

Combat-Related Moral Injury and Religiosity

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Abstract

The purpose of this study was to explore the relationship between combat-related moral injury and religiosity. This quantitative study relied on a convenience sample recruited from a 6,000-person database of veterans in upstate South Carolina. The participants were recruited via email invitation and screened for combat exposure and the presence of moral injury. Instrumentation consisted of the 45-item Moral Injury Symptom Scale-Military version (MISS-M) and the 15-item Centrality of Religiosity Scale. All participants were anonymous, and responses were given through self-report. Multiple linear regression was conducted on a sample of 119 combat veterans exploring the relationship between the MISS-M's 10 subscales of guilt, shame, betrayal, moral concerns, loss of trust, difficulty forgiving, loss of meaning/purpose, self-condemnation, religious struggles, and loss of religious faith/hope and with measurements of religiosity. The study found that the subscales of shame, difficulty forgiving, loss of trust, and loss of religious faith/hope were predictors of religiosity. Focusing treatment on these subscales of moral injury can enhance clinical and pastoral counseling treatment outcomes and assist clergy in meeting the needs of their congregations.

Keywords: Moral injury, religiosity, veteran, combat

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List of Abbreviations

American Psychiatric Association (APA)

Centrality of Religiosity Scale (CRS)

Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

Health Insurance Portability and Accountability Act (HIPAA)

International Classes of Diseases (ICD)

Moral Injury Symptom Scale-Military Version (MISS-M)

Operation Enduring Freedom (OEF)

Operation Iraqi Freedom (OIF)

Posttraumatic Stress Disorder (PTSD)

Potential Moral Injurious Events (PMIE)

Readjustment Counseling Services (RCS)

United Kingdom (UK)

United States (US)

Upstate Warrior Solution (UWS)

Veterans Affairs (VA)

Veterans Health Administration (VHA)

World Health Organization (WHO)

World Psychiatric Association (WPA)

Chapter One: Introduction

Overview

With recent combat incursions into Iraq and Afghanistan, the field of traumatology has flexed to meet the mental health needs of military service members who are returning from the modern-day battlefield. Over the past 20 years, increasing evidence has indicated that a condition currently referred to as moral injury plays a significant barrier and struggle for many combat veterans as they attempt to return to their civilian lives and society. The transition from civilian to combatant back to civilian is wrought with difficulty. The present study will explore the importance of understanding moral injury and its impact on combat veterans and the role combat-related moral injury has on a person's religiosity.

Background

Over the past 20 years, moral injury has become a growing area of interest in the field of mental health. Veterans returning from the wars in Iraq and Afghanistan have struggled to readjust to civilian life. Between 2001 and 2015, over 2.77 million military service members were deployed to combat operations (Wenger et al., 2018). Current research has indicated that, following combat deployments, these recent-era combat veterans are significantly more likely to experience mental health disorders such as posttraumatic stress disorder (PTSD), depression/suicidality, and substance use disorders (Ames et al., 2018; Brady et al., 2019; Bryan et al., 2014; Hoge et al., 2006; Lan et al., 2015; Maguen et al., 2012; Morgan et al., 2018). With mental health issues being a leading cause of disability across the globe, understanding the mental health needs of combat veterans is a public health imperative (Hoge et al., 2006).

The events of warfare are intrinsically complex. Militaries around the world recognize that the taking of human life is not natural and must be overcome by training. Service members

are trained in tactics and weaponry whose sole purpose is to take life as efficiently as possible. Combatants are taught to use neutral or dehumanizing terminology, such as collateral damage, to denote the death of innocent bystanders, who may often be women and children. Soldiers are taught to aim their rifles at targets and neutralize them upon command. Training targets on rifle ranges are designed as human silhouettes to desensitize soldiers to the act of shooting in a human form. These methods of training are deliberate and effective and are designed to overcome man's culturally and socially evolved instinct to not kill. Lieutenant Colonel Dave Grossman (1996), in his seminal work "On Killing," discussed that Napoleonic and civil war era muskets, fired in accordance with the tactics of the time, had a 60% hit rate at 75 yards, but most battles had firing rates of 100 to 200 rounds per hit (pp. 10–12). The commanders in these battles described threatening their soldiers with swords to prevent them from intentionally shooting over the heads of their enemy (Grossman, 1996, p. 10). The US military conducted a study in World War II regarding the firing rates of their combatants; it was estimated that only 15–20% of American soldiers fired their weapons at the enemy (Marshall, 1947, p. 57). The US took notice and deliberately changed its combat training programs, implementing various types of classical and operant conditioning. These changes proved effective. In Vietnam, studies have shown that 90–95% of American troops fired their weapons at the enemy (Grossman, 1996, p. 315). The military has focused on killing the enemy with the highest efficiency possible, but it has failed to prepare soldiers for the lasting impacts related to ever-improving killing efficiency.

Combat operations in Iraq and Afghanistan consisted of guerilla or counterinsurgency warfare. This type of warfare is rife with moral complexity. The enemy does not typically wear uniforms. There is no agreed-upon set of rules, such as those provided by the Geneva Conventions. There are no front lines. Enemy combatants may be men, women, or children.

American techniques and tactics used in these nonlinear battlespaces often result in ambivalent moralities (MacLeish, 2021). These actions can often be in direct conflict with the values and ethos of American warrior culture, which strives to promote values such as loyalty, duty, honor, integrity, commitment, courage, and selfless service. Moral transgressions and moral injuries are arguably unavoidable in war (Litz et al., 2009; MacLeish, 2021; Nash, 2019; Wood 2016, pp. 20–21).

These experiences can harbor lasting symptomology, resulting in dysfunction and disability. A recent qualitative study conducted by the VHA found that moral injury tends to present in chronic pain, crisis of faith, spiritual pain, shame, betrayal, emotional dysregulation, hopelessness, suicidal ideation, and exacerbate other mental health symptomology; these themes resulted in greater self-isolation, withdrawal, issues with trust, issues with forgiveness, self-medication with alcohol and drugs, and increased suicidal cognitions (Boska et al., 2021). The correlations between moral injury, depression/suicidality, and substance use will be explored further in the literature review.

The concept of moral injury is a relatively new concept within the field of mental health (Farnsworth et al., 2017; Koenig et al., 2020; Lancaster & Irene Harris, 2018; Litz et al., 2009; Litz & Kerig, 2019; Shay, 2002, 2014). As a relatively new concept, there is currently an absence of a unified definition, but there is a growing consensus. This introduction, along with the literature review, will explore the history of the definition and rationale for which the definition was chosen for the present research project.

As of 2017, there were roughly 17 different conceptualizations regarding moral injury (Hodgson & Carey, 2017). By July 2019, a peer review of 124 articles indicated that there are 12 common definitions of moral injury (Richardson et al., 2020). The variance in definition and

conceptualization largely stems from disagreement around issues of betrayal or spirituality, which are critical components of the contemporary and growing understanding of combat-related moral injury (Hodgson & Carey, 2017). Another difficulty is that moral injury is not formally accepted by the American Psychiatric Association (APA) and is not included in the current Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (Bélanger et al., 2018). Despite the lack of codified acceptance of moral injury as a tangible phenomenon, mental health clinicians treating veterans returning from war are increasingly encountering moral injuries and incorporating them into their case conceptualizations. Additionally, as descriptions of moral injury gain universal consensus and empirical support, academics and clinicians alike have recognized moral injury as a separate and unique syndrome (Jinkerson, 2016).

The concept of moral injury is ancient, but its inclusion in psychological treatment is relatively nascent. Many of the earliest human writings depict stories of people struggling for atonement, seeking forgiveness, and fighting to right perceived wrongs (Koenig et al., 2020). Most world mythologies, philosophies, and religions all include the basic concept or premise of moral injury and how to respond to it (McDonald, 2017). In the Christian and Jewish faiths, the first negative emotion experienced by Adam and Eve is arguably shame, which resulted in a moral injury—an injury that human beings have sought to reconcile ever since (McDonald, 2017).

In recent years, moral injury has garnered significant interest. Griffin et al. (2019) found that at least 116 epidemiological and clinical studies have been conducted on moral injury. Despite growing interest and research, moral injury is still considered a “fringe diagnostic status” (MacLeish, 2021). In fact, the pioneering researchers on moral injury, Maguen et al. (2012), argued that moral injury is not a mental disorder; rather, moral injury contributes to the

manifestation of shame, guilt, anxiety, depression, anger, and severe negative cognitions about the self and world. Nonetheless, moral injury is considered pathological and a condition that demands further study. A survey returned by 106 staff members at a Department of VA facility identified moral injury as a relevant mental health need that lacks awareness and understanding (Kopacz et al., 2018).

As a relatively new concept in the field of mental health, defining moral injury has been a challenging and hotly debated topic among practitioners and researchers alike. Jonathan Shay (1994) originally defined moral injury as a violation of what's generally considered right, proper, and customary. He broke this down further to describe how moral injury is present when a person experiences a betrayal of what they believe is morally correct by a person who is in authority in a situation with significant risk.

Litz et al. (2009, pp. 697) expounded on the definition of moral injury as committing, failing to prevent, or witnessing actions that violate one's moral values that in the long term may have negative impacts "emotionally, psychologically, behaviorally, and socially." Litz's definition has been the most widely accepted definition of moral injury and the foundation of what many moral injury studies have built on (Jinkerson, 2016; Neria & Pickover, 2019). The limits of this definition include problematic understandings of "transgressive acts," which have been largely understood as violations of "accepted boundaries of behaviors" (Frankfurt et al., 2017).

Drescher et al. expanded Litz's definition by including the witnessing of transgressive acts (Richardson et al., 2020). The present study will rely on the functional contextual definition recently espoused by Farnsworth et al. (2019, pp. 392), who defined moral injury as "an expanded social, psychological, and spiritual suffering stemming from costly or unworkable

attempts to manage, control, or cope with the experience of moral pain.” Moral pain is defined as an internal experience of dysphoria-based emotions and thoughts (e.g., self-condemnation) that result from a morally injurious event (MIE; Farnsworth et al., 2017).

MIEs are defined as situations in a high-risk environment in which a person discerns that a critical moral belief has been transgressed by themselves or another (Farnsworth et al., 2017). Not all morally injurious events result in moral injuries, but all moral injuries have a morally injurious event at their core (Litz & Kerig, 2019). A widely held understanding is that there are two broad types of morally injurious events (Litz & Kerig, 2019). The first type consists of people doing or failing to do something that transgresses their morality, and the second is witnessing transgressions committed by others (Litz & Kerig, 2019).

The definition of moral injury by Farnsworth et al. (2017) is arguably the most comprehensive available. Their definition builds on Shay’s pioneering work, the quantitative foundation provided by Litz, and addresses the weaknesses of each. This definition is congruent with the Moral Injury Symptom Scale-Military Version (MISS-M), which will be utilized in the research section of the present work. Until moral injury is included in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classes of Diseases (ICD), there will not be a universally accepted definition, and researchers are challenged to select the most appropriate and universally accepted definition available.

Moral injury and a professional contemporary understanding of it as a phenomenon emerged as a need to further explore the psychological damage resulting from war (Shay, 1994). As the mental health field gained a greater understanding of PTSD, a pattern of events, symptoms, and behaviors was identified that appeared to be conceptually and mechanistically different (Barnes et al., 2019). A biopsychosocial-spiritual based framework illustrating the

difference between these two conditions describes PTSD as an injury of the mind, while moral injury is an injury of the soul (Richardson & Lamson, 2021). This type of conceptualization helps demonstrate the distinction between PTSD being a fear-based condition and moral injury being a judgment-based condition. The difference between PTSD and moral injury will be fully explored in the next chapter.

Problem Statement

Moral injury is arguably a natural result of combat actions and experiences of war. Unfortunately, little empirical research was conducted on this phenomenon prior to 2000. Combatants returning from recent combat operations have described the symptoms resulting in significant dysfunction that do not fit within traditional PTSD frameworks. These situations have prompted clinicians and researchers to explore this phenomenon in greater detail. As information and data emerge, more evidence supports the existence of moral injury as a unique mental health condition that deserves specific research, exploration, understanding, and treatment.

Any discussion of morality is inherently subjective. Being subjective does not justify an argument for moral relativism, but it does make the topic definitively individualistic. This is not dissimilar from defining an index trauma necessary for the diagnosis of PTSD; both moral transgressions and trauma events can only be viewed from the perspective of the individual. What is a moral transgression for one person may not be a transgression to another. As such, exploring the moral foundations of the individual is necessary to further the understanding of moral injury and its impact as a distinct phenomenon. A common foundation of morality is the influence of religion and spirituality. The present study will combine religion and spirituality under the term religiosity, which will be further defined in the literature review. Understanding the role, if any, moral injury and its defining characteristics play in the relationship between

moral injury and religiosity is critical in understanding and treating combat veterans who are suffering from these conditions.

Purpose Statement

The purpose of this quantitative correlational study is to determine if or to what extent there is a statistically significant correlation between moral concerns and loss of meaning/purpose and religiosity among US combat veterans. The present study is aimed at increasing the empirical literature and clinical understanding of moral injury. Moral injury had been explored in relation to a person's self-described religiosity. Although the symptomology of moral injury overlaps with PTSD, moral injury will be explored independently of PTSD. The rationale supporting this decision will be found in the literature review.

The current study used survey-based measurements to conduct a quantitative analysis. A nonprofit veteran organization in the upstate regions of South Carolina allowed the researcher access to their 6,000-veteran database. Potential participants were contacted via email. Potential participants were provided with a brief description of the study, a consent agreement, a demographic sheet, and surveys measuring the participants' depression, moral injury, substance use, and religiosity.

Significance of the Study

The results can help broaden the professional understanding of combat-related moral injury. Specifically, the data enhance the understanding of the elements of moral injury in a person's religiosity. Confirming or denying moral injury as a mediator in religiosity can lead to further research on the topic and help improve treatment methods, ultimately improving the quality of life of combat veterans who suffer from moral injury and its sequelae.

Research Question(s)

RQ1: Do the combined moral injury dimensions—*guilt, shame, betrayal, moral concerns, loss of meaning, difficulty forgiving, loss of trust, self-condemnation, spiritual/religious struggles, and loss of religious faith/hope*—predict religiosity among US combat veterans?

H1₀: The combined moral injury dimensions—*guilt, shame, betrayal, moral concerns, loss of meaning, difficulty forgiving, loss of trust, self-condemnation, spiritual/religious struggles, and loss of religious faith/hope*—do not predict religiosity among US combat veterans.

H1_a: The combined moral injury dimensions—*guilt, shame, betrayal, moral concerns, loss of meaning, difficulty forgiving, loss of trust, self-condemnation, spiritual/religious struggles, and loss of religious faith/hope*—predict religiosity among US combat veterans.

RQ2: Does the moral injury dimension *guilt* individually predict religiosity among US combat veterans?

H2₀: The moral injury dimension *guilt* individually does not predict religiosity among US combat veterans.

H2_a: The moral injury dimension *guilt* individually predicts religiosity among US combat veterans.

RQ3: Does the moral injury dimension *shame* individually predict religiosity among US combat veterans?

H3₀: The moral injury dimension *shame* individually does not predict religiosity among US combat veterans.

H3_a: The moral injury dimension *shame* individually predicts religiosity among US combat veterans.

RQ4: Does the moral injury dimension *betrayal* individually predict religiosity among US combat veterans?

H4₀: The moral injury dimension *betrayal* individually does not predict religiosity among US combat veterans.

H4_a: The moral injury dimension *betrayal* individually predicts religiosity among US combat veterans.

RQ5: Does the moral injury dimension *moral concerns* individually predict religiosity among US combat veterans?

H5₀: The moral injury dimension *moral concerns* individually does not predict religiosity among US combat veterans.

H5_a: The moral injury dimension *moral concerns* individually predicts religiosity among US combat veterans.

RQ6: Does the moral injury dimension *loss of meaning* individually predict religiosity among US combat veterans?

H6₀: The moral injury dimension *loss of meaning* individually does not predict religiosity among US combat veterans.

H6_a: The moral injury dimension *loss of meaning* individually predicts religiosity among US combat veterans.

RQ7: Does the moral injury dimension *difficulty forgiving* individually predict religiosity among US combat veterans?

H7₀: The moral injury dimension *difficulty forgiving* individually does not predict religiosity among US combat veterans.

H7_a: The moral injury dimension *difficulty forgiving* individually predicts religiosity among US combat veterans.

RQ8: Does the moral injury dimension *loss of trust* individually predict religiosity among US combat veterans?

H8₀: The moral injury dimension *loss of trust* individually does not predict religiosity among US combat veterans.

H8_a: The moral injury dimension *loss of trust* individually predicts religiosity among US combat veterans.

RQ9: Does the moral injury dimension *self-condemnation* individually predict religiosity among US combat veterans?

H9₀: The moral injury dimension *self-condemnation* individually does not predict religiosity among US combat veterans.

H9_a: The moral injury dimension *self-condemnation* individually predicts religiosity among US combat veterans.

RQ10: Does the moral injury dimension *spiritual/religious struggles* individually predict religiosity among US combat veterans?

H10₀: The moral injury dimension *spiritual/religious struggles* individually does not predict religiosity among US combat veterans.

H10_a: The moral injury dimension *spiritual/religious struggles* individually predicts religiosity among US combat veterans.

RQ11: Does the moral injury dimension *loss of religious faith/hope* individually predict religiosity among US combat veterans?

H11₀: The moral injury dimension *loss of religious faith/hope* individually does not predict religiosity among US combat veterans.

H11_a: The moral injury dimension *loss of religious faith/hope* individually predicts religiosity among US combat veterans.

Definitions

Betrayal—This can occur at either or both the interpersonal and intrapersonal levels. It is a violation or transgression committed by one's own actions or by persons in power within a larger hierarchy (Jamieson et al., 2020; Richardson et al., 2020).

Moral injury—This is a type of suffering that encompasses social, psychological, and spiritual components and is a result of ineffective attempts to regulate, manage, and adapt to the experience of moral pain (Farnsworth et al., 2017, pp.392).

Moral injurious event (MIE)—These are situations in a high-risk environment where a person discerns that a critical moral belief has been transgressed by themselves or another (Farnsworth et al., 2017, pp. 392).

Moral pain—This is an internal experience of dysphoria-based emotions and thoughts (e.g., self-condemnation) that result from a morally injurious event (Farnsworth et al., 2017, p. 392).

Morality—This comprises the beliefs defining right from wrong. Within the military system and military culture, morality can include branch of service values, unit history, and mission purpose, which may impact a person's sense of self (Jamieson et al., 2020).

PTSD—This is the manifestation of characteristic symptoms following a traumatic experience; these symptoms include re-experiencing, avoidance, negative alterations in thoughts and mood, and significant changes in arousal and reactivity (APA, 2013, p. 271–272).

Psychological wound—This can include the aspects of moral injury, such as loss of meaning, loss of purpose, anger, self-loathing, guilt, shame, behavioral outbursts, social dysfunction, and self-sabotaging (Richardson et al., 2020).

Spiritual wound—This is an injury to a deeply held belief system or core value. The injury has an impact at the existential level and disrupts meaning-making, purpose, and understanding of the world (Richardson et al., 2020).

Summary

Over the past 20 years, increasing focus has been placed on a phenomenon known as moral injury. The growing interest in moral injury is largely a byproduct of the mental health treatment and observations of combat veterans returning from the asymmetric wars in Iraq and Afghanistan, which have been characterized by guerilla warfare techniques and tactics that often contrast with the values espoused by the American military. The disparity between established values and combat actions creates an opportunity for moral injury to develop. Moral injury is arguably an inherent byproduct of warfare. Combatants returning from the battlefield are often survivors who either personally witnessed or committed actions that violated their values and

deeply held beliefs. Although not everyone who experiences a PMIE develops moral injury, many do.

Although moral injury is a rapidly growing area of research and exploration, relatively little is known about the condition. Specifically, the mechanism(s) that correlate with the development of a moral injury, as well as the protective factors preventing the development of moral injury, remain undetermined. The present study provides a quantitative analysis to explore the correlation, if any, between moral injury and religiosity.

Chapter Two: Literature Review

Overview

The literature on moral injury has grown considerably since Shay first coined the term in 1994. The past two decades have seen an exponential explosion in research into moral injury, which has stemmed from a need to account for experiences and psychological phenomena that are distinct from the experience of PTSD; this section explores this distinction, as well as why the present study has focused on moral injury. Second, the literature review explores the history of moral injury from ancient religious texts and historical narratives and how the concept has expanded through modernity. This chapter will also evaluate the literature concerning combat veterans and their incidences of moral injury, moral injury–related depression, moral injury–related substance use disorders, and religiosity.

Theoretical Framework

The theoretical framework for the present study is based on Haidt’s moral foundations theory and Fowler’s faith development theory. The two core concepts are moral injury and religiosity. Haidt’s moral foundations theory provides the conceptual basis of morality and is integral to understanding the phenomena of moral injury. Similarly, faith is a critical factor in religiosity, and Fowler’s faith development theory serves as a framework that best conceptualizes the variable.

Haidt’s moral foundations theory posits that morality first stems from intuition or a perception of what seems right and, second, from active reasoning (Haidt, 2001, p. 814). Moral foundations theory argues that there are six moral modules consisting of care/harm, fairness/cheating, loyalty/betrayal, authority/subversion, sanctity/degradation, and liberty/oppression (Musschenga, 2013, p. 331). These modules are characterized by the contrast

of the proper domain with the actual domain (Haidt & Joseph, 2004, p. 2). Each of these modules is prewired in the human psyche; the proper domain is the designed goal that is desired, while the actual domain is an environmental challenge that triggers the need to achieve the desired goal (Graham et al., 2013, p. 67). Haidt argued that these prewired modules are akin to sensory receptors on the tongue that allow humans to experience taste; just as some individuals are born with a preference for one taste over another, some people are born with a predilection to have a preference for one module over another (Graham et al., 2013, pp. 62–63).

Haidt's moral foundations theory shapes the concept of moral injury, providing an explanation for why an individual may experience a moral injury in a situation where another person does not. Building on the notion that moral judgments start as inherent intuitions, with each person having an innate preference for one intuition over another, the individualistic nature of moral injuries becomes increasingly fathomable. This theoretical framework helps explain the individualistic nature of the phenomena of morality, moral judgment, and moral injury.

Fowler (1981) created seven stages of faith development: primal faith (stage 0), intuitive-projective (stage 1), mythic-literal (stage 2), synthetic conventional (stage 3), individuative-reflective (stage 4), conjunctive (stage 5), and universalizing (stage 6) (Fowler, 1991, pp. 34–41). The theory builds on the developmental conceptualizations of Piaget, Erikson, and Kohlberg (Fowler, 1991, p. 27). This theory of faith development is based on the construct that faith is a way of knowing and is not tied to any specific religious doctrine or major world religion (Fowler, 1974). Here, faith can be seen as a way of meaning-making that incorporates biological cognitive structures that urge people to believe in a higher power (Parker, 2010, p. 234).

Fowler's faith development model has impacted the modern understanding of posttraumatic growth and moral injury. Daniel (2017) argued that understanding Fowler's stages

of faith can assist individuals in recovering from trauma and traumatic loss. Usset et al. (2020) found that religious functioning, when consistent with one's religious belief system, served as a protective factor related to moral injury. Harris et al. (2015) posited that the majority of military service members enter combat at Fowler's mythic-literal or synthetic conventional stages of faith development (p. 259). Exposure to PMIEs at these stages of faith development can lead to distressing doubts about one's belief system and negatively impact one's relationship in their faith community and with their higher power (Harris et al., 2015, p. 261).

Both Haidt's moral foundations theory and Fowler's faith development theory provide the present study with an underlying framework for further exploring the concepts of moral injury and religiosity. These theories provide a strong cornerstone from which to understand the core concepts and the individualistic nature of both morality and religion.

Related Literature

PTSD and moral injury are similar yet distinct phenomena. Both conditions require a stressor-linked event; PTSD requires the presence of a trauma event, while moral injury requires the presence of a potentially morally injurious event (PMIE) (Litz & Kerig, 2019; McEwen et al., 2020; Yeterian et al., 2019). PMIEs, as with PTSD-based trauma events, can be personally experienced, observed, or indirect experiences (Frankfurt & Frazier, 2016; McEwen et al., 2020). Similar to PTSD, where not everyone who experiences a trauma event develops PTSD, not everyone who experiences a PMIE develops a moral injury (Hall et al., 2021; Litz et al., 2009). The understanding of why, following a PMIE, some people develop a moral injury and others do not has been a recent focus in the literature (Hall et al., 2021; Koenig & Al-Zaben, 2021; McEwen et al., 2020; Perez et al., 2021). Although PTSD and moral injury are stressor-initiated conditions, the stressors are distinctly different. PTSD is predicated upon an index of trauma

defined as “exposure to actual or threatened death, serious injury, or sexual violence” (APA, 2013, pp. 271). Alternately, moral injury is characterized by a PMIE, which is defined as a transgression of one’s moral, spiritual, or ethical beliefs (Drescher et al., 2011).

Although people suffering from moral injury often experience comorbid PTSD, the conditions are distinctly separate. PTSD is conceptualized as a trauma-based disorder predicated upon a fear response, while moral injuries are emotionally based, with these emotions developing after the morally injurious event has occurred (Barnes et al., 2019). The emotions associated with moral injury tend to be self-referential in nature (Barnes et al., 2019). Whereas in PTSD, persons may come to believe that the world is a bad or unsafe place, in moral injury, persons often have cognitions that they are bad or evil themselves. These alterations in cognitions will be further developed later in this chapter.

The difference between PTSD being trauma/fear based and moral injury being self-referentially emotion based is supported by differences in brain activity (Barnes et al., 2019; Lloyd et al., 2020; Sun et al., 2019). Neuroimaging studies exploring the neural activation of moral injury are currently sparse. However, the available studies do show a distinct difference between PTSD and moral injury. PTSD shows increased activation primarily in the amygdala, while moral injury shows increased brain activity in the left hemisphere (Barnes et al., 2019). This neurobiological difference is helpful in understanding how these two disorders impact an individual’s life. When trauma results in an overactive amygdala, there is often an increased release of norepinephrine, which results in hypervigilance and hyperarousal (Friedman et al., 2014); this correlates with PTSD criteria. Increased activity in the left hemisphere area, particularly the left precuneus and the left inferior frontal gyrus, is associated with self-referential cognitive emotions of shame, guilt, and self-loathing, which is the primary symptom

cluster of moral injury (Gifuni et al., 2016). A study of 26 military combat veterans demonstrated similar findings of increased left inferior parietal lobule activity for veterans with diagnosed moral injuries compared with those without (Sun et al., 2019). A similar study using functional magnetic resonance imaging of persons with comorbid PTSD and moral injury found that people with PTSD and moral injury demonstrate greater activation in their viscerosensory processing areas, hyperarousal regions, and in their top-down cognitive control areas, which the researchers concluded was because of a surge in blame- or shame-related processing (Lloyd et al., 2020).

The symptomology is also somewhat divergent; whereas PTSD will be triggered upon intrusion, re-experiencing, negative alterations in thoughts and mood, and hyperarousal (APA, 2013), moral injury only needs a trigger of negative alterations in thoughts and mood, such as self-loathing, self-sabotage, loss of self, hopelessness, guilt, shame, and other inwardly driven emotions (Litz & Kerig, 2019).

Similarly, Levi-Belz et al. (2020) explored the associations of moral injury, PTSD clusters, and depression; the authors found that moral injury and PTSD were connected almost exclusively through the PTSD network of negative alternations in cognition and mood. As such, PTSD is defined by descriptive terms, that is, the observation of what is, and moral injury by prescriptive, that is, the idea of how things should be (Farnsworth, 2019). Boska and Capron (2021) explored the difference between PTSD-based and moral injury-based maladaptive cognitions. In a sample of 253 combat veterans, they found that cognition associated with moral injury were characterized by self-worth, judgment, atonement, and forgiveness of others; PTSD-based cognitions were based on the threat of physical harm and forgiveness of the traumatic event (Boska & Capron, 2021). Although moral injury and PTSD share the symptomology of

negative alterations in mood, moral injury is much more than one PTSD diagnostic cluster. This topic will be further explored and refined in the literature review.

Herman (2015) argued that PTSD can have a complex presentation; she stated that individuals with long-term trauma that is chronic in nature may develop differing symptomology from traumas that, although horrific and terrifying, are short in duration and limited to a single occurrence. Herman (2015) defined this phenomenon as complex PTSD. Although Herman's original work focused on childhood traumas and domestic violence-type traumas, repeated combat deployments that can last well of a year meet her conceptualization of complex PTSD (*Complex PTSD: National Center for PTSD*, n.d.). Herman described complex PTSD as manifesting in behavioral difficulties, emotional difficulties, cognitive difficulties, interpersonal difficulties, and somatization (Herman, 2015; *Complex PTSD: National Center for PTSD*, n.d.). These presenting symptoms may overlap with the presentation of moral injury, but the causation of the symptomology is markedly different. Complex PTSD manifests from repeated and prolonged traumatic experiences, whereas moral injuries are incurred from witnessing, committing, and failing to prevent events that betray deeply held values or beliefs (Norman & Maguen, 2020). Although complex PTSD and moral injury are distinctly different phenomena, there are associations between the two. In fact, in a study of 173 veterans in the UK, Currier et al. (2021) found that 57.2% of individuals who met the criteria for complex PTSD also reported higher rates of moral injury.

Despite various points of overlap between PTSD and moral injury, these mental health conditions are distinct and independent (Currier et al., 2019; McEwen et al., 2020; Nickerson et al., 2018). PTSD is predicated upon index trauma. The DSM V has defined an index trauma as "exposure to actual or threatened death, serious injury, or sexual violence" (APA, 2013, p. 271).

This exposure can be directly experiencing, witnessed in person, learning that this trauma occurred to a close friend or family member, or experiencing elements of a traumatic event (APA, 2013). Moral injury does not require threatened death, serious injury, or sexual violence (Drescher et al., 2011; Farnsworth et al., 2019; Litz et al., 2009; Shay, 2002). Rather, moral injury is contingent on the betrayal of one's morality—either as a witness or perpetrator.

An additional discriminator pertains to victim versus perpetrator. PTSD inherently focuses on an individual being the victim of a traumatic event, not necessarily as an aggressor who intentionally initiated or created a traumatic event. Moral injury can be contingent on an individual acting as an aggressor, committing acts that betray their own morality, which can result in the victimization of another. Reyes et al. (2008) argued that PTSD trauma indexes typically involve a sense of imminence, which they have described as a lack of time to process the event in real time; trauma indexes lack a sense of controllability and manifest in emotional pain. The etiology of moral injury is not predicated upon danger- or fear-based events (Jordan et al., 2017). Indeed, in a study of 867 active duty marines, Jordan et al. (2017) found that only 30% of combat veterans identified a danger or fear-based event as their most distressing combat experience; therefore, the majority of distressing events were assessed to be more consistent with the definition of MIEs.

History of Moral Injury

The concept of moral injury is as old as humans' concept of morality and the systemic implementation of individual and societal moral foundations. Characterologically, descriptions of moral injury have been found in ancient writings, religious scriptures, and works of literature (McDonald, 2017). An overview of moral injury's omnipresence in human nature will be explored prior to exhausting the currently available literature.

Homeric Poetry

Although moral injury is a relatively new concept in Western mental health, as a concept, moral injury is as old as the ancient novels of the *Iliad* and *Odyssey* (Shay, 1994, 2002). Dr. Jonathan Shay (1994, 2002, 2014) framed the experiences of Vietnam combat veterans against the experiences of Achilles and Odysseus in Homeric poetry. Even though Homer's work was written over 2,700 years ago, Shay (1994) portended that Homer captured the psychological aspects of war that modern clinicians have missed; specifically, Shay (1994, p. 3) argued that Homeric poetry accurately depicts the "betrayal of what's right" and describes the spiritual wounds of war with horrific precision. Shay (2002) contrasted Vietnam veterans' homecoming with that of Odysseus in Homer's *Odyssey*. In his follow-up work, Shay (2002) utilized the story of Odysseus to portray the difficulties that Vietnam veterans often encountered on their journey back to civilian life. Building on these ground-breaking works, Shay (2014) illustrated the prevalence of moral injuries in Homeric poetry and compared with veterans he has treated as a psychiatrist in a Department of Veterans Affairs (VA) clinical setting. In addition to the presence of moral injury in classical texts, it is a phenomenon found in other ancient and modern literature.

Religious Texts and Scriptures

When reading ancient religious literature, there is a distinct presence of moral injury. Jewish, Muslim, and Christian scriptures and liturgical texts all contain stories depicting moral injury and its impact. In Genesis 42:21-22, the Old Testament introduced the phrase *tzarat nafsho*, which translates to "his soul's distress" (Geringer & Wiener, 2018). This particular scripture depicts a discussion between brothers who had previously conspired to kill their brother Joseph and sold him into bondage; the brothers, particularly Reuben, expressed the moral injury they incurred for how they treated Joseph. Reuben's treatment of his brother is descriptive of

Farnsworth's (2017) first definition of a MIE as he committed an act that violated their own morality; this transgression ultimately resulted in a moral injury. The brothers acknowledged that the pain and wounds they were suffering from were within their souls. Numbers 31 and Deuteronomy 20 described the attention paid to soldiers and the impact of war on their souls (Geringer & Wiener, 2018).

In the Jewish Tanakh, combatants were not allowed to return to their families and communities until they were formally welcomed by community leaders, had an opportunity to account for their individual actions, complete religious rituals to help them address their actions on the battlefield, and given time and space to process their war experiences (Geringer & Wiener, 2018). Similar to Judaic and Christian writings on moral injury, ancient Islamic texts acknowledged that actions in war can lead to feelings and thoughts that one has fallen away from Allah and taught that one's soul can be healed through the Islamic concepts of Salaat, praying five times daily, Tafakkur, meditating on the beauty of existence, and Dhikr, which is described as remembering (Kopacz et al., 2017). In Buddhist scripture, the story of Angulimala detailed the story of a murderer who killed at least 999 people before meeting the Blessed One and transforming his way (McDonald, 2017). During Angulimala's transformation to a monastic monk, he endured pain and suffering as a result of his heinous crimes and only found healing through a commitment to helping others (McDonald, 2017).

Modern Wars

Similar to Vietnam, contemporary veterans are returning from noncontiguous battlefields. Enemy combatants in Iraq and Afghanistan do not wear uniforms. These battlefields are asymmetrical, with no clearly defined front lines. The Geneva Convention, which establishes a basic moral and ethical framework to combat, is not accepted or adhered to by the opposing

insurgents and terrorists. These enemy forces typically live among innocent Iraqi and Afghani civilians, and they frequently attack American and coalition forces from positions nestled in civilian population centers, resulting in the incidental death of women, children, elderly, and innocent men. Fighting an asymmetric enemy that uses these types of insurgent and guerilla tactics increases the chances that American and coalition forces will experience transgressions of their moral values (Caforio, 2014). A study of infantry soldiers and marines found that 40–65% killed an enemy combatant and that an additional 14–28% killed a noncombatant (Hoge et al., 2004). Hansen et al. (2021) found that over 65% of Canadian combat veterans reported at least one event that would be considered a PMIE. Michaud et al. (2021) found that PMIEs had more impact on behavioral outcomes and organizational outcomes than other combat-related stressors. Veterans returning from this combat environment tend to bring moral injuries with them. Although this is not a new phenomenon, it is a signature wound of this combatant generation, and additional understanding and research is needed.

Wood (2016) explored the role of moral injury in what is now the nation's two longest wars—Operation Iraqi Freedom and Operation Enduring Freedom. Wood, a journalist who has spent over three decades reporting on the military, argued that the signature wound of the conflicts in Iraq and Afghanistan is not PTSD but, in fact, moral injury; his assertions are based upon his anecdotal experiences embedded with the US military and reporting on research being conducted at the Department of Veterans Affairs. The influence of Wood's (2016) work is not in its quantitative analysis but rather in the detailed qualitative description of moral injury, its treatment, and the distinction from PTSD.

The literature has been interested in the prevalence rates of PTSD versus moral injury, but research is growing, and the data that are available suggest moral injuries may be more

prevalent than PTSD. Jordan et al. (2017) surveyed 867 active duty marines who engaged in ground combat while in Afghanistan and found that only 30% identified their most distressing event as fear or danger based. In fact, a study of 122 active duty combat veterans found that the participants' most traumatic experiences were, in fact, MIEs, not fear-based traumas (Stein et al., 2012). Currier et al. (2014) argued that morally injurious stressors result in distinctly separate responses from those that result from fear-based stressors. As such, if more combat veterans experience MIEs than fear-based events, the prevalence of moral injury is logically greater than that of PTSD.

Clinical Studies

As of 2019, 116 epidemiological and clinical studies have been conducted on moral injuries (Griffin et al., 2019). The majority of these studies have been conducted within the past 10 years and consisted of qualitative, quantitative, and mixed methods exploring the psychological, behavioral, biological, social, and spiritual domains (Griffin et al., 2019). The meta-analysis conducted by Griffin et al. (2019) concluded that moral injuries can significantly impact relationships, emotions, health, and daily functioning and that family, social supports, and culture may assist in the healing of these wounds. Grimell and Nilsson (2020) similarly argued that the conceptual development of military-related moral injury needs to integrate physiological, psychological, spiritual, and social outcomes. A study of 204 British combat veterans found that moral injury is associated with adverse mental health outcomes such as PTSD, depression, suicidality, and anxiety (Williamson et al., 2021). McEwen et al. (2020) conducted a meta-analysis of 59 articles and concluded that moral injuries are associated with poor mental health that overlaps with other mental health disorders, including depression and PTSD; however, the specific mechanism that results in moral injury remains unknown; current hypotheses include

guilt (Lancaster, 2018), rumination (Bravo et al., 2019), meaning-making (Currier et al., 2014), and negative postmorally injurious event cognitions (Held et al., 2017) as likely mechanisms to manifest a moral injury. The present study builds on this foundational hypothesis and explores the relationships of moral concerns, self-condemnation, and loss of meaning/purpose in relationship to religiosity; further discussion will be provided at the end of the chapter and in the research design.

One of the earliest studies of moral injury explored the Portuguese Colonial War, which took place between 1961 and 1975; via qualitative methods, the study found a common theme that participants had a personal sense of failing to live up to their own moral standards (Ferrajão & Oliveira, 2015). Similarly, during the Vietnam war, Vargas et al. (2013) concluded that civilian deaths and a sense of betrayal were common themes resulting in moral injury in American combatants. Forkus and Weiss (2020) surveyed 203 military veterans and found that moral foundations focused on loyalty, authority, and purity were more prone to develop a moral injury. A recent qualitative study exploring the impact of strategic ambiguity and its impact on Dutch border guards during a European migration crisis found that ill-defined military tasks resulted in moral injuries by subordinate service members (Kalkman & Molendijk, 2019).

A study of 100 veterans of Iraq and Afghanistan at a VA in New Jersey found correlations between moral injury, physical health, general mental well-being, and depression; in fact, moral injury and combat experiences were found to be strong predictors of PTSD (Yan, 2016). A study of 191 Israeli combat veterans found that 20% had experienced a morally injurious event, which was strongly correlated to higher levels of PTSD and feelings of guilt, self-loathing, shame, and depression (Zerach & Levi-Belz, 2018).

Qualitative interviews involving six combat veterans from the UK and four clinicians working with UK combat veterans validated Litz and Kerig's (2019) conceptualization that moral injurious events consist of events the person has committed/omitted and those that they have observed (Williamson et al., 2019). Williamson et al. (2019) concluded that moral injuries were more likely to develop in veterans who were either younger or held a senior rank at the time of the morally injurious event. Senior officers were more likely to develop moral injury because of feeling high levels of responsibility for the event (Williamson et al., 2019).

A study of 131 Iraq and Afghanistan war veterans found that MIEs were more likely to develop into moral injuries when the veteran struggled to find meaning in the event (Currier et al., 2014). Currier et al. (2014) argued that difficulty or maladaptive meaning-making is a primary mechanism for developing a moral injury following a PMIE.

A narrative thematic analysis explored the process of moral injury development following a morally injurious event and found five critical issues: timing, context of the event and decision-making process, reactions to the event, search for meaning and purpose, and ability to talk about the event (Held et al., 2018). A quantitative study of 189 combat veterans found that moral injuries are more likely to develop following a morally injurious event if the veteran engaged in problem-focused rumination following the event (Bravo et al., 2019; Held et al., 2019).

Exploring the role of meaning-making and psychiatric syndromes has a long and robust history in psychology (Wong, 2017). Meaning-making is integral to logotherapy, existential therapy, existential humanism, and existential psychotherapy (Smith & Lapsansky, 2021). These constructs agree that suffering is inevitable, that human motivation is fueled by man's desire to have a meaningful existence, and that humans have free will to discover their own meaning

(Bugental, 1965; Frankl, 2020; May, 1995; Smith & Lapsansky, 2021; Yalom, 2013). Available empirical evidence has suggested that meaning-making is a primary driver of recovering from combat-related MIEs. Keller et al. (2020) concluded in a qualitative analysis of OIF and OEF veterans that meaning-making was a critical component of transitioning from the combat zone. A quantitative study of 174 combat veterans from multiple service eras concluded that meaning was strongly correlated with increased psychological distress (Owens et al., 2009).

Similar to meaning-making, transgressive acts are a mechanism in the development of moral injury. Transgressive acts are common occurrences in combat; war requires participants to violate their basic principles and beliefs (Frankfurt & Frazier, 2016). A study of 564 US combat veterans found that 10.8% identified the transgressions they committed themselves, 25.5% witnessed transgressions by others, and another 25.5% experienced transgressions of betrayal (Wisco et al., 2017). A common transgression with the greatest potential to develop into a moral injury is the act of killing an enemy combatant (Frankfurt et al., 2017).

A study of 277 US Air Force personnel who operated unmanned aerial vehicles and frequently observed real-time, high-quality video of graphic combat events found a correlation between PTSD presence/severity and occurrence of MIEs (Kelley et al., 2021). Specifically, the greater the number of MIEs, the more likely that a person is to experience severe PTSD (Kelley et al., 2021); this study did not specifically look at the presence of moral injury, but the presence of PTSD symptomology and MIEs strongly suggests that moral injuries would also be present in this population. Supporting this assumption, in an inductive qualitative study, Smith-MacDonald et al. (2020) found that unresolved MIEs served as catalysts for negative cognitions and mental health dysfunction to include moral injuries. Similarly, in a quantitative analysis of 72 combat

veterans, Jinkerson and Battles (2019) found that exposure to potentially morally injurious events was positively correlated with moral injuries.

Presseau et al. (2019) found that moral injuries, originating from acts committed by self, comprise 4.8% of combat-related traumas and that these types of moral injuries are correlated with poor mental health outcomes. A qualitative study of 80 Dutch veterans of the war in Afghanistan concluded that transgressions of one's political beliefs in war can further exacerbate the development of moral injuries following a MIE (Molendijk, 2018). For these veterans, being forced to engage in wars they do not support or believe in, their mere involvement in the war creates moral transgressions that may develop into moral injury, particularly when they view their involvement as a betrayal by the political institutions they pledged to defend (Molendijk, 2018).

Moral Injury and Religion

The present study focuses on the role of religiosity rather than spirituality. Contemporary definitions of religiosity and spirituality often overlap and may be used interchangeably. However, the present study views them as two distinct phenomena. Spirituality is more difficult to find an agreed-upon definition because many people will interpret spirituality for themselves (Koenig et al., 2012). Spirituality often has little to no focus on doctrine, scripture, or organizational structure (Pargament, 1999) and can even be set upon practices and beliefs that are entirely secular (Salander, 2006). Religion involves an agreed-upon organization, beliefs, and practices/rituals that are considered sacred (Koenig et al., 2012). Religiosity will be measured by five core dimensions of intellect, ideology, public practice, private practice, and experience (Huber & Huber, 2012). Although the current study does not focus exclusively on Christianity, the majority of the research presented in this literature review is Christian centric. This is a result

of Christianity being the majority religion of the US Armed Forces, not an intentional focus of the research.

Morality is regularly derived from an intrinsic system of determining right from wrong and typically intertwines faith, religion, and spirituality (Meador & Nieuwsma, 2017). As such, it is critical to have a culturally competent understanding of faith traditions and their impact on mental health conditions, such as moral injuries (Blinka & Harris, 2016; Vieten et al., 2013). Religious-based morality generally results from both written scriptures and long-standing traditions (Wortmann et al., 2017). The major world religions all have a detailed understanding of moral codes and stories of moral transgressions (Wortmann et al., 2017). With religion being a core foundation for the contemporary understanding of morality, it is imperative that the role of faith and religion be explored in its relationship with moral injury.

Moral injury can often be described as a spiritual injury, and these terms are often used interchangeably in military chaplaincy (Temoney, 2021). The term spiritual injury first emerged in 1992 and is described as either an event caused by oneself or outside one's control that damages one's relationship to God (Carey et al., 2016; Temoney, 2021). Often, this type of injury is associated with a loss of trust in faith, scripture, and God (Carey et al., 2016). Brock and Lettini (2012) argued that moral injury is less a psychological disorder and more accurately described a crisis of faith or spiritual wound. To explore and understand moral injury in a truly holistic and multidisciplinary manner, the role of religiosity is critical.

Grimell (2018) divided veterans with moral injury into four categories: Saul type, David type, Joab type, and Uriah type. Saul-type individuals suffer in silence. They feel that they are unaccepted by God and that their transgressions are unforgivable. David types are those who process their transgressions through song, poetry, discussions, and ask for forgiveness. Joab

types are those who experience betrayal transgressions. Uriah types are those who committed transgressions to support their military brethren. Kopacz et al. (2017) highlighted the differences and similarities between moral injury within a Christian, Judaism, and Islamic perspective; the authors argued that interdisciplined collaboration is necessary in both assessing and treating moral injury.

Prescribing the theology of Augustine of Hippo, Powers (2019) argued that moral injury is linked to the Christian concept of original sin and man's fall from grace. As such, he argued that moral injury is inherent to any armed conflict and that the subsequent guilt, shame, remorse, and hopelessness is a normal byproduct of combat (Powers, 2019). In fact, Powers (2019) further argued that veterans are particularly prone to moral injury because military culture begins to distort a participant's morality during the very first parts of military training; military training deliberately stifles an individual's faith-based values and requires one to pursue a new goal of defeating an enemy through violence (Kelle, 2020).

This is contrary to just war theory, as reasoned by Christian theologians Augustine of Hippo and Thomas Aquinas (Meagher, 2014). Both Augustine and Aquinas argued that war can be theologically just if it meets certain conditions, such as a declaration of war by a legitimate state authority, righting a wrong or recovering stolen land, and having a righteous intention (Aquinas, 2010; Catholic Church, 1994). Meagher (2014) highlighted that the concept of just war supported by divine law is merely theoretical and has never been validated in actual experience; from Meagher's perspective, war cannot be just and cannot be carried out in a just way because of the inherent nature of violence and killing. Even in the most righteous of situations, taking the life of another through direct action violence creates contradictions between Christian teachings and the deliberate horrors of warfare. As such, participation in war can create shattering damage

to an individual's spirit, mind, and body (Graham, 2017; Rambo, 2010; Ramsay & Doehring, 2019).

Koenig et al. (2017) argued that moral injury may be experienced differently depending upon their degree of religiosity. This hypothesis pertained to the fact that people with strong religiosity are likely to have more severe symptoms from moral injury than their less-religious counterparts (Koenig et al., 2017). The assumption is that any disruption caused by a transgression will be greater to those with a closer relationship with God than to those who do not have such a relationship.

Harris et al. (2015) proposed that the stage of psychospiritual development when exposed to a morally injurious event is likely to play a significant role in how that event is processed and in what symptoms, if any, manifest. These researchers framed their work against the psychospiritual stages of Fowler (1991). They provided a case study illustrating that persons in Fowler's stage 3 who are deferent to church authorities are likely to develop moral injuries, whereas persons who have moved into stage 4, which is characterized by the ability to consider religious doubts with little to no distress, are more likely to reconcile their reactions following a morally injurious event (Harris et al., 2015). Although this hypothesis is robust in its articulation, there is no quantitative analysis exploring its veracity.

Studies exploring the relationship between religiosity and moral injury have been exiguous. A quantitative study by Evans et al. (2018) surveyed 155 veterans at a large VA medical facility and found that religious or spiritual struggles were more predictive of psychological distress than were potentially morally injurious events. Jinkerson (2016) proposed that religious or spiritual crises are a symptom of moral injury; however, the study hypothesized

that religious or spiritual crises may be a contributing factor in the development of moral injury (Evans et al., 2018).

Harris et al. (2018) studied 214 veterans and found that retribution theodicy—the belief that bad things happen as a result of sin in support of a just world view—was a predictor of religious or spiritual struggle. In a study with two large samples, sample A with 3,083 participants and sample B with 1,047 participants, found a nuanced relationship regarding religious struggle and mental health (Wilt et al., 2016). Wilt et al. (2016) found that a person's understanding of God and His role in suffering mediates the relationship between religious struggles and mental health distress.

Carey and Hodgson (2018) argued that spiritual healing is necessary in both the assessment and treatment of moral injury for many veterans suffering from moral injury. Too often, chaplains are not included in the exploration, case conceptualization, and treatment of veterans with moral injury (Carey & Hodgson, 2018). Liebert (2018) advocated that spiritual practices are beneficial for healing and sustaining anyone who experiences a moral transgression. Although originating from a Christian perspective, Liebert (2018) purported that her techniques of spiritual practices, deep listening, circle processes, writing one's own psalm, and restoring or maintaining connections with God/self/community is applicable across the religious spectrum. A descriptive study looking at 84 veterans at the VA found that PMIEs had no correlation to veterans with spiritual backgrounds and those who did not (Kopacz et al., 2018).

Moral injuries impact both the spiritual and secular. Research is currently lacking as to whether spirituality increases or mitigates the presence of moral injury or if moral injury negatively impacts religiosity. In one of the few studies examining the relationship between religion and moral injury, Lancaster and Miller (2020) found that religious strain can increase an

individual's propensity to develop moral injury following a morally injurious event and that these moral injuries are correlated with greater self-directed symptoms and behaviors. Rogers (2020) concluded that combat veterans who regularly attended religious services were less likely to develop any mental health disorders, but he qualified his research as "exploratory at best" (p. 425).

Religion and Mental Health

The research on the role religion plays in mental health has been increasing over the past few decades (Koenig et al., 2020). As of 2016, over 3,000 empirical studies have examined the relationship between religiosity and health (Moreira-Almeida et al., 2016). The impact of religion on mental well-being was largely negative throughout much of the twentieth century (Koenig et al., 2012). Religiosity has been associated with psychosis, hysteria, and neurosis (Koenig, 2009). A study in 1969 concluded that there was no empirical evidence to support religion as a contributing factor to mental well-being and overall mental health (Sanua, 1969). During this time, research findings were perceived as increasingly biased; as mental health professionals became less affiliated with religious beliefs so too did the empirical findings of the day. This potential bias was supported by a survey of 231 British psychiatrists, who 73% reported no religious affiliation (Neeleman & King, 1993). A similar study of American psychiatrists found that 60% identified as agnostic or atheist (Franzblau & American Psychiatric Association, 1975).

Growing research has indicated that religion can be both a resource and potential liability in the manifestations of mental health disorders (Koenig, 2020). The World Psychiatric Association (WPA) and World Health Organization (WHO) identified religion as a dimension of quality of life (Moreira-Almeida et al., 2016). The WPA's official position on religion stated that

there are significant implications in the role of religiosity for the field of mental health disorders (Moreira-Almeida et al., 2016). Numerous studies have shown that religion can be influential in the mitigation and treatment of mental health disorders (Koenig, 2018; Miller et al., 2014; VanderWeele, 2016).

The role of religion in relation to suicide has been discussed or mentioned throughout much of recorded history (Colucci & Martin, 2008). Academics have explored religion as a protective factor against suicide since Emil Durkheim, in 1897, postulated that religiosity reduced the risk of suicide (Durkheim, 2013; O'Reilly & Rosato, 2015). By 2010, there were 141 studies exploring the interaction of religiosity and suicide (Koenig et al., 2012). This section will review the perspectives of suicide in Christianity, Judaism, Islam, and Buddhism. Because suicide is considered a moral violation in each of these four major religions, the role of religion in suicidality is pertinent to the context of this research project.

In Christianity, there are nine references to suicide in the Old Testament and one in the New Testament; however, these references are often nonjudgmental (Barraclough, 1992). Suicide was seen as justified by revenge, justice, shame, defeat, or martyrdom (Colucci & Martin, 2008; Goldsmith & Institute of Medicine, 2002). An official stance against suicide was first argued by St. Augustine and Thomas Aquinas (Colucci & Martin, 2008). Since the fourth century A.D., Christianity has viewed suicide as a sin and condemned it (Colucci & Martin, 2008); however, contemporary practice has taken a more nuanced perspective and viewed it through the lens of situational context (Stein, 1971). The research has indicated that suicide rates are lower in Catholic and Baptist denominations than other Protestant denominations (Pescosolido & Georgianna, 1989); Gearing and Lizardi (2008) hypothesized that this difference in suicide rate is attributed to the acceptability of suicide and level of church engagement.

Judaism often views suicide as a sin greater than murder because a person who commits suicide cannot repent after the act (Bailey & Stein, 1995). The Talmud prohibits persons who commit suicide from receiving burial rites and being buried within Judaic cemeteries (Bailey & Stein, 1995). This law was modified in the twelfth and sixteenth centuries to distinguish between persons with sound and unsound minds; the context of one's mental stability and capacity was acknowledged as a mitigating factor (Colucci & Martin, 2008). The rates of suicide among Jews are lower than their Christian counterparts (Maris et al., 2000) but are higher than Muslims (Bailey & Stein, 1995).

In Islam, the Koran explicitly forbids suicide and makes suicide a crime under Shariya law (Pridmore & Pasha, 2004). In fact, persons who commit suicide are prohibited from receiving a funeral prayer (Jahangir et al., 1998). The available research indicates that Muslims have the lowest suicide rates among these four major religions (Bertolote & Fleischmann, 2015; Koenig, 2001; Simpson & Conklin, 1989).

Buddhism, on the other hand, formally adopted suicide as an acceptable practice (Whalley 1964). The belief in reincarnation allows suicide to be seen as a way to be reborn and have a new start (Colucci & Martin, 2008). However, Buddhist teachings also promote nonviolence toward all living things, including oneself (Lizardi & Gearing, 2009). Despite teachings of nonviolence, Kawamoto (2014) discussed that Buddhism's relative ambivalence toward suicide is a primary driver of Buddhist's relatively higher suicide rates, which are the highest among the four religions explored.

Studies exploring the role that religiosity may have on suicidal ideation and the completion of suicidal acts have had mixed results (Colucci & Martin, 2008; Stack & Kposowa, 2011). In military samples, faith-based conflicts regarding thoughts of being punished by God or

lacking meaning and purpose were found to be correlated with higher suicidality (Smigelsky et al., 2020). Similarly, in a study of 3,151 military veterans, Sharma et al. (2017) found that religiosity and spirituality were correlated to decreased mental disorders and higher rates of posttraumatic growth. In a review of 444 quantitative studies covering the last 50 years, Bonelli et al. (2012) found that 60% of the studies found a lower incidence of depression and faster mental health recovery rates for persons with higher religiosity. In 178 of the more rigorous studies, the researchers found an inverse relationship between religiosity and depression (Bonelli et al., 2012).

Moral Injury and Depression/Suicidality

By 2011, depression and suicide rates among Iraq and Afghanistan war veterans were more than doubled compared with their civilian counterparts (Department of Defense, 2011). A common co-occurring disorder with moral injury is depression and increased incidence of suicidal ideation and suicide attempts (Ames et al., 2018; Bryan et al., 2014; Maguen et al., 2012).

In one study, 930 National Guardsmen from Utah and Idaho were surveyed, and the results concluded that PTSD and moral injury are distinctly separate constructs, but their co-occurrence results in a significant predictor of suicide attempts (Bryan et al., 2018). The researchers hypothesized that the overlap of negative cognitions, depression, guilt, and shame are likely driving factors in increased suicidal behavior (Bryan et al., 2018). Finally, the authors noted that severe moral injury symptomology was a greater predictor of suicidality than any level of PTSD symptoms (Bryan et al., 2018).

Bryan et al. (2014) found that transgressions committed by self and transgressions witnessed by others are associated with higher rates of suicidal ideation and suicide attempts; this

research suggested that betrayal-based moral injurious events are not as likely to experience suicidal ideation. In fact, betrayal was not associated with any increase in suicidal ideation (Bryan et al., 2014). In a study of 7,200 veterans, betrayal and perpetrating transgressions based on MIEs were found to significantly decrease overall functioning when depression was present (Maguen et al., 2021).

In a study of 191 Israeli combat veterans, Zerach and Levi-Belz (2019) found that persons who are unable to tolerate uncertainty are more likely to experience suicidal ideation following a PMIE. Although the precise mechanism of why uncertainty leads to increased depression and suicidal ideation is unknown, the authors suggested that rigidity in military culture, the desire to meet combat expectations under stress, and the often ambiguous and complex nature of MIEs creates significant distress when framed against an individual's well-defined values and morals (Zerach & Levi-Belz, 2019).

In a study by Williams and Berenbaum (2019), a sample of 50 Iraq and Afghanistan war combat veterans were sampled, and the researchers concluded that MIEs characterized by acts of omission resulted in significant increases in depression and suicidality. Ames et al. (2018) found that moral injury had a strong association with suicidal risk; this study also found that religiosity did not mitigate suicidal risk, which is of interest for the present study.

Interestingly, Kelley et al. (2019) concluded that moral injury is more prevalent in people who overidentify with their failures and shortcomings and that suicidality was decreased by practices of mindfulness and increased social connectedness. A study of 564 combat veterans found that people who experienced moral transgressions or betrayal experiences were significantly less likely to experience suicidal ideation if they had a sense of a higher global meaning of the war and with the larger context of their experience (Corona et al., 2019). Levi-

Belz et al. (2020) found that, in a population of Israeli combat veterans, potential MIEs may increase the risk of both suicidal ideations and attempts; these researchers also identified a correlation between potential MIEs, suicidal ideation, low levels of social support, and difficulty in self-forgiveness. Nichter et al. (2021) surveyed 1,321 US combat veterans and concluded that morally injurious events are greater predictors of suicidality than both PTSD and depression. Similarly, Battles et al. (2021) conducted a study with 129 combat veterans and concluded that guilt and shame related to moral injuries have a stronger correlation to suicidal behavior than PTSD-based symptomology. In a study of 14,057 veterans, those with PMIEs where the transgression was committed by the person with moral injury were 50% more likely to attempt suicide (Maguen et al., 2021).

In contrast to the negative perspectives that mental health professionals had toward religion in the 1960s, efforts are currently underway to integrate faith into mental health treatment. Pyne et al. (2019) discussed the potential benefits spiritually based counseling may have on veterans with moral injury. Moon (2017) advocated for how communities of faith are suited to treat moral injury and complement the work of evidenced-based mental health clinicians. Similarly, Doehring (2018) discussed how integrating spiritual care with an evidenced-based approach may best treat moral injuries. In a study of 269 service members, Kelley et al. (2021) found that having meaning in life was a protective factor in suicidality for veterans with moral injury. Current efforts by the VA are increasing chaplains' understanding of moral injury and working toward incorporating chaplaincy and faith into mental health care (Drescher et al., 2018).

Moral Injury and Substance Use Disorder

Substance use disorders, which include both alcohol use disorders and drug use disorders, are among the most common health conditions that veterans struggle with (Lan et al., 2015). Despite the consequences and cost of substance use disorders, studies exploring the etiology of substance use in combat veterans are still scarce (Seal et al., 2011). Combat veterans are at a higher risk for substance use disorders than veterans with no combat experience (Brady et al., 2019; Bray et al., 2013; Hoggatt et al., 2015; Larson et al., 2012). A review of 456,502 veterans from the wars in Iraq and Afghanistan found that 11% had a substance use disorder (Seal et al., 2011). Of these veterans with a substance use disorder, 55% to 75% also had a PTSD or depression diagnosis (Seal et al., 2011). Seal et al. (2011) found that multiple deployments and higher combat exposure were correlated with a greater risk of a substance use diagnosis. Similarly, a meta-analysis of 55 studies found that veterans with greater combat exposure or a prolonged length of combat deployments experienced significantly higher rates of substance abuse (Brady et al., 2019).

There is limited empirical data regarding the relationship between moral injury and substance use disorders, but because of the high rates of substance use in combat veterans, the relationship between moral injury and substance use may have significant potential for understanding and treating this burdensome syndrome. Studies have historically focused on alcohol use disorders, while other substance use disorders have been largely ignored (Seal et al., 2011). Focusing on the addiction process versus the type of substance used may be of greater value in understanding the mechanization of moral injury and substance use.

The current literature has been somewhat mixed in its conclusions regarding the relationship between moral injury and substance use (Hall et al., 2021). Overall, studies have indicated a positive correlation between moral injury and substance use, but studies with

increased complexity in the design tend to find fewer to no associations between moral injury and substance use (Hall et al., 2021).

A review of studies conducted between 1997 and 2004 found that veterans of the Gulf War, Iraq War, and Afghanistan War were at a significantly higher risk of alcohol use disorder than their civilian counterparts (Kelsall et al., 2015). Cameron et al. (2020) found that veterans with a substance use disorder and who were exposed to morally injurious events were more likely to experience suicidality. A study examining the correlation between moral injury and substance abuse in 191 Israeli combat veterans found that veterans with moral injury suffered from a higher incidence of substance abuse, but the abuse was mitigated by social support (Feingold et al., 2018). Davies et al. (2019) found that moral injury is positively associated with both PTSD and substance use disorder symptomology. Similarly, a study of 244 community-based combat veterans found that moral injury was a predictor of substance use disorders (Battles et al., 2018). A quantitative study of 256 veterans found that moral injury was positively correlated with hazardous alcohol use, but no correlation with other types of drug use was found. Ashwal-Malka et al. (2022) studied a sample of 215 Israeli Defense Force combatants and found that moral injury-related betrayal and self-perpetrated moral transgressions were positively correlated to increased cannabis use disorders. In a first known nationally representative sample of 1,321 US combat veterans, moral injury was the lifetime prevalence of substance use disorders (Maguen et al., 2021).

The current literature on the impact of moral injury on substance use is somewhat varied. The empirical research suggests a correlation between moral injury and alcohol use disorder, but the evidence has been less clear regarding the relationship between moral injury and other types

of substance use disorders. These mixed results are directly related to the lack of research on the relationship between moral injury and substance use.

Summary

The concept of moral injury is ancient, but its inclusion in psychological treatment is nascent. Many of the earliest human writings depict stories of people struggling for atonement, seeking forgiveness, and fighting to right perceived wrongs. Most world mythologies, philosophies, and religions all include the basic concept or premise of moral injury and how to respond to it. In the Christian and Jewish faiths, the first negative emotion experienced by Adam and Eve is arguably shame, which resulted in a moral injury—an injury that human beings have sought to reconcile ever since.

Moral injury is a stressor-initiated pathological condition that manifests after a person is exposed to a moral transgression, which is referred to as a morally injurious event. This transgression can be committed by oneself or witnessed by another. Although the exact mechanism that occurs between experiencing a morally injurious event and the actual development of moral injury is largely unknown, current understanding purports that negative rumination and an inability to assign meaning or purpose to the event are contributing factors. Once moral injury is present, mental health outcomes worsen, depression increases, and adverse alcohol consumption is more likely. Mental health practitioners working with combat veterans are recognizing the prevalence of moral injury and in need of increased awareness and understanding of this pervasive yet largely unfamiliar phenomenon. The present study has examined the relationship between the components of moral injury and their impact on religiosity. Building on the conceptual framework that moral injury contains moral concerns, loss of meaning-making, and self-condemnation, the current study has examined the correlations, if

any, these components have on religiosity . The present study has explored religiosity, not spirituality. Religiosity inherently involves faith in a higher power; therefore, the present study hypothesizes that religiosity is directly impacted by moral injury. The present study did not deliberately explore the role of any specific religious faith; it instead has grouped religious faiths together and measured these using a scale that defines and measures religiosity using five common domains. Although the present study has focused on religiosity across multiple faiths, demographic data allowed for participants to identify their specific religion, and the resulting data yielded information to be used in future studies.

Chapter Three: Methods

Overview

The methodology for the present research study is a survey-based quantitative analysis. The method is discussed and includes participants, procedure, methods, statistical analysis, and clinical significance. Finally, the internal and external validity factors are examined. Research has been conducted at a nonprofit veteran organization serving over 6,000 veterans in the upstate region of South Carolina.

Design

Following approval by the Institutional Review Board (IRB), the proposed study was presented to Upstate Warrior Solutions (UWS), a nonprofit veteran's organization, to enter into a memorandum of understanding. UWS advertised the study and asked members of its 6,000-person database to consider participating in the anonymous survey. The study involved combat veterans who were currently or recently treated in either VA or Readjustment Counseling Services (RCS).

Research Questions

Moral concern, as a variable, is conceptualized by moral transgressions (Koenig, 2018, p. 4). Operationally, moral concerns are identified by the commission/omission or witnessing of immoral acts (Koenig, 2018, p. 4). The MISS-M uses a three-item Likert subscale built on the foundation of the Moral Injury Events Scale (MIES) by Nash et al. (2013). For this scale, the respondents are asked to respond using a 1–10 fixed-choice option with fixed anchor points of “strongly disagree” and “strongly agree” (Koenig, 2018, p. 10). The moral concerns subscale has a CI of .783 to .844 and a Cronbach's alpha of .816 (Koenig, 2018, p. 262).

The variable of loss of meaning/purpose is conceptualized by the lack of presence and search for meaning in life (Steger et al., 2009, p. 89). This concept is operationalized by the degree to which one feels their life has meaning (Koenig, 2018, p. 5). The MISS-M uses a four-item Likert subscale based on the Meaning in Life Questionnaire (MLQ) developed by Steger et al. (2006). The participants are asked to choose the level of agreement with four statements using a 1–10 fixed-choice option measuring between “absolutely untrue” and “absolutely true” (Koenig, 2018, p. 10). Scoring of this subscale is aggregated; higher scores indicate a greater loss of meaning/purpose (Koenig, 2018, p. 7). The loss of meaning subscale has a CI of .894 to .922 and a Cronbach’s alpha of .909 (Koenig, 2018, p. 262).

Self-condemnation, as a variable, is conceptualized by self-worth. Self-worth is determined by both positive and negative feelings about the self (Koenig, 2018, p. 6). The MISS-M measures self-condemnation using a 10-item Likert subscale adopted from the Rosenberg Self-Esteem Scale (SES) (Rosenberg, 1965). The SES measures global self-worth and its opposite self-condemnation (Koenig, 2018, p. 253). Although the SES uses a Guttman scale (Rosenberg, 1965, p. 16), the 10-item self-condemnation subscale in the MISS-M uses a 1–10 fixed-choice option measuring between “strongly disagree” and “strongly agree” (Koenig, 2018, p. 253). Five of the items on this subscale were reverse scored. Scoring of the subscale is aggregated, with higher scores indicating greater self-condemnation (Koenig, 2018, p. 7). The self-condemnation subscale has a CI of .792–.844 and a Cronbach’s alpha of .819 (Koenig, 2018, p. 262).

In each of the research questions, the variable of religiosity is conceptualized by the centrality of religion in a person’s life (Huber & Huber, 2012, p. 710). Religiosity is operationally defined as the importance of the intellectual, ideological, ritualistic, experiential,

and consequential dimensions of religion (Huber & Huber, 2012, p. 711). The Centrality of Religiosity Scale (CRS) is a 15-item scale requiring each respondent to identify the frequency of a religious practice, tradition, or construct in their life (Huber & Huber, 2012, p. 716). Frequency is measured using a five-level response where “1” is never, “2” is a few times, “3” is one or three times per month, “4” is more than once a week, and “5” is once or more times a day (Huber & Huber, 2012, p. 720). Scores are totaled and divided by 15; averaged scores of 1.0 to 2.0 indicate “not religious,” 2.2 to 3.8 indicates “religious,” and 4.0 to 5.0 indicates “highly religious” (Huber & Huber, 2012, p. 722). The CRS has been utilized in over 100 studies across 25 countries and with more than 100,000 participants (Huber & Huber, 2012, p. 710).

RQ1: Do the combined moral injury dimensions—*guilt, shame, betrayal, moral concerns, loss of meaning, difficulty forgiving, loss of trust, self-condemnation, spiritual/religious struggles, and loss of religious faith/hope*—predict religiosity among US combat veterans?

RQ2: Do the moral injury dimensions—*guilt, shame, betrayal, moral concerns, loss of meaning, difficulty forgiving, loss of trust, self-condemnation, spiritual/religious struggles, and loss of religious faith/hope*—individually predict religiosity among US combat veterans?

Hypotheses

H1₀: The combined moral injury dimensions—*guilt, shame, betrayal, moral concerns, loss of meaning, difficulty forgiving, loss of trust, self-condemnation, spiritual/religious struggles, and loss of religious faith/hope*—do not predict religiosity among US combat veterans.

H1_a: The combined moral injury dimensions—*guilt, shame, betrayal, moral concerns, loss of meaning, difficulty forgiving, loss of trust, self-condemnation, spiritual/religious struggles, and loss of religious faith/hope*—predict religiosity among US combat veterans.

H2₀: The moral injury dimension *guilt* individually does not predict religiosity among US combat veterans.

H2_a: The moral injury dimension *guilt* individually predicts religiosity among US combat veterans.

H3₀: The moral injury dimension *shame* individually does not predict religiosity among US combat veterans.

H3_a: The moral injury dimension *shame* individually predicts religiosity among US combat veterans.

H4₀: The moral injury dimension *betrayal* individually does not predict religiosity among US combat veterans.

H4_a: The moral injury dimension *betrayal* individually predicts religiosity among US combat veterans.

H5₀: The moral injury dimension *moral concerns* individually does not predict religiosity among US combat veterans.

H5_a: The moral injury dimension *moral concerns* individually predicts religiosity among US combat veterans.

H6₀: The moral injury dimension *loss of meaning* individually does not predict religiosity among US combat veterans.

H6_a: The moral injury dimension *loss of meaning* individually predicts religiosity among US combat veterans.

H7₀: The moral injury dimension *difficulty forgiving* individually does not predict religiosity among US combat veterans.

H7_a: The moral injury dimension *difficulty forgiving* individually predicts religiosity among US combat veterans.

H8₀: The moral injury dimension *loss of trust* individually does not predict religiosity among US combat veterans.

H8_a: The moral injury dimension *loss of trust* individually predicts religiosity among US combat veterans.

H9₀: The moral injury dimension *self-condemnation* individually does not predict religiosity among US combat veterans.

H9_a: The moral injury dimension *self-condemnation* individually predicts religiosity among US combat veterans.

H10₀: The moral injury dimension *spiritual/religious struggles* individually does not predict religiosity among US combat veterans.

H10_a: The moral injury dimension *spiritual/religious struggles* individually predicts religiosity among US combat veterans.

H11₀: The moral injury dimension *loss of religious faith/hope* individually does not predict religiosity among US combat veterans.

H11_a: The moral injury dimension *loss of religious faith/hope* individually predicts religiosity among US combat veterans.

Participants and Setting

The present study consisted of United States (US) combat veterans who have served in recognized armed conflicts. UWS serves over 6,000 local veterans and maintains an active database with veteran contact information and their willingness to participate in research. The current study relied on a convenience sample of veterans engaged with UWS services. Participants were invited to participate in the study via an email. Using the UWS distribution list, the researcher disseminated the study via email to 6,000 local veterans and asked them to consider participating in the anonymous online survey.

Inclusion criteria consisted of reported combat service, presence of moral injury, and completion of all study documentation (consent, demographics, scales, and measures). Exclusion criteria consisted of the following: 1) veterans reporting psychosis, cognitive impairments, active suicidal ideation, or homicidal ideation per self-report, 2) veterans with no combat deployments, 3) veterans with military sexual trauma, 4) failing to complete the study's packet in its entirety, 5) nonwillingness to participate, and 6) absence of a moral injury as indicated by the included study measure.

Using G*Power analysis indicated that, with two research questions, sample size should be a minimum of 84; however, should nonparametric testing be required, the sample size would require a 15% increase; therefore, the targeted sample size was 118. With a potential recruitment size of 6,000, achieving a sample size of 118 would require less than a 2% participation rate. Should the sample size be considerably less than 97, a Kendall's tau-b will be utilized.

The researcher provided willing participants who met the inclusion criteria with a link to an online survey consisting of a consent section, demographic section, self-report measures, and

a list of local mental crisis resources; the entire process was electronic. Completed submissions were screened for completeness and for inclusion and exclusion criteria.

Instrumentation

The study relied on self-reported measures to assess the presence and severity of moral injury and the presence and level of religious faith.

Moral Injury Symptom Scale-Military Version (MISS-M)

The MISS-M is a 45-item multidimensional measure developed by Koenig et al. (2017). This scale builds on the strengths of the MIES, which was the first valid and reliable measure to quantify moral injuries (Nash et al., 2013; Lancaster & Harris, 2018), and the Moral Injury Questionnaire-Military version (MIQ-M), which was designed to identify both the presence of moral injury and then characterize it upon three common military MIEs (Braitman et al., 2018). The MIQ-M divides moral injury events into atrocities of war, psychological consequences of war, and leadership failure or betrayal (Braitman et al., 2018). The MISS-M has built on this work and incorporates 10 moral injury subscales: guilt, shame, betrayal, moral concerns, loss of meaning/purpose, difficulty forgiving, loss of trust, self-condemnation, spiritual/religious struggles, and loss of religious faith/hope (Koenig, 2018). This scale is unique in that it incorporates religious symptomology with psychology (Koenig et al., 2020). The MISS-M has strong internal reliability, as indicated for each of its three core components: atrocities of war $\alpha = 0.95$, psychological consequences of war $\alpha = 0.85$, and leadership failure or betrayal $\alpha = 0.88$ (Braitman et al., 2018). The MISS-M validated its subscales with confirmatory factor analysis (CFA) and an overall Cronbach's $\alpha = 0.92$; the test-retest reliability of 64 veterans with an interval of 10 d was 0.91 overall, and subscales ranged between 0.78 and 0.90 (Koenig et al., 2017).

Centrality of Religiosity Scale (CRS)

The CRS is an instrument developed by Stefan Huber and has been utilized in over 100 studies with over 100,000 participants across 25 countries (Huber & Huber, 2012). This instrument explores religion through five personal domains: the intellectual dimension, ideology, public practice, private practice, and religious experience. The present study utilized the CRS-15, which is a 15-item questionnaire. Construct validity for the CRS is 0.83 when completed as a self-reported tool (Huber & Huber, 2012). CFA was conducted using Amos 20.0, and the scale was found to be structurally sound, with an overall Cronbach's $\alpha = 0.93$ (Gheorghe, 2018).

Procedures

UWS disseminated an online survey link to over 6,000 veterans requesting that they engage in the study. The survey was built in Survey Monkey and included written consent, demographic questionnaire, and assessment, via self-report, for the presence of psychosis, cognitive impairments, and active suicidal or homicidal ideation. If any potential participants answered in the affirmative to these exclusion criteria, they were forwarded to a page encouraging them to reach out to a mental health provider; national civilian and military crisis resources were then provided.

Data Analysis

The data gained from the self-reported measures are part of a survey inventory with a convenience sample. The data were initially reviewed for normality using scatterplots. In the event that there is a linear relationship between the dependent variable plotted against the independent variable, then the data will be analyzed using multiple linear regression. The data analysis consisted of multiple linear regression (MLR), where religiosity was the criterion variable and 10 moral injury dimensions were the predictor variables. MLR analysis helped

identify the relationship, if any, that the predictor variables had with the criterion variable. A scale location plot was created to ensure that the data were homoscedastic. The residuals of the regression line were evaluated for normal distribution using both a Q-Q plot. To ensure there were no outliers, Cook's distance was calculated and plotted. The significance of the study greatly depended on survey response and sample size, and achieving a minimum sample size based upon the power analysis was critical. The present research study was subject to internal validity threats. The first threat was selection bias because the population was a convenience sample and can only reflect combat veterans in the state of South Carolina who have already engaged with a local veteran nonprofit organization. The findings may not be generalizable to veteran populations outside of South Carolina or outside the southeastern US. Second, although the instruments have been carefully chosen, instrumentation naturally has variances, and there is no known study that has utilized these instruments to measure these specific research questions.

External threats consisted of the willingness of participants to engage and Hawthorne effects. First, the participants were contacted and engaged via email and online surveys. Researchers did not administer the measures. Combat service was not verified and was subject to participant misrepresentation. Second, the participants may have exaggerated or minimized their symptomology knowing that they were a part of a study. An additional concern regarding the overreporting of symptoms is that veterans often receive service-connected disability pay from the VHA for any of their diagnoses related to their military service. The amount of their pay is based on the severity of their symptomology, so there is a statistically relevant tendency to overreport symptoms (Freeman et al., 2008).

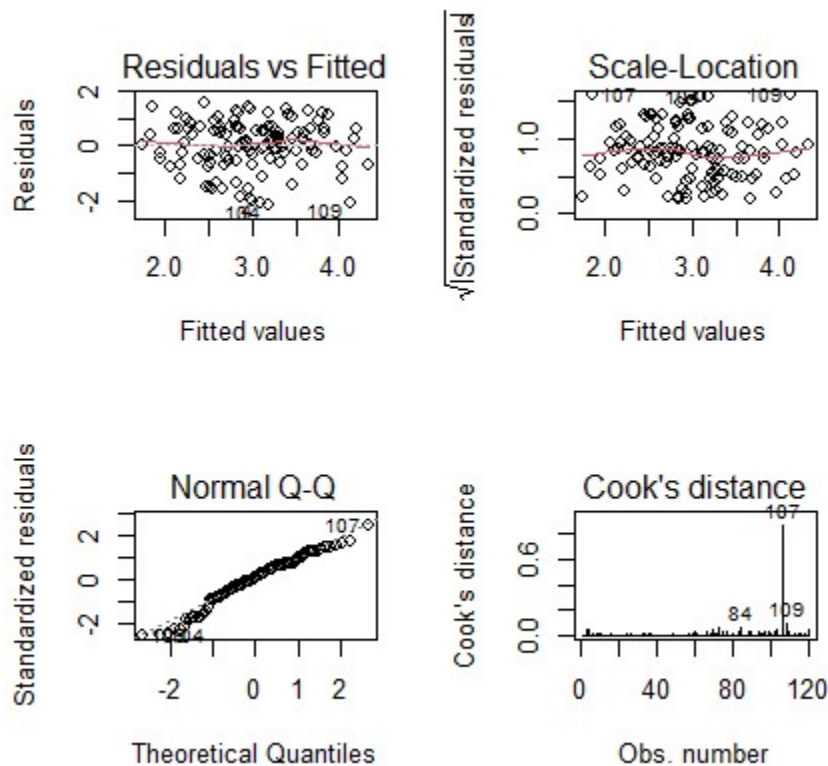
Chapter Four: Findings

Overview

The purpose of the present study was to examine moral injury as a predictor of religiosity. The study consisted of an anonymous online survey of combat veterans. Veterans were asked to complete MISS-M and CRS in Survey Monkey. The survey was open for one month. Potential participants received a recruitment email and a follow-up recruitment email two weeks later. In total, 120 veterans completed the survey and met all the criteria. The survey data were scored and analyzed using R software. Religiosity, as determined by scores on the CRS, was analyzed against 10 subscales of moral injury as found in the MISS-M. The data were normative and demonstrated linear relationships between the dependent and independent variables. Causal inference was explored using MLRs.

There are four assumptions of linear regression. Assumption one is linearity. The relationship between the predictor variables and the mean of the criterion (religiosity) is linear. To test this assumption, the residuals were plotted against the fitted observations. As illustrated in the upper left quadrant of Figure 1, the fitted line, illustrated in red, was horizontal, indicating there was no pattern of the residuals to the fitted values and that the model met the assumption of linearity. Assumption two is the homogeneity of variance. The homogeneity of variance of the residual is the same for any value of the predictor. As illustrated in the upper right corner of Figure 1, the residuals are spread equally along the range of the predictors because the line is horizontal and equally spread across the fitted values. The assumption of homogeneity of the variance was met. Assumption three is normality, meaning that any fixed value of the predictors and criterion is normally distributed. To test for normality, a normal Q-Q test was conducted. As illustrated in the upper right quadrant of Figure 1, in the lower left-hand corner, the normal

probability plot of residuals followed a straight line, indicating that the assumption of normality was met. The fourth assumption is that there are no outliers in the data that significantly change the model. To test this assumption, Cook's distance was plotted; Cook's distance is a measure of whether an observation is an outlier. Figure 1 (the lower right-hand corner) illustrates Cook's distance. To determine a high value, the following formula was used: $4 / (\text{sample size} - \text{number of predictors} - 1)$; this resulted in a value of 0.036 for the cutoff criteria score, meaning any observation with a Cook's distance value greater than 0.036 can be considered an outlier. As illustrated in Figure 1, the observation 107 was a significant outlier because the Cook's distance value exceeded the value of 0.036. As such, observation 107 was removed from the data set, as analyses of the results indicated it was an influence value in terms of being an outlier; an influential value is a value that, when included, can alter the results of the regression analyses.

Figure 1. *Plots to Test the Assumptions of Linear Regression*

Descriptive Statistics

Table 1 (Appendix E) depicts the demographics of the sample. Here, 98% of respondents were male, 33% were aged 35–45, 56% served in the Army, 56% separated from the military at the rank of E-1 to E4, 62% served in a direct arms military occupational specialty, 37% served in Iraq, 97% engaged in direct combat, 59% reported a diagnosis of PTSD, 69% identified as religious, and 67% identified as Christians.

Table 2 shows descriptors such as the means and standard deviations of each variable. Religiosity was scored on the CRS-based 0 to 5 scale ($M = 3.1$, $SD = 1.0483$). Guilt was scored on a four-question subscale ranging from 4 to 40 ($M = 29.38$, $SD = 8.077$). Shame was scored on a five-question subscale ranging from 5 to 50 ($M = 16.08$, $SD = 4.18$). Betrayal was scored on a

six-question subscale with possible scores ranging from 6 to 60 ($M = 18.87$, $SD = 5.973$). Moral concerns were scored on a three-question subscale with possible ranges of 3 to 30 ($M = 19.98$, $SD = 5.337$). Loss of meaning was scored on a four-question subscale with possible scores of 4 to 40 ($M = 14.59$, $SD = 6.487$). Difficulty forgiving was scored on a seven-question subscale with scores possible from 7 to 70 ($M = 38.81$, $SD = 11.031$). Loss of trust was scored on a four-question subscale with possible scores of 4 to 40 ($M = 19.22$, $SD = 7.662$). Self-condemnation was scored on a 10-question subscale with possible score ranges of 10 to 100 ($M = 34.13$, $SD = 13.131$). Spiritual and religious struggles were scored on a six-question subscale with possible score ranges of 6 to 60 ($M = 28.59$, $SD = 14.939$). Loss of faith was scored on a two-question subscale with possible scores of 2 to 20 ($M = 11.10$, $SD = 3.44$).

Table 2

Means, Standard Deviations, and Correlations

Variable	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7	8	9	10
1. Religiosity	2.99	1.05										
2. Guilt	29.34	8.10	-.07									
3. Shame	16.08	4.18	.09	.67**								
4. Betrayal	18.86	6.00	-.09	.40**	.44**							
5. Moral Concerns	19.95	5.35	-.08	.65**	.63**	.62**						
6. Loss of Meaning	14.58	6.51	-.05	.03	.19*	-.03	.16					
7. Difficulty Forgiving	38.75	11.06	-.30**	.42**	.45**	.09	.32**	.34**				
8. Loss of Trust	19.24	7.69	-.31**	.04	-.03	.18	.14	.16	.05			
9. Self - Condemnation	34.03	13.14	-.28**	.15	.08	.09	.14	.37**	.48**	.26**		
10. Spiritual and Religious Struggles	28.53	14.99	-.06	.49**	.38**	.17	.34**	.08	.47**	-.05	.07	
11. Loss of Religious Faith/Hope	11.10	3.44	-.37**	.41**	.39**	.21*	.43**	.37**	.65**	.11	.39**	.57**

Note. *M* and *SD* are used to represent the mean and standard deviation, respectively. * indicates $p < .05$. ** indicates $p < .01$.

Results

Hypotheses

The present study consisted of 11 hypotheses. Each hypothesis was first assessed for correlation. Hypotheses that demonstrated correlation were then tested using linear regression. Because the data met all four assumptions for the linear regression analyses, the one outlier was removed for a total sample size of 119 participants. Multiple regression analysis was conducted to determine whether the MISS-M accounted for significant variance in religiosity. Additionally, each subscale of the MISS-M was explored to determine if any of the subscales explained the unique variance in the regression model.

Research Question #1

The first research question asked if the combined moral injury dimensions—*guilt, shame, betrayal, moral concerns, loss of meaning, difficulty forgiving, loss of trust, self-condemnation, spiritual/religious struggles, and loss of religious faith/hope*—predict religiosity among US combat veterans. The null hypothesis was that the combined moral injury dimensions—*guilt, shame, betrayal, moral concerns, loss of meaning, difficulty forgiving, loss of trust, self-condemnation, spiritual/religious struggles, and loss of religious faith/hope*—do not predict religiosity among US combat veterans. The hypothesis was that the combined moral injury dimensions—*guilt, shame, betrayal, moral concerns, loss of meaning, difficulty forgiving, loss of trust, self-condemnation, spiritual/religious struggles, and loss of religious faith/hope*—predict religiosity among US combat veterans.

Table 3*Regression Results Using Religiosity As the Criterion*

Predictor	<i>b</i>	<i>b</i>		<i>SE</i>	β
		95% CI [LL, UL]			
(Intercept)	4.45**	[3.56, 5.33]			
Betrayal	-0.02	[-0.05, 0.02]		-0.10	-0.10
Guilt	-0.01	[-0.04, 0.02]		-0.06	-0.06
Shame	0.09**	[0.02, 0.15]		0.34	0.34
Moral Concerns	0.00	[-0.05, 0.05]		0.02	0.02
Loss of Meaning	0.03	[-0.00, 0.06]		0.16	0.16
Difficulty Forgiving	-0.03*	[-0.05, -0.00]		-0.28	-0.28
Loss of Trust	-0.03**	[-0.06, -0.01]		-0.24	-0.24
Self-Condensation	-0.00	[-0.02, 0.02]		-0.00	-0.00
spiritual and Religious Struggles	0.01	[-0.00, 0.03]		0.20	0.20
Loss of Religious Faith	-0.13**	[-0.21, -0.06]		-0.43	-0.43

Note. $R^2 = .340$, $p < .01$. A significant *b* weight indicates that the beta weight and semipartial correlation are also significant. *b* represents unstandardized regression weights. β indicates the standardized regression weights. *SE* indicates the standard error. *LL* and *UL* indicate the lower and upper limits of a confidence interval, respectively. * indicates $p < .05$. ** indicates $p < .01$.

The overall model was statistically significant [$R^2 = 0.33$, $F(108) = 5.58$, $p < .001$], indicating the total MISS-M scale accounted for 33% of the variance in religiosity; therefore, the null hypothesis was rejected and the alternative hypothesis accepted.

Research Question #2

The second research question explored whether the moral injury dimension *guilt* individually predicts religiosity among US combat veterans. The null hypothesis proposed that the moral injury dimension *guilt* individually does not predict religiosity among US combat veterans, while the hypothesis stated that the moral injury dimension *guilt* individually predicts religiosity among US combat veterans.

Table 4*Regression Results Using Religiosity as the Criterion and Guilt as the Predictor*

Predictor	<i>b</i>	<i>b</i>		<i>SE</i>	β
		95% CI	[LL, UL]		
Guilt	-0.01	[-0.04, 0.02]		-0.06	-0.06

Note: $R^2 = .004$, $p = .61$. A significant *b* weight indicates that the beta weight and semipartial correlation are also significant. *b* represents unstandardized regression weights. β indicates the standardized regression weights. *SE* indicates the standard error. *LL* and *UL* indicate the lower and upper limits of a confidence interval, respectively. * indicates $p < .05$. ** indicates $p < .01$.

The guilt subscale ($\beta = -0.06$, $p = .61$) was not a significant predictor of religiosity; therefore, the results failed to reject the null hypothesis.

Research Question #3

The third research question evaluated whether the moral injury dimension *shame* individually predicts religiosity among US combat veterans. The subsequent null hypothesis was that the moral injury dimension *shame* individually does not predict religiosity among US combat veterans. The hypothesis affirmed that the moral injury dimension *shame* individually does predict religiosity among US combat veterans.

Table 5*Regression Results Using Religiosity as the Criterion and Shame as the Predictor*

Predictor	<i>b</i>	<i>b</i>		
		95% CI [LL, UL]	<i>SE</i>	β
Shame	0.09**	[0.02, 0.15]	0.34	0.34

Note. $R^2 = .007$, $p = .006$. A significant *b* weight indicates that the beta weight and semipartial correlation are also significant. *b* represents unstandardized regression weights. β indicates the standardized regression weights. *SE* indicates the standard error. *LL* and *UL* indicate the lower and upper limits of a confidence interval, respectively. * indicates $p < .05$. ** indicates $p < .01$.

The shame ($\beta = .34$, $p = .006$) subscale was a significant predictor of religiosity. As illustrated by the standardized beta weight, an increase in one unit of the shame subscale resulted in an increase of 0.34 in the prediction of the religiosity score; therefore, the null hypothesis was rejected, and the alternative hypothesis was accepted.

Research Question #4

The fourth research question asked if the moral injury dimension *betrayal* individually predicts religiosity among US combat veterans. The null hypothesis stated that the moral injury dimension *betrayal* individually does not predict religiosity among US combat veterans. The hypothesis stated that the moral injury dimension *betrayal* individually predicts religiosity among US combat veterans.

Table 6*Regression Results Using Religiosity as the Criterion and Betrayal as the Predictor*

Predictor	<i>b</i>	<i>b</i>		<i>SE</i>	β
		95% CI	[LL, UL]		
Betrayal	-0.02	[-0.05, 0.02]		-0.10	-0.10

Note. $R^2 = .008$, $p = .35$. A significant *b* weight indicates that the beta weight and semipartial correlation are also significant. *b* represents unstandardized regression weights. β indicates the standardized regression weights. *SE* indicates the standard error. *LL* and *UL* indicate the lower and upper limits of a confidence interval, respectively. * indicates $p < .05$. ** indicates $p < .01$.

The betrayal subscale ($\beta = -0.10$, $p = .35$) was not a significant predictor in the model; therefore, the results failed to reject the null hypothesis and rejected the alternative hypothesis.

Research Question #5

The fifth research question explored whether the moral injury dimension *moral concerns* individually predicts religiosity among US combat veterans. The null hypothesis stated that the moral injury dimension *moral concerns* individually does not predict religiosity among US combat veterans. The hypothesis stated that the moral injury dimension *moral concerns* individually does predict religiosity among US combat veterans.

Table 7*Regression Results Using Religiosity as the Criterion and Moral Concerns as the Predictor*

Predictor	<i>b</i>	<i>b</i>		<i>SE</i>	β
		95% CI	[LL, UL]		
Moral Concerns	0.00	[-0.05, 0.05]		0.02	0.02

Note. $R^2 = .006$, $p = .87$. A significant *b* weight indicates that the beta weight and semipartial correlation are also significant. *b* represents unstandardized regression weights. β indicates the standardized regression weights. *SE* indicates the standard error. *LL* and *UL* indicate the lower and upper limits of a confidence interval, respectively. * indicates $p < .05$. ** indicates $p < .01$.

The moral concerns subscale ($\beta = 0.02$, $p = .87$) was not a significant predictor of religiosity in this model, so the results failed to reject the null hypothesis, consequently rejecting the alternative hypothesis.

Research Question #6

The sixth research question evaluated whether the moral injury dimension *loss of meaning* individually predicts religiosity among US combat veterans. The null hypothesis stated that the moral injury dimension *loss of meaning* individually does not predict religiosity among US combat veterans. The hypothesis stated that the moral injury dimension *loss of meaning* individually predicts religiosity among US combat veterans.

Table 8*Regression Results Using Religiosity as the Criterion*

Predictor	<i>b</i>	<i>b</i>		<i>SE</i>	β
		95% CI	[LL, UL]		
Loss of Meaning	0.03	[-0.00, 0.06]		0.16	0.16

Note. $R^2 = .003$, $p = .087$. significant *b* weight indicates that the beta weight and semipartial correlation are also significant. *b* represents unstandardized regression weights. β indicates the standardized regression weights. *SE* indicates the standard error. *LL* and *UL* indicate the lower and upper limits of a confidence interval, respectively. * indicates $p < .05$. ** indicates $p < .01$.

The loss of meaning subscale ($\beta = 0.16$, $p = .087$) was not a significant predictor of religiosity in the model; therefore, the results failed to reject the null hypothesis, consequently rejecting the alternative hypothesis.

Research Question #7

The seventh research question questioned whether the moral injury dimension *difficulty forgiving* individually predicts religiosity among US combat veterans. The null hypothesis stated that the moral injury dimension *difficulty forgiving* individually does not predict religiosity among US combat veterans, while the hypothesis stated that the moral injury dimension *difficulty forgiving* individually predicts religiosity among US combat veterans.

Table 9

Regression Results Using Religiosity as the Criterion and Difficulty Forgiving as the Predictor

Predictor	<i>b</i>	<i>b</i>		
		95% CI [LL, UL]	<i>SE</i>	β
Difficulty Forgiving	-0.03*	[-0.05, -0.00]	-0.28	-0.28

Note. $R^2 = .091$, $p = .022$. A significant *b* weight indicates that the beta weight and semipartial correlation are also significant. *b* represents unstandardized regression weights. β indicates the standardized regression weights. *SE* indicates the standard error. *LL* and *UL* indicate the lower and upper limits of a confidence interval, respectively. * indicates $p < .05$. ** indicates $p < .01$.

The difficulty forgiving subscale ($\beta = -0.24$, $p = .022$) was a significant predictor of religiosity in the model. As illustrated by the standardized beta weight, an increase in one unit of the difficulty in the forgiving subscale resulted in a decrease of 0.28 in the prediction of the religiosity score; therefore, the null hypothesis was rejected and the alternative hypothesis accepted.

Research Question #8

The eighth research question explored whether the moral injury dimension *loss of trust* individually predicts religiosity among US combat veterans. The resulting null hypothesis stated that the moral injury dimension *loss of trust* individually does not predict religiosity among US combat veterans. The hypothesis stated that the moral injury dimension *loss of trust* individually predicts religiosity among US combat veterans.

Table 10*Regression Results Using Religiosity as the Criterion*

Predictor	<i>b</i>	<i>b</i>		
		95% CI [LL, UL]	<i>SE</i>	β
Loss of Trust	-0.03**	[-0.06, -0.01]	-0.24	-0.24

Note. $R^2 = .033$, $p = .005$. A significant *b* weight indicates that the beta weight and semipartial correlation are also significant. *b* represents unstandardized regression weights. β indicates the standardized regression weights. *SE* indicates the standard error. *LL* and *UL* indicate the lower and upper limits of a confidence interval, respectively. * indicates $p < .05$. ** indicates $p < .01$.

The loss of trust subscale ($\beta = -0.24$, $p = .005$) was a significant predictor of religiosity in the model. As illustrated by the standardized beta weight, an increase in one unit of the loss of trust scale resulted in a decrease of 0.24 in the prediction of the religiosity score; therefore, the null hypothesis was rejected, and the alternative hypothesis was accepted.

Research Question #9

The ninth research question examined whether the moral injury dimension *self-condemnation* individually predicts religiosity among US combat veterans. The null hypothesis was that the moral injury dimension *self-condemnation* individually does not predict religiosity among US combat veterans, while the hypothesis postulated that the moral injury dimension *self-condemnation* individually predicts religiosity among US combat veterans.

Table 11*Regression Results Using Religiosity as the Criterion and Self-Condensation as the Predictor*

Predictor	<i>b</i>	<i>b</i>		<i>SE</i>	β
		95% CI	[LL, UL]		
Self-Condensation	-0.00	[-0.02, 0.02]		-0.00	-0.00

Note. $R^2 = .077$, $p = .999$. A significant *b* weight indicates that the beta weight and semipartial correlation are also significant. *b* represents unstandardized regression weights. β indicates the standardized regression weights. *SE* indicates the standard error. *LL* and *UL* indicate the lower and upper limits of a confidence interval, respectively. * indicates $p < .05$. ** indicates $p < .01$.

The self-condemnation subscale ($\beta = 0.00$, $p = .999$) was not a significant predictor of religiosity in the model; therefore, the results failed to reject the null hypothesis, consequently rejecting the alternative hypothesis.

Research Question #10

The tenth research question explored whether the moral injury dimension *spiritual/religious struggles* individually predicts religiosity among US combat veterans. The null hypothesis stated that the moral injury dimension *spiritual/religious struggles* individually does not predict religiosity among US combat veterans. The hypothesis stated that the moral injury dimension *spiritual/religious struggles* individually predicts religiosity among US combat veterans.

Table 12*Regression Results Using Religiosity as the Criterion*

Predictor	<i>b</i>	<i>b</i>		<i>SE</i>	β
		95% CI	[LL, UL]		
Spiritual and Religious Struggles	0.01	[-0.00, 0.03]		0.20	0.20

Note. $R^2 = .004$, $p = .064$. A significant *b* weight indicates that the beta weight and semipartial correlation are also significant. *b* represents unstandardized regression weights. β indicates the standardized regression weights. *SE* indicates the standard error. *LL* and *UL* indicate the lower and upper limits of a confidence interval, respectively. * indicates $p < .05$. ** indicates $p < .01$.

The spiritual/religious struggles subscale ($\beta = 0.20$, $p = .064$) was not a significant predictor of religiosity in the model; therefore, the results failed to reject the null hypothesis, hence rejecting the alternative hypothesis.

Research Question #11

The final research question asked if the moral injury dimension *loss of religious faith/hope* individually predicts religiosity among US combat veterans. The null hypothesis stated that the moral injury dimension *loss of religious faith/hope* individually does not predict religiosity among US combat veterans. The hypothesis stated that the moral injury dimension *loss of religious faith/hope* individually predicts religiosity among US combat veterans.

Table 13

Regression Results Using Religiosity as the Criterion and Loss of Religious Faith as the Predictor

Predictor	<i>b</i>	<i>b</i>		
		95% CI [LL, UL]	<i>SE</i>	β
Loss of Religious Faith	-0.13**	[-0.21, -0.06]	-0.43	-0.43

Note. $R^2 = .138, p < .001$. A significant *b* weight indicates that the beta weight and semipartial correlation are also significant. *b* represents unstandardized regression weights. β indicates the standardized regression weights. *SE* indicates the standard error. *LL* and *UL* indicate the lower and upper limits of a confidence interval, respectively. * indicates $p < .05$. ** indicates $p < .01$.

The loss of faith/hope subscale was a significant predictor of religiosity in the model. As illustrated by standardized beta weight, an increase in one unit of the loss of religious faith/hope scale resulted in a decrease of 0.43 in prediction of the religiosity score; therefore, the null hypothesis was rejected, and the alternative hypothesis was accepted.

Summary

The present study focused on combat-related moral injury as a predictor of religiosity in US military veterans. Specifically, the study explored whether the combined moral injury dimensions of *guilt, shame, betrayal, moral concerns, loss of meaning, difficulty forgiving, loss of trust, self-condemnation, spiritual/religious struggles, and loss of religious faith/hope* and each one individually could predict religiosity among US combat veterans. Eleven hypotheses were developed and tested against the collected data. Multiple linear regression was utilized to

determine whether causal inference existed. The results rejected the null hypotheses for hypotheses 1, 3, 7, 8, and 11; therefore, the alternative hypotheses were accepted, indicating that the 10 moral injury dimensions combined predict religiosity and that, individually, the dimensions of *shame*, *difficulty forgiving*, *loss of trust*, and *loss of religious faith/hope* were predictors of religiosity. The results failed to reject the null hypotheses for hypotheses 2, 4, 5, 6, 9, and 10, indicating that the remaining dimensions of *guilt*, *betrayal*, *moral concerns*, *loss of trust*, *self-condemnation*, and *spiritual/religious struggles* are not predictors of religiosity. These findings will be further analyzed in the remaining portion of the present dissertation to identify implications, limitations, recommendations for future research, and recommendations for future practice.

Chapter Five: Conclusions

Overview

The current study examined the relationship between combat-related moral injury and religiosity. Subjects were recruited via email and asked to complete a self-reported online survey. Moral injury was measured using the MISS-M and religiosity via the CRS. The total sample size consisted of 119 participants, all of whom reported that they were combat veterans and experienced a combat-related moral injury. The results were analyzed by linear regression using R software. Of the 11 hypotheses, the 10 dimensions of moral injury combined accounted for a significant variance in religiosity. Here, 4 of the 10 subscales were significant predictors of religiosity, while six subscales were not. This chapter includes a discussion of the study's findings, broken down by each research question, implications of the findings, limitations of the studies, and recommendations for future research.

Discussion

The purpose of the present study was to explore the relationship between combat-related moral injury and religiosity. The past two decades have demonstrated that veterans returning from combat in Iraq and Afghanistan are struggling with a condition that has previously gone largely unnoticed. Moral injury is a condition that can adversely impact a person's readjustment to civilian life and often creates dysfunction in multiple domains of life. The mental health profession is increasing its knowledge and understanding of moral injury. The present study aimed to increase the understanding of moral injury and how it may impact a person's religiosity. The study utilized the MISS-M to measure moral injury and the CRS to measure religiosity. The MISS-M consists of 10 subscales measuring betrayal, guilt, shame, violation of moral values, loss of meaning, difficulty forgiving, loss of trust, self-condemnation, spiritual and religious

struggles, and loss of religious faith. Moral injury and each of its 10 elements were examined to identify any relationship with religiosity.

The present study found that the 10 dimensions of moral injury combined had a significant impact on religiosity. The dimensions of shame, difficulty forgiving, loss of trust, and loss of faith/hope were found to have a significant impact on religiosity, whereas the dimensions of guilt, betrayal, violation of moral values, loss of meaning, self-condemnation, and spiritual/religious struggles did not demonstrate any predictive influence on religiosity. The findings for each of the study's 11 research questions will be explored in detail.

The first research question explored whether the combined moral injury dimensions—*guilt, shame, betrayal, violation of moral values, loss of meaning, difficulty forgiving, loss of trust, self-condemnation, spiritual/religious struggles, and loss of religious faith/hope*—predict religiosity among US combat veterans. The study found that the combined subscales of the MISS-M were a statistically significant predictor of religiosity. In fact, the combined subscales of moral injury accounted for 33% of the variance in religiosity.

The second research question explored the moral injury dimension *guilt* individually and whether it predicted religiosity among US combat veterans. Guilt was not a significant predictor ($\beta = -0.06, p = .61$). The current literature examining the relationship between war-related guilt and religiosity is extremely limited. As of the writing of the present study, no known studies have specifically looked at this relationship. Increased feelings of being disconnected from God and those with spiritual struggles have been associated with increased measures of guilt (Murray & Ciarrocchi, 2007), but the current study did not focus on combat-related guilt and utilized religiosity as the predictor variable and guilt as a dependent variable. Guilt is a common

symptom of moral injury, but there is no known current association between combat-related guilt and religiosity.

The third research question examined the moral injury dimension *shame* individually and whether it predicted religiosity among US combat veterans. Shame was a significant predictor of religiosity ($\beta = .34, p = .006$). Increased measures of shame predicted an increase in religiosity. The more shame a veteran has from their combat experiences, the more likely they will have a greater sense of religiosity. There are no known studies examining combat-related shame and levels of religiosity. Although shame is a predictor of increased religiosity, it is unknown whether higher religiosity prior to combat is related to higher levels of shame following a morally injurious event or if higher levels of combat-related shame is a causation for veterans with shame seeking out religiosity.

The fourth research question explored whether the moral injury dimension *betrayal* individually predicted religiosity among US combat veterans. Betrayal ($\beta = -0.10, p = .35$) did not predict religiosity. There are no known studies exploring the relationship between combat-related betrayal and religiosity. In fact, at the time of this study, no peer-reviewed studies exploring betrayal and religiosity were found.

The fifth research question examined whether the moral injury dimension *violation of moral values* individually predicted religiosity among US combat veterans. Violation of moral values ($\beta = 0.02, p = .87$) was not a significant predictor of religiosity. At the time of the present study, no peer-reviewed studies existed focusing on this relationship.

The sixth research question evaluated whether the moral injury dimension *loss of meaning* individually predicted religiosity among US combat veterans. Loss of meaning ($\beta =$

0.16, $p = .087$) was not a significant predictor of religiosity. No peer-reviewed studies were found examining the relationship between the loss of meaning and religiosity. However, this finding is interesting given that religiosity is often believed to provide people with meaning and purpose (Clark, 1958; Pargament, 1997; Francis et al., 2010). As such, one would expect either a positive or a negative relationship between these two variables.

The seventh research question assessed whether the moral injury dimension *difficulty forgiving* individually predicted religiosity among US combat veterans. Difficulty forgiving ($\beta = -0.24, p = .022$) was a significant predictor of religiosity. No peer-reviewed studies were found looking at the relationship between forgiveness related to combat acts and an individual's religiosity. An increase in one unit of difficulty forgiving resulted in a decrease of 0.28 in religiosity. This finding is consistent with a meta-analysis by Evans et al. (2013), which reviewed the literature on multiple types of forgiveness and religiosity; they determined that higher levels of forgiveness are associated with higher religiosity measures. Similarly, an unforgiving attitude is a predictor of negative emotions (Exline et al., 1999; Karremans et al., 2003), which has been found to have an inverse relationship with religiosity (Koenig et al., 2019). This finding was consistent with the researcher's expectations.

The eighth research question explored whether the moral injury dimension *loss of trust* individually predicts religiosity among US combat veterans. Loss of trust ($\beta = -0.24, p = .005$) was also a significant predictor of religiosity. An increase in one unit measuring loss of trust resulted in a decrease of .024 in religiosity. No known studies have examined the relationship between loss of trust related to combat experiences and religiosity. A recent study by Valente and Okulicz-Kozaryn (2020) examined trust and religiosity outside of moral injury; the study found that social religiosity and congregational involvement increased trust, while individualized

religiosity, defined as feeling close to God and private prayer, decreased trust. Valente and Okulicz-Kozaryn concluded that God or faith could serve as a barrier to generalized trust when people practice their faith alone. The authors argued that, the closer to God individuals may feel, the more distant and distrustful they are of their fellow man; this is mitigated, however, and develops an inverse relationship when individuals frequently engage in group religious practices and attendance. Their conclusion may have implications for the present study. The CRS score combines measures of both individual spiritual experiences with group religious attendance/participation; as such, a loss of trust could negatively impact group attendance, thereby resulting in a decreased overall CRS religiosity score, even though their individualized religiosity and faith have increased. However, the most likely explanation for loss of trust as a predictor of religiosity can be attributed to individuals developing distrust of people, groups, and organizations, including one's religious organization.

The ninth research question explored whether the moral injury dimension *self-condemnation* individually predicted religiosity among US combat veterans. Self-condemnation ($\beta = 0.000, p = .999$) was not a predictor of religiosity. There are no known studies on the relationship between combat-related self-condemnation and religiosity, but a meta-analysis by Evans et al. (2018) found that higher levels of religiosity were associated with greater self-forgiveness. Although self-forgiveness is not directly antithetical to self-condemnation, lower self-condemnation would be consistent with higher measures of self-forgiveness and, therefore, per Evans et al. (2018), associated with higher religiosity; however, that is not what was found in the present study.

The tenth research question evaluated whether the moral injury dimension *spiritual/religious struggles* individually predicted religiosity among US combat veterans.

Spiritual/religious struggles ($\beta = 0.20, p = .064$) were not a significant predictor of religiosity. There are no known studies related to combat-related spiritual/religious struggles and religiosity, but a recent study by Evans et al. (2018) found that potentially moral injury events did predict greater religious struggles, which mediated greater moral injury and greater anxiety. The study did not look at whether the subscale of religious struggles ultimately correlated with or predicted religiosity. Religious struggles not being a predictor of religiosity was an unexpected finding. The researcher anticipated that religious struggles would predict a decrease in religiosity because it would appear to be fundamentally associated. The absence of religious struggles as a predictor may be unique to this sample or a result of design limitations.

The eleventh research question assessed whether the moral injury dimension *loss of religious faith/hope* individually predicted religiosity among US combat veterans. Loss of religious faith/hope ($\beta = -0.43, p = .001$) was a significant predictor of religiosity. An increase in one unit of the loss of religious faith/hope measure resulted in a decrease of .43 in religiosity. This finding was anticipated because the two variables share definitional characteristics; loss of religious faith is inherent in less religiosity. Looking at hope and religiosity alone, this finding supports Koenig et al.'s (2020) result that religiosity is positively related to hope. The predictor nature found in the present study helps support its overall validity and reliability; a contradictory finding would have been disconcerting.

Implications

The present study has several implications for community care and counseling. First, it furthers the clinical understanding of combat-related moral injury and its relationship with religiosity. The current study demonstrated that moral injury accounts for 33% of the variance in religiosity. Looking at the subscales of moral injury, shame associated with moral injury

increased religiosity, while difficulty forgiving, loss of trust, and loss of religious faith/hope all decreased religiosity. Meanwhile, the subscales of guilt, betrayal, violation of moral values, loss of meaning, self-condemnation, and spiritual/religious struggles were shown not to be predictors of religiosity. This can be of value to professional clinicians and pastoral counselors; this information can help focus the treatment on elements of shame, difficulty forgiving, loss of trust, and loss of religious faith/hope. Theoretically, by focusing on these areas, clinical professionals can achieve a reduction in symptoms, and pastoral counselors can help veterans manage these symptoms so that they do not experience a loss of their religiosity or can re-engage with their faith.

Second, the present study provides information that is useful in improving presently available clinical treatment options for moral injury. There is growing consensus on the treatment of moral injury using adaptive disclosure (Litz et al., 2018); in fact, this treatment modality is a first-line treatment for moral injury by mental health clinicians in the Department of Veterans Affairs. Another modality that is growing in prevalence is the forgiveness interview protocol, which uses a narrative therapy approach (Buhagar, 2021). Both of these modalities are based on the verbalization of experiences and identification of resultant emotions that manifest from moral injury. Understanding the predictors of religiosity can help clinicians focus or guide patients in discussions of their experiences with shame, difficulty forgiving, loss of trust, and loss of religious faith/hope. As veterans with moral injuries improve their insights, awareness, and understanding of their experiences with moral injury subelements, their overall religiosity can be maintained, returned to their premoral injury baselines, or improved.

Third, the current study provides information that can be used in military or veteran-based chaplaincy in the treatment of combat-related moral injury. Military chaplains have

traditionally relied on a confessional process, sometimes referred to as a Sacrament of Penance or Sacrament of Reconciliation, to encourage veterans to identify their moral injury experiences and seek a path for forgiveness (Carey & Hodgson, 2018). Building on the fundamental concepts of Sacraments of Penance and clinically focused adaptive disclosure, chaplains and clergy members have developed a modified version that focuses more on a faith-based perspective called pastoral narrative disclosure (Carey & Hodgson, 2018). Knowing the moral injury subelements that predict religiosity can be integrated into these treatment options to further improve outcomes.

Finally, the present study is of value to community-based clergy who have combat veterans with moral injury within their congregations. Some veterans do not engage in VHA-provided healthcare for a variety of reasons, including distrust of government agencies, geographical distance barriers, and not knowing they have access to cheap and often free care at their local VHA facility (Cheney et al., 2018). As such, community-based pastors can find themselves as first-line treatment providers for this population. Identifying moral injuries in this population can improve veteran engagement, attendance, and well-being. Pastors can use screening tools to help identify moral injuries and then focus their pastoral counseling on the subelements that predict lower rates of religiosity. This may be of significant value to congregations that are more missional in nature and regularly engage with the unchurched and those who have left their faith. Congregations with higher numbers of combat veterans may consider facilitating a faith-based group or educational class that can incorporate the growing literature on combat-related moral injury so that they can gain better self-awareness, insights, and access to treatment options.

Limitations

The present study has several limitations. First, all data were received via self-report from the participants. The researchers did not interact with any participants and did not verify any reported information. Knowing that their responses are part of a research study, the veterans may have exaggerated or minimized their symptomology. Many veterans receive disability payments related to their service-related conditions; in fact, 41% of veterans who served in combat theaters after 2001 received some type of service-connected disability payments (US Department of Labor, 2023). These payments can be very large depending on their disability rating; as such, there may be a propensity to overreport the level of dysfunction because of an erroneous perception that the government and VHA will be able to access their responses to the present study and reduce their monthly disability payments. Self-administered reliability instruments were not included because they can be lengthy and possibly have discouraged volunteers from participating and reduced the sample size. Another limitation is that religiosity was measured only at one point in time. The current study was not designed to determine if moral injury or any of the subscales changed a participant's level of religiosity over time; the study did not account for the premoral injury level of religiosity.

Recommendations for Future Research

Because the concept of combat-related moral injury is still nascent, there is significant room for future research. One recommendation for future research is a longitudinal design; researchers could measure veterans' religiosity prior to deploying to combat environments and again upon their return. This would allow researchers to better understand whether persons with higher religiosity are more prone to moral injury or if moral injury moderates one's religiosity. This type of study could have considerable significance because any data identifying those who

are more prone to a moral injury could be used to mitigate the occurrence. Knowing that a cohort of service members may be at higher risk would allow clinicians and military leaders to focus on resources such as education, resiliency training, pastoral care, and clinical resources during predeployment readiness training, deployment activities, and postdeployment assessments.

Future research can explore the types of potential MIEs that typically occur in combat and their relationship with religiosity. This type of study could determine if moral injury resulting from observing a transgression, conducting a transgression, or being a victim of a transgression has a greater impact on religiosity than the other types. Types of premorally injurious events could be further broken down. For example, observing a transgression could be studied based on their types to include witnessing torture, killing innocent civilians, excessive use of force, sexual assaults, mutilation of enemy combatants, murder of fellow service members, willful misconduct that results in physical harm to others, or other violations of accepted standards (Geneva Convention, General Orders, etc.). Conducting a potentially morally injurious transgression could be broken down into specified actions such as taking life via hand-to-hand combat, rifle, aerial bombing, remote initiated bombing (drone pilots), friendly fire, killing/injuring noncombatants (women, children, elderly), or actions such as disgracing/desecrating an enemy corpse. Similarly, being the victim of a moral transgression could include being sexually assaulted while in combat, physically assaulted for attempting to adhere to accepted morals/values, ordered to commit torture, ordered to violate a military or personal value/moral, ordered to detain a known innocent, ordered to raid the homes of innocent civilians, ordered to destroy the homes of innocent civilians, or ordered to not render aid to wounded enemy combatants. This information could be used in predeployment training to educate military leaders and service members on the negative impacts that this type of

inappropriate and unethical combat behavior has on all parties involved—victims, perpetrators, and witnesses. Additionally, these data can assist in the treatment of moral injury. Clinicians, chaplains, pastors, and military leaders could use these data in postdeployment screenings, treatment screenings, interviews, leadership mentoring, and pastoral care discussions so that individuals at higher risk are identified and are encouraged to receive timely care to treat or manage their moral injuries.

Future studies could explore the relationships between combat-related moral injury and specific faiths. Researchers could examine whether moral injury is more prevalent in Christianity, Islam, Judaism, Buddhism, Hinduism, secular spirituality, or atheism. Current studies show that there are significant differences between various faiths and suicide (Bertolote & Fleischmann, 2015; Gearing & Lizardi, 2008; Koenig, 2018; Pescosolido & Georgianna, 1989; Simpson & Conklin, 1989); as such, it is plausible to postulate differences between religious faiths and rates of moral injury. Again, knowing that a potential religious faith is at higher risk can help in both predeployment readiness training and postdeployment clinical and pastoral assessments and responses.

Studies could explore whether there is a relationship between moral injury and conversion; specifically, this type of study would examine if moral injury has any relationship or causation for a combat veteran to change faiths. The study would likely be of less value to military leaders and of greater value to chaplains and community pastors. Chaplains could use any data resulting from this type of research to better assist service members and veterans who are experiencing a crisis of faith, in spiritual distress, abandoning their original faith, or adopting the beliefs of a different faith. Community pastors could use the resulting findings to assist

veterans in their flock who might be considering leaving their place of worship or to better connect with potential new members who are searching for a new faith system.

Understanding moral injury and its relationship with religiosity is an understudied yet critical area in meeting the needs of modern combat warriors. These research recommendations will add to the understanding of the relationship between moral injury and religiosity, resulting in better treatment and pastoral care to the men and women who have served on the battlefield and, ultimately, in their reintegration to civilian society.

Recommendations for Future Practice

The findings of the present study provide mental health clinicians with additional information that can directly improve their practice. Having a better understanding of a phenomenon that causes dysfunction in a client population invariably improves treatment. Specifically, these findings can improve a clinician's ability to build rapport, improve their case conceptualizations, improve their treatment methods, and, ultimately, improve their clients' treatment outcomes. These findings are of particular importance to clinicians, pastoral counselors, chaplains, and pastors who work with combat veterans.

The first recommendation for future practice is for all individuals who work with combat veterans to use the findings of the present study to improve their ability to build rapport. For example, a psychologist working at the VA suspects that a veteran is struggling with a moral injury related to his combat service and also mentions that he is having a crisis of faith; the psychologist can use the findings of this study to further the veteran's buy-in for counseling. When clinicians can demonstrate an understanding of a mental health condition and provide their clients with an environment of acceptance and community, the clients are more likely to remain

engaged in treatment and are more apt to disclose to their providers (Bowlby, 1988; Kazantzis et al., 2010; Rogers, 1957).

The second recommendation is for clinicians to use these findings to improve their case conceptualizations. By understanding the impacts that shame, difficulty forgiving, loss of trust, loss of religious faith, and moral injury as a whole have on their clients' religiosity, they can build a more comprehensive case conceptualization. This can be done in a bidirectional manner. If a veteran discloses symptomology that is consistent with moral injury, then the clinician should explore their religiosity and if there has been any change in their levels of religiosity. Similarly, if a provider learns that their client has had a significant change in their level of religiosity, then they should assess for the presence of a combat-related moral injury. Should they find that their client has a combat-related moral injury, then they should focus a portion of their assessment on shame, difficulty forgiving, loss of trust, and loss of religious faith, along with how those subdomains of moral injury are experienced by their client. Focusing a portion of the initial assessment time on these variables will offer the provider a better and more comprehensive case conceptualization.

Third, the current study's findings are recommended to be utilized in improving a clinician's or pastor's treatment plan. If the first two recommendations are utilized in a provider's practice, then they should have a strong understanding of how moral injury and the subdomains of shame, difficulty forgiving, loss of trust, and loss of religious faith impact their client's religiosity. With this additional information, they can then target these areas of concern during the development process of the treatment plan and subsequent treatment modalities. This recommendation encourages providers to apply their modality of choice to directly address these statistically significant subdomains. An application of this recommended process is for a

cognitive behavioral therapist to assess for changes in schema, and presence of catastrophizing, black or white thinking, and/or cognitive dissonance; any changes in schema or presence of these cognitive dysfunctions should be further assessed to determine if they are related to moral injury, shame, difficulty forgiving, loss of trust, and loss of religious faith. Once assessed, the clinician can then use traditional CBT-based treatment techniques such as Socratic dialogue or thought replacement to directly target issues with these relevant subdomains.

The last recommendation is for pastors or chaplains to use these findings to help return lost sheep to the flock. Veterans who are deployed to combat areas and do not return to their religious community may suffer from a moral injury that adversely impacts their religious participation and faith system. The present study provides information to aid the pastor/chaplain in connecting with the veteran who stopped his religious participation or to the veteran who is new to their congregation and seems ambivalent or trepid. Pastors/chaplains can utilize these findings to assist that veteran by understanding their needs, concerns, and barriers and then using this understanding to provide them with the spiritual teachings and faith tenets that can unite or reunite them with their religiosity.

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Appendix A: Demographic and Consent Forms

Demographic Questionnaire

Name: _____

Address: _____

Age: _____

Gender: ___ Male ___ Female

Dates of military service: _____ Branch of Service: _____

Military Occupational Skill (MOS): _____ Rank at time of separation: _____

Combat deployments: _____

Were you engaged in combat actions (i.e., indirect fire attacks, small arms firefights, improvised explosive devices, etc.)? ___ Yes ___ No

Have you ever been diagnosed with a mental health condition? If so, what was the diagnosis?

Are you experiencing any of the following: ___ Hallucinations ___ Delusions ___ Suicidal thoughts ___ Homicidal thoughts

Do you consider yourself religious? ___ Yes ___ No

What is your religion? _____

Consent

Title of the Project: Combat-Related Moral Injury And Religiosity

Principal Investigator: James Capobianco, LCSW, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be 18 years of age and a military veteran who has served in a combat theater. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

What is the study about and why is it being done?

The purpose of the study is to explore the relationship between moral injury and religious faith. Veterans of war may often return home with various mental health issues. This study is aimed at gaining a better understanding of these often unseen consequences.

What will happen if you take part in this study?

If you agree to be in this study, I would ask you to do the following things:

1. Complete the demographic form and all surveys to include:
 - Moral Injury Symptom Scale—Military Version
 - Centrality of Religiosity Scale

How could you or others benefit from this study?

Participants who complete the survey questions in their entirety will receive a ten-dollar gift card.

Benefits to society include improving the mental health's professional understanding of moral injury in combat veteran populations.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life. The researchers in this study are mandatory reporters. This means that the researchers must report any information that indicates the presence of child abuse, child neglect, elder abuse, or intent to harm self or others to the proper authorities.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher[s] will have access to the records. Data collected from you may be shared for use in future research studies or with other researchers. If data collected from you is shared, any information that could identify you, if applicable, will be removed before the data are shared.

- Participant responses will be kept confidential through the use of numeric codes; names will be removed from their corresponding survey responses.
- Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted.

How will you be compensated for being part of the study?

Participants will be compensated for participating in this study. Participants who complete all forms and surveys in their entirety will be mailed a ten-dollar gift card to the address listed on their demographic sheet. Participants may expect to receive their gift cards approximately 60 days after completing this study. Email addresses will be requested for compensation purposes; however, they will be pulled and separated from your responses to maintain your anonymity.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University or any other institution. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please exit the survey and close your internet browser. Your responses will not be recorded or included in the study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Jim Capobianco, LCSW. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact him at jcapobianco@liberty.edu

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

Printed Subject Name

Signature & Date

Appendix B: The Moral Injury Symptom Scale-Military Version

Introduction: *The following statements/questions may be difficult, but they are common experiences of combat veterans or active duty military returning from battle. They concern your experiences while in a combat or war zone and how you are feeling now. Just do the best you can and try to answer every question. Circle a *single* number between 1 and 10 for each (“strongly disagree” to “strongly agree”):*

Guilt

1. I feel guilt for surviving when others didn't.
2. I feel guilt over failing to save the life of someone in war.
3. Some of the things I did during the war out of anger or frustration continue to bother me.
4. It bothers me sometimes that I enjoyed hurting/killing people during the war.

Shame

5. If people knew more about the things I did during the war they would think less of me.
6. I feel ashamed about what I did or did not do during this time.

Betrayal

7. I feel betrayed by leaders who I once trusted.
8. I feel betrayed by fellow service members who I once trusted.
9. I feel betrayed by others outside the US military who I once trusted.

Moral Concerns

10. I am troubled by having witnessed others' immoral acts.
11. I am troubled by having acted in ways that violated my own morals or values.
12. I am troubled because I violated my morals by failing to do something that I felt I should've done.

Loss of Meaning

Introduction: Circle a *single* number between 1 and 10 that describes how true each statement is for you (“absolutely untrue” to “absolutely true”):

13. I understand my life's meaning.
14. My life has a clear sense of purpose.
15. I have a good sense of what makes my life meaningful.

16. I have discovered a satisfying life purpose.

Difficulty Forgiving

Introduction: Circle a *single* number between 1 and 10 that describes how true or false each statement is for you (“almost always false of me” to “almost always true of me”):

17. Although I feel bad at first when I mess up, over time I can give myself some slack.

18. I hold grudges against myself for negative things I’ve done.

19. It is really hard for me to accept myself once I’ve messed up.

20. I don’t stop criticizing myself for negative things I’ve felt, thought, said, or done.

21. I believe that God has forgiven me for what I did during combat.

22. I have forgiven God for what happened to me or others during combat.

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

Loss of Trust

Introduction: Circle a *single* number between 1 and 10 that describes how much you agree or disagree with each statement (“strongly disagree” to “strongly agree”):

24. Most people are basically honest.

25. Most people are trustworthy.

26. Most people are basically good and kind.

27. Most people are trustful of others.

Self-Condensation

Introduction: Circle a *single* number between 1 and 10 for each statement (“strongly disagree” to “strongly agree”):

28. On the whole, I am satisfied with myself.

29. At times I think I am no good at all.

30. I feel that I have a number of good qualities.

31. I am able to do things as well as most other people.

32. I feel I do not have much to be proud of.

33. I certainly feel useless at times.

34. I feel that I’m a person of worth, at least on an equal plane with others.

35. I wish I could have more respect for myself.

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

37. I take a positive attitude toward myself.

Introduction: Below are feelings that combat veterans often have because of combat experiences. How much have you? Circle a *single* number between 1 and 10 for each statement (“a great deal” or “very true” to “not at all” or “very untrue”):

Spiritual/Religious Struggles

38. I wonder whether God had abandoned me.

39. I felt punished by God for my lack of devotion.

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

41. I questioned God’s love for me.

42. I questioned the power of God.

43. I wondered whether my church had abandoned me.

Loss of Religious Faith/Hope

44. *Compared to when you first went into the military* has your religious faith since then... (“weakened a lot,” “weakened a little,” “strengthened a little,” “strengthened a lot”)

45. How hopeful are you about the future? (“not at all” to “very hopeful”)

Scoring: First, reverse score items 13–16, 17, 21–28, 30–31, 34, 37, and 44–45, and then sum all items together (or those of individual subscales if subscale scores are desired). Possible score range is 45 to 450, with higher scores indicating more severe moral injury. For a fully formatted version of the 45-item MISS-M (and the 10-item MISS-M-SF), contact the author: Harold.Koenig@duke.edu.

Appendix C: Centrality of Religiosity Scale

Item	Question	Frequency				
		Never	A few times a year	1 or 3 times per month	More than once a week	Once or more times a day
1	How often do you think about religious issues?	1	2	3	4	5
2	To what extent do you believe that God or something divine exists?	1	2	3	4	5
3	How often do you take part in religious services?	1	2	3	4	5
4	How often do you pray?	1	2	3	4	5
5	How often do you experience situations in which you have the feeling that God or something divine intervenes in your life?	1	2	3	4	5
6	How interested are you in learning more about religious topics?	1	2	3	4	5
7	To what extent do you believe in an afterlife- -e.g. immortality of the soul, resurrection of the dead or reincarnation?	1	2	3	4	5
8	How important is to take part in religious services?	1	2	3	4	5
9	How important is personal prayer for you?	1	2	3	4	5
10	How often do you experience situations in which you have the feeling that God or something divine wants to communicate or to reveal something to you?	1	2	3	4	5
11	How often do you keep yourself informed about religious questions through radio, television, internet, newspapers, or book?	1	2	3	4	5

12	In your opinion, how probable is that a higher power really exists?	1	2	3	4	5
13	How important is it for you to be connected to a religious community?	1	2	3	4	5
14	How often do you pray spontaneously when inspired by daily situations?	1	2	3	4	5
15	How often do you experience situations in which you have the feeling that God or something divine is present?	1	2	3	4	5

Scores are totaled and then divided by 15
--

1.0 to 2.0 = “not religious”

2.2 to 3.8 = “religious”

4.0–5.0 = “highly religious”

Appendix D: IRB Approval Letter

Date: 12-4-2022

IRB #: IRB-FY21-22-1178
Title: Combat Related Moral Injury and Religiosity
Creation Date: 6-6-2022
End Date:
Status: Approved
Principal Investigator: James Capobianco
Review Board: Research Ethics Office
Sponsor:

Study History

Submission Type	Initial	Review Type	Exempt	Decision	Exempt
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Key Study Contacts

Member	Jason Ward	Role	Co-Principal Investigator	Contact	jward165@liberty.edu
Member	James Capobianco	Role	Principal Investigator	Contact	jcapobianco@liberty.edu
Member	James Capobianco	Role	Primary Contact	Contact	jcapobianco@liberty.edu

Appendix E: Data Analysis**Table 1***Demographics*

Characteristics (N = 120)	<i>n</i>	%
Gender		
Male	117	98
Female	3	2
Age		
18–24	0	0
25–34	18	15
35–44	40	33
45–54	18	15
55–64	17	14
65+	27	23
Branch of Service		
Army	67	56
Air Force	9	8
Marine Corps	32	27
Navy	11	9
Coast Guard	0	0
Rank at Separation		
E1–E4	67	56
E5–E7	29	24
E8–E9	4	3
O1–O3	9	8
O4–O6	11	9
O7+	0	0
Military Occupation (N = 119)* 1 person did not answer		
Infantry, Special operations, Armor, Cavalry, Field Artillery, Aviation, Engineering	74	62
Military Intelligence, Signal, Chemical, Military Police	17	14
Quartermaster (Logistics, Supply), Food Services, Transportation, Chaplaincy, other	28	24

Conflict Location		
Vietnam	28	23
Somalia	1	1
Desert Storm	12	10
Afghanistan	31	26
Iraq	45	37
Other	3	3
Combat Engagement		
Did not engage in direct combat	3	3
Engaged in direct combat	117	97
Mental Health Diagnosis		
Adjustment disorder	1	1
Anxiety disorder	4	3
Depressive disorder	3	3
Posttraumatic stress disorder	71	59
Other	18	15
No mental health disorder	23	19
Religiosity		
Not religious	37	31
Religious	83	69
Denominations		
Buddhism	1	1
Christianity	81	67
Islam	1	1
Judaism	1	1
Spiritual	19	16
Other	1	1
Not religious	16	13

Table 2*Means, Standard Deviations, and Correlations*

Variable	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7	8	9	10
1. Religiosity	2.99	1.05										
2. Guilt	29.34	8.10	-.07									
3. Shame	16.08	4.18	.09	.67**								
4. Betrayal	18.86	6.00	-.09	.40**	.44**							
5. Moral Concerns	19.95	5.35	-.08	.65**	.63**	.62**						
6. Loss of Meaning	14.58	6.51	-.05	.03	.19*	-.03	.16					
7. Difficulty Forgiving	38.75	11.06	-.30**	.42**	.45**	.09	.32**	.34**				
8. Loss of Trust	19.24	7.69	-.31**	.04	-.03	.18	.14	.16	.05			
9. Self-Condernation	34.03	13.14	-.28**	.15	.08	.09	.14	.37**	.48**	.26**		
10. Spiritual and Religious Struggles	28.53	14.99	-.06	.49**	.38**	.17	.34**	.08	.47**	-.05	.07	
11. Loss of Religious Faith/Hope	11.10	3.44	-.37**	.41**	.39**	.21*	.43**	.37**	.65**	.11	.39**	.57**

Note. *M* and *SD* are used to represent the mean and standard deviation, respectively. * indicates $p < .05$. ** indicates $p < .01$.

Figure 1

Plots to Test Assumptions of Linear Regression

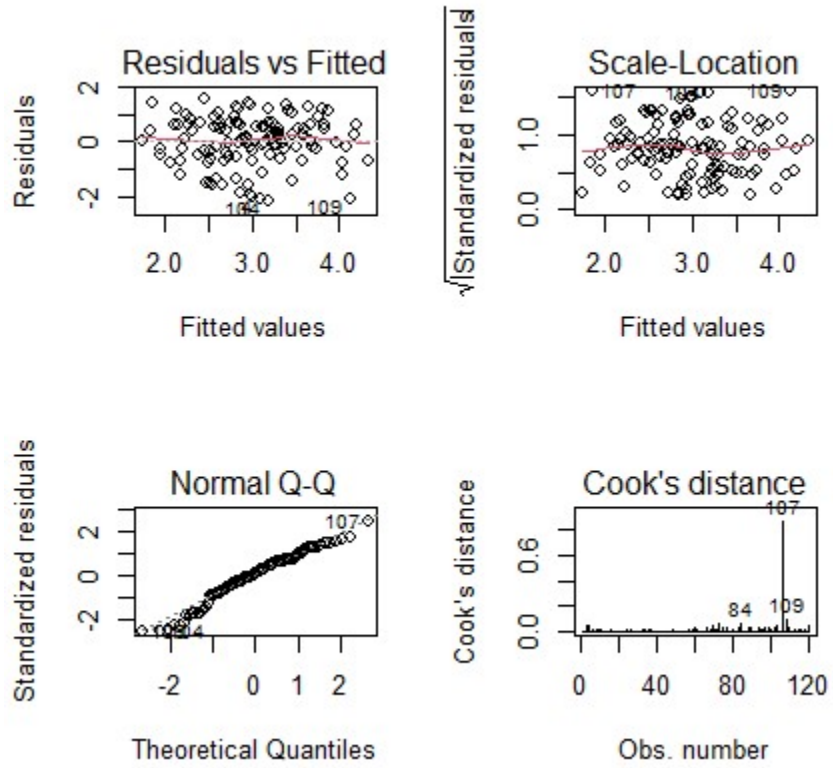


Table 3*Regression Results Using Religiosity as the Criterion*

Predictor	<i>b</i>	<i>b</i>		<i>SE</i>	β
		95% CI	[LL, UL]		
(Intercept)	4.45**	[3.56, 5.33]			
Betrayal	-0.02	[-0.05, 0.02]		-0.10	-0.10
Guilt	-0.01	[-0.04, 0.02]		-0.06	-0.06
Shame	0.09**	[0.02, 0.15]		0.34	0.34
Moral Concerns	0.00	[-0.05, 0.05]		0.02	0.02
Loss of Meaning	0.03	[-0.00, 0.06]		0.16	0.16
Difficulty Forgiving	-0.03*	[-0.05, -0.00]		-0.28	-0.28
Loss of Trust	-0.03**	[-0.06, -0.01]		-0.24	-0.24
Self-Condensation	-0.00	[-0.02, 0.02]		-0.00	-0.00
spiritual and Religious Struggles	0.01	[-0.00, 0.03]		0.20	0.20
Loss of Religious Faith	-0.13**	[-0.21, -0.06]		-0.43	-0.43

Note. $R^2 = .340$, $p < .01$. A significant *b* weight indicates the beta weight and semipartial correlation are also significant. *b* represents unstandardized regression weights. β indicates the standardized regression weights. *SE* indicates the standard error. *LL* and *UL* indicate the lower and upper limits of a confidence interval, respectively. * indicates $p < .05$. ** indicates $p < .01$.

Table 4*Regression Results Using Religiosity as the Criterion and Guilt as the Predictor*

Predictor	<i>b</i>	<i>b</i>		<i>SE</i>	β
		95% CI	[LL, UL]		
Guilt	-0.01	[-0.04, 0.02]		-0.06	-0.06

Note: $R^2 = .004$, $p = .61$. A significant *b* weight indicates the beta weight and semipartial correlation are also significant. *b* represents unstandardized regression weights. β indicates the

standardized regression weights. *SE* indicates the standard error. *LL* and *UL* indicate the lower and upper limits of a confidence interval, respectively. * indicates $p < .05$. ** indicates $p < .01$.

Table 5

Regression Results Using Religiosity as the Criterion and Shame as the Predictor

Predictor	<i>b</i>	<i>b</i>		
		95% CI [LL, UL]	<i>SE</i>	β
Shame	0.09**	[0.02, 0.15]	0.34	0.34

Note. $R^2 = .007$, $p = .006$. A significant *b* weight indicates the beta weight and semipartial correlation are also significant. *b* represents unstandardized regression weights. β indicates the standardized regression weights. *SE* indicates the standard error. *LL* and *UL* indicate the lower and upper limits of a confidence interval, respectively. * indicates $p < .05$. ** indicates $p < .01$.

Table 6

Regression Results Using Religiosity as the Criterion and Betrayal as the Predictor

Predictor	<i>b</i>	<i>b</i>		
		95% CI [LL, UL]	<i>SE</i>	β
Betrayal	-0.02	[-0.05, 0.02]	-0.10	-0.10

Note. $R^2 = .008$, $p = .35$. A significant *b* weight indicates the beta weight and semipartial correlation are also significant. *b* represents unstandardized regression weights. β indicates the standardized regression weights. *SE* indicates the standard error. *LL* and *UL* indicate the lower and upper limits of a confidence interval, respectively. * indicates $p < .05$. ** indicates $p < .01$.

Table 7*Regression Results Using Religiosity as the Criterion and Moral Concerns as the Predictor*

Predictor	<i>b</i>	<i>b</i>		
		95% CI [LL, UL]	<i>SE</i>	β
Moral Concerns	0.00	[-0.05, 0.05]	0.02	0.02

Note. $R^2 = .006$, $p = .87$. A significant *b* weight indicates the beta weight and semipartial correlation are also significant. *b* represents unstandardized regression weights. β indicates the standardized regression weights. *SE* indicates the standard error. *LL* and *UL* indicate the lower and upper limits of a confidence interval, respectively. * indicates $p < .05$. ** indicates $p < .01$.

Table 8*Regression Results Using Religiosity as the Criterion*

Predictor	<i>b</i>	<i>b</i>		
		95% CI [LL, UL]	<i>SE</i>	β
Loss of Meaning	0.03	[-0.00, 0.06]	0.16	0.16

Note. $R^2 = .003$, $p = .087$. significant *b* weight indicates the beta weight and semipartial correlation are also significant. *b* represents unstandardized regression weights. β indicates the standardized regression weights. *SE* indicates the standard error. *LL* and *UL* indicate the lower and upper limits of a confidence interval, respectively. * indicates $p < .05$. ** indicates $p < .01$.

Table 9*Regression Results Using Religiosity as the Criterion and Difficulty Forgiving as the Predictor*

Predictor	<i>b</i>	<i>b</i>		
		95% CI [LL, UL]	<i>SE</i>	β
Difficulty Forgiving	-0.03*	[-0.05, -0.00]	-0.28	-0.28

Note. $R^2 = .091, p = .022$. A significant *b* weight indicates the beta weight and semipartial correlation are also significant. *b* represents unstandardized regression weights. β indicates the standardized regression weights. *SE* indicates the standard error. *LL* and *UL* indicate the lower and upper limits of a confidence interval, respectively. * indicates $p < .05$. ** indicates $p < .01$.

Table 10*Regression Results Using Religiosity as the Criterion*

Predictor	<i>b</i>	<i>b</i>		
		95% CI [LL, UL]	<i>SE</i>	β
Loss of Trust	-0.03**	[-0.06, -0.01]	-0.24	-0.24

Note. $R^2 = .033, p = .005$. A significant *b* weight indicates the beta weight and semipartial correlation are also significant. *b* represents unstandardized regression weights. β indicates the standardized regression weights. *SE* indicates the standard error. *LL* and *UL* indicate the lower and upper limits of a confidence interval, respectively. * indicates $p < .05$. ** indicates $p < .01$.

Table 11*Regression Results Using Religiosity as the Criterion and Self-Condensation as the Predictor*

Predictor	<i>b</i>	<i>b</i>		
		95% CI [LL, UL]	<i>SE</i>	β
Self-Condensation	-0.00	[-0.02, 0.02]	-0.00	-0.00

Note. $R^2 = .077$, $p = .999$. A significant *b* weight indicates the beta weight and semipartial correlation are also significant. *b* represents unstandardized regression weights. β indicates the standardized regression weights. *SE* indicates the standard error. *LL* and *UL* indicate the lower and upper limits of a confidence interval, respectively. * indicates $p < .05$. ** indicates $p < .01$.

Table 12*Regression Results Using Religiosity as the Criterion*

Predictor	<i>b</i>	<i>b</i>		
		95% CI [LL, UL]	<i>SE</i>	β
Spiritual and Religious Struggles	0.01	[-0.00, 0.03]	0.20	0.20

Note. $R^2 = .004$, $p = .064$. A significant *b* weight indicates the beta weight and semipartial correlation are also significant. *b* represents unstandardized regression weights. β indicates the standardized regression weights. *SE* indicates the standard error. *LL* and *UL* indicate the lower and upper limits of a confidence interval, respectively. * indicates $p < .05$. ** indicates $p < .01$.

Table 13

Regression Results Using Religiosity as the Criterion and Loss of Religious Faith as the Predictor

Predictor	<i>b</i>	<i>b</i>		
		95% CI [LL, UL]	<i>SE</i>	β
Loss of Religious Faith	-0.13**	[-0.21, -0.06]	-0.43	-0.43

Note. $R^2 = .138, p < .001$. A significant *b* weight indicates the beta weight and semipartial correlation are also significant. *b* represents unstandardized regression weights. β indicates the standardized regression weights. *SE* indicates the standard error. *LL* and *UL* indicate the lower and upper limits of a confidence interval, respectively. * indicates $p < .05$. ** indicates $p < .01$.