

Running head: Military Veteran's Therapy Experiences for Combat Trauma

Military Veteran's Therapy Experiences for Combat Trauma

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MILITARY VETERAN'S THERAPY EXPERIENCES FOR COMBAT TRAUMA

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DEDICATION

I would like to dedicate this work to **Jesus Christ** who is and always will be my Lord, King and Savior. John 3:16-17 "For God so loved the world that He gave his only begotten son that whosoever believes in Him shall not perish but have everlasting life." For God did not come into the world to condemn the world, but in order that the world might be saved through Him.

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ABSTRACT

Military veterans frequently return from combat with a diagnosis of Posttraumatic Stress Disorder (PTSD). The debilitating disorder is often caused by experiencing trauma caused by war related distressing events. There are various clinical treatment modalities offered to help PTSD injured veterans. Despite numerous options, however, many military personnel receive little or no clinical relief after attending counseling. Moral Injury (MI) is often the underlying culprit, yet due to a lack of clinical clarity and understanding about the MI paradigm, many therapists use a catchall diagnosis of PTSD when treating combat veterans. The term Moral Injury has its inception as a military term and will be discussed in depth through the entirety of this dissertation.

Moral Injury, at a glance, is the unremitting effects of witnessing or perpetrating acts that violate one's inner moral code. It typically causes demoralizing emotions and is associated with an increased risk of mental disorders and even suicidality. The extent of potentially morally injurious events (PMIEs) among United States combat veterans, and the issues associated with PMIEs in this population remains unidentified. In order to best facilitate help for our veteran community, it is vital to obtain accurate diagnoses and to understand the differentiations between PTSD and MI. Unfortunately, research indicates that clinicians struggle doing so as the two intersect and overlap in many areas. As such, many veteran's symptoms worsen, as the underlying reason for their emotional decline remains unaddressed. To effectively facilitate proper clinical care for this population, therapists need to thoroughly assess for not only PTSD, but for the MI construct as well.

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Research Questions

Research Questions this researcher will be exploring include:

RQ1: What is the lived experience of Combat Veterans who have been diagnosed with Post-Traumatic Stress Disorder, and report symptoms of Moral Injury, specifically regarding their therapy experiences?

RQ2: Does Religious Commitment influence MI in Combat Veterans?

Keywords: Anger, Guilt, Military Veterans, Moral Injury, Posttraumatic Stress Disorder, shame.

CHAPTER ONE: INTRODUCTION

Military soldiers in war zones face terrifying, life-threatening situations and these exposures may cause a returning soldier to experience significant mental health challenges (Anaki, Brezniak, & Shalom 2012). Post-Traumatic Stress disorder (PTSD) is one such malady (American Psychological Association (APA, 2013). The symptoms of PTSD according to DSM-5 Criteria (309.81) include exposure to a traumatic event followed by symptoms of reexperiencing the event, avoiding situations which remind the person of the trauma, and experiencing an inner state of hyperarousal. These symptoms may begin within three months of the traumatic event, but often have long lasting repercussions. The intensity and duration of PTSD fluctuates from person to person. Significant resources, both personal and governmental, are directed every year toward the treatment of PTSD for veterans (V.A., 2019). Despite available therapeutic treatments, many military personnel do not receive help and struggle with significant mental health issues following combat trauma. Many feel so hopeless that they become suicidal. In fact, suicide rates among combat veterans in 2017 were 1.5 times higher than the rate for the general public when adjusted for age and gender (VA, 2019).

The reasons that many veterans do not receive the clinical help they need remains unclear. Some research indicates that PTSD sufferers wait too long before actually seeking professional help, if they seek it at all (Sayer et al., 2009). Other researchers have postulated that PTSD is complicated by a concept called Moral Injury (MI), which is a particular type of trauma characterized by guilt, existential crisis, and loss of trust which often develops following a perceived moral violation (Jinkerson, 2016).

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Background

The purpose of this study is to explore the lived experience of veterans who have been diagnosed with PTSD, struggle with MI symptoms, and have reported having negative therapy experiences while attempting to seek treatment for PTSD. What many fail to comprehend is that combat exposure often causes significant mental health problems for military service personnel (Dekel & Monson 2010). PTSD causes veterans to re-experience war time events such as being shot at or watching friends die. This leaves them in a state of physiological hyper-arousal (Maloney, 1988). The suffering person tries to cope with the plaguing memories but often disconnects with the outer world, as even daily routines become too difficult to maneuver. Sufferers from PTSD may isolate from friends and family, which can cause them to lose the support of those who could have been available to provide support (Solomon, 1993).

Understanding PTSD

The American Psychiatric Association (APA) notes that people with PTSD commonly experience intrusive symptoms such as flashbacks, nightmares, severe anxiety, and hallucinations. Often the sufferer finds it difficult to control their thoughts, and reexperiencing the trauma causes intense distress for the sufferer. In an attempt to manage the pain, those with PTSD tend to avoid people, places, thoughts, or circumstances which trigger reminders of the disturbing memories. There is significant emotional dysregulation associated with re-experiencing the trauma. PTSD often invokes hyperarousal symptoms, causing the person to be easily startled, on edge or irritable as they seek to be 'prepared' for all threats (APA, 2013). Often, the person with PTSD loses interest in activities which once gave them pleasure (anhedonia). There may be memory challenges, concentration difficulties, disheartenment about the future, and feeling emotionally numb (APA, 2013). When combat veterans experience such

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symptoms, it often leads to depression and even suicide (Kimbreal, Myeer, DeBeer, Gulliver & Morissette, 2016).

Understanding Moral Injury

As difficult as PTSD is for a soldier to face, there is another war scar called Moral Injury which may be far more damaging (Pugh, Taylor, Berry, 2015; Shay, 2014).

Moral Injury is characterized by the following:

- (1). In unusually stressful circumstances, people may perpetrate, fail to prevent, or witness events that contradict deeply held moral beliefs and values (Normal & Maguen, 2000).
- (2). When a person does something that goes against his inner compass, it is referred to as an act of *commission* and when they fail to do something in line with their deeply held expectations, it is referred to an act of *omission*.
- (3). Moral Injury (MI) refers to the lasting guilt, emotional, psychological, social, behavioral, and spiritual impact of actions that violate a service member's core moral values and behavioral expectations (Litz et al., 2009).
- (4). Moral Injury first came into prominence in the research literature in 2009 with Litz et al., whose was to understand the impact that violating one's values had on military veterans (Litz et al., 2009).
- (5). A moral injury can occur in response to acting or witnessing behaviors which violate a person's inner moral values (Litz et al., 2009).
- (6) In order for moral injury to occur, the individual must feel like an offense occurred which perpetrated his own inner convictions (Normal & Maguen, 2020).
- (7) Typical reactions of MI are guilt (feeling distress and regret regarding the event (e.g., "I did something bad") and shame (when the belief about the troubling event generalizes to the

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person's core self (e.g., "I am bad because of what I did in combat"). Disgust may occur when the person remembers acts of perpetration, and anger may occur in response to a loss or feeling betrayed (Normal & Maguen, 2020).

(8). Another response to MI is an inability to forgive one's-self, which often causes the person to engage in self-sabotaging behaviors (e.g., feeling they don't deserve to succeed in relationships, they unintentionally sabotage it with negative behaviors (Normal & Maguen, 2020).

(9). Moral injury typically has an impact on an individual's religious life (Normal & Maguen, 2020).

MI and PTSD differentiation

A significant challenge for clinicians is differentiating between MI and PTSD, as the two overlap in many ways. For Moral Injury to occur, the individual must feel as though he crossed a line regarding his moral beliefs. Guilt and shame are the hallmarks of MI. PTSD may include guilt but not to the severity of MI. PTSD includes hyperarousal symptoms that are not central to moral injury (Norman & Maguen, 2020).

Situation to Self

Moral Injury has affected me as a wife of a retired military paratrooper/ combat veteran and also as a therapist. My husband had been diagnosed with Post-Traumatic Stress Disorder and received a plethora of treatments. However, none came close to helping him. Moral Injury better accounts for much of the emotional pain he endured as he witnessed atrocities during war such as witnessing friends who were killed in front of him. As a therapist, I have counseled numerous combat veterans, including Vietnam veterans who overwhelmingly reported that it was not PTSD that scarred them the most. Rather, it was MI and the psychological warfare of guilt caused from either perpetrating morally offensive acts or being witness to such horrors. The

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long-lasting mind torture caused by thoughts such as 'I should have done something to stop this' or 'I am a bad person because of what I did in combat' was often enough to cause suicidal ideation in my patients. My husband has lost many wonderful military friends from suicide. Not one happened because they were in a hyperarousal state (PTSD) from being shot at. The men had intense guilt which they could not face. Similarly, the participants in this study largely reported that MI was far more mentally painful to traverse than PTSD.

Statement of the Problem

The diagnosis most often associated with combat veterans is Post-Traumatic Stress Disorder, PTSD (Cohen, Gima & Bertenthal, 2010). The problem is that while PTSD helps to explain some level of the mental health challenges combat veterans face, it does not explain the emotional devastation and increased suicide risk associated with military service members.

Moral Injury may better account for veteran's emotional decline, even after receiving mental health counseling. Unfortunately, as a relatively new construct, anecdotal evidence suggests that MI may not be widely known or discussed in therapeutic realms (Kerr, 2017). The literature is sparse or nonexistent, which has caused other researchers to utilize a knowledge base from relevant empirical studies and clinical observations from active practice with service members and veterans (Klassen, Brennan, Held, 2021). Since most therapists do not understand MI and how it differentiates from PTSD, many veterans are not receiving effective clinical help (Battles et al., 2018).

Guilt, Shame & MI

Guilt and shame have been identified as contributory factors of MI as well as byproducts of MI. When guilt and shame are left untreated, chronic emotional pathology can arise prevents both physical and mental healing (Pugh, Taylor & Berry, 2015; Shay, 2014). Repressing guilt

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and shame may be the pressure cooker that can lead to a host of other disturbances such as somatic issues, distorted thoughts, fatigue, anger, and self-hatred (Vermetten & Jettley, 2018).

MI and Religious Influence

Although religion is often a source of comfort for some, it can also cause psychological stress for others. Moral Injury typically has an impact on an individual's spirituality in one way or another. Religious strain can be associated with fear and guilt. In particular, if a person believes they have committed an unpardonable sin it can lead to suicidal ideation (Exline, Yali & Sanderson, 2000). A soldier may have difficulty understanding how his relationship with God could be real after experiencing a traumatic war-time event (Norman & Maguen, 2020).

Guilty thoughts often maintain post-traumatic painful emotions, which can be just as damaging as physical pain caused by war injury. Despite a few preliminary reports in this area, however, a comprehensive understanding of MI and the ability to measure it is largely unavailable (Campbell, 2016; Currier, Holland & Malott, 2015; Nash et. al., 2013).

Military Personnel obtaining Clinical Treatment for MI

Existing research suggests that therapists are well acquainted with PTSD and screen adequately for it but are remiss in doing so for MI (Kerr, 2017). As such, military veterans may suffer from debilitating emotional pain. If we suspect a patient to be suffering from emotional trauma, it is our duty to provide appropriate care. For veterans, initiating treatment is often very difficult, as asking for help is frequently seen as a sign of weakness. Sadly, those who do reach out for therapy sessions often feel misunderstood, misdiagnosed and judged (Kerr, 2017).

To effectively treat military personnel, clinicians need to assess for not only for PTSD, but for MI as well. The therapist must recognize that the interplay between the two disorders may complicate assessment.

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Therapist's understanding of PTSD & MI differentiation and similarities

It is essential for counselors to know how to differentiate between PTSD and MI and to learn how to ask difficult questions that veterans with Moral Injury are reluctant to initiate or discuss. Healthcare professionals ought to be fully trained in conceptualizing the MI paradigm, especially regarding the excruciating and often long-lasting emotional pain which lingers on for many veterans (Kerr, 2017). It is quite difficult to receive help for MI as there is often a fear being judged and also due to the fact that feelings of guilt and shame are difficult to discuss (Kerr, 2017). In addition, therapists should be cognizant of the fact that MI does not typically present itself immediately. While some will experience symptoms days after an incident, for others, difficulties with MI will not surface for years (Norman & Maguen, 2020).

Purpose of the Study

The purpose of this case study was to explore the lived experiences of combat veterans who have been diagnosed with PTSD, who have experienced symptoms of Moral Injury, and who have reported not being helped through traditional American mental health practices. This is to shed light on the MI topic which research suggests is under-studied. In particular, the topic of focus will be the experiences which combat veterans have had while working with licensed mental health workers. It is important to determine if veterans feel that the clinicians who they worked with (a) asked appropriate questions indicating they understood MI conceptually (b) could create a clinically healthy atmosphere to allow veterans to feel comfortable enough to discuss MI in order to help facilitate healing.

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Significance of the Study

This study strives to illuminate the mental health challenges that combat veterans face following combat emotional trauma. It seeks to uncover whether military personnel feel understood, and validated, by their clinicians. It also aims to obtain the veteran's perceptions of their clinical experiences during therapy sessions. The findings of this study may be valuable tools for mental health practitioners who are treating patients with post combat emotional pain. It is this writer's hope that engaging with servicemen in this capacity will facilitate dialogue among mental health workers and shed light on the unique inner struggles of this population.

Definitions

For purposes of clarification, this writer will be defining terms pertinent to the study.

Post-Traumatic Stress Disorder (PTSD) is characterized by the persistence of intense reactions to reminders of a traumatic event, altered mood, a sense of imminent threat, disturbed sleep, and hypervigilance (Shalev, Liberzon. & Marmar., 2017).

Moral Injury- Within the context of military service, particularly regarding the experience of war, Moral Injury refers to the lasting emotional, psychological, social, behavioral, and spiritual impacts of actions that violate a service member's core moral values and behavioral expectations of self or others (Litz et al., 2009).

Religious Commitment – refers to how much an individual is engaged in his or her religion (Koenig et al., 2001).

Transgressive Acts- an act that goes past set limits or breaks a law (Litz et al., 2009).

CHAPTER TWO: LITERATURE REVIEW

Introduction

Post-Traumatic Stress Disorder (PTSD) tends to be dispensed by therapists as a “catch-all” diagnosis for post-combat maladaptive emotions exhibited in post combat veterans (Drescher et al., 2011). Unfortunately, PTSD does not adequately capture ‘all’ of the mental and emotional challenges that veterans face. Moral Injury (MI) is rarely talked about and often misunderstood by both clinicians and those who suffer from it despite the fact that it may be the actual root of many veteran’s inner emotional turmoil (Drescher et al., 2011).

There is currently a desperate need for military personnel to obtain comprehensive mental health services. However, there is evidence to suggest that therapists have not been well versed in conceptualizing MI and facilitating treatment, due to spotty, divergent and confusing current literature (Litz et al., 2009; Shay, 2014). Research fails to provide a consistent explanatory definition for MI and to clearly delineate what constitutes the transgressive acts that would contribute to moral wounding. In addition, there is no evidenced based, standardized clinical measure, offered to help therapists identify MI (Litz et al., 2009). In fact, MI is currently not even classified as a mental disorder (APA, 2013).

The following is a review of literature which helps to identify the challenges veterans face in trying to obtain mental health assistance for the perplexing concept known as Moral Injury. The review will include the origins of MI, factors contributing to MI, difficulties differentiating between PTSD and MI, deleterious consequences of PTSD and MI, religious impact on PTSD & MI, foundational measures for assessing MI, clinical steps toward treating MI, as well as barriers for treatment.

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Theoretical Orientation

This writer based her theoretical orientation on the assumption that Moral Injury should be differentiated from PTSD since PTSD is largely a fear-based model and MI is based on a faulty inner dialogue of guilt and shame (Lee, Scragg & Turner, 2001).

Related Literature

Researchers are largely in agreement that combat exposure may cause mental health disturbances. However, the most repeatedly studied effects of post war emotional pain continues to be PTSD, not MI. A cursory search on Google Scholar using key words "PTSD" and "Veterans," produced 1150 results. Conversely, searching for "Moral Injury" and "Veterans," only produced only 75 results. In addition to PTSD, there are other mental disorders which can be related to military trauma.

Mental Disorders related to military trauma

Acute Stress Disorder-Acute stress disorder is similar to PTSD in that the symptoms are the same and that it occurs in reaction to a traumatic event. The difference is that symptoms occur between three days and one month after the event. Approximately half the people with acute stress disorder will end up with PTSD.

Adjustment disorder- Adjustment disorder occurs in response to a stressful life event. The emotional and/or behavioral symptoms such as feeling tense, sad or hopeless; or acting in a defiant or impulsive manner are generally more severe than what would be reasonably expected. The symptoms cause significant distress or problems in important areas of functioning. Symptoms of adjustment disorders begin within three months of a stressful event and last no

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longer than six months after the stressor has ended. The stressor may be a single event (such as a divorce), or there may be more than one event with a cumulative effect. Stressors may be recurring or continuous (APA, 2020).

Major Depressive Disorder Approximately half of people with post-traumatic stress disorder (PTSD) also suffer from Major Depressive Disorder (MDD). The comorbidity reflects overlapping symptoms in the two disorders. The co-occurrence of PTSD and MDD represents a trauma-related phenotype, possibly a subtype of PTSD (Flory & Yehuda, 2015).

Military personnel are at risk of developing serious mental health difficulties and chronic substance use disorders as a result of military deployment (Brown et al., 2012). When veterans exhibit symptoms of post combat emotional dysregulation, most therapists will adhere to the PTSD, fear-based modality that has dominated for years (Vermetten & Jetley, 2018). This model is based on fear conditioning and anxiety-related symptoms which contribute toward pathology following combat trauma. The method for treatment is often consolation and distraction (Vermetten & Jetley, 2018).

The problem with this approach is that it fails to consider the moral dimensions of a veteran's psyche (Bryan et al., 2014). Numerous gaps exist in the ability for clinicians to understand the damaging effects of war on a soldier's mind. Though veteran's often face MI post combat, treatment modalities focus more on PTSD (Hoge et.al, 2014). Proper assessment of MI is still in its infancy (Vermetten & Jetly, 2018) despite the fact that MI is experienced frequently among veteran's and may explain why only 20-30% of those seeking help for PTSD achieve anything close to a reduction of symptoms utilizing current treatments (Koenig, 2015).

Origins of MI and factors contributing to MI

Regarding the origins, causes, and sources of MI, Frankfurt and Frazier (2016) indicated that the lived suffering of MI was conceptualized by Litz et al. (2009) as a constellation of PTSD symptoms (i.e., intrusive thoughts, avoiding, and numbing) and collateral effects (i.e., self-injury, demoralization, and self-handicapping). Self-injurious behaviors include substance abuse, risk-taking, and suicidality. "Demoralization" is an affective (expressed and observable emotion) and cognitive (thought) phenomenon that manifests as despair, worthlessness, and meaninglessness. This can also lead to self-handicapping (shunning positive experiences such as success) as well as denying oneself to freely feel positive emotions (Litz et al., 2009).

Though service members deployed to war are often at risk for MI, the potential sources causing MI are poorly understood. Some combat related examples include; using deadly force which causes harm or death to civilians (knowingly but without alternatives, or accidentally), giving combat orders that result in the injury or death of a fellow service member, failing to provide medical aid to an injured civilian, returning home from deployment and hearing of the executions of cooperating local nationals, failing to report knowledge of a sexual assault, following orders that were illegal, immoral, and/or against the Rules of Engagement, or a change in belief about the necessity or justification for war, during service (Brown et al., 2016; Stein et al., 2012). Often MI involves memories of killing, especially of non-combatants. For example, in a firefight a soldier may kill a young teenaged fighter who had threatened the lives of his fellow soldiers. Another may blow up an enemy structure, only to discover the dead "enemies" are primarily women and children (Copeland, 2013; Dombo et al., 2013; Williamson et al., 2018). Beristianos (2017) reported that people are susceptible to MI after witnessing someone

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being maimed or killed, doing something that accidentally leads to injury or death of another person, and/or purposely killing someone else

MI can arise when a combat veteran cannot reconcile what he has done or experienced in war with his inner ethical worldview. It manifests when there has been a betrayal of what he deems is "right." MI impairs the capacity for trust, increases despair and interpersonal violence, and may even lead to suicide (Dombo et al., 2013). Copeland (2013) mentioned that damning thoughts such as "I am a terrible person" can cause and maintain MI. Behavioral indicators of MI often include self-condemnation, self-harm, self-destructive behaviors such as drug or alcohol abuse, and self-sabotage both professionally and in relationships (Litz et al., 2009).

Dripchak (2007) stated that secrecy, guilt and shame are central to the intense internal conflicts that veterans endure. Keeping MI a secret may be attributed to rigid military training, which instructs personnel to exhibit strength at all times and avoid demonstrating signs of weakness. Conflicting values may arise between a veteran's high moral standards and the sanctions for killing during combat (Dripchak, 2007; Zerach & Levi-Belz, 2019).

In the psychiatric world, a post-traumatic event must encompass exposure to death or serious injury, directly experienced or witnessed. This harrowing experience is typically accompanied by intense emotional reactions, including fear, helplessness, and horror (APA, 2013). Moral injury involves guilt related to traumatic combat events. Data also indicates that personnel with strong anger, high levels of combat trauma exposure, or who had mental health problems were twice as likely to report having mistreated non-combatants, which can lead to MI. (Drescher & Foy, 2011)

MacLeish (2018) presents across era war information regarding MI; (a) those who kill in war are at greater risk for a number of mental health consequences and functional difficulties (b)

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Taking another's life was a significant predictor of post trauma, alcohol abuse, relationship difficulties and anger issues (c) Veterans who reported killing were twice as likely to report suicidal ideation as those who did not (d) Veterans who reported killing were twice as likely to report PTSD and depression diagnoses (e) Killing in war was said to be a significant risk indicator for MI.

Schorr et al., 2018 & Kelley et al., 2019 also stated that MI, not PTSD is frequently the underlying reason causing veterans demoralizing emotions (Sharpless & Barber, 2011). Shame, guilt and difficulty forgiving oneself for acts committed in war, are only a few of the debilitating symptoms of MI (Bryan et al., 2016).

Frankfurt and Frazier (2016) reported that qualitative research could be used to gather data on exactly what a transgressive act entails. The MI field could benefit from the debate regarding bracket creep (i.e., the expansion of events considered traumatic) that has occurred in the PTSD field (Rosen & Grunert, 2012) in terms of setting the threshold for what should be considered a transgressive act. The prevalence of exposure to a full range of transgressive acts among veterans from different eras, combat theaters, and branches of service and the relations between these transgressive acts and indicators of MI should be systematically assessed. This research can also be used to help define the boundaries of what should be considered a transgressive act (Frankfurt et al., 2017). While the authors explained that transgressive acts differ among military personnel, they do not sufficiently explain how to offer conceptual consideration regarding the normativity of MI (Frankfurt & Frazier, 2016, Fritts, 2013).

Differentiating MI and PTSD symptoms

Kelley et al., 2019; Nash & Litz, 2013 and Schorr et al., 2018, reported that combat veterans are at risk for MI and determined that a classification structure was needed to treat

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veterans who struggle with it. Schnurr et al., 2003, suggest that the missing protocol is providing a clinical distinction between PTSD and MI.

MacLeish (2018) stated that MI and PTSD appear similar. However, those who work closely with veterans are concerned by PTSD's inability to account for moral distress which often occurs post combat. MI theorists describe MI as a phenomenon that is actually more overwhelming to sufferers than PTSD (Antal, 2017). Sadly, MI is not classified as a mental disorder (APA, 2013).

Kelley et al., 2019, Litz et al., 2009, and Schorr et al., 2018 have all noted that the difference between MI and PTSD is where the veteran's perception lies regarding who is to blame for the traumas causing MI and PTSD. MI occurs when a soldier feels that he was personally responsible for the war trauma, whereas those who struggle with PTSD do not seem to blame themselves since they place the responsibility of what happened on someone or something else. Many therapists feel it necessary to provide an intact, well-defined treatment measure and protocol for MI, as it would benefit mental health professionals and those who work with suffering military personnel (Nieuwsma et al., 2015).

Literature states that it is difficult to separate and assess for MI because of the entangled indicators between MI and PTSD (Farnsworth et al., 2019). There should be broadened research and evidenced-based treatment modalities to offer to clinicians who are working with combat veterans (Farnsworth et al., 2019).

Clinicians who work with veterans have identified MI as an additional cluster of symptoms that are related to military deployment, but do not fit into the traditional criteria for PTSD (Holiday et al., 2018). Combat veterans who have suffered from symptoms of PTSD may also struggle with simultaneous MI indicators (Beristianos, 2017). The overlap of MI and PTSD

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features include alienation, anhedonia, avoidance, a need to self-medicate, nightmares, and numbing. MI features which typically differ from PTSD include grief, guilt, preoccupation, distress, regret, remorse, self-care neglect, self-condemnation, self-harm, self-regret, shame and sorrow.

PTSD features which differ from MI features include concentration difficulties, exaggerated startle response, fear, hypervigilance, intense psychological distress when exposed to cues resembling the traumatic event, irritability, outbursts of anger and reactivity (Litz et al., 2009).

MI has been speculated to result in some of the avoidance symptoms seen in PTSD such as emotional numbing, re-experiencing traumatic events and using avoidance as a coping strategy. The authors suggested that there is an association between war time killing and subsequent mental and behavioral issues leading to MI (Litz et al., 2009; Nash & Litz, 2013; Schorr et al., 2018). Antal (2017) discussed the post war symptoms which invoke intrusive memories, negative changes in thinking and mood, and deviations in physical and emotional reactions for veterans. Shame maintains the use of avoidant coping strategies which sustain PTSD symptoms.

Specifically, Worthington and Langberg (2012) investigated but were unable to answer how to successfully reduce guilt and change the beliefs categorized as MI. Since there is a lack of viable research in the area of standardized mental health care for MI, clinicians must learn how to ask painful and often intrusive questions, in order to free veterans from it (Worthington & Langberg, 2012).

Elbogen et al., 2014 indicated that though MI and PTSD each had unique specifications, both overlapped in features, causing difficulty for clinicians attempting to treat mental health

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difficulties in military personnel. In addition, Nash et al., (2013) indicated a connection between violated moral values and an accumulation of guilt, shame, anger and suicidality.

PTSD and MI can both be associated with depressed mood and night terrors (Farnsworth et al., 2014). Calhoun et al., 2018 investigated guilty thoughts associated with MI related traumatic events and its influence on the relationship between combat exposure and sleep difficulties in combat veterans. The connection between combat exposure with trauma-related sleep disturbance is significantly influenced by self-perceived transgressions related to the disturbing war occurrences (Calhoun et al., 2018). There are holes in this realm of the literature, as the authors do not explain or define what self-perceived transgressions encapsulate.

Deleterious consequences of PTSD & MI post combat

Though there is a sizable body of peer-reviewed data discussing the difficulties caused by PTSD, the literature for MI is lacking. The MI postulate has been presented to explain the devastating emotional influence on combat veterans. MI often leaves a toxic impact on a veteran's psyche. It also causes soldiers to question their worth (Reivich et al., 2011).

Transgressive acts can lead to the shame-based syndrome of MI, which often leaves veterans feeling demoralized (Nazarov et al., 2015). MI can leave military veterans with a vicious inner struggle which can destroy their sense of self and character (Drescher & Foy, 2008) and can lead to deleterious mental health issues (Nickerson et al., 2015).

There is a large body of peer-reviewed data discussing the psychiatric difficulties that PTSD often generates. The literature for MI, however, is *comparatively weak*. The Moral Injury postulate has been presented to explain the devastating influence on many combat veterans. Dr. Timothy Lindeberry (2012), a Mayo Clinic psychiatrist, reported that the effects on service members mental health are just beginning to be felt. Moreover, the potential effect of

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their war experiences may manifest indefinitely into the future in the form of emerging psychiatric illnesses" (Frankfurt, 2015).

Alcohol abuse, Violence and Suicide

There is research to suggest an increased rate of alcohol misuse among veterans who return from combat (Elbogen et al., 2014). When alcohol abuse and post combat trauma are combined, there is a significant increase in the rate of severe violence among veterans (Taft et al., 2007). In addition, in the past 10 years, there has been an alarmingly increased rate of suicide in the combat veteran population both nationally and worldwide. Self-reproach (Taft et al., 2007) and untreated trauma exposure (Elbogen et al., 2014; Litz et al., 2009) is reported as the cause of the increase in suicidal behavior among military personnel.

Night Terrors / Sleep disturbance

There is an association between MI and night terrors. However, exactly how guilt impacts nightmares is not readily understood by current research (Litz et al., 2009).

A case study investigated the methods in which guilty thoughts caused by traumatic events, influenced the relationship between combat exposure and sleep difficulties in traumatized combat veterans. Trauma-related sleep disturbance was significantly influenced by self-perceived transgressions related to disturbing war occurrences (Dedert, Dennis, Cunningham, Ulmer, Calhoun, Kimbrel, Hicks, Neal & Beckham, 2018). The authors do not explain or define what "self-perceived transgressions" encapsulate and are vague in explaining how guilt may be impacting a veteran's tendency toward night terrors, indicating a further gap in research.

MI can rob the lives of those who have it since it incapacitates people, preventing them from living full and healthy lives (Litz et al., 2009). The effects of MI do not merely affect the

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individual but can destroy a veteran's ability to trust others. This not only affects the veteran but also the family system and greater community (Connor, 2006).

The combination of both PTSD and MI may be associated with a greater risk for emotional difficulties (Elbogen et al., 2014).

Bryan & Leifker, et al., 2018, indicated that the interaction between PTSD and MI had a higher association with a drastic increase for suicidal thoughts (Bryan & Leifker, et al., 2018). Post combat trauma often involves Traumatic Brain Injury (TBI), depressive and anxiety disorders which further complicate MI and receiving proper clinical care (Bryan et al., 2013). Ultimately, if left untreated, MI may prevent sufferers from recovering (Frankfurt & Frazier, 2016).

Religious impact on PTSD & MI

There is a divergence in the literature regarding whether religiosity has an effect on MI, and what that effect may look like. Due to the fact that MI is a newer construct, there are relatively few peer-reviewed articles on the topic. Although MI is explained as an ethical struggle, which encompasses combat trauma, it is not well encapsulated within the Post-Traumatic Stress Disorder diagnosis (Bryan, et al., 2018). Belanger et al., 2018, indicated that when a veteran has a strong sense of religiosity, the moral standard can be more easily triggered than if they were not spiritual. Conversely, Koenig (2015) indicated that spiritual factors have been shown to impact veteran's depressive symptoms over time by increasing the speed of remission by 50-70%. Spiritual involvement for some, has been shown to differentiate resilient from non-resilient veterans by improving emotional stability, serving as a protective factor, and increasing social connections (Koenig, 2015).

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Koenig (2015) stated that spiritual struggles are common in Veterans with Post-Traumatic Stress Disorder. Symptoms of PTSD have been significantly and positively associated with alienation from God, religious splits, religious trepidation, and guilt associated with religiosity. In contrast, Post-Traumatic Growth (PTG) in veterans is drastically and positively associated with spiritual practices. Koenig (2015) also identified that spiritual factors were the second strongest predictor of overall PTG, stronger than any other psychological or social measure. Koenig (2015) indicated that 532 veterans endorsed spiritual resources had improved outcomes during an inpatient PTSD treatment program. In contrast, those with spiritual conflicts were associated with worsening PTSD outcomes.

Currier, Holland, Drescher, et al. (2015) also assessed the relationship between Religious Involvement (RI) and MI symptoms, as well as the effects of PTSD in combat veterans. MI was reported 90% by soldiers in the study. Feelings of shame, grief, meaninglessness, and remorse were experienced (Koenig et al., 2018).

Studies have been conducted discussing the associations between spirituality and the severity of PTSD symptoms among combat veterans. Results denoted that baseline spirituality factors (spiritual regular practices, ability to forgive, etc.) often predicted the intensity of PTSD symptoms. Those with high spirituality at the start of the program had lower PTSD symptoms when the program ended (Yeterian et al., 2017). Another study indicates that a healthy spiritual life may facilitate successful clinical treatment (Piderman et al., 2014). More research is needed as there are very few studies regarding MI and religious commitment. Drescher et al., 2011, reported that war intensely affects the moral and spiritual aspects of veterans. The study described MI as a disturbance in an individual's sense of personal goodness and capability to behave in a rational manner. The authors studied a group of diverse religious professionals who

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had worked for many years with combat veterans. Following the study, researchers indicated strong support for creating a distinct conceptualization for MI from that of PTSD. Research discussing links between combat and changes in spirituality is clearly lacking at the present time (Drescher et al., 2011).

Current clinical practices and challenges for treating combat veterans

For years, well-meaning clinicians working with those with post combat, have focused most of their attention on the impact of life-threatening events which caused trauma. As mentioned previously, the clinical concept addressing PTSD has focused solely on fear and anxiety (Litz et al., 2009). Research suggests that clinicians should also focus on the impact of events which have had moral repercussions for veterans (Litz et al., 2009) as qualifying factors that cause or worsen the disorder (Vermetten & Jetly, 2018). MI may be the true underlying reason that military veterans are not obtaining help, despite attending therapy (Snyder, 2014). This and many other factors pose as clinical challenges in obtaining help for combat veterans.

Steenkamp et al., 2011, indicated that the MI assessment tools currently utilized are not standardized and reliable. Due to a scarcity of literature, and a lack of MI standardized measures for clinicians to utilize, veteran's may not be obtaining sound, effective clinical treatment (Harwood et al., 2019). There is also a scarcity of research and insufficient statistical and standardized information regarding what constitutes transgressive acts which lead to the development of MI (Dokoupil, 2012).

In order to understand the effects that MI has on veterans, MI should be recognized as a distinct entity as it is a danger in not differentiating the overlapping features of MI and PTSD (Holiday, 2018). Litz et al., 2009 also discussed the importance of assessing MI and PTSD as separate manifestations of war trauma in order to provide proper clinical assistance to veterans.

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Because MI is not addressed in evidenced based treatments, more research is needed to help bridge this gap (Schumacher, 2017).

Current Foundational Measures for Assessing MI

Due to the scarcity of research, Litz et al. (2009) developed rudimentary assessment measures; the MI Events Scale (Nash & Litz, 2013; Cash et al., 2018) and the MI Questionnaire. Both measures facilitate a rudimentary foundation toward comprehensive treatment for soldiers. Another assessment is the 45-item MI Symptom Scale-Military Version (MISS-M), Koenig et al., 2018. This is reported as a helpful foundational tool in which to measure MI in veterans who have been diagnosed with PTSD. The scale measures 10 subscales including shame, betrayal, guilt, moral issues, meaninglessness, difficulty with forgiveness, trust issues, self-condemnation, spiritual difficulties, and hopelessness (Koenig et al., 2018). Though both are helpful beginning steps toward facilitating healing for veterans, in no way are they comprehensive.

Clinical steps toward effectively treating MI

In order to understand which clinical tools would help veterans, the research must engage with military heroes. Encouraging dialogue will help determine what veterans feel would be helpful because the current comprehensive, clinical understanding for defining, assessing, and treating MI, is lacking (Koenig et al., 2018). Current testing interventions are still in their inception stages so it would benefit veterans to share their stories regarding what *they* feel constitutes MI and use this to formulate standardized measures (Litz et al., 2009).

There is insufficient research to indicate whether clinicians are assessing for damage caused by MI. This could explain why approximately one-third to one-half of all veterans do not demonstrate symptom improvement after engaging in trauma-focused therapies such as

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prolonged exposure and cognitive processing therapy. Specifically, addressing factors such as guilt, shame, and anger and not only PTSD repercussions (Schnurr, et al., 2003). Guilt is commonly reported post-combat and may prove to promote development and/or maintenance of MI (Worthington Jr & Langberg, 2012). Self-reproach can prevent successful integration of traumatic events with prior beliefs. Clinicians are frequently negligent in discussing MI with military veterans (Dokoupil, 2012).

Faucher and Lucci (2010) proposed MI treatment goals to utilize with those who are suffering with it. They include; to reduce shame and guilt from *intense* to *mild* remorse, to correct faulty thoughts, to return to a state where the veteran is able to see the good in himself and the world, to increase connection with others, to foster preparation and education, to apply modified exposure, to increase examination and integration, to improve dialogue with a moral authority, to promote reparation and forgiveness, to foster reconnection with loved ones and friends (connection includes the veteran feeling unconditional acceptance) and to plan for the long haul (Krouse et al., 2009).

Current therapies often involve sustained engagement in the painful aspects of the traumatic experience and its aftermath. Discussion with a moral authority is sought out to alter the meaning of the transgressive act and to create a curative experience for the veteran suffering with MI. This includes a conversation with a therapist or trusted friend who is invested in the veteran's healing (Litz et al., 2009). It is important for a therapist to learn how to scrutinize a patient's faulty perceptions by asking what the event means to the veteran. This includes how the soldiers view themselves. Unhealthy thoughts such as "I deserve to die" are aptly corrected. The goal is a perceptual change (Parrish, 2008). Changing a patient's inner dialogue in order to forgive oneself is another tool which can be utilized. Promoting connection includes generalizing

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learned therapy tools with loved ones and planning for the future. It offers a tangible plan for taking steps forward and closing the chapter on agonizing combat events (Elbogen et al., 2014).

McLay et al., 2011 stated that a helpful technique for veterans with MI includes asking difficult questions that are not routinely examined during therapy. The author encourages therapists to initiate uncomfortable questions regarding MI and to ask the veteran to candidly express painful combat memories, which maintain MI.

Another strategy some returning soldiers have found helpful is working with a therapist to accurately apportion some of the negative actions committed in war. For example, McLay et al., 2011 suggested that one could assign a percentage of the charges to the enemy who trained a child to fight in a war, and a portion to the commanders who have been involved in the overall battle. This allows the emotionally wounded soldier to feel not entirely responsible. McLay et al., 2011 mentions a customary healing tool in which a therapist asks veterans to write down their horrifying memory. All such veterans, in a ceremony of forgiveness and healing, simultaneously burn the papers in a fire (McLay et al., 2011). Research is lacking in this area, as such there are gaps in the literature.

Schorr (2018) indicated that clinicians did not discuss Morally Injurious events which involved the perpetration of another person. The authors encouraged providers to thoroughly question Potentially Morally Injurious Events (PMIE's) in a nonjudgmental and compassionate way (Schorr et al., 2018). Clinicians are cautioned to prepare for the veteran's impending emotions of guilt, shame, and anger (Paul et al., 2014).

Barriers to Treatment

A barrier for veterans trying to obtain treatment for MI, is often fear of disclosure. Many veterans are terrified of divulging the truth and being treated with disgust and disdain.

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A powerful healing tool for veterans is the use of empathic, non-judgmental, active listening. Veterans often hold onto the notion that they are evil people and are frightened of admitting it to themselves or others (McLay et al., 2011). Those with MI can view themselves as deprived, irredeemable, and un-repairable. They may struggle with faith issues, and have difficulty living in what they view is a wicked and immoral world. These perceptions may interfere with treatment unless attended to (Koenig, 2015). Preparation and education are suggested to ease their fears and to help them feel comfortable collaborating with their therapists (Litz et al., 2009). It also necessitates accepting and obtaining responsibility for their role in moving toward wellness.

Dokoupil (2012) identifies recent research which has investigated the influence of moral trauma which may indicate extended psychological wounds. Though there are treatment modalities, which may lower PTSD symptoms, they are often minimally helpful, at best for MI. Research is needed to broaden the understanding of what MI means to a countless number of military servicemen and veterans (Cloitre et al., 2011).

Literature Limitations

Limitations of the literature included varying definitions of morally injurious events, the lack of a clear definition and outcome measure for MI, inadequate studies of MI, which are limited due to insignificant sample sizes and ambiguous mechanisms of therapeutic effect (Griffin et al., 2019). There are significant gaps in research focused on the association between moral challenges caused in the line of duty and PTSD, shame, guilt, and suicidality (Vermetten & Jetly, 2018). Koenig et al., 2018 explained that despite the frequent presence of MI in those with combat-related PTSD, it is often ignored in current psychotherapeutic treatments and remains under-researched. Treatments for MI in some settings for PTSD are being developed and

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research conducted to assess these treatments. Few mental health workers, however, are aware of these treatments. They are also not familiar with the measures used to identify those with MI, despite the millions of military personnel who seek treatment for PTSD and associated psychiatric co-morbid disorders which may be driven by MI symptoms that had not been addressed in the first place (Koenig et al., 2018).

Conclusion

Since clinical research for MI remains in its inception stage, the pursual of a well-established MI treatment protocol is needed. It would benefit researchers to engage in continued discussions regarding unraveling the complexities of MI. We must ensure that effective help is available for those who face MI and the mental health difficulties that result from it. It would likely benefit combat veterans, as well as mental health workers, to conduct numerous MI clinical studies in the future. MI as a research construct has only recently been introduced into the combat trauma literature, as such, it is only in its infancy stages of construct validation (Drescher et al., 2011).

CHAPTER THREE: METHODS

This chapter includes an overview of the methods used for this research design. The purpose of this study was to explore the lived experiences of military veterans who have been diagnosed with PTSD, scored high on a measure of MI, and expressed dissatisfaction with their experiences in therapy.

Research Design

The design method used in this study is a phenomenological approach. This form of qualitative research focuses on the study of an individual's lived experiences within the world based on membership in a particular group (Neubauer, Witkop, & Varpio, 2019). By design, this study is qualitative which refers to research that produces descriptive data, written or spoken words and observable behavior (Taylor, Bogdan & DeVault, 2015). The goal of a phenomenological study is to obtain a conclusive description of the particular phenomenon (Creswell, 2013).

Recruitment

To begin the data collection, a survey was initially constructed and distributed to combat veterans who met inclusion criteria. The survey questions were developed to elicit information regarding demographics, questions that categorize veteran's thoughts regarding therapy, and the degree to which each rated the emotional healing received from therapy. The questions were specific to combat veterans' difficulties with PTSD/MI symptoms post military deployment(s) and were used to determine whether or not participants met inclusion criteria. This included 2 assessments: The Religious Commitment Inventory and Moral Injury Symptom Scale- Military Version.

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Setting

Students at a private Christian university, who were military veterans, were chosen as the population for this study. This university prides itself on being open to military members and has a relatively large number of veterans enrolled. Being a Christian institution, it was logical to suppose that a large number of students will also hold Christian values. Thus, it was hoped that using the students at this university might more easily provide a population of persons who also expressed a high level of Religious Commitment.

All interviews were conducted online using the conferencing software Zoom. The purpose of this collection method was two- fold. First, the collection of data using online interviews allowed for participation from participants from a wider geographical area. Second, due to restrictions surrounding COVID-19, face to face interviews were restricted.

Participants

To participate in this study, individuals needed to affirm that they were United States military veterans with at least one active- duty tour. Participants were recruited in two steps. First, the military affairs department of the participating university sent an email to all veterans inviting them to participate in a potentially two- step process. In the first step, a convenience sample of self-identified military veterans completed a survey that assessed inclusion criteria for the second part of the study. Participants who met inclusion criteria were invited to participate in the qualitative data collection. The inclusion criteria included males between the ages of 18 and 64 who have served in the United States Military in active combat situations for a minimum of 1 tour. Participants have been diagnosed with Post-Traumatic Stress Disorder (PTSD) as a

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result of their military involvement, attended therapy due to PTSD and had experienced unfavorable results. This researcher focused on males in the study since overall men typically have a more difficult time discussing emotional pain and thus may be more susceptible to Moral Injury. Participants have demonstrated that they have Moral Injury as evidenced by a score of 315 (following the completion of the Moral Injury Symptom Scale- Military Version, which is included in the initial screening demographic survey). Participants have demonstrated that they have religious commitment. This is evidenced by their cutoff score of 40 (following the completion of the Religious Commitment Inventory which is included in the initial screening demographic survey).

Procedures

Permission to conduct this study was provided by the Institutional Review Board. Potential participants were initially contacted through the school's military affairs department. This letter (see Appendix A) included a brief explanation of the study, an invitation to participate in the study, and an electronic link that connected participants to an electronic version of the survey (see Appendix B). Participants who met inclusion criteria and who volunteered to be interviewed were contacted. In part 1 of the study, participants completed the survey via online with ESurv.com. After inclusion and exclusion criteria were met, the remaining participants volunteered to be interviewed (part 2 of the study) via teleconference on ZOOM online platform.

Data Collection

The main task for the interviewer is to maintain mindfulness of the accumulating descriptive criterion through the entirety of the study. This involved making continuous

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deliberate modifications between the subject-subject relation and the subject-phenomenon relation while remaining within an overall single mode of awareness (Giorgi, 2009).

All data that are collected initially are included under the primary data collection method.

Three approaches are comprised under the primary data collection method such as observation method, in-depth interview and survey through questionnaire (Scruggs and Mastropieri, 2006).

This writer designed a survey (Appendix A) to obtain information from military combat veterans. Five hundred military personnel were invited to participate in the online survey via an invitation sent by Liberty University Military Affairs Office. Once Liberty University sent the recruitment email, 74 total people responded.

The areas that the survey inquired about were the veterans' demographics. Gender needed to be male and age group was between 18 and 64 to qualify. Other questions investigated whether the veteran had been engaged in combat for a minimum of 1 tour, diagnosed with PTSD, and attended therapy with poor results. Of the 74 who responded, only 18 met criteria for survey questionnaire, RCI-10 and MISS-IV scales. From the 18, not everyone answered emails and/or phone calls. Ultimately, 7 remained who met criteria and were willing and able to participate in the interviews. In Stage 2, the interview design and protocol (see below) was administered to the final 7 veteran respondents who were chosen to participate based on the preliminary delimitations set for the study. The interview questions supported the purpose of the study and were intended to expand upon the questions asked during the online survey. Finally, a follow up phone call was implemented in order to thank veterans who had been interviewed and to follow up on them after the interviews .

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The Role of the Researcher

As a clinician who counsels veterans suffering from PTSD and MI, and also as the spouse of a military veteran who suffers with such challenges, it was important for me to acknowledge the biases with which I entered this study. Conducting a qualitative study can prove to be problematic to the researcher if precautions are not taken. In order to properly address these challenges, this researcher studied and followed the interview protocol. This included reviewing courses taken at Liberty University such as Research Methods, which explained how to effectively conduct and analyze compiled data while interviewing, as well as being in frequent contact with my chairperson Dr. Bird.

Instruments

To support the research questions and to aid in identification of appropriate participants for the qualitative portion of the study, three instruments were utilized with participants: a demographic survey created by this researcher for this study, the Religious Commitment Inventory – 10 (RCI-10), and the Moral Injury Questionnaire—Military version (MISS-MV).

The RCI-10 measures the extent to which a person adheres to his religious beliefs, values and practices and uses them in everyday life (Worthington et al., 2003). It has been used in numerous studies and has a high level of validity and reliability (Worthington et al., 2003). The RCI-10 is a 10 item self-report measure and asks questions such as “I enjoy working in the activities of my religious organization” (Worthington et al., 2003). The RCI-10 uses a Likert rating scale from 1 – (‘Not at all true of me’) to 5 (‘Totally true of me’).

The MISS-MV (Koenig et al, 2018) is a multi-dimensional measurement tool targeting moral injury symptoms in Veterans and Active- Duty Military diagnosed with PTSD. It consists

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of 45 questions and 10 subscales which assess guilt, shame, moral issues, religious difficulties, loss of religious faith and hope, loss of meaning and purpose, difficulty forgiving, loss of trust and self-condemnation. Statements making up each subscale are rated from 1-10 from agreement (or truth of the statement) to disagreement (falsehood of the statement), (Koenig et al., 2018). An example is “I am troubled by having acted in ways that violated my own morals or values” (Koenig et al., 2018).

Interviews

Seven participants agreed to continue with the second part of the data collection and participated in a semi-structured interview. A semi-structured interview is used as a qualitative data collection tool in which the researcher asks participants a series of predetermined but open-ended questions. They are helpful because they are “used widely in qualitative research to understand the reasons why people act in particular ways, by exploring participants’ perceptions, experiences and attitudes” (Jordan & Long, 2001, p.219).

“Qualitative research begins with questions, and it’s ultimate purpose is learning” (Bloomberg et.al, 2012). The questions for this study’s interviews focused on those diagnosed with PTSD who reported little or no improvement after attending therapy. The questions investigated the war experiences that resulted in Post-combat emotional trauma. In addition, they sought to determine if the actual reason participants had not experienced clinical help was due to Moral Injury, and not PTSD. The following are the Interview questions utilized for this study:

1. What were your combat experiences like?
2. Could you discuss anything that happened in combat that caused you to feel proud?
3. Could you discuss anything that happened in combat that caused you to feel guilt or remorse ?

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4. What feelings do you have now when you think of your combat experiences?
5. If you could change anything about the events from combat, what would you do differently?
6. How have the events from combat changed your relationships?
7. Please discuss your experiences with your therapist.
8. If your therapist said or did anything to make you feel validated, could you discuss it?
9. If your therapist said or did anything to make you feel invalidated, could you discuss it?
10. If you felt understood by your therapist, could you explain what he or she did to make you feel this way?
11. If you felt misunderstood by your therapist, could you explain why?
12. If your therapist helped you to relieve any residual guilt from combat, could you explain what he or she did or said to make you feel this way?
13. After meeting with your therapist, were you able to lessen the time you spent thinking about the distressing events from combat?
14. Please talk to me about what was helpful and what was unhelpful about your experiences with your therapist.
15. Did your therapist directly ask you if you had killed or maimed anyone in combat?
16. Did you ever discuss something difficult during therapy and your therapist made you feel embarrassed or ashamed?
17. Did your therapist ask you if you felt guilty after coming home from combat because one or more of your fellow soldiers had gotten killed and you lived?
18. Did your therapist ask if you had experienced shame or embarrassment regarding something that you had done in combat?

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19. Did your therapist ask you if you felt embarrassment, shame or guilt about something that you *didn't do* during combat that you wish you would have?
20. Did your therapist asked you if you blamed yourself from events from war?
21. Were you afraid to share the truth with your therapist, for fear that something you witnessed would get you or someone else in trouble?
22. Were you afraid to share with your therapist, for fear that something you participated in would get you or someone else in trouble?
23. Were you afraid to share with your therapist for fear of being judged?
24. Did your therapist attempt to audio or videotape you ?
25. Have you ever attended group therapy and not spoken up for fear of being recorded?

The first group of questions were intended to discuss the difficulties which may have created Moral Injury caused by wartime events. The second half of the questions were intended to inquire about the veteran's experiences with his therapist and how each felt about those particular encounters.

Data Analysis

The initial step in analyzing the data was to screen the online survey respondents to determine those who met the restrictions set for the study. They included males aged 18-64, who had engaged in active-duty combat for a minimum of one year, diagnosed with PTSD and reported that therapy did not alleviate their mental health difficulties. In addition, the participants could have no significant cognitive impairment such as schizophrenia or Bipolar. They reported having no suicidal thoughts in the past year. Participants had no current alcohol or drug problems. In addition, the participants' accessibility, participation interest, and communicative abilities were considerations in the interview selection process. Once the survey data was

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analyzed, interviews were scheduled and completed using an online conferencing application. The interview recordings were transcribed, ideas regarding themes that encapsulated the guided research questions were reviewed and analyzed. The interview transcripts were scrutinized to identify developing patterns and themes. Since interviewing the participants, this researcher cross-analyzed the transcript data to ensure accuracy. This researcher kept detailed notes for every segment of the study and had many discussed with my chairperson Dr. William Bird. Also, this researcher conducted member-checking to ensure that the systematic collection of all data from participants were accurate from each veteran's perspective. Survey responses were analyzed for patterns consistent with the purpose of the study. The following refers to characteristics needed for a distinguished case study.

Characteristics for a distinguished case study

Trustworthiness refers to the degree of confidence in data, interpretation, and methods used to ensure the quality of a study (Pilot & Beck, 2014). Researchers must establish the necessary procedures for a study to be considered worthy of consideration by readers (Amankwaa, 2016). These criteria include credibility, dependability, confirmability, and transferability and authenticity (Guba & Lincoln, 1985, 1994).

Credibility -Credibility is the confidence in the truth of the study and therefore the findings, is the most important criterion (Polit & Beck, 2014). Techniques this researchers used to establish credibility included member-checking, and reflective journaling.

Dependability- Dependability refers to the stability of the data over time and over the conditions of the study (Polit & Beck, 2014). It is similar to reliability in quantitative research, but with the understanding that stability of conditions depends on the nature of the study. A process log

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(researcher notes of all activities that happened during the study and decisions made about aspects of the study) was utilized.

Confirmability- Confirmability ensures that the findings are consistent and could be repeated (Polit & Beck, 2014). Methods include maintenance of an audit trail of analysis.

Transferability The nature of transferability, the extent to which findings are useful to persons in other settings, is different from other aspects of research in that readers actually determine how applicable the findings are to their situations (Polit & Beck, 2014). Qualitative research involves recording the participant experience and insights, and as such, only the participants themselves can evaluate the credibility of the research.

Validity in qualitative research depends on the capability and determination of the researcher, as the researcher is the instrument (Golafshani, 2003). Qualitative research involves dependability rather than reliability. Dependability is the explanation of changes which occur during the progression of research. It is an understanding of how such changes may affect the research and/or the study. Each qualitative research design is unique, but the investigator must still implement means such as documenting the procedures for rechecking data, uncovering negative occurrences that contradict previous observations, and sometimes even playing devil's advocate to ensure conformability (Golafshani, 2003).

Investigator Biases

Qualitative research is a type of scientific investigation that aims to provide answers to a question without bias. Bias is generally understood to be any influence that provides a distortion in the results of a study. Biases occur naturally in the design of one's research, but one can minimize their impact by recognizing and dealing with them. Finch (2017) suggested the

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following in order to reduce/omit bias; (a) Create an impartial qualitative research project which respects the dignity of the research participants, observes fundamental principles of ethics and takes all of the variables into account (b) Ensure that the participants are independent and treated with respect, so they are protected from exploitation. This ensures that people are not selected based on a desire to prove a specific research objective (c) Avoid focusing exclusively on one viewpoint when observing participants as this jeopardizes the impartiality of the research (d) Allow research participants enough time to complete questionnaires as procedural bias can occur if too much pressure is placed on a participant (e) Be aware of errors in data collection and measuring processes. Researchers often deal with measurement bias by using numerous interviews and anonymous questionnaires. They recognize that people will tell the interviewer what they think he wants to hear instead of the truth (f) Review all the variables arising from the experiment to ensure that there are no experimental errors (g) Ensure that the results of the research are accurately recorded in literature to avoid reporting bias.

During this process, this researcher made every effort to recognize internal biases and to record all data in a careful and methodical manner,

Ethical Considerations

This study was approved by the Liberty University Institutional Review Board. At the onset of the initial survey, participants were asked to indicate whether or not they gave permission to engage in the study (Appendix L2). Veterans who did not consent to participate were immediately prompted to exit the survey. Respondents who were willing to participate provided their contact information prior to engaging in the initial survey. Permission for the study was attained by all participants and all risks were explained. This writer also divulged that

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all names would be changed for confidentiality purposes, and that participants would be able to read and approve of the final draft of writing before it would be submitted for publication purposes. In addition to the consent form which included limits of confidentiality, the participants also signed a consent for inclusion in the PTSD/MI study. This form described the expectations of the participants and researcher in the PTSD/MI study treatment, as well as a thorough explanation of all questionnaires and surveys which were used. After reviewing the surveys, and assessing for inclusion criteria, a discussion of how participants' information would be safeguarded was included. This entailed changing all names and utilizing a password protected computer to store all information received. The Suicide hotline and Veteran's Administration telephone numbers were also included for all participants.

Summary of Chapter

The purpose of this study is to explore the lived experience of male veterans who served in the U.S. military for at least one tour of duty, suffered from PTSD, reported a MI, and indicated negative results with therapy. Data was collected using a semi-structured interview process in a phenomenological study.

CHAPTER FOUR: FINDINGS

The analysis of qualitative data is said to be the most challenging aspect of the use of these methods. The temptation in qualitative work is to simply generate impressions based on an initial review of notes and quickly move to written summaries that blur the distinction between the raw data and the interpretation of the data. Findings must be carefully presented separate from conclusions (Finch, 2017). In qualitative work one must differentiate between observations and interpretations of those observations. An unprejudiced qualitative research project respects the dignity of research participants, observes essential ethical principles, and takes all variables into account (Finch, 2017).

Findings

In this study, seventy-four veterans agreed to complete the survey. Of the 74, 18 men were identified as meeting the inclusion criteria for the first part of the study. Specifically, these 18 indicated that they were male, had served in active duty, had been diagnosed with PTSD, and had sought treatment for this disorder. Of these 18 people, 7 were able and willing to participate in the second part of the research study. These seven men were invited to be interviewed. These men reported that they were relatively committed to religious activity, with a mean score 3.9 on the Religious Commitment Inventory scale (maximum 5) with a standard deviation of 0.87. The perceived value of treatment was measured using a single item 10-point scale. Where 1 indicated low value of therapy and 5 indicated a high value. The participants who met criteria for part one of the study had a mean treatment rating of $m=1.8$ which was lower than the

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participants who did not meet full criteria and hence were not eligible to complete the rest of the study ($M=2.7$, $s=1.5$, $p=0.015$). The Moral Injury scale had a mean score of 274.9 out of a maximum score of 450, with a standard deviation of 69.9 and a relatively high level of Moral Injury ($M=274.9$, $s=69.9$) with a maximum score of 450. Though there are few articles which discuss what accounts for higher-than-average scores on the MISS-MV, a sample score was on Koenig et al, 2018 study indicated higher than average scores were between 208-212.

Unfortunately, there were not enough respondents in this researcher's study who met criteria to allow for appropriate statistical analysis. This may have been due to the Covid-19 pandemic which had just emerged during the beginning of this study. The population chosen likely had a higher degree of Religious Commitment due to the fact that the participants were recruited from Liberty University which is a Christian College. There were not enough participants to determine whether there was a correlation between religious commitment and Moral Injury. The people who met criteria had an average rating on the therapy scale of 1.8. This was a low rating and indicated that they did not feel that they were helped during therapy sessions. The following are the participants who met criteria.

Interviews with Combat Veterans

Clarke

"Clarke" is 50 years old and currently employed by the department of the Navy. He was deployed to Desert Storm. This veteran is married with 3 children. He was a pastor of a church for almost 10 years but due to emotional difficulties experienced after returning home from deployment, he coped by self-medicating with marijuana and alcohol. He eventually stepped down from his leadership position as pastor.

Clarke uses self-disparaging language toward himself. Regarding his "self-medication"

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he calls himself a hypocrite. He felt that God could no longer trust him. Clarke reported that his behavior post combat was noticeably different to his family and friends. He suffered with “awful feelings” but wasn’t diagnosed with PTSD for almost 15 years post combat. He stated that the “worst of everything was not feeling understood.” He attended therapy for many years because he didn’t feel “normal.” He said he knew there was something wrong, that he wasn’t the same person he was before going overseas. He also stated that after so many years he still doesn’t feel normal. He has “bad thoughts” that frequently run through his head, and although he has learned not to act upon them, they never go away.

Nick

“*Nick*” is 52 and stated that his military combat experiences were “horrific.” “There is no way to describe to a person who has not been there what the veterans have to see and endure. There is no stopping it once it starts playing out.” He said he couldn’t cope with the nightmares and the flashbacks even after engaging in “all these different therapies, because none of them worked.” He said the only therapy that was “decent” was group therapy. The 13 medications they prescribed him did not help and left him like “a zombie” feeling exhausted all the time. Nick discussed his guilt for what he had done overseas and stated “we really didn’t have much of a choice. People in the civilian world just believe everything they see on t.v. They feel bad for these people.” “They are not nice people” (referring to the government). Nick reported that “even the kids shoot at you.” He reported having guilt due to “all the kills” and stated that “you can’t control who dies.”

Adam

“*Adam*” is in his fifties and served as an “army grunt” in the Persian Gulf, Iraq and

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Kuwait. He has been married and divorced several times. He describes combat as “hours of boredom and moments of terror.” During the interview, he discussed guilt and remorse. “In the Kuwait clearing areas there were babies laid out on the ground, piles of them.” He said that this was a memory he could not erase despite attending therapy. When discussing how he feels currently about his combat experiences, he said that the only place he feels normal is with other veterans. He feels “pretty normal after being with the group guys” but said it was isolating “being with most civilians who don’t get it.”

Micah

“Micah” described combat as “harsh, scary, loud and fast” and felt that there was not a lot he was proud of. He felt “intense guilt and remorse” about returning home from combat when others did not. Referring to feelings regarding combat, he stated he was glad he was no longer there. He reported that the events overseas “ruined” his relationships. He has divorced twice. When discussing his therapists, he felt that there were “some good and some bad” but despite some positive aspects of therapy, he remains unable to let go of the pain from overseas. He reported that one therapist asked him how he was impacted by his war time experiences, and he didn’t want to talk. The clinician persisted and “wanted to hear the details” which Micah was not ready to share. After this encounter, Micah was left feeling that his therapist was “sadistic.” He felt that the therapist shamed him by asking questions he didn’t want to answer and expected details after “very repeatedly” telling him that he was not yet comfortable.

Peter

“*Peter*” is a disabled infantry soldier who lives with his wife and children and served in Afghanistan and Iraq. He discussed events which caused him to feel remorse. “When the Taliban attacked us, the kids would get killed.” His guilt was due to inner thoughts such as “if I

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wasn't there, that little kid wouldn't have lost his life." He discussed difficulties in his relationships, particularly with his wife and children. "Being in the military is not easy on relationships." One of the contributing factors to his struggles was being on heightened alert all the time and the people in his life not understanding. He reported that he "knocked out many people" when he first got out of the military and ended up in a psychiatric hospital. He stated when he first returned home after combat, he would drink excessively and black out. He said he couldn't cope, "couldn't take the pain" because the memories were so awful.

Chip

"*Chip*" is a retired marine and recalls that he was "scared" and thought a lot about dying. "We saw things that no one should see." "Nothing" he did overseas made him feel proud. When he thinks now about his combat experiences, he hates the feeling, even to this day. He has recurrent nightmares and says it's like he is there all over again. He has seen countless therapists, but none talked about ensuing guilt from war. Chip felt that it would have been beneficial if they had. He has endured decades of emotional turmoil as he often feels "very guilt ridden" for what he saw in combat. The therapists he saw talked about his feelings and gave him medications, but Chip didn't feel he was getting better. He "kept hoping" that he would "see the light at the end of the tunnel, that something positive would come out of counseling." He blames himself by insinuating that his less than positive therapy experiences may have been due to forming negative opinions of people too quickly and not giving them a chance because of always feeling on edge.

Lloyd

"Lloyd" is 47-year-old who was enlisted in the army as an E7 medic and retired as an E8. He was an Infantry combat medic in MITT (military transition teams). "The most stressful times

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were the first and last 2 weeks. The first two weeks, what goes through your head is that dread of what could happen, and your mind plays out so many things.” Lloyd stated that the last 2 weeks were filled with fear and thoughts of the possibility of dying with such a short time left. We discussed triggers for anxiety. “It was my job to isolate the threat so confirmed kills were fine. Unconfirmed kills were not. If I knew I hit someone but once I got there the body was gone, it was really hard on me. I started picturing what could have happened. In my mind, I questioned “Was this someone who was a threat and got away? Did I injure an innocent local civilian? That feeling haunts me.” Lloyd also noted that his “friends that died were another source of guilt and remorse.”

Emerging Themes

Interviewing the combat veterans led this researcher to discover commonalities and patterns that the men shared. Most felt deep and lasting remorseful feelings for actions taken in combat. There was also a feeling of isolation upon entering back into the civilian world, as if no one understands them or comprehends the gravity of the life and death decisions which they once had to make. Transitioning into the civilian world was difficult to begin with, but only worsened by negative therapeutic experiences.

Theme 1 “The memories of killing, wrong-doing and death haunts us”

A prevalent theme discussed during the veteran’s interviews was the pain caused by overwhelming inner feelings of guilt for wrongdoing committed during wartime. They recount stories of innocent lives that were lost, friends who were killed and comrades they couldn’t save. There seemed to be deep moral implications for these soldiers. Clarke stated that he had never been a depressed person until he came back from deployment. Nick had “so many regrets because of all the kills” and for the fact that many of his own men died and he lived. He reported

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he cannot go a single day without replaying the “hell” in his mind. Adam could not get rid of the image of the piles of Kuwaiti babies lying on the ground and admitted to feeling shame, embarrassment and regret for what he had done overseas. Micah felt “intense guilt and remorse” for returning home when others didn’t. Peter stated that he felt continual guilt for the children who had been killed in Afghanistan. In particular, he remembers a mother who had watched her baby burn to death. Chip has not been able to rid himself of horrible memory of watching women and children going up in flames during an explosion and says he can still smell burning flesh even to this day.

Most of the men felt as though they had not done enough, had failed somehow and were a disappointment to their family and friends. For example, Clarke stated that he lost the trust of everyone in his life, even God. Micah possessed “intense guilt” for making it home safely when others did not. Peter endured lasting guilt for having a part in killing the innocent, particularly children. Lloyd stated that he experienced guilt for being unable to capture or kill certain enemies as he believes he may have allowed a terrorist to go free.

Because of a deep sense of unworthiness, many turned to drugs and alcohol to numb the pain. Peter drank until he blacked out for over 6 months after returning back from overseas. Chip said he lost a lot of friends and almost his marriage because his drinking was “out of control.” Lloyd reported that he had a drinking problem for several years after he arrived back from deployment and divulged that he drank a case of beer every night in order to fall asleep. Adam “drank all the time” when he first came home because he was “so angry and didn’t know where it was coming from.”

Theme 2 “We were not served well”

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Most of the men described therapy as largely unhelpful. Some even stated that it worsened their symptoms and caused them to lose hope in ever becoming whole. Many of their therapists were described as wanting to hear the details of the soldier's experiences without first establishing solid rapport or demonstrating effective clinical skills. Most of the men interviewed felt that their therapists did not understand their lived experiences which intensified the inner pain they were experiencing and made it more difficult to open up and trust. Clarke felt that a negative therapy experience was the therapist's "lack of concern" for him. He reported that it was "hard enough to break down and finally talk" but when the therapist downplayed what he was saying, it made him want to quit. He also had a psychiatrist who "started giggling" when he told her he was having trouble with physical intimacy issues due to the pills they prescribed him and stated that the experience was "devaluing."

Nick found it frustrating that "therapists try to "fit you into their prescribed mould." He also found it "invalidating" that the therapists acted arrogantly. In particular, he felt civilian doctors acted like they knew everything. He divulged that he walked out of one therapist's office because the man "told" Nick what he was feeling. He asked his therapist where he was stationed and after finding out that he had no military training, Nick left the office because his anger was "through the roof." He reported that he had seen the "face of hell" overseas and was angry that a therapist was that patronizing. The concern was not because the therapist had never been to combat, it was a lack of basic empathy. "If he would have just said you know I can't imagine what you've been through and just been straight with me," Nick says he would have stayed. After that he had a "bad taste" in his mouth for therapists.

Adam had some good therapists but didn't feel like he was helped by therapy. He stated "the problem with therapists at the V.A. is that the "therapists come and go so fast, even if you

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relate to one and it's a good match, they end up leaving. You tell them your soul and then they're gone, and you have to repeat the hell all over again." Chip revealed that he felt that therapists "didn't do much: to make him feel validated and felt they actually made him feel "bad a lot because they would go into too much detail" and Chip would lose focus. He wanted his therapist to "keep it simple" but she made it "pretty complicated and he ended up feeling that he got nothing out of it. Chip felt that he could not tell her what really happened for fear of being judged. Another therapist Chip worked with made him angry. "He was very pushy and kept pacing back and forth which made Chip's anger "go through the roof." Chip wished that one of the therapist's would have addressed remorse. "They never really talked about my guilt and it would have been good if they did." Chip said he was very guilt-ridden after what he saw overseas.

Theme 3 "We needed to know we weren't alone"

All participants struggled feeling understood upon returning to the civilian world. The majority stated that group therapy was the most helpful of all therapies because there was a shared camaraderie with other veterans. This was a healing factor for the participants I interviewed. Also, in group therapy, the men did not feel as though they were on the spot. In individual counseling, there may be a tendency to be on guard, a fear of being exposed. In group counseling, this seemed not to be a factor. Adam felt that the only therapy that helped him was in his group treatment. He felt "pretty normal" after being with the "group guys" and said it's isolating being with most civilians who "just don't get it." Peter revealed that "group therapy was the best of all of the therapies" because "they get you because they've been there." He said even if he couldn't speak up during group, someone else would end up saying what he was thinking or

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feeling. He found it “comforting” being around the guys and said it was the only time he could relax.

Summary of Chapter

In conclusion, the emerging themes from participant interviews was returning from war with an overwhelming feeling of guilt and remorse from watching or participating in killing or having to endure fellow soldiers who have been killed in combat. Therapy was mostly reported to be unhelpful, as many therapists did not exhibit a safe environment for the veterans to share their war-time experiences with.

CHAPTER FIVE: DISCUSSION

The paradigm of Moral Injury may be fundamental to understanding the internal, spiritual and ethical conflicts that veterans are often faced with post-combat. Moral Injury may better account for much of the unaddressed portions of a veteran's psychopathology.

Summary of Findings

Most participants in this study felt misunderstood by not only civilian society in general, but also by their therapists. Veterans interviewed did not feel that therapy was helpful. In fact, the majority felt it was unhelpful, even damaging to their emotional states. The exception was group therapy which helped most veterans because of the shared camaraderie they experienced. Most trusted other veterans because they felt understood by them.

Implications for Practice

The implications for clinical practice may include working to improve training for therapists who intend to work with this brave yet vulnerable population. The research this writer conducted indicated that the current treatment protocols utilized with veterans may be inadequate. This is consistent with the current research indicated earlier in this paper which shows that veterans have poor outcome measures post combat despite attending long courses of therapy. If therapists are to best serve military personnel, effective and consistent treatment protocols should be created and implemented. Clinicians treating veterans should be well versed

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in understanding not only the parameters of PTSD but of Moral Injury as well. Educating practitioners regarding utilization of best clinical practices may facilitate inner healing for those with MI.

Also, helping veterans normalize overwhelming post combat emotions at the onset of treatment, may provide much needed hope that recovery is possible. It would also be helpful to tighten the criteria for recruiting clinicians who work with veterans. The guidelines should be clear and consistent for all clinical staff. There should be more checks and balances for treatment outcomes, so our veterans do not fall through the cracks. Perhaps earlier interventions and more in-depth training for all workers who provide care to veterans would help. Also, it may be beneficial to look for ways to make religious faith a protective factor instead of a contributory factor to Moral Injury.

Recommendations for Future Research

Further research in this field is necessary for promoting effective clinical treatment for combat veterans. Increasing MI awareness and improving clinician's utilization of screening tools are the next logical steps in the field of Moral Injury. It is essential to continue exploring the concept of Moral Injury and the pivotal role it plays in military populations. The repercussions for the onset, maintenance, and treatment for MI combat-related mental conditions need to be continually examined. Since guilt and shame can be the drivers to a veteran's mental health decline, the mental health community would best serve this population by implementing further research studies. Much was uncovered in this study after speaking with each participant. Their heartfelt expressions of war trauma was painful to hear. Even more disturbing to me was the fact that our heroes sought mental health help and did not obtain it. Not one of the interviewed men stated that they felt "whole" after therapy. If a therapist is only punching a time

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clock, or there is a lack of genuine care, these keenly observant men will notice and ultimately, will pay the price. Several of the men preferred to have a therapist with combat experience. However, not all said this was necessary. If a therapist had no combat experience, veterans did not want the clinician to regurgitate book knowledge. A better strategy would include empathic listening, building rapport and conveying heartfelt concern with no judgement. Since most combat veterans have experienced hell on earth, clinicians need to better prepare for what they will hear during a session. The guided research questions were: *What is the lived experience of Combat Veterans who have been diagnosed with Post-Traumatic Stress Disorder, and report symptoms of Moral Injury, specifically regarding their therapy experiences*

Overall, from the sample population I interviewed, therapy experiences post combat were not reported as beneficial. Further research is needed in this area.

Religious commitment did not seem to help this with the participant's emotional angst. Many noted that they felt they could not go to God to work through their pain because of their sense of deep shame and guilt. Their moral compass seemed to have been shattered in multiple places. Clarke was a pastor and could not allow God to comfort him and even felt that God could no longer trust him because of his drinking. He called himself a hypocrite and described his very harsh inner dialogue. He reported that he no longer felt that God loved him and has since struggled with his relationship with Him. Many of the men stated they self-medicated when returning home from deployment because they couldn't handle the war memories of what they had seen and done. This made them feel guilty because their behaviors weren't 'Christian.'

In summary, guilt and shame were difficulties that these veterans had to endure post combat. The difficult transition from the military to the civilian world was exacerbated by hellish memories. These findings are consistent with the research that states veterans experience high

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levels of distress when trying to navigate between military and civilian cultures. It often leaves them feeling alienated from family and friends, and creates an identity crisis (Demers, 2010).

When the veterans decided to attempt therapy, they did not receive help. What each wanted was to feel understood. Instead, they felt more isolated and alone.

With a larger study, some of these questions may have been easily answered. "Loss of religious faith was found to be a stronger predictor of a higher number of outpatient mental health treatment sessions. There is extensive literature indicating a strong association between religious faith and the spiritual concept of hope" (Clarke 2002; Koenig et al. 2012). Most of the men I interviewed identified as a Christian but had lost much of their faith. This is consistent with Clarke (2002) and Koenig et al. (2012) literature indicating higher Moral Injury scores for those whose faith is not strong.

Limitations

The limitations included a concentrated group of veterans at a Christian college. The study was conducted during the Covid-19 epidemic which would account for so few participants. Very few men in their 30's and 40's were able to be interviewed, possibly due to busier times in their lives, and also for the fact that men in their 50's may have more time to volunteer because of being retired from the military.

Summary

To best serve veterans, clinicians must fully understand the Moral Injury paradigm since MI may better account for much of the unaddressed portions of a veteran's psychopathology. Further research in this field is needed. If the mental health community provided consistent definitions and treatment measures, as well as improved training for therapists, the outcome measures for veteran's mental health treatment would likely improve. By implementing

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standardized measures and improving education in the area of Moral Injury, clinicians may promote improved emotional health and wholeness for military personnel. Increasing MI awareness and improving the utilization of screening tools among clinicians are the next sensible steps in the field of Moral Injury.

It is essential to continue exploring the concept of Moral Injury and the pivotal role it plays in military populations. The repercussions for the onset, maintenance, and treatment for MI combat-related mental conditions need to be scrutinized in further research studies. Since guilt and shame can ignite a veteran's mental health decline, the mental health community would best serve this population by further research studies.

It was this writer's sincerest intent to provide a qualitative case study which will provide an in-depth, beneficial and scientific analysis regarding the experience veterans have had in trying to obtain clinical mental health treatment for post-combat trauma.

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APPENDICES

Appendix A

Survey Questions

Q1. Select your gender

Male Female

Q2. Select your age group

18-28

29-39

40-50

51-61

62 and older

Q3. Have you served in the U.S. military for 1 tour or longer in active-duty combat?

Yes No

Q4. Have you ever been diagnosed with Post Traumatic Stress Disorder (PTSD)?

Yes No

Q5. If yes to the above question, have you ever gone to therapy for treatment of PTSD?

Yes No

Appendix L2

Should you have questions or comments regarding this study, please feel free to contact.

Laurie Gramlich Parker at (508) 965-7629 or LParker27@liberty.edu.

There is a Standing Committee for Human Subjects in Research at Liberty University to which complaints or problems concerning any research project should be reported if they arise. ***Please***

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contact the Committee Chairperson at irb@liberty.edu. Do you consent to participate in this survey?

- I consent to participate
- I do not consent to participate

Appendix L3

LIBERTY UNIVERSITY

INSTITUTIONAL REVIEW BOARD

January 27, 2020

Laurie Parker

IRB Approval 4071.012720: Military Veterans' Therapy Experiences for Post Combat Emotional Trauma

Dear Laurie Parker,

We are pleased to inform you that your study has been approved by the Liberty University IRB. This approval is extended to you for one year from the date provided above with your protocol number. If data collection proceeds past one year or if you make changes in the methodology as it pertains to human subjects, you must submit an appropriate update form to the IRB. The forms for these cases were attached to your approval email.

Your study falls under the expedited review category (45 CFR 46.110), which is applicable to specific, minimal risk studies and minor changes to approved studies for the following reason(s):

7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. (NOTE: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. [45 CFR 46.101\(b\)\(2\)](#) and (b)(3). This listing refers only to research that is not exempt.)

Thank you for your cooperation with the IRB, and we wish you well with your research project.
Sincerely,

G. Michele Baker, MA, CIP

Administrative Chair of Institutional Research

Research Ethics Office

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Post note:

The plight of military veterans is one this writer has lived. My husband Jim is a combat veteran and retired paratrooper in the 82nd AIRBORNE division of the United States Army. He was an amazing fighter and intense protector of this country. Unfortunately, heroism came with a price. Like so many veterans, Jim suffered from a horrible case of Post-Traumatic Stress Disorder (PTSD) following combat. Despite receiving several modalities of mental health therapies, his emotional health steadily declined. Attending therapy made him feel worse because like many veterans, this is often their last resort (my husband felt that therapy was his last option which was devastating to him). Though his numerous therapists screened for PTSD, they ignored an integral aspect for my husband's inner torture: Moral Injury. This term refers to the lasting emotional, psychological, social, behavioral, and spiritual impacts of actions that violate a service member's core moral values and behavioral expectations of self or others (Litz et al., 2009). What my husband had witnessed overseas left him feeling shattered.

It was initially difficult for him to admit having a problem because the military encourages soldiers to demonstrate strength and therapy is often perceived as admitting weakness. Thus, after the difficulty of acknowledging the problem, facing the fear of therapy, and then feeling no emotional relief- this veteran's inner world was shattered. My husband spent

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years in a vicious inner battle, feeling alone and misunderstood. At one point his doctor had prescribed him 32 different medications. He described himself as a “drooling vegetable.” If this wasn't bad enough, he also lost many of his combat “brothers” to suicide.

This writer owns a counseling practice and has worked with many combat veterans over the past 15 years. From observations in therapy sessions, independent research, and countless painful talks with my husband, it is my hypothesis that Moral Injury may actually be the silent inner “venom” plaguing military personnel and veterans. Since the onset of this dissertation, I have inquired with 18 veteran family friends about the topic of Moral Injury. Interestingly enough, each agreed that Moral Injury (MI) is more of a problem than PTSD. Only one from the group even knew there was a name for what they and other veteran friends were experiencing.

In addition, I have asked several colleagues if they screen for Moral Injury. They had a vague notion of MI, but did not know how to define, measure or help veterans with it. It is my desire to illuminate what combat veterans and military personnel have experienced while trying to obtain mental health help post combat.