy for an ambush to cause the vehicle to leave the road and hit an improvised explosive device (IED). The soldier must keep his unit safe and drive on, even if this means that he must run over the person in the road (Colonel Patti Tackett (Ret.), personal communication, May 11, 2012). Was that an enemy combatant or was that really an innocent woman and her baby? It is this type of

unanswered question that can lead to moral injury. However, even if the answer was, “Yes, that was an enemy combatant,” it is still the act of killing that can lead to moral injury.

Moral injury can entail, but is not limited to: taking part in war time atrocities, such as desecrating the bodies of killed enemies; killing an innocent civilian, because the lines between enemy and friendly are so blurred in counterinsurgency operations; failing to prevent cruel and inhumane behavior by others, such as the rape of a civilian girl; witnessing the ravages of war, such as being unable to help a wounded child; and touching the devastations of war when handling human remains. In essence, moral injury occurs when an experience severely conflicts with the person’s individual or shared sense of what is right (Litz et al., 2009). Above all, moral injuries are the invisible wounds suffered in war.

The psychological sequela of moral injury can be haunting states of inner conflict. Emotions can manifest such as intense guilt and shame. The individual may come to believe that they are an unforgivable and evil person. This global sense of being a bad person can lead to thoughts, feelings, and behaviors of self-condemnation. Additionally, many Veterans struggling with moral injury may experience religious or spiritual inner conflict. Finally, for some Veterans the choice of suicide comes to be seen as the only escape from their inner torment (Drescher & Foy, 1995; Fisher & Exline, 2010; Fontana & Rosenheck, 2004; Litz et al., 2009; Maguen et al., 2011).

Guilt can be a painful but motivating experience. It can decrease the likelihood that a person will again engage in the behavior which the caused the guilt. When a person feels guilt, they are more likely to participate in behaviors to make amends. Therefore,

guilt, while painful, can lead to reparative behaviors and emotions. However, when guilt becomes oppressive, when reparative behaviors are insufficient or impossible, some people may attempt to bring about a sense of justice through their own suffering. They may deny themselves pleasurable activities, criticize themselves, or physically harm themselves (Fisher & Exline, 2010). Shame, unlike guilt, is not about the behavior; it is an evaluation of the self. Feelings of shame tied to transgressions in traumatic circumstances will very likely lead to excessive avoidance and withdrawal, as shame is fundamentally connected to expected negative appraisals by others (Litz et al., 2009). Therefore, the individual suffering from moral injury is not likely to discuss the feelings of shame with others, which only serves to further isolate them in their suffering.

Closely connected to both excessive guilt and shame is self-condemnation, the polar opposite of self-forgiveness. Veterans suffering from moral injury may be hesitant to discuss feelings of excessive guilt and shame surrounding their inner conflict. The inability to come to terms with these emotions can lead to a global sense of being a bad person, creating obstacles to self-forgiveness (Fisher & Exline, 2010). Over time the language of self-condemnation can become engrained and they may feel that they are unforgivable. As one veteran of both OIF and OEF stated, “I can’t forgive myself. . . . and the people who can forgive me are dead” (Jelinek, 2012, p. 1). Self-forgiveness has been studied less than other types of forgiveness but interest is increasing. While self-forgiveness is mentioned in articles on moral injury, it has yet to be empirically researched with Service members or Veterans (Worthington & Langberg, 2012).

In addition to self-condemnation and feelings of guilt and shame, many Veterans who experience moral injury are also struggling with spiritual or religious conflict

(Fontana & Rosenheck, 2004; Worthington & Langberg, 2012). Drescher and Foy (1995) found that in response to survey items, 74% of 100 Vietnam Veterans diagnosed with PTSD indicated that, “I have had difficulty reconciling my religious beliefs with the traumatic events that I saw and experienced in Vietnam” (p. 4). Of this same group 50% indicated that, “Feelings of guilt about things I experienced in Vietnam have caused my religious faith to diminish” (p. 4). Historically there has been scant research on the efficacy of spirituality/religion as a treatment modality in the psychological literature. However, there is evidence that Veterans struggling with the inability to forgive themselves can be helped with treatment that has a spiritual focus (Drescher & Foy, 1995; Fontana & Rosenheck, 2004; Hufford, Fritts, & Rhodes, 2010; Worthington & Langberg, 2012).

Suicidal individuals tend to have intensely negative self-views and focus on their perceived personal defectiveness. Individuals with suicidal ideations are more likely to experience feelings of extreme guilt, shame, and hopelessness. Moral injury may be a serious risk factor for self-injurious thoughts and behaviors. Bryan, Bryan, Etienne, and Ray-Sannerud (2014) found in a sample of active military personnel, that moral transgressions committed (act or omission) by the self were associated with significantly greater suicidal ideation over the past week. Additionally, Maguen et al. (2011) found that Veterans who killed in combat had twice the odds of reporting suicidal ideation than those who did not kill. This finding persisted even after accounting for PTSD, depression, substance use disorder diagnosis, and adjusted combat exposure.

Moral injury has been said not to take the place of PTSD but rather to stand alongside of it (Boudreau, 2011). While more research is needed in the area of moral

injury, it is clear that the construct is unique from PTSD. Transgression is not necessary for a PTSD diagnosis and PTSD syndrome does not sufficiently capture the key conflicting psychological sequela of moral injury (e.g., shame, self-condemnation, etc.) (Maguen & Litz, 2012). Drescher et al. (2011) researched the usefulness of the construct of moral injury in war Veterans. The study was qualitative in design and interviewed a wide range of health care and religious professionals with many years of service to military personnel. The results showed that the professionals universally agreed that the construct of moral injury was not fully described by the current PTSD criteria. Additionally, the neuropsychological correlates of PTSD are primarily found in the brain's amygdala and hippocampus. These areas control responses to fear and fear conditioning, as well as connecting fear to memory (Brock & Lettini, 2012). Moral injury takes time for reflection. It is the brain's prefrontal cortex that organizes emotionally intense memories. A healthy brain that can experience empathy is necessary in order to feel the intense emotional burden of moral injury (Brock, 2012). Furthermore, evidence based PTSD treatments are primarily based on fear conditioning and extinction models (Drescher et al., 2011). They generally work from the premise that the individual is a victim of a traumatic experience, rather than the individual as the perpetrator of the traumatic experience. While Veterans suffering from moral injury may display the re-experiencing, emotional numbing, and avoidance symptoms of PTSD, traditional treatments for PTSD are likely to be less efficacious in treating moral injury (Maguen & Litz, 2012).

Assessments, such as Nash et al.'s Moral Injury Events Scale (MIES) (2013) are in the process of being further evaluated and researchers are determining ways to more

accurately word items on the MIES to better fit the Veterans recalled experience of moral injury (Nash et al., 2013). Currier, Holland, Drescher, and Foy (2015) developed and provided initial psychometric evidence for the Moral Injury Questionnaire –Military Version (MIQ-M) (Currier et al., 2015). The MIQ-M is a 20-item self-report measure to assess for moral injury. Currier et al. found that 19-items yielded favorable psychometric properties and found preliminary evidence for the validity of the MIQ-M to be used in further research and clinical work.

While models for treatment of moral injury have been proposed (Gray et al., 2012; Litz, Lebowitz, Gray, & Nash, 2016; Litz et al., 2009; Maguen & Burkman, 2013; Smith, Daux, & Rauch, 2013; Southwick, Gilmartin, McDonough, & Morrissey, 2006; Sreenivasan, Smee, & Weinberger, 2014) there are no current evidenced based practices for treating moral injury specifically. In fact the term “moral injury” may need to be modified as research with providers has indicated that the term may need to be better explained and may not be accepted by Veterans (Drescher et al., 2011). Additionally, there is some evidence that the term may be seen as pejorative and insulting to Service members, as it may imply some type of immorality (McCloskey, 2011).

The conceptual issue of attempting to study a construct which does not have a unanimous definition is unavoidable at this time. The construct of moral injury is currently being explored in the literature. This study used the working definition of moral injury as proposed in the seminal article on moral injury by Litz et al. (2009). Litz et al. define moral injury as perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations.

The current study sought to add to the research a clearer definition of moral injury and the associated inner states of conflict, by examining its meaning for combat Veterans. This study was qualitative in nature using a phenomenological approach asking Veterans to describe their lived experience of moral injury, as defined by Litz et al. (2009). This exploration utilized face-to-face interviews with 8 combat Veterans from both OIF and OEF. Because a robust inquiry into the construct of moral injury is in its early stages this is the time for building a consensus on a definition of moral injury and the concomitant aftermath of psychological conflict. By reaching consensus on definitions at an early stage, future research into moral injury will not be plagued by troubling methodological issues. One method to construct a conceptual definition is through a concept analysis whereby the concept is logically and systematically investigated. In the concept analysis proposed by Walker and Avant (1995) the first step is to identify all uses of the concept. This may include but not be limited to; dictionary definitions, usage in philosophy and psychology, and colloquial uses. Then defining attributes are identified; these are characteristics of the concept that are seen to appear repeatedly. Constructed cases are then utilized to aid in understanding what the concept is and what it is not. A model case is constructed that contains all of the critical attributes of the concept; a borderline case is constructed that contains some but not all of the critical attributes; a related case which contains none of the critical attributes; and lastly a contrary case is constructed describing what the concept clearly is not. Next there is an examination of the constructs antecedents and consequences. The antecedents are factors that must be present before the concept occurs and consequences are the events that occur as a result of the concept. Finally, the occurrence of the actual phenomena provides

evidence of the concept itself, Walker and Avant refer to this as the empirical referent. From this construct analysis one can provide a clearer definition of the construct under inquiry. In the present study an exploration of the definition of moral injury as experienced by combat Veterans provided data related to the usage of the concept, the antecedents and consequences, and the empirical referent component.

Moral injury, as defined (Litz et al., 2009), could be applied to other circumstances beyond military combat, and to other individuals in addition to combat Veterans. For example, morally injurious events can affect active military, those in law enforcement, firefighters, or health care workers to name a few. However, for the purposes of the current study only combat Veterans from OIF and or OEF were investigated.

Because there is limited research on moral injury, its definition, and its psychological effects, it needed to be further explored. This qualitative study exploring the experience of moral injury allowed for the voices of combat Veterans to help further define our understanding of moral injury and in doing so, hopefully open pathways supporting an effective treatment to alleviate the heavy burden carried by our combat Veterans.

Chapter II: Literature Review

The following literature review addresses the concept of moral injury throughout history and military history, followed by the current proposed definitions of moral injury and the psychological and behavioral sequela related to each definition. The only two studies to date which have endeavored to define the concept of moral injury will then be discussed in some detail. Next the U.S. military's task of training Service members to kill and how killing and atrocities exposure can be connected to the perpetration element of moral injury is covered. The possible connections between killing in combat, moral injury and suicide are then explored. The limited research looking at failure to prevent, witnessing, or learning about acts that transgress deeply held moral beliefs are considered. The chapter concludes with a discussion of the assessment tools developed to measure morally injurious events and proposed treatment strategies.

The Concept of Moral Injury Throughout History

The understanding that trauma of war can induce moral injury is not a new concept. Ancient Greek tragedies used the word "miasma," which can be translated to mean a moral defilement or pollution of the soul. Miasma can arise from the trauma of war (Meagher 2006; Nash et al., 2013). The Greek's cure for miasma was called "catharsis," best described as a cleansing or a return of normalcy. It can be said that when the miasma of a war veteran is denied, for example by society not wanting to hear about the horrors of war, the veteran is then denied catharsis and thus denied a return to normalcy (Meagher, 2006). This understanding of the need to cleanse the soul from the suffering of war can be seen in the first millennium Christian church's prolonged

penances for returning warriors and in the purification rituals of the U.S. Southwest Navajo Indians (Brock & Lettini, 2012; Verkamp, 1988).

In the Christian tradition a penance is a sacrament by which the sins committed after baptism are forgiven. One of the first steps is for the penitent to examine his conscience and be sorry for his sins. Additionally, the penitent must willingly submit to having a contrite heart, perform verbal confession, and be perfectly humble. (Slick, 2014). Examples of penances that first millennium Christian church's imposed on warriors returning from battle were: "Anyone who knows that he killed a man in the great battle must do penance for one year for each man that he killed." "The archers who killed some and wounded others, but are necessarily ignorant as to how many, must do penance as for three Lents" (Verkamp, 1988, p. 225). While Christian penances served a primary purpose of forgiveness of sin, it is also likely that warriors were seeking relief from a sense of guilt and of shame. By giving alms, or fasting, etc. they may have been attempting to prove to themselves and to others a continued capacity to do and to be good. The returning warriors of medieval times may very well have been trying to show that they deserved to belong to the Church Militant devoted to the establishment of a kingdom of justice and peace (Verkamp, 1988).

The Navajo Indians of the American Southwest have a ceremonial process called '*Anaa' ji*— the Enemy Way. This ceremony is used to cure sickness thought to come from contact with dead non-Navajo, participating in war, fatal accidents, or other experiences related to death, corpses, or graves (Brock & Lettini, 2012). Navajo tribal members understand that a warriors experience may threaten his or her physical, emotional, and spiritual health. Ceremonies for cleansing, healing, and a letting go are

important to counterbalance these experiences. The ceremonies also serve to help the warrior transition back into their roles in the community that they had before they experienced war: as parents, children, husbands and wives, brothers and sisters, and their roles in the community as a whole. Not performing this ritual is seen as harmful not only for the returning warrior but for his or her family and the community (Administration for Native Americans, 2012). The Navajo tribe has adapted the ‘Anaa’ jí to assist current Veterans in reintegrating back into civilian life and its use is supported by Veterans Administration (VA) health professionals (Brock & Lettini, 2012).

As suggested, historically moral injury is not a new concept, and it is not a new concept in the U.S. military’s history either. During the time of the American Revolutionary War (1775–1783) the first recorded description of psychological symptoms seen in soldiers were identified as *nostalgia* and *nervous disease*. During one of the most blood-stained wars in U.S. history, the American Civil War (1861–1865), the psychological stress of combat was termed *soldiers’ heart*, *irritable heart*, and *sunstroke* (Dombo, Gray, & Early, 2013; Nash, Silva, & Litz, 2009; Verkamp, 1993). During the early part of World War I (WWI: 1914–1918) the term *shell-shocked* was used to describe the psychological consequences thought to be the result of being too near an explosive blast. The shell-shocked military casualties were evacuated from war zones and provided disability compensation if they did not recover (Nash et al., 2009). During WWI (1914-18) the Germans identified their warriors’ psychological suffering as *nerven-shock*. By 1916 shell-shocked French and British troops and *nerven-shocked* German troops had depleted financial resources and manpower on both sides of the war. In September 1916 the German Association for Psychiatry convened a special War

Congress to address the nerven-shock crisis. It was decided that any functional impairment following a warzone traumatic stressor could only occur in a person with hysteria, a pre-existing personal weakness (Lerner, 2003; Nash et al., 2009). The German government was thus relieved of its responsibility of removing warriors with psychological combat trauma from the battlefield and relieved of compensating them for their disability. It was not long after that the French, British, and Americans followed suit. The use of the term hysteria was meant to deter warriors from coming forward with psychological stress. It was chosen because it was intentionally stigmatizing, as it was a known feminine disorder (Nash et al., 2009). Over time hysteria as a diagnosable condition disappeared. During World War II (WWII: 1939–1945) and the Korean War (1950–1953) Service members struggling with the trauma of war experienced *battle exhaustion* and *traumatic war neurosis*. During the Vietnam War (1964–1973) Service members with psychological suffering were said to have *post-trauma syndrome* and *post-Vietnam syndrome* (Dombo et al., 2013; Verkamp, 1993). The barrier of shame to seeking psychological help was well established by the time of the war in Vietnam. The rates of psychiatric evacuations were approximately 10% during WWII and had dropped to barely 1.2% during the Vietnam War (Nash et al., 2009). The heavy emotional burden of Vietnam Veterans later gave rise to the PTSD diagnosis (Verkamp, 1993). With current Veterans moral injury may be their signature harm.

Proposed Definitions of Moral Injury

Jonathan Shay (1991) is credited with first using the phrase moral injury. In his article Shay compared Homer's *Iliad* and the account of Achilles, to Vietnam combat Veterans with severe PTSD. Shay illustrated this comparison by using personal

experiences of working with Vietnam combat Veterans with severe and chronic PTSD in a partial hospitalization program at the Boston Department of Veterans Affairs. Shay stated that combat related PTSD very often reflects a warrior's moral and philosophical injury, including shattered assumptions about the self, the world, and their relation to each. Shay went on to describe instances in which this type of moral and philosophical injury can occur and advised clinicians to use these examples as tools in taking a veteran's complete combat history: 1. a betrayal of what's right; 2. shrinkage of the moral and social horizon (e.g., that Service members fight mainly for their comrades and not their country); 3. grief and guilt over the death of a special comrade; 4. renunciation of ever returning home; 5. seeing one's self as already dead; 6. berserking (e.g., a killing frenzy while in a godlike possessed state); and 7. dishonoring the enemy (e.g., dehumanizing with language and physical atrocities). Shay later went on to refine his definition of moral injury, again based on his patients' narratives and from Homer's narrative of Achilles in the *Iliad* (Shay, 2014). Specifically he defines moral injury as, "A betrayal of what's right by someone who holds legitimate authority (in the military – a leader) in a high stakes situation" (Shay, 2012, p. 59; Shay, 2014, p. 183). In Shay's description of moral injury the transgressor is not the individual but another entity, specifically a power-holder (i.e., military leader). This definition of moral injury can be likened to a sense of betrayal.

Camillo C. Bica (1999) a former Marine Corps officer, Vietnam veteran, and professor of philosophy, used the term moral casualty as being caused by moral injury. He provided an essay applying philosophy to aid in understanding and approaching treatment for warriors experiencing moral injury. Bica described moral injury etiology as

the necessary result of having one's moral identity manipulated into that of a warrior, what Bica termed the "warrior mythology." Through basic military training a recruit's individual identity is replaced by a group identity, which aids in creating unit cohesion. This group identity fosters a sense of anonymity and a diffusion of responsibility, even group absolution. It is the recruit's vision of themselves as part of a band of brothers who are noble and proud which creates, what Bica terms the warrior mythology. However, when confronted with the reality and horror of war, the warrior/veteran may be faced with the awareness of having transgressed a deeply held sense of self; his non-martial moral identity. The warrior becomes painfully aware that the group identity cannot shield him from his own individual responsibility. It is this realization and transgression which Bica proposes leads to moral injury.

Based on a review of the current literature, Litz et al. (2009) presented a seminal article on moral injury providing a working conceptual definition of moral injury as well as a proposed specific treatment strategy. Moral injury was defined as, "Perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" (p. 700). The authors elaborated on this definition stating that the experiences may be inhumane, cruel, or immoral. The experience of moral injury must entail an act of transgression that seriously contradicts a person's expectations about a code of conduct, either during the event or at some time after the event. The individual's awareness of the transgression must bring about dissonance and inner conflict. In this working definition of moral injury the transgressor can be the self (e.g., perpetrator, failing to act) or the transgressor may be another entity including a power-holder (e.g., bearing witness to, learning about acts).

Drescher et al. (2011) proposed a similar definition of moral injury as that suggested by Litz et al. (2009). Based on a review of the literature Drescher et al. generated their construct of moral injury in an effort to describe a disruption in a person's sense of personal morality and the ability to act in a just manner. Drescher et al. defined moral injury as:

Disruption in an individual's confidence and expectations about one's own or others' motivation or capacity to behave in a just and ethical manner. This injury is brought about by bearing witness to perceived immoral acts, failure to stop such actions, or perpetration of immoral acts, in particular actions that are inhumane, cruel, depraved, or violent, bringing about the pain, suffering, or death of others.
(p. 9)

Again, this definition of moral injury allows for the self as transgressor as well as another including a power-holder. However, this definition expands the concept of moral injury to specifically include acts that bring about pain, suffering or death.

Psychological and Behavioral Sequela of Moral Injury

Shay (2014) describes the impact of moral injury as the deterioration of a person's character. The person struggling with moral injury finds their ideals, ambitions, and attachments are changed and shrinking. Often the person's capacity for trust is destroyed. With the destruction of social trust what follows is the expectation of harm, exploitation, and humiliation from others. This can lead to withdrawal and isolation to defeat the anticipated negative appraisal from others.

Bica (1999) proposes that the suffering from moral injury includes debilitating remorse, guilt, shame, anguish, and grief. Additionally, he states that the returning

warrior suffers from disorientation, and a sense of alienation from the rest of the moral community. The returning warriors' experience of isolation and alienation is connected to their martial identity and the behavioral characteristics necessary in war; e.g., violence and killing. The warrior returns to a society where killing is once again homicide. This disconnect can make the warrior feel as if adrift between two very different worlds and their relationship to both worlds can become incoherent. Bica terms this disorientation, moral identity confusion.

Litz et al. (2009) suggest that the type of attribution one makes about a moral transgression will greatly affect the psychological sequela. When the attribution is global (i.e., not context dependent [war]), internal (i.e., seen as a personal shortcoming), and stable (i.e., lasting experience of being tainted) the result can be the enduring, negative, self-focused, moral emotions of guilt, shame, and anxiety. These emotions, specifically guilt and shame are related to the expectation of negative appraisal by others. Over time the Service members' expectation of being judged can lead to withdrawal and concealment from significant others, peers, leaders, their spiritual community, and society at large. When this withdrawal becomes persistent the Service member may become convinced and confident that they are morally corrupt and that not only their transgressions, but they themselves are unforgivable. The consequences of a persistent belief in being unforgivable can lead to the experience self-condemnation. Litz et al. point out that the Service members' beliefs about their moral transgressions are often very rigid and resistant to disconfirming evidence. These Service members come to believe that they deserve to suffer. In the worst case scenarios, the Service member suffers in total isolation, experiencing helplessness and hopelessness.

Research to Define Moral Injury

Research into the concept of moral injury is still in its early stages with the majority of studies published over the last five years. There have only been two studies which endeavored to evaluate a working definition of the construct of moral injury (Drescher et al., 2011; Vargas, Hanson, Kraus, Drescher, & Foy, 2013). Drescher et al. explored the viability and usefulness of the concept of moral injury. Based on the themes discovered by Drescher et al., Vargas et al. conducted a follow-up study in an effort to extend validity of the moral injury construct as uncovered by Drescher et al. Because the Drescher et al. study was the first to investigate the validity of the concept of moral injury and the Vargas et al. study attempted to expand upon their results it is important to look at the Drescher et al. results in some detail.

Drescher et al. (2011) conducted a qualitative study with seasoned mental health and religious professionals who had extensive experience working with active duty military and Veterans. Twenty-three interviews were conducted with representatives from both the VA and Department of Defense (DoD). The participants included chaplains, mental health providers, academic researchers, and policy makers. Eleven participants were chaplains, and 11 were trained as mental health providers, one was specifically trained as an educator. Of the participants, five had served in infantry roles and had experienced a traumatic event prior to their training as helping professionals. Through a questionnaire participants were asked, among other items: what they thought of the term moral injury; what they thought of the researchers' definition (*supra*); if they found PTSD adequate to capture morally injurious events; what types of events might

give rise to moral injury; and what might the long-term mental health and social consequences of moral injury be.

The results indicated universal agreement that the construct of moral injury was needed. More than half of the respondents (65%) reported that the term moral injury was adequate. However, a fairly large minority (35%) found the label inadequate. Suggestions for a different label included substituting the term *moral* with alternatives such as, spiritual injury, emotional injury, personal values injury, and life values injury. Other suggestions included maintaining the term moral but substituting injury with alternatives such as, moral trauma, moral wounds, and moral disruption. All respondents found the researchers definition of moral injury to be inadequate. Some suggestions were to add examples of events or qualifying experiences so as to help clarify the definition for Veterans. There was universal agreement that PTSD diagnostic criteria did not sufficiently capture the construct of moral injury, seeing the problems as separate but frequently co-occurring (Drescher et al., 2011).

The themes which emerged regarding what type of events might give rise to the experience of moral injury included: betrayal, disproportionate violence, incidents involving civilians, and within-rank violence. Betrayal events included failures in leadership, betrayal by peers, trusted civilians, and oneself for failure to live up to personal moral ethics. Instances of disproportionate violence included mistreatment of enemy combatants and acts of revenge. Examples of incidents involving civilians included destroying civilian property and assault. Within rank violence was described as military sexual trauma, friendly fire, and fragging (i.e., within ranks killing) (Drescher et al., 2011).

Themes surrounding potential signs or symptoms of moral injury included: social problems, psychological symptoms, self-deprecation, spiritual and existential issues, and trust issues. Examples of potential social problems were social withdrawal, misconduct, sociopathy, estrangement from children, and difficulty fitting in. Possible psychological symptoms included depression, anxiety, anger, and denial. The theme of self-deprecation included guilt, shame, self-loathing, feeling damaged, and a loss of self-worth. Examples of spiritual and existential issues centered on loss of faith, loss of meaning, loss of caring, giving up or questioning morality, and fatalism. Trust issues related to a sense of betrayal and loss of trust (Drescher et al., 2011).

Acknowledged limitations included the small convenience sample of professional care-providers and that no non-provider Veterans were included. The authors called for future qualitative research to investigate the construct of moral injury with combat Veterans of the present and previous wars (Drescher et al., 2011). The current study sought to address this limitation as it relates to male combat Veterans of the present war and exploring the definition proposed by Litz et al. (2009).

The follow-up study conducted by Vargas et al. (2013) attempted to expand validity of the concept of moral injury as well as the moral injury themes reported by Drescher et al. (2011). Vargas et al. conducted a qualitative study exploring archival data from the National Vietnam Veterans' Readjustment Survey (NVVRS) (Kulka et al., 1988). The NVVRS was a congressionally mandated major epidemiological study conducted from November 1986 through February 1988 on a large stratified random sample of 3,016 Vietnam-era Veterans. Participants included Vietnam theatre Veterans as well as era Veterans who never went into combat. The NVVRS used a multi-method

assessment approach using self-report surveys as well as in-depth clinical interviews. The final NVVRS report consists of four separate volumes and is approximately 3,000 pages in length. Vargas et al. examined narrative responses from an initial 100 theatre Veterans and 200 era Veterans, and then an additional 100 theatre Veterans for saturation of themes.

The potentially morally injurious events reported by Vargas et al. supported the themes described by Drescher et al. specifically, civilian deaths or other disproportionate violence, within-ranks violence, and betrayal. Additionally, potential signs and symptoms of moral injury were consistent with those uncovered by Drescher et al. However, Vargas et al. found that the theme of loss of trust was particularly prevalent, while Drescher et al. found this theme to be the least mentioned by professional care-providers. Another finding of note by Vargas et al. was the potentially morally injurious event of civilian deaths or other disproportionate violence being most likely to have associated signs and symptoms. Furthermore, this association showed greater emphasis on the Veterans' spiritual/existential problems, pointing to a potential unique correlation between this type of moral injury and spiritual/existential harm.

Vargas et al. (2013) acknowledged that a limitation of the study may have been an inherent bias due to the fact that the researchers were not blind to the themes of events and signs and symptoms reported by Drescher et al. (2011). Vargas et al. noted that the researchers may have been more prone to find instances which supported those themes, potentially blinding them to other aspects of the phenomenon. This may explain why Vargas et al. did not code traditional combat experiences such as sanctioned killing as a morally injurious event. Vargas et al. commented on the fact that many of the traumatic

events reported in the NVVRS were related to these types of combat experiences but were not coded. This is somewhat perplexing as Vargas et al. acknowledges that research indicates sanctioned killing can impact the perpetrator. Additionally, Drescher et al. (2011) defined moral injury to specifically include acts that bring about the pain, suffering, or death of others. However, Drescher et al. did not establish any themes related to the act of sanctioned killing, only related to within-ranks violence of fragging.

It is of interest that in the themes uncovered by Drescher et al. (2011) regarding the types of events which may give rise to moral injury only one reference was made to killing; fragging. Fragging is a term that developed out of the conflict in Vietnam originally meaning the killing of an officer by his troops, usually by a fragmentation grenade. Fragging can also refer to any within ranks killing (Olson, 1999). The lack of reference to killing in combat could be due in part to the tendency of clinicians who work with active duty military and Veterans to focus on life-threatening trauma and not those issues with moral and ethical implications (Litz et al., 2009). Maguen and Burkman (2013) found that for many Veterans the topic of killing seemed off limits unless they were directly asked about it. In fact, they stated that a veteran can progress through various levels of evaluation and treatment and never be asked directly about killing. A veteran is especially unlikely to offer the information if shame is associated with the experience. Additionally, a veteran may believe that since they were trained to kill the aftermath of killing should not bother them. These explanations may be true in this instance given that Hoge et al. (2004) found that 65% of Marines and 48% of soldiers returning from Iraq reported killing an enemy combatant, and 28% of Marines and 14% of soldiers reported killing a noncombatant.

Arguably the act of killing another human being has the potential to negatively affect a person's sense of morality. Two of the definitions of moral injury (Drescher et al., 2011; Litz et al., 2009) speak directly to the circumstances of perpetration and failure to prevent acts that transgress moral beliefs. Drescher et al. specifically consider that a morally injurious event is likely to bring about the pain, suffering, or death of others. Additionally, moral injury as a construct is being looked at among active duty military and Veterans who are trained to kill in service to their country. Therefore, it is highly probable that when looking at a military population with combat experience one would expect to find incidents of killing, and for some the associated experience of moral injury.

U.S. Troops Are Trained to Kill

Service members are trained to kill. The military has the daunting task of taking a civilian raised in a society that condemns and punishes individuals who kill, and transforming that civilian into a warrior who kills to defend their country. War requires that lives are taken, on both sides. This is necessary. However, even though the military is charged with training Service members to kill, it does not mean that in doing so the Service member loses their moral compass in the process. On the contrary, military culture fosters an intensely moral and ethical code of conduct. The training and preparation of Service members in times of war necessarily assumes that being violent, witnessing violence, and killing is, to the degree possible, expected and sanctioned (Litz et al., 2009).

After WWII with the publication of General S.L.A. Marshall's book, *Men Against Fire* (1947), the U.S. Army discovered that up to 75% of soldiers did not fire their weapons when given the opportunity to do so. Marshall's reporting on firing rates was

and continues to be controversial (Chambers, 2003). Notwithstanding the controversy, this statistic shocked America's generals, and a new form of combat training emerged: "reflexive fire training." This type of training is meant to do just what the name implies; Service members are trained to fire their weapons reflexively without hesitation. This combat training was so successful that firing rates rose to at least 90% during the Vietnam War (Ryan & Weimberg, 2007). It is of note that the psychological distress experienced by Vietnam Veterans contributed to the creation of the diagnostic disorder PTSD. Hoge et al. (2004) found that 87% of Marines and 77% of soldiers returning from combat in Iraq reported shooting or directing fire at the enemy. Of soldiers returning from Afghanistan 27% reported shooting or directing fire at the enemy. Unofficial estimates of the overall firing rates during OIF are upwards of 98% (Ryan & Weimberg, 2007). This generation's warriors may be the ones to shed light on the likely pervasive but as yet unacknowledged pain of moral injury.

Reflexive fire training maximizes lethality and battles are won by killing the enemy. Therefore, the military is doing its job of creating efficient fighters who can defend their country, their comrades, and themselves. The warrior is able to kill even if they are not willing to kill. An example of the fierce efficiency with which this training works is the 1993 battle at Mogadishu. During 17 hours of brutal urban combat, a few hundred soldiers battled thousands of Somalis. The U.S. lost only 19 soldiers, yet it is estimated that 300 to 1,000 Somalis were killed. This is the battle which was the basis for the best-selling book, *Black Hawk Down* and subsequent motion picture (Kilner, 2002). One soldier who fought at the battle of Mogadishu, reflected on his experience of taking many lives and only years later did it occur to him that the enemy was another human

being like him, with a family and friends, “And so that’s hard to deal with, but that day it [the killing] was too easy. That upsets me more than anything else, how easy it was to pull the trigger over and over again” (p. 28). It is this conscious deliberation after the fact of killing that can lead to moral injury. Moral injury resonates with the idea that killing hurts the killer too, even in self-defense and even in the line of duty (Boudreau, 2011).

Since 1999, all service branches have been required by the Department of Defense to create policy which addresses the prevention and management of deployment related stress, known as combat and operational stress control (COSC). All branches of the military have complied. In recent years there has been an unprecedented attempt by the U.S. military to provide psychological interventions to promote troops mental health both before and after deployment (Steenkamp, Nash, & Litz, 2013). However, there is concern that what the military is not doing is providing Service members with the moral justification of killing in order to prepare them to deal with the conscious reflection of taking a human life (Barrett, 2011, 2012; Kilner, 2010, 2002). Very little is done in preparing Service members for how to manage the emotional impact of killing another person or watching a friend die in front of them (Barrett, 2011). Lieutenant Colonel Peter Kilner, a professor at the U.S. Military Academy, West Point, argues that military leaders, while training Service members to kill effectively, are also responsible for training them to live effectively after they kill (2010). Kilner (2013) provides West Point cadets with training on the morality of killing. Essentially the starting point is the conviction that all human beings possess the right not to be killed. A person forfeits this right when they intentionally threaten to violate this right of an innocent person. If someone kills the aggressor that person has done nothing wrong. The defender has not

violated anyone's right and they do not forfeit their own. An aggressor's forfeiture of right is not permanent. Once the aggressor no longer has the intent or the capability to violate the right of another, they should not be killed. When fighting in a just war the Service member is the defender and enemy combatants are those who have forfeited their right not to be killed by directing threats to noncombatants and to our military personnel. Kilner acknowledges that killing in war is more complicated than merely determining who has forfeited their right not to be killed. However, he urges that his justification for killing be used as a set of basic principles to initiate deeper conversations (2010). In November 2007 the U.S. Army founded the Center for the Army Profession and Ethic (CAPE) which has developed training programs to increase awareness of moral/ethical issues. One unique example is a computer game titled, "Moral Combat," which places Soldiers in ethically challenging situations. While this is encouraging it remains a somewhat tertiary effort for the Army (Barrett, 2012). There remains an engrained military belief that if Service members are trained hard enough in the art of combat, that by osmosis they will also somehow be prepared for the mental punishment and trauma of sustained military action (Barrett, 2011).

In 2009 the Army instituted its Comprehensive Soldier Fitness (CSF) program with a \$125 million investment. The CSF program has been criticized, for among other issues, having no initial pilot program to determine the effectiveness of the training in a military population and no clear theoretical framework linking intervention strategies to intended outcomes (Eidelson, Pilisuk, & Soldz, 2011; Steenkamp et al., 2013). One component of the CSF program is spiritual fitness, which is also not without criticism. Brock and Lettini (2012) report that the spiritual fitness component has no moral content.

It encourages soldiers to view events in a neutral light, rather than seeing things as good or bad and to create nightly lists of positive events that happened during the day. Brock et al. express alarm at what they see as an utter lack of awareness as to what it may mean for a soldier to think about the death of a close friend, or the killing of a child as neutral, and in light of events such as these, how a soldier can be expected to focus on the other positive events of the day.

The U.S. Navy and Marine Corps train their personnel in Combat and Operational Stress First Aid (COSFA) which specifically addresses morally injurious experiences (Nash, Westphal, Watson, & Litz, 2010). This program is directed to military leaders and focuses on preventing, identifying, and treating stress injuries that arise from any of four sources: life threat, loss, inner conflict, and wear and tear (i.e., accumulated effects of smaller stressors over time such as too little sleep). The term inner conflict is synonymous with moral injury. However, because the term moral injury is deemed by some Navy and Marine Corps Service members to be pejorative, the term inner conflict has been used instead (Nash et al., 2013). COSFA provides leaders in the U.S. Navy and Marine Corps with seven steps, the “Seven C’s” as tools to aid in the management of stress injuries: 1. Check. This is a continuous action of assess and reassess. The distressed Sailor or Marine needs to be constantly monitored checking for severity of and changes in their reaction; 2. Coordinate Care. This is ensuring that the distressed Service member receives the follow-up care they need. This is also a continuous action to ensure continuity of care between leadership and medical resources; 3. Cover. If the Service member is endangering themselves or others move them to safety as soon as possible; 4. Calm. Reducing physical and emotional arousal by aiding the Service member in

slowing down, relaxing, and refocusing. Use of breathing techniques are recommended such as having them hold their breath for four seconds and release for four seconds; 5. Connect. This is focused on ensuring that the Service member does not feel isolated or ostracized from their peers by maximizing social support and unit cohesion; 6. Competence. This requires the military leader to become actively involved in restoring the Service members skills and effectiveness and reintegration back into the command; and 7. Confidence. The military leader must ensure reintegration is effective by mentoring the Service member to rebuild their competence and confidence which may take weeks (Nash, Westphal, Watson, & Litz, 2010; Navy Leaders Guide, 2012).

Atrocities Exposure and Killing: Perpetration Element of Moral Injury

Despite its prevalence, our understanding of the psychological impact of killing in war is still in its infancy (Maguen & Burkman, 2013). MacNair points out at least three major reasons why the concept that the act of killing could produce trauma has received little interest. Firstly, is society's sympathy for the veteran and not wanting him to feel guilty for anything. Secondly, wanting to blame only the enemy for any harm to our Veterans, and not the country and citizenry responsible for sending them to war. Lastly, there are those individuals for whom people will have no sympathy, such as Nazis or torturers. For these main reasons, the idea that these individuals could struggle with emotional pain related to their actions does not occur to many people. The research available looking at mental health symptoms related to combat exposure, specifically the commission of atrocities and war-zone killing provides us with some evidence of the perpetration element of moral injury.

War-time atrocities have been defined as abusive war-zone violence (Ford, 1999). Specifically, raping, torturing, mutilation (e.g., cutting off ears, putting heads on sticks, placing bodies in grotesque positions), and killing of innocents, including women and children (Beckham, Feldman, & Kirby, 1998; Singer, 2004). Ford (1999) found that atrocities participation was a significant risk factor for psychosocial impairments beyond those associated with the diagnostic criteria for PTSD (e.g., fundamentally altered beliefs concerning self and relationships, self-fragmentation, and existential confusion). However, atrocities participation was not found to be an independent risk factor for PTSD. Therefore, perpetration of wartime atrocities may produce psychological distress outside the scope of diagnostic criteria necessary for a PTSD diagnosis.

Singer (2004) reported that Vietnam Veterans diagnosed with PTSD who participated in war-time atrocities continued to experience mental health symptoms outside the purview of a PTSD diagnosis. These Veterans experienced guilt, shame, self-hatred, and a sense of being interminably unforgivable all relating to the atrocities they committed. Singer was not afraid to point out that some of these Veterans described being driven by revenge and intense hatred, feeling powerful, invincible, and in the moment they enjoyed committing the atrocities. However, after time for reflection, coming to terms with the knowledge that they had taken pleasure in something so horrible felt unbearable.

Beckham et al. (1998) measured PTSD symptom severity and trauma related guilt in a sample of Vietnam combat Veterans. When controlling for combat exposure, atrocities exposure (perpetration and witnessing) was significantly related to overall PTSD symptom severity, and guilty cognitions about both hindsight/responsibility and

violations of one's personal standards or wrongdoing. Moral injury's elements of perpetration of and witnessing acts that transgress deeply held moral beliefs, clearly speaks to the veteran who is struggling to make sense of their participation in and witnessing of war-time atrocities.

Moral injury is in its infancy as a psychological construct. Therefore, many researchers looking at the psychological impact of killing in combat have described potential elements of moral injury as an increase in PTSD symptom severity, depression, alcohol abuse, anger, and overall functional impairments (e.g., employment, finances, relationships, education, physical health, and legal issues). MacNair (2002) found that Vietnam Veterans engaged in heavy combat, but reported not killing produced lower PTSD scores than those Veterans who reported killing but were engaged in light combat. Furthermore, she found that even when combat intensity was held constant, killing still provided significant predictive power to PTSD scores. Similarly, Maguen et al. (2009) looked at Vietnam Veterans who reported killing combatants and noncombatants. They found that after controlling for demographics and combat intensity, killing was associated with PTSD symptoms, dissociation experiences, functional impairments, and violent behaviors. Maguen et al. (2011) also investigated the mental health impact of killing on Gulf War Veterans. After accounting for perceived danger, exposure to death, and witnessing killing, reported killing was a significant predictor of posttraumatic stress symptomatology (PTSS). Additionally, after controlling for prior problem drinking, reported killing was the only significant predictor for each alcohol related measure. However, reported killing was not a significant predictor of depression symptoms. Research into the impact of killing on mental health symptoms in Iraq War

Veterans has provided similar results. After controlling for combat exposure, reported killing was found to be a significant predictor of PTSD symptoms, alcohol abuse, hostility/anger, and relationship problems (Maguen et al., 2010).

The experience of killing in combat undoubtedly has the potential to transgress a deeply held moral belief and thus qualify as the perpetration element of moral injury. It is not surprising that research has found reported killing linked to PTSD symptomatology. War-zone stressors necessarily include life-threat, the necessary antecedent for a PTSD diagnosis, and killing is the sanctioned response to that threat. What is important to discover is if and how the experience of killing is distressing to the Service member in ways not fully addressed through a PTSD diagnosis. Additionally, killing in combat is not always related to life-threat. Killing can occur in the context of revenge and anger. Focus groups conducted with Veterans from multiple war eras reported that killing in situations which were revenge or anger based caused feelings of guilt, remorse, and shame. Based on these focus groups and consultation with expert clinicians, Maguen and Burkman (2013) have constructed a measure currently being validated, to evaluate killing-related maladaptive cognitions.

Killing in combat, moral injury, and suicide. Fontana, Rosenheck, and Brett (1992) found that killing in combat or failure to prevent death or injury was associated with suicide attempts among Vietnam Veterans. Research looking at newly returning soldiers of OIF showed that the effect of killing in combat on suicidal thinking was explained by an indirect effect in which depression and PTSD symptoms mediated the relationship between killing in combat and suicidal thinking (Maguen et al. 2011).

Killing in combat may also be independently associated with suicidal ideation among Veterans. Maguen et al. (2012) looked at archival data from the NVVRS utilizing a subsample of these data, the clinical interview sample (CIS) which is representative of 1.3 million Vietnam Veterans. After controlling for demographics, PTSD, depression, substance use disorder, and combat exposure, the association between killing in combat and suicidal ideation remained. Furthermore, those Veterans reporting higher killing experiences had twice the odds of suicidal ideation compared to those with lower or no killing experiences. Maguen et al. suggested that a potential mediator between killing and suicidal ideation may be moral injury. Veterans who have killed in combat may struggle with remorse, guilt, and shame. Left unaddressed these emotions can lead to isolation and withdrawal, a sense of being unforgivable, and to self-condemnation, leaving the veteran feeling hopeless and helpless (Litz et al. 2009).

Guilt and shame levels have been shown to be significantly higher among active duty military personnel with a history of suicidal ideation. Bryan, Morrow, Etienne, and Ray-Sannerud (2013) researched active duty Air Force personnel seeking outpatient mental health services to determine if guilt and shame were potential contributors to suicidal ideation. They reported that guilt and shame were independently associated with

current suicidal ideation above and beyond the effects of depression, PTSD, and the depression-by-PTSD interaction. Additionally, guilt and shame fully mediated the relationships of depression and PTSD symptom severity with suicidal ideation. This finding suggests that guilt and shame may be more closely associated with suicidal ideation among military personnel than depression or trauma symptoms.

Intensive combat-related guilt has been shown to be a significant predictor of both suicide attempts and preoccupation with suicide among Vietnam Veterans diagnosed with PTSD, with survivor guilt significantly associated with suicide attempts but not suicidal preoccupation (Hendin & Hass, 1991). Additionally, Hendin, and Hass found that the Veterans in their study were more likely to experience marked guilt when they had killed civilians while in a state of being out of control because of terror or rage. This is in contrast to those Veterans who had killed civilians through firing orders, who only later questioned the judgment of their superiors and their own role. This state of being out of control while killing speaks to one element of Shay's (1991) initial definition of moral injury, the beserker state.

To date there has been one study which looked specifically at the effect of moral injury on suicidal ideation and suicide attempts among Service members (Bryan et al., 2014). Bryan et al. measured moral injury and its association with lifetime incidence of self-injurious thoughts and behaviors (SITB) and with severity of current suicidal ideation. The participants were 151 Air Force and Army personnel who were currently receiving outpatient mental health services at two military clinics. Patients were invited to take part in the study and those who were interested completed a packet of anonymous self-report surveys.

In order to assess for moral injury, in a prior study, Bryan, Bryan, Etienne, Morrow, and Ray-Sannerud (2013) (as cited in Bryan et al., 2014) had measured three factors of morally injurious behavior which they categorized as; transgressions committed by the self (i.e., transgressions-self), transgressions committed by others, such as witnessing or learning about acts committed by others (i.e., transgressions-other), and feeling betrayed by others (i.e., betrayal). These three factors were derived from the Moral Injury Events Scale (MIES) (Nash, et al. 2013) to be discussed in detail below. Bryan et al. found the scores for those Service members who endorsed experiencing transgressions-other and transgressions-self were significantly higher for the suicide attempt group as compared to the control group, with transgressions-other showing the largest difference between those with and without a history of suicide attempt. Furthermore, the suicide attempt group also scored significantly higher than the suicidal ideation group on transgressions-other and transgressions-self scales, showing a somewhat larger effect for the transgressions-other scale. No effects were found for the betrayal scale. When looking at the severity of current suicidal ideation, transgressions-self was associated with significantly more current severe suicidal ideation than transgressions-other. Betrayal was not associated with current suicidal ideation. These results suggest that transgression-other, the witnessing and learning about acts that transgress deeply held moral beliefs, may be an important aspect of moral injury as it relates to SITB. Transgression-self was found to have the strongest correlation to severity of current suicidal ideation, again suggesting that this dimension of moral injury may be another important feature related to SITB among military personnel.

Elements of Moral Injury: Failure to Prevent, Witnessing, Learning About Acts

Examining the elements of moral injury which relate to failure to prevent, witnessing, or learning about acts that transgress deeply held moral beliefs has received little attention in the literature as it relates to traumatic combat experiences. Laufer, Gallops, and Frey-Wouters, (1984) recognized war stress among Vietnam Veterans to have at least three conceptually distinct elements; 1. combat experience (e.g., facing threat to life and limb); 2. witnessing abusive violence (e.g., acts against civilians, mistreatment of prisoners of war, and use of cruel weapons); and 3. participating in abusive violence. In this study Laufer et al. specifically eliminated any instances in which a veteran had learned about an event secondhand. They determined that witnessing and participating in abusive violence were not cumulative experiences additively reflecting the same type of stress in combat, but rather were distinct stressors.

Fontana et al. (1992) organized combat trauma into four distinct roles; target, observer, agent, and failure. They found that being a target, experiencing the terror of being killed or wounded, was most uniquely and strongly associated with PTSD symptomatology. Guilt for having been an agent (i.e., perpetrator) of death or injury, or failure to prevent death or injury was more significantly related to suicide attempts than either having been a target or observer (i.e., witness). Additionally, having been an agent and/or failing to act was especially pertinent to the presence and severity of psychiatric comorbidity with PTSD.

MacNair (2002) found that when looking at PTSD scores of Vietnam Veterans those who reported they only witnessed the killing of civilians or prisoners of war had lower scores than those Veterans who reported they were directly involved in atrocities.

However, Bryan et al. (2014) found that the moral injury factor of transgressions-other (i.e., witnessing or learning about acts) was significantly related to suicide attempts as compared to controls. The transgression-other group also scored significantly higher on suicide attempts as compared to the suicidal ideation group.

The limited research looking at failure to prevent, witnessing, or learning about acts that conflict with a Service member's moral beliefs and expectations, tells us at the very least that these three elements of moral injury are very likely distinct types of combat injury. Therefore, future research is needed to more fully address these unique experiences faced by Service members. The current study, being phenomenological in nature, addressed these features of moral injury to varying degrees.

Assessment Tools

There are two assessment tools which have been developed specifically to measure the prevalence and intensity of potentially morally injurious events; the Moral Injury Events Scale (MIES) (Nash et al., 2013) and the Moral Injury Questionnaire – Military version (MIQ-M) (Currier et al., 2015). Additionally, Stein et al. (2012) have proposed a scheme to categorize multiple types of trauma in the military context which includes morally injurious events. Also, as indicated Maguen and Burkman (2013) are in the process of validating a measure to evaluate killing-related maladaptive cognitions, which may serve to expand our understanding of the perpetration/failure to act element of moral injury.

Nash et al. (2013) developed and evaluated psychometric properties of the MIES. The MIES was developed to measure traumatic events that may lead to PTSD, but not due to experiencing a life threatening event, but rather due to experiencing trauma that

violates deeply held moral beliefs and expectations. The instrument is a self-report measure composed of nine items. Each item is scored on a six point Likert-scale ranging from 1 (strongly disagree) to 6 (strongly agree). The items were constructed after a full literature review and expert consensus on events involving perpetrating, failing to prevent, bearing witness to, learning about, or being the victim of acts that transgress deeply held moral beliefs and expectations (Litz et al., 2009). The results of exploratory and confirmatory factor analyses revealed two factors: perceived transgressions by self or others, and perceived betrayal by others. The first factor, transgressions by self or others, included acts of commission and omission, as well as witnessing acts of commission with concomitant distress related to all three. The second factor, betrayal by others, included betrayal by leaders, fellow Service members, and nonmilitary others. The researchers found the MIES to have excellent internal consistency and good temporal stability. They also established initial discriminant and concurrent validity. Nash et al. reported they were expanding on the content of the MIES by conducting focus groups and considering alternative ways of wording the instructions and items to best fit the experience of Veterans. This assessment tool is an important step in evaluating the prevalence and intensity of perceived morally injurious war-zone experiences.

Currier et al. (2015) conducted an initial psychometric evaluation of the newly developed Moral Injury Questionnaire—Military version (MIQ-M: Currier et al., 2015). The MIQ-M is a 19-item self-report questionnaire scored on a four-point frequency scale with 1 = Never, 2 = Seldom, 3 = Sometimes, and 4 = Often. The researchers developed the items by using the findings from Drescher et al.'s (2011) study, available research, theory, and clinical evidence for the moral injury construct. Six different domains are

covered in the MIQ-M; 1. acts of betrayal (i.e., by peers, leadership, civilians, or self); 2. acts of disproportionate violence inflicted on others; 3. incidents of death or harm to civilians; 4. violence within military ranks; 5. failure to prevent death or suffering; and 6. ethical dilemmas/moral conflicts. Currier et al. pointed out that because of potential guilt/shame or fear of legal ramifications some Veterans may be unlikely to accurately report instances in which they violated rules of engagement, committed atrocities, or committed other types of morally injurious acts. Therefore, the researchers chose to combine direct involvement with witnessing acts for several items (e.g., I saw/was involved), pointing out that this likely confounded two distinct types of war-zone stressors. Overall, the researchers reported preliminary evidence for the factorial, concurrent, and incremental validity of the MIQ-M lending support to the utility of the moral injury construct and preliminary evidence for the MIQ-M as a tool to assess morally injurious events among Veterans.

In an effort to address the multidimensional quality of war-zone trauma, Stein et al. (2012) reviewed structured clinical interviews of 122 active duty Service members and assigned identified distressing events to one of six categories. The categories developed by the researchers were based on the available war-stress and trauma literature, and clinical experiences with active duty military. The six categories are; life threat to self; life threat to others; aftermath of violence (e.g., exposure to grotesque or haunting images, sounds, or smells); traumatic loss (e.g., witnessing or learning about death of family member, friend, or unit member); moral injury by self (e.g., killing, injuring others, rape, atrocities); and moral injury by others (e.g., witnessing or being the victim of acts of others including betrayal and acts learned about if directly relevant to

the individual). Stein et al. considered these categories as individual but not mutually exclusive. They also consider these six classifications to be an exhaustive list of potential war-zone traumas. The researchers found high interrater reliability for their coding scheme and found support for construct validity of the categories, providing tentative support for the use these categories.

Treatment Interventions

Given the relative newness of the concept of moral injury in the research literature it is not surprising that studies exploring how best to treat those struggling with moral injury has been a neglected topic (Steenkamp, Nash, Lebowitz, & Litz, 2013). Well established evidence based practices for other conditions such as PTSD or depression may not completely address the full spectrum of psychological and behavioral sequela of moral injury. Treatment modalities for PTSD commonly utilize exposure based strategies which are used to address fear and anxiety based PTSD symptoms. Repeated exposure to a memory of an act of moral transgression could be counterproductive or even potentially harmful without a strategic therapeutic framework specifically addressing moral injury (Litz et al., 2009). Cognitive approaches assume there is a distorted belief which is causing the person to suffer. In the case of morally injurious events, the appraisals and beliefs surrounding the moral transgression may in fact be fitting and accurate (Litz et al., 2009). In an effort to address the unique needs of Service members struggling with moral injury Litz et al. (2009) were first to propose a working clinical care model that targets moral injury. The approach consists of eight steps or elements with the understanding that there will be substantial overlap with some steps occurring throughout the entire treatment.

Step one addresses the therapeutic connection. There must be a strong working alliance and the therapist must have the ability to listen to difficult and morally conflicted material without experiencing aversion. It is suggested that therapists familiarize themselves with the range of potential gratuitous violence that can occur in combat. The therapist needs to be able to express empathy for someone who has engaged in morally questionable acts. Step two is psychoeducational. The client needs to understand that painful experiences and feelings can and need to be expressed in order to move forward. Step three is a modified exposure component. The client is supported in reliving the painful event but with the goal of helping the client stay with the event long enough to articulate an emotion-focused disclosure of the experience. This step is done in tandem with steps four and five. Step four is an examination of maladaptive beliefs about the self and the world with the aim of promoting or least dialoguing about the possibility of new more constructive meanings. Step five is an imaginal dialogue with a benevolent moral authority (e.g. parent, clergy, coach) on the event and how it is impacting the client and their future plans. The goal is to have the client verbalize the event, how it has affected them and what should happen to them with a figure that does not wish to see them suffer and believes forgiveness is possible. If the client cannot think of an authority figure then they are asked to counsel a fellow Service member who feels they are unredeemable and convinced they deserve to suffer. Step six fosters reparation and self-forgiveness so that the client sees that future good is still possible in the face of past mistakes. Step seven fosters reconnection with various communities, such as family and religious/spiritual groups. Step eight is an extensive conversation about future goals and moving forward.

These eight steps should not be construed as eight sessions, but rather a model of care to guide the difficult work of alleviating the suffering of moral injury (Litz et al., 2009).

Litz, Lebowitz, Gray, and Nash (2016) developed a brief psychotherapy for active-duty Marines with combat-related PTSD, termed Adaptive Disclosure (AD). Adaptive Disclosure is a manualized treatment developed specifically for active duty Service members experiencing combat-related PTSD emerging from life-threat/fear-based experiences, traumatic loss, and moral injury. The intervention is designed for Service members who have redeployed and are in garrison (i.e., who have returned to the U.S. after deployment and are stationed at a stateside military post) and seeking clinical care.

Treatment begins with an introductory psychoeducational session followed by at least four possibly six, exposure-based sessions. The treatment concludes with a final session discussing future planning. One of the primary goals of AD is to initiate a process experientially, rather than anticipating full symptom remission. The aim is to plant seeds so that the Service member experiences an example of how change can occur and a guide for new ways of coping and thinking about combat and operational experiences going forward. Another goal of AD is to change the Service member's negative expectations about revealing painful and morally conflictual deployment events and foster a willingness to disclose rather than conceal traumatic combat experiences. In this way Service members learn that they can share difficult experiences, tolerate painful emotions, and gain helpful guidance surrounding their experiences (Litz et al., 2016; Steenkamp et al., 2011).

There are three main components to AD: 1. a core imaginal exposure component; 2. a breakout component to target traumatic loss/grief; and 3.) a breakout component to target moral injury and associated shame and guilt. The exposure component in AD differs from traditional prolonged exposure therapy because it does not consist of multiple retellings of the event with the purpose of in-session extinction. Instead the exposure sessions are used to show Service members that they can share difficult material without losing control, being judged, or rejected. The exposure sessions serve to promote one of the main goals of AD which is to challenge maladaptive appraisals and avoidant strategies before they become entrenched coping mechanisms (Litz et al., 2016; Steenkamp et al., 2013).

The breakout component addressing traumatic loss/grief utilizes a modified Gestalt technique of the empty chair. The Service member is asked to describe the deceased person, what they were like and what the person meant to them. Using the empty chair technique the Service member is asked to have an imaginal conversation with the deceased person telling them how the person's death has impacted the Service member. The Service member is then asked to consider and describe how the deceased person would respond after hearing what was disclosed. The aim of this imaginal exercise is to stimulate forgiveness and acceptance themes (Litz et al., 2016; Steenkamp et al., 2011).

The breakout component addressing moral injury utilizes two versions of the empty chair technique. After the Service member has processed the moral injurious event during the exposure component they are asked to have an imaginary conversation with a respected and generous moral authority. Next the Service member is asked to describe for

the moral authority, in the present tense, the guilt and shame related to the event and how this has impacted their life. Then the Service member is asked to consider and describe what the moral authority figure would say to them. The aim of this exercise is to promote forgiveness-related content. If the Service member cannot think of a moral authority figure then they are asked to choose someone for whom they feel protective. They are then instructed to imagine that this person has just confessed all that the Service member has disclosed. The Service member is then asked to consider what they would say to the person, with the goal of emphasizing forgiveness-related themes (Litz et al., 2016; Steenkamp et al., 2011). In the final session feedback is elicited regarding what the Service member has learned and a discussion of what challenges may lie ahead. It is emphasized to the Service member that the intervention was only the beginning of a continuing process in which what was experienced in therapy can serve as a guide to aid them in facing deployment related challenges in the future.

Gray et al. (2012) conducted an uncontrolled open clinical trial of AD with 44 active duty Marines and Navy Corps personnel stationed at Camp Pendleton, California, with 43% of participants endorsing a morally injurious event. Utilizing the initial model of six sessions, results showed significant reductions in PTSD as measured by the PTSD Checklist-Military Version (PCL-M); significant reductions in depression as measured by the Patient Health Questionnaire (PHQ-9); significant reductions in negative posttraumatic appraisals (e.g. negative appraisals about the self, the world, and self-blame) as measured by the Posttraumatic Cognitions Inventory (PTCI); and results also showed an increase in posttraumatic growth, as measured by the Posttraumatic Growth Inventory (PTGI). A post-intervention satisfaction measure was developed by the

researchers; the Post-Intervention Satisfaction Measure (PISM) which included seven items each rated on a scale ranging from 1 (strongly disagree) to 5 (strongly agree). The PISM showed that the Service members agreed or strongly agreed that they would recommend AD to other Marines, that AD was helpful, that they would use an intervention like AD in the future, AD helped them to feel more in control, and was tailored to their needs. Based on feedback from both therapist and participants the researchers stated they intended to modify AD by adding two additional sessions for a total of eight sessions. Because at the time of this study there was not a measure for moral injury researchers utilized the Posttraumatic Cognitions Inventory to measure maladaptive beliefs about the self and self-blame. However, since that time the MIES has been developed (Nash et al., 2011). Gray et al. (2012) indicated that in future AD trials the MIES will be included.

Smith, Daux, and Rauch (2013) propose that traditional prolonged exposure therapy (PE) which is commonly used to address PTSD in combat trauma survivors, very often will also address the guilt and shame related to the contextually appropriate use of violence. The researchers provide clinical vignettes utilizing PE with trauma experiences that include perceived perpetration. They define perceived perpetration as acting with violence or lethal force or failing to act when violence was done to others, interpreting the act as a violation of their moral code, and the act was the result of the trauma context and not premeditated or done with instrumental intent to victimize. The researchers state that studies support the assertion that PE results in significant reductions in guilt and PTSD symptoms (Foa & Rauch, 2004; Resick et al., 2002).

Steenkamp et al. (2013) provide commentary on Smith et al. (2013) pointing out that the studies referenced by Smith et al. showing that PE reduces guilt and PTSD symptoms were both studies of victims of violence not perpetrators of violence. Steenkamp et al. argue that victimization-related guilt is not interchangeable with perpetrator-related guilt, further stating that survivor guilt and perpetrator guilt in combat very likely involve different cognitive components. Steenkamp et al. additionally state that the definition of perceived perpetrator limits the actual experiences of many Service members pointing out that when in combat a Service member may engage in acts of violence out of deliberate revenge and still experience debilitating guilt and shame after the act. In their commentary, Steenkamp et al. maintain that PE is designed to provide exposure to corrective information primarily through habituation and extinction, which includes contextualizing the perceived transgressive act in an effort to change presumed distortions about culpability and self-blame. However, they emphasize that when considering the full range of morally injurious experiences, a Service members self-blame may not be entirely unfounded. They argue that in these instances no amount of contextualization will adequately relieve the Service member's sense of accountability. Steenkamp et al. conclude that traditional PE may be suitable to very limited types of moral injury involving a strong fear element, when there are contextual aspects that exonerate or explain the morally questionable behavior, and when the culpability is more perceived than actual. However, they maintain that traditional PE without a modified component to specifically address the full spectrum of potentially morally injurious deployment experiences faced by Service members will not adequately treat the subsequent psychological and behavioral sequela.

Additional treatment options have been proposed such as Logotherapy (Frankl, 1959; Southwick et al., 2006) and the Transpersonal-Existential Meaning-Based model (TEMB) (Osran, Smee, Sreenivasan, & Weinberger, 2010; Sreenivasan et al., 2014). Logotherapy is considered an adjunctive therapy which serves to enhance other therapies by specifically focusing on an individual's strengths and a personal search for meaning in life. Viktor Frankl developed logotherapy based on his belief that man's primary need is to find meaning in life. Frankl's tragic optimism encompasses the idea that human beings have the potential to transform their suffering into human achievement and to transform guilt into meaningful action (Frankl, 1959; Southwick et al., 2006). Service members who have experienced combat come to realize that each day may be their last and that for some of their comrades, it is. Many Service members struggle to make meaning out of why some died in combat, and why they and others survived. War provides a constant reminder of one's mortality and thereby creates a unique sense of the fleeting nature of existence (Osran et al., 2010).

In approximately 2001 the PTSD program of the Connecticut Veteran's Hospital began utilizing logotherapy in treating Veterans with chronic combat-related PTSD (Southwick et al., 2006). Southwick et al. provided case examples of using logotherapy with inpatient groups, outpatient groups, and individual therapy with promising results. The researchers found that the addition of logotherapy directly addressed commonly seen problematic symptoms with their population of Veterans, including a sense of a foreshortened future, an external locus of control, guilt and survivor guilt, and existential loss of meaning. Southwick et al.'s use of logotherapy for treating chronic combat-related PTSD is referenced here in treatments for moral injury because all of the disclosed events

that tormented the Veterans were events that could very readily be defined as moral injury (Litz et al., 2009). The case examples were primarily Vietnam War Veterans, with one Persian Gulf War veteran in the individual therapy example. Among the Vietnam War Veterans the themes of continued suffering were; survivor guilt over losing a friend in combat; guilt surrounding killing Vietnamese civilians or being forced to leave villages, thereby leaving the inhabitants vulnerable to atrocities from the Viet Cong; anguishing over the inability as a soldier to help the children orphaned by war; feeling the need to make restitution to Cambodian refugees for the secret bombings by the U.S. that led to instability and the rise of Pol Pot; and the Persian Gulf War veteran, a pediatric medic, who was haunted daily by the image of a 3-year-old girl who had lost all her limbs. None of the longstanding pain carried by these Veterans over decades was related to life-threat or fear.

Osran et al. (2010) proposed a new therapeutic model framed by Frankl's (1959) logotherapy as an approach for promoting resilience in returning Veterans which is both meaning based and transpersonal in focus, termed the Transpersonal-Existential and Meaning-Based model (TEMB). Sreenivasan et al. (2014) propose that TEMB is well suited to address moral injury in combat Veterans. When human beings fail to live up to their moral values they can experience guilt, anxiety, and emptiness which leads to self-rejection, or a sense of non-being. Moral injury is despair. Despair is seen as suffering without meaning. The loss of existential meaning from combat can come about in two ways: disillusionment about the goodness of human nature and guilt or shame for one's action or inaction. It is proposed that by recapturing meaning moral injury can be repaired. The TEMB model encompasses four elements: 1. identifying signature strengths

from the combat story by emphasizing meaningful aspects of the event embedded in the context of the larger self; 2. identifying the events meaning in a larger context such as in the role of Service member with a sense of purpose larger than oneself; 3. addressing the spiritual context looking at forgiveness of self and others and overcoming cynicism; and 4. promoting resilience by identifying pitfalls and traps to avoid such as holding onto resentment, guilt, or shame. The TEMB model is well-suited to address the emptiness of meaning and the spiritual anxiety associated with moral injury (Sreenivasan et al., 2014).

Operationalizing a new construct such as moral injury is essential for future research, for proper assessment, and ultimately effective treatments. When there is consensus on the definition of a concept, to the degree consensus is possible, it greatly reduces future methodological problems. Even at this early stage in the research on moral injury we are already seeing divergent views on the element of betrayal as it relates to moral injury. We see that Litz et al. (2009) and Bryan et al. (2014) define betrayal to mean a betrayal by others and not the self. Additionally, the MIES developed by Nash et al. (2013) also defines acts of betrayal to have been committed by others and not the self. However, when we look at Drescher et al. (2011), and Vargas et al. (2013) they define acts of betrayal to include acts committed by the self. Furthermore, we see that the MIQ-M (Currier et al., 2015) follows Drescher et al.'s definition and includes acts of betrayal by the self in its measurement. The lack of agreement on definition can lead to the inability to: generalize research, to effectively assess for risk factors, and to create effective interventions. Reaching agreement on a definition of moral injury is of great importance for the future well-being of our service-members and Veterans. While the current study cannot remedy the disparity in definitions it can add to the growing

literature on the definition of moral injury. In this way it is hoped that future research will utilize this study as an aid in completing a formal construct analysis so that we can all work with a common definition which will enable us to generalize our research and ultimately better serve those who so courageously have served us and our country.

Chapter III: Methods

Research Design

This study explored combat Veterans lived experience of what may be considered moral injury. The working definition of moral injury proposed by Litz et al. (2009) was utilized in this study. Litz et al. define moral injury as perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs. This exploration was undertaken using the qualitative descriptive phenomenological psychological research method of Amedeo Giorgi (Giorgi, 2009). A qualitative research approach using a phenomenological analysis was used to provide rich contextual examples of the lived experience by combat Veterans. Phenomenological research is focused on the discovery and exploration of a phenomenon and is not an effort to validate a hypothesis about a phenomenon (Applebaum, 2012). Because the concept of moral injury is in need of further definition by those who have had first-hand experience, a phenomenological approach was best suited to the task.

The philosophical premises underlying the phenomenological research approach of Giorgi is that of Husserlian descriptive phenomenological philosophy. To more fully understand the Giorgi research method it is necessary to discuss some key Husserlian concepts. One important concept is that of intentionality; the term does not have the same meaning as acting in a deliberate manner to achieve a desired goal. Instead, intentionality as Husserl conceived is the essence of consciousness and is always directed to some object or other. Intentionality contemplates that all acts of consciousness are directed to objects that transcend the acts themselves (e.g., compassion is directed toward the object

of the compassion) (Giorgi & Giorgi, 2008). Consciousness is always conscious of something other than itself (Giorgi, 2009).

When individuals communicate to each other their intentionality, how do they let the other know the way in which their consciousness grasps the object in the world? Husserl answers that in order to express and to understand the intentionality of the other, one must do so by careful description. In order to secure the most accurate data from descriptive research, Husserl proposes the use of attitudinal modifications. These modifications are meant to help combat our preconceived notions and known and unknown biases. One attitudinal adjustment is the *epoche* or bracketing and the other is the phenomenological reduction. With bracketing it is our knowledge that is bracketed, which is to set aside knowledge about the phenomenon under investigation that comes from prior experiences or any other indirect source. Husserl's transcendental phenomenological reduction is the attitude in which one must consider everything that is given to consciousness from the perspective of consciousness itself; this includes the consciousness of all beings, not only human consciousness. Giorgi's scientific phenomenological reduction (scientific reduction) likewise necessitates that consideration of the given come from the perspective of consciousness. However, Giorgi defines this consciousness as human consciousness engaged with the world. Giorgi (2009) further expands his scientific reduction to include the premise that the objects or states being explored are taken to be presences, and not realities. "They are taken to be exactly as they present themselves to be, but no claim is made that they actually *are* the way they present themselves to be" (Giorgi & Giorgi, 2008, p. 34). These Husserlian concepts are

important to understand as they inform the basic steps in the Giorgi method of data analysis to be described in detail in the Procedures section below.

Procedures

Participants. Participants for this study were from a purposeful sample of individuals recruited from the population of male combat Veterans from any branch of military service who served in OIF and/or OEF. Study participants consisted of eight male combat Veterans. Due to the fact that women were not officially allowed in combat until 2013 the pool of candidates were male combat Veterans. This decision was not meant to discount in any way the fact that many female Veterans were involved in combat operations due to the nature of insurgency warfare (Bowser, 2005). Furthermore, given the working definition of moral injury used for this study, which includes bearing witness to and learning about events that transgress deeply held moral beliefs, it is certainly likely that female as well as male Veterans not in direct combat would also have experiences of moral injury. However, in order to maintain as true a definition as possible of the participants as combat Veterans, for the purposes of this study the participants were limited to male combat Veterans. The experience of moral injury can affect the young and old equally. Therefore, no limitation on the ages of the participants was required. Based on the definition of moral injury as being the perpetration of, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs (Litz et al., 2009), the participants were asked to identify personal experience(s) that resonated with that definition, and were willing to discuss those experiences.

Recruitment. Participants were recruited from centers that provide, among other services, psychological services for military Veterans; through online community forums;

posting flyers on college campuses and coffee houses; and word of mouth. The basis of recruitment was a flyer (see Appendix A) which described the topic of moral injury, the opportunity to participate in research, and contact information (e.g., telephone number and an email address) in order to obtain more information and eligibility screening.

Inclusion/exclusion criteria. Criteria for inclusion in the study was: (a) participants were male combat Veterans of OIF and/or OEF, they were not active duty personnel; (b) they were under the care of a licensed mental health professional; (c) they were willing to discuss their experience relating to moral injury as defined in this study; and (d) they were willing to have their interview audiotaped. Criteria for exclusion in the study were: (a) female Veterans; (b) male and female active duty personnel; and (c) if they were experiencing severe psychological symptoms even if under the care of a mental health professional.

Prescreening. All potential participants were prescreened via telephone to determine if they were eligible for the study (see Appendix B). The prescreening was meant to ensure that the participants met the inclusion criteria of the study. The overarching concern during the prescreening interview was twofold; 1. Did the participant have the experience related to moral injury as defined in this study; and 2. Was the participant in a healthy psychological state to share that experience. Only after participants were found eligible for the study were they informed that they would be compensated \$40.00 for approximately one and a half hours of their time. The \$40.00 was paid at the end of the actual interview. At this time a preliminary meeting was scheduled as well a time for the actual interview. The individuals who were found ineligible for the study because they were not currently under the care of a mental health

professional were provided with three referrals for mental health services (see Appendix C).

Preliminary meeting. The preliminary meeting took place approximately one week before the scheduled interview. This meeting took place at a location of mutual agreement conditioned on the requirements that there be privacy and the opportunity for clear audio recordings without interfering background noise. The preliminary interviews lasted approximately one half hour and were audiotaped with a digital voice recorder and with a smartphone recording application. Data storage is discussed below. One of the main purposes of the preliminary meeting was to establish trust with the participant. They are being asked to share lived experiences that, given the definition of moral injury, can bring up painful feelings such as guilt and shame. Spending more time in establishing rapport is necessary when researching this type of sensitive phenomena (Giorgi, 2009). The preliminary meeting was a time for discussing and signing the informed consent document (see Appendix D) and the authorization to release/request confidential information document (see Appendix E). The participant was informed how their information would be stored. Confidentiality was discussed and how their personal information would be protected. All efforts were made to disidentify the information shared, such as not using the exact locations of events and not using the participants or any discussed individual's real names. The participant was asked to provide a non-identifying pseudonym to be used in the research. If they could not decide on a pseudonym at the preliminary meeting they could provide the name at the actual interview. This meeting was a time to discuss any of the participants concerns. The research question was reviewed which can aid in obtaining a richer description during the

actual interview without having to ask too many questions (Englander, 2012).

Additionally, all participants were informed that they could bring with them to the interview any photographs, writings (e.g. journals, poems, etc.) or other objects of significance which they believed would aid in providing a deeper understanding of their experience (Creswell, 2009).

Interview. Raw data was collected through separate one-on-one interviews and was audiotaped for later transcription and analysis. Interviews were conducted in person. The research topic of moral injury and the concomitant emotional states; for example, self-condemnation, required that the participant not feel judged and feel able to talk freely. Telephone interviews lack that responsive feedback of acceptance and understanding that may be necessary to allow the participant to fully share their experiences. Additionally, if the participant had any symbolic items to share, phone interviews would have been prohibitive for that type of sharing.

In preparation for the interview it was important to imagine, ahead of time, the range of possible acts of gratuitous violence that may be reported. A strong effort was made to become familiar with some of the horrible acts that people commit and witness in war. This was undertaken in part based on research for this study and also through watching documentaries on the devastations of war, as well as popular main stream movies, and searching the internet for images of the horrors of war. The effort was not only to become familiar with these types of events but to examine any feelings of judgment or condemnation surrounding these events (Litz et al., 2009) and to work through them. The purpose of this preparation was to make every effort that the

participants felt accepted no matter what they report and that they would not be harmed by any perceived condemnation from the interviewer.

Prior to the interview, confirmation that the participant was currently under the care of a mental health provider was confirmed. The interview took place at a mutually agreed upon location with the conditional requirements that there be privacy and the opportunity for clear audio recordings without interfering background noise. The interviews lasted approximately one and a half hours and were audiotaped with a digital voice recorder and with a smartphone recording application. Data storage is discussed below. The interview began with an ice-breaker discussion in order to allow to the participant to feel comfortable. Because the purpose of the interview was to explore the participants lived experience of moral injury the initial interview question was open-ended; “Please tell me in as much detail as possible your experience or experiences of moral injury?” A semistructured outline for the interview was prepared that included a short list of questions with subsequent probing questions if necessary in order to ensure that the participant was speaking to the phenomenon under investigation (see Appendix F). The intention during the interview was to make mental and/or written note of transitions in the participants’ description where they may have digressed from a topic. Once they had completed a spontaneous recounting their attention was directed to the topic of transition mentioned by inquiring, “You mentioned “xyz” please tell me more about that.” The specific research interest of moral injury required that efforts were made to ensure that the data collected was relevant to that interest. The directing of the participant needs to be distinguished from leading the participant. In the later, one is pushing the individual to say something specific that the researcher is looking for.

However, here the specific details or the content was not what was of interest. What was of interest was that the participant's description was genuinely exposing the experience of moral injury. When directing the participant, one is steering the subject back to the experience that is revelatory to the phenomenon being researched and the process is therefore not prejudicial (Giorgi, 2009). As Giorgi (2009) states, "After all, one cannot simply say to a participant, 'Speak!'"

Once it appeared that the participant had reached a level where no further spontaneous descriptions were recalled; that any topics mentioned but veered away from during their retelling had been explored; and as much as possible the areas of research interest had been explored; the interview was concluded. At the conclusion the participant was given \$40.00 in cash which was placed inside a thank you card in their presence. The card had the written acknowledgment, "Thank you so much for your participation, it was greatly appreciated." The participant was asked to sign a receipt for the \$40.00 and was provided with a carbon-copy of the receipt. The receipt only stated "Interview" and "\$40.00 cash."

Treatment of Data

Informed consent/authorization. All signed informed consent and authorization documents were given a numerical identifier beginning with 9901, 9902, etc. The informed consent and authorization documents were placed in a manila envelope and sealed. The outside of the envelope was marked with the numerical identifier. A single document listed the numerical identifiers and was matched with the pseudonym provided by the participant. All informed consent and authorization documents were stored in a locked file cabinet.

Data recording. All interviews, both preliminary and actual interview were audio recorded using a digital recording device and a smartphone with a voice recording application. The recorded data was immediately downloaded to a hard disk and a memory stick and placed in a locked file cabinet.

Transcription. Audio files of each interview were uploaded to the transcription service agency, www.Rev.com which provides 128-bit SSL (Secure Sockets Layer) encryption, the highest level of internet security available. All professional transcribers of [Rev.com](http://www.Rev.com) have signed strict confidentiality agreements. Additionally, for each interview transcribed [Rev.com](http://www.Rev.com) signed a Transcribers Confidentiality Agreement (see Appendix G) specific to this study. Once the transcriptions were received they were reviewed and compared to the audio recording to ensure accuracy. Upon confirmation that the transcript was accurate, [Rev.com](http://www.Rev.com) was instructed to delete the audio recording from their files. All interview transcripts were placed in a white envelope and labeled with the participants' pseudonym on the outside. The envelope was stored separately from the informed consent envelopes in the locked file cabinet. All computer files were password protected and stored on a non-internet storage device. All raw data, coded transcripts, and identity codes will remain stored in a locked file cabinet for seven years and then destroyed.

Data Analysis

Assume the reductionist psychological perspective. To begin the analysis a perspective of the scientific reduction was assumed. Here is where the attitudinal modification of bracketing suggested by Husserl was adopted. All past knowledge about moral injury and its definition was set aside, or bracketed. This was necessary in order to

more fully comprehend how the object (moral injury) presented itself to the participant. In this way what was described by the participant was viewed as a phenomenon, something which was experienced by the participant. However, no concern was directed to whether the claims by the participant were in fact the actual reality of how the experience of moral injury presented itself to the participant (Giorgi, 2009). Once centered in the scientific reduction mindset the next step was the analysis.

Holistic review. The phenomenological perspective is a holistic one. Therefore, each individual's transcribed interview was read in order to gain a sense of the whole. This step was completed without effort to clarify or to identify meanings. The purpose of this holistic review was to gain an appreciation of the description with an awareness of the forward and backward references (Giorgi, 2009; Giorgi & Giorgi, 2007). Once the transcript was reviewed for an overall sense of the whole, the next step was defining meaning units.

Define meaning units. The goal of phenomenological inquiry is to define the meaning of an experience. Therefore, in this portion of the analysis meaning units were identified. This is accomplished by a re-reading of the transcript, always with a scientific reduction mindset, and identifying the constitution parts of the descriptions. Specifically, meaning units were identified every time a significant shift in meaning was experienced (Giorgi, 2009). This is meant to be more of a spontaneous exercise that is experientially determined and not an intellectual exercise. The actual notation when finding meaning units was delineated by placing a slash mark in the text each time a meaning transition is found. The meaning units that were identified were connected to the attitude of the researcher. Therefore, different researchers can discover different meaning units. The

identification of meaning units has no objective meaning in and of themselves. This process allowed for the description to become manageable, and ultimately allowed for the parts of the whole of the description to be transformed from the implicit to the explicit (Giorgi, 2009; Giorgi & Giorgi, 2007). Once the transcript had been re-read and the meaning units identified the next step was transforming the participants' description into phenomenologically psychologically sensitive expressions.

Transform the implicit into the explicit in ways that are psychologically sensitive. This step in the analysis was what allowed for meanings to be revealed that are experienced by the participant but not always clearly articulated or brought into full awareness (Giorgi & Giorgi, 2007). This step in the Giorgi method is the heart of the analysis and it was the most intensively laborious (Giorgi, 2009). In this step the transcript which was now marked in meaning units was reviewed from the beginning. Each meaning unit was probed to discover a way to express the description so that the psychological associations could be made more explicit. This required working with the data in a way that allowed for imaginative variation, including considering the opposite of what one may consider expressing, ultimately finding the expression that was proper (Giorgi, 2009). One key aspect of the transformations was that the descriptions of the participant were changed from the first-person to the third-person. The reason for this was connected to the attitude of the researcher. It is important to be sensitive to the viewpoint of the participant, but the goal was not to identify with the participant. By transforming the description into the third-person the researcher was maintaining the attitude of scientific reduction (Giorgi, 2009). The importance of this step, as it is seen as the heart of the Giorgi method is best described by Giorgi (2009):

With this procedure, what comes to intuitive givenness to the researcher is something quite other than what the participant was aware of while providing the description. The participant recounts the living of the situation as she experienced it, but the researcher focuses on *how* the participant lived in the situation by highlighting the relationship between the participant and the worldly circumstances. The focus of consciousness is different in the two cases. In other words, the participant focuses on the situation as lived from her perspective, the researcher focuses on what the participant was aware of and actually lived unawarefully to the extent that such factors reveal themselves. Descriptions reveal more than what the describer is aware of, and that is one reason the method works. (p. 181)

These transformations also needed to create some generality so that it could become easier to integrate data from all of the participant descriptions. This did not require any distortion of the data; rather many different facts can have identical psychological meanings (Giorgi, 2009; Giorgi & Giorgi, 2007). In this way general structures could begin to emerge across all the data and surrounding the phenomenon of moral injury. Once the transformations had been completed in a psychologically sensitive manner, the analysis continued by creating structures of experience from these transformations.

Create structures of experience. In this step the transformed meaning units were reviewed to determine if there were underlying similar experiences that could be placed in one type of structure. Structures will generally consist “[o]f several key constituent meanings and the relationship among the meanings is the structure” (Giorgi, 2009,

p. 166). A structure is a summary of the lived experience of a phenomenon, and this may include aspects of the experience that were not in the participants' full awareness (Giorgi, 2009). When writing the structure there needed to be a determination of whether the differences seen were only minor so that they could be described as *intrastructural* differences, or if the differences were so vast that they must be identified as *interstructural*. If they were identified as interstructural, they needed to have their own structure type. In making these determinations a key consideration was whether the structure would collapse if one of the constituents was removed. If it would then the constituent was essential to the structure, if not then it was not essential (Giorgi, 2009). One always attempts to discern one structure from the data, however this is not always possible and one should never attempt to force the psychological transformations into one structure. When there are several structures emerging it is indicative of a fairly high degree of variation in the data (Giorgi & Giorgi, 2007). The structure is not a definition of the phenomenon, but rather it is a depiction of how the phenomenon was lived and experienced from a psychological perspective (Giorgi, 2009). The creation of the structure types serves as the basis for a discussion of the findings.

Methodological Assumptions and Limitations

Due to the retrospective nature of the interview there existed the possibility of error in recall or deceit on the part of the participant. Error in recall due to false memories or incomplete information can obviously occur. However, these are not crucial limitations to the phenomenological analysis (Giorgi & Giorgi, 2007). It is important to know the objective facts surrounding a phenomenon but it is the subjective lived experience that phenomenological inquiry seeks to understand. Therefore, distortions in

memory can provide even richer subjective psychological meaning because this is how the phenomenon was actually experienced by the participant—not necessarily how the event actual was. Thus, error or incomplete descriptions were issues to be aware of, but for phenomenological analysis where no claims to objective reality are made, the concern was not overwhelming (Giorgi, 2009; Giorgi & Giorgi, 2007).

The issue of participant deceit was more of a concern. Giorgi and Giorgi (2007) state that with deception it is more likely to go unnoticed in brief interviews and interactions. However, they believe that in sustained interviews such as those for doctoral dissertations, the researcher will be aware that something is wrong. One reason for this is that the phenomenological interview is not structured to prove a hypotheses or to advance a theory. Therefore, the interview seeks details about the persons lived experience in as spontaneous a way as possible. While it is certainly true that a participant could concoct an elaborate description of the phenomenon under investigation, the motivation for doing so is suspect. Especially, as in the current study which looked to uncover potentially painful emotional experiences. This should decrease the likelihood that a participant was motivated to provide contrived experiences. Additionally, compensation was revealed upon screening into the study, so motivation for deceit was reduced.

One potential limitation was that this method has the appearance of being dependent upon the researchers' subjectivity. All scientific inquiry transforms raw data in one way or another. In phenomenological investigations the transformation is inductive or is done a posteriori; knowable by appeal to experience (Agnes, 2003). In quantitative research the transformation is deductive or is done a priori; knowable without appeal to particular experience. The very definition of phenomenological investigations requires us

to look at the experience of the participant in all its subjectivity. Because the method used required transformation of raw data there were assurances of neutrality that were practiced. The first being that a complete track record of the identifications of meaning units and the transformations as well the creation of structures, was kept, such that the critical other can fully review the researchers processes. The second assurance and most important was that the attitude of the researcher was one of intersubjectivity. Meaning that the psychological attitude assumed was the role of the researcher who was constantly aware of the fact that the critical other will be reviewing the processes by which transformations were made and structures were created. The intuitions that guided these processes were not person based but were role based. These are not guarantees of objectivity, but they are principles to guide an objective outcome. When seeking to explore the phenomenon of moral injury it is better to “[e]rr on the side of fidelity to the phenomenon and struggle with intersubjective agreement” (Giorgi & Giorgi, 2007, pp. 49–50) than to conduct a study which would reduce the psychological richness of the phenomenon being studied.

Ethical Assurances

The most important ethical consideration for this study was the safety and protection of the participants. The topic of moral injury as currently identified in the literature is connected to intense states of psychological suffering. The protection of the participants was addressed through the following means: (a) all participants were fully informed as to the nature of the topic under investigation during the prescreening interview; (b) during the prescreening interview only participants who were currently under the care of mental health professional were considered for inclusion in the study;

(c) a preliminary interview was scheduled for the specific purpose of creating rapport with the participants, to fully address any of the participants' concerns, and to ensure that the participants fully understood the informed consent agreement; and (d) the participants were informed that they may stop the interview or their involvement in the study at any time without negative repercussions. Additionally, in relation to the protection of the participants' well-being, the researcher held over 2,000 hours of clinical training experience working with adults who had been diagnosed with a wide variety of disorders. The researcher also had experience treating clients who were experiencing/had experienced a crisis.

Chapter IV: Results

This chapter presents the results of data analysis and is organized in two sections. The first section provides a summary of the demographic data. The second section presents the results of analyzing eight in-depth interviews and the findings as they relate to male combat Veterans lived experience of morally injurious events. A table that identifies the combined general constituent themes and the individual constituent themes is included as part of the presentation of the results.

Demographics

All participants were male. Branches of the military were represented by six participants from the Army; one participant from the Navy; and one participant from the Marines. The mean age of participants was 32 years ($M = 32$). The average years of military service was 8.75 ($M = 8.75$). The average number of combat deployments was 2.37 ($M = 2.37$). General demographic information of the participants is provided below in Table 1. All referenced names are pseudonyms and participants are not listed in the order interviewed.

Table 1

Participant Demographic Data

Name	Age	Sex	Ethnicity	# Tours	Branch of Service	Conflict OIF/OEF*
William	27	M	Hispanic	1	Army	----/OEF
Brandon	26	M	Caucasian	1	Army	----/OEF
Gary	34	M	Hispanic	1	Army	OIF
Mark	37	M	Caucasian	3	Marines	OIF/OEF
Brian	49	M	Caucasian	3	Army	OIF/OEF
John	28	M	Caucasian	3	Army	----/OEF
Bill	27	M	Caucasian	4	Navy	----/OEF
Joseph	30	M	Hispanic	3	Army	OIF

Note. *OIF: Operation Iraqi Freedom / OEF: Operation Enduring Freedom

A brief biographic outline of the participants including their number of years in service and their rank and/or job classification as described by them, along with the year they left the military will aid in contextualizing the results below.

William was 27 years old, he served in the Army for 4 years as a Combat Medic and he left military service in 2013.

Brandon was 26 years old, he served in the Army for 4 years as an Air Defense Command, Control, Communications, Computers and Intelligence Tactical Operations Center Enhanced Operator/Maintainer and he left military service in 2014.

Gary was 34 years old, he served in the Army for 4 years rising quickly to the rank of Sergeant- Team/Squad Leader and he left the military in 2003.

Mark was 37 years old, he served in the Marines for 12 years rising to the rank of Sergeant-Platoon (Infantry Unit) Leader and he left military service in 2008.

Brian was 49 years old, he served in the Army for 20 years rising to the rank of Sergeant Major and he left military service in 2013.

John was 28 years old and he served in the Army for 8 years as a Communications Operator / Gunner and he left military service in 2012.

Bill was 27 years old and he served in the Navy for 8 years rising to the rank of Crew Chief as part of a Special Forces Helicopter Squadron Combat Search and Rescue team, he left military service in 2014.

Joseph was 30 years old and he served in the Army for 10 years, his official job description was Field Artillery and he also served as part of a Quick Reaction Force unit, he left military service in 2011.

Summary of Results

The structure of combat Veterans lived experience of morally injurious events provided six different combined general constituent themes that emerged across the data, and are delineated below. A table is provided which identifies the combined general constituent themes and the connection with the individual constituent themes. The general constituent themes are then discussed in detail and examples are given of the specific constituent themes in relation to the transformed meaning units from the raw data of the interview protocols. It is important to note that the direct quotes listed from the participants will not correlate with their assigned pseudonym. The quotes will reference the participant number assigned in the order they were interviewed instead. The reason for this is to further protect the Veteran's confidentiality.

Combined general constituent themes.

1. Participants experienced shame, guilt, and feeling unforgivable connected to the involvement of children in war.
2. Participants experienced shame, guilt, and anger for taking part in killing others.
3. Participants experienced shame, guilt, anger, and feeling unforgivable when they did not speak-out regarding morally injurious events they were a part of as a group.
4. Due to what they experienced in war participants no longer held the same religious/spiritual beliefs.
5. Participants experienced a loss of meaning in life after viewing death and a sense that they deserved to be disgraced after the way they handled the human remains of the enemy and the way they saw others disgrace human remains of the enemy.
6. Participants experienced difficulty reconnecting on an emotional level with loved ones after their morally injurious experiences in combat.

Table 2 shows the data for the participants specific constituent themes and their connection to combined general constituent themes.

Table 2

Combined General Constituent Themes Among Participants

Combined General Constituent Themes	Specific Constituent Themes
Combat Veterans experience shame, guilt, and feeling unforgivable connected to the involvement of children in war (75% of participants).	Killing children
	Witnessing children die
	Witnessing children being shot
	Witnessing children being beaten
	Failure to help a child
	Thinking about not wanting to help a wounded child
	Failure to speak-up to check on a possibly injured child
	Witnessing children used as weapons
	Witnessing children handle dead bodies
	Thinking about having to shoot children
	Thinking about being reprimanded for not running over children
	Thinking about almost killing an innocent child
	Learning that a unit has to consider killing children
Combat Veterans experience shame, guilt, and anger for taking part in killing others (50% of participants).	Killing innocent civilians repeatedly through drone warfare
	Killing at close range and seeing the insurgents face
	Thinking about killing others and finding it unbelievable that they actually took part in killing others

Combat Veterans experience shame, guilt, anger, and feeling unforgivable when they feel unable to speak-out regarding events they were a part of as a group (50% of participants).

Combat Veterans no longer hold the same religious/spiritual beliefs after what they experienced in war (50% of participants).

Ordering others to action that led to their death

Witnessing an innocent man thrown to his death

Being part of a group and not personally responsible for death is no consolation

Considering conscientious objector status because killing is unbearable

Overcome with emotion and unable to discuss taking part in killing

Failure to speak-out when civilians deaths were reclassified as enemy combatants

Failure speak-up for the welfare of his troops and as a result some were harmed for life

Feeling unable to make any impact upon learning how subcontractor Indian cooks were treated

Failure to speak-out when weapons captured were not turned in and later planted on those who were killed

Failure to speak-out and stop some bad things from happening because did not want to be seen as the bad guy

No longer believes in the goodness of humanity

Cannot reconcile what he took part in and witnessed with a just God/spiritual belief system

Lost all faith now and has a sense of meaninglessness to life and identifies as an atheist

Combat Veterans experience a loss of meaning in life after viewing death and a sense that they deserve to be disgraced after the way they handled human remains of the enemy and the way they saw others disgrace human remains (37.5% of participants).

Combat Veterans experience difficulty reconnecting emotionally with loved ones after their morally injurious experiences in combat (37.5% of participants).

No longer believes in God or how taking an innocent life could be part of God's plan

No longer believes there is anything after this life

Taking part in callously treating the dead bodies of the enemy

Witnessing others disgrace dead bodies of the enemy

Losing a love for life after taking part in the indifference with which human remains of the enemy were handled

No amount of training or horrific videos could prepare someone for witnessing a real dead body

Afraid that family members will see the broken person they are inside

Being unable to have meaningful relationships with others for fear they will find out that they are a bad person

Feeling an unexplainable sense of disconnect from loved ones

Losing faith in the ability of any relationship to be truly meaningful

Combined general constituent theme 1: Participants experienced shame, guilt, and feeling unforgivable connected to the involvement of children in war. One of the most prominent combined themes to emerge from six of the eight participants was the shame, guilt, and feelings of being unforgivable experienced by the Veterans

connected to the involvement of children in war. Participant 3 (P3) described feeling intense shame when his team accidentally hit a young girl in the street with their Humvee:

She wasn't crying, so we just kept going, and that to me I thought was wrong. We should have at least taken her home maybe. We didn't know what kind of injury she had but she was on the ground looking at us. She might have been in shock. That was kind of barbaric in a way. (P3, p. 9)

That's just wrong. You can't just leave her there. In the streets, they have no sewers or anything so there's urine and feces right beneath the sidewalk where we would have the sewer gutter thing. They don't have that so it's just green and mossy. Over time I guess it turns that way. She was there lying in this dirty water, probably urine. Yeah, and we didn't stop. We just kept going. It was more shame. It was more of a shameful, 'I can't believe we just allowed that to happen.' (P3, p. 10)

Participant 4 (P4) endorsed feeling shame, guilt, and a sense of being unforgivable with regard to his involvement in the killing of innocent children. This sense of being tarnished translated to his no longer wanting to have children of his own because he did not feel he should be allowed to be in the company of children:

A good example of how it spills over is I don't feel comfortable around children anymore. I just don't feel like I deserve to be around them. I don't know how to put it. I feel like I've seen things and participated in things that preclude me from being allowed to be around children. I told that to my wife, and I don't want to have kids anymore. I feel like there's certain . . . we live in a society where when you transgress certain boundaries, you're cast out and you're put in a place where

you are no longer allowed to do that again and harm anyone. If you do it in a military capacity, with rules that are just geographically bound, then there's no sort of separation for you. It's you did what you had to do, and if that involved murdering children, so be it. (P4, p. 3)

Participant 1 (P1) witnessed the death of a young boy, no more than 11 years old. The boy had been shot by one of the soldiers in P1's squad. His team had been placed in an area to protect building supplies. The young boy had attempted to take some wood from the site and he was shot, ultimately dying in front of P1. Even though P1 did not have any part in actually shooting the child, he still felt just as guilty for his death as if he had:

He looked at all of us. He's like, almost kept looking at us like, 'What have you guys done?' Like it wasn't him looking at us. Metaphorically, it wasn't him and it was like, 'You guys are all shit bags.' It was like we knew that, like he was almost talking. It's almost like third person type of thing. He's just like scorning us before he died. I don't know and that's what I had a problem with... You know like the bad things that you've done in your life, like that's one of them, even though it wasn't me. (P1, pp. 20–21)

Participant 7 (P7) described a scenario in which in order to protect the lives of two Service members, he and they, had to watch a young boy, maybe 8 years old, being horrifically beaten by an Afghan police officer. Participant 7 reflects on his actions and feels he was wrong not to help the boy, but at the time he felt he had no choice. This incident is one of P7's morally injurious experiences:

The kid couldn't be 8. He is beating the living shit out of this child. I've never seen a child get beat like that in my life. Beating him on the ground, to the ground, kicking him. The National Guard guys are like, 'Staff Sargent, Staff Sargent, what do we do?' You fucking do nothing, you stay right there, that fucking kid can get the shit kicked out of him...I didn't want to lose them. I sat down and watched that kid get the living shit kicked out of him. The cop picked his little butt up, dragged him over to the side of the road and let him sit there and bleed out. I don't know if the kid lived. That's not right . . . I should've walked out there and did something to that officer. I should've pulled my gun up and shot him in his face . . . but I didn't. Because I didn't want those two National Guard guys who didn't know their butt from a hole in the ground to go out there and make a mistake and get killed. It's dangerous outside that gate. (P7, pp. 10-11)

Participant 8 (P8) described an extreme level of guilt related to his witnessing children being shot because the insurgents would arm children to shoot at U.S. troops. Participant 8 was not willing to share if he himself had ever shot a child, "Yeah. I can't say if whether or not I fired on them... Yeah. There was definitely times when kids and pregnant women were firing at us. It just doesn't end well" (p. 14). He did witness children being shot and stated, "It's definitely an extreme level of guilt because it's hard to think about because that could have been us. We could be dead, or they could be dead. We have that decision" (p. 15). Even more troubling for P8 was the fact that the enemy would actually use their children in this way:

To me I feel the worse thing is them. Me witnessing that they would do something like that is I think even worse than having to protect people they already hurt.

Making sure we get off the ground safely and in time. (p. 14)

Participant 2 (P2) described another aspect regarding children in war. He did not have to shoot a child nor did he witness children being shot, but he did have to think about shooting children. After P2 learned that his team had to contemplate whether or not to shoot children he realized that he may similarly be faced with that decision. As he considered what he would do, the realization that he would actually shoot a child was disturbing:

I told myself, if somebody pointed a gun at me, I am going to shoot him. That was the thing. That was the outcome... When we get in a firefight, obviously if there is a guy shooting at me, I am going to shoot back but when it came to kid. If a kid pointed a gun at me I was thinking ... Yeah I would shoot that kid. Which is awful. (p. 17)

Overall, one of the salient aspects of the Veterans' experiences of moral injury revolved around the inclusion of children in war. This ranged from not taking action to aid a child; taking part in killing children; seeing children die; watching children being shot; seeing children being used as weapons of war; to considering that one would actually kill a child if they had to. Additionally, Veterans reported being distressed by watching children moving dead bodies; being troubled by the thought that they came within seconds of shooting an innocent child in the face; being reprimanded for not following orders to run over children; to experiencing guilt for having the thought of not

wanting to save the life of child who was severely injured because he was collecting mines to sell to the Taliban.

Combined general constituent theme 2: Participants experienced shame, guilt, anger, and feeling unforgivable for taking part in killing others. Half of the Veterans interviewed endorsed experiencing feelings of shame, guilt, anger, and feeling unforgivable related to their participation in the killing of others. Participant 4 (P4) experienced repeated instances in which he was witness to civilian casualties being reclassified as insurgents. Even though he was not the one who personally killed the civilians he felt overwhelming guilt and shame for the part he played. These feelings led him to consider applying for conscientious objector status, but he was talked out of it:

Looking at it now in a different light, it's easy for therapists and chaplains to say, 'Well you didn't have much of a choice. You couldn't stop the war on your own, blah blah blah.' It doesn't change the level of personal responsibility that you feel. Even though you're not the one pulling the trigger, you're still a cog in the machine and you're complicit in it. You're protecting those who are pulling the trigger. (P4, p. 5)

I wanted to get conscientious objector status while I was out there actually, because it was bothering me so much. I let myself get talked out of it and I didn't pursue it again. That's something that I still regret to this day. (P4, p. 5)

Participant 7 (P7) carries a heavy burden of guilt and feeling unforgivable for the five Service members who overtime were killed under his command. "I know I carry a large burden. Five men are dead because of me. Five" (p. 9):

People who depended on me to take them home ... And I didn't do my job. I failed. No matter what I do in life, I'm a failure. You can't wash that away; you can't put a Band-Aid on top of that. It's a hard pill and you have to swallow it. (P7, p. 13)

How do I go to sergeant XX's parents and tell them I'm the one that got your son killed. How do I go to lance corporal YY's parents and say I'm the one that got your son killed. I told him to stay at that corner and not move. Why am I alive? Why am I not dead? I should've died in that Humvee. (P7, p. 16)

Participant 8 (P8) experienced a strong sense guilt and of being unable to forgive himself, for a killing that he did not even perpetrate, but witnessed. He and his team had picked up several men for questioning and as they were mid-air in the helicopter there was the realization that one of the men was not who they were looking for. Without any notice, another team member pushed the man out of the helicopter. "I participated in that and witnessed that. I feel just as guilty for doing that. It's a human life, above all" (p. 5).

I'll never be able to forgive myself for certain things that didn't have to happen especially pushing that guy out of the cabin of the helicopter. We didn't have to do that. It was an easy decision for another individual to make. It didn't even come to a vote. It was just like, boom! Boot to the back and out. Who knows if he lived or he just died there. He could have been in pain. I hope to God that he landed on his head or something that he died instantly... It's hard to even think about it. He had been somebody's dad. (P8, p. 16)

That was definitely just because I was there. I felt just as guilty because I felt I didn't stop it. At the same time, I didn't know it was going to happen. I didn't know that the guy was just going to kick him out. (P8, p. 17)

The most heartbreaking thing I'd ever heard in my life was when my girlfriend went with to me to see the psychiatrist. She says that, 'P8 is a good person. I know he is.' I just don't feel that way just because I feel like I'll never be able to ever, no matter what, be able to forgive myself what I'd witnessed, my "brother's" taking a human life. (P8, p. 10)

The moral injury of taking a human life was further explained by the act of killing at close range. Participant 7 (P7) described a definitive difference between thinking and knowing one has killed another person. When shooting off into the distance there is the potential solace that one of the other guys next to you is responsible for the killing. But, when you are face-to-face, then you know you killed a person, "It's something different when it's right in your face and you know you've done that" (P7, p. 13). He expressed feelings of anger related to his killing of an insurgent at close range. "You should feel regretful. You should feel remorse. I'm still angry. Still to this day I'm mad. I don't know why I'm mad" (P7, p. 13).

In sum, Veterans experienced feelings of guilt, shame, anger, and of being unable to forgive themselves for the role they played, both directly and indirectly in the killing of others. Furthermore, the emotions related to experiencing of killing another were so overwhelming for Participant 5 (P5) that when he began to talk about the first time he killed someone he fought back tears and emotion and was unable to discuss his experience at all.

Combined general constituent theme 3: Participants experienced shame, guilt, anger, and feeling unforgivable when they did not speak-out regarding morally injurious events they were a part of as a group. Half of the Veterans described instances in which they felt unable to speak-out regarding events that they identified as morally injurious. As a result they experienced anger, guilt, shame, and feelings of being unforgivable. Participant 6 (P6) found himself experiencing guilt and shame over his failure to speak-up for the welfare of his unit. His unit was charged with an ammunition collection duty. Essentially, after the major conflict ended in Iraq, Saddam had left various munitions in depots. Participant 6's unit and others were ordered to collect those munitions so that the insurgents could not use them. In the past when they received these orders another unit with forklift equipment would also be ordered to assist. However, in this one instance there was no forklift support ordered. Participant 6 pointed this out to his higher up, but nothing was done and P6 did not pursue it further. He believes he should have been the last person in line to say that his men needed assistance and he failed them:

What this meant is that the troops had to physically move these artillery rounds. These artillery rounds had been lying in the sun with the oil baking on them at 120 degrees for days on end. Basically, our guys had to pick these up with their hands and carry them to the truck. The oil soaked through their uniforms and burned their skins. Somewhere around the United States Army are a bunch of former or current artillery men that have nice burns on their forearms because of a mistake that the Corps made, that our G3 at that time allowed to continue, and that I, personally by not forcing the issue, allowed to happen. That isn't right.

I definitely feel guilty about that. It's not like I was totally ignorant of the thought. I still knew that, in the back of my head, there was something wrong with that. I definitely felt very bad about that and I definitely feel very ashamed about that. The fact that some of that shame should also be borne by our G3 and our higher headquarters, that helps a little bit but it doesn't help that much. They were sequentially responsible. I was the last sign post that should have sat up and said, 'Oh no, this is going too far.' (P6, pp. 9–10)

Participant 4 (P4) endorsed feeling guilty and sense of being unable to forgive himself for not speaking out when he saw innocent civilians being killed and reclassified as insurgents:

I still feel guilty for not taking a stronger stand about what I was seeing while I was there. I feel like how complicit that I was, was something that I wasn't expecting. It's made it really difficult for me to connect with people. When you participate in things like that, that you feel are unforgivable. (P4, p. 7)

The sense of wanting and needing to belong and be a part of the group was so strong for the Veterans that they reported not wanting to speak-out and stop bad things from happening because they did not want to be seen as the bad guy. One example was witnessing others not turning in small weapons, such as handguns taken from dead insurgents. These weapons would later be used and placed with dead insurgents if it was found that they were unarmed. Knowing this was happening and knowing it was wrong, was still no incentive to go against the group. With the result that now the individual Veterans struggle with the aftermath of what their silence cost them.

Combined general constituent theme 4: Due to what they experienced in war, participants no longer held the same religious/spiritual beliefs. The loss of a belief in religion or spirituality after the experience of war affected one half of the Veterans in the study. Of the other half of the Veterans; three did not ascribe to any religious/spiritual belief system; and one Veteran maintained his religious belief.

Participant 5 (P5) described himself as being saved, a Christian. But after his experiences during deployment he no longer believes in religion and defines himself as an Atheist. He also attributes the dullness, or the loss of love for life that he feels to be connected to losing his religion:

I was saved, yes, I was Christian and baptized and all that and after I came back I just . . . you know the other side. I completely shut out religion after that. After I went there I just kind of gave up on it, I was like, ‘Why?’ It doesn't matter. If I pray to somebody are they not going to pull that trigger and explode us? No, it doesn't matter. It stops, it kind of goes with the dullness, I think, I don't know. I just said, ‘I quit,’ completely kind of become Atheist. (P5, pp. 8–9)

Participant 8 (P8) joined the Catholic Church while still a senior in high school. He believed he was doing something good for himself, his future, and his moral development. However, after the things he took part in and witnessed while in combat he no longer goes to church or believes in the teachings of the church:

Yeah. Now, I don't go to church anymore. I don't believe certain things. I do believe there's a God or like a watchmaker. Other than that, I don't think there's any other. I don't really believe what I used to believe. I don't believe that we're going to be saved or anything like that. I believe that it's necessary to have God

and to believe in a God. Other than that I don't think there's anything else. Before I joined, I thought for sure or something. There has to be something greater than this. I don't believe that anymore. (p. 8)

Participant 4 (P4) saw himself as believing in an Eastern spiritual philosophy. Believing that people are essentially good and bad things happen because good people are placed in extraordinary circumstances. However, he came to believe that there was true evil in the world:

After I was there for a while I started feeling like people commit evil knowingly, willingly. That there is such a thing as evil. After I was there, I don't know, it's difficult trying to establish spirituality after coming back. You don't know how to put together what you've seen and what you've done with a deeply spiritual experience. (P4, p. 6)

Participant 7 (P7) was raised in a very religious household in a very religious rural area. "I grew up in rural town. Everybody is Baptist, hardcore bible thumping... went to Sunday school all that stuff" (P7, p. 4). Now he no longer believes in God. He described being unable to come to terms with the idea that people can die for what appears to be no reason and how that can be part of God's plan, makes no sense to him, nor does it console him. "It's God's plan to let people die. For what? For dying's sake? To torment others on earth?" (P7, p. 4). "I don't go to church anymore. I don't feel there is a God anymore" (P7, p. 4). "It's hard to talk, especially with my mom who is really about this stuff and to let her know that I don't feel there is a God anymore. How's my mom going to take that?" (P7, p. 13).

Overall of the five Veterans who endorsed having a religious or spiritual identity as part of their upbringing and prior to enlisting in the Armed Services, four of those Veterans lost their belief system as a result of their experiences in combat.

Combined general constituent theme 5: Participants experienced a loss of meaning in life after viewing death and a sense that they deserved to be disgraced after the way they handled human remains of the enemy and the way they saw others disgrace human remains. The sight of death and the handling of human remains were reported as disturbing by three of the Veterans. Participant 8 (P8) reported that even though he had been specifically trained to be desensitized to death and violence and had watched horrific videos, nothing prepared him for actually seeing a dead body:

That was the very, very, very first time I saw a dead human body. I cried. I remember. I won't ever forget. I was pretty much pointless like the first about probably 2 weeks because it was just hard for me to comprehend. I cried. I just couldn't believe that I was seeing a real-life human body. Like I said, the military spends an awful lot of time and resources on this; trying to desensitize you before you go in. We were exposed to videos, horrendous videos, absolutely horrendous videos, that I would never want anybody to see. Yeah. Nothing compares to actually seeing a lifeless human being. Something that used to breath and had a value to somebody somewhere. It's just lying there. (P8, p. 9)

Participant 5 (P5) experienced handling the dead bodies of insurgents and the indifference in the way the bodies were treated took away the meaning of life for him and now he is left with a sense of dullness of life:

We got to tag them and everything like that. We got to ID them, take all their weapons from them, everything like that. So you pretty much after you get done, just load them up like cattle and drive into base and take photos of them, register it, and burn the bodies. It takes the meaning of life away . . . it just makes everything dull. It's just, I don't know, it's a bittering sense. It just takes kind of a dullness of life and it doesn't really mean as much, and just knowing that at one second it could be gone because of something, somebody else, you know, or ten minutes ago that person was alive, but not anymore. (P5, p.3)

I felt bad about the things like taking the bodies and after you record them and then just ten feet away putting them in the burn pit and burning them. (P5, p. 8)

Participant 1 (P1) experienced taking part in treating the bodies of dead insurgents with little humanity. He also experienced his team disgracing the dead bodies. For P1 this means that the only way he can be forgiven in this life is for him to be humiliated, to be disgraced in the same way. He says it is an eye for an eye:

An eye for an eye. I think it's fairness and fairness is you being dead, you being disgraced, you being humiliated, I guess. I had a friend like sometimes, he had to piss, he just pissed on the bodies like on the way to the ALOC, and to me, I'm thinking just piss off the side. Why you have to like fucking piss on it, but like disgrace from A to Z. You get them down; you don't wait for the gurney and just pull them from their ankles. Let them fucking hit the dirt. I mean they're already dead, they don't feeling anything. I don't know, like that's an eye for an eye. (P1, p. 16)

In general just under half of the Veterans reported being troubled by their participation in the handling of dead bodies of the enemy and being distressed at the sight of death. The result was a loss of meaning of life and a feeling of deserving to be punished somehow.

Combined general constituent theme 6: Participants experienced difficulty reconnecting emotionally with loved ones after their morally injurious experiences in combat. The Veterans who expressed difficulty in their personal and familial relationships due to their morally injurious experiences tended to see themselves as somehow flawed, or so broken that they did not deserve to have meaningful relationships.

Participant 7 (P7) grew up in a very close knit family out of state. All of his family are still very close with each other and even live close to each other. However, P7 cannot bring himself to visit his family out of fear that they will witness him becoming emotional when triggered by something related to the moral injuries he has experienced. He knows that it is not good to hide from his family but he cannot bring himself to do otherwise. “I just don't want to be around them and something happens. I don't want them to see me get emotional over something that's on television or an article I read” (P7, p. 4). He used to have a wide circle of friends, and now he has no friends:

I'm a grown man and I have no friends. I don't have any friends. None. It's not that people aren't friendly towards me and I'm not friendly towards people. I've learned to cope with social situations to the point where I can fake it. I don't like the person that I am anymore so if I don't let anybody see that person I am, I feel better about it. I don't know. There's a void inside of me and no matter how I try

to fill it, it's always empty. I have done things and I have seen things that I try every day to figure out, to come to grips with. (P7, p. 5)

Participant 8 (P8) described having difficulty connecting with his girlfriend and one of his children. He attributes this difficulty entirely to his combat experiences but has begun to seek help over the last year and he is making good progress:

I definitely have a hard time, not as much anymore. It's been about a year since I started actually seeking help and taking like a low-dose of antidepressants and seeing the psychiatrist. It's worked out well. I've been able to finally make myself emotionally available to my girlfriend. Before that, it was very hard to make any kind of emotional connection with her. That was definitely due to my experience. Absolutely, I believe that. (P8, p. 10)

Definitely I think that what I experienced the most still that really affects my life and relationships is I can't find forgiveness in myself. My girlfriend says that she believes I'm a good person but I don't believe that. I don't walk around and thinking I'm not a good person. I try to feel like I'm doing the right thing all the time and I think I do. I don't feel that I am as good of a person as she believes me to be. (P8, p. 10)

Participant 4 (P4) feels that his morally injurious experiences have made it difficult for him to bond with other people, "It's made it really difficult for me to connect with people. When you participate in things like that, that you feel are unforgivable" (P4, p. 7).

Overall the Veterans that experienced interpersonal distress connected to their moral injuries felt a sense of being disconnected from loved ones and a sense

that somehow they were tarnished and not wanting to be fully seen for who they believed they had become.

Betrayal by friends and family. It is worth noting that two participants reported ending relationships with friends and family due to feelings of betrayal. These were instances wherein the Veterans were not contacted by their best friends and family members back home while the Veterans were deployed. Both P2 and P5 felt betrayed by these people and severed their relationships with them. As P2 remarked:

I mean, especially nowadays with technology, it is so easy to email, Facebook or whatever. Yeah, I mean, even though I try to give them some benefit of the doubt because I don't tell them some of that stuff. Like, 'Hey I feel like I am going to die every day, so could you talk to me' or, 'I am getting shot at all the time, could you say hi?' I can give them the benefit of the doubt that I don't do that but also, you know where I am at. (P2, pp. 24–25)

As indicated these instances were of note but this sense of betrayal felt by Veterans was only a potential theme as there were not enough reported aspects.

Veterans' description of moral injury. Another area of importance but that did not result in an identifiable theme was several of the participants providing their own understand of what they thought moral injury was. Participant 8 (P8) stated:

That's what it all comes down to it. I think it's like, we're still humans. It's hard to believe that we do these things to each other, but we do. It definitely, all of it violates all morals that anybody has. Every religion, every belief, Atheist even, nobody believes that somebody should be killed for whatever reason. You

shouldn't still purposely hurt somebody. There's definitely, especially with your definition how you describe it. It's definitely a violation of every moral that I hold still to this day and will for the rest of my life and what I teach my kids. (P8, p. 15)

Participant 7 (P7) saw his moral injuries as experiences that have broken him as a person. He views moral injury as the necessary result of engaging in actions that by nature we as humans are not supposed to engage in. Participant 7 believes the result of moral injury as not being able to discern between right and wrong anymore:

It's weird when I read your thing asking about moral injury. I thought about it and I am not the same person I used to be and I know I'll never be that person again. It is like I'm broken and I'm never going to be fixed. It changes you; it's supposed to change you. You're not supposed to do those things, I honestly believe that. You do them because you're told. You tell others to do things, you tell them to kill people. You tell them to. (P7, p. 10)

I think that's what moral injury is about. You don't know what's right or wrong anymore. You're always questioning your motives, you're always questioning yourself, you're always doubting yourself. You're afraid to act a certain way. You're afraid to show who you are, who you've become. Because people out here haven't experienced what you experienced. (P7, p. 16)

Participant 4 (P4) described moral injury as experiencing a deep despair over the loss of his belief in human potential:

I'd say a profound despair for what it means to be human, and what humanity can be. I was very much like a humanist before I went over there. I really believed

that if people put their mind to stuff and they committed themselves to things, they'd get this map that you could really achieve great things. After coming back I just feel like people are not very strong-willed. (P4, p. 7)

In general the participants who described what moral injury meant to them identified feelings of being a broken person; not being able to trust themselves; not being able to show their true self out of fear of negative judgments; and despair over the human condition.

Suicidal ideation. It should be noted that while each participant was specifically asked about having any suicidal ideations if they did not spontaneously recount any incidents, only one participant acknowledged having some passive suicidal ideations. Participant 4 (P4) recounted entries in his journal while deployed such as, "I hope a round lands on me while I'm asleep" (P4, p. 6). He also stated that there were numerous entries where he talked about turning his rifle on himself, but felt the only thing that stopped him was his wife and his family at home. He also found himself engaging in more risky behavior:

Something else that I noticed was that I started doing more and more risky stuff while I was there. I volunteered to take flights to bases that got hit with a lot of artillery just to be over there for it. I started going on the roof to fix wires while we were taking artillery. I started just spending more time outside not under cover. I just remember thinking that I didn't have a death wish per se but I wanted to put myself in those situations because I just felt like if I was to be killed it would make things more even. I know that sounds so weird but . . . it's how I was feeling at the time. I felt like I deserved to have something happen to me at least.

Even if I wasn't killed I probably deserved to take some shrapnel in the back or something. That's how I was thinking. (P4, p. 2)

The other seven Veterans denied having any suicidal ideations while deployed or since they had left Service. Some of the reasons given for not considering suicide were; never crossed their minds; having children was a strong motivator; not wanting to hurt their family like that; and being happy just to have made it out of war alive.

Chapter V: Discussion

This chapter discusses the results of the current study initially looking at any support for the proposed definition of moral injury (Litz et al., 2009) and suggesting a potential additional qualifier for the proposed definition. The chapter goes on to discuss the themes uncovered in detail: children in war, killing, failure to speak-out, loss of spirituality, death and human remains, and interpersonal relationships. Limitations of the study are then discussed followed by the implications of the findings and future research areas. The chapter ends with a conclusion of the study as a whole.

Discussion of Results

Proposed definition of moral injury. The current study endeavored to add to the research a clearer definition of moral injury and the associated inner states of conflict by examining it's meaning for combat Veterans. The study utilized the working definition of moral injury as proposed by Litz et al. (2009): the perpetration of, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs. As this study was qualitative in nature the results were analyzed for their themes as described in chapter four. However, in keeping with the purpose of this study it is now necessary to determine if the working definition of moral injury (Litz et al., 2009) was supported by the findings. In doing so the Litz et al. definition can be seen as comprising four distinct combined general constituent themes: perpetration; failure to prevent; bearing witness to; or learning about acts that transgress deeply held moral beliefs. Therefore, the specific constituent themes will be examined to determine if they support the four moral injury themes. Table 3 below outlines the general themes of the proposed definition of moral

injury and the connection to the specific constituent themes from the participants in this study.

Table 3

Themes of Proposed Definition of Moral Injury

General Themes	Specific Constituent Themes
The perpetration of acts that transgress deeply held moral beliefs (50% of participants).	Killing children
	Killing innocent civilians
	Killing at close range and seeing insurgents face
	Ordering others to action that led to their death
	Taking part in callously treating the dead bodies of the enemy
Overcome with emotion and unable to discuss taking part in killing	Failure to help a child
	Failure to speak-up to check on a possibly injured child
	Failure to speak-out when civilians deaths were reclassified as enemy combatants
	Failure speak-up for the welfare of his troops and as a result some were harmed for life
	Feeling unable to make any impact upon learning how subcontractor employees were treated
	Failure to speak-out when weapons captured were not turned in and later planted on those who were killed
The failure to prevent acts that transgress deeply held moral beliefs (62.5% of participants).	Failure to help a child
	Failure to speak-up to check on a possibly injured child
	Failure to speak-out when civilians deaths were reclassified as enemy combatants
	Failure speak-up for the welfare of his troops and as a result some were harmed for life
	Feeling unable to make any impact upon learning how subcontractor employees were treated
	Failure to speak-out when weapons captured were not turned in and later planted on those who were killed

	Failure to speak-out and stop some bad things from happening because did not want to be seen as the bad guy
Bearing witness to acts that transgress deeply held moral beliefs (50% of participants).	Witnessing children die Witnessing children being shot Witnessing children being beaten Witnessing children being used a weapons Witnessing children handling dead bodies Witnessing innocent man thrown to his death Witnessing death Witnessing others disgrace dead bodies of the enemy
Learning about acts that transgress deeply held moral beliefs (25% of participants).	Learning that his unit had to consider shooting and killing children Learning how subcontractor Indian cooks were being treated

It appears that the results of the specific combined themes do support each general theme of the proposed definition of moral injury. The perpetration theme was supported by 50% of the participants. The failure to act theme was the most supported with 62.5% of the participants endorsing this experience. The witnessing theme was supported by 50% of the participants, and the learning about theme was somewhat supported by 25% of the participants. The element of children in war was seen in every general theme of the working definition of moral injury. Furthermore, this aspect of children in war was most prevalent in the theme of witnessing acts that transgress deeply held moral beliefs. The distress reported by the Veterans in this study related to combat experiences involving

children permeated both the thematic analysis as well as the proposed working definition of moral injury.

A notable finding was that outside the four themes of the proposed definition of moral injury, there appeared a potential fifth theme; that of contemplating morally injurious actions. These actions were those not taken, but did not fit within the rubric of failure to act. They were related to having to consider taking action, or thinking about actions that one almost engaged in. Table 4 delineates this potential fifth theme.

Table 4

Potential Theme of Contemplation

General Theme	Specific Constituent Theme
Contemplating actions that did not take place or that almost took place which transgress deeply held moral beliefs (25% of participants).	Thinking about not wanting to help a wounded child
	Thinking about having to shoot children
	Thinking about being reprimanded for not running over children
	Thinking about almost killing an innocent child

For these Veterans the act of contemplating these types of morally injurious actions produced concomitant feelings of guilt, shame, or a sense of being a bad person. While this was only a potential theme related to the proposed definition of moral injury, it may be that Veterans experience moral injury from the anticipation of consequences arising out of moral dilemmas. The reviewed literature did not reference this type of moral injury. However, some of the proposed treatments for moral injury include an imaginative component to promote self-forgiveness (Litz et al., 2009; Litz et al., 2016;

Steenkamp et al., 2011). It should follow that if the act of imagining self-forgiveness has the potential to heal, then imagining taking part in a morally injurious act can harm. As stated by Steenkamp et al. (2013) it may be that these types of moral injuries would be most responsive to traditional prolonged exposure therapy (Smith et al., 2013), because the injury is more perceived than actual. Another important aspect of this potential fifth general theme was that all of the specific constituent themes relate to the element of children in war. This is where we now turn our attention; children in war.

Children in war. The experience of children in war was the most endorsed aspect related to moral injury as reported by the Veterans in this study. Of the literature reviewed in attempts to define, measure, and treat moral injury there were only three studies that referenced children in war. Litz et al. (2009) in putting forth a proposed definition of moral injury referenced the possible scenario of experiencing moral injury by not being able to help wounded women or children. This experience, of not being able to help a child was endorsed by Veterans in this study. Currier et al. (2015) in an effort to measure the experience of moral injury included in the Moral Injury Questionnaire – Military Version (MIQ-M) one item which specifically addressed children in war, “Item 11: I saw/was involved in the death(s) of children” (p. 57). This item does not specify if the death(s) of children were related to the children being a threat, such as a child soldier, or the child as an innocent civilian. It may be a combination of both, even though the MIQ-M does include an item which addresses witnessing or being involved in the death(s) of innocents. The Veterans in the current study endorsed experiences of: killing children, watching children die, and witnessing children being shot. Additionally, Southwick et al. (2001) in describing treatments to aid Veterans with treatment resistant

PTSD provided the case example of a Gulf War Veteran who was haunted daily by the image of a 3-year-old girl who had lost all her limbs. The Veterans in the current study also recounted images of children that caused them distress: watching a child beaten, witnessing children handling dead bodies, and seeing children used as weapons. Other than these three references there was no focused discussion on the complicated events surrounding children in war and the connection to moral injury.

This researcher conducted a limited review of the current literature outside the initial review of the present study to determine the extent of this lack of focus on encountering children in war. In 2011 the Research and Technology Organization (RTO) of North Atlantic Treaty Organization (NATO) published a final report and technical memorandum titled, *Child Soldiers as the Opposing Force*. This report included a comprehensive literature review investigating the psychological well-being of professional armed forces personnel who confront child soldiers (Mircica, Hickmott, Kilbey, Hughes, & McManus, 2011). The researchers commented on the apparent ‘black hole’ of literature addressing the psychological impact on soldiers deployed to areas where child soldiers operate. In part, what they uncovered related to the recruitment of child soldiers; some willing and some forced. The researchers also discussed the cultural difficulty that Western armed forces experience when they encounter young children in war zones. The Western ideal is that children do not take on adult roles until the age of 18 years. However, in areas which have suffered years of warfare, many children take on adult roles at much earlier ages. The Western cultural response is to see children as innocent and deserving of protection from harm. This belief can be shattered when

military personnel are faced with a 12-year-old attempting to kill them with small arms fire (Mircica et al., 2011).

Of the Veterans in the current study the majority reported experiencing moral injury related to the involvement of children in war. Of the experiences reported many involved child soldiers: having to kill children in self-defense; watching children being shot because they were engaged in a fire fight; witnessing children used as child soldiers; contemplating having to shoot a child; and thinking about not wanting to help a wounded child because they were assisting the enemy. A complete investigation of this experience is beyond the scope of the current study, and in fact could easily be the basis for a separate in-depth study. However, it would appear that this area is in need of further serious exploration, both as it relates to engaging with child soldiers and innocent children in war zones. For example it would be important going forward with research related to the experience of killing in combat and subsequent moral injury, to determine if the individual(s) killed were adult(s) or children, and particularly as it relates children; were they combatants or noncombatants?

Killing. Of the participants in the current study one-half endorsed experiencing shame, guilt, and anger for taking part in killing others. Kilner (2010) and Barrett (2011) have argued that the military has let down its Service members by not providing them with a moral justification for killing, and not preparing them for the emotional impact of killing. Of the Veterans in this study who endorsed moral injury connected to killing, one commented on the lack of preparation for the emotional sequela of killing and another commented on the lack of moral justification for killing:

I never would have thought that I would be in this position now. As far like my mental and thought process and my psyche. I would have never thought when I was 17 years old, 18 years old going through my training and being taught to like just desensitize like all violence. I would have never thought that I would've changed. I would never have thought that, because I had no idea. Nobody ever talked about it. They never certainly train us about it. They never said, 'Well, when you engage in some of these activities that you're going to take part in, you might have this happen.' It's never talked about. They'll only, all they talk about is, 'What you are doing is the right thing.' (P8, p. 18)

This statement brings to mind Barrett's (2011) comment that the military believes that if Service members are just trained hard enough in the art of combat that somehow, they will also be either prepared, or immune to the possible emotional punishment of sustained military action. Participant 4 (P4) experienced a complete lack of acknowledgement of any moral justification for killing:

The ridiculous part about it is that you're never even told that any of its wrong. (P4, p. 7)

Meaning that the words right and wrong become very strange to use. People replace them with legal and illegal, with fair and unfair, with authorized and unauthorized. It all seemed like an Orson Welles-type [sic] use of language just to obscure what's really happening. We had our JAG attorneys there. You'd have the lawyers telling you whether or not what you did was right. It just felt like Alice in Wonderland or something. (P4, p. 11)

As pointed out earlier, moral injury as a psychological construct is in its infancy. Therefore, many researchers looking at the emotional impact of killing in combat have used an increase in PTSD symptom severity to measure potential morally injurious events (MacNair, 2002; Maguen et al., 2009; Maguen et al., 2010; Maguen et al., 2011). The current study did not measure PTSD symptoms. Therefore, it is difficult to extrapolate support for much of the available research into the effects of killing. However, in addition to PTSD symptoms Maguen et al. (2009) reported killing in combat was also associated with dissociative experiences, functional impairments, and violent behaviors. The Veterans in this study did not endorse dissociative experiences or violent behaviors. However, they did endorse functional impairments related to social and familial roles. Maguen et al. (2011) also reported difficulty with alcohol in addition to posttraumatic stress symptomatology. The Veterans in this study did not endorse difficulties with alcohol; two of the Veterans denied any drug or alcohol use. However, if they did not volunteer the information there was no probe in the interview protocol to ask about alcohol use. Additionally, Maguen et al. (2010) found killing to be a significant predictor of alcohol abuse, hostility/anger, relationship problems, as well as PTSD symptoms. The Veterans in the current study endorsed experiencing anger that they could not explain related to killing as well as relationship problems.

Killing in combat is not always related to life-threat. Maguen and Burkman (2013) through focus groups and consultation with expert clinicians discovered that killing related to revenge or anger produced feelings of guilt, remorse and shame. The Veterans in this study did not endorse killing in revenge or anger, but did endorse lack of life-threat. One participant described his experience of sitting in the tactical

operations center (TOC) with large screen televisions supplying a constant feed from unmanned aerial vehicles (UAV). “They were basically just 24/7 kill-cams. You just had a constant feed of death on your screen coming in, that you had to watch” (P4, p. 7). The participant did not feel he experienced life-threat as he witnessed the death of enemy combatants and civilians alike:

If you're in a firefight and civilian casualties occur, it might be easier to rationalize because the whole fog of war and whatnot. When you're sitting hundreds of miles away and you're watching a feed of it, and your life isn't in danger, I feel like the calculus is different. I feel like you can't write off these terrible decisions due to adrenalin, or stress, or unfamiliarity because your life wasn't in danger at the time. To me, I don't mean to be humorous, but I felt like we were the Empire in *Star Wars*, the entire time I was there. (P4, p. 10)

For several of the Veterans who reported experiencing moral injury related to killing, they had witnessed the death, but did not actively take part in the killing. However, the psychological impact of killing was so powerful that they felt just the same as if they were the perpetrator. When Participant 1 (P1) watched a young boy die after being shot because he was trying to take some wood from a construction site he recounts: “You know like the bad things that you've done in your life, like that's one of them, even though it wasn't me (P1, p. 21). Participant 8 (P8) saw himself as somehow tarnished for life because he could not forgive himself for watching an innocent man killed, “I feel like I'll never be able to ever, no matter what, be able to forgive myself what I'd witnessed, my ‘brother's’ taking a human life (P8, p. 10). These experiences find support in Laufer et al.’s (1984) determination that witnessing and participating in

violence are not cumulative stressors which build over time indicating the same type of combat stress, but rather they are very distinct stressors.

While witnessing morally injurious events may be a distinct stressor, there is some research indicating that it may not be as psychologically harmful as being directly involved in such events. Fontana et al. (1992) found that the guilt experienced for having been a perpetrator of death or injury, or failure to prevent death or injury, was more significantly related to suicide attempts versus having been a witness or a target. Additionally, McNair (2002) found that the PTSD scores of Vietnam Veterans who were directly involved in the killing of prisoners of war, or civilians were higher than for those Veterans who only witnessed such actions. However, Bryan et al. (2014) found that the moral injury factor of transgressions-other (i.e., witnessing or learning about acts) was more significantly related to suicide attempts than the controls and the transgression-other group also scored higher on suicide attempts as compared to suicidal ideations.

When we are looking at morally injurious events it should not be surprising that we should see distress and inner conflict surrounding the witnessing of events. We can postulate that the person witnessing the act which violates their moral beliefs and expectations, would themselves not engage in such actions. Therefore, for some Veterans the only experience they may have of moral injury will be from the witnessing of events that violate their moral beliefs.

As indicated in Chapter II of this study, there has been very little research to date on the effects of witnessing actions that violate moral beliefs and the subsequent emotional distress. Of the participants in the current study, five of the eight Veterans endorsed experiencing moral injury from witnessing an action. Particularly when it

related to witnessing killing, the Veterans felt as if they themselves were the perpetrator. This is clearly an area that deserves more attention in the literature. Perhaps the emotional distress experienced by these Veterans in witnessing morally injurious events is in part related to Bica's (1999) warrior mythology and the powerful cohesion of the fighting unit to be seen as one. Bica described one of the strongest motivators of soldiers to kill and die in battle as their loyalty and accountability to their comrades. It is the indoctrination of basic training that the soldier no longer see himself as an individual but rather to have a group identity. The strong devotion that most Service members feel toward their comrades may play a role in the intensity of emotional distress experienced when one of their own engages in morally injurious actions. The warrior mythology may also play a part in a Veterans inability to speak-out regarding events that cause moral disruption. We shall now explore the reported moral injury related to the Veterans feeling unable to speak-out regarding events they were part of as a group.

Failure to speak-out. In the current study half of the Veterans reported experiencing shame, guilt, anger, feeling unforgivable for their inability to speak-up regarding events that violated their moral beliefs. These events related to experiences as a group, except one related to a chain of command, still arguably a part of a group. There is very limited research looking at failure to act or to prevent acts that conflict with a Service member's moral beliefs. Fontana et al. (1992) found that having been a perpetrator or failing to prevent death or injury was more significantly related to suicide attempts than witnessing or being a target. Additionally, being a perpetrator or failing to prevent death or injury was a key indicator of the presence of and severity of psychiatric comorbidity with PTSD.

Bica (1999) described how the new military recruit is trained to have a group identity; the warrior mythology. This group identity can foster a sense of group anonymity and a diffusion of responsibility. However, when the individual Service member is faced with the harsh realities of war, and/or returned home from the warzone, they realize the group identity is no longer shielding them. The individual is left alone to come to terms with all that they participating in and witnessed. Participant 4 (P4) experienced guilt and surprise at his own complicity in reclassifying civilian deaths as enemy combatants:

I still feel guilty for not taking a stronger stand about what I was seeing while I was there. I feel like how complicit that I was, was something that I wasn't expecting. It forces me to understand why people are complicit in mass tragedies, historically. It just changed what I think about human-to-human connection and how close people can really be. (P4, p. 4)

Another participant described how he believed he could have stopped some morally injurious events from happening but it would have required him to go against his team and as he said:

I was trying to give you defining moments. There's a lot of different things but those are definitely the main ones; with children and innocent lives who absolutely didn't have to happen. Like I said, sometimes I feel like I could have stopped certain things but I would have been the bad guy. I didn't want to be the bad guy. (P8, pp. 18–19)

Looking ahead it may be beneficial to explore the ways in which the military group identity, which is so important for combat effectiveness, may also lead some Service members to decline to act in instances where they observe a moral dilemma.

A sense of personal responsibility for failure to prevent the death of others commonly contributes to feelings of guilt, of self-condemnation, and a weakening of religious faith (Fontana & Rosenheck, 2004; Worthington & Langberg, 2012). The Veterans in this study endorsed guilt and feeling unforgivable because of their failure to speak-out regarding not only the death of others but instances of harm inflicted on those under their command, civilian workers being treated inhumanely, and watching others engaging in actions to cover up wrongful deaths. Regarding a weakening of religious faith the Veterans in the current study did not specifically connect their failure to speak-up to a loss of spirituality. However, the Veterans did experience an abatement of their spirituality and we now discuss this loss of religion.

Loss of spirituality. A loss of religion related to morally injurious experiences was endorsed by half of the Veterans in this study. Out of all participants, four endorsed traditional Western Christian beliefs and one endorsed an Eastern religious philosophy, prior to enlisting in the military. The other three participants did not describe themselves as having any strong religious convictions one way or the other. Of the five participants who did endorse religious beliefs, four of them reported losing their faith due to their morally injurious experiences in combat.

Drescher et al. (2011) and Vargas et al. (2013) both reported spiritual and existential problems in relation to morally injurious events. Vargas et al. in particular noted a potential unique correlation between Vietnam Veterans experience of civilian

deaths/disproportionate violence and a greater emphasis on symptoms concerning spiritual/existential issues. Two of the Veterans in the current study who endorsed a loss of religion/spirituality described witnessing civilian deaths and one described taking part in civilian deaths. Another Veteran described a sense of responsibility for the death of those in his command who he saw as innocents which caused him to no longer have any faith in God. The final Veteran described the indifference with which human remains of the enemy were treated leading to a loss of meaning in life and losing belief in God. Each of these events was strongly related to the Veteran's experience of losing their faith and provides some support for Vargas et al.'s findings.

The first millennium Christian church's practice of imposing penances on those returning from war, such as giving alms or fasting could be a healing practice for current war Veterans (Verkamp, 1988). The possibility to obtain forgiveness from real or perceived moral injuries may serve to allow Veterans to find lost goodness within themselves and find meaning again. This may be especially true for Veterans who had Christian beliefs prior to becoming Service members. For others, such as the one participant who ascribed to an Eastern religious philosophy and those who do not endorse any spiritual belief; the Navajo healing ceremony 'Aann' ji may be helpful. The ceremony focuses on cleansing, healing, and a letting go to counterbalance the experiences of war. This type of ritual may aid Veterans in breaking free from their moral wounds (Administration for Native Americans, 2012). This ceremony may be particularly useful for those Veterans struggling with the experience of handling human remains. The 'Anaa' ji is used especially to cure sickness from experiences related to death, corpses, or

graves (Brock & Lettini, 2012). With this in mind a discussion of the experiences related to witnessing death and handling human remains follows.

Death and human remains. Just under half of the Veterans in the current study reported morally injurious experiences related to seeing a dead body, callously handling human remains of the enemy, and witnessing others disgrace human remains of the enemy. Litz et al. (2009) commented that for those who are not prepared, exposure to human remains can be one of the most consistent predictors of long-term psychological distress. McCarroll, Ursano, and Fullerton (1995) found that Persian Gulf War (1990–1991) Veterans who handled human remains during wartime were at higher risk for PTSD symptoms, more than one year after exposure. Again, as in other research prior to acknowledgment in the literature of moral injury, McCarroll et al. utilized PTSD symptoms to measure functioning. Additionally, they discovered that the Veterans who had little experience handling human remains had more symptoms than those with experience. It is of interest to note that the subjects in that study who handled human remains were all school-trained in handling human remains and all were from Army mortuary affairs companies. Furthermore, the participants in McCarroll et al.'s study were not engaged in combat.

In the current study none of the Veterans who endorsed moral injuries from contact with dead bodies were formally trained in mortuary affairs and all Veterans engaged in combat operations. Additionally, as one Veterans stated, no amount of preparation in desensitizing him to violence could prepare him for actually seeing a dead human being:

Like I said, the military spends an awful lot of time and resources on this; trying to desensitize you before you go in. We were exposed to videos, horrendous videos, absolutely horrendous videos, that I would never want anybody to see. Yeah. Nothing compares to actually seeing a lifeless human being. Something that used to breath and had a value to somebody somewhere. It's just lying there. (P8, p. 9)

For Veterans engaged in combat and not trained to handle the dead we could expect to see at least similar, if not greater negative psychological difficulties as those in McCarroll et al.'s (1995) study. The Veterans in the current study described how their experiences with the dead led to a loss of meaning in life; a loss of religious faith; and a belief that they deserved to also be disgraced and humiliated. These descriptions fall more in line with the proposed psychological sequela of moral injury; spiritual/existential problems (Descher et al., 2011; Vargas et al., 2013); and the experience of self-condemnation to the degree that the Service member believes they deserve to suffer (Litz et al., 2009).

Of the two assessment tools developed to measure potentially morally injurious events, the Moral Injury Events Scale (MIES) (Nash et al., 2013) and the Moral Injury Questionnaire Military Version (MIQ-M) (Currier et al., 2015) neither specifically addresses the Service members experience of handling the dead. The closest question in MIQ-M was "Item 18: Seeing so much death has changed me" (p. 57). As moral injury is an emerging clinical construct, to date there has been no academic research exploring the connection between witnessing death, handling human remains, and the experience of moral injury with combat Veterans.

Interpersonal relationships. Just less than half of the Veterans in the current study reported interpersonal difficulty in reconnecting emotionally with family and loved ones after their morally injurious experiences. The overarching theme endorsed by these Veterans was feeling a sense of being scarred, broken, unforgivable, and no longer a good person. Drescher et al. (2011) identified the theme of self-deprecation as the result of experiencing moral injury to include feelings of being damaged, self-loathing, and a loss of self-worth which was supported in this study.

These feelings of self-loathing led the Veterans to turn away from close relationships for fear of being seen as they perceived themselves to be. Shay's (2014) depiction of the impact of moral injury as the deterioration of a person's character leading to withdrawal and isolation for fear of negative appraisal by others was supported by these Veterans. Litz et al. (2009) described the impact of moral injury to potentially cause feelings of guilt and shame which over time can lead to withdrawal and concealment from significant others. Litz et al. stated that if the withdrawal was persistent the Service member may come to see themselves as morally corrupt.

Of the Veterans in the current study who endorsed interpersonal difficulties related to their own negative self-appraisal; one had left the military 8 years prior and the other two Veterans had been out of the military for 1 year. Depending on the definition of persistent withdrawal (Litz et al., 2009), the one Veteran with 8 years out of the military may have more rigid beliefs about his moral transgressions. One of the Veterans with one year out of the military was attempting to make changes in his personal relationships. However, he still saw himself as flawed. Even the Veteran with eight years out of the military still expressed hope for being able to reconnect with others:

It's like I am passing by shadows, I can't make that contact with these people. Something's stopping me. But I yearn for it, I want it. I remember it. All I can hope is one day it comes back. Like a lost puppy, and finds me somewhere. Yeah . . . that's my whole story. Everything I had to deal with in combat. I don't think I ever told anybody all of it before. (P7, p. 17)

The Veterans comment at the end, of never telling anyone his whole story before was, in the opinion of the researcher an attempt at connection by showing his true self to someone without fear of judgment. This truly surmises the genuine purpose behind this study, hope. Hope that our Veterans who struggle with moral injury can find healing.

Limitations

The current study was limited in generalizability by its small sample size, 8 participants. The participants were all male, as defined in the inclusion criteria for combat Veterans. However, as female Service members are now formally included in combat operations, future research should seek to include their voices in defining the experience of moral injury.

As discussed, because moral injury is an emerging clinical construct many of the studies seeking to measure psychological distress from combat have looked at increases in PTSD symptomology. The current study did not utilize a PTSD measure and therefore could not compare results with certain studies.

Implications and Future Research

The findings of the current study may contribute to the growing literature on moral injury and future research in the following ways. First the findings may serve to direct attention to the psychological impact of combat troops engaging with children in

warzones. Due to the asymmetrical nature of warfare during OIF and OEF encountering children as both soldiers and innocent civilians, it is likely to be a very common occurrence. The findings of the study appear to suggest that experiences of children in war can lead to moral injury in varied ways. The most endorsed theme by the Veterans in this study related to morally injurious experiences with children in war. Furthermore, when looking for support for the proposed definition of moral injury (Litz et al., 2009) every aspect of the proposed definition; perpetration of, failure to prevent, bearing witness to, and learning about acts—all were supported with morally injurious elements related to the experience of children in war. This is an area that deserves some thoughtful attention as there is no research exploring moral injury and experiences related to children in war zones. As indicated, there is current research looking at the effect of killing in combat and subsequent moral injury. However, what has not been made clear is if the individuals killed were adults or children, and if they were children were they child soldiers or innocent civilians? This would be an important area for future exploration as research could help to define ways to prepare Service members for encountering child soldiers as well as potential ways to manage witnessing the suffering of children in war.

Second, the findings of the current study showed support for the proposed definition of moral injury as described by Litz et al. (2009): the perpetration of, failure to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs. The most endorsed aspect was failure to prevent acts and the least endorsed aspect was learning about acts that transgress deeply held moral beliefs. The findings suggested that there may be an additional potential component to the proposed definition; that of contemplating actions. In the current study Veterans endorsed more incidents

related to the contemplation of actions that were morally injurious than they did learning about acts that were morally injurious. Even though there was not strong support for the contemplation of actions, future research could include this experience rather than exclude it. In doing so it may aid in preparing Service members for difficult moral dilemmas they may encounter in combat.

The results also appear to support the research that killing in combat can lead to psychological distress. Half of the Veterans in the current study endorsed the experience of killing as a morally injurious event. Additionally, there was some support for the potential unique correlation between engaging in civilian deaths and spiritual/existential problems as suggested by Vargas et al. (2013). This may be a topic for future research specifically exploring the association between loss of religion/spirituality and having either perpetrated or witnessed civilian deaths. The outcomes could possibly aid military chaplains and others in addressing this specific type of killing and the subsequent loss of meaning, both prior to and after combat experience.

Another area of possible future research related to the findings in the present study is as follows. Recognizing that there were less than half of the Veterans endorsing moral injury from contact with dead bodies and human remains, it still appears that there is no current research looking at this area. Future studies could examine the differences between exposure to comrade dead and enemy dead and subsequent moral injury. Future research could also explore the experience of actively handling dead bodies or witnessing the handling of dead bodies and subsequent moral injury. Finally, future research could investigate if the mistreatment of human remains is connected to moral injury and

specifically to spiritual or existential problems, as well as the development of specific treatment approaches.

Conclusion

Eight male combat Veterans from OIF and/or OEF who self-identified as having the experience of moral injury as put forth in the proposed definition by Litz et al. (2009) were individually interviewed. Qualitative analysis was utilized to uncover themes related to morally injurious events and psychological and behavioral sequela. The findings revealed support for the proposed definition of moral injury as well six combined constituent themes describing morally injurious experiences.

1. Participants experienced shame, guilt, and feeling unforgivable connected to the involvement of children in war.
2. Participants experienced shame, guilt, and anger for taking part in killing others.
3. Participants experienced shame, guilt, anger, and feeling unforgivable when they did not speak-out regarding morally injurious events they were a part of as a group.
4. Due to what they experienced in war participants no longer held the same religious/spiritual beliefs.
5. Participants experienced a loss of meaning in life after viewing death and a sense that they deserved to be disgraced after the way they handled the human remains of the enemy and the way they saw others disgrace human remains of the enemy.
6. Participants experienced difficulty reconnecting on an emotional level with loved ones after their morally injurious experiences in combat.

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Appendix A
Recruitment Flyer

**Would you be willing to participate in research to help combat
Veterans?**

OIF and OEF Combat Veterans – Has your combat experience included moral injury?

I am a doctoral student in clinical psychology at Antioch University Santa Barbara and I am researching the concept of “moral injury” for my doctoral dissertation. Moral injury has been defined as: The perpetration of, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs. If you believe that during your combat experience you have an experience that would fall into this definition of moral injury, I would like to interview you and learn about your experience.

Your participation in the study will be confidential and interviews will be conducted one on one, (unless you request otherwise) by me.

To qualify for the study you will:

Be an OIF and/or OEF male combat veteran who has experienced moral injury similar to the definition as outlined above;

Be willing to speak about your combat experience and events related to moral injury;

Your participation will help to expand the research on moral injury and help to inform ways of assessment and treatment for Veterans.

**Please contact Margie at 310-663-2371 or email: Moral.Injury.Research@gmail.com
for more information and eligibility screening. Dissertation Chair: Dr. Ron Pilato
(805)962-8179**



Antioch University Santa Barbara • 602 Anacapa Street • Santa Barbara, CA • 93101

Appendix B

Prescreening Phone Questionnaire

All responses will remain confidential.

1. Are you an Operation Iraqi Freedom (OIF) or Operation Enduring Freedom – Afghanistan (OEF) combat veteran? YES / NO
2. What is your interest in participating in this study?
3. Are you presently under the care of a licensed mental health provider? YES ? NO
4. Are you willing to provide authorization to speak with your mental health care provider in order to confirm that you are under their care and should you be included in this study, to contact them in case of a psychological emergency on your behalf?
5. Are you currently experiencing any severe psychological symptoms? (such as severe nightmares, flashbacks, anxiety, suicidal ideation) YES / NO
6. How many times have you been deployed?
7. How long have you been back (months/years) from deployment?
8. Have you talked with others about your combat experience?
9. Do you feel comfortable talking about your combat experience?
10. Based on the definition provided of moral injury, do you feel that you have experienced moral injury during combat?
11. Do you want to talk about your experience of moral injury?
12. Do you have any objections to having your interview audiotaped?

Appendix C

Mental Health Referrals for Individuals that do not qualify at Prescreening

National:

1. National Veterans Crisis Line: 1-800-273-8255 Press 1
2. National Veterans Crisis Line: Text: 828255

Ventura County:

3. Ventura Vet Center: 1-805-585-1860 –or- 1-877-927-8387
4. Ventura Crisis Line: 1-877-727-4747.
5. Reins of H.O.P.E. Warriors Program, Ojai, CA: 1-805-797-5539 (no cost)

Santa Barbara County:

6. Santa Barbara Crisis Line: 1-888-868-1649
7. Santa Barbara Veterans Community Based Outpatient Clinic: 1-805-683-1491
8. New Beginnings Counseling Center Santa Barbara: 1-805-963-7777 (sliding scale)

Appendix D



Informed Consent Agreement

Project Title: The Exploration of Moral Injury as Experienced by Combat Veterans

Project Investigator: Marjorie McCarthy, JD, MA

Dissertation Chair: Ronald Pilato, PsyD

1. The purpose of this study is to more fully understand the meaning of moral injury as experienced by combat Veterans. It is important to have a better understanding of moral injury so that it can be better understood by mental health care providers. This will help to better identify those dealing with moral injury and will help to create treatments geared directly to the experience of moral injury.
2. I understand that this study is of a research nature. It may offer no direct benefit to me
3. Participation in this study is voluntary. I may refuse to enter it or may withdraw at any time without creating any harmful consequences to myself. I may refuse to answer any questions that I do not feel comfortable answering. I understand also that the investigator may drop me at any time from the study.
4. As a participant in the study, I will be asked to take part in the following procedures: A preliminary interview and an individual interview conducted one-on-one with the Project Investigator, Marjorie McCarthy. The interview will be audiotaped. Participation in the study will take approximately 1.5 to 2.0 hours of my time and will take place at a mutually agreed upon location.
5. The risks, discomforts and inconveniences of the above procedures might be: Discussing my experiences may bring up uncomfortable thoughts, memories and/or symptoms such as hyper-arousal, numbing, or unwanted thoughts. I will be

required to be under the care of a licensed mental health care professional to take part in this study. I will be asked to inform them of my participation in this study and to ensure that they will be available to me after the interview should I need their services. I will be required to complete a separate Authorization to Release/Request Confidential Information for the sole purposes of confirming that I am currently under the care of a mental health professional and that they be contacted in the case of a psychological emergency during my participation in this study.

6. The possible benefits of the procedure might be:
 - a. Direct benefit to me: I may gain personal insight into my own experience of moral injury
 - b. Benefits to others: By sharing my experience of moral injury I will be potentially helping other Veterans understand the effects of moral injury and potentially helping mental health providers properly identify and treat the effects of moral injury. There is also the potential indirect effect of decreasing veteran suicides related to moral injury, as it is currently not fully understood and may be a factor in veteran suicides.
7. For the protection of my privacy, all information obtained from me will be kept confidential as to source and my identity will be protected. My identity will be protected with a pseudonym of my choice. Additionally, all efforts will be made to disidentify the information shared, such as not using the exact locations of events and not using any discussed individual's true names. Interviews will be transcribed only after a Transcriber Confidentiality Agreement has been signed. All information, documents, and digital files will be stored in a locked file cabinet accessible only to the Project Investigator, Marjorie McCarthy.
8. Though the purpose of this study is primarily to fulfill a requirement to complete a formal research project as a dissertation at Antioch University, the Project Investigator also intends to include the data and results of the study in future scholarly publications and presentations. Our confidentiality agreement, as articulated above, will be effective in all cases of data sharing and any information that may potentially identify me will be altered and/or protected by a pseudonym of my choice.
9. If I decide to participate in this research, I may withdrawal my consent and discontinue my participation at any time during the study for any reason and without any penalty or prejudice.

If you have any questions or concerns about the study, you may contact the Project Investigator, Marjorie McCarthy at (310)663-2371 or at Moral.Injury.Research@gmail.com or Dr. Ron Pilato at (805)962-8179 ext. 5167 or

at rpilato@antioch.edu

If you have any questions about your rights as a research participant, you may contact Dr. Sharleen O'Brien, Chair of Antioch University Santa Barbara's Internal Review Board (IRB) at (805) 962-8179 ext. 5309 or at sobrien3@antioch.edu

I confirm that I have read and understood this form and have had any questions about this research answered to my satisfaction. My participation in this research is entirely voluntary. My signature indicates my willingness to be a participant in this research.

Participant Signature

Date

Project Investigator Signature

Date

Appendix E



Authorization to Release/Request Confidential Information

I, _____, hereby authorize
(Study participant name)

Insert participant’s mental health care provider’s information:

Name: _____

Address: _____

Phone: _____

Fax: _____

To share information with:

Primary Investigator: Marjorie McCarthy, J.D., M.A.

Antioch University Santa Barbara

Phone: 310-663-2371

Email: Moral.Injury.Research@gmail.com

Regarding:

- 1) As a requirement to participate in the Primary Investigator's dissertation research on Moral Injury in Combat Veterans; To confirm that I am currently receiving mental health services from the provider listed above and;
- 2) In the event of a psychological emergency during my participation in said study, the Primary Investigator may contact the mental health provider listed above on my behalf.

This consent is subject to revocation by the undersigned at any time, if not revoked it shall terminate one year from the date of signing or upon completion of participation in the study.

Signed: _____

Date: _____

Witnessed: _____

(Print name)

Witnessed: _____

(Signed)

Date: _____

Appendix F

Interview Protocol

Introduction:

Before we begin I would like to thank you again for agreeing to share your experiences with me. We will be exploring the concept of Moral Injury and how it has affected or made an impact on your life. I am going to be paying close attention to what you are saying, and even though we are audiotaping the interview I may occasionally write down notes for myself. Also, I may occasionally need to interrupt you and ask for clarifications because I want to make sure that I fully understand your descriptions. Lastly I want you to know that if at any time you start to feel uncomfortable for any reason please let me know and we can make whatever adjustments necessary.

1. Please tell me in as much detail as possible your experience or experiences of Moral Injury?

Probes if necessary:

- a. I am wondering if in your experience of Moral Injury there were circumstances in which your role was that of a perpetrator? If yes, please describe that experience for me.
- b. I am wondering if your experience of Moral Injury is related to your perceived failure to act? If yes, please describe that experience for me.
- c. I am wondering if your experience of Moral Injury is related to events that you bore witness to? If yes, please describe that experience for me.
- d. I am wondering if your experience of Moral Injury is related to events that you learned about? If yes, please describe that experience for me.

2. Please describe for me any emotions that you identify with your experience of Moral Injury?

Probes if necessary:

- a. Please describe for me any feelings of shame related to your experience of Moral Injury. If not, please describe other emotions which you connect to your experience of Moral Injury.
- b. Please describe for me any feelings of guilt related to your experience of

Moral Injury. If not, please describe other emotions which you connect to your experience of Moral Injury.

c. Please describe for me any feelings of being unforgivable/unworthy related to your experience of Moral Injury. If not, please describe other emotions which you connect to your experience of Moral Injury.

3. Please tell me about how your experience of Moral Injury has impacted your spiritual and/or religious beliefs?

Probes if necessary:

a. Please describe your spiritual/religious beliefs prior to your experience of Moral Injury.

b. Please describe any changes in your spiritual/religious beliefs as a result of your experience of Moral Injury.

b. If report losing spirituality/religion as a result of experience, how would you describe this?

4. Please describe for me any circumstances related to your experience of Moral Injury in which you thought about suicide or attempted suicide.

Probes if necessary:

a. What are the strongest emotions related to your experience of Moral Injury which you associate with your suicidal thoughts and/or suicide attempts?

5. What effects or impacts has your experience of Moral Injury had on you and your life situation?

Probes if necessary:

a. I'm wondering if your interpersonal relationships have been effected by your experience of Moral Injury? If yes, in what ways?

b. I'm wondering if your familial relationships have been effected by your experience of Moral Injury? If yes, in what ways?

c. I'm wondering if you see your experience of Moral Injury having an impact on your employment? If yes, in what ways?

Appendix G

Transcriber Confidentiality Agreement

I, _____, the Transcriber, individually and on behalf of Rev.com, do hereby agree to maintain full confidentiality in regard to any and all audio recordings received from Marjorie McCarthy, JD, MA (Researcher), related to her research study titled: An Exploration of Moral Injury in Combat Veterans. Furthermore I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of the audiotaped interview, or in any associated documents;
2. To not disclose any information received for profit, gain, or otherwise;
3. To keep all research information shared with me confidential by not discussing or sharing the research information in any form or format with anyone other than the Researcher;
4. To not make copies of any audiotapes or computerized files of the transcribed interview texts;
5. To store all research related audiotapes or computerized files in a secure manner and location as long as they are in my possession;
6. To return all audiotapes and or computerized files to Marjorie McCarthy, JD, MA upon request; and
7. After consulting with Marjorie McCarthy, JD, MA, erase or destroy all research information in any form or format regarding this research project that is not returnable to the Researcher(s) (e.g. Information stored on computer hard drive).

Contact information for transcriber and researcher:

Transcriber:

Researcher:

Address: _____

Address: _____

Telephone: _____

Telephone: _____

Email: _____

Email: _____

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotaped interviews and/or computerized files and/or paper files to which I have access. I am further aware that if any breach of confidentiality occurs, I will be fully subject to the laws of the State of California.

Transcriber Name:

Transcriber Signature: _____

Date: _____