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The Impact Of Moral Injury And Moral Distress On Spirituality From A Military Perspective

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The Impact of Moral Injury and Moral Distress on Spirituality From a Military Perspective

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CERTIFICATE OF APPROVAL

Clinical Research Project

This is to certify that the Clinical Research Project of

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Dedication

I would like to dedicate this research to our veterans who selflessly contributed to this work. Your willingness and courage to share your truth have touched my heart deeply and changed my life. It is not enough to thank you. I may be at the beginning of my mission to help provide support and encouragement to you, and yet you have already given me a most precious gift that far surpasses my humblest words of gratitude: your sacred stories. Thank you.

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Abstract

The purpose of this study was to gain greater insight and understanding of how moral injury, moral distress, and shame can influence spirituality and to determine ways to effectively improve treatment to support and serve those carrying these unspeakable wounds. The experience of loss, betrayal, uncertainty, and fractured spirits can affect an individual's beliefs about the self. The primary aim of this study was to explore how veterans now view themselves in the eyes of God or their Higher Power or why they so choose not to partake in their spirituality. Results were based on aggregate analyses and summations of veterans' responses. A full determination of the impact of spirituality can only be gained through an in-depth analysis of veterans' verbal accounting of moral injury and moral distress.

The Impact of Moral Injury and Moral Distress on Spirituality From a Military Perspective

Introduction

Moral injury (MI) and moral distress (ND) are wounds that represent pieces of an individual's life that have been shattered by witnessing or partaking in actions in some way that have violated the individual's beliefs, morals, and values to the point of the warrior believing they are unlovable and unforgivable (S. Lancaster & Miller, 2018). The depth of these wounds requires mental health practitioners to go beyond typical measures to willingly explore the stories of suffering, heartbreak, suicidality and the brokenness of families. According to S. Lancaster and Miller (2018), more in-depth research is needed regarding the impact of MI on spiritual/religious beliefs, the impact of religious/spiritual beliefs (negative or positive) on the wounds sustained from MI, the impact of MI on decision-making, and the impact of shame on overall well-being. This leads many to question whether redemption is available for them. Some believe they have surpassed the right to receive mercy or forgiveness and have been sentenced to eternal condemnation. Others believe the hope of forgiveness and redemption may apply to the guilt and shame their souls bear. The beliefs with which an individual aligns regarding their spirituality can have a significant impact on their treatment and healing. This study was conducted in an attempt to capture the value of an in-depth exploration of the meaning and value of spirituality according to veterans.

Literature Review

Moral Injury

Over the past few decades, MI has received notable attention, particularly as it relates to veterans and active duty personnel. According to Norman and Maguen (2021), MI is a powerful reaction an individual may experience when they are in some way exposed to a traumatic event that violates their values and deeply held morals. MI is defined separately from posttraumatic stress disorder (PTSD). Whereas PTSD is considered a mental disorder, MI is classified as a "dimensional problem that can have profound effects on critical domains of emotional, psychological, behavioral, and spiritual functioning" (Barnes et al., 2019, p. 99). Much like PTSD, MI is not an injury that appears as a physical wound, but transpires as an invisible wound that can create serious effects. Barnes et al. (2019) stated "whether a moral injury develops is determined by how the individual interprets the potentially injurious event . . . the appraisal process determines whether the event generates significant dissonance with the individual's belief system and worldview" (p. 99).

Originally, MI was looked upon as an experience during which the failures carried out by the leader of a service member were deemed injurious (Barnes et al., 2019). Dr. Jonathan Shay (1995), an American psychiatrist, referred to MI as occurring when someone in authority is experienced as betraying the rights of another due to a circumstance being of high risk in nature. This notable research was based on reported experiences stemming from the Vietnam era. Additional experiences were incorporated to broaden the criteria for moral injurious experiences during the Iraq and Afghanistan wars. For example, other experiences of moral failures may become injurious when there

is an occurrence of "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" (Litz et al., 2009, p. 700) that significantly affects the individual biologically, spiritually, behaviorally, and socially. As stated by former Marine Captain Tyler Boudreau in reference to his time of service in Iraq,

> moral injury is about the damage done to our moral fiber when transgressions occur by our hands, through our orders, or with our connivance. When we accept these transgressions, however pragmatic (for survival, for instance), we sacrifice a piece of our moral integrity. (Jamieson, Maple, et al., 2020, p. 1053)

Decision-making is affected when faced with circumstances that directly interrupt our moral judgments according to our beliefs and values, especially when facing extreme circumstances such as war.

To assess for MI, Norman and Maguen (2021) explained that effects occur within seven explicit domains that each reflect potential encounters to which the individual may have been exposed and how such an encounter affects their overall well-being. The first domain is defined as follows:

> When someone does something that goes against their beliefs, this is often referred to as an act of commission and when they fail to do some things in line with their beliefs, that is often referred to as an act of omission. Individuals may also experience betrayal from leadership, others in position of power or peers that can result in adverse outcomes. (Norman & Maguen, 2021, What is Moral Injury? section, para. 1)

The second domain indicates exposure to a traumatic event can create notable distress psychologically, behaviorally, socially, and even spiritually (Norman & Maguen, 2021). Third, "Moral injury can occur in response to acting or witnessing behaviors that go against an individual's morals and values" (Norman & Maguen, 2021, What is Moral Injury? section, para. 1). Domains four and five refer to feelings of guilt and shame. Shame is based on the individual's belief that the whole self is bad as a result of what they did, whereas guilt is experienced as a deep sense of remorse or distress that derives from the belief that the individual did something bad (Norman & Maguen, 2021). Domains six and seven address the individual's relational experience with the self and their Higher Power. Norman and Maguen (2021) noted the inability to self-forgive is considered a hallmark reaction of MI and MD, which perpetuates behaviors of self-sabotage. Litz et al. (2009) also noted an "individual with moral injury may begin to view him or herself as immoral, irredeemable, and un-reparable or believe that he or she lives in an immoral world" (p. 698). Therefore, self-blame, trust issues, and spiritual/existential issues are the core indicators of the potential development of MI (Barnes et al., 2019, p. 99). Research indicates

> In general, events involving individual responsibility are more likely to lead to negative internally directed (self-referential) emotions and cognitions (e.g., guilt, shame, lack of self-forgiveness), whereas events involving other responsibility are more likely to lead to negative externally-directed emotions and cognitions (e.g., anger, trust issues, lack of other-forgiveness). Both types of events are associated with spiritual/existential issues (e.g., loss of faith, questioning morality). (Barnes et al., 2019, p. 99)

Moral Distress

Moral distress (MD) is a well-known term in the field of nursing. As noted in Hebert's research regarding MD and MI, the term moral distress is more customary within the civilian health care system than among veterans of the Armed Forces health care system (Hebert, 2020). In 1984, Andrew Jameton coined the term MD and defined it as "the experience of knowing the right thing to do while being in a situation in which is it nearly impossible to do it" (Jameton, 2017, p. 617). Campbell et al. (2016) stated that in "the traditional view, moral distress arises only in cases where an individual believes she knows the morally right thing to do but fails to perform that action due to various constraints" (p. 2). Smith-MacDonald et al. (2018) conducted a study to increase the understanding of operational stress injuries (OSIs), including MD, that were sustained by soldiers. The term OSI was created to "acknowledge and give credence to the considerable variation of these invisible injuries" (Smith-MacDonald et al., 2020, p. 235). Veterans Affairs Canada (2021) defined an OSI as "any persistent psychological difficulty resulting in or from performing operational duties while serving" (What is an operational stress injury? section, para. 1). In a study conducted by Smith-MacDonald et al. (2018), the researchers selected 18 volunteer veterans who had sustained OSIs during deployment in peacekeeping missions in either Afghanistan or Canada. The researchers used classical grounded theory, which is an "inductive qualitative research method that focuses on understanding social processes and interactions within a specific population" (Smith-MacDonald et al., 2020, p. 236).

The results of this study showed the overall concern to be "transitioning fractured identities," which was further expressed as a means "to change the broken form of

personal oneness, individuality, selfhood" (Smith-MacDonald et al., 2020, p. 236). The participants experienced their fracturing experiences as interrupting moments that then became injurious. The participants "frequently spoke of them [morally injurious experiences] as small unresolved wounds that began to fester, causing mental, emotional, and spiritual gangrene" (Smith-MacDonald et al., 2020, p. 238), and categorized these "wounds" into four experiences as follows: (a) mission over morals, (b) evil, (c) military betrayal, and (d) self-judgement. Mission over morals is the act of compromising one's values (i.e., morals) in order to complete a mission. Smith-MacDonald et al. (2020) explained that when an individual puts the mission before morals, it can produce a potentially damaging experience, as missionizing and moralizing are two soldering processes that become at odds with one another. "Shaking hands with the devil" was the phrase one of the participants used regarding his experience of mission over morals (Smith-MacDonald et al., 2020, p. 238).

Participants expressed how they felt "internally unprepared to manage the emotional and spiritual realities and horrors, . . . such as witnessing genocides, mass starvations, poverty, sexual abuse, and mutilation" (Smith-MacDonald et al., 2020, p. 238). As stated by one of the participants when explaining the experience of evil,

> I cannot speak to it for any other countries, but I find what causes a lot of our PTSD is moral and ethical issues, moral and ethical dilemmas. You cannot justify some of the stuff you've had to do. It doesn't fit with how you were brought up. (Smith-MacDonald et al., 2020, p. 238)

Smith-MacDonald et al. (2020) stated that due to the "moralizing and mentalizing training, participants felt angry and bitter when they realized they were powerless to

rectify ‘evil’ situations” (p. 238). This led to a “a deep-seated sadness and hatred toward themselves, humanity, and the military” (Smith-MacDonald et al., 2020, p. 238). This was especially true of those who experienced an “inability to act” caused by “orders or rules of engagement, as this compounded their sense of having failed to live up to who they are as soldiers and protectors” (p. 239).

Participants reported considering military betrayal to be “extremely injurious,” as actions made by “peers, superiors, and the military as an institution did not act in ways congruent with implicit norms, values, and morals” (Smith-MacDonald et al., 2020, p. 238). Betrayals were considered passive or active. Passive betrayals included “leaders being perceived as incompetent, soldiers being placed in unnecessary risk, or peers being deemed as unwilling to die for another” (Smith-MacDonald et al, 2020, p. 238). Active betrayals were described as “abuse, bullying, or the shifting of guilt and blame from superiors to lower soldiers” (Smith-MacDonald et al., 2020, p. 238). Self-judgement was another category the participants described as being painfully difficult to cope with, as they acknowledged knowing that “what is morally acceptable in a combat zone is often deemed unacceptable or unethical in civilian society,” such as others knowing the service member killed one or many in combat or “when despite following orders, unexpected adverse incidents occurred” (Smith-MacDonald et al., 2020, pp. 238–239). A deeply painful example was given by one of the participants as he recalled being “responsible for clearing improvised explosive devices from a road and believing they were all cleared, letting the convoy move ahead only to have the first vehicle hit an improvised explosive device and kill his best friend” (Smith-MacDonald et al., 2020, p. 239). These experiences represent the countless number of military service members who carry deep

wounds, which creates indescribable pain and makes it difficult to share and express the grief, remorse, guilt, and shame they bear on a daily basis.

Guilt and Shame

According to Miceli and Castelfranchi (2018), guilt and shame share a lot of commonalities and are considered to be self-conscious emotions; however, they are notably distinguishable from one another. Because they are self-conscious emotions, they are therefore more likely to coexist, more likely to elicit negative self-perceptions and self-evaluation, and in turn more likely to evoke failure and transgression within the perceived self (Miceli & Castelfranchi, 2018). Combat veterans are likely exposed to situations that require them to make decisions that may or may not align with their values. According to Harris (2008), a value can be defined as "a direction we desire to keep moving in, an ongoing process that never reaches an end" (p. 169). War calls upon service members to make committed actions regarding how they are going to respond to situations that fall outside of what many civilians (and service members) would consider to be normal experiences. Values are deeply-committed beliefs rooted in the way we as human beings so choose to conduct ourselves. Combat-related experiences are unlikely situations that enable a service member to thoughtfully choose what measures to take in order to reap an outcome that is in alignment with their values. As stated by Litz et al. (2009), "Violence and killing are prescribed in war and encounters with the grotesque aftermath of battle are timeless and expected aspects of a warrior's experience" (p. 696).

War is perpetually filled with ethical and moral dilemmas that continually confront service members. Service members are therefore more likely to find themselves in situations that require them to make decisions and committed actions that transgress

their deeply-held moral beliefs. Such encounters are not limited to a service member committing an action that may go against their own moral and ethical convictions—it may very well be that that service member has witnessed cruelty and human suffering that significantly affects their values and core beliefs about humanity (Litz et al., 2009). According to Litz et al. (2009),

> [results showed] 52% of service members deployed to Afghanistan or Iraq in 2003 were exposed to high levels of violence and its aftermath and reported directing fire or shooting at the enemy, and 32% reported being "directly responsible for the death of an enemy combatant." (p. 696)

Litz et al. also found "65% of those surveyed reported seeing dead bodies or human remains, 31% reported handling or uncovering human remains, and 60% reported having seen ill/wounded women and children who they were unable to help" (p. 696).

Cunningham et al. (2019) conducted a study in which they sought to identify whether shame significantly contributed to suicidal ideation among service members. Results showed shame can have a notable impact on PTSD and suicide and may factor into a veteran's experience regarding symptoms of PTSD and suicidality (Cunningham et al., 2019).

Spirituality

Brémault-Phillips et al. (2019) indicated MI occurs when "military personnel are exposed to morally injurious events that conflict with their values and beliefs" (p. 276) and argued for the need for a holistic approach, as the complexities of MI occur within the physical, social, emotional, and spiritual constructs of an individual. Mental and spiritual distress can be the result of sustained morally injurious experiences (Brémault-

Phillips et al., 2019). According to Brémault-Phillips et al., MI can occur throughout the course of an individual's "military service, missions, disaster relief efforts, stateside and/or training accidents, drone warfare, or military sexual trauma" (p. 276) and the individual's life can be significantly altered as morally injurious experiences occur. According to Pargament and Sweeney (2011), realizing the essential self and aspirations of higher order comes with recognizing that growth ebbs and flows, and spirituality can provide a level of ambition to pursue the sense of meaning. The struggle of growth parallels the deepest of pain when one begins to recognize the unspeakable heartache that comes from sustaining the deepest of sorrows.

According to Smith-MacDonald et al. (2018), "Spirituality and spiritual distress have been recognized in the literature as core features of moral injury" (p. 2). Spirituality often provides a sense of connectedness to core values, morals, and beliefs, which brings validation and inspiration to an individual's purpose or mission in life. According to Verghese (2008), a "lack of spirituality can interfere with interpersonal relationships, which can contribute to the genesis of psychiatric disturbance" (p. 234). Though spirituality is personal and its experience can vary from one individual to another, it remains globally recognized, exemplifying its universality across culture and creed (Verghese, 2008). Dein et al. (2010) stated "spirituality and religious faith are important coping mechanisms for managing stressful life events" (p. 63). However, there is a "religiosity gap between mental health clinicians and their patients" (Dein et al., 2010, p. 63), as there is a notable perception among some clinicians that inquiring about an individual's religious or spiritual beliefs is not appropriate. There has been a more recent increase of inquiry, within the United States, among psychiatrists who subscribe to the

belief that gaining an understanding of individual's religious or spiritual beliefs can help to create a holistic approach regarding treatment recommendations (Dein et al., 2010).

Hourani et al. (2012) conducted research with randomly selected active duty personnel in reference to spiritualty potentially serving as a personal buffer against depression, PTSD, and suicidality for those who subscribe. The results indicated military personnel who rated spirituality as high in significance were more likely to have experienced some protective effects against depression and PTSD, if their exposure to combat was considered low to moderate (Hourani et al., 2012). Schimsa (2018) conducted research pertaining to combat veterans experiencing MI and their pre-war worldview, with results indicating that, per self-report, several veterans did not believe they were welcomed in the church either due to the perceptions of others or beliefs pertaining to guilt and shame of what was done and witnessed while in combat. Others believed God had forgiven them but they were unable to forgive themselves, and still other veterans were unable to reconcile their faith/spirituality after combat and had since renounced what they once subscribed to as their spiritualty/faith (Schimsa, 2018). Results of Hourani et al.'s (2012) study, in comparison to previous studies, "suggested that high combat exposure may increase emotional vulnerability leading to poorer mental health among highly spiritual personnel" (p. 7). Additional findings also indicated,

> it may be beneficial to enhance chaplain involvement across the entire deployment cycle (before, during, and after), ensuring that service members are encouraged to attend to their spiritual needs in whatever manner makes sense to them, and to integrate spiritual assessment into physical and mental health care to improve care of the whole individual. (Hourani et al., 2012, p. 7)

The presence of a chaplain may contribute to creating an environment that encourages service members to seek necessary support.

Posttraumatic Stress Disorder

PTSD is defined by the U.S. Department of Veterans Affairs: National Center for PTSD (National Center for PTSD, n.d.-b) as a mental health problem that can potentially develop following exposure to an event that is experienced, whether directly or indirectly, in a traumatic manner. Examples of such events can include witnessing or being involved in a car accident, combat, sexual assault, or a natural disaster (National Center for PTSD, n.d.-b). It is not uncommon for an individual to experience stress at a higher intensity when the event is experienced in a threatening manner. However, even though the stress response is natural, the endurance of the response is where the importance lies in deciphering whether the individual is experiencing symptoms of acute stress disorder (ASD) or more chronic symptomology of PTSD. Symptoms of PTSD, according to the American Psychiatric Association (2013), may not appear immediately following the experience of a traumatic event; instead, it is possible for an individual to experience a delayed onset of symptoms even years after the event. Many factors are involved in the likelihood of an individual experiencing symptoms, which can further influence whether an individual will develop symptoms as well as the onset of those symptoms.

Within the *DSM–5* (American Psychiatric Association, 2013; Reisman, 2016), PTSD has four clusters that categorically define how the symptoms manifest:

- Intrusion—spontaneous memories of the traumatic event, recurrent dreams that are related, flashbacks, and other intense or prolonged distress.

- Avoidance—distressing memories, thoughts, feelings, or external reminders of the event.
- Negative cognitions and mood—myriad feelings that include a distorted sense of blame of self or others, persistent negative emotions (e.g., guilt, shame, fear), feelings of detachment, and constricted affect.
- Arousal—aggressive, reckless, or self-destructive behavior; sleep disturbances and hypervigilance.

According to Grinage (2003), the epidemiology of PTSD is "directly linked to the trauma" (p. 2403). The development of PTSD derives from risk factors that affect the probability of likely development. Grinage stated "approximately 25 to 30 percent of victims of traumatic events develop symptoms of PTSD; however, response to trauma varies with the severity and the subjective experience associated with the trauma" (p. 2403). The most commonly associated traumatic events leading to PTSD for men are exposure to military combat or the witnessing of someone sustaining a serious injury or being killed, whereas for women, sexual molestation and rape are the most common traumatic events associated with a diagnosis of PTSD (Hidalgo & Davidson, 2000).

History of PTSD

PTSD has a lengthy history of life-altering symptoms in addition to changes to its name several times over. According to Crocq and Crocq (2000), PTSD became a household name when it made its debut in the *Diagnostic and Statistical Manual of Mental Health Disorders* (*DSM-III*) in 1980, as its symptoms became more distinguished in the 1970s following the Vietnam War. Prior to the Vietnam War, there was recorded evidence of trauma sustained that manifested in a manner that was different than in

comparison to a physical wound. PTSD is not something that can be seen per se, such as a sustained physical wound, but rather is the sum of psychological symptoms that contribute to behaviors and the changing of perceived experiences often producing notable distress and difficulty with coping. Prior to the Vietnam era, PTSD was referred to as "soldier's heart" (Da Costa syndrome) during the Civil War and was known for its symptoms of increased arousal and irritability, in addition to cardiac symptoms; World War I referenced it to be "shell shock" due to exploding shells causing brain trauma; and during World War II, "operational fatigue" and "combat neurosis" were designated terms used to describe an individual displaying combat-related symptoms (Grinage, 2003).

According to Crocq and Crocq (2000), the symptomology of combat-related stressors was originally documented in a biblical passage found in Deuteronomy 20:1-9 that referenced the need to remove soldiers from the frontlines due to psychological symptoms:

> When thou goest out to battle against thine enemies, and seest horses, and chariots, and a people more than thou . . . the officers shall say, What man is there that is fearful and fainthearted? Let him go and return unto his house, lest his brethren's heart faint as well as his heart. (*King James Bible*, 1769/2021)

Classical literature is filled with pages of what is described as re-experiencing combat-related symptoms of PTSD. For example, Queen Mab in Shakespeare's *Romeo and Juliet* was reportedly being awakened by nightmares or night terrors (Crocq & Crocq, 2000). In the Hundred Year's War (1337–1453), Pierre de Bearn was awakened by nightmares and reacted as though he was fighting his enemies in the present moment (Crocq & Crocq, 2000). Hippocrates acknowledged having dreams that were experienced as frightening

battle scenes (Crocq & Crocq, 2000). In the French Revolutionary Wars and the Napoleonic Wars, there were also reports of soldiers having "collapsed into protracted stupor after shells brushed past them, although they emerged physically unscathed, hence where the term 'vent du boulet' syndrome, where subjects were frightened by the wind passage of a cannonball" (Crocq & Crocq, 2000, p. 51). "Derealization and depersonalization [were] induced by this frightening environment," as described by Goethe (Crocq & Crocq, 2000, p. 48).

PTSD is predominantly attributed to war though accounts of civilians experiencing symptoms of PTSD began receiving interest during the Industrial Revolution (1760–1840), as the "introduction of steam driven machinery were to give rise to the first civilian man-made disasters and cases of PTSD outside the battlefield" (Crocq & Crocq, 2000, p. 48). "Railway Spine" and "Railway Brain" were names used to identify individuals who displayed "mental symptoms caused by lesions of the spine and brain" (Crocq & Crocq, 2000, p. 49), versus the theory that individuals were displaying symptoms as a result of emotional shock and hysteria. This controversy, as described by Crocq and Crocq (2000), remained until the beginning of World War I. It was during this time that German physician Hermann Oppenheim introduced 42 cases of individuals displaying symptoms of PTSD as a result of workplace or railway accidents in 1884 (Crocq & Crocq, 2000).

The American Psychiatric Association (2013) revised the criteria for stress-related disorders in the *DSM–5* in 2013. According to the *DSM–5*, PTSD is classified as a trauma and stress-related disorder and is no longer considered to be an anxiety disorder. Additionally, there are two subtypes, the first being dissociative and the second preschool

for children 6 years old and younger (American Psychiatric Association, 2013). Symptoms such as re-experiencing or reliving the event; avoiding people, places, or things that are reminders of the traumatic experience; harboring negative feelings and beliefs about one's self or others; and enduring feelings of hyperarousal are just a few indications of the onset of a stress disorder (American Psychiatric Association, 2013). The National Center for PTSD (n.d.-b) acknowledged the varying phases an individual is likely to experience following a disaster. For example, phase one is deemed the "impact" phase, during which the individual experiences the event in a manner that is traumatically distressing regardless of whether the symptoms are prevalent immediately or are delayed. The second phase is deemed "immediate-rescue" and involves the individual attempting to make sense of the traumatic event, which is likely to occur over the course of several days or weeks (Wilson & Raphael, 1993). This phase is often where the individual will begin to assess immediate needs, such as identifying loss, physical injury, shock, and emotional stress. However, the expression of anxiety, anger, confusion, hopelessness, or grief may or may not indicate whether the individual will continue to experience symptoms in the long term.

The National Center for PTSD (n.d.-b) indicated the third phase is known as "intermediate-recovery." In this phase, the individual experiences sub-phases wherein hesitation to express fears or concern may occur. The individual will experience the need to attend to basic needs, such as survival and safety. Additionally, the individual may experience feelings of altruism or disillusionment. Galea et al. (2002) explained that how the individual experienced the traumatic event and when interventions were provided can influence the experience during this phase, in addition to the duration of this phase.

Wilson and Raphael (1993) referred to the fourth phase as the “long-term reconstruction” phase. During this phase, an individual’s perception of the event will significantly influence how the individual experiences daily living in addition to thoughts and concerns for the future.

According to the *DSM–5* (American Psychiatric Association, 2013), certain criterion must be met in order for the most accurate diagnosis to be given. As previously indicated, an individual must have been exposed to a traumatic event and experienced symptoms as a result. The experience of intrusive thoughts, images, nightmares, and flashbacks is common for an individual who is re-experiencing the traumatic effects of an event. These stimuli result in the re-evoking of the traumatic experience in a manner that causes the individual to feel as though the event is occurring again, such that emotional reactions occur in response to the intrusion (American Psychiatric Association, 2013). Due to such symptoms being intense, the likelihood of an individual learning to use avoidance in a manner that creates the appearance of relief and distance from the disturbance is very high and is displayed behaviorally.

The National Center for PTSD (n.d.-b) identified how daily activities can be affected by experiencing a traumatic event. It is not uncommon for an individual to blame themselves or others regarding the occurrence of the traumatic experience, and because of this shift in thinking, the individual is likely to experience feelings of inadequacy in addition to developing associations with negative thoughts and feelings. These beliefs can alter the way in which the individual experiences life on a daily and how they may find it difficult to connect with others.

The criterion for arousal or reactivity addresses the changes an individual experiences regarding hypervigilance (Wilson & Raphael, 1993). The intensity of the traumatic event creates an undeniable experience where the individual feels very unsafe, making it difficult to remove themselves from the past that is being experienced as though it was the present (van der Kolk, 2014). Within the *DSM–5* (American Psychiatric Association, 2013), the emotional and behavioral components have been separated to specify more accurately the experience of the individual; for example, the individual may experience irritability or anger outbursts that are displayed in an aggressive manner or through self-destructive behavior. Overall, symptoms must be persistently experienced for 1 month or longer (American Psychiatric Association, 2013). Additional factors include experiencing distress within the individual's occupational environment, social environment, and other related factors. The *DSM–5* (American Psychiatric Association, 2013) rules out symptomology due to illness, medication, and substance abuse.

Neurobiologically, PTSD is associated with alterations within the central nervous system and autonomic nervous system (Sherin & Nemeroff, 2011). "The use of eyetracking has received attention and shows promise in being used for research identification of levels of PTSD" (Bair & Long, 2013, p. 206). This type of information has the potential for significantly improving interventions as it provides a deeper understanding of PTSD at a neurobiological level. In comparison to the criterion previously discussed, symptomology of hyperarousal, the startle-response, and disruption of sleep would be the result of experiencing ongoing stressors related to the traumatic event. According to Brown and Morey (2021), "High intensity acute stress, as experienced during a traumatic event, sets off a cascade of neurobiological changes

which initially help the body respond to acute threat . . . however, the stress response is maintained and becomes maladaptive" (p. 1). PTSD can also be a chronic disorder. According to the National Center for PTSD (n.d.-b), the experience of certain symptoms must have occurred for at least 1 month prior to diagnosis; however, it is not uncommon for a delayed expression to occur. The *DSM–5* (American Psychiatric Association, 2013) indicates full diagnostic criteria may not be met for as long as 6 months or more.

According to the National Center for PTSD (n.d.-c), there is an overlap regarding PTSD and acute stress disorder (ASD). Symptoms of ASD last for at least 3 days after the traumatic event occurs (American Psychiatric Association, 2013). Symptoms of ASD also overlap with PTSD; however, feelings are involved in a manner as though the individual is outside of their body or does not know where they are. Research indicates the likelihood of an individual being diagnosed with PTSD is greater when the individual has already been diagnosed with ASD; however, the diagnosis of ASD is not a prerequisite for the diagnosis of PTSD (National Center for PTSD, n.d.-c). Regarding treatment for ASD, individuals who are active participants in receiving treatment, such as cognitive behavioral therapy (CBT), soon after the trauma has occurred are less likely to develop symptoms of PTSD (National Center for PTSD, n.d.-c). Psychological debriefing is sometimes used to treat ASD; however, it is strongly recommended that psychological debriefing not be used in situations where the traumatic event is considered severe or the severity of the reaction is high (National Center for PTSD, n.d.-c).

Within the *DSM–5* (American Psychiatric Association, 2013), adjustment disorder (AD) is likely to be considered when an individual has experienced a stress-induced occurrence that has created notable behavioral and emotional symptoms within a 3-month

timespan since the occurrence. Additionally, one or both of the following must occur: clinically significant symptoms that produce some level of impairment in functioning or distress that is experienced in a manner that is out of proportion in comparison to the expected reaction (American Psychiatric Association, 2013). The *DSM–5* categorizes stressors as not stemming from existing mental health disorders; additionally, they are not classified as a normal reaction within the realm of bereavement, and the symptoms begin to subside after a period of 6 months (American Psychiatric Association, 2013). There are six subtypes of AD that occur after a period of 3 months that may be classified as acute or persistent according to the length of time: anxiety, depressed mood, mixed anxiety and depressed mood, disturbance of conduct (e.g., anger outbursts), with disturbance of conduct and mixed emotions, and unspecified symptoms (American Psychiatric Association, 2013). Treatment for AD has been found to be most helpful when the individual receives support socially, such as broadening treatment to family therapy (Bressert, 2018). There is evidence to support solution-focused therapy as an effective treatment for those diagnosed with AD (Bressert, 2018).

According to the National Center for PTSD (n.d.-a), 11%–20% of veterans who served in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) are diagnosed with PTSD within a given year; 12% of veterans who served during the Gulf War (Desert Storm) have PTSD in a given year; and 30% of veterans who served during the Vietnam War were diagnosed with PTSD in a given year. C. L. Lancaster et al. (2016) stated “exposure-based interventions have the most empirically supported treatment modalities for PTSD” (p. 4).

Treatment of PTSD

Treatment for PTSD includes several evidence-based psychotherapies in addition to pharmacotherapy. According to C. L. Lancaster et al. (2016), "PTSD is rooted in both biological and psychological factors with regard to onset of symptoms, development of PTSD, and maintenance of the disorder" (p. 4). Research has shown biological and psychological interventions provided shortly after exposure to a traumatic event have a greater likelihood of significantly reducing or eliminating the symptoms of ASD, in addition to reducing the symptoms of PTSD (C. L. Lancaster et al., 2016). Research has provided evidence regarding the effectiveness of current treatments.

Cognitive behavioral therapies (CBT) are designed to address the cognitions of the veteran regarding their patterns of maladaptive thinking (C. L. Lancaster et al., 2016). There is substantial evidence that CBT is an effective treatment for the symptoms of PTSD (Reisman, 2016). Prolonged exposure therapy (PE) and cognitive processing therapy (CPT) are considered to be primary treatments for PTSD practice guidelines around the world, including the guidelines jointly issued by the VA and Department of Defense (Reisman, 2016).

Prolonged exposure (PE) is a treatment rooted within behaviorism and requires the individual to repetitively share their traumatic experience over a period of eight to 15 sessions for the first part of treatment, which may occur on a weekly or bi-weekly basis (C. L. Lancaster et al., 2016). During each session, relaxation techniques are taught to the individual alongside psychoeducation regarding symptoms of PTSD and likely factors that directly influence the individual's experience (C. L. Lancaster et al., 2016). The second half of PE treatment is the individual revisiting the traumatic memory in pursuit

of extinguishing the fear response directly influenced by the memory (C. L. Lancaster et al., 2016). According to Tuerk et al. (2011), PE is an effective treatment for combat-related PTSD among Veterans of OEF/OIF, particularly if the course of the treatment is longer. C. L. Lancaster et al. (2016) found the dropout rates of PE range from 10%–38%; however, in comparison to the dropout rates of other therapies, PE did not produce a significant difference. Tuerk et al. (2011) concluded PE treatment can be effective in VA settings. According to Eftekhari et al. (2013), veterans displaying symptoms of PTSD and depression have been shown to experience some benefit from PE treatment.

CPT is a trauma-focused treatment that addresses the impact of the trauma and the negative thoughts pertaining to the trauma. This provides the veteran an opportunity to gain a greater understanding of how negative thoughts, also known as maladaptive thoughts, are derived from the traumatic experience and, in turn, cause stress (C. L. Lancaster et al., 2016; Reisman, 2016). Additionally, psychoeducation is provided to help the veteran learn about and recognize the symptomology of PTSD throughout the course of treatment. Coping skills are taught as a means of helping the veteran to work through moments of difficulty as needed (Reisman, 2016). According to Monson et al. (as cited in C. L. Lancaster et al., 2016), the dropout rate for veterans diagnosed with combat-related PTSD is 20%. This is in contrast to other psychotherapies that had a lower drop-out rate.

Eye Movement Desensitization and Reprocessing (EMDR) is another type of therapy provided to veterans diagnosed with PTSD. According to C. L. Lancaster et al. (2016), EMDR attends to the reprocessing of the memory regarding the traumatic event in addition to distorted patterns of thinking that may be attached to the memory, such as the veteran believing they are a failure. The process of bilateral movement helps reduce

symptoms of the traumatic memory (C. L. Lancaster et al., 2016). While the veteran is revisiting the traumatic experience, the therapist provides strategic guidance for the veteran to follow so they may be able to simultaneously experience bilateral stimulation, such as with a light bar, the following of a baton as directed by the therapist, or hand taps (Reisman, 2016). EMDR is unique in comparison to its counterparts in that it relies more so upon the rhythmic movements of the eyes throughout the processing of the traumatic experience and less so on talking about the traumatic event (Koven, 2021).

Narrative exposure therapy (NET) is another CBT-based treatment that addresses the symptoms and experiences of PTSD (Koven, 2021). In contrast to other CBT-based therapies, NET requires less time while remaining efficacious (Koven, 2021). During session, the therapist will ask the veteran to talk about the traumatic experiences in addition to other "unhappy" experiences as well as "happy" experiences (Koven, 2021). The purpose of this is to assist the veteran to become more acclimated to the traumatic events and therefore experience a meaningful reconciliation of the traumatic memories (Koven, 2021). However, some researchers have reservations regarding "insufficient clinical and empirical studies to validate assertions of the treatment's advocates" (Koven, 2021, p. 26). CPT, PE, and EMDR are considered to be the most effective CBT-based therapies and are recommended by both the Veteran's Administration and Department of Defense (Koven, 2021).

According to Landis-Shack et al. (2017), theoretically-informed assessments have shown music therapy can also be used as a tool to address the symptoms of PTSD. A pilot study was conducted to measure to measure whether veterans experienced decreased symptoms of PTSD as a result of music therapy (Dillingham, 2011). This study involved

measuring the outcomes of 40 veterans who consented to participate, upon which they individually received an hour of guitar training weekly in addition to a group session that also occurred weekly (Dillingham, 2011). Over the course of the 6-week intervention, bivariate comparisons of pre- and postinterventions revealed significant improvements regarding PTSD symptomology (Dillingham, 2011). The PCL-C scale revealed a 21% decline in symptomology overall, the Beck Depression Scale revealed a 27% decrease in depressive symptomology, and the quality of life measure (EuroQoL) revealed a 37% overall improvement (Dillingham, 2011).

Moral Injury and PTSD: Similarities and Differences

According to Jamieson, Usher, et al. (2020), the overlap in the symptoms of MI and PTSD strongly indicates comorbid existence. Misdiagnoses, however, are not uncommon and clinicians are more likely to be treating symptoms of PTSD only and not addressing symptoms of MI. This can lead to long-term devastating effects, including suicidality (Jamieson, Usher, et al., 2020). The co-occurrence of MI and PTSD appears to be more likely than what was originally perceived. Though PTSD and MI are substantially different, it is important to continue to understand their co-occurring nuance because MI is not featured in the *DSM–5* and "debates continue as to whether moral injury should be considered a diagnosable mental health condition or a normal human response to an abnormal event(s)" (Jamieson, Usher, et al., 2020, p. 107).

Brief measures that are psychometrically validated are available in the United States and are used to measure MI symptoms (Jamieson, Usher, et al., 2020). According to Barnes et al. (2019), the current treatment for MI is unclear, as a more prominent focus is given to decreasing the symptoms of PTSD. This is likely due to the coexisting nature

of MI and PTSD. According to Jamieson, Usher, et al. (2020), “Research has shown that >50% of veterans with PTSD symptoms have four or more symptoms of MI in the severe range (9 or 10 on a 1–10 scale) (4), and nearly 60% of veterans with PTSD have five or more such symptoms” (p. 106). According to Farnsworth et al. (2017), ACT may help decrease the symptoms of MI by encouraging a nonjudgmental relationship with the experiences while developing an intentional focus on behaviors that align with the individual’s values.

Other research has shown mental health clinicians addressing MI and PTSD in group settings with a focus on combining cognitive processing therapy and loving kindness meditation; cognitive processing therapy with a spiritual component; and cognitive processing therapy combined with brief exposure therapy, which was derived from emotion-focused exposure therapy in an imaginal form, to address the deep pain and suffering services members were experiencing (Barnes et al., 2019). As Norman and Maguen (2021) strongly indicated, the overlap of MI and PTSD is profound and cannot be ignored. Research continues to reveal that both MI and PTSD require an event to occur that is likely experienced as potentially harmful to the individual or others and may even be life threatening, with likely side effects of guilt, shame, betrayal, and loss (Norman & Maguen, 2021).

Methodology

According to Smith-MacDonald et al. (2018), “Spiritual struggles and illnesses often reside within and mimic mental health concerns developed during military service” (p. 2). Research shows it is not uncommon for healthcare providers to be unaware of or uncomfortable with approaching MI, MD, and spirituality (Smith-MacDonald et al., 2018). The minimizing and overlooking of spiritual and religious suffering dimensions contributes to (a) therapist biases, (b) scientific avoidance, and (c) illiteracy regarding spiritual and religious suffering perspectives, processes, and practices (Smith-MacDonald et al., 2018, p. 2). Addressing spiritual/religious suffering (e.g., guilt and shame) is essential to disentangle underlying causes of MI and allows for more in-depth healing (Smith-MacDonald et al., 2018). This study was intended to provide more in-depth insight and understanding of the stigmas, cultural taboos, and the unspeakability that are associated with shame, guilt, avoidance, and pain, and how these factors contribute to an individual’s chosen engagement, abandonment, or distance from spirituality.

Study Design

This study was based on a larger program evaluation and qualitative study conducted by Bair et al. (2021) in which they addressed the effectiveness of teaching veterans about MI and MD. This sub-study involved the use of semi-structured interviews and did not involve clinical intervention. The larger study was reviewed by the Hines/Lovell Institutional Review Board (IRB) and determined not to be research. Therefore, a consent was not required. Prior to the implementation of this sub-study and the larger program evaluation study, 9 months of psychoeducation and discussion were provided regularly to nine outpatient therapy groups. The training team consisted of one

senior psychologist, two Chaplains, and one pastoral counselor. The purpose of the psychoeducation was to provide information and to address questions and concerns that went beyond symptoms of posttraumatic stress and clearly identified the details of MI and MD. The information provided by the training team was both didactic and experiential learning, which allowed for the creation of a sacred space for veterans to share what they believed to be relatable experiences that remain morally injurious. The unique information provided by this psychoeducation program provided a fine opportunity for in-depth program evaluation and research to be conducted.

Bair et al. (2021) obtained a wide range of MI and MD responses that were reduced to a listing of themes and scores. They referred to Kahneman et al.'s (2021) finding regarding stress and fatigue as creating ideal circumstances for noise to adversely influence decision-making, especially during high-intensity situations, such as combat. The minimization of biases and the decreasing of "noise" were sought when the research team strategically conducted their decision-making in accordance with Kahneman et al.'s recommendations. These included having well-trained scorers pertaining to the topic being rated. Consistent team discussions and well-informed individual judgement led to consensus and cohesive decision-making of each score given (Kahneman et al., 2021). This formal team process assisted in decreasing the noise and the bias among the scorers. All scoring was agreed upon through consensus (Kahneman et al., 2021).

The aim of the current study was to gain an increased understanding of MI and MD and their impact on an individual's spirituality from the perspective of service members. The foundation of this study was based on the traditions of qualitative research. According to Levitt et al. (2018), qualitative research is described as a "set of approaches

that analyze data in the form of natural language (i.e., words) and expressions of experiences (e.g., social interactions and artistic presentations)" (p. 27). In qualitative research, language is the very essence of gaining greater insight and knowledge into participants' experiences, in this case the experiences veterans have sustained that have led to MI and MD. Language is the channel through which experiences can be shared and expressed individually and collectively with regard to the past, present, and future. Grounded theory is not based on a linear process, which allowed for the gathering of data and the analysis process to be executed in a manner that honored the sacredness of the stories and experiences shared. According to Chun Tie et al. (2019), grounded theory "sets out to discover or construct theory from data, systematically obtained and analyzed using comparative analysis" (p. 1). The methodology used for addressing the analysis of spirituality was interpretive phenomenological analysis (IPA).

Participants

A total of 45 volunteer veterans receiving treatment for PTSD and MI were screened and selected as appropriate by the Research Team Leadership and agreed to participate by completing the interview questionnaire. Each volunteer veteran was screened according to the following criteria. The inclusion criteria required the veteran to have a diagnosis of PTSD, at least 1 consistent year of treatment for PTSD, no current use of substances, and the capacity to expose and process MI/MD events. Exclusion criteria included that the veteran had recent use of substances or a consistent pattern of embellishing, distorting, or lying about their experiences. The interviews were 30–40 minutes in length and were conducted as follows: 15 in-person, 28 by telephone, and two via Zoom. Each interview was conducted by a pastoral counselor with additional support

from a primarily observing senior psychologist. The interview questionnaire approach was semi-structured to allow for open-ended answers through which the veterans could concisely yet quite deeply share the experiences that led to their MI and MD.

The volunteer veterans represented the following wars: Korean War; Vietnam War, Gulf War (Operation Desert Storm/Operation Desert Shield); Iraq/Afghanistan War [Operation Iraqi Freedom (OIF); Operation Enduring Freedom (OEF); Operation New Dawn (OND)]. Ethnicities represented were as follows: African American, Hispanic, Native American, and White. Experiences shared were combat and non-combat related. Forty-four of the volunteer veterans were male and one was female. Forty-four of the volunteer veterans were combat and one was non-combat.

Data Collection

To assess for MI and MD, we designed an interview questionnaire, which is provided in Appendix A. All questions were verbally read to the interviewee by the pastoral counselor interviewer. Notes were taken verbatim. The scoring guidelines are provided in Appendix B. The data set consisted of 45 completed interview questionnaires, which included the following: 90 MD responses, 90 MI responses, 45 spiritual impact responses, and 45 psychotherapy ratings. These responses primarily consisted of two to 10 sentences, with several responses being brief phrases. Each participant answered two MI and two MD questions in addition to five demographic questions.

Participants were de-identified and numerically represented. IPA was used to examine and analyze each response provided by every participant to each interview question. IPA is suited to the intricate exploration and rich phenomenology of the

individual experience and aims to capture the meanings a particular phenomenon may hold for the individual (Smith & Osborn, 2015), and is "especially valuable when examining topics which are complex, ambiguous and emotionally laden" because humans are "sense-making organisms" (p. 1).

At the end of each interview, a debriefing was conducted by the pastoral counselor, with additional support from a senior psychologist if deemed necessary. This debriefing was used to inquire about the veteran's current welfare after sharing their MI and MD and to gather additional information to determine if supplementary support was needed.

Data Analysis

Data analysis involved using Excel to look for comparisons, patterns, and relationships between scores (e.g., interview themes). The use of this program allowed for comparisons of the frequency of responses between scores, themes, and rankings, which were identified by the scoring team. The analyses were then transposed into figures and graphs.

The hypothetical examples listed below illustrate the application of this scoring system. The scoring system provided a rating of 1 to 3 on the following: cognition, affect, guilt, shame, and distortion.

- **Level 0:** No word(s), reflection, insight, judgement, or inference on topic.
- **Level 1:** Minimal word(s), reflection, insight, judgement, or inference on topic.
- **Level 3:** High level of word(s), reflection, insight, judgement, or inference on topic.

Moral Injury Example A

I decimated a village with artillery and saw the bodies afterwards. It broke my heart, and I've never been the same. I feel guilty. I can't help but think of those people every time I'm with my family.

Score: high level - moral injury; 2 on cognition; 2 on affect; 3 on guilt; 1 on shame; 0 on distortion. Giving shame a 1 because he did state shame specifically however, it was specified within the context of him comparing his family with the families killed in the village.

Moral Injury Example B

I witnessed several women and children mistreated and some even brutally killed. Every time I hear a child or woman scream or cry, I feel overwhelmed with anger and anxiety. I should've been able to do more, to stop the violence. How could I have let that happen? I feel so guilty for not going to church now; it was something you just did growing up. But I can't go; not like this. I'm too ashamed for letting God down.

Score: high level – moral injury; 2 on cognition; 3 on affect; 2 on guilt; 3 on shame; 0 on distortion.

Results

Figure 1 shows the self-rated impact of spirituality and indicates MI and MD created a probable impact on spirituality, as associated with ratings of shame given by the scorers (0–3). This figure represents notable levels of change in spirituality pertaining to MI and MD experienced according to each represented veteran. The levels of shame are also notable and were identified and rated by the scorers. Each scorer assessed for shame according to how it was expressed within the interview. The ratings provided were then discussed and decided upon as a team. This figure represents the impact of spirituality and shame cohesively.

Figure 1

Veterans With MD/MI Self-Rated Impact on Spirituality and Scoring Team Ratings of Shame

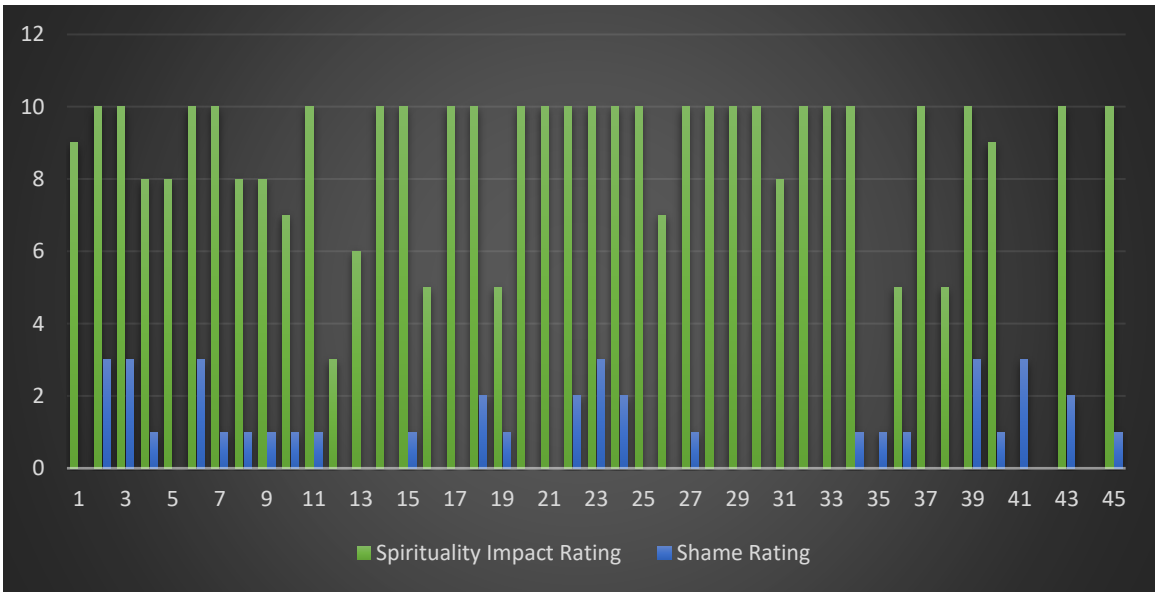


Figure 2 shows the self-rated impact of spirituality and indicates a probable pattern of MI minor, as associated with ratings of shame given by the scorers (0–3). The classification of MI minor was in concert with the veteran describing the injury and

concurring with its classification. The levels of shame are also notable and were identified and rated by the scorers. Each scorer assessed for shame according to how it was expressed within the interview. The ratings provided were then discussed and decided upon as a team. This figure represents the impact of spirituality and shame cohesively according to ratings of MI minor.

Figure 2

Veterans With MI Minor Self-Rated Impact on Spirituality and Scoring Team Ratings of Shame

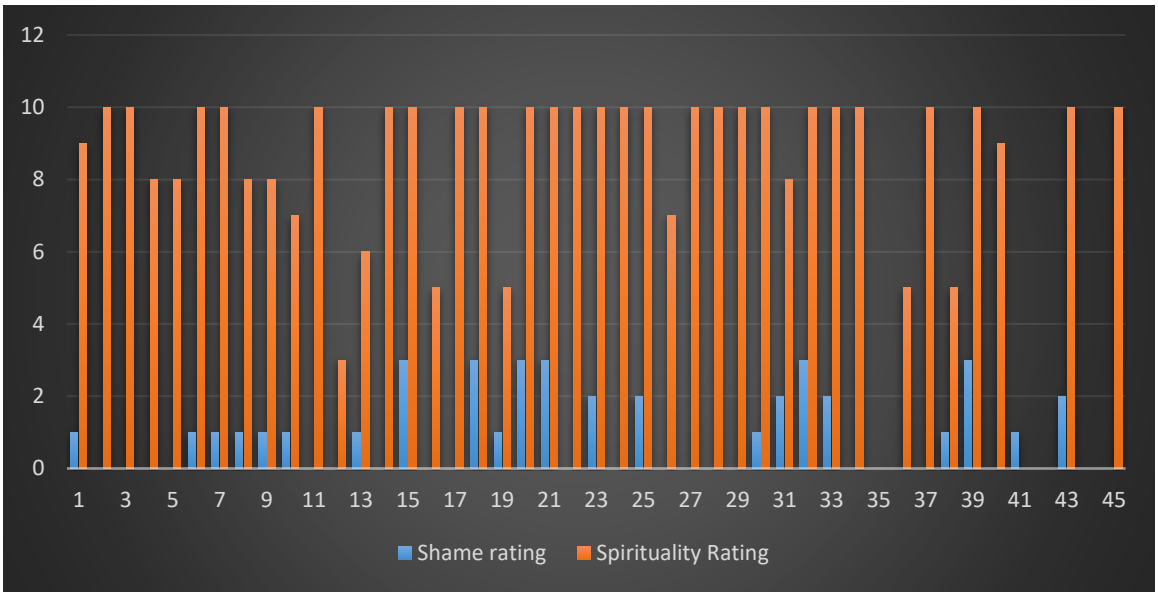


Figure 3 shows the self-rated impact of spirituality and indicates a probable pattern of MI major, as associated with ratings of shame given by the scorers (0–3). The classification of MI major was in concert with the veteran describing the injury and concurring with its classification. The levels of shame are also notable and were identified and rated by the scorers. Each scorer assessed for shame according to how it was expressed within the interview. The ratings provided were then discussed and

decided upon as a team. This figure represents the impact of spirituality and shame cohesively according to ratings of MI major.

Figure 3

Veterans With MI Major Self-Rated Impact on Spirituality and Scoring Team Ratings of Shame

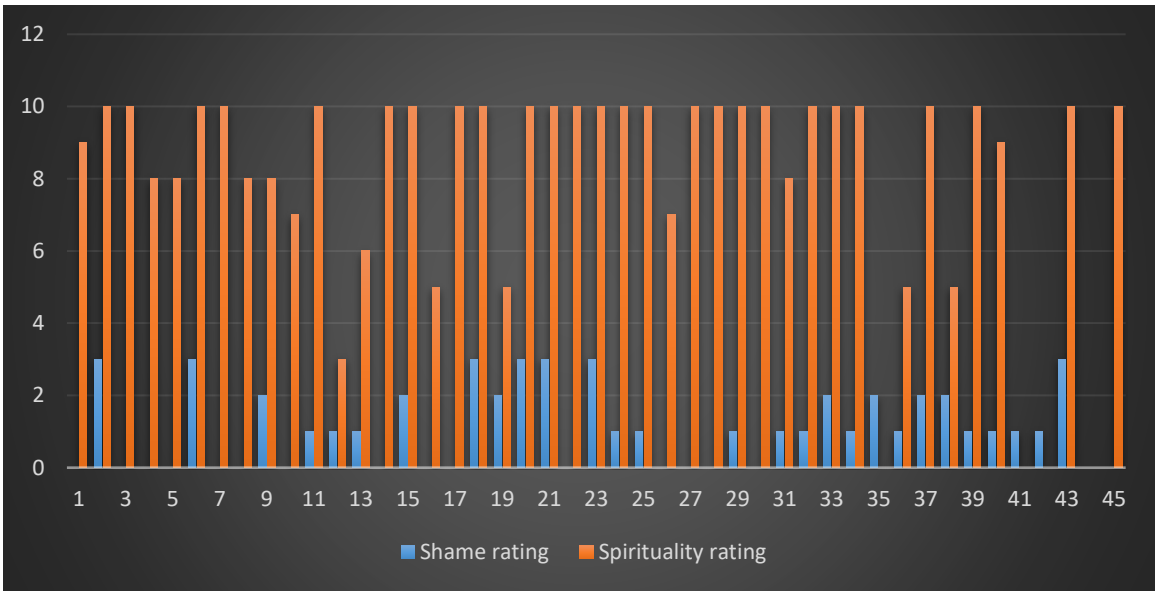


Figure 4 shows the self-rated impact of spirituality and indicates a notable pattern of MD minor, with probable ratings of shame given by the scorers (0–3). The classification of MD minor was in concert with the veteran describing the injury and concurring with its classification. The levels of shame are also notable and were identified and rated by the scorers. Each scorer assessed for shame according to how it was expressed within the interview. The ratings provided were then discussed and decided upon as a team. This figure represents the impact of spirituality and shame cohesively according to ratings of MD minor.

Figure 4

Veterans With MD Minor Self-Rated Impact on Spirituality and Scoring Team Ratings of Shame

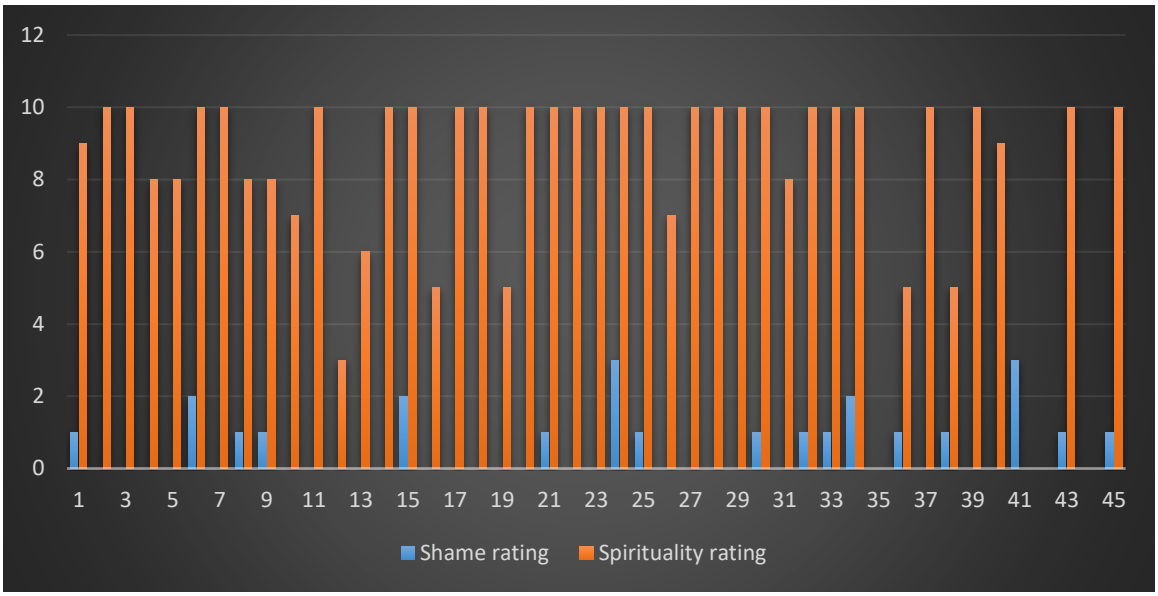


Figure 5 shows the self-rated impact of spirituality and indicates a probable pattern of MD major, with probable ratings of shame given by the scorers (0–3). The classification of MD major was in concert with the veteran describing the injury and concurring with its classification. The levels of shame are also notable and were identified and rated by the scorers. Each scorer assessed for shame according to how it was expressed within the interview. The ratings provided were then discussed and decided upon as a team. This figure represents the impact of spirituality and shame cohesively according to ratings of MD major.

Figure 5

Veterans With MD Major Self-Rated Impact on Spirituality and Scoring Team Ratings of Shame

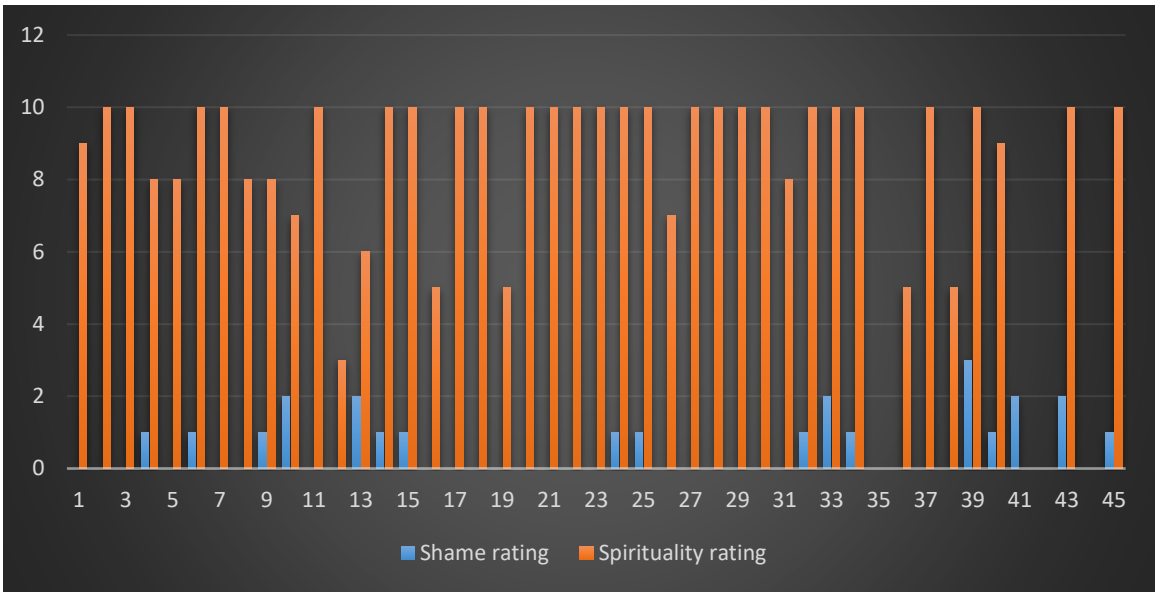
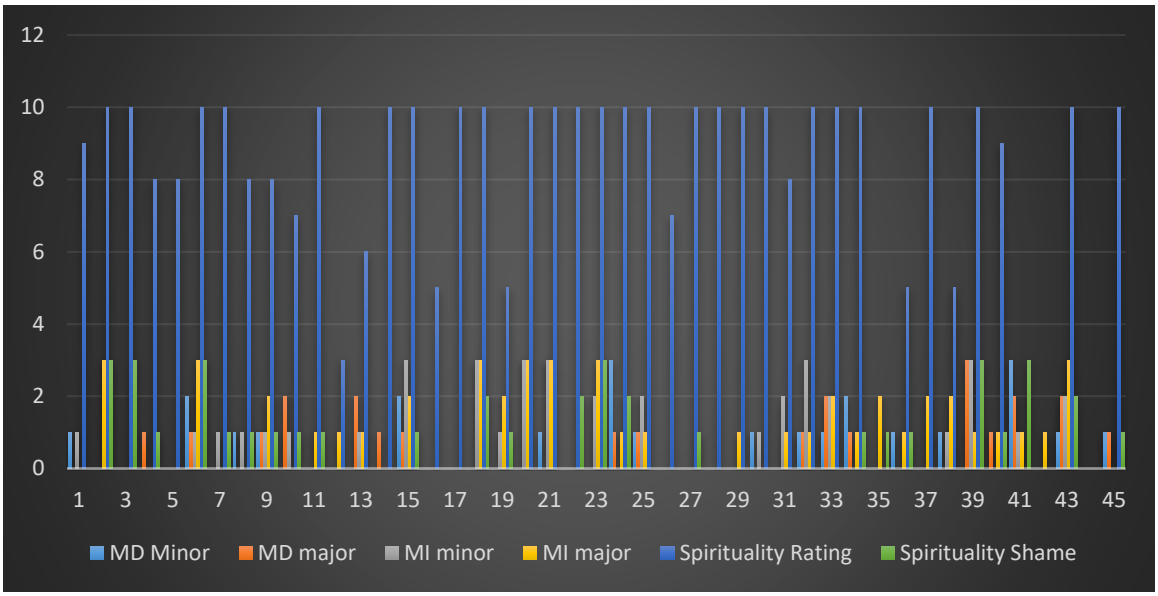


Figure 6 shows the combined self-rated impact of spirituality and indicates a probable pattern, as associated with ratings of shame given by the scorers (0–3). This figure represents all levels of MD minor/major, MI minor/major, and shame of this study.

Figure 6

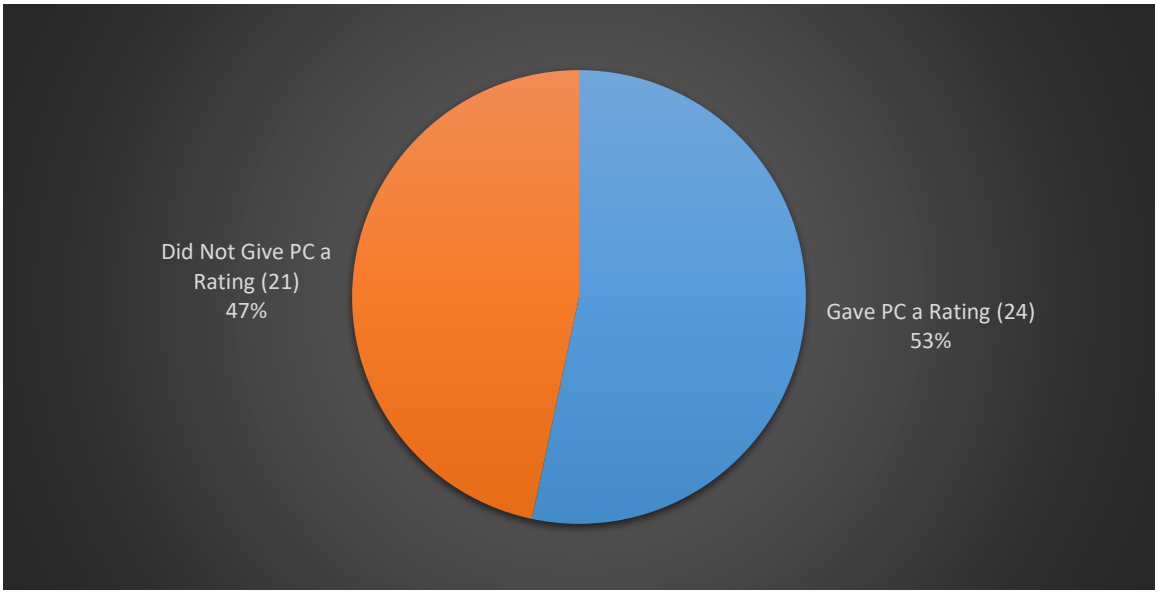
Combined Veterans' Self-Reported Impact on Spirituality and Scoring Team Ratings of Shame



As shown in Figure 7, the percentages are represented according to who sought and did not seek pastoral counseling as a means of support. The percentages of those who did and did not seek/receive pastoral counseling for MI/MD are notable. The modality of pastoral counseling is not highly used in VAs or hospitals.

Figure 7

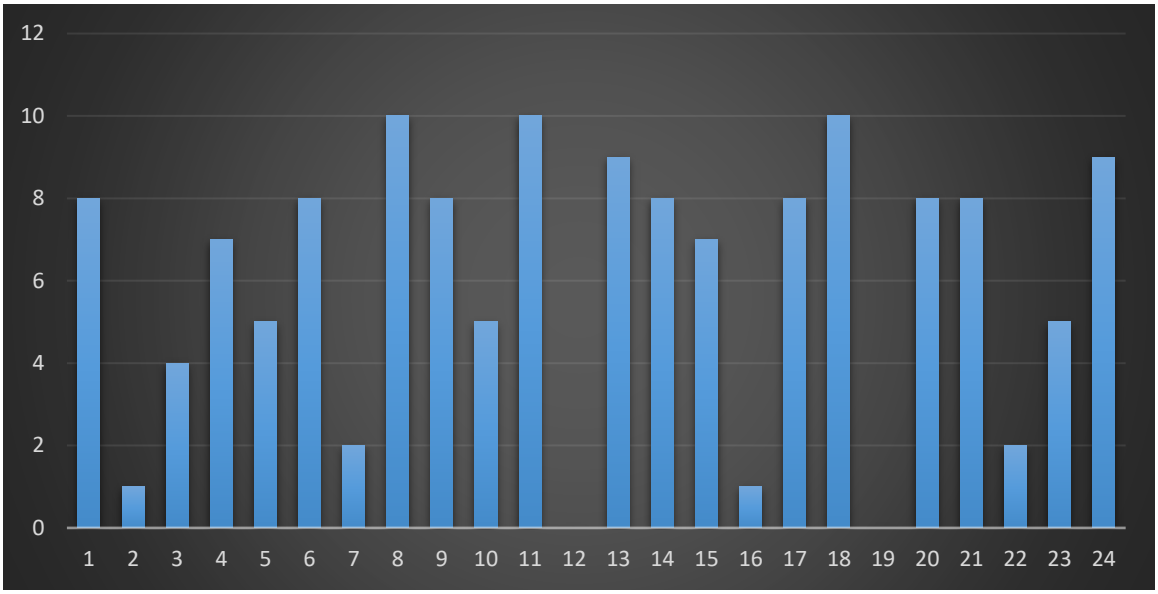
Veterans With MD/MI Who Did or Did Not Seek Pastoral Counseling



As shown in Figure 8, the self-rated impact of pastoral counseling is represented according to the effectiveness experiences. The classifications of MD/MI self-ratings of pastoral counseling were in concert with the veteran describing the experience and its effectiveness.

Figure 8

Veterans With MD/MI Ratings of Pastoral Counseling Effectiveness



Discussion

It is to be expected that spirituality and shame will be affected by traumatic events, especially with regard to MI and MD. This pattern was addressed in the leading MI research by Banister et al. (2019), who reported there is no "shame-free guilt" and DeCou et al.'s (2018) finding that trauma-related shame mediates levels of PTSD. MI has been defined as the "emotional, spiritual, and moral consequences of committing and/or observing others commit transgressions of deeply held moral values during combat or combat-related circumstances" (Koenig et al., 2019, p. 1). Our findings are in concurrence with those of Koenig et al. (2019):

> MI often accompanies posttraumatic stress disorder (PTSD) and is especially common in active duty military (ADM) and veterans as a result of combat experiences and other military-related traumas. MI may also be common in noncombat veterans . . . and in noncombat veterans, healthcare workers, and civilians. (p. 1)

Figure 1 indicated more than half of the volunteer veterans in this study identified their spirituality as having been affected, in a negative manner, after sustaining MI and MD. For example, some veterans indicated a significant change regarding their spirituality, by which they did not believe they were worthy of God's forgiveness and mercy. This shows they did not believe they could be redeemed. Other veterans reported they believed God may choose to forgive them or had forgiven them, but they could not forgive themselves.

Some of the veterans' self-reports indicated the actions they committed, witnessed, or experienced through the actions of others were expressed as deep levels of shame and guilt. This reflects that some of the veterans' beliefs were formed from such

experiences where they were not engaging in activities as before, such as attending church services. Additional examples given were associated with veterans having made a vow with God that if he would allow them to survive the treachery of combat, they would attend church for the rest of their lives. The experiences of shame from the veterans' perspectives support the beliefs that others (i.e., civilians) would perceive the veterans or the actions taken (or not taken) as unacceptable. The fear of being known or found out reflects a preconceived belief that judgement and condemnation will be the end result of forming relationships with others or with God or a Higher Power. This indicates that the deeper a connection or bond formed the greater the potential risk of becoming known, found out, and rejected. The fear of not being fully known also reflects a probable cause for creating distance from relationships, routines, and a lifestyle of the past, present, and future.

In Figures 2 through 5, the veterans' self-rated changes in spirituality reflected how impactful MI minor/MI major and MD minor/MD major were to these veterans. Scorers identified probable levels of shame and noted a pattern had been created for some veterans who were more likely to express shame and identify changes in spirituality. Comparatively, other veterans only addressed changes in spirituality and did not directly address or acknowledge shame. This supports that veterans who have been in treatment longer are more likely to talk about the unspeakable with someone they trust because they have developed more resilience and skills to support them in facing such difficult matters. Figures 6 and 7 showed that over half of the volunteer veterans did seek pastoral counseling as a means of wanting to address the pain and suffering they experienced from the wounds of MD, MI, and shame. These findings are in concurrence with Laubmeier et

al.'s (2004) finding regarding the importance of healthcare providers being able to assess an individual's level of spirituality in order to assist them with adverse psychological affects when experiencing chronic illness. Our study provides notable findings to support the importance of mental healthcare providers assessing a veteran's spirituality in order to provide best practice of support and healing. These findings are also in concurrence with Schimsa's (2018) study, which showed moral injury is expressed as having experienced a rupture in one's faith/spirituality.

MI, MD, and shame are not topics that are easily spoken of. The atrocities of war have carried on for centuries. It is highly probable that many veterans have died without the opportunity to safely share their deeply painful experiences and connect with those who can relate. This also supports that MI, MD, and shame may be associated with notable rates of suicidality. According to Jamieson, Usher, et al. (2020), "We could view MI as a natural reaction to an unnatural experience, questioning the validity of diagnosis and treatment approaches for MI" (p. 107). As clinicians, it is important to keep in mind how extreme and abnormal MI and MD experiences can be felt by veterans.

The veterans who volunteered to participate in this study are a unique population because they have had a considerable amount of treatment for their traumatic experiences in which the cultural dynamic of discussing MI and the depth of pain is considered an expected norm. The depth of human suffering cannot afford to be limited to typical measures of treatment, such as treatment for PTSD. According to Hostetler (2020), shame is elusive and difficult to measure. It must be addressed on a much deeper level in order to be consciously and effectively treated. Building genuine trust enables a culture to be created so the most unspeakable experiences can be safely and honorably shared.

Creating such a culture will provide an opportunity to discuss the travesties of military service. It will also lead to hope, forgiveness, and healing that can be explored and discussed within the safety of a shared presence by those who relate and understand.

Recommendations

The growing need for treatment of MI and MD is becoming increasingly recognized. New data are needed and sought in pursuit of deeper explorations for more in-depth information regarding the impact of MI, MD, and psychotherapeutic treatments. Numerous studies of MI and MD have been conducted in recent years, including four other MI studies associated with the Captain James A. Lovell Federal Health Care Center. There is a major increase in the recognition of MI and the need for more understanding in this important professional realm. According to Laubmeier et al. (2004), assessing for a patient's level of spirituality may be helpful in supporting them as they face the challenges of chronic illness and the adverse psychological effects of life-altering diagnoses.

It is recommended that more in-depth training be provided to mental healthcare practitioners regarding MI, MD, and spirituality. This will aid in the differentiation of PTSD and MI/MD. It will also enable them to take a more in-depth holistic approach to addressing veterans' needs that goes beyond typical treatment measures. Researchers can then deepen and create naturalistic clinical inquiry that can honor and address what becomes unspeakable. These recommendations are in agreement with those made by Schimsa (2018), Hostetler (2020), and Bair et al. (2021).

Limitations

Restrictions related to the COVID-19 pandemic led to a reduction in attendance on the part of volunteer veterans who met the criteria to participate, and the results are likely skewed because of these restrictions. However, we believe these restrictions did affect the responses in a positive manner. The use of a hybrid methodology and interviewing via technology enabled us to include veterans who were previously a part of this treatment and were located in various states across the country.

Implications

This study was a success in pioneering the phenomenological in-depth reporting of the impact of MI and MD on spirituality among veterans. There will be more research done and further analyses will be run with this study. These results will be increased in later analyses regarding the severity and type of MD and MI. Going forward, the scoring system could be deepened by using a more extensive Likert scale and more questions to explore more spiritual change, as well as using an expanded rating scale.

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Appendix A: Interview Questionnaire

Veteran # ____

1. Years in Tx for PTSD-Moral Injury: _____
2. Years Familiar with Moral Injury: _____
3. Branch of Military: _____
4. Years/Months served: _____
5. War: _____

Key Words:

1. Moral Distress Minor

Cognition ____ Affect ____ Guilt ___ Shame ____ Distortion ____

2. Moral Distress Major

Cognition ____ Affect ____ Guilt ___ Shame ____ Distortion ____

3. Moral Injury Minor

Cognition ____ Affect ____ Guilt ___ Shame ____ Distortion ____

4. Moral Injury Major

Cognition ____ Affect ____ Guilt ___ Shame ____ Distortion ____

5. Spiritual Impact

Cognition ____ Affect ____ Guilt ___ Shame ____ Distortion ____

Theme Identification:

1. Moral Distress Minor

2. Moral Distress Major

3. Moral Injury Minor

4. Moral Injury Major

5. Spiritual Impact

Moral Injury/Distress Study: Rating Scale

Psychotherapy Rating

1. Individual _____ 6. Expressive Therapy/Pos. Psychology____
2. Group Psychotherapy_____ 7. Grief/Loss Course

_____

3.Family Therapy _____ 8. Mindful Meditation

_____

4. Pastoral Counseling _____ 9. Prayer

_____

5.Psychiatrist _____ 10. Other

_____

REMARKS:

Appendix B: Moral Injury/Distress Study: Rating Scale

Level 0
No word(s), reflection, insight, judgement, or inference on topic.

Level 1
Minimal word(s), reflection, insight, judgement, or inference on topic.

Level 2
Moderate word(s), reflection, insight, judgement, or inference on topic.

Level 3
High level of word(s), reflection, insight, judgement, or inference on topic.