INJURIES OF THE MIND, BODY, AND SOUL: AN EXPLORATION OF MORAL INJURY AMONG MILITARY SERVICE MEMBERS AND VETERANS

by

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Military service often requires engaging in activities, witnessing acts, or immediate decision-making that may violate the moral codes and personal values to which most individuals ascribe. If unacknowledged, these factors can lead to injuries that can affect the physical, psychological, social, and spiritual health of military men and women. The term *moral injury* has been assigned to these soul-ceasing experiences. Although researchers have attempted to define moral injury and what leads to such experiences, inconsistencies across definitions exist. In addition, nearly all existing definitions have lacked empirical support. Thus, an in-depth literature review, systematic review, and phenomenological qualitative study were completed to explore how moral injury has been conceptualized and defined across the literature and to respond to the need for an empirically-based, veteran-informed definitional understanding of such injuries. Findings from a qualitative study with United States veterans revealed that moral injuries can be conceptualized by chronic, deep-rooted experiences of (a) betrayal, (b) moral ambivalence, (c) soul injuries, and (d) lack of reconciliation. Recommendations for future research and clinical practice with moral injury must consider the systemic roots and implications for these injuries of the soul. Rather than viewing moral injury as a construct distinct to the field of psychology, trauma, or theology, applying a more systemic framework

may be most appropriate for capturing the multi-level implications. For instance, a biopsychosocial-spiritual lens may support the cellular to society and spiritual implications of moral injuries. Additionally, Bronfenbrenner's ecological theory was proposed as a potentially influential theory in grounding future assessments and interventions for the constructs by emphasizing the interplay between context, personal characteristics/values, and multi-level systemic influences on the development of moral injury.

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DEDICATION

To my biggest cheerleader, my best friend, and my forever angel: thank you.

My constant in the chaos; my unconditional supporter amongst the uncertainty.

This accomplishment is a direct result of your unwavering love and support.

The embodiment of strength, compassion, grace, and humility.

Everything that I am, I owe to you, Momma.

I love you, more.

And to any of our military men and women who have ever felt that they must carry around their moral injuries in silence: I see you, and I hear you.

Now, others will, too.

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believe, to always see the good in others, and to lead with my heart. She is the reason I am who I am today. Karen Lynn, I will forever be grateful for your unconditional love, unwavering support, endless encouragement, and continuous positivity. You provided me with the most solid foundational roots to always come back to, while also celebrating and encouraging the spreading of my wings. Thank you for being my person through it all.

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PREFACE

Growing up with small-town American values, the dedication of service members and veterans was viewed as highly honorable, and having extended military family of my own, I have always looked to military personnel with admiration and respect for their personal and relational sacrifices to serve our country.

I completed my undergraduate internship at the Family Life Chaplain Training Center at Fort Hood, Texas, where I had the opportunity to learn beside chaplains as they attempted to provide healing for the many psychosocial, spiritual, and relational challenges that impacted active duty service members and their families. That was my first exposure to the breadth of emotional and moral challenges facing many service members as they navigated their differing – and often conflicting – roles as both a service member and human being. Both the rawness and depth of their unique lived experiences and a recognition of coercive power of military rank structure led to my own recognition of service members as a vulnerable population. I became intrigued with the subcultural norms and expectations of military culture and how societal discourses impact the meaning-making and relational experiences of service members and veterans, but I never imagined it would develop into my own passion for serving military through clinical and research opportunities.

During my graduate studies in marriage and family therapy at Oklahoma State University, I initially aimed to become a skilled trauma clinician, prepared to serve the unique needs of military populations and their families. Over time, my interest in trauma grew into a passion for helping individuals and families navigate grief and loss. While I felt such gratitude and privilege for clients' vulnerability when sharing of some of their darkest times after a loss or death, it was the grief experiences that appeared to be more complicated as a result of ambiguous

losses that often captured my attention. Ambiguous Loss Theory (Boss, 2006) provided language for the clinical challenges I witnessed with such losses, in that "ambiguity coupled with the loss creates a powerful barrier to coping and grieving and leads to symptoms such as depression and relational conflict that erode human relationships" (p. 1). This greatly ignited my desire to extend my skills and training as an MFT clinician (who supported individuals and families that experienced trauma and loss) into my desire to become a practice-informed researcher who could focus on barriers to coping through research and ultimately improve clinical outcomes for patients.

This led to the decision to pursue a PhD in Medical Family Therapy where I was given the opportunity to work with Dr. Angela Lamson on various military research projects. As I learned more and more of the biopsychosocial and spiritual challenges impacting service members and the alarming number of deaths by suicide occurring daily for veterans, I began to dive deeper into possible answers to the question: *What are we missing in our understanding about military service?*

My two passions began to merge as I started to explore the unique trauma and grief experiences of military populations and was introduced to the construct "moral injury." I started to conceptualize my understanding of these deeper-rooted injuries of military service (as injuries of the soul) and wondered if this may be the missing link for why suicide is the second leading cause of death among U.S. veterans. Therefore, I developed the current dissertation in hopes of exploring the impact of military service on veterans' values and beliefs in hopes of providing insight into the experiences that may have silenced so many veterans for centuries.

As a qualitative researcher, it is important to acknowledge how my presumptions and biases of military experiences and culture could influence this research with veterans. Therefore,

ongoing reflexivity and reflection will take place throughout each phase of the research. While I am overwhelming grateful for the opportunity to learn from the lived experiences of U.S. veterans through my research, an ongoing concern is whether or not I will be viewed as trustworthy as a civilian "outsider." My hope is that through authentic interactions and genuine openness that I may be able to bridge this gap as my greatest desire is to appropriately capture *their* stories and provide voice to the experiences of those who have sacrificed so much.

CHAPTER 1: INTRODUCTION

Experiences of military service have long been connected to issues of internal conflict, feelings of guilt, and ongoing distress (Friedman, 1981), and recent studies suggest that moral transgressions from the field may serve as an underlying mechanism for the relationships between posttraumatic stress and suicidal outcomes (i.e., suicidal ideation, attempts, and deaths; Bryan, Bryan, Morrow, Etienne, & Ray-Sannerud, 2014). Interestingly, suicide was not historically viewed as an outcome associated with mental health issues, but rather a result of "moral crisis" related to an individual's wrongdoing (Barraclough, Bunch, Nelson, & Sainsbury, 1974), and yet, our understanding of moral issues of combat have only been explored through empirical research for less than a decade (i.e., Drescher et al., 2011). These findings highlight a need to better understand the biopsychosocial and spiritual experiences of service members as they relate to issues of morality and support the need for the use of moral injury as a helpful construct to address the wider range of complex and potentially lethal outcomes associated with military service (Drescher et al., 2011).

In his 2012 novel, *The Yellow Birds,* Kevin Powers described this inner conflict and the challenges with reaching out for support as an active duty service member:

> *I feel like I'm being eaten from the inside out and I can't tell anyone what's going on because everyone is so grateful to me all the time and I'll feel like I'm ungrateful or something. Or like I'll give away that I don't deserve anyone's gratitude and really, they should all hate me from what I've done but everyone loves me for it and it's driving me crazy.* (p. 144).

Experiences as those highlighted by Kevin Powers are sadly familiar to many service members. The suicide rate among United States veterans is significantly higher than that of

civilian populations (Houtsma, Khazem, Green, & Anestis, 2017; U.S. Department of Veteran Affairs [USDVA], 2018a) and continues to rise, with approximately 20 deaths by suicide occurring daily (USDVA, 2018b). Findings from a 2018 report from the U.S. Department of Veteran Affairs revealed that more than 6,000 veterans died by suicide each year from 2008 to 2016 (USDVA, 2018a), making suicide the second leading cause of death among U.S. veterans (Department of Defense Task Force on Prevention of Suicide by Members of the Armed Forces, 2010) compared to the tenth leading cause of death for non-military in the United States (USDVA, 2018a). In 2016, the rates of suicide were 26.1 per 100,000 for veterans and 17.4 per 100,000 for non-veteran adults, making the suicide rate 1.5 times greater for veterans compared to their non-veteran counterparts (USDVA, 2018a). These numbers highlight the imperative need for better understanding the biopsychosocial and spiritual experiences of our men and women returning to civilian life after service.

Given the historical connection between issues of morality (i.e., moral crises) and suicidality (Barraclough et al., 1974), it is important that we bring awareness to the morally-jolting lived experiences of military personnel. Military service often requires service members to engage in life or death activities, witness acts that contradict one's values or beliefs, or partake in immediate decision-making without knowing the consequences; any of these could be construed as moral crises. The word "moral injury" has been assigned to these soul-ceasing experiences (Shay, 2002).

While researchers have attempted to define moral injury and what leads to such experiences, inconsistencies exist across definitions and nearly all definitions lack empirical support (Richardson et al., 2020). Researchers have proposed a key precondition for moral injuries as "an act of transgression, which shatters moral and ethical expectations that are rooted

in religious or spiritual beliefs, or culture-based, organizational, and group-based rules about fairness, the value of life, and so forth" (Maguen & Litz, 2019). If unacknowledged, these injuries have the potential to influence the physical, psychological, social, and spiritual health of military personnel.

Although much of what we know about moral injury is conceptual in nature, there is growing evidence that supports immense feelings of guilt and shame as possible indicators of moral injury that increase one's risk for personal self-harm or deprecation. The following excerpt from *The Yellow Birds* highlights the experiences that service members and veterans are too often silently, yet intensely faced with during and after their time in the military:

> *Or should I have said that I wanted to die, not in the sense of wanting to throw myself off of that train bridge over there, but more like wanting to be asleep forever because there isn't any making up for killing women or even watching women get killed, or for that matter, killing men and shooting them in the back and shooting them more times than necessary to actually kill them. And it was like just trying to kill everything you saw sometimes because it felt like there was acid seeping down into your soul and then your soul is gone and knowing from being taught your whole life that there is no making up for what you are doing; you're taught that your whole life, but then even your mother is so happy and proud because you lined up your sight posts and made people crumple, and they were not getting up ever…* (Powers, 2012, pp. 144-145).

To date, few studies have explored the phenomenon of moral injury directly with service members or veterans. Therefore, the current authors believed a most purposeful step was to design the current dissertation in order to explore the morally injurious experiences of military service that are likely being overlooked and misdiagnosed among U.S. veterans. Our hope is to

expand the current understanding of moral injury by providing a more accurate definition and conceptualization of the construct and associated experiences through the lived experiences of military veterans so that diagnostic criteria, clinical treatments, and services may be better tailored to address these injuries to the soul. Thus, the current authors believed giving voice to the experiences that have likely silenced many for decades is a necessary next step.

Dissertation Purpose and Design

The overarching purpose of this dissertation is to better explore and understand how service members and veterans' personal beliefs and values may be impacted by their military service. This dissertation evolved first from a review of the literature exploring the history of traumatic stress research and differentiating between common injuries of the mind, body, and soul impacting service members and veterans (Chapter 2) into an in-depth systematic review (Chapter 3) that sought to identify key definitions used throughout the literature to describe the moral injuries endured by service members and veterans. Based on the results of the systematic review, the qualitative design for the empirical research is described in Chapter 4.

More specifically, Chapter 2 offers a review of the current literature on moral injury in the context of military service members, by differentiating moral injury and symptomology from other military traumatic stress disorders, including posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI), and providing a theoretical exploration of the common injuries experienced by military personnel. The biopsychosocial-spiritual framework (BPSS; Engel, 1977, 1980; Wright, Watson, & Bell, 1996) was introduced as an important foundation for better understanding the interconnected yet distinct differences between common military experiences that often lead to injuries of the mind (PTSD), body (TBI), and soul (moral injury) for our men and women in uniform. The literature review highlighted that much of what we know about

moral injury is conceptual in nature, and that while significant strides have been made for differentiating between diagnostic criteria for common trauma responses impacting service members and veterans since in the 1980s (i.e., when PTSD was first included in the 3rd edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; APA, 1980), additional actions in delineating the deeper-rooted morally injurious experiences of military service is needed. Key steps for addressing the gaps in our understanding of and empirically validated treatments for moral injury are also introduced.

Findings from an in-depth systematic review of key definitions for moral injury are presented in Chapter 3. This review was conducted to address this research question: *What are the operational definitions of moral injury constructs with military service members and veteran populations?* The systematic review included a two-phase review using four databases, which yielded a total 124 articles that met inclusion criteria (i.e., published in English; incorporated a definition of moral injury or related concepts; included a construct related to military populations who were at least 18 years or older). Twelve key definitions were cited across the literature with themes related to ethics, betrayal, and issues of reconciliation with spiritual and psycho-behavioral implications. This review found that contradictions for the origin of moral injury remain, as some definitions suggest a specific event or high-stress environment is necessary for such injuries, whereas others provided less detail about the origin or cause. The review highlighted the dearth of empirical evidence needed to inform the conceptualization of moral injury. This chapter ended with a call for a more accurate definition grounded in empirical support that could aid in fulfilling conceptual clarity for moral injuries, which in turn may allow professionals to more appropriately acknowledge and treat the deeper wounds associated with military service.

Based on the results from Chapter 3, the methodology for an empirical study was constructed. The methodology, including a phenomenological design, procedures for recruitment and data management, and proposed analysis, is presented in Chapter 4. The overarching research question that guided this phenomenological exploration is: *How do U.S. military veterans describe and make meaning of the morally challenging experiences associated with their military service?* Due to a lack of theoretical understanding or research-informed definition of moral injury and the complexity of the construct, a flexible inductive qualitative process was needed to gain insight into such injuries. A two-phased qualitative approach was employed by first (i.e., Phase I) collecting contextual information about participants' military service and biopsychosocial-spiritual experiences. Participants were then given the option to engage in face-to-face qualitative interviews (i.e., Phase II) to further explore how their personal values and morals may have been impacted by their military service.

The aim of the qualitative study (presented in Chapter 5) was to use a phenomenological design to better understand the meaning-making experiences of U.S. veterans and their beliefs, values, and morally challenging experiences related to military service. Findings from the study revealed that moral injuries can be conceptualized by chronic, deep-rooted experiences of (a) betrayal, (b) moral ambivalence, (c) soul injuries, and (d) lack of reconciliation. An important contribution to science based on these findings was the emphasis on systemic implications of moral injury; additionally, findings supported the ongoing need for empirically-based and veteran-informed definitional clarity to increase construct validity and to develop appropriate assessments and treatments for such injuries.

Recommendations for future research and clinical practice with moral injury were presented as part of Chapter 6, which highlighted the need to consider the systemic roots and

implications for these injuries of the soul. Rather than viewing moral injury as a construct distinct to the field of psychology, trauma, or theology, applying a more systemic framework may be most appropriate for capturing the multi-level implications. For instance, a biopsychosocial-spiritual lens may support the cellular to society and spiritual implications of moral injuries. Additionally, Bronfenbrenner's ecological theory was proposed as a potentially influential theory in grounding future assessments and interventions for the constructs by emphasizing the interplay between context, personal characteristics/values, and multi-level systemic influences on the development of moral injury.

Conclusion

Empirical evidence exploring moral injury is needed in order to more holistically understand the biopsychosocial and spiritual implications of moral injury. With the number of deaths by suicide for service members and veterans increasing each day, it is clear that researchers are missing something in our understanding of military experiences. Therefore, the significant contribution of this dissertation could be a matter of life or death for those who continue to be silenced, or even haunted, by the experiences and memories of military service that have torn at the core values of men and women for centuries, leaving long-lasting, soul-ceasing moral injuries.

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CHAPTER 2: UNDERSTANDING MORAL INJURY IN THE MILTIARY: A LITERATURE REVIEW OF MILITARY-RELATED INJURIES OF THE MIND, BODY, AND SOUL

Over the course of their military service, service members are often required to make difficult decisions or be exposed to actions in war or other missions that violate their deeply held personal values and core ethics distinct from those that commonly present themselves in civilian contexts. If left unresolved, these violations may result in significant inner conflict (Gray, Nash, & Litz, 2017; Kelley et al., 2019; Yeterian et al., 2019). Although some service members who experience this inner conflict can reconcile and adapt to their experiences, those who cannot are at risk for developing deeper-rooted injuries to the soul – what has also been referred to as *moral injuries.* Experiences during military service have long been connected to issues of internal conflict, feelings of guilt, and ongoing distress (Friedman, 1981), and recent studies suggest that experiences of moral injury and moral transgressions from the field may serve as an underlying mechanism for the relationship between post-traumatic stress and suicidal outcomes (i.e., suicidal ideation, attempts, and deaths; Bryan, Bryan, Morrow, Etienne, & Ray-Sannerud, 2014). These findings more than punctuate the possibility that service experiences can impact the biological, psychological, social, and spiritual health of service members. However, the need for understanding moral injury as a construct is necessary in order to better address the ways in which service members think about their physical, mental, relational, and spiritual health and how providers can better attend to the complex nature of health across a service member's lifespan.

Because the literature on moral injury is relatively young (i.e., first conceptually defined by Litz et al., 2009), a consensus on the operational definition of the construct is limited, likely

resulting in these injuries being masked by a variety of diagnoses, such as posttraumatic stress disorder (PTSD; Hodgson & Carey, 2017). While researchers have attempted to define what constitutes moral injuries, inconsistency in understanding the construct remains (Richardson et al., 2020). To date, the most widely used definition for moral injury among researchers and mental health providers was developed by Litz and colleagues (2009) to capture the shame and guilt-based disturbances that many veterans experience after engaging in wartime acts. Litz et al. (2009) defined morally injurious experiences as, "events in which an individual perpetrates, fails to prevent, bears witness to, or learns about acts that transgress deeply held moral beliefs and experiences" (p. 700). Though this is the mostly widely accepted explanation of moral injury among researchers in the field, the conceptualization of the construct lacks empirical evidence (Richardson et al., 2020).

A research-informed understanding of moral injury and the causes of these invisible injuries is needed, particularly as distress among service members and veterans continues to significantly increase (i.e., deaths by suicide continue to rise; United States Department of Veteran Affairs [USDVA], 2018). With approximately 20 deaths by suicide occurring daily among Veterans (USDVA, 2018), it is imperative that we explore the deeper-rooted injuries endured by service members and better understand the psychological, emotional, spiritual, and ethical challenges that these individuals experience as they return home to their families. The purpose of this review is to: (a) highlight the history of military traumatic stress, (b) explore the current literature on moral injury with military service members by differentiating moral injury symptomology from other military traumatic stress disorders (i.e., PTSD and TBI), (c) provide a theoretical exploration of the common injuries to the mind, body, and soul experienced by military personnel, and (d) put forward benefits for constructing an official diagnosis for moral

injury along with implications that can further research for moral injury across other occupations (e.g., police officers and firefighters).

History of Military Traumatic Stress Research

Within the past ten years, the construct of moral injury has begun to receive more serious attention in the military literature (Drescher, et al., 2011; Fontana & Rosenheck, 2004; Litz et al., 2009; Neria & Pickover, 2019). While morally injurious experiences have likely existed for centuries, it wasn't until recently that issues of morality, spirituality, and military ethics started to gain more attention (Drescher et al., 2011). Issues of psychological distress and military trauma, however, date back to ancient times and were first documented as part of American war-time experiences during the Civil War. Between 1861 and 1865, service members were given diagnoses of "nostalgia" – a term used to describe soldiers who suffered from despair, homesickness, sleep disturbances, sadness, and anxiety (Friedman, 2018). A new wave of military research and psychological diagnoses within the military began during and after World War I. A consolidation of present-day symptoms of PTSD (e.g., sleep disturbances, panic attacks, etc.) became known as "shell shock" because they were seen as typical reactions to explosions during combat; however, perspectives of this condition shifted as medical providers realized that the same symptoms were showing up in soldiers who had not been near any explosions (Friedman, 2018).

During World War II, the concept of shell shock was replaced with Combat Stress Reaction (CSR), also known as "battle fatigue" (Friedman, 2018). This was believed to be a result of long excursions during World War II, where soldiers would become weary and mentally and physically exhausted (Friedman, 2018). While experiences of post-traumatic stress and military trauma were commonly found as a result of war-time experiences across history, it

wasn't until 1980 that the American Psychiatric Association (APA) added PTSD to the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*; APA, 1980; Friedman, 2018). This official diagnosis was a result of research involving Vietnam veterans, Holocaust survivors, victims of sexual trauma, and many others impacted by traumatic stress (Friedman, 2018). More recently, growing attention has also been given to differentiating between traumatic brain injury (TBI) and PTSD as distinct trauma reactions as a result of experiences from Operation Iraqi Freedom and Operation Enduring Freedom. Lindquist and colleagues (2017) even referred to TBI as a "signature injury" of the conflicts in Iraq and Afghanistan. While strides have been made in research, practice, and policy since the first printing of an official diagnosis of PTSD and recent criteria for a TBI, the growing epidemics of suicide and traumatic stress suggest that something is still missing from our understanding of the military experience.

Drawing from over 20 years of experience working with Vietnam veterans, Jonathon Shay was the first to publish on the phenomenon of *moral injury*. In 1994, Shay published *Achilles in Vietnam: Combat Trauma and the Undoing of Character,* which stated that his aim was to "put before the public an understanding of catastrophic experiences that not only cause life-long disability but can ruin good character" (p. xiii). In 2002, in his book entitled Odysseus in *America: Combat Trauma and the Trials of Homecoming,* Shay highlighted a need for the prevention of "psychological and moral injury in military service" (p. 6).

Although researchers have been exploring the construct of moral injury for just over a decade, it has likely existed since the first wars in history. Perhaps, it has been moral injury that has silenced so many service members from talking about their experiences from previous wars, such as Vietnam. In fact, Litz et al. (2009) believed that the potential for moral injury increased

during nontraditional, guerilla warfare (e.g., wars such as Vietnam, OIF, OEF) especially when service members found it challenging to distinguish between civilians and enemies during combat. Unfortunately, as service members returned from battlefields or into civilian life, these injuries were often overlooked or unacknowledged. Only the extraordinary provider would identify the deeper routed injuries of the psyche or soul. Given the chasm between providers who may not investigate psychosocial-spiritual injuries and service members or veterans who do not give a voice to their psychosocial-spiritual wounds, a BPSS framework is necessary to fully capture the dimensions of moral injury.

Theoretical Foundation

The biopsychosocial-spiritual (BPSS) framework (Engel, 1977, 1980; Wright, Watson, & et al., 1996) is an essential foundation to better understand moral injury in relation to other stress disorders (i.e., PTSD, TBI). Engel (1977) developed the biopsychosocial (BPS) model from his belief that something was missing from the typical medical model of treatment and healing. He believed that in order to accurately understand and treat patients, the interrelatedness of the biological, psychological, and social influences on the human system and illness must be considered (Engel, 1977, 1980). Engel argued that not only do medical conditions affect multiple levels in a system's hierarchy (i.e., subatomic to biosphere), but treatment also reverberates across a continuum of multiple systems (McDaniel, Doherty, & Hepworth, 2014). In 1996, Wright, Watson, and Bell added a *spiritual* component to the BPS model, suggesting the importance of beliefs and meaning making in the context of BPSS health, illness, and healing. Because of the overlap between BPSS domains, yet distinct differences within each domain, it is important to explore moral injury through a systemic and holistic conceptualization.

The BPSS framework highlights the interweaving of cellular to societal complexities that researchers and practitioners have faced for decades as they unpeel the injuries of the mind (PTSD), body (TBI), and soul (moral injury). While considerable attention has been given to PTSD and TBI, much less is understood about the origins of moral injury. Military service members often experience morally ambiguous and emotionally ambivalent situations that require decisions or acts that may lead to inner turmoil and personal conflict (Bryan et al., 2016). These transgressions provoke an array of responses that inherently impact the physiological, psychological, social, and spiritual well-being of service members and veterans. However, unlike the acknowledgment of physiological injuries (i.e., TBI) or psychological injuries (i.e., PTSD), moral injuries continue to progress or worsen without any direct acknowledgment (e.g., no recognition through the *DSM*, disability services, insurers) leaving them void of best treatment practices. As such, it is essential to distinguish the unique etiology, symptoms, and outcomes of moral injury when grounded through the BPSS framework including a systemic optic that can clarify any potential overlap between moral injury, PTSD and/or TBI.

Injuries to the Mind, Body, and Soul

Exploring trauma injuries through a BPSS lens highlights both the interconnectedness and distinct difference in symptoms that continue to impact military personnel and many others on a daily basis. *Psycho-social* indicators of health are often viewed as front-runners for posttraumatic stress (i.e., startle response, fear, avoidance, mood disturbance, depression, suicidality) that may result in *biological* implications (e.g., numbness, disruptions in sleep, flashbacks, changes in brain structure, memory loss). Traumatic brain injuries can be conceptualized as *biological* injuries (i.e., physical injuries to the head and brain) with *bio-psycho-social* implications (e.g., headaches, memory loss, irritability, depression, substance use,

etc.; Stanley, Joiner, & Bryan, 2017; Stefan and Math, 2016; Terrio et al., 2009). Research exploring moral injuries, on the other hand, has been linked to *spiritual/existential* dimensions of health (e.g., guilt, shame, lack of trust of self and others, changes in faith, questioning of morals/values, etc.) with *psycho-social* implications (e.g., anhedonia, social alienation, suicidality, depression, anxiety, mood disturbance, etc.). The overlap in BPSS domains for this triad of injuries highlights the challenge, yet importance of differentiating between diagnostic criteria for such injuries so that providers may appropriately treat those impacted by these injuries of the mind, body, and soul.

PTSD - An Injury of the Mind

Although some iteration of PTSD began around the 1860s, a formal diagnosis of PTSD wasn't approved until 1980 (Horowitz et al., 1980). PTSD and other mental illnesses, including depression, are reportedly more common in combat service members as compared with nondeployed service members during current ongoing military operations (Blakely, 2013). According to the American Psychiatric Association (APA; 2013), a current diagnosis of PTSD requires the exposure to a trauma that may threaten or cause actual or perceived injury or harm (e.g., direct exposure, witnessing a trauma, learning of a close relative or friends' trauma experience, or indirect exposure to aversive details of the trauma). Additionally, PTSD includes psychological symptoms of intrusion (e.g., intrusive thoughts/memories, flashbacks, nightmares), avoidance, negative changes in cognitions and mood, and changes in physical and emotional behaviors (APA, 2013). The experiences associated with PTSD wouldn't be uncommon for service members to encounter. While most service members do not develop PTSD following service, those who have recently returned from combat are at an elevated risk for PTSD due to increased rates of witnessing or direct exposure to trauma (USDVA, 2017). Those who

experience more deployments or have a longer cumulative length of deployment are at an even higher risk for symptoms (Xue et al., 2015).

Diagnostic criteria of PTSD. A broad classification system was developed post-World War II by the U.S. Army (and modified by the Veterans Administration) to incorporate outpatient presentations of service members and veterans. At the same time, the World Health Organization (WHO) published the sixth edition of the ICD, which for the first time, included a section for mental disorders which was highly influenced by the Veterans Administration's classifications (APA, 2019). The first edition of the *DSM* was developed by *the APA Committee on Nomenclature and Statistics* and published in 1952 (APA, 2019), which included "gross stress reaction" for individuals who had symptoms from traumatic events such as disaster or combat. Despite growing evidence that trauma exposure was associated with psychiatric problems, this diagnosis was eliminated in the second edition of the *DSM* (1968; APA, 2019).

While presentations of mental health symptoms from World War II veterans supported the initial need for diagnostic classifications for mental health disorders, it wasn't until decades later in 1980 that an initial diagnosis PTSD was included in the *DSM* (edition III; APA, 2019). The *DSM-III* criteria for PTSD were revised in the *DSM-III-R* (1987), *DSM-IV* (1994), *DSM-IV-TR* (2000), and *DSM-5* (2013) to reflect updated findings within the research. Since 1980 and in the latest revision, the *DSM-5* (APA, 2013) has made several notable evidence-based revisions to the PTSD diagnostic criteria, with both important conceptual and clinical implications. Most notable, it has become apparent that PTSD is not just a fear-based anxiety disorder (as explained in both *DSM-III* and *DSM-IV*; Friedman, 2018). Thus, PTSD is no longer categorized as an Anxiety Disorder but distinguished as a new category: *Trauma- and Stressor-Related Disorders* (Friedman, 2018).

While traumatic stress can be assessed in many ways with military service members and veteran populations, the U.S. Department of Veterans Affairs' National Center for PTSD has authorized specific standardized assessments for posttraumatic stress symptoms. Examples of validated measures for PTSD symptoms in military populations include the PC-PTSD (Prins et al., 2015) and the PLC-5 (Weathers et al., 2013). The Primary Care PTSD Screen for *DSM-5* (PC-PTSD-5; Prins et al., 2015) is a 5-item measure initially designed to identify individuals in primary care settings with probable PTSD. This measure was developed by the National Center for PTSD to reflect the new *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association [APA], 2013) criteria for PTSD. The PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013) is a 20-item self-report measure designed to assess common symptoms of PTSD outlines by the DSM-5.

Questions remain about the diagnostic criteria of PTSD regarding untreated symptomology, differential subtypes of PTSD, and clinical experiences of prolonged and repeated traumas (Friedman, 2018). Herman (1992) argues that the current PTSD formulation fails to characterize the major symptoms commonly experienced by victims of prolonged, repeated interpersonal violence (e.g., domestic, sexual abuse, and political torture). PTSD has also been criticized as a diagnosis that does not accurately reflect the clinical picture of traumatized individuals from non-Western traditional societies and cultures, as there is substantial cross-cultural variation and the expression of PTSD may be different in different countries and cultural settings, even when *DSM-5* diagnostic criteria have been met (Friedman, 2018; Marsella, Friedman, Gerrity, Scurfield, 1996). These injuries of the mind are often complicated by physical injuries (e.g., neurological comorbidities) and functional impairments,

such as those caused by TBI, and further complicated by substance use, depression, anxiety, suicidal ideation, and complex support systems (Libin, 2019).

TBI – An Injury of the Body

Traumatic brain injury (TBI) is a common injury to the body among military service members (www.military.com). It occurs when a sudden trauma or head injury disrupts the function of the brain. Service members are at increased risk for TBI because of potential exposure to blasts, both from combat exposure and training (CDC, 2019). Most reported military TBI cases are related to Improvised Explosive Devices, or IEDs (www.military.com). Before modern-day medical advancements, speedy battlefield treatments, and advanced armor were developed, most people who suffered these types of injuries rarely survived (www.military.com). TBI is a significant health issue which affects service members and veterans during times of both peace and war. The high rate of TBI and blast-related concussion events resulting from current combat operations directly impacts the health and safety of individual service members and subsequently the level of unit readiness and troop retention (www.military.com).

Diagnostic criteria of TBI. The Centers for Disease Control and Prevention (CDC) define TBI as "a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head, or penetrating head injury" (2019). To diagnosis TBI, health care providers may use one or more scales to assess brain and nerve functioning, level of consciousness, and physical injuries. The Glasgow Coma Scale is a common measure used to assess a person's functioning in three areas: (a) ability to speak, (b) ability to open eyes, and (c) ability to move in response to stimuli (National Institute of Neurological Disorders and Stroke, 2017). A total score is calculated based on an individual's responses in each category, with scores of 13 and higher indicating mild TBI, 9 to 12 indicating moderate TBI, and scores of 8

and below indicating severe TBI (National Institute of Neurological Disorders and Stroke, 2017). Military situations that result in severe TBI may be more obvious, while mild TBI may not be as easily identified. Therefore, the U.S. Department of Defense and Department of Veterans Affairs have developed procedures to quickly assess whether the person experienced a loss of consciousness, memory problems, and neurological symptoms (e.g., confusion, poor coordination) in order to determine necessary actions for care (Defense and Veterans Brain Injury Center, 2011).

Although psychological conditions are commonly conceptualized as risk factors for suicidal behavior, researchers also suggest that a history of TBI independently increases risk for suicide (Brenner et al., 2011). Although symptoms of TBI span both physical (e.g., headaches) and psychological (e.g., irritability) domains, common psychological consequences of TBIs, including anger and depression, have also been found to increase one's risk for suicide (Stanley et al., 2017; Terrio et al., 2009). With approximately 20 deaths by suicide occurring daily among veterans (USDVA, 2018), it is imperative that we extend our understanding of common military injuries of the mind and body to also include guilt- and shame-based injuries of the soul.

Moral Injury – An Injury to the Soul

While some overlap in symptomology may exist between PTSD and TBI (e.g., changes in mood, irritability, nightmares, sleep disturbances, memory loss) less is known about the symptoms of moral injury and how those symptoms are unique from or interface with PTSD and TBI. Researchers who have published on moral injury have suggested that the fundamental distinction between PTSD and moral injury lies in the core emotional experiences: moral injury is rooted in *shame and guilt*, whereas PTSD is based in overwhelming experiences of *fear* (Antal & Winings, 2015).

Moral injury does not necessarily revolve around fear; rather, it results from experiences that violate deeply held moral beliefs and values (Nieuwsma et al., 2015). Farnsworth (2019) proposed that PTSD and moral injury can be differentiated, at least in part, by distinguishing between descriptive and prescriptive cognitions. Descriptive cognitions highlight the way things are in terms of nature or causal relationships (Farnsworth, 2019). In contrast, Farnsworth et al. (2017) proposed that moral injury is defined in part by prescriptive cognitions—that is, an individual's judgment about what morally ought to be. Conceptual definitions of moral injury have further introduced probable diagnostic criteria that includes: (a) guilt and shame, (b) existential or spiritual distress, and (c) appraisals of betrayal, blame, and wrongdoing (Currier et al., 2019).

Guilt and shame. Emotions such as fear, anxiety, and sadness are natural reactions to traumatic stress (Bryan, Bryan, Roberge, Leiker, & Rozek, 2017). Moral injury, however, includes experiences of deeper-rooted emotional pain that manifests from feelings of guilt and shame. Although guilt and shame are often used interchangeably, especially in the moral injury literature, they represent distinct constructs. The primary distinction between the two psychological constructs is the object of evaluation (i.e., the type of transgression and who committed such acts; Bryan et al., 2017; Nazarov et al., 2015). Guilt and shame direct their moral evaluations inward (Moon, 2017). Specifically, guilt is associated with the negative evaluations of one's own actions in the context of interpersonal interactions and is associated with remorse and regret over the perceived infringement (e.g., "I feel bad about what I did;" Bryan et al., 2017; Tangney, Stuewig, & Mashek, 2007). In contrast, shame is comprised of negative evaluations about one's self in general, regardless of the context (e.g., "I feel bad about who I am;" Bryan et al., 2017). Researchers have also proposed that exacerbated feelings of guilt

and shame from moral injuries may be related to challenges with existential or spiritual issues (Farnsworth et al., 2014; Griffin et al., 2019; Hodgson & Carey, 2017; Zerach & Levi-Belz, 2018).

Existential or spiritual distress. In addition to challenges with core moral emotions, spiritual distress has been recognized in the literature as a key feature of moral injury (Carey et al., 2016; Pargament et al., 2005), with some researchers considering moral injuries to be a form of spiritual/religious struggle (Currier et al., 2015; Exline et al., 2014; Pargament et al., 2005; Nash & Litz, 2013;). Additional symptoms which are common for service members returning from combat yet distinct from PTSD diagnostic criteria include: (a) negative changes in ethical attitudes and behaviors, (b) changes in or loss of spirituality, (c) issues with forgiveness, (d) reduced trust in others and in social-cultural contexts, and (e) poor perceptions of self (Currier et al., 2015). The painfully emotional, psychological, spiritual, and social experiences of moral injury fall outside of the diagnostic criteria for PTSD. Additionally, potential causes of moral injury extend beyond a threat of life and do not require direct exposure to a traumatic event (Currier et al., 2015; Litz et al., 2009; Paul et al., 2014).

Betrayal. Researchers have found that the most commonly identified stressors that may lead to moral injury include betrayals from others (e.g., leadership failures or lack of trust among authority figures; Fransworth et al., 2014; Nash et al., 2013; Shay, 2014), betrayals within self (e.g., failure to act in accordance with one's own personal values through active participation or passive witness of actions; Blinka & Harris, 2016; Farnsworth et al., 2014; Litz et al., 2009), infliction of physical harm or injury to innocent civilians (Drescher et al., 2011; Farnsworth et al., 2014), violence within ranks or assault among service members, and inability to prevent suffering or death. (Farnsworth et al., 2014). While moral injury is most often associated with the

exposure of violence and aggression during combat experiences (Bryan et al., 2016), service members have also reported experiences of inner turmoil related to non-violent secondary events, such as continuous exposure to human remains or witnessing and being unable to assist wounded or dying civilians and/or children (Hoge, Auchterlonie, & Milliken, 2006). While potentially shielded from the physical acts that may cause such tragedies, these secondary experiences continue to challenge one's personal moral code, leading to additional experiences of moral pain for what has happened or what one was unable to prevent or assist with. These experiences have the potential to create immense moral dissonance, which if unresolved, may lead to deeper-rooted moral injuries.

Moving Toward a Diagnosis of Moral Injury

In order for moral injuries to be perceived as legitimate injuries associated with military service and other traumatic experiences, diagnostic criteria for such injuries must be determined. Moving toward a diagnosis of moral injury means: (a) that there is a research-informed understanding of individuals' moral injury experiences, (b) that a diagnosis may correspond with disability (similar to what has been developed for TBI and PTSD) for insurance recognition, and (c) that evidence-based practices can be developed to appropriately treat the unique symptoms of moral injuries.

Research-Informed Understanding of Moral Injuries

Previous researchers have suggested that there are areas of overlap and distinction between MI and other mental and behavioral health outcomes, particularly PTSD, following exposure to trauma stress (Currier et al., 2017; Farnsworth et al., 2017; Jinkerson, 2016; Litz et al., 2009). Understanding the apparent interplay between PTSD and MI symptoms first requires an important clarification of terminology with respect to potentially morally injurious events

(Litz et al., 2009) and moral injury (Currier al., 2019; Shay, 2002;). Just as measuring trauma exposure (cause) is not the same as measuring symptoms of PTSD (outcome), assessing exposure to potentially morally injurious events (cause) is not proportionate with assessing symptoms of moral injury (outcome; Frankfurt & Frazier, 2016).

Because of the proposed overlap of symptomology between moral injury and PTSD (Drescher et al., 2011; Litz et al., 2009; Maguen & Litz, 2012; Shay, 2014), it is conceivable that experiences of moral injury and its impact on biopsychosocial-spiritual and relational health may initially parallel the experiences of service members returning from combat with PTSD. However, because of the unique qualities that have been cited in the literature to distinguish moral injury as a separate construct (Drescher et al., 2011; Litz et al., 2009; Maguen & Litz, 2012; Shay, 2014), there are likely distinct intrapersonal and systemic outcomes that differ from PTSD for service members and veterans.

Research looking specifically at combat-related PTSD in Vietnam era veterans suggests that the most significant predictor of both suicidal ideation and attempts is combat-related *guilt* (Hendin & Haas, 1991) – a key indicator, not of PTSD, but of moral injury. A research-informed understanding of moral injury and the causes of these invisible injuries is needed, particularly as distress among service members and veterans continues to significantly increase (i.e., deaths by suicide continue to rise; USDVA, 2018). Acknowledging moral injury as a separate trauma-related diagnosis with distinct symptom parameters may increase awareness and understanding of these injuries of the soul for both providers and service members, thus, impacting deserved disability access and proper treatment reimbursement.

Formal Recognition of Moral Injuries

Without a formal diagnosis, treatments for moral injury are unable to be linked to public and private insurance codes, thus, reducing the incentive to treat these injuries. A diagnosis for moral injury increases the likelihood for provider awareness of moral injuries and offers an accurate recognition of symptoms. A formal diagnosis may also increase veterans' willingness to discuss these injuries of the soul in their health care visits, as well as improve accessibility to appropriate treatment and resources.

Depending on the extent of the injury, veterans diagnosed with TBI may be eligible for up to 100% disability rating (USDVA, 2019). A service-connected diagnosis of PTSD also qualifies a veteran for disability benefits, including healthcare, compensation, and treatment (USDVA, 2019). To date, the only diagnosis that even highlights the spiritual implications of moral injury remains a V-code (i.e., V62.89 "Religious or Spiritual Problem"; APA, 2013), which is not a reimbursable code nor qualifies a veteran for disability. Having a formal diagnosis may not only influence insurance coverage but also enhance recognition for disability coverage, including treatment of symptoms that includes evidenced-based practices.

Development of Evidenced-Based Practices

Without a formal diagnosis for moral injury, providers are more likely to fill any gaps in knowledge with best practices for the most closely aligned diagnosis. Therefore, it is not surprising that treatment strategies for healing moral injuries, to date, have primarily been the same approaches utilized for treating PTSD (e.g., cognitive behavioral therapy [CBT]; acceptance and commitment therapy [ACT]; prolonged exposure [PE]; cognitive processing therapy [CPT]; Bryan et al., 2017; Doss et al., 2012; Farnsworth, 2019; Frankfurt & Frazier, 2016; Gray, Nash, & Litz, 2017). Such treatment strategies, and other traditional and

empirically-based treatments for PTSD, may not be sufficient to successfully treat moral injury because of the strong components of guilt and overwhelming shame (Blinka & Harris, 2016; Litz et al., 2009). A primary reason for the continued use of fear-based conceptual and treatment models of trauma is the assumption that fear and anxiety are the core components that lead to post-traumatic stress (Steenkamp et al., 2013). However, because moral injury places a larger emphasis on shame and guilt opposed to fear, researchers believe that approaches for PTSD may not be the best treatment strategies for treatment of moral injury (Blinka & Harris, 2016). Blink and Harris (2016) suggest the shame and self-blame that accompanies violations of one's own moral code requires a different approach to therapeutic intervention.

In order to work toward the development of more effective and empirically supported intervention strategies for moral injury among service members and to prepare and sustain a mission ready force, additional research is needed that explores the impact of such experiences on overall functioning and health of military service members. The following section highlights current gaps in the literature and proposes future directions to be considered when moving forward with moral injury research.

Implications for Future Research

To date, there is a lack of understanding of what constitutes or causes a moral injury (Hodgson & Carey, 2017). As such, the following recommendations are necessary in order to move toward developing empirically-based and practice-informed diagnostic pillars for these injuries of the soul. The first step to studying, identifying, and treating moral injury is better operationalizing the construct. Much of what we know about moral injury is conceptual in nature. Therefore, it is important that future studies be grounded in empirical evidence in order to provide a more accurate operational definition for moral injury. Previous studies have

highlighted this lack of conceptual clarity for moral injury due to the dearth of empirical studies (e.g., Frankfurt et al., 2017; Hodgson & Carey, 2017) – therefore, efforts in broadening our conceptualization of this construct through research with military populations is needed.

Additionally, more research is needed to delineate symptom parameters that differentiates moral injury as a distinct diagnosis separate from other trauma-related conditions (i.e., PTSD, TBI). The APA's goal in developing the DSM was to provide clinicians with an evidenced-based manual to assist with accurate diagnosis of mental health disorders (APA, 2019). Decisions to include particular diagnoses are based on consideration of scientific advances in research, as well as collective clinical knowledge of experts in the field (APA, 2019). Therefore, further clinical research and empirically-validated support from experts in the field of trauma and moral injury is needed in order to move towards developing diagnostic criteria.

Finally, future researchers may benefit from identifying additional populations who face ethical dilemmas that threaten or violate their moral code. Specifically, research exploring the potential morally injurious experiences of first responders, police, and health care providers outside of military contexts is needed in order to generalize diagnostic criteria for the construct. The concept of moral injury was initially developed and studied in the context of military combat (Barnes et al., 2019; Braitman et al., 2018; Currier et al., 2015; Griffin et al., 2019; Koenig, 2018; Stein et al., 2012). However, there is growing recognition that many of these situations also put civilians (e.g., residents/refugees, journalists, military family members) at risk for moral injury (Bryan et al., 2016; Currier et al., 2015; Griffin et al., 2019; Schorr et al., 2018). Occupations outside of the military (e.g., first responders, police, health care providers) can include experiences equivalent to exposures that lead to moral injury (Currier et al., 2015; Griffin et al., 2019; Haight et al., 2016; Murray et al., 2018). Experiences of moral distress and burnout

have been explored extensively among health care professionals (Fry, Harvey, Hurley, & Foley, 2002; Talbot & Dean, 2018). Talbot and Dean (2018) stated "physicians, like combat soldiers, often face a profound and unrecognized threat to their well-being." The morally injurious experiences within health care, however, are not a result of killing another human in the context of war; instead, it is the inability to provide high-quality care and healing for patients that may result in death (Talbot & Dean, 2018). Just as better understanding the experiences of biopsychosocial and spiritual outcomes of moral injury among military populations may help us prepare and sustain a mission ready force, recognizing and acknowledging that other populations outside of the military are continuously being impacted by experiences of moral injury could help ensure the continuation of compassionate and ethical services for our communities.

Conclusion

The purpose of the current review was to highlight the current literature on moral injury in the context of military service members, by differentiating moral injury from other military traumatic stress disorders, including PTSD and TBI, and providing a theoretical exploration of the common injuries to the mind, body, and soul experienced by military personnel. Most of our current understanding of moral injury is conceptual in nature (Smigelsky et al., 2019), and while researchers have attempted to define what constitutes moral injuries, inconsistency in understandings of the construct remains (Richardson et al., 2020). While significant strides have been made for differentiating between diagnostic criteria for common trauma responses impacting service members and veterans since in the 1980s, additional actions in delineating the deeper-rooted morally injurious experiences of military service is needed.

The current authors proposed key steps in moving toward a more holistic understanding of moral injury. Researchers must work to develop a clear operationalized definition with

boundary and symptom parameters that differentiates moral injury as a distinct diagnosis separate from other trauma-related conditions. Then, more can be done to explore morally injurious experiences of individuals outside of military contexts in order to generalize diagnostic criteria for the construct.

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CHAPTER 3: DEFINING MORAL INJURY AMONG MILITARY POPULATIONS: A SYSTEMATIC REVIEW[1]

Background

During combat, military service members may be required to perform acts that would be illegal or violate typical rules of engagement in most other contexts, such as intentionally killing another person (Drescher et al., 2011). Specifically, military personnel are trained to react quickly, with the understanding that they may be called upon to make immediate decisions as part of their duties that could put their own lives at risk, risk the lives of fellow service members, or harm or kill the enemy (Drescher et al., 2011). These experiences often require continuous violations of moral codes to which most people ascribe and may lead to feelings of shame and guilt among service members following their mission or service (Frankfurt & Frazier, 2016; Nazarov et al., 2015). Such intense feelings of shame and guilt affect one's sense of self, and, if unacknowledged, can influence the physical, psychological, spiritual, and social health of individuals impacted by morally jolting experiences.

Experiences of military combat have long been connected to issues of internal conflict, feelings of guilt, and ongoing distress (Friedman, 1981), and findings from recent studies suggest that moral transgressions from the field may serve as an underlying mechanism for the associations between posttraumatic stress and suicidal outcomes, including suicidal ideation, attempts, and deaths (Bryan, Bryan, Morrow, Etienne, & Ray-Sannerud, 2014). These findings highlight a need to better understand the biopsychosocial and spiritual experiences of service members as they relate to issues of morality, and they support the need for the use of *moral*

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injury as a helpful construct to address the wider range of complex and potentially lethal outcomes associated with military combat (Drescher et al., 2011). Drawing from over 20 years of experience working with Vietnam-era veterans, physician–researcher Jonathon Shay was the first to publish material on the phenomenon of moral injury (Blinka & Harris, 2016). In his 1994 book entitled *Achilles in Vietnam: Combat Trauma and the Undoing of Character* (1994), Shay compared Vietnam veterans' experiences to Homer's *Illiad*, stating that his aim was to "put before the public an understanding of catastrophic experiences that not only cause life-long disability but can ruin good character" (p. xiii). In his 2002 book entitled *Odysseus in America: Combat Trauma and the Trials of Homecoming*, Shay highlighted a need to prevent, what he called, "psychological and moral injury in military service" (p. 6).

The high rates of suicide among veterans and service members provide an impetus for addressing issues pertaining to moral injury. The findings from a 2018 report from the U.S. Department of Veteran Affairs (USDVA) revealed that more than 6,000 veterans died by suicide each year from 2008 to 2016 (USDVA, 2018), making suicide the second-leading cause of death among U.S. military personnel (Department of Defense [DoD] Task Force on Prevention of Suicide by Members of the Armed Forces, 2010) compared to the tenth-leading cause of death for nonmilitary individuals in the United States (USDVA, 2018). With the high number of deaths by suicide for service members and veterans, an improved understanding of military experiences is essential. An understanding must build upon recent wartime experience during nontraditional, guerilla warfare, when service members have reported finding it challenging to distinguish between civilians and enemies; examples of such conflicts include the Vietnam War and current operations in Iraq and Afghanistan (Litz et al., 2009). A variety of wartime experiences have challenged even the most resilient service members, yet the symptoms or outcomes associated

with such morally jarring experiences have been largely ignored in published clinical interventions and research, or they have been potentially lumped into other psychiatric diagnoses, such as posttraumatic stress disorder (PTSD). Although it is important to understand the root cause of all forms of military trauma, such as traumatic brain injury or posttraumatic stress, the focus of the present article relates to the need for clarity and an empirically informed definition of moral injury.

For over a decade, researchers have attempted to define moral injury and identify factors that lead to such experiences; however, inconsistency in the understanding of the construct remains, and definitional clarity is needed. Understanding how definitions of moral injury were developed and the ways researchers have come to conceptualize the moral injury construct is a necessary step toward supporting future empirical research. To date, no systematic review of which we are aware has been conducted to specifically explore how moral injury is defined in relation to service members or veterans. As such, the purpose of the present article was to conduct a systematic review to answer the following research question: What are the operational definitions for moral injury within military service members and veteran populations?

Method

Procedures

Cooper's (2010) approach to research synthesis and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Moher, Liberati, Tetzlaff, Altman, & The PRISMA Group, 2009) guidelines provided the methodological framework and reporting procedures for the current review. Search strategy, study selection, data extraction, and analyses were performed according to a predefined protocol outlined by the PRISMA framework (Moher et al., 2009).

Article Search

The present search included four databases: PsycINFO via EBSCOhost, PubMed via Medline, CINAHL, and Military Database via ProQuest. These databases were selected based on their foci on psychology, allied health, and military research, respectively. The search process included the following search terms: *moral injury, moral injuries, morally injurious, moral repair, moral dilemma, moral distress, and morals.* Each of these search terms was paired with military-related terms, including *military, military personnel, service member, active duty, veteran(s), Army, Navy, Air Force, Marine(s), Airmen, Armed Force(s), Coast Guard, National Guard, Reserve(s), submariner(s), sailor(s),* and *soldier(s).* To help narrow the search process, we applied filters, including: (a) English, (b) peer-reviewed, (c) humans, (d) journals, and (e) all searches. To be included in the review, articles had to have been published in English and include (a) moral injury or related concepts, as listed earlier, and (b) military populations of individuals who were at least 18 years of age and older. No specific exclusion criteria, other than the exclusion of books, case studies, opinion pieces, systematic reviews, dissertations, or conference proceedings, were initially employed as part of the search process.

Article Selection

Article titles and abstracts were screened to determine if they were relevant for the current review. Articles that met the inclusion criteria and were deemed relevant based on the initial review underwent a full-text review to determine eligibility. Articles that provided definitions for *moral injury* or *potentially morally injurious experiences/events* in the context of military experiences were included. Two reviewers conducted the screening procedures independently to establish interrater reliability. The primary reviewer (first author) reviewed a random selection of approximately 65% of the eligible full-text articles, and the secondary

reviewer (third author) analyzed the other 35% of the eligible full-text articles. Fidelity checks, with 90% interrater reliability, that involved reviewing 10 full-text articles simultaneously, were performed during the initial review process and again periodically throughout the review process to ensure reliability and trustworthiness between reviewers. If eligibility of an article was unclear, the inclusion and exclusion was resolved through reviewer discussion. Only two of the 20 total fidelity checks necessitated further discussion until consensus between reviewers regarding inclusion or exclusion was reached. After all the articles were reviewed, the reference lists of the included articles were reviewed to capture any additional articles that may have fit the inclusion criteria.

Method of Analysis

After articles were screened for inclusion and exclusion criteria and key definitions were extracted from the literature, two analyses were conducted in parallel with one another. They were (a) a thematic analysis of the key definitions found within the included articles and (b) assignation of quality rankings, which were given based on the empirical support of each of the included articles. For the initial analysis, all cited definitions of moral injury and related concepts, such as morally injurious experiences and potentially morally injurious experiences, were extracted from each of the included articles by reviewing each article in full. To provide definitional clarity for moral injury, thematic analysis (Braun & Clarke, 2006) procedures were used to code themes within and across key definitions found within the included articles. The authors generated initial codes and themes separately and came together for consensus, using the definitions listed in Table 1 to guide the analysis. A secondary analysis, which occurred simultaneously, was employed to determine how moral injury and related constructs were being

explored within the included articles. Thus, quality rankings were assigned to help clarify the empirical support for research pertaining to moral injury.

Quality rankings ranged from 1, whereby a brief definition of moral injury appeared somewhere in the article but there was no further mention or support, to 5, whereby the article was empirical in nature but did not necessarily incorporate empirical support of a definition of moral injury. A quality ranking of 5 was assigned to empirical articles (n = 28) that explored moral injury as the outcome variable, thus providing more evidence for what constitutes a moral injury; empirical articles with moral injury as a predictor variable were assigned a ranking of 4 (n = 38). Although these articles helped us to better understand possible outcomes that may be associated with morally injurious events, such as suicidal ideation, depression, substance use, self-injury, psychosocial issues, anxiety, and existential issues, they provided little information that aided in the operational definition of the construct, including how it was defined or what constituted such an injury. A quality ranking of 3 was assigned to literature reviews and conceptual papers with a primary focus on moral injury (n = 28), whereas a ranking of 2 was assigned to 22 articles that provided only a brief description of moral injury regardless of the study design. Finally, articles that provided only a definition of moral injury with no description were given a 1 ranking (n = 8).

Once all decisions regarding the quality rankings were made, it became clear that there was a dearth of empirically designed research studies that had been conducted on moral injury—that is, there was little empirical support for the definition of moral injury or for moral injury as an outcome variable. An additional analysis of methodological design was conducted on all of the articles with a 5 ranking, as these articles were deemed to have the most rigorous evidence associated with a definition of moral injury and, collectively, they would most likely shape the

future research implications from this systematic review. The demographic information reported and assessment methods used in these articles were reviewed in order to identify the studies' samples, designs, and processes for constructing definitions of moral injury. The articles assigned a quality ranking of 1 through 4 were not included in the final analysis because we did not find that these articles provided the necessary details (e.g., they lacked psychometric rigor or a cited definition) to support a research-informed definition of moral injury.

Results

An initial search of the literature conducted between May 2018 and August 2018 yielded a total of 3,089 results. The full search strategy was conducted through a PRISMA flowchart (Moher et al., 2009; see Figure 1). After duplicates were removed, the titles and abstracts of 2,934 articles were screened for eligibility by the two reviewers. A total of 141 articles were reviewed in full for population criteria, type of publication, and the inclusion of moral injury or related concepts. Initially, 102 articles met the inclusion criteria; however, after an in-depth review, both reviewers agreed to omit 12 articles from the analysis because they merely mentioned moral injury without providing a definition or explanation. There were 90 studies that remained and were included in the initial review. In anticipation of a series of special issue publications on moral injury in 2019, a follow-up review was conducted in July 2019 to capture articles with more recent publication dates; this review yielded an additional 34 articles that met the initial inclusion criteria. Therefore, a total of 124 articles were included in the final review.

Defining Moral Injury

After reviewing the full text of the identified 124 articles, variance emerged in the way moral injury was defined across the data. There were 12 different definitions of moral injury cited throughout the included articles (Table 1). The definition that emerged most frequently was

that constructed by Litz and colleagues (2009) and described morally injurious experiences as "perpetrating, failing to prevent, and bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" (p. 697). Of the 124 included articles, 96 cited Litz et al. (2009) when defining moral injury. Eighteen articles cited Shay's (2014) definition of moral injury, defining it as "a betrayal of what's right by someone who holds legitimate authority (e.g., in the military-a leader) in a high stakes situation" (p. 183). An additional 17 articles included a definition by Drescher and colleagues (2011), which describes a moral injury as a "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" (p. 9). Drescher and colleagues' (2011) definition also stipulates that the "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 pain, suffering, or death of others" (p. 9). The fourth most common definition, cited within 10 articles, was also from the works of Shay (1994) and defines moral injury as an "'undoing of character' that results from witnessing or participating in acts that transgress against the moral values they were raised with" (p.104). Five articles cited Shay (2011), who provided an additional definition of moral injury in his later works, describing moral injury as a "betrayal of what's right by someone who holds legitimate authority in a high stakes situation" (p. 183). It is important to note that three of the most frequently cited definitions for moral injury were provided from original works by Jonathan Shay; although these definitions overlap with one another, we chose to list these as distinct definitions because of the minor differences and multiple articles within the review that used them as separate citations. Five additional articles cited Jinkerson (2016), who defined potentially morally injurious experiences as "a particular trauma syndrome including

psychological, existential, behavioral, and interpersonal issues that emerge following perceived violations of deep moral beliefs by oneself or trusted individuals (i.e., morally injurious experiences)" (p. 126).

Six of the 12 definitions found across the articles were cited three times or fewer. Definitions taken from Brock and Lettini (2013), Gray and colleagues (2012), Shay (2002), and Stein and colleagues (2012) were each cited in three articles. Brock and Lettini (2013) define moral injury as "a deep sense of transgression including feelings of shame, grief, meaninglessness, and remorse from having violated core moral belief" (p. xiv), whereas the definition by Gray et al. (2012) describes moral injury as "a term used to describe a syndrome of shame, self-handicapping, anger, and demoralization that occurs when deeply held beliefs and expectations about moral and ethical conduct are transgressed" (p. 408). Similar to his previous definitions, Shay (2002) defined moral injury in his 2002 book, *Odysseus in America: Combat Trauma and the Trials of Homecoming*, as "betrayal of 'what's right' in a high stakes situation by someone who holds power" (p. 240). Stein and colleagues' (2012) definitions of moral injury by self and moral injury by others were cited by three articles. They defined moral injury by self as "committing an act that is perceived to be a gross violation of moral or ethical standards (e.g., killing or injuring others, rape, atrocities)", whereas moral injury by others was defined as "witnessing or being victim of an act that perceived to be gross violation of moral or ethical standards (e.g., killing or injuring civilians, rape, atrocities, betrayal" (p. 802). One article cited Farnsworth and colleagues' (2017) definition of moral injury, stating that moral injuries include "expanded additional psychological, social, and spiritual suffering stemming from costly dysfunctional and or unworkable attempts to manage, control, or cope with the experience of moral pain" (p. 395). A final definition by Nash and Litz (2013), which was used in one included

article, defines a moral injury as "the consequence of a challenge to moral belief systems that exceeds the information- processing capacity of the person at their current stage of development, given available social and spiritual resources" (p. 370).

Definitional Themes

Nine themes emerged through a thematic analysis (Braun & Clarke, 2006) across all definitions. Operational descriptions and frequencies for each of the key definitional themes are provided herein.

Ethics. A primary theme of ethics was described as expectations of "right" and "wrong." We found two subthemes for operationalizing ethics: personal ethics and general ethics. Eight definitions discussed transgressions of personal beliefs or intrapersonal expectations of justice and fairness toward others (i.e., Brock & Lettini, 2013; Drescher et al., 2011; Gray et al., 2012, Jinkerson, 2016; Litz et al., 2009; Nash & Litz, 2013; Shay, 1994; Stein et al., 2012). These definitions suggested that moral injury is a result of ethical dilemmas that arise due to subjective beliefs. Three definitions (i.e., Shay, 2002, 2011, 2014) included more general ethical violations as the root of moral injury, or a disruption in one's belief about "what's right."

Betrayal. Almost all the definitions highlighted a sense of betrayal at either the intrapersonal or interpersonal level, with some suggesting that both occur simultaneously. Eleven definitions included descriptions of moral injury as an intrapersonal betrayal or violation of one's core values or personal belief system based on the rules and values by which one was raised with (i.e., Brock & Lettini, 2013; Drescher et al., 2011; Gray et al., 2012; Jinkerson, 2016; Litz et al., 2009; Nash & Litz, 2013; Shay, 1994, 2002, 2011, 2014; Stein et al., 2012). These definitions included descriptions of extreme disruptions, violations, and transgressions of moral beliefs and core intrapersonal values. Additionally, we found that eight of the definitions of moral injury

included a sense of interpersonal betrayal either against another individual or from an authority figure. Four definitions included the betrayal by an authority figure (e.g., military leader or command) as one of the primary elements for meeting criteria for moral injury. Two definitions (i.e., Shay, 2011, 2014) described moral injury as a betrayal by an individual who holds "legitimate authority," whereas Shay (2002) suggested the violation is perpetuated by someone who holds "power" during a "high-stakes situation." Jinkerson (2016) described these authority figures as "trusted individuals" who violated moral expectations. These definitions suggest that there was another layer of interpersonal betrayal occurring. This more complex layer of interpersonal betrayal may be a result of requirements associated with one's position (e.g., forced to exert power or authority over others whereby a decision or action was implemented that then resulted in a moral injury). As an example, one's values may be violated due to hierarchical expectations placed upon them, orders they are asked to carry out, or by learning about moral transgressions conducted by trusted authority figures.

Interestingly, five of the cited definitions (i.e., Drescher et al., 2009; Jinkerson, 2016; Litz et al., 2009; Shay, 1994; Stein et al., 2012) hinted at an association between intrapersonal and interpersonal betrayal, stating that the intrapersonal wound was brought about by the interpersonal engagement that betrayed one's sense of right versus wrong. For example, Jinkerson (2016) defined moral injury as a "trauma syndrome" that emerges from "perceived violations of deep moral beliefs" (intrapersonal betrayal) "by oneself or trusted individuals" (interpersonal betrayal).

Orientation. Themes related to the origin, or root cause, of moral injuries emerged in 11 of the definitions, suggesting that moral injury is a result of either (a) ones' own perception or meaning of morality and beliefs (i.e., *perception-oriented*) or (b) one's encounter with a morally

injurious event (*action-oriented*). Four definitions included specific events that are likely to result in moral injury, including "bearing witness to perceived immoral acts, failure to stop such actions, or perpetration of immoral acts" (Drescher et al., 2011). The additional seven articles that hinted at orientation did not specifically state that an act or event must take place but rather that moral injuries may occur based on how an experience or dilemma is personally perceived. This conflict in subthemes suggests a lack of clarity about what leads to a moral injury and whether a specific act or event must have occurred (i.e., perpetrating vs. witnessed or learned about).

Reconciliation. Three definitions included themes related to restoring one's own belief system after violations have occurred. For example, definitions suggested that moral injury stems from "unworkable attempts to manage, control, or cope" (Farnsworth et al., 2017) with the pain "that exceeds the information-processing capacity" (Nash & Litz, 2013) of the individuals and leads to the "undoing of character" (Shay, 1994), suggesting that it is not just the violation of values or ethical transgression that leads to moral injury but also the inability to cope or make sense of one's experience that may exacerbate the depth of such wounds.

High-stress environment. In Shay's (2002, 2011, 2014) description of moral injury, he suggests that moral injury takes places in a "high-stakes" environment. This theme emphasizes the urgency behind decisions that may lead to moral injury; however, only three of the 12 cited definitions, all of which were developed by Shay, included this qualification, suggesting that a high-stress environment may not be the only circumstance that cultivates moral injuries.

Spiritual wound. Four definitions described moral injury as having spiritual or existential suffering, likely resulting from the intrapersonal crisis of personal values and belief systems (i.e., Farnsworth et al., 2017; Gray et al., 2012; Jinkerson, 2016; Nash & Litz, 2013).

Jinkerson (2016) suggests that existential issues "emerge following the perceived violations of deep moral beliefs," emphasizing that when one's core value or belief system is disrupted, the wound is inflicted at a higher, existential level, making it difficult for an individual to make meaning or sense of the world around them.

Psycho-behavioral wound. Four definitions provided specific emotions or behavioral challenges characterized by moral injury (i.e., Brock & Lettini, 2013; Farnsworth et al., 2017; Gray et al., 2012; Jinkerson, 2016). In addition to the existential challenges that may arise from moral injuries, experiences of guilt, shame, meaninglessness, remorse, anger, self-handicapping, demoralization, and social and behavioral issues were all highlighted within key definitions as potential symptoms or outcomes associated with this type of injury.

Summary of the Thematic Analysis

The thematic analysis conducted as part of this systematic review provided an examination into key themes that emerged from the 12 cited definitions from across the 124 included articles. Using the 12 most-cited definitions for moral injury found within the literature, nine definitional themes emerged from the data. These findings, outlined earlier, suggest that moral injury includes a sense of perceived betrayal unto others, within self, and/or by an authority figure, that violates personal values and ethics and may result in spiritual and/or psychobehavioral wounds if reconciliation cannot be achieved. Nine themes embedded within just 12 definitions—a seemingly large number of qualitative themes based on a relatively small data set—confirmed that moral injury has a multifaceted definition at best and was a definitionally confusing construct at worse. Thus, we felt that a necessary second step (i.e., employing quality rankings) was needed to determine what empirical support existed for the definition of moral injury; that is, does a research-informed definition exist?

Quality rankings were assigned to each article, as described in the Method section, and, as a result, it emerged that only two of the key definitions for moral injury included empirical evidence to support the definition as part of the original article when initially developed (e.g., Drescher et al., 2011; Stein et al., 2012). Drescher et al. (2011) evaluated their working definition of moral injury using semi-structured interviews with chaplains, mental health providers, academic researchers, and policymakers with knowledge of and experience working with military service personnel or combat veterans. Their findings suggested a general consensus among professionals of the usefulness of the moral injury construct for better addressing the complex consequences of combat for many service members. Although participants identified moral injury as a useful and needed construct, all participants suggested that changes needed to be made to the definition provided by Drescher and colleagues (2011).

Stein and colleagues (2012) reviewed structured clinical interviews of 122 active duty service members, which yielded two distinct categories of moral injury experienced by participants. The following were included as part of a categorization scheme of military-related traumatic experiences: moral injury by self (i.e., committing an act that violates moral or ethical standards) and moral injury by others (i.e., witnessing, being the victim of, or indirectly experiencing an act that violates moral or ethical standards). Significant differences were found between the two types of moral injury, as moral injury by self was found to be the better predictor of two aspects of guilt (i.e., hindsight bias and responsibility and wrongdoing) as well as re-experiencing symptoms (Stein et al., 2012).

Although only two studies had empirical support for their definition of moral injury, rigorous empirical studies, which we assigned a ranking of 5, provided additional insight into how previous researchers have attempted to understand what is known and what has yet to be

understood about moral injury. We explored the samples and research designs of empirical studies that incorporated moral injury as an outcome variable. The aims of this process were to (a) discern if service members and veterans were engaged in the construction of the definition of moral injury, maximizing face validity of the construct, and (b) better understand past researchers' methods and designs for defining moral injury. A description of the sampling and research design of the empirically based articles (i.e., those with a quality ranking of 5) in which moral injury was an outcome variable are provided herein.

Characteristics of Empirical Studies: A Deeper Look into Articles Given a Quality Ranking of 5

Given the limited number of articles that included an empirically supported definition of moral injury (n = 2), we determined that a review of other empirically supported articles pertaining to moral injury was needed (i.e., those with a quality ranking of 5) for the advancement of moral injury research. Therefore, we analyzed the sampling and methodological design used in these 28 articles as we found them to be most tightly tied with a definition or understanding for the make-up of moral injury.

Publication dates for included articles ranged from 2011 to 2019. Sample sizes ranged from 8 to 5,227 participants (Mdn = 2,617.5), with men representing a majority of the population (82.5%) used to explore moral injury; details related to population demographics and methodological approaches are presented in the Supplemental Materials. Of the articles that reported information regarding military service branch (n = 16), participants from the U.S. Army (35.4%) were most frequently represented, with 18.3% representing Navy personnel, 18.1% for the Air Force, 16.4% for the National Guard, 13.8 for the Marine Corps, and less than 1% representation for U.S. Reservists, U.S. Coast Guard, and Dutch Infantry, respectively.

All articles included populations with experience with military service either directly through their personal service or indirectly as professionals working with military personnel. Articles with quantitative procedures (n = 17), including psychometric analyses, collected data from U.S. veteran populations (i.e., Braitman et al., 2018; Currier, Foster, & Isaak, 2019; Currier, Holland, Drescher, & Foy, 2015; Currier et al., 2018; Forkus, Breines, & Weiss, 2019; Frankfurt et al., 2018; Lancaster & Harris, 2018; Richardson et al., 2019; Smigelsky, Mallot, Veazey Morris, Berlin, & Neimeyer, 2019), both veterans and active duty personnel (i.e., Battles et al., 2018; C. Bryan et al., 2016; Koenig et al., 2018a, 2018b; Litz et al., 2018), active duty Marines (i.e., Nash et al., 2013), or members of the National Guard/Reserves (i.e., C. Bryan, Bryan, Roberge, Leifker, & Rozek, 2018). Additionally, Battaglia et al. (2019) used quantitative analyses with a sample of participants from the Canadian Armed Forces. Mixed-method approaches were utilized in three of the articles (i.e., Frankfurt, Frazier, & Engdahl, 2017; Stein et al., 2012; Sun et al., 2019), which explored moral injury in 216 U.S. veterans and 122 active duty personnel.

Of the top-ranked articles, eight explored moral injury through qualitative approaches, such as semistructured interviews and focus groups, with U.S. veterans, chaplains, and other professionals or clinicians working directly with U.S. military personnel (Drescher et al., 2011, 2018; Gibbons, Shafer, Hickling, & Ramsey, 2013; Held et al., 2018; Schorr et al., 2018; Sullivan & Starnino, 2019; Yeterian et al., 2019). Additionally, Molendijk (2019) used qualitative semi-structured interviews to capture the lived experienced of 80 Dutch Infantry veterans.

With just 28 empirical studies that direc1tly explored the definition of or experiences related to moral injury, there is a clear dearth of empirical support to guide the causes and

definition of moral injury and the intrapersonal implications of such experiences. In fact, we found that, of the 28 articles with the highest quality ranking, only five included designs with aims that intentionally sought to provide better a understanding of or clarity for an operational definition of moral injury (i.e., Drescher et al., 2011, 2018; Stein et al., 2012; Sullivan & Starnino, 2019; Yeterian et al., 2019). Of these five studies, four of which were qualitative in nature and one of which had a mixed-method design, only two were conducted directly with service members or veterans (i.e., Stein et al., 2012; Sullivan & Starnino, 2019). The demographics information, designs, and aims of the empirically based studies highlight the need for more empirical support in larger samples of diverse military populations as well as rigorous research designs to strengthen the definition of moral injury. Specifically, more information is needed from female service members and active duty military personnel and better representation is needed from all branches of the military.

Discussion

The aim of the present systematic review was to examine how moral injury has been defined in military populations and conceptualized within the current literature. Among the 124 articles that met the initial inclusion criteria, 12 key definitions were cited across the literature, with themes related to ethics, betrayal, and issues of reconciliation. We found that contradictions for the origin of moral injury remain, as some definitions suggest that a specific event or high-stress environment is the foundation of such injuries, whereas others implicate one's beliefs or perspective on morality as the origin or cause of these wounds. With nine different themes found in just 12 key definitions, it is apparent that a lack of consistency exists in how moral injury is being defined and understood across the literature.

The gap in empirical evidence informing the conceptualization of moral injury was made evident through this systematic review. The most widely used citations for defining moral injury either lacked empirical support when initially constructed (e.g., data-driven or psychometric properties) or relied on provider or professional perspectives rather than the voices of service members or veterans. The present findings do not suggest that the definitions of moral injury that currently exist are inaccurate or misguided. Instead, a key next step to strengthen the face validity and reliability of a definition is to test the themes that have emerged through previous definitions in samples of service member and veteran stakeholders to discern a credible reflection of their experiences and ensure other key elements related to moral injury are not disregarded.

To further strengthen the need for service member and Veteran voices, A. Bryan and colleagues (2014) suggested that as research on moral injury continues to grow, so too will our understanding of the conditions and circumstances under which this particular form of internal distress occurs. Much of what we know about the definition of moral injury has come from the perspectives of professionals who work with service members (i.e., chaplains, mental health providers, medical providers). These professionals are a helpful starting point as they often serve on the "front line" of biopsychosocial and spiritual health for our men and women in uniform; however, these perspectives merely provide objective viewpoints of what has been heard about what seems to be a subjective personal wound experienced by others. When developing a research-informed understanding of moral injury, it is necessary to highlight the need for samples that include the voices of service members and/or veterans themselves. Giving voice to the experiences that likely have been silenced many for decades is an important next step toward solidifying definitional clarity.

It is possible that future research with service member and veteran populations could confirm or deny the fit of any previously cited definition based on participants' aggregate experiences. The definition by Litz et al., (2009) has clearly been meaningful to many researchers, as it has been cited in multiple publications. However, it is quite possible that key elements of moral injury have been overlooked by this definition. For example, Litz et al. (2009) do not explicitly mention betrayal, although this was one of the most commonly found themes across many of the other definitions within this systematic review.

Other researchers have taken strides to incorporate empirical support for their definitions (e.g., Drescher et al., 2011; Stein et al., 2012). Rather than relying on service members and veterans as the source to define the concept or moral injury, Drescher et al. (2011) formed their definition based on the perspective of professionals who treat service members or veterans. As such, researchers could build on Drescher's research to discern whether service members or veterans align with these previous findings. Stein and colleagues (2012) conducted an empirical study that focused on traumatic military events, and two schemas pertaining to moral injury emerged; however, the study was based on a review of clinical records rather than a direct sampling about moral injury in service members or veterans. The articles by both Drescher et al. (2011) and Stein et al (2012) are important contributions, yet their impact may be further enhanced by considering the findings in tandem with the nine themes that emerged in this systematic review. Implementing a study that honors all previous definitions of moral injury by testing the themes through a rigorous research design, conducted in military populations that are diverse in gender, rank, job duty, and branch, would strengthen the legitimacy and clarity of a definition.

Ultimately, an empirically supported definition would strengthen face validity and reliability for scientists and practitioners who seek to incorporate moral injury into future studies or clinical programs. An operational definition would advance the understanding of moral injury when developing measures or assessments for research and practice. So much is still unknown about the soul-ceasing and, perhaps, life-ending experiences that service members and veterans have endured. Work pertaining to the definition of moral injury is needed to strengthen the rigor, validity, and credibility for what many describe as morally injurious. Future researchers owe it to current and future service members as well as veterans to attend to the intra- and interpersonal complexities of their military service. The largest contribution of the present article is the intentional focus on the need for a clear and empirically supported definition of moral injury that may ultimately influence future research in service members and Veteran populations as well as research-informed clinical interventions.

Although the current review provides important contributions to the literature, there are limitations worth mentioning. This research was specifically focused on military and veteran populations, but it is critical to note that moral injury is not unique to these populations. Future researchers should explore a similar analysis related to the experiences of moral injury among other groups that are commonly predisposed to traumatic stress. Although the method and analysis of the systematic review were thorough, it is possible that some articles that would have met inclusion criteria were overlooked as we chose only four of the largest search engines out of numerous possible search engine options.

The findings of this systematic review help to untangle the definitions of moral injury that currently exist for moral injury with regard to military populations and punctuate the need for an empirically supported, operational definition. Having definitional clarity gives legitimacy

to the construct, particularly for service members who struggle to put into words to their experiences. Furthermore, definitional clarity can strengthen future research studies that seek to learn more about moral injury in contrast to other military-related injuries or traumas. Our service members and veterans deserve to know that researchers have done their due diligence to properly define moral injury rather than blindly applying an untested term or description to their lives. A research-informed definition can dually assist researchers who may be curious about the elements of trauma that are not otherwise accounted for and clinicians who notice a theme in client language that does not align with other trauma-based diagnoses. Ultimately, the next steps for moving toward an empirically supported definition of moral injury are within the reach of researchers who recognize the important need of this endeavor.

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Table 1

Cited Definitions of Moral Injury

Citation	Definition	Number of articles with citation for definition (*n*)	Cited term in included articles (*n*)		Originally defined by primary source as:	Quality ranking[a]
			MI	PMIEs		
Litz et al., 2009	"…perpetrating, failing to prevent, and bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations."	96	73	23	morally injurious experiences	3
Shay, 2014	"…a betrayal of what's right; by someone who holds legitimate authority (e.g., in the military—a leader); in a high stakes situation."	18[b]	17		MI	3
Drescher et al., 2011	"…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 pain, suffering, or death of others."	17	11	6	MI	5

Shay, 1994 ‘	"…‘undoing of character’ that results from witnessing or participating in acts that transgress against the moral values they were raised with."	10	10		MI	N/A
Shay, 2011	“… betrayal of what’s right by someone who holds legitimate authority in a high stakes situation.”	5	5		MI	2
Jinkerson, 2016	“…a particular trauma syndrome including psychological, existential, behavioral, and interpersonal issues that emerge following perceived violations of deep moral beliefs by oneself or trusted individuals (i.e., morally injurious experiences).”	5	2	3	MI	3
Brock & Lettini, 2013	“…a deep sense of transgression including feelings of shame, grief, meaninglessness, and remorse from having violated core moral belief.”	3	3		MI	N/A
Gray et al., 2012	“…a term used to describe a syndrome of shame, self-handicapping, anger, and demoralization that occurs when deeply held beliefs and expectations about moral and ethical conduct are transgressed.”	3	3		MI	3
Shay, 2002	“… betrayal of 'what's right' in a high stakes situation by someone who holds power.”	3	3		MI	N/A

Stein et al., 2012	"[Committing] OR [Witnessing or being the victim of] an act that is perceived to be a gross violation of moral or ethical standards (e.g., killing or injuring others/civilians, rape, atrocities, [betrayal])."	3	2[c]	1	MI by self/others	5
Farnsworth et al., 2017	"…expanded additional psychological, social, and spiritual suffering stemming from costly dysfunctional and or unworkable attempts to manage, control, or cope with the experience of moral pain."	1	1		MI	3
Nash & Litz, 2013	"…the consequence of a challenge to moral belief systems that exceeds the information- processing capacity of the person at their current stage of development, given available social and spiritual resources."	1	1		MI	3

Note. MI = moral injury; PMIEs = potentially morally injurious experiences; N/A = nonapplicable.

[a]1 = definition only; 2 = definition plus description of moral injury (MI)/PMIE; 3 = literature review/conceptual paper on moral injury; 4 = empirical study related to moral injury (MI not the primary focus); 5 = empirical study that included outcomes or psychometric properties to inform the definition of moral injury; N/A = included books that were not included in analysis because they did not meet inclusion criteria for the review.

[b]One article cited a tertiary citation of Shay (2014). [c]Defined as MI by self/others.

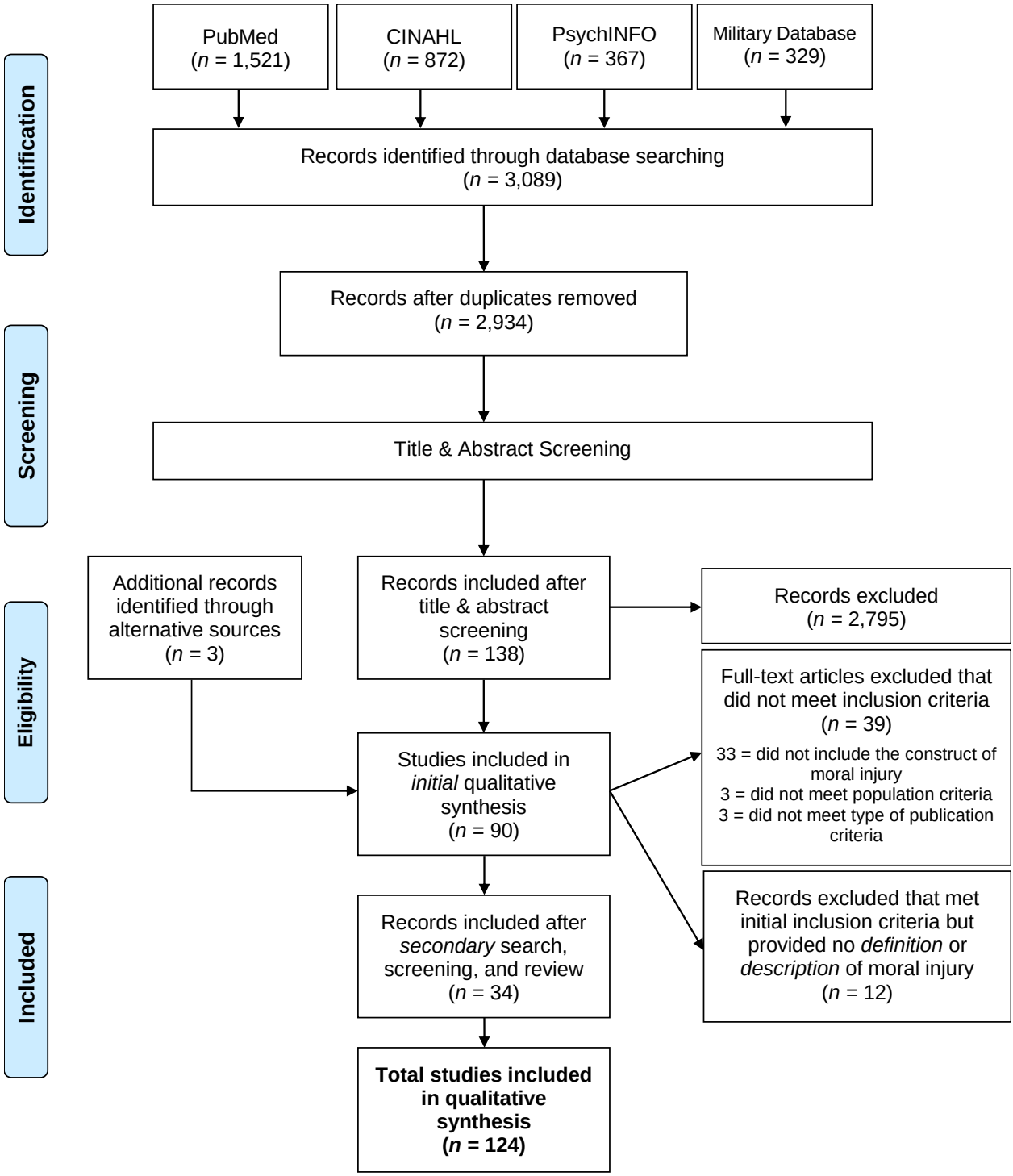

Figure 1. PRISMA flowchart of systematic review process.

CHAPTER 4: METHOD

Background

During military service, service members may be required to perform acts that would be considered illegal or in violation of typical rules of engagement in most other contexts (e.g., intentionally killing another person; Drescher et al., 2011). Training for military personnel involves the understanding that one may be called upon to make immediate decisions that could put their own lives at risk, risk the lives of fellow service members, or harm or kill the enemy as part of their duties (Drescher et al., 2011). These experiences require continuous violations of moral codes that most people (as civilians) ascribe to and often lead to feelings of intense shame and guilt among service members (Frankfurt & Frazier, 2016; Nazarov et al., 2015). Such intense feelings of shame and guilt affect one's sense of self, and if unacknowledged, can ultimately influence the psychological, spiritual, and social health of those impacted by such morally jolting experiences.

Defining Moral Injury

The biological, emotional, spiritual, and psychological wounds that stem from the moral challenges of military combat are often misunderstood and have the potential to produce ongoing inner conflict for service members and veterans (Drescher et al., 2011). Over time, continuous internal conflict can manifest as deep biopsychosocial or spiritual consequences, including distress related to personal safety (Drescher et al., 2011). These deep seeded issues may go unacknowledged, undiagnosed, and untreated because of a lack of understanding of what constitutes a morally injurious act and the unique biopsychosocial- spiritual symptomology of such experiences.

In order to more fully address the invisible wounds of military experiences, researchers are becoming increasingly interested in the construct of *moral injury* (Shay, 2002). Moral injury attempts to more accurately and completely capture the experiences that violate the personal values of a one's moral code, as well as the constellation of guilt, shame, and changes in meaning making. Such ethical affronts, ambiguous feelings, and spiritual afflictions can make it difficult for service members and veterans to forgive and trust themselves or others during or after service (Currier, Holland, & Malott, 2015; Drescher et al., 2011; Vargas, Hanson, Kraus, Drescher, & Foy, 2013). A systematic review exploring how moral injury has been defined across the academic literature highlighted a dearth of empirical support that aids in a conceptual understanding of the root causes of moral injury (Richardson et al., 2020). Previous researchers have also highlighted this lack of conceptual clarity for moral injury (e.g., Frankfurt et al., 2017; Hodgson & Carey, 2017) – therefore, efforts in clarifying the conceptualization of moral injury through research with service members and veterans is needed in order to more holistically understand the biopsychosocial and spiritual implications of such injuries.

While researchers have attempted to define what constitutes a morally injurious experience, inconsistency in the understanding of this construct remains (Richardson et al., 2020). To date, the most widely used definition for moral injury among researchers and mental health providers was developed by Litz and colleagues (2009) to capture the shame and guilt-based disturbances that many veterans experience after engaging in wartime acts. Litz et al. (2009) defined morally injurious experiences as, "events in which an individual perpetrates, fails to prevent, bears witness to, or learns about acts that transgress deeply held moral beliefs and experiences" (p. 700).

A research-informed understanding of moral injury and the causes of these invisible injuries is needed, particularly as distress among service members and veterans continues to significantly increase (i.e., deaths by suicide continue to rise; United States Department of Veteran Affairs [USDA], 2018). With approximately 20 deaths by suicide occurring daily among veterans (USDA, 2018), it is imperative that we explore the experiences associated with shame and guilt experienced by service members in order to better understand the psychological, emotional, spiritual, and ethical challenges that these individuals experience as they return home to their families.

Seeking Conceptual Clarity

Because the literature on moral injury is relatively young, a consensus on what moral injury entails is limited, likely resulting in moral injury being masked by a diagnosis of posttraumatic stress disorder (PTSD; Hodgson & Carey, 2017). This masking risks experiences of unresolved guilt and shame, symptoms that separate moral injury from PTSD (Bryan et al., 2017), to go unacknowledged and untreated. Therefore, it is necessary to differentiate between moral injury and other trauma-related diagnoses, so clinicians can appropriately tailor services and treatment strategies to meet the unique needs of service members returning from combat. Because of the proposed overlap of symptomology between moral injury and PTSD (Drescher et al., 2011; Litz et al., 2009; Maguen & Litz, 2012; Shay, 2014), it is conceivable that experiences of moral injury and its impact on biopsychosocial-spiritual and relational health may parallel the experiences of service members returning from combat with PTSD. However, because of the unique qualities that have been cited in the literature to distinguish moral injury as a separate construct (Drescher et al., 2013; Litz et al., 2009; Maguen & Litz, 2012; Shay, 2014), there are likely distinct intrapersonal and systemic outcomes that differ from PTSD for service members

and veterans. Therefore, it is imperative that a research-informed investigation of moral injury include an understanding of the distinct nature of PTSD in order to discern the unique biological, psychological, relational, and spiritual outcomes and symptoms that could accompany moral injuries.

A major step in understanding the parameters of moral injury is to better operationalize the definition of moral injury and more accurately and clearly describe its impact on those who experience its effects. A more accurate definition grounded in empirical support could aid in conceptual clarity for moral injuries, which in turn would allow professionals to more appropriately acknowledge and treat the deeper wounds associated with military experiences. In order to develop more effective and empirically supported identification and intervention strategies for morally injured service members and veterans and to prepare and sustain a mission-ready military force, additional research is needed that explores the definition, signs and symptoms, and impact of moral injury on the overall functioning and health of service members. To date, few studies have explored the phenomenon of moral injury directly with service members or veterans. Therefore, the current authors believed a most purposeful step was to conduct a qualitative study using a phenomenological theoretical approach to explore the morally injurious experiences of military service with veterans. Thus, the purpose of the study was to gain clarity about the morally injurious experiences and deeper wounds associated with military service. Our hope was to expand the current understanding of moral injury by providing a more accurate definition and conceptualization of the construct and associated experiences through the lived experiences of veterans.

Study Design

While researchers have attempted to define moral injury and what leads to such experiences, an inconsistency in the understanding and absence of a research-informed definition of the construct remains. Due to a lack of theoretical understanding and research-informed definition of moral injury and the complexity of the construct, a flexible inductive qualitative process was needed to gain insight into such injuries. Further, the proposed qualitative study used a phenomenological design to better understand the meaning-making experiences of U.S. veterans and their beliefs, values, and morally challenging experiences related to service. Colaizzi (1973) states: "Without thereby first disclosing the foundations of a phenomenon, no progress whatsoever can be made concerning it, not even a first faltering step can be taken towards it, by science or by any other kind of cognition" (p. 28). Thus, the phenomenological designed study allowed researchers to, "discover and describe the meaning or essence of participants' lived experiences and knowledge as it appears to consciousness" (Hays & Singh, 2012, p. 50). The overarching research question that guided this phenomenological exploration was: *How do U.S. military veterans describe and make meaning of the morally challenging experiences associated with their military service?*

Qualitative Phenomenological Approach

According to Husserl (1970), phenomenology is a method which allows us to explore a phenomenon as it actually occurs and is experienced. A phenomenological study emphasizes the shared experience and meaning but does not ignore perspectives and experiences that do not fit or that are unique or different from the predominant pattern. Phenomenology attempts to describe a common meaning of the lived experiences of individuals by exploring a particular concept or phenomenon (Creswell & Poth, 2018). Drawing heavily on the works by Edmund

Husserl (1856-1938) and refined by successors with diverging epistemologies in the twenty-first century, phenomenology has emerged and continues to serve as an important approach into human sciences research (Dowling, 2007; Moustakas, 1994; Wojnar & Swanson, 2007). Exploring a phenomenon requires researchers to suspend all judgments about what they know as "real" until assumptions are grounded on a more certain basis, confirmed through the lived experiences of a certain group of individuals (Creswell & Poth, 2018). Thus, genuine curiosity, suspension, and openness (i.e., *epoche*; Creswell & Poth, 2018) about a particular phenomenon by researchers is necessary.

During the development phase of the current study, the lead researchers (Richardson and Lamson) hosted a "round table discussion" with an interdisciplinary group of professionals from various departments across the university in order to discuss appropriate and intentional strategies for developing the method for the current study. The diverse group of professionals included qualitative researchers, military researchers, and veterans who had extensive experience working with service members or had developed complex qualitative research designs; the resulting consensus was that a phenomenological design was best suited for the proposed research project.

Sample and Sampling

For phenomenological studies, Creswell (1998) has recommended an approximate sample size of 5 to 25 participants. U.S. veterans were recruited in an effort to address the scope and depth of insight appropriate for a phenomenological study (Creswell, 2007; Patton, 2002). The inclusion criteria for the study included: (a) adults at least 18 years or older; (b) who previously served in the U.S. military with current veteran status; (c) have been inactive/retired from the military for at least two years but no more than 15 years; (d) experienced at least one

deployment during their time of service; (e) reside in the U.S. at the time of the study; (f) have fluency in the English language; and, (g) have access to phone, internet, and email. The timeline for inclusion criteria was selected to control for commonalities (e.g., locations, fighting methods, volunteer-force, etc.) based on a set of more recent wars (including Operation Enduring Freedom [2001-2014], Operation Iraqi Freedom [2003-2011], American intervention in Iraq [2014 – present], and American-led intervention in Syria [2014 – present]) in contrast to historical war-time experiences, such as Vietnam. The final sample for the current study included 19 U.S. veterans.

Participant Recruitment

Upon approval form the Institutional Review Board (IRB; Appendix A), participants were recruited using purposeful sampling via social media sites (e.g., Facebook and Instagram; Appendix B) and sent via email (Appendix C) through military-related list serves. Additionally, electronic recruitment flyers (Appendix D) were placed in professional outlets for military-associated mental health providers, including a newsletter for the *Alliance of Military and Veteran Family Behavioral Health Providers*. Each advertisement included a brief description of the purpose of the study, inclusion criteria, incentive information, and a link to the online portion (i.e., survey) of the study via REDCap (Harris et al., 2009). Gift cards were used as incentives to help recruit willing participants for both Phase I and II of the study. All recruitment strategies and interviews were conducted prior to the onset of COVID-19.

Data Collection

Data were collected using a two-phase approach. Phase I included collecting background information via REDCap (Harris et al., 2009) – an online, encrypted data storage program – and a brief survey regarding the biopsychosocial and spiritual health and military experiences of

participants. Responses from Phase I were used to provide context for the overall sample included within the qualitative portion of Phase II.

Phase I

In order to provide context for our understanding of the lived experiences of veterans who participated in the qualitative portion of the proposed study (Phase II), the research team first collected quantitative background information regarding personal demographics, biopsychosocial health, and military experiences from participants. While collecting both quantitative and qualitative data mirrors techniques utilized in mixed-methodologies, the purpose of Phase 1 was merely to collect information in order to provide context in a briefer format rather than asking about personal context during interviews in order to connect current participants' experiences with themes from Phase II. Thus, the intent of the current study was not to recruit a generalizable sample size from Phase I as the outcome. Phase I data were collected and managed using REDCap electronic data capture tools (Harris et al., 2009) hosted by East Carolina University. REDCap (Research Electronic Data Capture) is a secure, web-based software platform designed to support data capture for research studies, providing (a) an intuitive interface for validated data capture; (b) audit trails for tracking data manipulation and export procedures; (c) automated export procedures for seamless data downloads to common statistical packages; and, (d) procedures for data integration and interoperability with external sources (Harris et al., 2009). Separate consent processes were introduced at both phases of data collection.

Informed Consent

Informed consent procedures were employed using a two-step process: (a) the initial informed consent to collect online background information (Phase I) and (b) additional consent to interview (Phase II). When accessing the online survey via REDCap (Harris et al., 2009),

participants reviewed an initial consent document online before any data are collected (Appendix E). Participants were informed of the purpose of the study, limits of confidentiality, and data management procedures. Additionally, participants were reminded that participation was completely voluntary and were provided the numbers for the Veterans Crisis Line and Military OneSource, where they could connect with national or local resources to address any behavioral health concerns or discomfort.

Measures

Once consent procedures were reviewed, participants accessed the online survey via REDCap electronic data capture tools (Harris et al., 2009). The measures chosen for the study (Appendix F) were intended to capture potential biopsychosocial and spiritual health experiences related to military service. Participants were asked to complete self-report measures of personal demographics, military experiences, depression, personal self-harm and suicidality of others, post-traumatic stress, potentially morally injurious experiences and associated symptoms, and spiritual well-being. All measures included within the study were either open-access or used with permission from the original authors (Appendix G).

Demographic information. After informed consent was obtained, participants completed a background survey questionnaire before beginning the interview process (Phase II). The survey included information regarding personal demographics (i.e., age, race, gender, religious affiliation, relationship status; $k = 5$) and military experiences (e.g., branch, rank, discharge status, deployment history; $k = 10$).

Symptoms of depression. The Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001) is a 9-item screener of depressive symptoms. Participants rated the severity of symptoms from 0 (*not at all)* to 3 (*nearly every day*) over the past two weeks using a 4-point

Likert-type scale. Items were summed to generate a continuous measure of depressive symptoms, with scores ranging from 0 to 27. Total scores were indicative of severity of depressive symptoms (i.e., *0-4 = minimal; 5-9 = mild; 10-14 moderate; 15-19 = moderately severe;* and, *20-27 = severe*). The PHQ-9 has been widely used and has shown strong psychometric properties (Kroenke et al., 2001), including good reliability with military populations (α = 0.79; Simon et al., 2016) and active duty personnel (α = 0.92; Bryan et al., 2016).

Experiences of self-harm. A four-item scale was developed by the lead researchers (Richardson and Lamson) and was included to assess for participants' thoughts about self-harm and suicidality, as well as experiences of knowing other veterans who had been impacted by suicide (i.e., attempted or died). No other scale assessing for suicidality that captured the thoughts and behaviors of both self *and* others could be located. Because of the high rates of suicide for U.S. veteran populations, it was important to the researchers that a full understanding of exposure to suicidal behaviors for the current population be captured; thus, an assessment of both personal experiences of self-harm and experiences of knowing other service members with experiences of suicide was developed and included. Participants were asked two questions about their own experiences of self-harm and suicidal ideation/behaviors (i.e., *"Have you ever had thoughts that you would be better off dead or of hurting?"* and *"Have you ever attempted to end your own life?*"). Two additional items were included to assess for participants' experiences of personally knowing other veterans who had been impacted by suicidality (i.e., *"Do you personally know other veterans who have attempted suicide?"* and *"Do you personally know other veterans who have died by suicide?"*). Participants were asked to respond to each question using "yes" or "no."

Post-traumatic stress. The Primary Care PTSD Screen for DSM-5 (PC-PTSD-5; Prins et al., 2015) is a 5-item measure initially designed to identify individuals in primary care settings with probable PTSD that was developed by the National Center for PTSD to reflect the new Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association [APA], 2013) criteria for PTSD. The screener began with an item to assess whether participants have had exposure to traumatic events. If participants indicated a trauma history, they were asked five questions to assess for post-traumatic stress symptoms within the last month (i.e., re-experiencing the traumatic event, numbing, avoidance, hyperarousal, self-blame/guilt). Respondents were asked to answer each item with *yes* or *no*. Total scores ranged from 0 to 5, with a cutoff score of three indicative of a positive screen (i.e., *probable* PTSD). The PC-PTSD-5 has demonstrated excellent diagnostic accuracy (*AUC* = 0.941; 95 % C.I.: 0.912– 0.969) with veteran populations (Prins et al., 2016), and previous research has shown good test-retest reliability (r = 0.83; Prins et al., 2003).

Moral injury. The Moral Injury Symptom Scale – Military Version Short Form (MISS-M-SF; Koenig, et al., 2018a) is a 10-item measure used to assess the psychological and spiritual symptoms of moral injury, including guilt, shame, betrayal, moral concerns, loss of purpose, difficulty forgiving, loss of trust, self-condemnation, spiritual struggles, and loss of religious faith/hope. The MISS-M-SF has a condensed version that includes items from each of the 10 subscales of the original 45-item measure (i.e., Moral Injury Symptom Scale [MISS-M; Koenig et al., 2018b). A sliding scale ranging from 1 to 10 (1 = *strongly disagree* to 10 = *strongly disagree*) was used for each question to indicate how strongly participants agreed/disagreed with statements about how they currently feel about their military experience. Initial psychometrics of the MISS-M-SF indicated strong internal consistency (α = 0.72) and test-retest reliability (*ICC* =

0.87; Koenig et al., 2018a) with active duty and veteran samples. Additionally, criterion validity was demonstrated by a strong correlation between the MISS-M-SF and the original 45-item MISS-M (r = 0.92; Koenig et al., 2018b).

A second scale used in the current study to specifically capture possible military events which may lead to moral injury (i.e., morally injurious events) was the Moral Injury Events Scale (MIES; Nash et al., 2013). The MIES is a 9-item self-report measure developed to assess for specifics experiences of military service, including perceived violations of moral beliefs or betrayals by self or other. Respondents indicated how much they agreed with each statement on a scale ranging from 1 (*strongly agree*) to 6 (*strongly disagree*), with higher scores indicating greater moral injury. The MIES has demonstrated good preliminary factor structure and reliability (α = .82 - .89; Bryan et al., 2015). Additionally, the Cronbach's alpha for the nine-item scale with a sample of military personnel was 0.90, indicating excellent internal consistency (Nash et al., 2013).

Spirituality. The Functional Assessment of Chronic Illness Therapy – Spiritual Wellbeing (FACIT-Sp-12, Version 4; Peterman, Fitchett, Brady, Hernandez, & Cella, 2010) Scale is a 12-item self-report measure of spiritual well-being. While the original version included "illness" language in two of its items, the current authors chose to use the non-illness version. Therefore, two items referred to "difficult times" when assessing for the role of illness on faith or spiritual beliefs (i.e., *"Difficult times have strengthened my faith or spiritual beliefs"* and *"Even during difficult times, I know that things will be okay"*). The FACIT-Sp-12 has been used with military samples (Johnson, Bormann, & Glaser, 2015) and has been found to have good internal reliability in previous studies (α = 0.81–0.88; Bredle, Salsman, Debb, Arnold, & Cella, 2011). Participants were asked to respond to each statement as it applied to them within the last 7 days

using a 5-point Likert-like scale from 0 (*not at all*) to 4 (*very much*). Higher scores indicated greater levels of spiritual well-being, with two items reverse coded because of negative wording.

At the completion of each survey, participants were given the option to provide their contact information using a separate link within the survey in order to receive a gift card as compensation for their time. The first 25 participants who completed the online survey and provided their confidential contact information received a $10 Walmart gift card as a 'thank you' for their time. All identifying information (i.e., name, addresses) was collected and stored separately from survey responses. Once the full survey had been completed, participants were also given the option to provide their contact information if they were willing and interested in completing a face-to-face interview.

Phase II

Phase II included semi-structured face-to-face interviews with veterans from the United States Armed Forces. Consistent with a phenomenological theoretical design, data for this study was collected by means of in-depth interviews with each study participant. Participants who indicated interest in completing a face-to face interview (i.e., select "yes" to the final survey question and provided contact information) were contacted by the lead researcher via phone or email to schedule an interview. The lead researcher facilitated the semi-structured interviews using an interview guide and additional probes in order to elicit participants' descriptive responses about their meaning-making experiences associated with moral injury. All participants who completed an interview received an additional $30 Walmart gift card as compensation for their time. Gift cards were distributed either in-person or mailed with participant consent following the conclusion of the interview.

Consent to Interview

During the face-to-face meeting, the lead researcher reviewed an additional informed consent document with each participant (Appendix H), specifically outlining interview procedures and obtaining verbal consent before the formal interview began. Participants were given the opportunity to ask questions about the informed consent and Phase II procedures before proceeding. Participants were reminded that participation was completely voluntary and that they could choose to pause or end the interview at any point. Once informed consent for Phase II had been reviewed, consent to audio record the interview was affirmed prior to activating any recording mechanisms.

Interviews

During Phase II of data collection, participants engaged in semi-structured, open-ended individual interviews conducted by the lead researcher. It was important to the authors that data collection take place in a mutually agreed upon location that ensured safety, privacy, confidentiality, and empowerment for participants. Interviews were scheduled at mutually convenient times for both participants and the lead researcher and were conducted either in-person at a secure location, which ensured privacy, or online using a HIPAA-compliant video software approved by the university's IRB (i.e., Webex). Nineteen in-depth, semi-structured interviews were conducted as part of the current study ranging from 47 to 164 minutes in length. Each interview was audio-recorded, and the lead researcher took brief notes during interviews, followed by post-interview expanded notes. Data collection continued until the research team felt that the data reflected a full exploration of the phenomenon of moral injury and had reached redundancy.

Interview guide. The lead researcher used an interview guide (Appendix I), developed through consultation with professionals who had worked with service members and veterans in clinical or research settings. Using the interview guide as an outline, the researcher employed open-ended questions, probes, and a non-directive style to establish an interview dynamic intended to provide a sense of safety and empowerment for participants and to encourage detailed descriptions of the meaning-making experiences of U.S. veterans and their beliefs, values, and morally challenging experiences related to service (Patton, 2002). Open-ended questions allowed for an effective method for obtaining rich, thick descriptions and authentic experiences pertaining to the interview guide constructed for this study (Creswell & Poth, 2018; Moustakas, 1994; Patton, 2002).

The interview guide began with a conversation that explored how participants decided to join the military. The body of the interview focused on the participants' personal experiences during military service, including times that were physically, emotionally, socially, or spiritually difficult, and experiences that challenged their core values or beliefs. Interviews concluded with the lead researcher providing a commonly cited description of morally injurious experiences (e.g., definition by Litz et al., 2009) to elicit feedback from participants of how much the description aligned with their personal experiences during their time of service and any changes/additions that could enhance the description. Upon conclusion of each interview, participants were provided with verbal information regarding the potential member checking process that would be used later in the research process to obtain participants' feedback of the key findings.

Qualitative Data Management

With participant consent, the lead researcher audio-recorded interviews and transcribed them verbatim. Access to the audio-recordings was restricted to research team members who were approved by the university's IRB. The lead researcher informed participants that the recordings would be destroyed after a minimum of seven years had elapsed (per IRB regulations). All identifying information related to study participants was kept separate from the recordings and transcriptions, and all participants' names were replaced with pseudonyms in order to ensure anonymity and confidentiality. Raw data, including contact information, transcriptions, audio recordings, and codes, were stored on a password-protected computer network that was accessible only by approved research team members. Paper files, including gift card logs, questionnaires, analytic memos, and reflexivity journals, were stored in a lockbox in the on-campus office of the lead researcher's major professor (as approved by the IRB) under double lock and key.

Qualitative Analysis

Data analysis procedures were congruent with the guidelines outlined by Colaizzi's method of descriptive inquiry (1978) in order to capture the collective essence of individuals' beliefs, values, and morally challenging experiences related to their military service. The following guidelines outline the phenomenological analysis procedures that were employed throughout the study. These steps were ongoing until the essence of the data had reached saturation.

Step 1 - Familiarization

Research team members converted audio recordings into data for analysis using Rev.com transcription services to develop verbatim transcriptions. As data collection took place, the

research team simultaneously reviewed each of the interviews in full, in order to acquire an initial understanding of the participant's experiences. Analytic memos were kept throughout this step to capture initial thoughts and reactions from each researcher (Patton, 2002; Saldaña, 2014).

Step 2 – Identifying Significant Statements

After an initial review of each interview in full, the research team returned to each transcript and extracted key phrases and significant statements that directly pertained to the phenomenon using line-by-line coding. Any statements within the participants' interviews that related directly to the meaning-making experiences of U.S. veterans or their beliefs, values, and morally challenging experiences pertaining to military service were considered to be significant (Colaizzi, 1978).

Step 3 – Formulating Meaning

Once a complete list of significant statements from all protocols had emerged, the research team attempted to formulate meanings for the key statements. While remaining connected to the original protocol, the researchers explored the meaning within each statement, moving beyond the content of the messages to discover hidden messages of what was *meant* from key statements (Colaizzi, 1978; see Appendix J). Colaizzi (1978) suggested that within this step, "the researcher must go beyond what is given in the original data and at the same time, stay with it" (p. 59). Bracketing procedures (Moustakas, 1994) were employed to ensure that the lead researcher sets aside her own biases throughout this process. Examples of bracketing procedures included team-based analyses, memoing, and ongoing consultation.

Step 4 – Clustering Themes

The researcher completed the previous steps until a detailed list of meanings was formulated. Then, the research team organized the aggregate formulated meanings into clusters

of themes (Colaizzi, 1978). These clusters were formed by assigning and organizing formulated meanings into groups of similar types. Colaizzi's (1978) protocol suggested that discrepancies or contradictions in the data at this point may exist and that the researcher must allow for ambiguity in the findings. It was imperative that the researchers "proceed with the solid conviction that what is logically inexplicable may be existentially real and valid" (p. 61).

Step 5 – Developing an Exhaustive Description

The fifth phase of analysis included the integration of the results from all proceeding steps into an exhaustive description of the phenomenon. This was a comprehensive description of synthesized clusters from the experiences of participants.

Step 6 – Producing the Fundamental Structure

Once exhaustive descriptions of the phenomenon had been identified, the researchers began to develop the fundamental structure of the phenomenon (i.e., the "essence" of the experiential phenomenon as it was revealed by explication through a rigorous analysis of the exhaustive description of the phenomenon [Colaizzi, 1978]). The goal was to formulate the exhaustive descriptions into a clear statement of identification (Colaizzi, 1978).

Step 7 – Verifying the Essence of the Phenomenon

A final step from Colaizzi's (1978) procedures for descriptive analysis that was conducted by the lead researcher was to return to the participants to validate the essence of the findings (i.e., member checking). A brief summary of the findings was sent to approximately 20% of participants via email in order to elicit feedback about the essence of the phenomenon (see *Member Checking* below for more details). Any relevant information or alterations pertaining to the phenomenon from the member checks were integrated into the final findings.

Study Rigor and Trustworthiness

Throughout the development of the phenomenological design, the researchers attended to methodological congruence by ensuring that the purpose, theoretical orientation (i.e., phenomenology), research questions, and research methods were interconnected and related in order to increase cohesiveness of the study (Richards & Morse, 2012). Additionally, the researchers employed multiple strategies to ensure the rigor and trustworthiness of this phenomenological study (Creswell & Poth, 2018).

Member Checking

To foster credibility and enhance rigor of the proposed study, the lead researcher used member checking, an essential component of a descriptive phenomenological approach (Creswell, 2007), to elicit feedback from participants regarding the accurate inclusion of their perspectives and experiences in study findings. At the end of each interview, the lead researcher asked participants about their willingness to participate in member checks to review the key findings from the study. Following Step 6 of Colaizzi's (1978) data analysis, the lead researcher emailed a summary of study findings to all participants. Participants were asked to review the summary in full and provide brief feedback using an online survey. Relevant and new information or alterations from participants was integrated into the final product of research (Colaizzi, 1978).

Ethics

Attending to ethics in research was a primary concern in the design and conduct of the current study. In addressing "relational ethical concerns" (Tracy, 2010), the lead researcher recognized and valued "mutual respect, dignity, and connectedness between researcher and researched and between researchers and the communities in which they live and work" (Ellis,

2007, p. 4). Thus, the researchers were mindful of the sensitive nature of discussing military combat experiences and potentially traumatic stressors. Since this research focused on a military-connected population, it was critical to recognize the well-established vulnerabilities of this group. Military communities are characterized by reduced autonomy and liberty; additionally, the hierarchical system upon which the military institution is built relies on values of obedience and loyalty. The recognition of the coercive power of military rank structure led to the recognition of service members as a vulnerable population (or special population) requiring special protections to avoid coercion (McManus, McClinton, De Lorenzo, & Baskin, 2005; McManus, McClinton, & Morton, 2002).

To address any concerns or hesitation with participation, the lead researcher constructed and disseminated informed consent materials, identifying herself as a researcher from East Carolina University with no affiliation with the Department of Veterans Affairs before collecting any data. To protect participants from potential harm, the research team masked and omitted personally identifying information (specific units, deployment locations, etc.) within transcripts and assigned pseudonyms for each participant (Creswell & Poth, 2018) to ensure no identifiable information was shared in any publications. Additionally, all participants were provided the number for the Veterans Crisis Line and Military OneSource, where they could connect with national and local resources to address any behavioral health concerns that may have risen during or after as a result of their participation in the study.

Audit Trail

Seale (1999) highlights that auditing through memos and notes provide, "a methodologically self-critical account of how the research was done" (p. 468). Therefore, an audit trail was maintained throughout the entire study, which will include five key components:

(a) a research timeline, (b) reflexivity notes, (c) analytic memos, (d) a codebook, and (e) copies of study-specific materials such as informed consent documents and completed demographic questionnaires. A detailed codebook was developed during the transcription and analysis processes that identified specific code names, operational definitions, inclusion and exclusion criteria, and examples of each code.

Analytic Memos

The lead researcher developed analytic memos in order to annotate her reflections and interpretation of the data throughout the course of the study (Patton, 2002; Saldaña, 2014). The process of writing analytic memos allowed for a thorough development of codes, reflections, changes, or conclusions over time and summaries of emergent ideas within and across data (Creswell & Poth, 2018; See Appendix K for examples).

Reflexivity

Tracy (2010) suggests that sincerity within a study can be achieved through self-reflexivity, which requires vulnerability, honesty, and transparency about researchers' biases, assumptions, and goals about the specific phenomenon, methodology, and/or population of interest. The lead researcher engaged in an ongoing process of reflexivity. Reflexivity was one of the most valued and necessary practices of qualitative research that transitioned through the entire research process, from the early stages of research design through access and trust-building with participants, the process of data collection and analysis, and the dissemination of the findings (Tracy, 2010). During the current study, the researcher engaged in various reflexivity procedures, including engaging in research team members' discussions in an effort to bracket her personal experiences, biases, and assumptions. These procedures captured the "bracketing" process (i.e., researcher sets aside their own experiences with the phenomenon;

Moustakas, 1994) that allowed the lead researcher to set aside her preconceived experiences with the phenomenon in order to best understand the lived experiences of the participants.

Quantitative Analysis

As previously mentioned, Phase 1 of the study included an online, quantitative survey to collect demographic and biopsychosocial-spiritual information in order to provide context for the lived experiences highlighted throughout Phase II. Frequencies, correlations, and *t*-tests were run to assess for significant differences between groups by social location (i.e., gender, race, rank, and branch) and to inform the overall qualitative findings.

Conclusion

Empirical evidence exploring moral injury is needed in order to more holistically understand the biopsychosocial and spiritual implications of such injuries. The aim of the study was constructed in order to describe the essence of moral injury and provide depth and meaning related to the phenomenon. A more accurate definition, particularly one constructed through the voices of veterans, grounded in empirical support could aid in conceptual clarity for moral injury, which in turn would allow professionals to move toward appropriately identifying and treating the deeper wounds associated with military experience. The following chapter will introduce the implementation of this qualitative design, description of participants, outcomes from the key findings, and implications for research and practice from the study.

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CHAPTER 5: *"MY WHOLE MORAL BASE AND MORAL UNDERSTANDING WAS SHATTERED"*: A PHENOMENOLOGICAL UNDERSTANDING OF KEY DEFINITIONAL CONSTRUCTS OF MORAL INJURY

Introduction

The biological, psychological, social, and spiritual (Engel 1977; 1980; Wright, Watson, & Bell, 1996) wounds that stem from the moral challenges of military service are often misunderstood and have the potential to produce ongoing inner conflict for service members and veterans (Drescher et al., 2011). Over time, continuous internal conflict can manifest as deep biopsychosocial or spiritual consequences, including distress related to personal safety (Drescher et al., 2011). In order to more fully address the invisible wounds of military combat experiences, researchers are becoming increasingly interested in the construct of *moral injury* (Shay, 2002). These deep seeded issues may go unacknowledged, undiagnosed, and untreated because of a lack of understanding of what constitutes a morally injurious act and the unique biopsychosocial-spiritual symptomology of such experiences. Bessel van der Kolk (2014) suggested that "trauma is not just an event that took place sometime in the past; it is also the imprint left by that experience on mind, brain, and body" (p. 21). The current authors propose extending this explanation to encompass potential implications of trauma on the *soul*. With the number of deaths by suicide for service members increasing each day, it is becoming drastically clear that we are missing something in our understanding of military experiences. Given the historical connection between issues of morality (i.e., moral crises) and suicidality (Barraclough et al., 1974), it is important that we bring awareness to the morally-jolting lived experiences impacting military personnel.

A systematic review of the most commonly used definitions for moral injury across military literature (i.e., Richardson et al., 2020) revealed a gap in empirical evidence informing the conceptualization of moral injury, highlighting that the most widely used citations for defining moral injury either lacked empirical support when initially constructed or relied on provider or professional perspectives rather than the voices of service members or veterans. Based on the findings from that review, the authors were called to respond to the ongoing chasm in moral injury research.

While past researchers have attempted to define moral injury and what leads to such experiences, an inconsistency in the understanding and absence of a research- and veteran-informed definition of the construct has remained. Thus, the purpose of this study was to (a) seek out a research-grounded definition surrounding times when one's personal values or morals did not align with job duties or requirements associated with military service and (b) to conduct this study with veterans/former service members. Due to the lack of a theoretical grounded or research-informed definition of moral injury as well as the complexity of the construct, the authors believed a flexible inductive qualitative process was best suited for the design of this study.

Method

The current study used a phenomenological perspective to explore the meaning-making experiences of military veterans and their beliefs, values, and morally challenging experiences related to service. Questions did not directly focus on the construct of moral injury, but rather openly inquired about challenging experiences associated with veterans' service. The specific research question addressed in this study was: *How do U.S. military veterans describe and make meaning of the morally challenging experiences associated with their military service?*

Sample and Procedures

Data collection, analysis, and reporting were conducted using a team-based approach, which consisted of the lead researcher (first author), one graduate student (last author), and one faculty mentor (second author). Additionally, the lead researcher consulted with professionals who have worked with service members and veterans in clinical or research settings to develop the design, recruitment, and implementation strategies for conducting the study. All research procedures were approved by the University's Institutional Review Board (UMCIRB 19-001716) and conducted prior to the COVID-19 pandemic.

Data Collection

Data were collected using a two-phase approach. Phase I included collecting background information via REDCap (Harris et al., 2009) – an online, encrypted data storage program. Phase I was conducted primarily through a brief survey regarding the biopsychosocial-spiritual health and military experiences of participants. Responses from Phase I were used to provide context for the sample demographics and qualitative portion of Phase II.

Phase I. The initial sampling frame included 62 U.S. veterans who had been out of service for at least two years but no more than 15 years. Participants from Phase I were recruited using purposeful sampling via social media sites (e.g., Facebook and Instagram), military-related list serves, electronic recruitment flyers, and an international newsletter for the *Alliance of Military and Veteran Family Behavioral Health Providers*. When accessing the online survey, participants were informed of the purpose of the study, limits of confidentiality, and data management procedures. Additionally, participants were reminded that participation was completely voluntary and then given the number for the Veterans Crisis Line and Military

OneSource, where they could connect with local resources to address any behavioral health concerns or discomfort.

Measures. Measures chosen for the study were intended to capture potential biopsychosocial and spiritual health experiences related to military service. Participants were asked to complete self-report measures on personal demographics (i.e., age, race, gender, religious affiliation, relationship status; $k = 5$), military experiences (e.g., branch, rank, discharge status, deployment history; $k = 10$), depression (Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001)), personal self-harm and suicidality of others (Richardson and Lamson), post-traumatic stress (Primary Care PTSD Screen for DSM-5 [PC-PTSD-5; Prins et al., 2015]), potentially morally injurious experiences and associated symptoms (The Moral Injury Symptom Scale – Military Version Short Form [MISS-M-SF; Koenig, et al., 2018]; Moral Injury Events Scale [MIES; Nash et al., 2013]), and spiritual well-being (Functional Assessment of Chronic Illness Therapy – Spiritual Wellbeing [FACIT-Sp-12, Version 4; Peterman, Fitchett, Brady, Hernandez, & Cella, 2010]). The PHQ-9 (Bryan et al., 2016; Simon et al., 2016); PC-PTSD-5 (Prins et al., 2016); MISS-M-SF (Koenig et al., 2018); MIES (Nash et al., 2013); and FACIT-Sp-12 (Johnson, Bormann, & Glaser, 2015) have all been tested with active duty personnel and/or veterans.

While nearly all of the measures were standardized and validated, a four-item scale was developed by the lead researchers (Richardson and Lamson) to assess for participants' thoughts about self-harm and suicidality, as well as experiences of knowing other veterans who have been impacted by suicide (i.e., attempted or died). Two items asked participants about their own experiences of self-harm and suicidal ideation/behaviors (i.e., *"Have you ever had thoughts that you would be better off dead or of hurting yourself?"* and *"Have you ever attempted to end your*

own life?"). Two additional items were included to assess for participants' experiences of personally knowing other veterans who have been impacted by suicidality (i.e., *"Do you personally know other veterans who have attempted suicide?"* and *"Do you personally know other veterans who have died by suicide?"*). Participants were asked to respond to each question using "yes" or "no." Participants who provided a positive response on any of the four items were automatically provided contact information for the Veterans Crisis Line and Military OneSource, where they could connect with national and local resources to address any behavioral health concerns or discomfort that may have risen.

Upon completion of the survey, participants were given the option to provide their contact information using a separate link in order to receive compensation for their time. Once the full survey was completed, participants were also given the option to provide their contact information if they were willing and interested in completing a face-to-face interview. Incentives were used for recruitment purposes during both phases of data collection.

Phase II. Consistent with a phenomenological theoretical design, data for Phase II of the study were collected by means of in-depth interviews with each study participant. Participants from the initial sampling frame who indicated interest in completing a face-to-face interview (i.e., selected "yes" to the final survey question and provided contact information) were contacted by the lead researcher via phone or email to schedule an interview at mutually convenient times for both participants and the lead researcher. Interviews were conducted with veterans until theoretical saturation was achieved (Strauss & Corbin, 1998).

Participants. A total of 19 U.S. veterans completed in-depth, semi-structured interviews as part of Phase II. Full contextual and demographic information can be found in Tables 1 and 2. Of the 19 participants, approximately 20 percent were women (n = 4), which is slightly higher

than the current percentage of women in the active duty force (i.e., 16 percent of the enlisted forces and 19 percent of the officer corps; Council of Foreign Relations, 2020). Four branches of the military were represented, including Army (52.6%), Navy (21.1%), Marine Corps, (15.8%), and Air Force (10.5%). Our sample encompassed a large percentage of enlisted veterans (84.2%) with just 15.8% with officer status at the time of discharge/retirement. Number of years since discharge ranged from two to 14, with an average of 10.95 years of active duty service. A majority of participants experienced at least one combat (73.7%) and non-combat deployment (68.4%). Participants represented a variety of military occupational specialties, including Special Forces, infantry, medics, mechanics, electricians, and logistics officers. A number of participants disclosed a history of mental and physical health symptoms and diagnoses; just under 58% of participants described experiencing at least moderate to severe levels of depressive symptoms within two weeks of participation. Seventeen of the nineteen veterans (89.5%) who were interviewed disclosed a history of suicidal ideation, with two attempting suicide at least once.

Interviews. During Phase II of data collection, participants engaged in a new consent document followed by a semi-structured, open-ended individual interview conducted with the lead researcher. Interviews ranged from 47 to 164 minutes in length. The lead researcher used an interview guide, developed in consultation with professionals who had worked with service members and veterans in clinical or research settings. Interviews were scheduled at mutually convenient times for both participants and the lead researcher and were conducted either in-person (n = 9) at a secure location, which ensured privacy, or online (n = 10) using a HIPAA-compliant video software approved by the university's IRB (i.e., Webex). Each interview was audio-recorded and transcribed verbatim. All identifying information related to study participants

were kept separate from the recordings and transcriptions. Pseudonyms, chosen by the participants themselves, were used in order to ensure anonymity and confidentiality.

Analysis

Data analysis procedures were congruent with the guidelines outlined by Colaizzi's seven-step method of descriptive inquiry (1978) in order to capture the collective essence of individuals' beliefs, values, and morally challenging experiences related to their military service. First, research team members (including the lead researcher and one graduate student) individually read each interview transcript multiple times to acquire an initial understanding of the participants' experiences. Analytic memos were kept throughout this step to capture initial thoughts and reactions from each team member (Patton, 2002; Saldaña, 2014). As part of Step 2, significant statements within each interview were extracted individually by each team member using line-by-line coding, and then, team members met to discuss and agree upon the significant statements in each interview. In Step 3, research team members formulated general meanings for the significant statements identified. As part of Step 4, team members organized meanings into theme clusters and discussed primary salient themes and subthemes until agreement was reached. Step 5 consisted of organizing the data based on meanings and emergent themes into an exhaustive description. Data were then organized by 15 of the most frequently identified and salient themes and subthemes using strong quotes from participants for support in order to highlight the "essence" of the experiential phenomenon (i.e., Step 6; Colaizzi, 1978).

A final step included member checking strategies in order to collect feedback from participants to verify the essence of the findings. A brief summary of the findings was sent to all participants from Phase II via email with a 63 percent response rate. Participants were asked to review the summary in full and provide brief feedback using an online survey. Relevant and

new information or alterations from participants was integrated into the final product of research (see *Member Checking*; Colaizzi, 1978). A series of descriptive statistics, correlations, and *t*-tests were run using the quantitative survey data to assess for significant differences between groups by social location (i.e., gender, race, rank, and branch) and to better inform the overall qualitative findings (see Table 3). Ongoing reflexivity (Tracy, 2010), reflection, and verbal bracketing procedures (Moustakas, 1994) with research team members were implemented by the lead researcher at each phase of analysis to set aside any preconceived experiences with the phenomenon in order to best understand the lived experiences of participants.

Results

Through initial coding of qualitative interviews, we noted that participants' narratives related to their military experiences included a wide range of perspectives and emotions. Only two participants suggested that they could not fully identify with having their morals or values impacted or challenged during their military service. Thus, the descriptions of themes are focused on the commonalities shared across interviews with veterans.

Identified Themes

Four primary themes and eleven subthemes emerged from the interviews, suggesting that (a) betrayal, (b) moral ambivalence, (c) soul wounds, and (d) lack of reconciliation best describe the morally challenging experiences associated with military service. Examples of these constructs and related subthemes are organized in Table 4. Specifically, Table 4 highlights the total number of participants who shared lived experiences congruent with each particular theme. Excerpts from interviews were used to capture the essence of the phenomenon described by military veterans.

Betrayal

One of the most salient constructs identified across almost all interviews was the overarching sense of complex, cumulative *betrayal*, both unto self and imposed upon by others. Veterans described being placed in circumstances which seemed to violate their own understanding of the type of person they thought they were or what they once valued and believed to be true.

Self-betrayal. Experiences of betrayal included *self-betrayal* whereby participants described feeling that they "stabbed [themselves] in the back" by either avoiding encounters that ultimately resulted in harm or engaging in the oppression of others for the sake of their own self-preservation. Others described not living up to their own expectations of what they believed it meant to be a proud service member or leader. Luke described personal feelings of betrayal for not serving in his leadership role of protecting those around him appropriately when missing an IED in the field: "*I screwed up. I had a job to do and I didn't do it… I missed [the bomb] and then [my fellow service members] were the ones who suffered for it."*

Betrayal from or unto others. Perceptions of betrayal also occurred *from or unto others*; veterans described feeling that their personal values and trust within the system were impacted by witnessing or learning about the immoral acts or unethical decisions of others, including their peers, leaders, and local allies. These interpersonal transgressions seemed to influence their relationships, making it challenging to trust those whom they previously respected and embrace a sense of connection. For some, this mistrust in peers and leaders weighed heavily on participants' own values as they often questioned the actions and decisions of others which seemed to misalign with their personal morals. Scott, a medical sergeant, recalled:

We did all [these surgeries] to try to save this kid... all of these things. And, in the end, [the boy] is taken back to the village where he's going to be left to die. That was the most memorable [moment] to me. I guess, because [of] the way the system failed. Something failed. That shouldn't have happened. And it's hard to see and know that.

Systemic betrayal. Continuously being placed in unethical situations or witnessing the moral violations of others for the greater good or to complete a mission heightened a lack of trust in the hierarchical system of the military. This seemed to be exacerbated by a multi-level sense of *systemic betrayal* embedded within the interpersonal relationships and value system. For example, many experienced feelings of betrayal when asked by those in authority roles to "turn a blind eye" to the cultural rituals and norms of their allies or the local communities while on foreign soil which did not align with the values of most veterans. Carl recalled feelings of such distress as he described an inability to stand up for witnessed injustices due to systemic boundaries, specifically – in this instance - in response to the sexual injustices toward local women and children:

> *If you raise your voice about it, [the military is] going to ruin your lives. Which has happened to a couple of other [service members] that raised a big fuss about all the little dancing boys and everything, and they sent them home and that was the end.... the end for them [in the military], that was it; that's for sure. So, you can't do anything about [the injustices] even though you want to. And so, it's just more thrown onto the pile.*

Additionally, this systemic betrayal and misuse of power by many in authority positions extended into how participants felt that internal transgressions were handled. Specifically, Veterans described frustration and disappointment with how the system at large rigidly treated its members or handled the mistreatment of female service members, including allegations of sexual

assault, infidelity, and substance use. Shepherd described feelings of frustration over the lack of advocacy by leadership and justice for women in the military, particularly victims of sexual assault *"This was something that I saw frequently. [Leadership] would turn around and tell [you], 'Oh, we're with you for a sexual assault and sexual harassment.... blah, blah, blah, blah, blah.'"* Her apparent disappointment in the system appeared to be exacerbated by ongoing broken promises, which she described as just "lip-service."

Themes of betrayal were consistent with participants' quantitative reports which highlighted a significant correlation between symptoms of betrayal and exposure to morally injurious events ($r = 0.62$, $p = .001$), suggesting that experiences of betrayal increase as one is exposed to morally transgressive acts. It is worth noting, the witnessing of transgressive acts by others was related to a history of suicidal ideation ($r = 0.58$, $p = .009$), whereas experiencing violations of morals or values due to personal actions/decisions was correlated with increased severity of depressive symptoms ($r = 0.47$, $p = .043$).

Moral Ambivalence

Veterans acknowledged an ongoing struggle with holding onto multiple realities or identities which seemed to contradict with the roles, values, or expectations they ascribed to as service members, often igniting internal feelings of moral ambivalence. For example, some described joining the military in order to better provide for their family while also struggling with the idea of abandoning their family for years at a time to serve a system with which their personal ideals may no longer align.

Questioning of purpose. Veterans further described experiences during service which presented constant *questioning of the overall purpose* of the United States' involvement in

specific foreign disputes or reasons for particular decisions/actions. For example, many felt that the nation's involvement may have done more harm than good.

Thad, a 26-year-old Army veteran, recalled this personal shift in understanding and support of the United States' attempts at "helping" others during his time of service:

> *I guess I questioned whether us being there was any benefit...the whole mission set was for the liberation of the Afghan people and to implement democracy but just us being there was causing harm to those people. I thought about how they would feel about that, whether they even really wanted us to be there… or [were we] there to just essentially stir the pot...?*

Shifts in worldview. This questioning the purpose of the mission and the decisions of others in authoritative positions often led to major *shifts in worldviews* for many. Many veterans joined the armed forces with hopes of helping others, and while that deep desire continued throughout their service, it was often challenged by the actions they and others were forced to take. This often led to a shift in understanding or, for some, even newfound misalignment with the overall purpose of warfare, causing an unsettling shift in moral footing of what it meant to be a Veteran, particularly for those who clung tight to their initial purpose for joining the armed services of helping others. Sam, an ex-marine, stated:

> *I used to have this illusion that [governmental leadership] really were doing something for the best for [Americans], and I just don't see it. I had this conception that they really cared about the troops, and what we were doing, and how we managed things. Now it's like: 'Okay, that illusion's gone.' They view people like cannon fodder. It's just like: 'Okay, what are we going to do to meet the next big money goal?' The war's a fucking racket. It's all about the fricking money, and that's all anybody gives a shit about.*

Moral shades of gray. These experiences of heightened moral ambivalence were exacerbated with the recognition of morality as a spectrum, particularly in the military when decisions are often made in the moment and with the greater 'good' or mission in mind. Thus, veterans had no choice but to view ethical decisions and moral values on an ambiguous continuum, taking the context of the situation into consideration rather than always viewing things as "black and white." It seemed that these *moral shades of gray* were often a conscious decision made by veterans in order to get the job done or an indirect outcome and attempt toward meaning making for the moral transgressions endured as part of their role. John confirmed:

> *I kind of questioned everything.... especially joining the military. I don't know; I come from a military family, and so it was like...my parents are really religious so they're like: "Yeah, you're doing God's work... God's work." And I was like, "Is this God's work?" I don't even believe in God but is this really God's work? Is it what we're doing here? This shit? I don't know. It just all became more gray.*

Soul Wounds

Veterans described ongoing challenges to their personal values during services, often resulting in a fracturing or "cracking" of their once firm moral base. One participant shared that it was as if his "whole moral base and moral understanding was shattered." Implications for these morally injurious events endured during service suggested deep-rooted, internal injuries to the soul – the source of one's moral foundation, beliefs, and value system. Different than other responses to traumatic stress, ongoing experiences of betrayal and moral ambivalence seemed to unearth heightened feelings of guilt, demoralization, and isolation.

Guilt. Embedded within the roots of these injuries to the soul, seemed to exist the heavy burden of *guilt.* Descriptions of regret f were shared by many of the veterans through the things

they had experienced, witnessed, caused, or persons they lost or hurt, and the values they questioned or, for some, even abandoned. April described personal feelings of regret and guilt as she recalled challenges with balancing her role as a mother and service member; she expressed feeling "a lot of, I don't know, regret." She became emotional when describing missing out on much of her daughter's infancy and how she now felt emotionally distant from her after returning. She stated, "I wish things could have been different. There's a lot of pain... I think my issue is that I still lie to myself [about the decisions I made] and so I haven't forgiven myself."

Guilt was also found to be related to higher levels of depression for participants (r = 0.56, p = .013) with severity of depression related to a history of suicidal ideation (r = 0.47, p = .043), suggesting that guilt may be associated with experiences of suicidal ideation among veterans.

Demoralization. While the understanding of the overall mission as priority was consistent among all participants, many still questioned the purpose of the particular mission, often creating an overall sense of helplessness and *demoralization*. Shepherd expressed: "*It is very demoralizing. You know, knowing that I didn't do everything that I could."* Many described the military culture as a stressful, depressing environment often lacking support, where morals were often downplayed or pushed to the side in order to get the job done. These experiences seemed to heighten feelings of depressed mood, loneliness, sadness, and anger for many involved.

Isolation. For many, these experiences were intensified by feelings of *isolation* and loss of comradery both during service and after returning home. Veterans described a shared understanding and connection with members of their teams and units who had witnessed or been exposed to similar stressors and the military environment, which – regardless of viewpoints – uniquely bonded service member to service member. Yet, many described feeling an overall

sense of abandonment by fellow veterans and the military system as a whole once returning home. Not only were veterans working to navigate the transition back to "normal" society, they felt as if they were doing it alone due to emotional disconnect from family, friends, and peers. These experience – both during and after service – supported a climate of suffering in isolation.

When describing the loss of shared understanding with fellow service members that Andy experienced after leaving the military, he stated, *"There's comfort and strength in [the comradery] where something maybe crappy [is going on] at home, you go in the next day and you see those [fellow military] guys, and you're back to that security. So, when that was taken away and all these thoughts and feeling of 'I don't know what's going on inside my body.... outside my body.' It was a flood of everything ... I tried to [cope with] it my own way and tried to handle it myself, and it was not a good idea, not a good game plan.*

Lack of Reconciliation

Veterans described the ability – and often necessity - to avoid thinking about the morally injurious experiences endured during service by focusing on the mission at hand. Both during and after service, many struggled with *reconciliation* for the atrocities witnessed or experienced. These attempts to make sense and meaning of their service appeared disrupted by frequent conflicts between expectations of military and personal values.

Duty first. Veterans described that while the decisions made or experiences endured during service often challenged their personal values from their civilian upbringing, they found no choice but to come to terms with the reality that ethical boundary lines often become blurred and may require ones morals to shift depending on the importance of mission objectives as *duty always came first*. Further, what might be considered "wrong" to the larger society may be allowed, or even necessary, within a given context, whether veterans personally agreed with the

purpose and outcome(s) or not. Wilson described this process as the need to *"put your morals to the side...not forget them, but just put them on mute while you survive through this traumatic time…. Yes, it's either you do that, or you don't go home."* Whitley stated: *"You're not civilian anymore. Even if you feel your moral is a little bit morally ambiguous, you have to go with that [and] 'follow orders' mentality to a point."*

For many, this included attempts to make cognitive and ethical sense of the experiences one witnessed, engaged in, or endured. Luke recalled attempts of reconciliation during a time of injustice in his duty: *"I had to take them into a place where they know I'm about to turn this guy over so that [the investigators] can cattle prod his genitals for the next three days, until [he] gives [them] what [they] want. It's difficult to come to terms with that and try to find some moral justification for it, but at the end of the day, you have to do what you have to do.*

Penitence. While veterans described an inability to reconcile with the moral injuries endured during service, many discussed intentional efforts at rebalancing their morality spectrum by "doing better" or serving others after discharge. Carl reported: *[The experiences of betrayal] just caused me to try to work myself to be a better person and sort of like an offset. I've got assure going forward that I don't allow myself to fall back on any bad habits. And I sort of make up for things that I didn't correct, things that I didn't address. That's really just an offset… kind of an offset for my morals."*

The Phenomenological Description: Injuries of the Soul

A rigorous research- and veteran-informed description of the phenomenon was developed which highlighted primary themes related to participants' moral injurious experiences. To confirm our understanding of the themes related to the lived experiences of veterans, the current authors employed member checking procedures through the use of a brief online feedback form

to all participants. The following description was developed and shared with participants to highlight the essence of the moral injuries endured during military service:

> Veterans' descriptions of times when their personal values, morals, or beliefs did not seem to align with what was required of them during their military service suggested that moral injuries emerged and evolved through a "fracturing" or internal shift in one's moral foundation. One's spiritual, family, and/or military values were challenged by ongoing threats or infringements to an individual's worldview and the ethical expectations of self and others. These moral violations were often the result of witnessing, learning about, or engaging in acts that disrupted deeply held moral beliefs and reinforced by ongoing perceptions of betrayal, both unto oneself and imposed upon by others. Systemic betrayal emerged as a possible root cause for these overwhelming experiences, grounded in a multi-layered lack of trust and possible misalignment with the overall values of the larger [military] system. These morally injurious experiences and chronic feelings of betrayal often lead to a demoralizing cultural climate, resulting in the questioning of one's personal values and the values of those around them. With consistent questioning and lack of firm moral footing comes intense feelings of moral "ambivalence" and the potential for lasting wounds to the soul.

Member Checking

A majority of participants (58%) felt that the phenomenological description accurately captured the morally injurious experiences commonly endured by military personnel, particularly when compared to another commonly used description within military literature (i.e., Litz et al., 2009). Feedback confirmed our qualitative and quantitative findings that multi-level interpersonal betrayal has the potential to lead to deep-rooted moral injuries of the soul.

Additionally, participants emphasized experiences of questioning or shifts in worldviews were rarely "black or white" and often a necessary process for self-preservation, as many times the overall mission or duty of service required one to adjust, shift, or disregard the personal values one may typically ascribe to during non-military times. Additional feedback highlighted guilt, demoralization, and feelings of isolation as primary outcomes associated with moral transgressions.

While all veterans felt the phenomenological description from our study at least somewhat aligned with their personal experiences from service, some felt that the terms used to describe these experiences should be taken into further consideration, suggesting "moral injury" may not be the best way to refer to this phenomenon. Participants were asked what they would call this experience, and while almost all confirmed "moral" as an appropriate descriptor for the damaged 'location,' some felt the use of "injury" may not be appropriate, suggesting it implies a more *physical* wound. Other terms such as moral challenge, conflicts, stressors, and crises were noted as possible substitutions.

Discussion

Previous researchers have highlighted the importance of strengthening face validity and reliability for the definition and key constructs of moral injury (Richardson et al., 2020). Therefore, the purpose of this phenomenological study was to expand on the current understanding of moral injury by providing an operational and research grounded description and conceptualization of the key constructs through the lived experiences of U.S. veterans. Findings revealed four primary constructs for conceptualizing moral injuries: (a) betrayal, (b) moral ambivalence, (c) soul wounds, and (d) inability to reconcile with the atrocities endured during service.

Consistent with Litz and colleagues' (2009) conceptualization of morally injurious experiences, participants confirmed many of their most difficult and morally jolting experiences during service were the result of "perpetrating, failing to prevent, and bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations." However, this description – previously found to be the most commonly cited definition for these experiences across military literature (Richardson et al., 2020) - does not include explicit constructs such as betrayal, which emerged as the most salient construct across interviews.

Betrayal – particularly interpersonal betrayal and betrayal from those in leadership positions – has been highlighted in previous literature, as well, when describing moral injury (i.e., Blinka & Harris, 2016; Farnsworth et al., 2014; Nash et al., 2013; Shay, 2014). Because much of the past research on moral injury has been conceptual in nature or developed from the perspectives of professionals (e.g., clergy, chaplains, etc.), it was important to learn that experiences of betrayal – both of self and from or unto others – was confirmed as a primary construct within our veteran sample. Further, the findings revealed a multi-level systemic betrayal as a common aid in the development of moral injuries of the soul.

An important contribution to science based on these findings is the emphasis on systemic implications of moral injury. As highlighted throughout these narratives, veterans attributed much of their soul wounds to interpersonal betrayal and morally ambiguous contextual influences experienced on a systemic level. To date, a theoretical foundation that holistically supports our understanding of moral injury has not been used consistently throughout the literature. Atuel and colleagues (2020) suggested the slow process in laying a theoretical foundation is likely a result of having no agreed upon definition for moral injury, which may be "primarily attributed to social scientists being siloed without our own academic disciplines" (p.

252). Rather than viewing moral injury as a construct distinct to the field of psychology, trauma, or theology, applying a more systemic framework may be most appropriate for capturing the multi-level implications. For instance, a biopsychosocial-spiritual lens (Engel 1977; 1980; Wright et al., 1996) may support the cellular to society and spiritual implications of moral injuries. Additionally, Bronfenbrenner's ecological theory (1979) may be a potentially influential theory in grounding future assessments and interventions for moral injury. It became evident through the interviews that moral injuries could only be understood within the context of a series of nested multi-level systems. This is an important framework for understanding the interplay between context, personal characteristics/values, and systemic influences on the development of moral injury.

Limitations

Although the current study provides important contributions to the literature, there are limitations worth mentioning. This research was specifically focused on military veteran populations, but it is critical to note that moral injury is not likely unique to these populations. Future researchers should explore a similar analysis related to the experiences of moral injury among other groups that are commonly predisposed to traumatic stress to further generalize the findings, particularly for those in hierarchical systems supported by the ideal that duty or mission comes first or that may be at higher risk for moral ambivalence based on context (e.g., first responders [firefighters, police, medics], medical providers, etc.). Additionally, due to the design and sample of this study the authors did not control for specific extraneous variables; for example, the authors did not control for branch, military occupational specialty, number or type of deployment, or years in service – all of these variables could directly affect the outcomes of the study.

A final limitation worth noting is the primarily racially homogenous sample included within the study. While race was blinded prior to scheduling of interviews (i.e., researchers intentionally kept demographic information separate from contact information for confidentiality purposes) and no group differences were found across all variables when controlling for race or ethnicity across the full sampling frame, it is important that future researchers attend to the various social locations of veterans in relation to moral injury. Previous research confirms individuals from racial minority groups, particularly African American military personnel, are at greater risk for developing post-traumatic stress disorder compared to their White peers (Coleman, 2016). Thus, capturing the experiences of moral injury for persons of color and those from more racially and ethnically diverse populations is crucial, particularly given the potential role systemic betrayal may play for populations predisposed to historical and systemic oppression.

Implications for Future Research

To increase face validity of moral injury, the constructs from this study should be compared to themes found within a recent systematic review on moral injury (i.e., Richardson et al., 2020). The use of small focus groups with veterans that share social locations could be used to look at alignment of such themes and the name ‘moral injury’ as the most appropriate term for these soul injuries. These findings could further support a research- and veteran-informed definition of moral injuries, which could tell us how to adapt or create new assessments that align with moral injury, with long term goals of determining what diagnostic markers or signatures are present to distinguish moral injury from other common trauma-related diagnoses (i.e., PTSD, TBI).

In addition to future enhancing our understanding of key constructs of moral injury, future researchers should explore potential protective factors. Within the current sample, many veterans described an overall disruption or questioning of their spiritual and moral foundations; however, three participants discussed a need or ability to lean more into their religious and spiritual belief systems. It is unclear whether these decisions aided in the reconciliation process for these veterans. Therefore, a key next step would be to further explore the experiences or beliefs systems which may allow certain atrocities to "bounce off" or "bounce forward" rather than result in deep-rooted soul injuries, particularly as previous researchers have found that spirituality and religiosity can serve as protective factors for mental health symptoms (i.e., PTSD and major depressive disorder) for both active duty personnel (Hourani et al., 2012) and veterans from Vietnam and Iraq/Afghanistan eras (Currier, Drescher, & Harris, 2014).

Implications for Clinical Practice

In addition to expanding our understanding of these soul wounds through empirically supported, veteran-informed research, an important step toward providing appropriate clinic support for service members and veterans is to enhance collaboration between diversely trained providers (i.e., chaplains, behavioral health providers, medical providers). Providers must be willing to explore and incorporate constructs of moral injury into their practice when assessing, diagnosing, and treating experiences of traumatic stress to ensure validity of the phenomenon and support real-world clinical experiences. Acknowledging these constructs as reality when working with service members and veterans is an important step toward not overlooking such lived experiences. Further, bringing awareness to such experiences may also help to address the true root cause of distress that are otherwise not provided through existing healthcare derived diagnoses.

Conclusion

To date, there remains a chasm between our conceptualization of moral injury across the literature as well as practice and policy strategies to attend to such injuries of the soul. A systematic review of the most commonly used definitions for moral injury across military literature (i.e., Richardson et al., 2020) revealed a gap in empirical evidence informing the conceptualization of moral injury, highlighting that the most widely used citations for defining moral injury either lacked empirical support when initially constructed or relied on provider or professional perspectives rather than the voices of service members or veterans. Therefore, the current phenomenological study was developed in response to a call for action to develop a research-grounded description of moral injury directly with military veterans. Four primary themes and eleven subthemes emerged, suggesting moral injury can be conceptualized by chronic, deep-rooted experiences of (a) betrayal, (b) moral ambivalence, (c) soul injuries, and (d) lack of reconciliation. Having a more accurate description and specific constructs related to moral injury, particularly one constructed through the voices of veterans, is an important step toward conceptual clarity for moral injury, which in turn may allow professionals to move toward appropriately identifying and treating deeper wounds of the soul.

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Table 1

Contextual Information for Veteran Participants (n = 19)

Veteran Pseudonym	Branch	Years of Service	Rank	Age	Gender
Andy	Army	5	E5-E6	39	Male
Wilson	Army	4	E5-E6	37	Male
Scott	Army	8.5	E7-E8	40	Male
Bob	Army	20	E5-E6	44	Male
John	Air Force	7	E5-E6	29	Male
Sam	Marine Corps	17	E7-E9	41	Male
Shepherd	Navy	8	E5-E6	33	Female
Gene	Army	20	O4-O5	43	Male
Whitley	Navy	4.6	E5-E6	29	Female
Carl	Marine Corps	8	E5-E6	34	Male
Thad	Army	4	E1-E4	26	Male
Paul	Air Force	26	E7-E9	56	Male
Jack	Army	4	E1-E4	32	Male
April	Navy	8	E1-E4	33	Female
Alexander	Army	7	E1-E4	28	Male
Luke	Army	7	O1-O3	35	Male
Josh	Army	7	E5-E6	44	Male
Susan	Navy	21	O4-O5	47	Female
Donald	Marine Corps	22	E7-E9	46	Male

Table 2

Descriptive Statistics (N = 19)

Demographic Variables	Percent (%)/*M*	*SD*
Gender		
Female	21.1%	
Male	78.9%	
Age	37.68	7.80
Race		
Black or African American	5.3%	
White, non-Hispanic	89.5%	
More than one race	5.3%	
Religious Identity		
Agnostic	15.8%	
Christian	57.9%	
None/Non-religious	21.1%	
Don't know	5.3%	
Military Branch		
Air Force	10.5%	
Army	52.6%	
Marine Corps	15.8%	
Navy	21.1%	
Years of military service	10.95	7.32
Years since service	5.84	4.00
Rank		
Enlisted	84.2%	
Officer	15.8%	
Experienced at least 1 combat deployment	73.7%	
Experienced at least 1 non-combat deployment	68.4%	
Discharge Status		
Honorable	94.7%	
Medical	15.8%	
Retired	36.8%	

Hx of suicidal ideation	89.5%
Hx of at least 1 suicide attempt	10.5%
Prior dx of PTSD	36.8%
Prior dx of TBI	26.3%
Severity of Depressive Sxs	
None/Minimal	10.5%
Mild	31.6%
Moderate	31.6%
Moderately Severe	15.8%
Severe	10.5%

Table 3
Correlations

Variables	*M(SD)*	1	2	3	4	5	6	7	8	9
1. Morally Injurious Events	*30.95(10.22)*	-	.753**	.881**	.689**	.660*	.327	.349	-.306	.516*
2. Perpetration by Others[a]	*4.21(1.34)*		-	.600**	.336	.260	.142	.167	-.126	.583**
3. Perpetration by Self[a]	*2.80(1.51)*			-	.325	.722**	.288	.468*	-.415	.362
4. Betrayal[a]	*3.77(1.39)*				-	.300	.314	.063	-.066	.364
5. Moral Injury Symptoms	*456.08(63.86)*					-	.000	-.189	-.021	.005
6. Post-traumatic Stress Disorder	*2.71(2.14)*						-	.691**	-.447	.387
7. Depression Symptoms	*11.68(6.53)*							-	-.616*	.468*
8. Spiritual Well-being	*22.53(8.09)*								-	-.260
9. History of Suicidal Ideation	*.89(.32)*									-

[a]Subscales from the *Moral Injury Events Scale* (Nash et al., 2013)
*$p < .05$, **$p < .01$

Table 4

Themes and Subthemes Related to Veterans' Morally Injurious Experiences

Themes	*n* size (*N* = 19)	Subthemes	Thematic Examples	Quotes
1. Betrayal	*n* = 9	A. Self-betrayal	Engaging in or failing to prevent encounters that directly went against personal moral codes or what one once believed to be appropriate (i.e., a betrayal of what's right vs wrong).	*"It felt like I betrayed myself in a sense because these are things that I hold dear, that are part of me, and I didn't follow it. I look back at anger and that's where the anger, regret and this sense of like stabbing my own self in the back, I guess, comes in. It was a fact that if I tried to voice anything that it was going to end very poorly for me."* *"I felt like I failed them. I felt like even if I wasn't there, that the training I had instilled upon [my unit] should have still carried through, and it didn't. They should have still done what they had been trained and had done in rehearsals thousands of times. They froze, so then I questioned, 'All right, did I miss something? Or, was I the piece that was missing? Is it because it wasn't me, or was it because I didn't train them hard enough or I didn't do right?'"* *"Oh, there's anger towards them, there's anger towards me. I'm ashamed of doing what I fricking did, I feel fucking betrayed for some reason. It's just like, we were just doing our fucking job, which is bullshit. I don't know, I just feel ... absolutely fucking disgusted."*
	n = 14	B. Betrayal from or unto others	Witnessing, learning about, or indirectly experiencing the immoral or unethical actions and decisions of others; these actions often resulted in deep-rooted moral distress as a result of misalignment in value systems OR guilt due to an inability to prevent experiences from occurring.	*"There's some little boy that had been abused by a male relative. And it basically came down to, 'Oh, yeah, there's nothing we can do about it. It's none of our business....' Little kids being sexually abused has never been high on my moral acceptance."* *"It was both: I think the betrayal from higher [authorities] really impacted me in a different kind of way, but I even ... I even saw this shit from peers. It's just like, how can you betray my trust like that when you're the guy that I'm relying on… on my left or my right, to do what's right and to save my ass, and you're doing some shit like this, and you're okay with it?"*
	n = 15	C. Systemic betrayal[1]	Misuse of power across the greater hierarchical system as a whole, often resulting in lack of trust due to continuous moral violations	*"It's that powerlessness when you bring something up [to leadership], or you try to do something, or you try to right that moral compass, and it's like, no, we don't do that. That does kind of feel like fricking betrayal."* "*There were few incidences where you wanted to say something, but at the same time you couldn't because (1) you knew nothing was going to happen or (2) if something did happen, it would come back on you. [Leadership] would do their best to hide it or change it or whatever the case may be. It just really tested me. It also angered me because there were situations where it was like I ... that side of me wanted to do something, but I knew it would be very bad… it would end very badly for me if I said anything."*

					"*I look at the military and I'm still angry at the systemic sexism that exists; it still exists."*
2. Moral ambivalence	*n* = 16	A.	Questioning of Purpose	The misalignment in personal values and the decisions or outcomes of war often resulting in questioning the purpose of one's involvement within higher-level systemic affairs	"*I guess I questioned whether us being there was any benefit, like the whole mission set was for the liberation of the Afghan people and to implement democracy but just us being there was causing harm to those people. I thought about how they would feel about that…whether they even really wanted us to be there… or there to just essentially stir the pot, I guess."* *"I started to question like, 'What are we actually doing? Why did we go there?'.... When you go further up from that it starts to make me question the overall objective of what our point [was]. It seems so gratuitous now. The fact that we're still over there, we're still taking lives and losing lives, for what? It's just... I don't know."* *"What's the purpose? What was to be gained by [the war]? Do we personally have a beef with each other? No."*
	n = 13	B.	Shift in world view	The fracturing in one's moral foundation, once influenced by spiritual, family, and/or military values caused by ongoing threats and infringements to an individual's worldview and the ethical expectations of self and others.	*"The experiences in seeing the really nasty stuff just made me question, 'how is there an all loving and all powerful being or god that is allowing this to happen?' It just didn't make any sense to me how the teachings of the church and what God is and I'm seeing this on the other hand and this is real life and it's like, 'well this doesn't make any sense how somebody could allow this to happen or control it to not happen,' if that makes sense. So, it was like, 'is there anything out there? Is there anything up there?' Because from what I've seen, it can't be. If you're all powerful then you don't let this happen; if you're all loving then you don't let this happen to your people."* *"I felt like my whole moral base and moral understanding was shattered."* *"Then I used to really believe that our politicians and the people that sent us to war had our best interest in mind. I really don't believe that anymore."* "*But after going to the other side of the world and seeing that religious motivations were also causing this insane cruelty, it just made me start thinking... It is hard to believe that any sort of God, or religion, or anything could righteously motivate these kinds of actions."*
	n = 10	C.	Moral shades of gray	Viewing ethical decisions and moral values on an ambiguous spectrum that much consider context rather than "black and white"	*"There is a lot of gray in the world. There's a lot of 'depending on the situation.' The right answer isn't always the right answer depending on the context."* "*But it definitely shook the abstract morals that I held, those views that I was raised up with of good and evil being black and white. It made me realize that very rarely is it ever black and white."* *"I believe morals are on a sliding scale. Everybody's morals change when depending upon the situation. If self-preservation comes in, if preservation of others…."*

3. Soul wounds	*n* = 15	A.	Guilt	Presence of deep-rooted guilt or regret	*"At points, I've felt guilt because it was organized and funded ... The clinic [that was bombed] was funded by the American forces. Um, so the guilt of that and I know there's nothing directly tying me to that but still there's the guilt ..."* *"A lot of fucking guilt. A lot of guilt. I question shit. Then I feel bad for questioning shit."* *"I know there's not things that I could've done to really have changed the outcome for some people, but you almost get this hero complex, I guess, and it's like you want to save everybody. Then, when you can't, it just takes a toll."* *"It hurts. I've tried [to die by suicide] twice. Well, three times overall but twice since being out."* *"I see myself as an empty shell. I was once full of great potential....I'm not one that wishes to die, but I can't wait till I forget. If that makes sense."*
	n = 14	B.	Demoral-ization	Chronic disheartened feeling	*"Everyone's so demoralized that we're stuffing dead guys in garbage bags. We can't fight the enemy. And our allies are a bunch of drug abusing pedophiles who keep sex slaves."* *"I would just get super burnt out because I'd just be like ... because I just wouldn't have a meaning, and just I'll be like, all this is for nothing. All the sleepless nights or all these long hours that I'm putting in, it's all for nothing. It's all so that I'm just somebody's pawn, and I know it and that's just a very like, I don't know, demoralizing position to be in."* *"I feel like everybody has their own reasons, but I totally understand why people commit suicide in the Army. At least in the infantry; it was a super horrible, depressing environment."*
	n = 13	C.	Isolation	Experiences of loneliness, separation from others, disconnect both during and after service	*"I found when I got out, no longer is everything about a team, and trying to work together. It's almost 'everyone for themselves' is what it feels like. You get out, and you start looking for a job, or something; [then], teamwork doesn't really apply in that. It's more where everyone's out looking for themselves."* *"There's also the catch 22 of veterans, where they're just like, 'shut up, you don't understand, you weren't there,' but 'I'm not going to tell you because you wouldn't understand, because you weren't there.' That's even more isolating."*
4. Lack of reconciliation	*n* = 11	A.	Duty first	The expectation that the mission of the larger system should always be in the forefront of any encounter or decision; This may lead to blurred ethical lines as what might be considered "wrong"	*"When you're in the military, you basically have one thing you're supposed to do, and that's just follow instructions and do what you [are] told to do. You don't necessarily need to like the fact that you know all the stuff was going on. You just do what you do and carry on. You can be internally split between the good and the bad, but ultimately, it's just something you have to do because it's all part of the game, so to speak."*

			to the larger society may be allowed, or even necessary, within a given context.	*"You've got to balance the mission and your people, and for the Air Force, the mission always wins. Sometimes you have to put people in situations you don't want to."* *"I think I did good as a service member, but then in turn because of that, I failed as a mom [tearful]."* *"That's what the military's all about. You have to do your job and do your mission. There's no philosophers. You can't sit around and debate the ethics of what you're doing. You have to do it."*
	n = 9	D. Penitence	An attempt to make cognitive and ethical sense of the experiences one witnessed, engaged in, or learned about.	*"I am very solidly grounded in my ethics and my morals and my values. After everything I've been through, I've got a lot of ground to make up, and I'm not going to violate that shit again, on any level.... I'm doing a hell of a lot more to legitimately fricking help people, but I don't consider myself a better person, even though I have a lot of people tell me I'm a good person. It's like, nah, eh, no, I'm trying to make up some ground.... I'm trying to dig myself out of a fricking pretty deep hole. I do legitimately want to help people, but that's kind of the drive behind it."* *"It just caused me to try to work myself to be a better person and sort of like an offset. I've got to assure going forward that I don't allow myself to fall back on any bad habits. And I sort of make up for things that I didn't correct, things that I didn't address. That's really just [an] offset for my morals."* *"So, trying to bridge the gap of, I want to go in to [the military] help all these people, but I mean, I'm here trying to kill at the same time, which you're taking life, and saving life. Trying to bridge that gap. How does that work together?"*

[1]"Systemic betrayal" refers not to the military in general or a specific branch/unit but rather experiences of betrayal from a multi-level, systemic perspective. According to General Systems Theory (von Bertalanffy, 1968), "a system is a cohesive conglomeration of interrelated and interdependent parts. Every system is bounded by space and time, influenced by its environment, defined by its structure and purpose, and expressed through its functioning. A system may be more than the sum of its parts if it expresses synergy or emergent behavior. Changing one part of a system may affect other parts or the whole system."

CHAPTER 6: MORAL INJURY: A SYSTEMIC LENS FOR A SYSTEMIC ISSUE

Understanding morally injurious experiences that disrupt the lives of military personnel and other populations who are predisposed to traumatic and moral distress is complex and several strategic steps are necessary to uphold moral injury as a valid and legitimate construct. Originally, this dissertation was designed to examine differences between traumas of the mind (i.e., posttraumatic stress disorder), body (traumatic brain injury), and soul (moral injury) that occur with service members and veterans, only to find in the early construction of the dissertation that the primary definition for moral injury had little research to back the formation of the operational description. That reality set a series of strategic steps in motion toward a vision that would (a) critically review the historical literature pertaining to moral injury and (b) work toward a research- and veteran-informed operational definition that represented the voices who are most influenced by the construct.

The purpose of this chapter is to provide a brief overview of the dissertation which details a step by step process that adds rigor and validity to the construct: moral injury. Secondly, the findings from Chapters 2, 3, and 5 afforded an opportunity to end this dissertation with an additional contribution to science; the provision of a theoretical model that provides a framework in which to honor the complexity of moral injury and gives space for future research designs and clinical models. With so few data-driven research articles published on moral injury, particularly with service members or veterans, a challenge is put forward as part of this chapter for researchers and clinicians to connect the dots on moral injury at the systemic and conceptual levels. Implications are then provided to encourage researchers to further strengthen moral injury as a construct that may then compel experts to consider this trauma of the soul in relation to the DSM and the unique treatments indicated for those influenced by moral injury.

A Review of Chapters

To move toward a better understanding of moral injury, a step by step research strategy was set in motion to identify the historical research, current trends, and personal perspectives on the role of morally injurious experiences, beliefs, and values in relation to military service. Chapter 1 highlighted the need for empirical-research for moral injury by introducing readers to the inner conflicts often experienced by military personnel, suggesting that with the number of deaths by suicide for service members and veterans increasing each day, that it is becoming drastically clear that as researchers, we are missing something in our understanding of military experiences. A review of the current literature on moral injury in the context of military service members was included as part of Chapter 2, which also worked to differentiate moral injury and symptomology from other common traumatic stress disorders, including posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI) by providing a biopsychosocial-spiritual (BPSS; Engel, 1977, 1980; Wright, Watson, & Bell, 1996) theoretical exploration of the common injuries of the mind, body, and soul experienced by military personnel. This review proposed that in order to move toward a more holistic understanding of moral injury, researchers must work to develop a clear operationalized definition with boundary and symptom parameters that differentiates moral injury as a distinct diagnosis separate from other trauma-related conditions. Additionally, the chapter put forward benefits for constructing an official diagnosis for moral injury along with implications that can further research for moral injury across other populations outside of military contexts in order to generalize diagnostic criteria for the construct. This review evolved into an in-depth systematic review.

Chapter 3 sought to identify key definitions used throughout the literature to describe moral injuries endured by service members and veterans. Findings from the systematic review

revealed that only two of 12 key definitions for moral injury were grounded in empirical evidence when initially developed. The findings from Chapter 3 suggested that much of what we know about moral injury is conceptual in nature. The lack of a research-informed operational definition punctuated the need for such work to be conducted. A research-informed definition would strengthen the face validity and reliability for scientists and practitioners who seek to incorporate moral injury into future studies or clinical programs (Richardson, 2020b). In particular, findings from this systematic review and the development of a research-informed definition would provide legitimacy to any measure or screener pertaining to moral injury.

Chapter 4 responded to the call for action from Chapter 3 by developing a design that would help to construct a research-informed definition for moral injury. The design outlined in Chapter 4 was developed in order to capture a veteran-informed and empirically supported definition of moral injury. A panel of military and research experts hypothesized that a phenomenological qualitative research study with veterans would result in the most purposeful and important step for gaining insight into such injuries.

The purpose of the study implemented in Chapter 5 was to seek out a research-grounded definition surrounding times when personal values or morals did not align with job duties or requirements associated with military service among U.S. veterans. Throughout a series of 19 in-depth interviews, four primary concepts associated with moral injury emerged, including (a) betrayal, (b) moral ambivalence, (c) soul wounds, and (d) the inability to reconcile with the atrocities endured during service. Most compelling from these findings was the revelation of moral injury as a systemic issue and that there are elements of moral injury that are insidious, so much so that they were consistently illustrated through the voices of veterans.

The remainder of this chapter provides a description of the systemic and insidious elements that emerged from the interviews with U.S. veterans and compares as well as contrasts these elements with the previously published definitions on moral injury. The intention of this description is to connect the dots on the systemic layers of moral injury for future researchers and clinicians.

A Systemic Lens for a Systemic Issue: Connecting the Dots

According to Richardson (2020a), veterans attribute much of their soul wounds (i.e., moral injury) to interpersonal betrayal and morally ambiguous contextual influences that are experienced at numerous systemic levels. As the findings from Richardson's (2020a) research with veterans unfolded, it became clear that a theoretical framework was needed to guide future research on moral injury. Such a theory would further strengthen the rigor for future designs and interventions. Specifically, in relation to moral injury, a theoretical framework is needed to connect the dots that honor the systemic representation, tenets, and propositions between constructs that inform moral injury. We share in the enthusiasm of Carpiano and Daley (2006) who said:

> "In an era where interdisciplinary research is encouraged and embraced, where population health is being studied by researchers in a range of fields as diverse as epidemiology, sociology, political science, environmental science, anthropology, psychology, and medicine, research incorporating any two or more of these perspectives must be conducted with careful attention to theory" (p.564).

A theory such as Bronfenbrenner's ecological theory (1979) - which highlights the interconnectedness of one's intrapersonal development in relation to various influential systems – shows that we must consider the multi-level systemic experiences of service members in

tandem with their biopsychosocial-spiritual (Engel, 1977, 1980; Wright et al., 1996) and relational health.

Bronfenbrenner's ecological theory (1979) highlights the significant influence of multi-level systems of development, including the microsystem (i.e., the smallest and most immediate environment), mesosystem (i.e., interactions or connections), exosystem (i.e., indirect environments), and macrosystem (i.e., the largest system which encompasses influences of culture, values, belief systems). With the aim of connecting the systemic dots of moral injury, Bronfenbrenner's theory (1979) helps to better understand these injuries of the soul as they interface with military experiences from the microsystem to macrosystem level.

For example, findings from Richardson (2020a) suggest intrapersonal experiences of moral injury (i.e., the microsystem) include possible experiences of betrayal of one's personal values and feelings of guilt, which cannot help but to influence relationships with others both during and after service (i.e., mesosystem). Implications at the mesosystemic level were evident by veterans' descriptions' of interpersonal betrayal and feelings of isolation, relational experiences which supported a demoralization military climate (Richardson, 2020a). Moral injury at the exosystem level may be represented by the systemic betrayal that was described as one of the most prominent morally injurious experiences from military service, while macrosystemic influences were captured by the overarching cultural influences and motivations of the military system which many often questioned; additionally, Richardson (2020a) found that many veterans experience various shifts in worldviews (e.g., support of the U.S.'s involvement in warfare, spiritual beliefs, etc.) due to the their deep rooted injuries to the soul.

Given the multi-level systemic intricacies of moral injury, a BPSS perspective (Engel 1977, 1980; Wright et al., 1996) may also support the interweaving of cellular to societal

complexities of the construct as researchers and practitioners work to unpeel these injuries of the soul, particularly in relation to other traumatic stress conditions (e.g., PTSD, TBI). Engel (1977) developed the biopsychosocial (BPS) model in order to accurately understand the interrelatedness of the biological, psychological, and social influences on the human system and illness (Engel, 1977, 1980). In 1996, a *spiritual* component was added (Wright et al., 1996), emphasizing the importance of one's values, beliefs, and world view in the context of health, illness, injury, and healing. The theoretical tenets of Bronfenbrenner's ecological theory (1979) and/or the biopsychosocial-spiritual (BPSS; Engel, 1977, 1980; Wright et al., 1996) framework help to offer a systemic lens to address, test, analyze, and confirm the complex and systemic issues related to moral injury.

Moral Injury at the Systemic Level: The Chasm

Within the past ten years, the construct of moral injury has begun to receive more serious attention in the military literature (Drescher, et al., 2011; Fontana & Rosenheck, 2004; Litz et al., 2009; Neria & Pickover, 2019). While morally injurious experiences have likely existed for centuries, it wasn't until recently that issues of morality, spirituality, and military ethics started to gain more attention (Drescher et al., 2011). Issues of psychological distress and military trauma, date back to ancient times and were first documented as part of American war-time experiences during the Civil War. Overtime, our understanding of such experiences has developed into empirically informed conceptualizations and validated diagnoses for common trauma related stress conditions, including posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI). While strides have been made in research, practice, and policy since the first printing of an official diagnosis of PTSD and criteria for a TBI were developed (American Psychiatric Association [APA], 1980; National Institute of Neurological Disorders and Stroke, 2017), the

growing epidemic of deaths by suicide among military personnel suggests that something is still missing from our understanding of the military veteran experience.

A great deal of previous moral injury research focused on the overlap in symptomology with PTSD, and what we have learned is that standard treatments for PTSD often do not help with moral injury (Blinka & Harris, 2016; Harwood-Gross, 2020; Litz et al., 2009). A primary study of cognitive behavioral therapy (CBT) for PTSD – a commonly used and highly researched treatment modality for trauma – found that most participants still suffered from full-blown PTSD after three months in the study and only 15 percent of those who received CBT no longer experienced PTSD symptoms (Schnurr et al., 2007). Thus, a clear chasm remains as suicide continues to rise and ongoing use of validated treatments for PTSD do not result in beneficial, long-term outcomes. According to the Department of Veteran Affairs (2019), the strongest link to both suicide attempts and thinking about suicide for veterans with PTSD is guilt. Yet, guilt has been found to be more reflective of possible moral injury rather than a diagnostic symptom of PTSD, which posits the question: *Is it truly PTSD that continues to overwhelm our military men and women – or could it be moral injury?*

A primary concern from a systemic level is that as service members return from battlefields and transition into civilian life, moral injuries remain overlooked or misdiagnosed, leaving these deep-rooted injuries unacknowledged and unsupported. Moving beyond the understanding and treatment of traumatic stress disorders by acknowledging the possibility of moral injury as part of individuals' lived experiences, via the BPSS framework (BPSS; Engel, 1977, 1980; Wright et al, 1996) and an ecological systemic lens (Bronfenbrenner, 1979) also suggests the need to view prevention and treatment from a multi-level systemic perspective. We cannot continue to place the burden of healing on the individual alone but treat these issues

holistically by attending to the systemic and relational dynamics which may contribute to or that are affected by moral injury. To do this, we must also look deeper at the specific constructs (e.g., those that have a research basis (i.e., Richardson, 2020a) and those that have long been cited as pertinent to moral injury (i.e., Litz et al., 2009)) which may provide insight to connect the microlevel dots of such injuries.

Moral Injury at the Construct Level

A systematic review of the most commonly used definitions for moral injury across military literature revealed that the most widely used citations for defining moral injury either lacked empirical support when initially constructed (e.g., data-driven or psychometric properties) or relied on provider or professional perspectives rather than the voices of service members or veterans (Richardson et al., 2020b). To increase validity of the phenomenological description that emerged from recent interviews with veterans (Richardson et al., 2020a), an important next step for research was to compare and contrast key constructs and themes from other commonly used descriptions of moral injury. Specifically, key constructs from Richardson (2020a) – a study aimed at a research-informed definition of moral injury – were compared with themes from two definitions which were initially grounded in empirical support using provider and professional perspectives (i.e., Drescher et al., 2011 and Stein et al., 2012) and the most commonly cited definition of moral injury (i.e., Litz et al., 2009).

Richardson (2020a) revealed that moral injury may be conceptualized by chronic, deep-rooted experiences of (a) betrayal, (b) moral ambivalence, (c) soul injuries, and (d) lack of reconciliation. Many veterans described some of their most difficult and morally jolting experiences during service as related to "perpetrating, failing to prevent, and bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" - key constructs

also highlighted as part of Litz and colleagues' (2009) description of morally injurious experiences. However, these were not the only experiences described by veterans, as other key constructs emerged from the Richardson (2020a) study in relation to questioning the overall purpose of their mission, the misalignment of one's personal values with the values of the military or those around them, and being faced with morally ambiguous situations which did not have clear "black or white" answers.

Stein and colleagues (2012) conducted an empirical study that focused on traumatic military events based on a review of clinical records of service members and veterans, and two schemas pertaining to moral injury emerged: (1) moral injury by self as a result of "[Committing] an act that is perceived to be a gross violation of moral or ethical standards" and (2) moral injury by other as a result of "[Witnessing or being the victim of]" such acts. Rather than relying on service members and veterans as the source to define the concept or moral injury, Drescher et al. (2011) formed the definition from their study based on the perspective of professionals who treat service members or veterans. "The disruption in an individual's confidence" in "one's own and others' motivations" emerged as the primary morally injurious construct among their sample.

While all three of the historical descriptions (i.e., Drescher et al., 2011; Litz et al., 2009; Stein et al., 2012) highlighted the interpersonal and intrapersonal violations of moral and expectations, none explicitly highlighted betrayal as a core construct, particularly systemic betrayal – one of the most salient themes found from the recent study by Richardson (2020a). Additionally, previous descriptions of moral injury focused primarily on specific external events (e.g., witnessing, perpetrating, or failing to prevent transgressive acts) which may lead to the injury but lacked explanations for the wound itself, including specific symptoms/outcomes or the

intrapersonal processes occurring within. Richardson (2020a), in contrast, suggested that veterans' experiences of *betrayal* in tandem with feelings of *moral ambivalence* (i.e., questioning of purpose, shifts in world views, moral shades of gray), *soul wounds* (i.e., guilt, demoralization, isolation), and the *inability to reconcile* with such experiences (even with the understanding that duty comes first and after attempts with penitence) were foundational constructs of moral injury.

Implications

With very little overlap among constructs, this comparison supports the need for additional research on what remains unknown about moral injury. In addition, more research is needed on what is believed to be known about moral injury in order to further generalize the findings. While there has been a clear investment by many in learning more about moral injury, many loose ends remain. In our attempts to more fully connect the dots for moral injury and ground the findings in a theoretical framework (e.g. the biopsychosocial-spiritual framework (Engel 1977; 1980; Wright et al., 1996) and Bronfenbrenner's ecological theory (1979)), it is clear that chasms still exist. As such, researchers must continue to expand the understanding of the morally injurious experiences of service members and veterans by working to develop a more consistent and thorough definition, including theoretically grounded and research-informed constructs through service member or veteran-supported studies and clinical designs.

One suggestion would be that rather than viewing moral injury as a construct distinct to the field of psychology, trauma, or theology, applying a more systemic framework may be most appropriate for capturing the multi-level implications. As noted previously, a biopsychosocial-spiritual lens (Engel 1977; 1980; Wright et al., 1996) may support the cellular to society and spiritual implications of moral injuries. Additionally, Bronfenbrenner's ecological theory (1979) may be a potentially influential theory in grounding future assessments and interventions for

moral injury. It became evident through interviews with veterans (Richardson, 2020a) that moral injuries should be understood within the context of a series of nested multi-level systems. Thus, these theories provide important frameworks for understanding the interplay between context, personal characteristics/values, and BPSS systemic influences on the development of moral injury.

An example of one important next step in research involves the process of defining individual constructs unique to moral injury, which may then allow researchers to develop research-informed measures that best capture the phenomenon. These steps would provide the appropriate foundation for conducting confirmatory factor analyses of core constructs to streamline the development of appropriate measures. Without clear constructs, we cannot have accurate measures, and without appropriate measures, we cannot confirm appropriate diagnoses. Without accurate diagnoses and understandings, experiences of moral injury will continue to be overlooked, misdiagnosed, and mistreated. As van der Kolk (2014) suggested, "You cannot develop treatment for a condition that does not exist... [A] diagnosis informs treatment and getting the wrong treatment can have disastrous effects (p. 145)."

Conclusion

With the number of deaths by suicide increasing among veterans, we cannot turn a blind eye to the morally injurious experiences of our military men and women. In fact, we urge professionals to turn toward those faced with morally-jolting experiences and traumatic stress as part of their typical duties – turning away only further supports the systemic betrayal that many described as the most damaging part of their service. We owe it to those who have served to help bridge the chasm that exists between our understandings of these injuries of the soul and accessing the appropriate support and services that could potentially save a life.

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APPENDIX A: IRB APPROVAL

EAST CAROLINA UNIVERSITY
University & Medical Center Institutional Review Board
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600 Moye Boulevard · Greenville, NC 27834
Office **252-744-2914** · Fax **252-744-2284** ·
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Notification of Exempt Certification

From: Social/Behavioral IRB
To: Natalie Richardson
CC: Angela Lamson
Natalie Richardson
Date: 10/28/2019
Re: UMCIRB 19-001716
Values and Beliefs Associated with Military Service

I am pleased to inform you that your research submission has been certified as exempt on 10/25/2019. This study is eligible for Exempt Certification under category # 2c.

It is your responsibility to ensure that this research is conducted in the manner reported in your application and/or protocol, as well as being consistent with the ethical principles of the Belmont Report and your profession.

This research study does not require any additional interaction with the UMCIRB unless there are proposed changes to this study. Any change, prior to implementing that change, must be submitted to the UMCIRB for review and approval. The UMCIRB will determine if the change impacts the eligibility of the research for exempt status. If more substantive review is required, you will be notified within five business days.

Document	Description
Email Script(0.01)	Recruitment Documents/Scripts
Informed Consent to Interview(0.02)	Consent Forms
Online Flyer(0.01)	Recruitment Documents/Scripts
Online Survey Informed Consent(0.01)	Consent Forms
Permission to use measures(0.01)	Surveys and Questionnaires
Phase I - Background Survey(0.01)	Surveys and Questionnaires
Phase I - Background Survey(0.01)	Data Collection Sheet
Phase II - Interview Guide(0.01)	Interview/Focus Group Scripts/Questions
Richardson - Proposed Methods(0.01)	Study Protocol or Grant Application
Social Media Post(0.01)	Recruitment Documents/Scripts

For research studies where a waiver of HIPAA Authorization has been approved, each of the waiver criteria in 45 CFR 164.512(i)(2)(ii) has been met. Additionally, the elements of PHI to be collected as described in items 1 and 2 of the Application for Waiver of Authorization have been determined to be the minimal necessary for the specified research.

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

APPENDIX B: SOCIAL MEDIA RECRUITMENT POST

Military Veterans – We want to hear YOUR story!

Are you a U.S. military Veteran who has been out of the military for 2 to 15 years and experienced at least one deployment? Was there ever a time during your military service that you felt like your personal values or morals were questioned or challenged? We'd love to hear your story!

Many Veterans continue to struggle with separation from service and re-integration into the non-military world. With the number of deaths by suicide for Service members increasing each day, it is becoming drastically clear that we are missing something in our understanding of military experiences. Our hope is that this research will help us to better understand the potentially distressing symptoms and experiences of military Service members that may be getting overlooked and unacknowledged yet continue to impact the emotional and behavioral health of Veterans.

What do I do?
If you are eligible to participate, please complete an online survey that will take approximately 10-15 minutes. This survey is completely anonymous, and all information will be kept confidential. *The **first 25 veterans** to finish the survey will receive a gift card!*

TO PARTICIPATE, USE THIS LINK: …….
Not a Veteran, but want to help? If you know someone who is eligible to participate, *please **SHARE** this post and flyer*.

Thank you for your time and consideration!

APPENDIX C: RECRUITMENT EMAIL

To Whom It May Concern,

My name is Natalie Richardson, and I am a doctoral student from East Carolina University's Medical Family Therapy program. I am conducting a research study to explore how U.S. Veterans' personal values and morals are impacted by military experience. Many Veterans continue to struggle with separation from service and re-integration into the non-military world. With the number of deaths by suicide for Service members increasing each day, it is becoming drastically clear that we are missing something in our understanding of military experiences. My hope is that this research will help us to better understand the potentially distressing symptoms and experiences of military Service members that may be getting overlooked and unacknowledged yet continue to impact the emotional and behavioral health of Veterans.

To participate, you must be 18 years or older and a U.S. Veteran who experienced at least one military deployment and has been out of the military for *at least 2 but no more than 15 years*.

The first portion of this research is an anonymous online survey that is completely voluntary and confidential. *The first 25 people to complete their online survey will receive a gift card!*

Since your answers are to remain anonymous, PLEASE DO NOT PUT YOUR NAME ON THIS SURVEY.

The survey will take approximately 10-15 minutes to complete. Please answer the questions openly and honestly. You may end your participation at any time with no penalty.

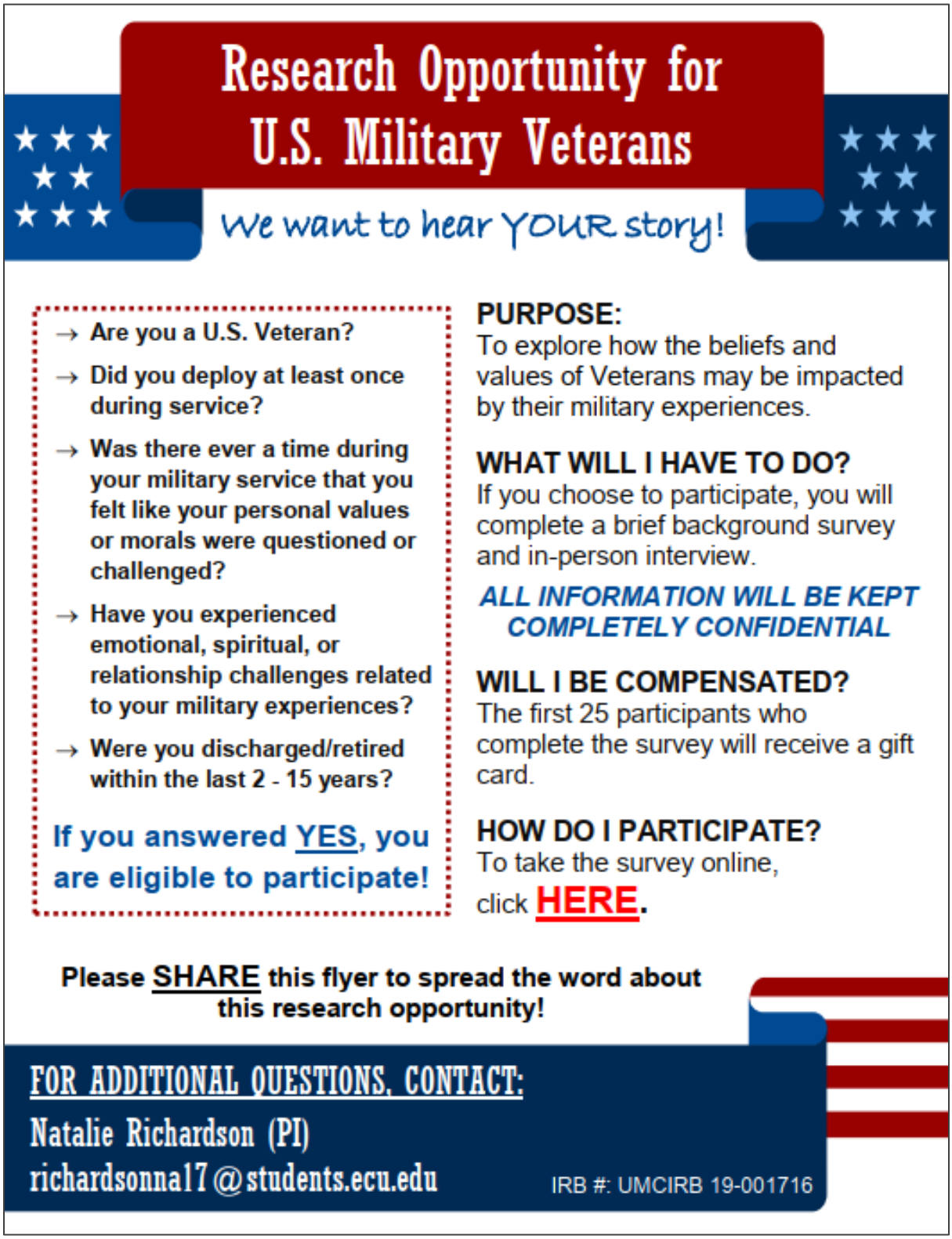
Thank you for your consideration!

Please click the following link to take the survey:
https://redcap.ecu.edu/surveys/?s=EJFJPLWFWL

All the best,

Natalie Richardson, MS
Medical Family Therapy
East Carolina University
richardsonna17@students.ecu.edu
IRB #: UMCIRB 19-001716

APPENDIX D: RECRUITMENT FLYER



APPENDIX E: CONSENT LETTER FOR ONLINE SURVEY

Study ID:UMCIRB 19-001716 Date Approved: 10/25/2019 Does Not Expire.

Department of Human Development and Family Science
College of Health & Human Performance
112 Rivers West | Mail Stop 505 | East Carolina University | Greenville, NC 27858-4353
252-328-4273 office | www.ecu.edu/cs-hhp/hdfs

Dear Participant:

I am a doctoral student at East Carolina University (ECU) in Department of Human Development and Family Science. I am asking you to take part in my research study entitled *"Exploring Veterans' Values and Beliefs Associated with their Military Service."* The purpose of this research is to better understand the beliefs and values associated with military experiences. You are being invited to take part in this research because you are a U.S. Veteran with at least one deployment experience. The amount of time it will take you to complete this survey is approximately 10 minutes. Your participation is completely voluntary.

If you agree to take part in this survey, you will be asked questions that relate to your personal background, military experience, your personal values, and the impact of your military service on your physical, emotional, social, and spiritual health. Our hope is that this research benefits other Veterans and future Service members by better understanding the symptoms and experiences of military service that may be getting missed but continue to impact the emotional and behavioral health of Veterans.

This research is overseen by the University and Medical Center Institutional Review Board (UMCIRB) at ECU. Therefore, some of the UMCIRB members or the UMCIRB staff may need to review your research data. *However, the information you provide will not be linked to you or your personal identifiers.* Therefore, your responses cannot be traced back to you. Your privacy is important to us and will be protected in several ways. All information from the study will be kept in encrypted files and stored on a password protected server. This report will be kept for a minimum of seven years after completion of the study. All identifying information that is requested as part of the informed consent or survey will be stored separately from any responses provided on the survey materials. Your identity will not be evident in relation to the survey data, and I will take precautions to ensure that your identity is protected from any information gathered through this research.

If you have questions about your rights when taking part in this research, call the University and Medical Center Institutional Review Board (UMCIRB) at 252-744-2914 (days, 8:00 am-5:00 pm). If you would like to report a complaint or concern about this research study, call the Director of Human Research Protections, at 252-744-2914.

You do not have to take part in this research, and you can stop at any time. If you decide you are willing to take part in this study, please continue with the survey.

If any part of this study causes you discomfort (whether during the study or in the days following), please contact either of the following resources:

- **Veterans Crisis Line – 24-hour, confidential support; 1-800-273-8255, press 1 or text 838255 – https://www.veteranscrisisline.net/**
- **Military OneSource – 24-hour support, can connect to local resources, 800-342-9647 – http://www.militaryonesource.mil/**

Thank you for taking the time to participate in my research.

Sincerely,
Natalie Richardson, MS
Principal Investigator

APPENDIX F: BACKGROUND SURVEY

Exploring Veterans' Values and Beliefs Associated with their Military Service

This research study seeks to examine the beliefs and values associated with military experiences among U.S. Veterans. We have put together a series of questions designed to explore your military experiences and overall physical, emotional, and spiritual health. We estimate that it will take you about 10-15 minutes to complete this questionnaire.

When you answer these questions, please keep the following in mind:

1. Please answer all questions to the best of your ability.
2. Answer as honestly as possible – please do not merely mark what seems to be "the right thing to say."
3. Remember there are no right or wrong answers. We are interested specifically in what YOU think and feel.
4. Please complete the questionnaire by yourself.

We appreciate your time very much.

Natalie Richardson, MS
Doctoral Candidate
East Carolina University

Angela Lamson, PhD
Faculty Researcher
East Carolina University

BACKGROUND INFORMATION

1. **What is your age? _____**

2. **Which describes your gender identity?**
   - ☐ Female
   - ☐ Male
   - ☐ Trans Woman
   - ☐ Trans Man
   - ☐ Transgender
   - ☐ Gender Variant/Non-conforming
   - ☐ Prefer not to answer
   - ☐ Not listed: _____

3. **How do you describe yourself?**
   - ☐ American Indian or Alaska Native
   - ☐ Asian Indian
   - ☐ Black or African American
   - ☐ White, non-Hispanic
   - ☐ Chinese
   - ☐ Filipino
   - ☐ Guamanian or Chamorro
   - ☐ Hispanic or Latino
   - ☐ Japanese
   - ☐ Korean
   - ☐ Native Hawaiian
   - ☐ Other Asian
   - ☐ Other Pacific Islander
   - ☐ Samoan
   - ☐ Vietnamese
   - ☐ More than once race
   - ☐ Not listed: _____

4. What religious affiliation do you belong with?

- ☐ Agnostic
- ☐ Atheist
- ☐ Buddhist
- ☐ Christian
- ☐ Hindu
- ☐ Islam
- ☐ Jehovah' Witness
- ☐ Jewish
- ☐ Muslim
- ☐ Other Non-Christian/Unspecified
- ☐ None/Non-religious
- ☐ Don't know
- ☐ Not listed: _____

5. What is your current relationship status?

- ☐ Single, never married
- ☐ Married or civil union
- ☐ Cohabitating with a relationship partner
- ☐ Widowed
- ☐ Divorced
- ☐ Legally Separated

MILITARY BACKGROUND

6. With what branch of the military did you serve?

- ☐ Air Force
- ☐ Army
- ☐ Coast Guard
- ☐ Marine Corps
- ☐ Navy
- ☐ Activated Guard or Reservists
  - Which branch? _____

7. What was your rank?

- ☐ E1 – E4
- ☐ E5 – E6
- ☐ E7 – E9
- ☐ W1 – W5
- ☐ O1 – O3
- ☐ O4 – O5
- ☐ O6
- ☐ General or Flag Officer
- ☐ Other: _____

8. What was your Military Occupational Specialty (MOS)?

_____

9. How long did you serve in the military?

_____ years

10. What was your last year of military service? _____

11. Check <u>all</u> that apply in relation to your discharge status:

- ☐ Honorable discharge
- ☐ General Discharge Under Honorable Conditions
- ☐ Other Than Honorable (OTH) discharge
- ☐ Bad Conduct discharge
- ☐ Dishonorable discharge
- ☐ Medical discharge
- ☐ Entry-level Separation (Basic Training discharge)
- ☐ Separation for Convenience of the Government
- ☐ Retired
- ☐ Other: _____

12. Have you ever been deployed to a combat zone?

- ☐ Yes
  - i. How many combat deployments have you experienced? _____
  - ii. When was the year of your ***first*** combat deployment? _____
  - iii. When was the year of your ***last*** combat deployment? _____
- ☐ No

13. Have you ever been deployed to a non-combat zone?

- ☐ Yes
  - i. How many non-combat deployments have you experienced? _____
  - ii. When was the year of your ***first*** non-combat deployment? _____
  - iii. When was the year of your ***last*** non-combat deployment? _____
- ☐ No

14. Have you ever been given a diagnosis of post-traumatic stress disorder (PTSD) by a mental health or medical professional?

- ☐ Yes
- ☐ No

15. Have you even been given a diagnosis for a brain injury or traumatic brain injury (TBI) by a medical professional?

- ☐ Yes
- ☐ No

Patient Health Questionnaire (PHQ-9)

Thank you for your responses so far.

Sometimes Service members and Veterans experience changes in their mood after military service. The following questions ask about how you have felt in regard to your emotions and mood over the last two weeks.

Over the last TWO (2) WEEKS, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
16. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
17. Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**
18. Trouble feeling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
19. Feeling tired or having little energy	**0**	**1**	**2**	**3**
20. Poor appetite or overeating	**0**	**1**	**2**	**3**
21. Feeling bad about yourself…or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
22. Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
23. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	**0**	**1**	**2**	**3**
24. Thoughts that you would be better off dead, or of hurting yourself	**0**	**1**	**2**	**3**

Experiences of Self-Harm

25. Have you *ever* had thoughts that you would be better off dead or of hurting yourself?

- ☐ Yes
- ☐ No

26. Have you ever attempted to end your own life?

- ☐ Yes
- ☐ No
  - If "yes," how many attempts have you made? _____

27. Do you *personally* know other Veterans who have attempted suicide?

- ☐ Yes
- ☐ No

28. Do you *personally* know other Veterans who have died by suicide?

- ☐ Yes
- ☐ No
  - If "yes," how many Veterans do you personally know who have died by suicide? _____

PC-PTSD-5

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide

29. Have you ever experienced this kind of event?

- ☐ **Yes**
- ☐ **No**

→ **If "Yes," please answer the following questions.**

IN THE PAST MONTH, have you:		
30. Had nightmares about the event(s) or thought about the events(s) when you did not want to?	**YES**	**NO**
31. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?	**YES**	**NO**
32. Been constantly on guard, watchful, or easily startled?	**YES**	**NO**
33. Felt numb or detached from people, activities, or your surroundings?	**YES**	**NO**
34. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?	**YES**	**NO**

The Moral Injury Symptom Scale – Military Version Short Form

Instructions: Please circle ***the number*** that most accurately indicates how you are feeling NOW related to your military experience.

35. I feel betrayed by leaders who I once trusted.

1	2	3	4	5	6	7	8	9	10
Strongly disagree		Mildly disagree		Neutral		Mildly agree		Strongly agree	

36. I feel guilt over failing to save the life of someone in war.

1	2	3	4	5	6	7	8	9	10
Strongly disagree		Mildly disagree		Neutral		Mildly agree		Strongly agree	

37. I feel ashamed about what I did or did not do during this time.

1	2	3	4	5	6	7	8	9	10
Strongly disagree		Mildly disagree		Neutral		Mildly agree		Strongly agree	

38. I am troubled by having acted in ways that violated my own morals or values.

1	2	3	4	5	6	7	8	9	10
Strongly disagree		Mildly disagree		Neutral		Mildly agree		Strongly agree	

39. Most people are trustworthy.

1	2	3	4	5	6	7	8	9	10
Strongly disagree		Mildly disagree		Neutral		Mildly agree		Strongly agree	

40. I have a good sense of what makes my life meaningful.

1	2	3	4	5	6	7	8	9	10
Absolutely untrue	Mostly untrue	Somewhat untrue		Can't say true or false		Somewhat true		Mostly true	Absolutely true

41. I have forgiven myself for what happened to me or others during combat.

1	2	3	4	5	6	7	8	9	10
Strongly disagree		Mildly disagree		Neutral		Mildly agree		Strongly agree	

42. All in all, I am inclined to feel that I am a failure.

1	2	3	4	5	6	7	8	9	10
Strongly disagree		Mildly disagree		Neutral		Mildly agree		Strongly agree	

43. I wondered what I did for God to punish me.

1	2	3	4	5	6	7	8	9	10
A great deal (very true)		Quite a bit				Somewhat			Not at all (very untrue)

44. *Compared to when you first went into the military,* has your religious faith since then…

1	2	3	4	5	6	7	8	9	10
Weakened a lot		Weakened a little			Strengthened a little			Strengthened a lot	

Moral Injury Events Scale (MIES)

Please circle the appropriate number to indicate how much you *agree or disagree* with each of the following statements regarding your experiences at any time since joining the military.

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
45. I saw things that were morally wrong.	**1**	**2**	**3**	**4**	**5**	**6**
46. I am troubled by having witnessed others' immoral acts.	**1**	**2**	**3**	**4**	**5**	**6**
47. I acted in ways that violated my own moral code or values.	**1**	**2**	**3**	**4**	**5**	**6**
48. I am troubled by having acted in ways that violated my own morals or values.	**1**	**2**	**3**	**4**	**5**	**6**
49. I violated my own morals by failing to do something that I felt I should have done.	**1**	**2**	**3**	**4**	**5**	**6**
50. I am troubled because I violated my morals by failing to do something, I felt I should have done.	**1**	**2**	**3**	**4**	**5**	**6**
51. I feel betrayed by leaders who I once trusted.	**1**	**2**	**3**	**4**	**5**	**6**
52. I feel betrayed by fellow service members who I once trusted.	**1**	**2**	**3**	**4**	**5**	**6**
53. I feel betrayed by others outside the U.S. military who I once trusted.	**1**	**2**	**3**	**4**	**5**	**6**

FACIT- Sp-12 (Version 4)

Below is a list of statements that other people have said are important.

Please select one number per line to indicate your response as it applies to you <u>IN THE LAST 7 DAYS</u>:	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
54. I feel peaceful.	**0**	**1**	**2**	**3**	**4**
55. I have a reason for living.	**0**	**1**	**2**	**3**	**4**
56. My life has been productive.	**0**	**1**	**2**	**3**	**4**
57. I have trouble feeling peace in my life.	**0**	**1**	**2**	**3**	**4**
58. I feel a sense of purpose in my life.	**0**	**1**	**2**	**3**	**4**
59. I am able to reach down deep into myself for comfort.	**0**	**1**	**2**	**3**	**4**
60. I feel a sense of harmony within myself.	**0**	**1**	**2**	**3**	**4**
61. My life lacks meaning and purpose.	**0**	**1**	**2**	**3**	**4**
62. I find *comfort* in my faith or spiritual beliefs.	**0**	**1**	**2**	**3**	**4**
63. I find *strength* in my faith or spiritual beliefs.	**0**	**1**	**2**	**3**	**4**
64. Difficult times have strengthened my faith or spiritual beliefs.	**0**	**1**	**2**	**3**	**4**
65. Even during difficult times, I know that things will be okay.	**0**	**1**	**2**	**3**	**4**

Thank you for taking the time to complete this survey!

If any part of this survey has caused you discomfort, please contact any of the following resources:

- Veterans Crisis Line – 24-hour, confidential support; 1-800-273-8255, press 1 or text 838255 – https://www.veteranscrisisline.net/
- Military OneSource – 24-hour support, can connect to local resources, 800-342-9647 – http://www.militaryonesource.mil/

OPTIONAL INCENTIVE INFORMATION

To thank you for your time and participation, the research team would like to send you a gift card. If you would like to receive a gift card, you will need to provide your contact information when prompted for us to send your gift card. Your personal information will not be connected to your survey responses.

66. Would you like to receive a gift card?

- ☐ Yes – *I am willing to provide my contact information in order to receive my gift card.*
- ☐ No – *I am not interested in receiving the gift card.*

→ **If "yes," please provide your preferred mailing information:**

- Name (*first, last*): _____
- Mailing Address: _____

_____

City State Zip Code

- Email Address: _____

The next section will ask about your interest in scheduling a face-to-face interview to complete the research process.

CONTACT INFORMATION (OPTIONAL)

To further explore the military experiences of veterans, we would appreciate hearing more about YOUR values and beliefs associated with military service, if willing, through a face-to-face interview. The interview will take approximately 60 minutes to complete.

It is rare that Veterans have the opportunity to share their *transparent voices and honest opinions* related to their military service.

Our hope is that this research will help us to better understand the potentially distressing symptoms and experiences of military Service members that may be getting overlooked and unacknowledged yet continue to impact the emotional and behavioral health of Veterans so that services and supports may be better tailored to meet the needs of Veterans.

67. Are you willing to complete an *in-person or online* interview?

- ☐ Yes
- ☐ No

- First Name: _____
- Last Name: _____
- Phone Number: _____
- Email: _____
- City of Residence: _____
- State of Residence: _____

Thank you for your willingness to participate in this research!

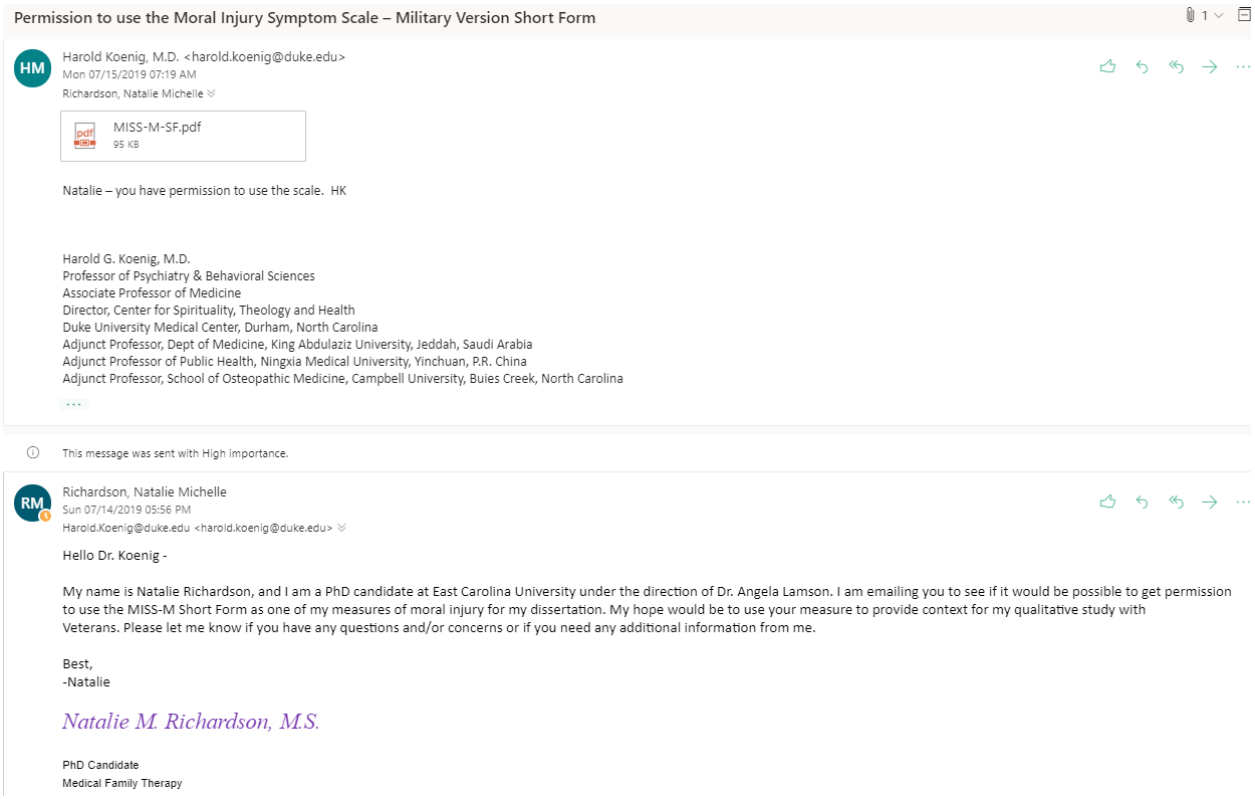
If you consented to an interview, you will be contacted within the next 1 to 2 weeks about scheduling your interview. The interview will take approximately 60 minutes to complete.

All participants who complete an interview will receive a gift card.

Please contact the Lead Researcher with any questions and/or concerns about the study OR if you would like to receive information back about the outcomes from this study:

Natalie Richardson, MS
East Carolina University
richardsonna17@students.ecu.edu
(580) 214-0941

APPENDIX G: PERMISSION TO USE MEASURES



Permission to use the Moral Injury Symptom Scale – Military Version Short Form

HM Harold Koenig, M.D. <harold.koenig@duke.edu>
Mon 07/15/2019 07:19 AM
Richardson, Natalie Michelle

MISS-M-SF.pdf
95 KB

Natalie – you have permission to use the scale. HK

Harold G. Koenig, M.D.
Professor of Psychiatry & Behavioral Sciences
Associate Professor of Medicine
Director, Center for Spirituality, Theology and Health
Duke University Medical Center, Durham, North Carolina
Adjunct Professor, Dept of Medicine, King Abdulaziz University, Jeddah, Saudi Arabia
Adjunct Professor of Public Health, Ningxia Medical University, Yinchuan, P.R. China
Adjunct Professor, School of Osteopathic Medicine, Campbell University, Buies Creek, North Carolina

This message was sent with High importance.

RM Richardson, Natalie Michelle
Sun 07/14/2019 05:56 PM
Harold.Koenig@duke.edu <harold.koenig@duke.edu>

Hello Dr. Koenig -

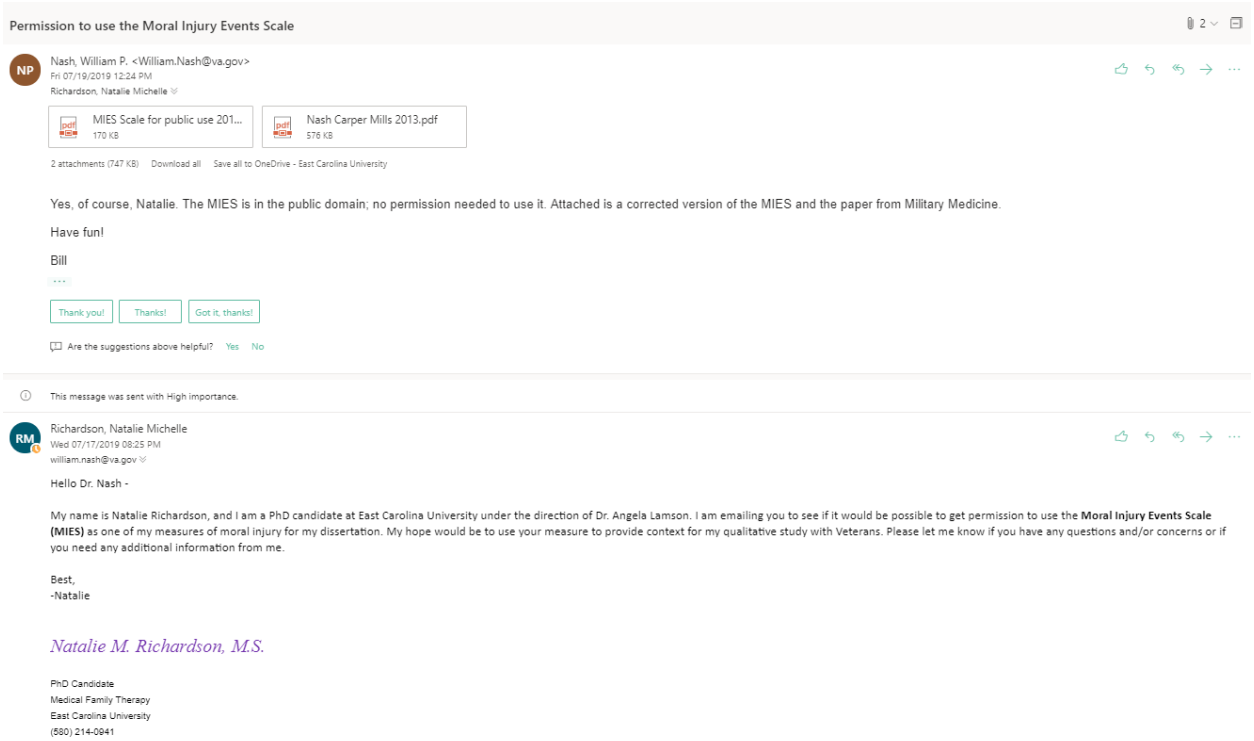
My name is Natalie Richardson, and I am a PhD candidate at East Carolina University under the direction of Dr. Angela Lamson. I am emailing you to see if it would be possible to get permission to use the MISS-M Short Form as one of my measures of moral injury for my dissertation. My hope would be to use your measure to provide context for my qualitative study with Veterans. Please let me know if you have any questions and/or concerns or if you need any additional information from me.

Best,
-Natalie

Natalie M. Richardson, M.S.

PhD Candidate
Medical Family Therapy

Image 1. *Permission to Use the Moral Injury Symptom Scale - Military Version Short Form*



Permission to use the Moral Injury Events Scale

Nash, William P. <William.Nash@va.gov>
Fri 07/19/2019 12:24 PM
Richardson, Natalie Michelle

MIES Scale for public use 201...
170 KB

Nash Carper Mills 2013.pdf
576 KB

2 attachments (747 KB) Download all Save all to OneDrive - East Carolina University

Yes, of course, Natalie. The MIES is in the public domain; no permission needed to use it. Attached is a corrected version of the MIES and the paper from Military Medicine.

Have fun!

Bill

Thank you! Thanks! Got it, thanks!

Are the suggestions above helpful? Yes No

This message was sent with High importance.

Richardson, Natalie Michelle
Wed 07/17/2019 08:25 PM
william.nash@va.gov

Hello Dr. Nash -

My name is Natalie Richardson, and I am a PhD candidate at East Carolina University under the direction of Dr. Angela Lamson. I am emailing you to see if it would be possible to get permission to use the **Moral Injury Events Scale (MIES)** as one of my measures of moral injury for my dissertation. My hope would be to use your measure to provide context for my qualitative study with Veterans. Please let me know if you have any questions and/or concerns or if you need any additional information from me.

Best,
-Natalie

Natalie M. Richardson, M.S.

PhD Candidate
Medical Family Therapy
East Carolina University
(580) 214-0941

Image 2. *Permission to Use the Moral Injury Events Scale (MIES)*

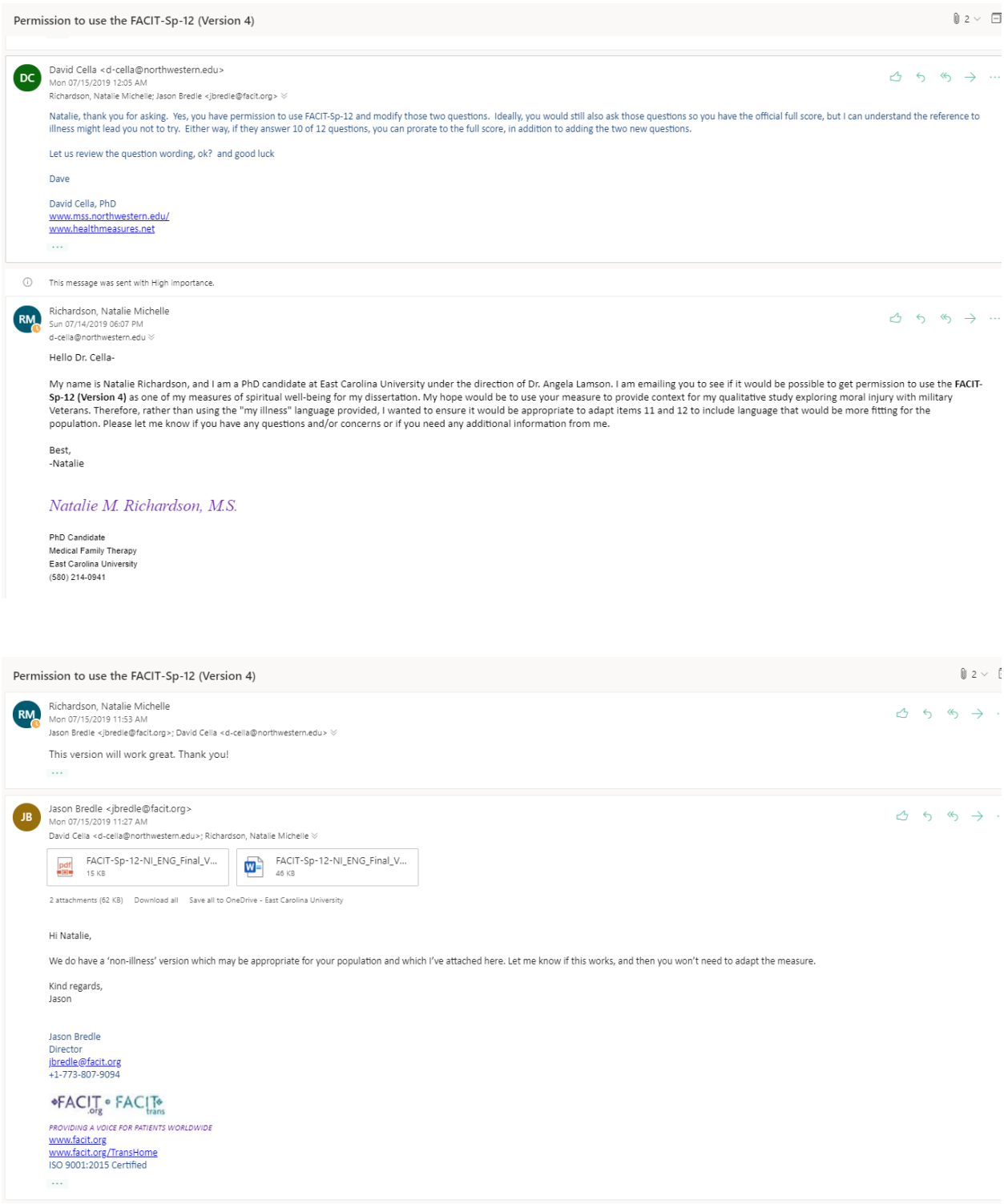


Image 3. *Permission to Use the FACIT-Sp-12*

APPENDIX H: INTERVIEW INFORMED CONSENT

Study ID:UMCIRB 19-001716 Date Approved: 10/25/2019 Does Not Expire.

ECU

Department of Human Development and Family Science
College of Health & Human Performance
112 Rivers West | Mail Stop 505 | East Carolina University | Greenville, NC 27858-4353
252-328-4273 office | www.ecu.edu/cs-hhp/hdfs

Dear Participant:

Researchers at East Carolina University (ECU) study issues related to society, health problems, environmental problems, behavior problems and the human condition. To do this, we need the help of volunteers who are willing to take part in research.

Why am I being invited to take part in this research?
You are invited to participate in a research study being conducted by doctoral candidate Natalie Richardson from East Carolina University's Medical Family Therapy PhD program. The purpose of this research is to better understand the beliefs and values associated with military experiences. You are being invited to take part in this research because you are a U.S. Veteran with at least one deployment experience. Participation in this research is completely volunteer, and the decision to share your experiences is completely up to you. Our research team has no affiliation with the Department of Defense or the Department of Veterans Affairs.

Are there reasons I should not take part in this research?
You should *not* take part in this study if you are not a U.S. military Veteran, if you have been out of the military for *more* than 15 years or are under the age of 18.

What other choices do I have if I do not take part in this research?
You can choose not to participate.

Where is the research going to take place and how long will it last?
If you agree to participate, the interview will take place in a mutually agreed upon location that ensures your safety, privacy, and confidentiality. Therefore, the interview will take place either in the participant's home, participants' work environment, or the Redditt Building on the East Carolina University campus. Interviews will take approximately one (1) hour to complete. With your consent, the interview will be *audio recorded* and transcribed in full. All identifying information will be kept separate from the recordings and transcriptions.

What will I be asked to do?
You will be asked to complete at least one face-to-face interview with the Lead Researcher about your military experiences as a Veteran. All information will be kept completely confidential.

Will I be compensated for taking part in this research?
Upon completion of the interview, you will be provided a gift card as a 'thank you' for your time and willingness to participate.

Will it cost me to take part in this research?
It will not cost you any money to take part of this research.

How will it benefit me to take part in this research?
While there may not be any personal benefit to you, the information gained by doing this research may help others in the future. Our hope is that this research benefits other Veterans and future Service members by better understanding the symptoms and experiences of military service that may be getting missed but continue to impact the emotional and behavioral health of Veterans.

What might I experience if I take part in the research?
There are no identifiable risks (the chance of harm) associated with this research. Any risks that may occur with this research are no more than what you would experience in everyday life. While there may not be physical risks from participating in this study, some of the questions asked during the interview could cause some emotional distress. *Remember that you are welcome to stop at any time.*

If any part of this study causes you discomfort (whether during the study or in the days following), please contact any of the following resources:

- *Veterans Crisis Line* – 24-hour, confidential support; 1-800-273-8255, press 1 or text 838255; https://www.veteranscrisisline.net/
- *Military OneSource* – 24-hour support, can connect to local resources, 800-342-9647 – http://www.militaryonesource.mil/

Who will know that I took part in this research and learn personal information about me?
This research is overseen by the University and Medical Center Institutional Review Board (UMCIRB) at ECU. Therefore, ECU and the people and organizations listed below may know that you took part in this research and may see information about you that is normally kept private. However, the information you provide will not be linked to you or your personal identifiers. Therefore, your responses cannot be traced back to you. With your permission, these people may use your private information to do this research:

- The lead researchers (Richardson & Lamson)
- The University & Medical Center Institutional Review Board (UMCIRB) and its staff have the responsibility for overseeing your welfare during this research and may need to see research records that identify you.

How will you keep the information you collect about me secure? How long will you keep it?
Your privacy is important to us and will be protected in several ways. Access to data will be restricted to only research team members who were approved by the university's IRB. All identifying information will be kept separate from audio recordings and transcriptions, and all names will be replaced with pseudonyms in order to ensure anonymity and confidentiality. All information from the study will be kept in encrypted files and stored on a password protected server. Any paper files will be stored in a locked file cabinet under double lock and key.

Information gathered from this study will be used to publish potential findings in scientific communities and/or report these results to government agencies, funding agencies, or manufacturers. However, strict guidelines regarding confidentiality will be enforced and no identifying information will be published.

What if I decide I don't want to continue in this research?
Your participation is completely volunteer. You may stop at any time after the research has already started. You are free to withdraw your consent and discontinue participation at any time. There will be no consequences if you stop, and you will not be criticized. Your decision whether or not to participate will not affect any relationship you have with East Carolina University.

Who should I contact if I have questions?
The people conducting this study will be able to answer any questions concerning this research, now or in the future. You may contact the Lead Researcher by phone at (580) 214-0941 or via email at richardsonna17@students.ecu.edu.

If you have questions about your rights when taking part in this research, call the University and Medical Center Institutional Review Board (UMCIRB) at 252-744-2914 (days, 8:00 am-5:00 pm). If you would like to report a complaint or concern about this research study, call the Director of Human Research Protections, at 252-744-2914.

Are there any Conflicts of Interest I should know about?
There are no conflicts of interest.

If you decide you are willing to take part in this study, please continue with the interview.

Sincerely,
Natalie Richardson, MS
Principal Investigator

By participating in an interview, I acknowledge that I have read and understand the purpose and procedures associated with this project. I agree to the previous and following terms of the project outlined in this form and agree to be a volunteer participant:

- I have read (or had read to me) all of the above information.
- I have had an opportunity to ask questions about things in this research I did not understand and have received satisfactory answers.
- I know that I can skip any questions that I prefer not to answer or stop the interview at any time.
- I know that I can request a copy of this consent form to keep for my own records.

Thank you for your time and willingness to participate in this project!

APPENDIX I: INTERVIEW GUIDE

RESEARCH QUESTION: ***How do U.S. military veterans describe and make meaning of the morally challenging experiences associated with their military service?***

Thank you for your willingness to meet with me today to share your experiences. The purpose of this research is to better understand the beliefs and values associated with military experiences. Please remember that you can skip any questions that you prefer not to answer or stop the interview at any time. If you have any questions, you may stop me to ask at any point in the interview.

INTERVIEW QUESTIONS:

I'd like to start by asking about when you first joined the military.

- **How did you first make the decision to join the military?**
  - **PROBE:** Who chose for you to join the military?

- **How would you describe yourself when you first joined the military?**
  - **PROBE:** How would you describe your [personality, priorities, values, beliefs, relationships] when you first joined the military?

- **How would you describe yourself since being discharged/retiring from the military?**
  - **PROBE:** How would you describe your [personality, priorities, values, beliefs, relationships] since being discharged/retiring from the military?
  - **PROBE:** What type of person do you view yourself as now?

- **What is different about how you see yourself now verses when you first joined the military?**
  - **PROBE:** What is different about your [personality, priorities, values, beliefs, relationships] since being discharged/retiring from the military?
  - **PROBE:** How so? What changes do you see in yourself now?
  - **PROBE:** Are there specific events/experiences you attribute to this change or consistency in your values/beliefs?

Now, I'd like to ask you to engage in a brief exercise for the next question. If you feel comfortable, I'm going to ask that you close your eyes and visualize your *most memorable day* in service – the day that you feel made the biggest impact on you as a person; possibly your most challenging day in the military. Visualize the events or experience that you believe possibly challenged or changed you the most, including who was with you and where you were. Can you see it? Now take a deep breath.

- **Please describe what you see/saw. What stands out to you most?**
  - **PROBE:** What feelings/emotions are you currently experiencing as you visualize your most memorable day?
  - **PROBE:** Where are you? Who else is with you?

- **Which of your values, beliefs, or morals do you connect most to that experience?**
  - **PROBE:** Are these specific values/beliefs/morals that were most present during the experience? Felt challenged during the experience?
  - **PROBE:** Were there specific events or experiences that led to these feelings?

- **What do you feel like that experience/event says about who you are as a person?**
  - **PROBE:** How does this experience influence how you view yourself as a veteran? As a person? Your role in your family [parent, son/daughter, partner/husband/wife, etc.]?

- **Describe anything else about that experience/event that may have compromised the kind of person you thought you were.**
  - **PROBE:** Describe who else may have been involved in this/these experience(s) that may have compromised the kind of person you thought you were.
  - **PROBE:** What else about this experience impacts how you view yourself now? Who else's opinion/actions impact this belief about yourself?

(Pause and check-in after reflection to ensure participant feels comfortable to continue)

Thank you for your openness so far. The next set of questions will focus more on your personal beliefs and values.

People often grow up with strong beliefs or opinions about the right and wrong ways to behave and treat other people (your morals). Experiences in the military may reinforce, challenge, or change those beliefs.

- **In what ways do you think military service did or did not impact your beliefs or morals?**
    - **PROBE:** Can you describe a time during your military service when you felt like your personal values or morals were consistent with those of the military?
    - **PROBE:** Can you describe a time during your military service when you felt like your personal values or morals were questioned or challenged?

- **Describe how consistent you felt like your beliefs/values/morals were with:**
    (a) your superiors *(pause for response)*
    (b) your unit *(pause for response)*
    (c) your family *(pause for response)*

- **Were there times during your service that you realized when your beliefs were similar to or different from your superiors, your unit, your family?**
    - **PROBE:** When did you come to realize the impact/severity of these experiences/differences?

- **Were you able to talk about these experiences during or after service?**
    - **PROBE:** With whom did you share your experiences with?
    - **PROBE:** What made it (a) easy and/or (b) challenging to share your experiences with these individuals/others?

- **What meaning do you make about the experiences/events (that didn't fit with your beliefs, values, morals) you were involved in during your time of service?**
    - **PROBE:** What meaning have you made about the morally challenging experiences you endured when in the military?
    - **PROBE:** How do you make sense/meaning of the military experiences that DIDN'T align with your beliefs/values/morals?

- **If you were to give a name to the experiences that some Service members or veterans have when their values, beliefs, morals seem to conflict with their duties or demands within the military what would you call it?**
    - **PROBE:** What name would you give to your experiences when your values, beliefs, morals seemed to conflict with your military duties?

Researchers have offered a description of a challenge that could happen for military personnel but has never been asked directly of Service members or veterans:

> *"Morally injurious experiences are defined as 'perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations"* (Litz et al., 2009, p. 700).

- **What comes to mind when you read/hear this description?**
    - **PROBE:** How does it compare/contrast to what you've experienced?

- **On a scale of 1 to 5 (with 5 being *"very much aligns"*), how much does it align with what you've described today about your own life?**

Does not align at all	Aligns a little bit	Somewhat Aligns	Aligns Quite a bit	Very Much Aligns
1	2	3	4	5

- **What would you change/add to this description?**

- **Is there anything you would like to add about your military experience and how it relates to your moral/values or how you view yourself or others?**

Thank you for your time and willingness to share your story through this interview. Your military service and sacrifices for our country do not go unacknowledged nor unappreciated. The information you shared today, while morally difficulty, is an important step in helping us to find the gaps in military experiences that may help to save the lives of other Service members and Veterans!

PERMISSION FOR MEMBER CHECKING:

Once all interviews have been completed, we would like to be able to confirm our understanding of the military experiences like you have described today. Our hope is to collect feedback about the major themes found across all interviews by sending a brief summary to willing participants.

- **May we send you the initial findings and contact you to provide feedback about what we come to learn?**

APPENDIX J: SAMPLE OF BRACKETING DURING ANALYSIS

	CODE	Questioning –> Purpose of Service/War/US involvment	Systemic Issues
1			
9		like, "The fuck. Did this guy really, I mean, this guy was like, he should have been dead." In all reality should that have happened? I mean, why the fuck? Like what was the moves that got up to that point? Was this really necessary ?; (Line 378) is this all worth it?;	(Line 712) My job was very clear. I just need to help them. So it was ... my direct job was very fulfilling in that aspect . Whereas a lot of the things, a lot of the systemic things that I'm pissed about is my patients that got blown up for no fucking reason or my good friends that like, same sort of thing.
10	1020	(Line 117) I don't believe in the wars. I don't think it was worth it. I don't think we fought for the right reasons; (Line 141) What the hell did we just do ?; (Line 152) When I look at it now, it's all a bunch of fricking bullshit. It really is; (Line 393) it makes me wonder, what did you experience that, that was great, and you're proud of that? Apparently I fucking missed the boat. I don't know. I look back on it, and it's like, how in the fuck did we do that shit, and celebrate it?; (Line 166) I used to have this illusion that they really were doing something for the best for us, and I just don't see it. I had this conception that they really cared about the troops, and what we were doing, and how we managed things. Now it's like, okay, that illusion's gone. They view people like cannon fodder. It's just like, okay, what are we going to do to meet the next big money goal? War's a fucking racket. It's all about the fricking money, and that's all anybody gives a shit about; (Line 181) It has nothing to do with fricking protecting the American people; (Line 193) it was supposed to be the last resort, and it's no longer the last resort. That, to me, it's absolute fricking bullshit; (Line 346) Then it's, why in the fuck were we even there to begin with? Why were we still there? That was five years after fucking 9/11; (Line 545) You're supposed to be there to fucking protect the people that can't fricking protect themselves, and to liberate people from oppression, and that ... then in the name of an ally, you're going to put up with some fucking morally just ... who the fuck kind of shit, because you're supposedly on their side. It's like, no.	(Line 160) Then I used to really believe that our politicians and the people that sent us to war had our best interest in mind. I really don't believe that anymore .
11	1021		(Line 514) My view of the military had changed because they really stop this thing that were there for sailors, soldiers, marines, airman. Having all these events and talking into the media and then going through with what I did and then seeing what others had to deal with, it just opened my eyes. It's just a bunch of lies; (Line 672) the military talks about integrity. That's that whole ... if you see something wrong, do something. And yet, they don't hold to it themselves; (Line 851) And I hate the face that the military puts on that it's there for its members. It does everything in its power to help and improve. When you've actually been there and you still have friends and family, you know it's a blatant lie, but the rest of the community or the rest of civilian life, they don't know; (Line 177) I had saw personally is that there were incidences of sexual harassment or what have you. They did their best to either make that person look guilty or they did their best to cover it up. Especially if it was a higher ranking person. If it was a chief or above or an officer, especially. They would do whatever they had to to cover it up and get rid of it;
12	1027	(Line 599) I participated in something that really ultimately was not a good thing, and that country is still just an absolute basket case . Of course, it was kind of a basket case before we went in, but I'm not sure. Maybe fewer people would have died had we not;	(Line 365) The only thing I really questioned at that point was, were we doing something wrong that could have fixed that? Was I not seeing something I should've seen? Or was there ... I had an open door policy, but as I've said, I've always been kind of reserved and people always acted kind of scared of me. I'm a larger individual, and I think that plays into it, so I don't know if maybe my just general personality, maybe he was a little scared of me, didn't want to use the open door policy or something;

Coding - CLEANED 5.20 | Code Frequencies 5.25 | Notes 08.30 | FINAL CODES 9.27 | DESCRIPTION | +

The previous image highlights just a snap shot of the in-depth process of qualitative coding and analysis. During the bracketing process, researchers organized quotes by initial codes and themes based on the content of the narrative; next, researchers worked to push beyond the content of the message to capture the meaning that related to the essence of the lived experiences. For example, in the sample provided, significant statements highlighted experiences of not trusting the military, shifts in one's view of the military, sexual harassment, and questioning of the overarching goal of the mission. When initially reviewed, researchers coded these experiences as 'systemic issues;' however, after further analysis, they felt that the meaning behind the message was an overarching lack of trust the system, likely a result of ongoing feelings of betrayal. After numerous conversations, bracketing procedures, and personal reflections, the researchers finally felt that the most appropriate theme which captured the meaning/essence of these lived experiences was *systemic betrayal*.

APPENDIX K: SAMPLES OF REFLEXIVITY

1. Photo Reflexivity Project during Qualitative Methodology course prior to data collection – Sample from Reflection

A key theme in my assumptions that really stood out when completing this project that I did not realize was a major concern or assumption was the worry about being trusted and viewed as an "outsider" because of having no experience with the military. This was apparent in multiple slides and photos. Another themed assumption was that participants may not be willing to open up and share their experiences with me for various reasons. I think I was more aware of the latter concern; however, this project really made me see how much of a concern and the pressure I feel to be trusted and "let in" by this population. It will be important that each of these biases and assumptions are acknowledged and given attention to before, during, and after any work that I do with moral injury and the military. While the direction of the project I will conduct for my dissertation is unclear, this project reinforced my passion and desire to better understand moral injury in hopes of developing appropriate treatment and trainings for populations who may be faced with repetitive and ongoing potentially morally injurious experiences.

2. Memos – Samples of individual and team memos following conjoint analysis meetings with co-researchers

memo

TEAM MEETINGS

Re: Olivia & Natalie

Date	Discussion	Questions/ Comments	Disagreement
02.01.20	- starting to see a lot of questioning of/change in faith (questioning of a higher power) - questioning of purpose (purpose for being there; idea that we went to help but did we actually help; 2 discussed purpose parents vs. service member and was that worth it) o guilt, anger, sadness, etc. over loss of innocent lives - questioning patriotism (?) → association as an American (for both locals = safety concern); guilt over being American and the destruction that may have caused - some strengthening of values that grew up with (outside of religion) due to seeing a lot of immorality and loss - more accepting of differences between people/cultures - having to hold two "truths" at once - frustration towards the military (larger systemic issues) - guilt, anger, sadness, etc. over loss of innocent lives **After line by line:** - **1002** → guilt, witnessing, rebalancing, questioning why they were there, change in faith - **1009** → loss in religion, meaning making, loss, witnessing/learning about others (empathetic loss?? Guilt??), guilt		1002 (5/77) 1009 (11/63)
	-		

02.09.20	- **1014** – LOTS OF QUESTIONING, SYSTEM ISSUES; zooming in and out process (staying zoomed in (aka focuses his job and duties) allowed him to avoid the depth of what was happening but when "zoomed out" that's when the questioning took place) - **1020** → while others were able to positively rationalize their actions (e.g., killing), he believed his were out of revenge and not necessarily a part of his duties → which led to lots of guilt and shame. LOTS OF QUESTIONING, SYSTEMIC ISSUES; GUILT, BETRAYAL - **1021** → sexual harassment/assault; balancing speaking up against/for others and still having a successful career (guilt associated with not doing more). BETRAYAL; MILITARY CULTURE; LEARNING OF OTHERS (MSA); veteran identity → getting hurt, not feeling like did enough - **1027** → hinted at possible guilt from the loss of his SM by suicide; his experience with having support within his unit where he could talk with others, or welcomed others to come to him; also within his family at home → this was very different than what we've heard from others about lack of support or isolation; SOME QUESTIONING, CHANGE IN PERSPECTIVE; VETERAN IDENTITY; SEEMED MOSTLY IMPACTED BY SENSE OF HELPLESSNESS D/T SUICIDE - **1039** → LOTS OF QUESTONING; he struggled with the loss of innocent life (for children and women), especially being a father; BARRIERS TO SUPPORT; ISOLATION; CHANGE OF PERSPECTIVE; he did seem to somewhat question if helpful to be there. - **1049** → LOTS OF GUILT, particularly with dual roles as mother and service member. Felt like she failed as a mother; QUESTIONING IN HER DECISION MAKING – other seemed to question her values or put her in situations that made her question right from wrong. ISOLATION → not feeling like she could talk about it NOR wanting to talk to her family (didn't feel like she deserved their forgiveness) ****Added code:** "inflicting harm to others"		

memo

1009.1

Date: 1/11/20

Re: Initial Review of Transcript

- Mechanic
- Joined the military ~3 weeks prior to 9/11 → I signed up for "this" but it turned out to be a whole other thing.
- Participant described experiences of "all the loss" he experiences through attendance to so many memories. He highlighted he played on a basketball team and that he went to all 8 of his team members funerals while overseas. → 'they volunteered just like me…it could have been me.'
- "all those people I lost don't have a story to tell or don't have the experiences I have (survivor's guilt??)
  - Hearing the national anthem and seeing a flag brings up a lot of emotion and memories
  - Sadness hurt
  - I owed it to others to ask why
- No other choice – either pop some caps or come home in a box
- Such a relief that I didn't have to kill anyone
- 'Discontinued' anything religious (military experiences did away with that)
  - So much loss and how it came about
  - God's supposed to protect us → so many that volunteered to protect others had to die
  - Shifted after about 2nd memorial service
  - "I didn't expect to experience all the loss"
  - Joined military to get out of home town and violence and to be safe and how a purpose but then so many more people I knew still died
- Called these experiences "morally challenging" or "unfortunate"
- Everyone I knew who came back from Iraq was different
  - A lot of things people didn't expect to see or do or were made to do
  - Mental illness. It's nasty. It is not prejudiced at all.
  - Many questions why we were ever there
- War isn't morally right
  - Something you walk through that door of knowing what has to happens sometimes is worse than having to deal with it.
- Most memorable experiences: positive memory of promotion from basic training when whole family came – so much pride
- Simultaneous losses were difficult → those happening at home and in the military
  - Memory of Marcus is very impactful – young, talented guy who reminded him of brother had to die
  - Brother died ~1 year about discharge
- Didn't love the authority piece of military – described himself as having a voice and who liked to express his thoughts, but military was very "shut up and wait"

- Participant was very positive, upbeat → seemed to somewhat minimize but discussing his brother and young SM (Marcus) seemed to provoke some emotion and depth. Very cognitive-based interview.