MORAL INJURY IN ACTIVE SERVICE AND VETERAN FEMALE MILITARY COMBATANTS

by

William C. Neal, Jr.

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

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ABSTRACT

A topic of concern and discussion in the mental health community, and maybe a special concern from both governmental and civilian practitioners, is the subject of moral injury. Moral Injury has been widely researched over the last 10 years and is a known and discussed condition that is linked to military personnel and veterans who have experienced events while deployed or operating in adverse conditions such as combat. The following descriptive study focuses on one group from which they have been excluded or overlooked in past studies. This creates a gap in the published literature: female servicewomen and veterans. Both governmental and civilian mental health communities must further the research to close this gap. This descriptive statistical study provides a sample of 45 participants of which 21 have some level of MI and were deployed or operated in a combat environment. The results of the study: compare MI between men and women. The results reveal a possible difference between genders concerning different MIEs and the effect MI has on each gender.

Keywords: Moral Injury, PTSD, History, Impact of Killing (IOK), mental health, combat, women service members, women veterans, female combatants, female soldiers, female Marines, female combat air pilots, drone operators, female veterans, guilt, shame, betrayal, spirituality combat environment, deployment, warfighters

Dedication

To the men and women of the United States military who have made sacrifices for their God, country, and family—especially to those who fight the internal battle with mental health due to service-related injuries. May we now serve you, finding ways to better assist in your battle of mind, body, and soul. To find peace, joy, and happiness living in the country you love so much that you give your all to defend and protect. Semper Fidelis, brothers, and sisters.

Acknowledgments

To my family, who have continuously supported me through my many battles and struggles with mental health issues. To Lieutenant Colonel Randall Colson, United States Marine Corps (Retired), who congratulated me when I achieved my bachelor's degree and then mentored/motivated me by saying, "You are not done; you earned the title Marine. Now go and earn the title of doctor." Master Gunnery Sergeant John DeBerry, United States Marine Corps (Retired), trained me to be the best man, father, and Marine I could be, and then enlightened my path forward by telling me, "The reason the review mirror is small: is that what is now behind us, is now small and behind us. The windshield is wide and open, giving us a view of what is ahead of us to see and explore". To Kourtney, whose love and friendship have endless bounds. Finally, to all the men and women of the United States Marine Corps present, past, and future. May God continue to bless you and instill in you: Honor, Courage, and Commitment to achieve your goals and to protect you in every challenge and battle you will encounter. You are the Few, the Proud, and by the grace of God, we are Marines!

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List of Abbreviations

CAA	Combat Action Award
DoD	Department of Defense
FOIA	Freedom of Information Act
KJV	King James Version
IRB	Institutional Review Board
MME	Meaningful military engagement
MOS	Military occupational specialty
MV	Military veterans
MI	Moral Injury
MIE	Moral Injury Event
MIS-MVC v. 1	MI Survey for Military and Veteran Combatants
MST	Military Sexual Trauma
PMIE	Primary MI Event
PTSD	Post-traumatic stress disorder
SWB	Social Well-Being
SOCOM	Special Operations Command
VA	Veterans Administration

CHAPTER ONE: INTRODUCTION

Overview

The following information will make the reader more aware of the effects MI may have on female soldiers, sailors, Marines, and so forth after witnessing events that may have impacted or affected their moral beliefs or events in which an individual's action or inaction later affected their moral views. The necessity to kill another person or persons is a job risk in the military; as well, military personnel may be directed (ordered) to look the other way when horrific events i.e., killing, interrogations, etc. unfold and potentially cross morals and ethics for some servicemembers. Should an event such as this happen, a rational, well-trained, disciplined, professional warrior should be able to assess which type of actions to take to address the event at hand on the battlefield, as noted and supported by findings from Stebnicki (2020): he states:

> A fundamental aspect of exposure to trauma in the military is that service members are not passive victims of a critical incident. Rather, military personnel train for the physical and psychological demands of combat on an ongoing basis, whereas civilians do not. Therefore, for service members, the physiological and psychological reaction to combat is to 'aggress—not stress.' Whereas citizens or those who have not served or been trained in reacting to traumatic events, naturally react as victims because they are not prepared mentally and physically to be confronted or aggress against such unpredictable traumatic experiences such as combat (Stebnicki, p. 9).

Though the following research is related to female military and veterans who have experienced combat, information is provided to distinguish between cultural settings and the military: which is considered a culture within itself.

The most notable cultural differences between the military and civilian life are the demands of killing, avoiding being killed, caring for the wounded, and witnessing death and injury are all part of service members' military training, all happening while deployed in combat situations. However, with the constant deployments, being on call 24 hours 7 days a week, and separation from family, friends, and their homes (Stebnicki p.9).

These factors alone create a distinct cultural setting for military families that those in the civilian population do not have to contend with. The following chapter provides the reader with a history of MI which includes social aspects as well. In this chapter, I present the problems and gaps in the current literature I have found, along with the purpose of the study and the research questions I have created, which are designed to support the purpose of my research and highlight the significance of my study.

Background

Combat is a force-on-force fight, battle, or engagement that often requires deadly force to be used. The catalyst for this type of action is when a force, for example, a military force, desires an opposing force to surrender and succumb to the will of the stronger opponent, i.e., the opposing military force. The armed forces of the United States of America are composed of individuals who voluntarily choose to take up arms in defense of their country, countrymen, and women. This job or call to duty is taken on by our young men and women, who eventually become our combat heroes, such as the American Soldier or Marine (the Army and Marine Corps have an infantry structure for combat engagement; the other services do not have a committed or “warfighting” force). They are the warfighters who fight America’s battles (Stebnicki, 2020).

In the summer of 2020, the American military ended the longest war in America's history, the war in Afghanistan. Research shows the ongoing effects of MI on American soldiers and Marines regarding the emotional and behavioral actions of both active-duty military and veterans. However, published literature does not discuss or provide empirical research on the effects of MI and female warfighters or female veterans. Yet, the following information justifies why the forthcoming research is imperative: I submitted to the Joint Chiefs of Staff (JCS), and the Department of Defense (DOD): a Freedom of Information Act (FOIA) request. In this request, I requested the number of female service members (all branches of service) and how many female service members have 'earned' the Purple Heart Medal or been awarded a Combat Action Award (CAA), for participation in combat operations since 2000. The DOD supplied the following information on the 23rd of August 2023 via email correspondence:

Table 1

Females Awarded the Purple Heart Medal or Combat Action Award (CAA) Since January 2,000

Service/Component	Purple Heart	Combat Action Award	Total Combined
Army National Guard	2,212	31,724	33,936
Army Active Duty	1,347	12,539	13,886
Army Reserve	1,165	16,265	17,430
Marine Corps Active Duty	1,012	861	1,873
Marine Corps Reserve	2,803	171	2,974
Air National Guard	68	163	231
Air Force Active Duty	232	250	482
Air Force Reserve	0	2	2
Space Force Active Duty	3	1	4
Coast Guard Active Duty	2	44	46
Coast Guard Reserve	0	8	8
Total	8,844	62,028	70,872

Source: Workforce Transaction File

Department of Defense: Defense Manpower Data Center, August 2023 Freedom of Information Act (FOIA) 23-F-1144.

Table 1 lists a combined 70,872 female military and veteran women who have been wounded or participated in combat actions; however, journal articles do not discuss, or present statistical status concerning women in combat actions and MI impacts. One of the main purposes of this dissertation research is to highlight the gap in information relating to females who have deployed and participated in combat operations. Current published literature provides truly little information concerning the topic of civilian or military culture as well. The following data Casualty Status report displays those killed in the most recent conflicts involving the American Armed Forces. As depicted in Table 1: female service members have been reported as participating in direct combat actions and being wounded in combat actions as evident from the enormous number of female military personnel listed in Table 1. However, governmental reports do not identify the wounded or killed by gender, as shown in Figure 1. cited from the DoD website for the number of service member and civilian deaths. This report, like others, does not identify the deaths by gender during past wars. Taking this information into consideration, and the limited amount of published material on MI to date: there is extraordinarily little data concerning female service members or veterans published. This leads me to believe that more than likely there are female service members and veterans who are suffering from MI, therefore research presented in this dissertation is particularly important I believe to both the military and civilian mental health communities and will bring more awareness and attention to the subject.

Figure 1

Casualty Status

U.S. Department of Defense

IMMEDIATE RELEASE

CASUALTY STATUS

as of 10 a.m. EDT May 30, 2022

OPERATION IRAQI FREEDOM U.S. CASUALTY STATUS[1]					
	Total Deaths	KIA	Non-Hostile	Pending	WIA
OIF U.S. Military Casualties	4,418	3,481	937	0	31,994
OIF U.S. DOD Civilian Casualties	13	9	4	0	
Totals	**4,431**	**3,490**	**941**	**0**	**31,994**

[1] OPERATION IRAQI FREEDOM includes casualties that occurred between March 19, 2003, and Aug. 31, 2010, in the Arabian Sea, Bahrain, Gulf of Aden, Gulf of Oman, Iraq, Kuwait, Oman, Persian Gulf, Qatar, Red Sea, Saudi Arabia and the United Arab Emirates. Casualties in these countries before March 19, 2003, were considered Operation Enduring Freedom. Personnel injured in OIF who die after Sept. 1, 2010, will be included in OIF statistics.

OPERATION NEW DAWN U.S. CASUALTY STATUS [2]					
	Total Deaths	KIA	Non-Hostile	Pending	WIA
OND U.S. Military Casualties	74	38	36	0	298
OND U.S. DOD Civilian Casualties	0	0	0	0	
Totals	**74**	**38**	**36**	**0**	**298**

[2] OPERATION NEW DAWN includes casualties that occurred between Sept. 1, 2010, and Dec. 31, 2011, in the Arabian Sea, Bahrain, Gulf of Aden, Gulf of Oman, Iraq, Kuwait, Oman, Persian Gulf, Qatar, Red Sea, Saudi Arabia and the United Arab Emirates. Personnel injured in OND who die after Dec. 31, 2011, will be included in OND statistics.

OPERATION ENDURING FREEDOM U.S. CASUALTY STATUS [3, 4]					
OEF U.S. Military Casualties	Total Deaths	KIA	Non-Hostile	Pending	WIA
Afghanistan Only 3	2,218	1,833	385	1	20,093
Other Locations 4	130	12	118	0	56
OEF U.S. DOD Civilian Casualties	4	2	2	0	
Worldwide Total	**2,352**	**1,847**	**505**	**1**	**20,149**

[3] OPERATION ENDURING FREEDOM (Afghanistan only) includes casualties that occurred between Oct. 7, 2001, and Dec. 31, 2014, in Afghanistan only.

[4] OPERATION ENDURING FREEDOM (other locations) includes casualties that occurred between Oct. 7, 2001, and Dec. 31, 2014, in Guantanamo Bay (Cuba), Djibouti, Eritrea, Ethiopia, Jordan, Kenya, Kyrgyzstan, Pakistan, Philippines, Seychelles, Sudan, Tajikistan, Turkey, Uzbekistan and Yemen. Wounded in action cases in this category include those without a casualty country listed.

Figure 2

Casualty Status

OPERATION INHERENT RESOLVE U.S. CASUALTY STATUS [5]					
	Total Deaths	KIA	Non-Hostile	Pending	WIA
OIR U.S. Military Casualties	107	20	87	0	272
OIR U.S. DOD Civilian Casualties	2	0	2	0	
Totals	**109**	**20**	**89**	**0**	**272**

[5] OPERATION INHERENT RESOLVE includes casualties that occurred in Bahrain, Cyprus, Egypt, Iraq, Israel, Jordan, Kuwait, Lebanon, Qatar, Saudi Arabia, Syria, Turkey, the United Arab Emirates, the Mediterranean Sea east of 25° longitude, the Persian Gulf and the Red Sea.

OPERATION FREEDOM'S SENTINEL U.S. CASUALTY STATUS [6]					
	Total Deaths	KIA	Non-Hostile	Pending	WIA
OFS U.S. Military Casualties	107	77	30	0	619
OFS U.S. DOD Civilian Casualties	2	2	0	0	
Totals	**109**	**79**	**30**	**0**	**619**

[6] OPERATION FREEDOM'S SENTINEL includes casualties that occurred in Afghanistan after Dec. 31, 2014.

(https://www.defense.gov/casualty.pdf)

Historical Context

Volunteering to serve in the United States military comes with the risk that during a servicemember's tour of duty, they may witness or participate in an event that will put their life or the lives of others at risk of danger or even death. Yeterian et al. (2019) discuss how veterans and active-duty service members are put at risk and participate in events that violate moral and ethical beliefs. Their research also determined that the trauma for both active-duty service members and veterans is exacerbated by morally injurious events (MIE) either participated in or witnessed, resulting in unrelieved feelings of guilt, shame, self-betrayal, and the inability to find closure or forgiveness for the acts or events. According to Jordan et al. (2017), "an emerging

prevalence of MI as upwards of 80% of veterans reported experiencing a potentially morally injurious event (e.g., “I saw things that were morally wrong”; Evans et al.,2018) and 38% endorsed significant distress directly related to at least one morally injurious event” (p.315).

Equivalent, but not equal to Post-Traumatic Stress Disorder (PTSD), MI shares elements for diagnostics by trained professionals. However, much is still to be learned and more research should be conducted because MI referencing female service members and veterans has only been addressed vaguely for the last several years. McGuire et al. (2019) performed a pilot study considering moral elevation as a potentially effective treatment for veterans who are diagnosed with PTSD and who suffer from MI. In their study of all male veterans, 26% of those tested and evaluated had experienced an event that caused MI (p. 321). Another historical element concerning this important topic is the inclusion and direct participation of female service members in combat roles and operations of all branches of the American armed forces.

In the last few decades, due to significant changes in policies and military structural change, the roles, and responsibilities of females in the United States military, branches have been impacted. (Breeden et al., 2018) note that during the most recent wars, females have participated in combat actions and that little research exists to understand better which combat roles, experiences, or how combat deployments affect women service members and veterans. They also reported that “60% of deployed women experienced combat in post 9/11 wars, compared with 39% during the beginning of the Gulf War in 1991” (p. 1449), however, it was not until 2015 that all branches of the American military would officially allow women the option to serve in both combat and non-combative Military Occupational Specialties (MOSs) (Kamarck (2016).

A change came in late 2015. According to a Congressional research report submitted by Kamarck (2016) on December 3, 2015, Secretary of Defense Ashton Carter ordered the military to open all combat jobs to women with no exceptions, including the Special Operations Command (SOCOM). On March 10, 2016, Secretary Carter announced that the Services' and SOCOM's implementation plans for integrating women into direct ground combat roles were approved (p.14). Before this date, combat arms roles were closed to all female active duty and reserve members except for a few MOSs who served on aircraft carriers, flew fighter aircraft, operated drones, and participated in support roles for combat forces yet remained behind or off the front lines of the forward battlefields.

Social Context

When those who have fought and defended the country wonder whether the struggles and lost lives were worth it, mental health caregivers within the military and local communities need to take heed. Countless service members and veterans must contend with life after the battle. Richardson et al. (2020) state that battles come with internal struggles in the form of mental health disorders. MI has gained significant attention (from the military community) through research and evolving practices from the Veterans Administration (VA) and the military mental health community. Considering the act of killing. Those who served and have served in the military must endure long-term ramifications from this type of event. What is known about MI? Practitioners, scholars, and therapists know the basic elements are shame, guilt, and feelings of regret for actions and events that occurred during an MIE, and the actions they did or did not take when witnessing an event. For military personnel, MI's root cause is MIEs or actions and events taking place during their combat deployments.

In the past decade, concerns for service members' and veterans' mental health and the mental health of those known to suffer from MI either through a professional diagnosis or self-assessment have gained the attention of practitioners. Chesnut et al. (2020) note that when military members suffer from MI because of events in which they took part or were witnessed during deployment, their social well-being may be impacted. Chesnut et al. (2020) determined that "Self- and other-directed MI reactions are differentially related to the intercepts and slopes of the SWB outcomes. Self-directed MI reactions also have a statistically significant impact on the intercept of social functioning and social activity" (Chesnut et al. p. 593). The effect on the social functioning intercept aligned with theoretical expectations that increased levels of self-directed MI reactions would be associated with lower levels of social functioning. Nash (2019) determined that mental health stigmas remain a problem today as they were at the start of the Iraq war in 2003. Nash (2019) also notes that mental health stigmas are not limited to just warfighters, but other support personnel, and civilians as well. The information in my research focuses on female military and veterans who are affected by MI.

Conceptual/Theoretical Context

MI and the Military

Litz and Kerig (2019) describe MI as a stressor-linked problem, which has similar characteristics and elements to those associated with PTSD. However, MI or MIEs have different classifications than PTSD in that the traumatic events shift" to MI based on empirical evidence that the events' stressors have a longer and more lasting impact on the individual. MI to date has not been classified as a mental health diagnosis. Koenig and Al-Zaben (2021) noted: "In 2009 psychologist for the VA Litz et al. published a report concerning MI and war veterans, the topic began to expand throughout the clinical and academic psychological institutions" (p. 2990).

Farnsworth (2019) suggests that treatments for PTSD, such as Prolonged Exposure therapy (PET) and Cognitive Processing Theory (CPT), can be effective for clinicians collaborating with individuals who have experienced an MIE or are suffering from MI. Many of the researchers who study MI and PTSD events, including Farnsworth (2019), consider the military a prime organization for sustaining traumas or MIEs, research has determined that MI from military MIEs most often affect military and veterans' moral conciseness, behaviors, and decisions. Shay (2014), considered one of the earliest and most well-versed researchers of MI, discusses a second form of MI from other authors.

> Several clinician-researchers, among them Brett Litz, Shira Maguen, and William Nash, have done an excellent job of describing an equally devastating second form of moral injury that arises when a service member does something in a war that violates their ideals, ethics, or attachments (p. 184).

The second form of MI arises based on discussions from research that provide empirical evidence of service members participating, witnessing, and 'order to actions' which are wrong even in the environment of war and combat. These actions have violated service members' and veterans' ideals, ethics, or behaviors (p. 184). Research conducted by Litz and Kerig (2019), concerning PTSD diagnostics does not recognize or 'capture' the forms or elements associated with MI. Basically, according to the researchers, PTSD nicely describes the persistence in life after mortal danger of the valid adaptations to the real situation of other people trying to kill you. The authors explain in their own words, PTSD rarely is the main item that wrecks people or individuals' lives; driving them to a life of suicide or domestic or criminal violence, yet MIEs and moral injuries can be the main cause of these actions (p. 344). Having discussed MI in the concept of the military, I will discuss how MI correlates with PTSD.

Post-Traumatic Stress Disorder and the Military

Post-traumatic stress disorder (PTSD) has been associated with military and military wars, and other combative operations since the Civil War, when it was known as soldier's heart (Currier et al. 2021). PTSD was also formally recognized and diagnosed as shell shock during World War I (p. 4). According to Currier et al. (2021),

> PTSD diagnoses in the Veterans Administration (VA) system roughly doubled within just 5 years after 9/11. As these conflicts persisted, new waves of men and women enlisted to serve their country for varying lengths of time. However, many veterans have endured exceptionally heavy physical, emotional, and spiritual burdens from their wartime service (Currier et al., 2021, pp. 3–4).

Recent conflicts in Afghanistan and Iraq highlighted a major problem that concerned the military and concern for the nation's military veterans. Currier et al. (2021) discussed how mental health concerns are linked or associated with PTSD. PTSD as listed by the Diagnostics and Statistics Manual of Mental Disorders V (DSM-V) with a clear and definitive diagnosis, whereas MI has not been identified as an official diagnostic, though it shares similarities with PTSD. MI and PTSD are so closely related that researchers concur that the best treatments for both are prolonged exposure therapy (PET) and cognitive processing therapy (CPT). According to Steenkamp et al. (2020):

> Two well-established first-line cognitive-behavioral psychotherapies for posttraumatic stress disorder (PTSD), (PE) and (CPT), are used in the US Department of Veterans Affairs (VA) and US Department of Defense (DoD) based chiefly on good outcomes in randomized clinical trials (RCTs) with civilians (p. 656)".

Farnsworth (2019) noted the same two treatments have been identified also to treat persons suffering from MI, however, other evidence suggests that these interventions may be relatively less effective in military populations which has prompted some researchers to propose that military traumas involve moral concerns distinct from those that present themselves in civilian populations (p. 373).

Elements of MI are adequately evaluated, and treatment plans are developed based on traditional PTSD treatments, if the MI construct continues to mature, further clarity on these points is needed to inform and develop more aggressive treatment plans and further the research. The DSM-V lists criteria for PTSD diagnosis. There are direct and indirect exposure to a traumatic event, followed by symptoms in the following four categories: intrusion, avoidance, negative changes in thoughts and moods, and changes in arousal and reactivity (American Psychiatric Association, 2013). Experiencing or exposure to an MIE can replicate traumatic "elements" such as those that are associated with PTSD. However, MI is not recognized by the DSM-V as a mental disorder and there are no categories for a diagnostic cluster to be determined. MI does affect individuals due to MIE impacts on behaviors, thoughts, and actions i.e., suicidal attempts or violent and aggressive behaviors. With the information just covered it is clear these two conditions PTSD (only recognized mental health condition) and MI are closely related. However, past and current literature does not distinguish clearly or empirically between men and women combatants or service members including veterans. To date, there is truly little information that has been collected or verified by research; has been published concerning the impact of MI and MIEs upon female service members and veterans, especially those who have served in combat.

Gaps in the Literature

There are many studies on the emotional and behavioral effects of MI and MIEs concerning active-duty military members and veterans. However, many published works do not delineate between male and female warfighters. It is imperative to narrow and eliminate this gap if possible: especially given the immense changes in military structure in recent years. Since 2016, female service members have served in combat arms roles and led service members in combat. Before 2016, combat MOSs and military duties in warfare were reserved for males only. However, from January 1991, the beginning of the Gulf War and the liberation of Kuwait, to Operations Iraqi Freedom, Enduring Freedom, and Restore Hope: America's longest war, the withdrawal of American forces from Afghanistan in September of 2021: female service members have been assigned to and joined with military units directly involved in combat operations. Nevertheless, there are "gaps" of information concerning female combatants and MI.

Current literature on MI and MIEs provides extraordinarily little information or data concerning women service members or veterans which I believe is an egregious oversight, yet researchers encounter problems reporting or discussing female active duty and military veterans who have or are reporting to have MI conditions. MI comprises components such as anger, sorrow, and grief, yet there are very few reports to accurately assert that women military and veterans suffer with or from MI as their male counterparts. Ames et al. (2019) discuss the difficulty of accurately measuring veterans' responses and self-reports as they may be falsifying them when applying for compensation and health benefits. Further research should include clinical mental health workers addressing known biases and reviewing self-reports more carefully to ensure participants are not inflating their condition because of anticipated benefits. Jamieson et al. (2020) determined limitations of their concept analysis study were due to

> The number and unrepresentativeness of the papers reviewed may have limitations on the current nomenclature and the construct definition. Investigation into moral injury is limited by both geography and sample size due to the small number of studies and predominantly theoretical literature from the United States primarily with previously deployed military members that focus on the concept (Jamieson et al., 2020, p. 1062).

Studies such as the concept analysis by Jamieson et al, (2020) are just one of the examples of information concerning MI that does not analyze or discuss the female warfighter, making this dissertation research that much more necessary.

Problem Statement

Practitioners, educators, and military leadership must have a much better understanding of MI and its effects on groups and individuals within the different military communities. However, the problem addressed here is the lack of information and resources dedicated to servicewomen and women veterans who have participated in combat operations and who have been affected by MIEs and whether MIEs affect female servicemembers and veterans more than males. According to Kelley et al. (2018;2019), research has not determined if female active military members or veterans are at an equal or greater risk of suffering from MI than their male counterparts. Previously as noted, research studies have revealed extraordinarily little evidence that combat experiences place females at a greater risk for mental health diagnoses or such concerns as PTSD or MI. Hansen et al. (2021) found that female service members were less likely to report potentially morally injurious events (PMIE) exposure than their male counterparts. The “sex-based difference in exposure” resulted from female service members representing less than “15% of the total Canadian military, with only 2.4% and 5.6% in the Regular and Reserve Forces, respectively, serving in combat arms roles (i.e., infantry, armor,

artillery, and combat engineers; Department of National Defence, 2014)" (p. 770). The remainder of the women in the Canadian armed forces served in more support roles such as logistics support, communications, and medical support.

Purpose Statement

The purpose of this study is to expound on the limited existing information concerning female service members and veterans; using a descriptive statistical research design, to determine whether there is a difference between genders in the military and veteran population, and if the possibility exists that female service members and veterans suffer more than the males do from PMIEs. This research dissertation will provide an understanding of whether American military (active, reserve, and veteran) women who experience combat suffer from MI or more than their male counterparts from MI. The primary issue that should be considered: is that previous research does not include women primarily due to the prohibition on women serving in combat roles.

Significance of the Study

Since the Iraqi and Afghanistan conflicts more veterans have enrolled in the VA healthcare network than past generations of veterans (VA, 2020). VA medical care centers are overwhelmed, as are the care providers working in specialty units. Koenig et al. (2016) noted that VA specialty care providers, especially in the specialized care for the welfare and mental health concerns of veterans across the country and the most. Since this new precedence has been determined, and the numbers of future veterans are anticipated to rise, (VA, 2020); there is a greater potential for critical care needs and community-based treatment and support. In addition, base medical treatment centers for active-duty service members must be included to ensure all receive the assistance they need. Communities near a primary military installation will have

more access to potential providers than most local or rural practitioners with limited to no experience working with active military members or reserves. It is plausible they will have little or no experience collaborating with veterans. Therefore, it is important to delineate and establish foundational knowledge for the various populations within the military organizations and which of those populations are more susceptible to be affected by MI Events (MIE).

Women now serve in combat roles, boosting the significance of this study for both the military and mental health practitioners. Mr. Mark Manieri a retired Marine who served in Iraq with the 8th Communications Battalion stated in an interview "The Marine Corps implemented a program during the wars in Iraq and Afghanistan, they selected and trained female Marines deployed (from non-combat MOSs) to the front lines to augment infantry units, known as the Lioness Program." (M. Manieri, personal communication, October 31, 2023). The purpose of this combat program for the Marines was to respect the Muslim culture and traditions so that local women could be searched by a female (female Marines) since insurgents and female terrorists were martyring themselves by using suicide vests to kill American military personnel at military checkpoints in areas of combat operations. Therefore, many of these female Marines were exposed to direct combat situations/environments that, we must presume, they were more than likely exposed to PMIEs during their deployments.

Maguen et al. (2020) discuss the differences between the genders, psychological functional problems, and PMIEs. In their research American military women who witnessed MIEs and experienced betrayal from leadership reported events and their psychological distress more than men. Earlier Hansen et al, (2021), determined that Canadian female military service members were less likely to report an MIE, which could lead to the element of fear, guilt, shame, etc., whereas men could tend to either deal with or ignore the perpetration. Gender is a significant

factor concerning crisis responsibilities due to findings that; 1) women have more negative perspectives of the military than men, 2) negative opinions about female soldiers in combat and non-combat roles, and 3) an overall opinion of servicemembers that female servicemembers are not fully accepted in any military roles (p. 65).

Research Questions

RQ1: What are the experiences related to death for MI participants while in combat?

RQ2: What were the emotional experiences related to MIEs for MI participants while in combat?

RQ3: Are there gender differences in MI percentages in the military?

Definitions

1. *MI* – No single definition has been established for MI, yet it can best be defined as distress (due to guilt, shame, disgust, withdrawal, self-condemnation, etc.) following situations involving moral transgressions (Hall et al., 2021).
2. *MI event* – An event in which a person fails to prevent, bears witness to, or learns about acts that transgress deeply held moral beliefs and expectations (Litz et al., 2019).
3. *Post-traumatic stress disorder* (PTSD) – Listed in the DSM-5, post-traumatic stress disorder (PTSD) is an anxiety disorder that develops about an event that creates psychological trauma in response to actual or threatened death, acute injury, or sexual violation. (APA, 2013).
4. *Military occupational specialty* (MOS) – is a categorized list of military occupational fields https://www.marines.com/about-the-marine-corps/roles/military-occupational-specialty.html (2023).

5. *Combatant* – "While the contexts of MI differ, examples from the combat veteran community offer hope for morally injured healthcare professionals. As mental health clinicians who work with veterans will attest, MI is not a disorder of the combatant alone; it is deeply tied to the circumstances of the veteran's experience of war and trauma" (Cahill et al. 2023, p.361).
6. *Impact of Killing* – "Clinicians1 and researchers2 have observed that veterans who report participating in violence, such as killing (justified or not) or atrocities, or who witnessed and were unable to prevent horrifying violence, appear to have much worse post-deployment functional and psychiatric outcomes than those veterans who have not committed or been exposed to such acts. The psycho-bio-socio-spiritual disturbance associated with these acts has been labeled MI" (Frankfurt et al. 2017, p. e1950).

Summary

This chapter addresses the lack of information and comparison information between male and female combatants and MI. Also, there is extremely limited information concerning the care and treatment of female servicewomen and veteran female combatants suffering from MI and MIE. To determine the effects of MI and MIE upon military women and women veterans, military organizations and mental health communities alike must take this topic seriously and strive to learn more about it. The purpose and intent of this research dissertation are to add to the limited existing information using a quantitative descriptive design research method to determine if female combatants suffer more than or equal to their male counterparts regarding MI and MIE.

CHAPTER TWO: LITERATURE REVIEW

Overview

MI, according to Griffin et al. (2019), has caught the attention of the mental health profession during the last decade. Military and civilian practitioners must learn as much about MIEs and the emotional, moral, and spiritual effects that MI has on individual military members and veterans alike. Cahill et. al (2023) state the following in their research:

> While the contexts of MI differ, examples from the combat veteran community offer hope. Mental health clinicians who work with veterans will attest; that MI is not a disorder of the combatant alone; it is deeply tied to the circumstances of the veteran's experience of war and trauma. To understand how best to respond to MI, both its contextual and social features must be considered (p. 316).

The following literature review discusses the significance and purpose of this dissertation's primary research questions concerning the impact of MI on female combatants. The overarching goal is to determine what further research is needed to educate and assist current military personnel and the veteran community to better prepare for and respond to the problem to determine treatment goals. The primary focus concerns the effects of MI on female combatants during and after wars—both those in the past and any we might face in the future.

Conceptual Framework

MI and Post-Traumatic Stress Disorder

After more than 20 years of combat engagement, the American military is experiencing a post-war time of peace. However, as in other post-war periods, such as Vietnam, many military personnel and veterans struggle to get back to their normal lives. "Normal" life for military personnel, veterans, and their families is not easy to define after they leave the military culture.

According to Cacace et al., (2022), those who are serving or have served in the military represent a unique population in the United States. Also noted on (p. 223) the authors cite barriers to resources and access for veterans and those military active-duty families serving in communities, such as military recruiters, and how different the civilian lifestyle is, and it is not relatable to the military culture. However, approximately 10% of the adult U.S. population has served in the American armed forces, according to Stebnicki (2020): many active-duty service members do not endorse the diagnostic category of PTSD because of the stigma attached to having or possibly have a mental disorder (p. 26). Moreover, having a medical record of PTSD may hinder one's military career, such as not being promoted, losing security clearances, and not being able to carry weapons.

Some argue that MIE has a greater impact on spirituality and internal moral turmoil than emotional, psychological, or behavioral effects or impacts. In studying MI, Borges et al. (2022) focused on the subtopic of spirituality, religious beliefs, and practices. Their research also included published information from Farnsworth et al. (2017), using their ideas and research development which supported their group's focus concerning spiritual and religious aspects concerning MI. The authors discuss how spiritually oriented practices can often become associated with moral pain following an MIE. Farnworth and group state that "the avoidance of moral pain can manifest into the avoidance of values and related activities i.e., prayer, meditation, being in nature and other beliefs" (p. S33). The authors determined that those suffering from moral pain due to an MIE should engage in spiritual beliefs and practices—the key to breaking free from spiritual suffering and the impact of the MIE or MI. In the same vein, Coady et al. (2021) note that MIEs raise questions of "right and wrong or good and evil" (p. 187) and that the lasting impact affects spirituality and self-identified morals rather than mental

health. The authors suggest MI sufferers may benefit more from spiritual or pastoral care treatments and counseling rather than mental health counseling.

Litz et al. (2019) defined MIE as "the types of events in which a person perpetuates, fails to prevent, bears witness to, or learns about acts that transgress deeply held moral beliefs and expectations" (p. 342). Farnsworth, Drescher, Evans, and Walser (2017) offered a refinement to this definition by suggesting that events can only be potentially morally injurious if they occur "in a high-stakes environment" (p. 392), echoing Shay's (2014) sentiments about leadership betrayal in battle. Farnsworth and colleagues (2017) further state that an event can be injurious if "an individual perceives that an important moral value has been violated by the actions of self or others" (p. 392). These are good starts but, to date, attempts to describe the necessary features of high-magnitude moral stressors have been mostly limited to consideration of the experiences of U.S. military personnel exposed to war zone demands and combat. Shay (2014) discusses how he coined the term MI: Here is my version of MI. It is, to a degree, within our control., derived from my patients' narratives and Homer's narrative of Achilles in the *Iliad*. MI is 1- A betrayal of what is right. 2- by someone who holds legitimate authority (e.g., in the military—a leader). 3- in a high-stakes situation, including all three. The nature and importance of MI first crystallized for me from Homer's *Iliad*, resulting in a little didactic article on taking a decent combat history that appeared in the *Journal of Traumatic Stress* (Shay, 1991).

This evolved into the book *Achilles in Vietnam* (Shay, 1994), for the narrative of Achilles is a story of MI." (p. 183). According to Shay (2014), MI leads to the deterioration of a person's ideals and ambitions, and their attachments begin to change and shrink. In addition, MI impairs and sometimes destroys the capacity for trust. When social trust is destroyed, it is replaced by the settled expectancy of harm, exploitation, and humiliation from others.

The effects of MI have behavioral elements that mimic PTSD, a term dating to the early 1980s, when it became a mental health diagnosis (Friedman et al., 2011). The condition is commonly associated with individuals who are serving or have served in the armed forces and suffer from traumatic events and incidents that occurred in a combat environment. To date, however, MI has not been classified as a mental health condition as PTSD has. Though the elements mimic each other MI characteristics prevail much longer than those of PTSD with adequate and successful treatment.

According to Jovarauskaite et al. (2022), MI may occur due to the violation of one's moral code and because of a particular action or inaction. However, as the authors note, although MI is not recognized as a mental disorder yet, it should be associated with mental health conditions i.e., depression, PTSD, and suicidal ideations, there is a 'gap' in the terms of knowledge between MI and PTSD. Many people who have participated in and been exposed to combat or multiple combat exposures suffer from emotional struggles of guilt and shame. These elements, though not as conclusive and broad as the elements and criteria for PTSD, affect individuals in significantly separate ways, and can have more prolonged effects. MI has been researched over the last decade to determine if its elements impact have causal effects on those who suffer from PTSD as well because the two are so similar.

Stebnicki (2020) discusses issues concerning PTSD and its characterizations i.e. elements such as intense levels of emotional and psychological stress, (p. 97), these characterizations do affect persons especially those who served or have served in the military, because many service members fear this diagnosis will put their career in jeopardy, (p. 97), and are more likely to be hesitant to seek help.

> The disclosure aspects of HIPAA are particularly relevant to service members who may have a mental health condition (i.e., PTSD) requiring treatment or psychoeducation. This component may be viewed by some military mental health advocates as perhaps a move forward with the intention to reduce the stigma of seeking mental health and substance abuse treatment (p.41), by society and the people they associate with, including family.

Farnsworth et. al. (2019) studied the Navy and Marine Corps Combat Operational Stress Control (COSC) model, which delineates moral stress injuries and PTSD. The authors determined that the model contained no guidance for practitioners determining how to treat targeted MI patients.

Ames et al. (2019) identified correlations between MI and suicide risks. Through their research, they found that both secular and spiritual interventions are in development that address veterans and active-duty military personnel who are diagnosed with PTSD. As previously noted, MI elements that impact or disrupt an individual's psychological, religious, and spiritual emotions also, is strongly related to factors known to increase the risk of suicide in a sample of U.S. veterans and active-duty military. However, this relationship was not mediated or moderated by the degree of religious commitment. "Both cross-sectional and longitudinal studies are needed to replicate these findings" (p. e277). Practitioners and educators to be keenly aware of the role spirituality plays in both good and bad decisions of service members and veterans alike. To date, existing literature has a definitive gap concerning MI and female active-duty, veterans of the United States Armed Forces. Most articles that have been published concern or have a large male-based population or sample. As noted in Table 1: Females Awarded Purple Heart Medal or CAA, a substantial number of females have been in combat environments and actions since 2000. This number alone signifies or should catch the attention of both the military

and civilian mental health communities as those numbers are most likely to increase in coming conflicts involving the United States military. MacGregor et al. (2020) highlight the matter of women's involvement in the American armed forces, which has been steadily rising since the early 20th century. Since 1901, the U.S. Army has deployed "thousands" of women overseas to staff hospitals, and in World War II women deployed and worked as translators and clerks. By the time of the Gulf War in 1991, women expanded their MOS roles and served alongside their male counterparts in many combat support functions. The latest wars in Iraq and Afghanistan have placed female soldiers, sailors, airmen, and Marines closer to or on the front line of battle more than ever before in the history of the military. Females in combat and any effects of MI need to be researched and the mental health communities within the DoD and civilian communities need to be prepared for further development for future wars and the warrior's care during and after the conflict.

Related Literature

Military Sexual Trauma (MST)

The primary purpose of this study is to bring attention to how MI affects female service members and women veterans. Most current research concerning female military members and veterans focuses on Military Sexual Trauma (MST) rather than MI. Nillni et al. (2022) discuss the topic of women veterans and their exposure to "more traumatic events in a lifetime" (p. 248) compared to non-veteran women. The authors discuss how "during a woman's tour of duty they experience a variety of stressful or traumatic events that increase their risk for adverse perinatal outcomes, including exposure to warfare and military sexual trauma (MST), defined as sexual assault or harassment during military service" (p. 731). 30 women out of 51.5% of female veterans reported an actual sexual assault. According to Gilmore et al. (2020), while both women

and men in the military are victims of MST, the rate is 38.4% higher for active-duty women and women veterans (p. 462). According to the U.S. Department of Veterans Affairs (2004), MST is defined as "sexual harassment that is threatening in character or physical assault of a sexual nature that occurred while the victim was in the military" (p. 1). Gibson et al.'s (2020) research on MST found that most studies focus on the younger generation of female service members and veterans. Several recent studies conducted by the VHA concentrated on gender reporting and treatment. Disparities were noted by post-9/11 era MV women concerning their reporting and treatment received for PTSD and PTSD associated with MST (Conard et al., 2021). Research shows and supports that long-reaching effects from remote sexual traumatic events have extended into the more mature population of women veterans, yet little is known about the potential impact of MST on older servicewomen (p. 207). What is known is that MST has a broad range of effects on the victim and that sexual assault is prevalent in the military, as discussed by Chinman et al. (2023) "The Department of Defense (DoD) has given increased attention and priority to preventing sexual assault and sexual harassment (SA/SH), it remains a problem for the US military. DoD's epidemiological estimates among active-duty Service Members (SMs) in 2021 show 8.4% of women (about 19,000) and 1.5% of men (about 17,000) experienced unwanted sexual contact in the past year" (p. 1352). Therefore, MST and MI may be congruent.

Research conducted by Hamrick et al. (2022) found "that sexual harassment is a form of within-rank violence and leadership failure that may result in other-directed MI symptoms, including feelings of betrayal, anger, mistrust, and disgust" (p. NP10010). The authors also discuss how the military is structured to potentially contribute to the development of other-directed MIs after a person (male or female) has experienced military sexual trauma. Hamrick et

al. (2022) shed light on the issue in explaining how one's identity transforms when going from civilian to military: the transition from civilian life to military service requires service members to renegotiate their identity such that collective goals take precedence over individual needs. This transformation, uncommon in most civilian professions, is essential to prepare service members for combat operations (p. NP10010).

Individuals who have experienced identity fusion have been "transformed" (Hamrick et al. p. NP10010) to contribute to a unit or organization, military members who become veterans must balance their personal identity with their new social structure identity. Often in such scenarios, the individual will make more extreme sacrifices for a group, such as a platoon/unit in the military, based on a perception of personal loyalty or loyalty to the unit. MST has the effect of negatively altering one's expectations about a trusted institution. Events such as MST serve as the basis of one's professional and personal identity, increasing the likelihood of an MIE, which often leads to feelings of betrayal, mistrust, anger, guilt, and shame. Because MST and MI are congruent, the next section discusses MI and sexual harassment within the military and veteran communities,

Sexual Harassment of Women in the Military

For the past several years, a prominent topic that has impacted American culture and society is the MeToo Movement, which raises awareness about sexual abuse, sexual harassment, and rape culture. The sexual harassment of anyone, of any gender, is not to be tolerated, yet the primary focus is usually women as the victims in a professional environment, from the film industry to the political arena and the corporate world. The United States military has also had an ongoing problem with sexual harassment spanning several decades, and though it is a well-known and egregious problem, it is swept under the rug and not reported.

According to the U.S. Department of Defense (2021), “Sexual assault and sexual harassment remain persistent challenges across all Military Services.” Their 2021 report estimated that 35,875 active-duty servicemembers (8.4% of active-duty women and 1.5% of active-duty men) indicated experiencing unwanted sexual contact in the 12 months before being surveyed. Thomas et al. (2021) reported that:

According to the DoD, reports of sexual assault in the military increased from 2,688 in 2007 to 6,083 in 2015. Despite the considerable number of reported events, evidence suggests that the actual prevalence of sexual harassment and sexual assault is much greater because these events are vastly underreported (p. 7044).

Why would such egregious crimes not be reported or investigated? Stebnicki (2022) alerts his readers to his discussion concerning service members not reporting mental health issues: many service members do not report mental health concerns due to fears of some sort of negative impact on their careers, such as not being able to handle weapons or deploy to combat environments. The information provided by (Thomas et al, 2021; Stebnicki, 2022), may allude to the question as to why MST is not reported as well. Therefore, trauma from an MIE can be physical or mental health-related and underreported to MI behaviors. Finkelstein-Fox et al. (2021) conducted research concerning Meaningful Military Engagement (MME) and found that men had a better experience than women in terms of the number and length of deployments. Women were negatively affected during their service due to their being victims of sexual harassment while serving in uniform.

Moreover, Conard et al. (2021) state that sexual harassment and MST are no longer “just a war-zone event” (p. 141). More than 41.7% of non-deployed female veterans reported MST, 41.2% reported sexual harassment, and 10.2% reported sexual assault (Conard et al., 2021). The

numbers are similar or higher to those among deployed female veterans. Conard et al. (2021) also state that "the occurrence is at least twice the reported numbers, due to those MV and other military members, keeping their silence" (p. 141). Having a clearer understanding of the interconnections between MI, MIE, PTSD, MST, and sexual harassment and assault, it is necessary to discuss if there are emotional differences between the genders.

Moral Injury

MI is no longer in the infancy stage of research since the subject has been researched and discussed over the last 10 years and has gained momentum over the last several years. Whether PTSD and MI share diagnostic criteria is still debated. The Disabled American Veterans Association (DAV) discusses "symptoms and concepts between those of MI and PTSD, how they fall along the same line, but each has its unique constructs." The Department of Veterans Affairs (VA) identifies PTSD as a "mental disorder" and considers MI "a dimensional problem" that is non-diagnosable as opposed to PTSD (Disabled American Veterans, 2022). Neria and Pickover (2019) note: "A valid definition of MI is key to its reliable measurement (p.460). MI is "the lasting psychological, biological, spiritual, behavioral, and social impact of perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations" (p. 459). As recently as 2020, Stebnicki discussed MI in his book, *Clinical military counseling: Guidelines for practice*, addressing the fact that "war has such a profound and psychosocial impact on both service members' and veterans' mental, physical, and spiritual health, and within this group, they are either overcomers, or defeated mentally, physically, spiritually, and often socially as well" (p. 120).

Guilt and shame negatively impact spiritual and existential conflicts. They can also lead to a loss of trust in self and others: according to Jinkerson (2016); "the decision to make guilt a

necessary criterion was made because of the demonstrative empirical associations between guilt and the secondary symptoms found in individuals with MIE history and/or PTSD diagnoses" (p. 126). Guilt and shame are the types of emotions that are core "symptomologies which can alert practitioners to the possibility of an MIE, or the individual suffers with MI" (p. 122). Yet Jinkerson (2016) determined that "depression, anxiety, anger; re-experiencing self-harm and societal problems contribute negative elements to these same symptoms, however, they are secondary symptoms in value of criteria for a diagnosis" (p. 127). Corona et al. (2019) describe MI as a "distressing psychological experience, in which a personal moral code is aggravated by potential psychological mechanisms which can lead to suicide in a person who has served or is currently serving in the military" (p. 615). Farnsworth (2019) explored the relationship between

> MI and PTSD and in this article, Farnsworth appeals to the scientific principle of falsifiability by comparing its role in cognitions related to PTSD and MI (p.373). He suggests that MI and PTSD can be differentiated using the criteria from D from PTSD in the *Diagnostic and Statistics Manual 5* (DSM5) (p. 374).

Which allows researchers and practitioners to distinguish between cognitions for MI and PTSD separately and consider what they share, along with their impact on a person's emotions and spirituality, and how both MI and PTSD can be effectively treated together.

History

MI research of the last 10 years focuses primarily on the military and veteran communities. MI events can result from an extreme event, such as killing a person or witnessing persons being killed, tortured, or maimed, or a lesser event, such as betrayal by leaders whom a person held in high regard or betrayal by peers within the same unit and rank structure. Currier et

al. (2018) created a "working definition for MI as a disruption in an individual's confidence and expectations about their or other's motivation to act and behave in an ethical manner" (p.4754).

Griffin et al. (2019) highlight Litz et al.'s (2009) study of MI which defines MIE as "perpetrating, failing to prevent, and bearing witness to or learning about the events of a certain or many MIE that 'transgresses' against the witnesses' deeply held moral beliefs and expectations." (p. 350). This study was one of the earliest on MI. Schorr et al. (2018) note that there is limited empirical research concerning the consequences of MI, the impacts of which must be further examined. In addition, more counselors and practitioners need to become more familiar with MI and the associated criteria. Schorr et al. (2018) also reference Nash et al. (2013), who further validated MI by developing a self-report questionnaire that measures exposure on the MI Event Scale (MIES).

MI Events (MIE)

MI Events (MIE) are like traumatic events, and the criteria and elements that link traumatic events to PTSD also link MIE events to MI. Jamieson et al. (2020) redefine MI as "moral trauma" (p. 1062). and focus on correlations between MI and military members. Active and reserve military personnel and veterans are most likely to experience or witness an MIE. Though the primary focus of the literature reviewed, and the purpose of the current study concerns American military women and female veterans, studies and research from other countries provide key supportive findings concerning MI and mental health concerns for service members and veterans who have experienced war-type environments. Corona et al. (2019) identify PMIEs as acts or inactions that violate people's moral codes and their grounded beliefs of what is right and wrong as Litz et al. (2009) and Molendijk (2008) have discussed. Other research suggests that three types of PMIEs are the transgressions created by self, transgressions

created by others, and transgressions by those held in high regard or authority (Bryan et al., 2016; Currier et al., 2015; Held et al., 2019; Litz et al., 2009; Nash et al., 2013).

Molendijk (2018) examined the role that politics plays in decision-making capacities during battle conflicts that coincided with possible onsets of MI. His research captures decisions made at higher levels of authority. These decisions, Molendijk concluded, created distress and chaos on the battlefield. He then compared the problems experienced by the veterans of those battles and examined how they reacted to the political governing of the battle. His study revealed that veterans, though they took responsibility for their moral injuries, also noted that the persons making these decisions should also be holding themselves "morally accountable" (p. 268). Hamrick et al. (2020) support Litz et al.'s (2009) "conceptual model of MI" (p. 111) and suggest that veterans who act with awareness and do not perceive or make judgments based on actions witnessed are at a "lower risk" (p. 111) for developing a MI.

The reporting of MIE and MI in literature is limited to men and very few studies include women active, reserve, or female veterans. For example, in an article that discussed the defining and assessing of MI and MIEs, Litz et al. (2022) conducted interviews with service members and veterans across consortium countries: UK, Israel, Canada, and Australia. Out of all the countries, only men were interviewed, and Israeli forces are known for their women service members as they get national attention for their rigorous training and sustained performance with their male counterparts. To emphasize the problem, most of the current literature cannot distinguish major variances or determine if men or women have a higher percentage of MI when evaluating survey or test results. The literature reviewed, including articles that have not been included in this study mostly reports as does Koenig et al. (2018) that "No significant difference ($p > 0.10$), however, was found based on gender (48.6 for men vs. 50.1 for women)" (p. e663). MIEs are often

witnessed due to events such as killings or events that end or lead to the death of someone or something that had life.

Impact of Killing

There is no event, especially in a battle, with a more severe and lasting impact than knowingly killing other human beings. Ali et al. (2022) discuss how one of the military's primary functions is to train all its members to kill. In the initial phases of training, newly recruited military members are indoctrinated into both dehumanization and camaraderie to acclimate and remain numb to the violence they are surrounded by—yet also able to show compassion to both enemy and friendly forces. Burkman et al. (2019) determined that veterans who reported they had killed while fighting a battle are at a higher risk of having PTSD, abusing substances, committing suicide, and being socially withdrawn compared to those who did not report killing during their military service. According to Frankfurt et al. (2017), veterans who participated in events in which killing took place, justified or not, and those who merely witnessed such events display worse post-deployment functional and psychiatric outcomes compared to those who had not been exposed (p. e1950). Research such as this supports hypotheses that those who have killed or witnessed killings suffer mentally as well as socially, emotionally, and spiritually. Frankfurt et al. (2017) also note that the underlying mechanisms of MI, such as shame and guilt, are not equal to those mechanisms of fear and threat-based mechanisms concerning PTSD. Mechanisms refer to the diagnostic elements for those who are diagnosed with PTSD, elements that trigger fear or threaten the victim. Therefore, certain criteria and elements of PTSD and MI are not the same, which does not prove, support, or defend that MI is a lesser concern or issue for persons who suffer from it.

Maguen et al. (2017) conducted qualitative studies with combat veterans subjected to MI and discovered that in addition to other such psychological conditions associated with PTSD and personal concerns, their individual spirituality and social functioning are often impacted negatively after leaving the combat zone. Also, due to the stigma associated with diagnoses such as PTSD and the taking of life, many military personnel and veterans have serious concerns that they will be negatively "judged or condemned" (p. 998) for their wartime actions. Another qualitative study conducted by Keller et al. (2020) examined the mental health effects of deployments on Iraqi and Afghanistan combat veterans. Study participants were mostly male (86%) with a mean age of 30. Keller et al.'s analysis determined that during and after deployments in combat environments, all had negative reactions and thoughts concerning the service they were a part of and the government they were serving, possibly contributing to MI effects of guilt, shame, mistrust, and remorse.

Emotions

A commonality between MI and PTSD is the effects that each has on a person who suffers from one or both conditions. Persons with PTSD experience maladaptive emotional regulation and are unable to control their emotions, according to Powers et al. (2019). As discussed earlier, Farnsworth (2019) argued how criteria D in the diagnostics of PTSD can be used by practitioners to identify persons suffering from MI. Koenig et al. (2020) found that criteria D symptoms related to negative emotions about oneself, and others combined with inner psychological conflicts are more commonly related to MI than PTSD. Drescher et al. (2018) identify emotions such as guilt, shame, and anger as predominant emotions caused by PMIEs. Borges et al. (2020) determined that veterans suffering from MI preferred not to confront their emotions and avoided discussing them with counselors. Providers will benefit from a better

understanding of MI and the regulation of emotions with more specialized training and knowledge of MI.

Unfortunately, to date, researchers have extraordinarily little data on the emotional effects of MI on female service members and veterans. Finkelstein-Fox et al. (2021) state that female service members experience unique challenges when trying to assimilate into their branches of service. Evidence demonstrates that women face higher rates of harassment than men and feel less supported by fellow service members. Maguen et al. (2020) determined "While differences in moral reasoning could contribute to differences in the experience of moral injury, with debate as to whether women are more oriented to care of others and men more to justice, meta-analyses do not offer strong support for this theory" (p. 98). More research needs to be conducted to examine differences, if any, between male and female servicemembers, particularly concerning the symptoms related to MI.

Gender Differences in Emotions

Emotions influence many aspects of a person's life. Zurek et al. (2022) found that "military training has proven to contribute to the service persons' ability to maintain control over their thoughts and emotions" (p. 2). According to Hall (2023), (excluding gender) and considering emotionally driven actions, thoughts, speech, and behaviors only. Many people are avoidant and cannot regulate their emotions. However, individuals serving in, or who have served in, the U.S. armed forces often and in especially dangerous situations such as combat must at times be emotionless yet display the right amount of emotion when called to perform (Stebnicki, 2020). Zurek et al. (2022) discuss how the military develops and trains warriors and leaders to control their thoughts and emotions. Military leaders and commanders (not excluding the lower and middle enlisted ranks depending on the nature and mission structure of the service

branch) are placed in high-stress situations and environments, are under scrutiny from higher authority or governmental figures, and are often in extremely dangerous situations while having to make decisions for themselves and others. How do the genders differ in emotions?

Research concerning men's emotions gives us much to consider. Schaefer et al. (2021) explain how the military portrays men's masculinity and how male service members can and are in control of their emotions. Yet the same research group determined that military culture does not dictate or train their male members by directing them or ordering them to use or show self-control of their emotions or, how they should or should not display emotions. How Schaefer et al. (2021) explain as follows: "Military culture provides mixed messages about emotional displays that may ultimately hinder men's ability to seek support and express distress, despite some acceptance of certain emotions in some contexts McAllister et al., 2019" (p. 613).

Emotions are in general described or related to feminine type qualities: which may threaten military effectiveness and the display of rules sometimes resemble efficient emotion regulation (e.g., resilience; Ashley et al., 2017), and at other times are more akin to suppression or overcontrol (e.g., stoicism; Green et al., 2010). This is a nontrivial difference given the divergence of concomitants of efficient emotion regulation versus suppression; emotion suppression is linked to strict gender norm beliefs and a slew of negative outcomes including aggression, social impairment, disinterest in seeking help when needed (Schaefer et al. (2021). Yet the military seems to "confuse the issue for its male personnel and are concerned for how" (p. 613) their standards for men showing and working with and displaying their emotions. This confusion about emotional displays could "ultimately hinder men's ability to seek support and express distress despite some acceptance of emotions in certain context" (p.613).

As Schaefer et al. (2021) discuss, military culture does not present a clear stance concerning how military personnel should display or regulate their emotions. “Emotions are generally described as feminine, threatening to military effectiveness and display rules sometimes resemble efficient emotion regulation” (p. 613). The authors argue that sound leadership decisions and actions can also be detrimentally affected by emotional decisions. This could be construed as suppression or overcontrol of emotions from military superiors. In Schaefer et al. study, it is unclear whether any type of emotions or all emotions that can be displayed by men in the armed forces are integral to the American military structure and organization. Sun et al. (2019) state: that individuals are left to make sense of their actions and the actions of others, integrate those actions with their existing moral and ethical frameworks, and manage emotional responses promoted by the relative congruence or incongruence between PTSD and moral beliefs (p. 93). To develop a foundation for emotional gender differences if they exist in the military, we must review what the literature says concerning events or in this case PMIE which have differentiating effects on gender.

To bridge the genders: regulation of emotions for men is to be more controlled as it is not socially acceptable for men to display emotions.

> Emotion regulation is broadly defined as a self-regulatory function related to emotional self-awareness and understanding, acceptance, and tolerance of negative emotion; use of goal-directed behavior and management of impulsive behavior; and consideration of social context in the selection of emotion regulation strategies (Gratz & Roemer, 2008) (Gilmore et al. (2020), p. 463).

To this point, research and the discussion of differences of gender and emotions have been focused on males’ actions and the perspective and the differences in gender population

when reporting MST related to MI. Are there any, or a significant difference in emotions for females that are serving or have served in the military?

Finkelstein-Fox et al. (2021) found what appears to be gender differences in adjustment among military personnel, including veteran deployment stress, combat exposure, MST, etc. Kelley et al. (2019) in their research believe "it is possible that women and men may discern and/or may respond to MIEs differently, which may yield different mental health and substance use outcomes" (p. 338). Also, the authors note:

> Findings also revealed that none of the mental health variables (e.g., suicidality, PTSD, depression, anxiety) were significantly different for men and women. Sex differences in mental health outcomes among military personnel are mixed, with some studies revealing that women are more likely than men to report symptoms of depression and anxiety (p. 341).

Research concerning (MME), as noted earlier by Finkelstein-Fox et al. (2021), the research group found that:

> Despite apparent gender differences in deployment stressor exposure, no literature to our knowledge has examined gender differences in either the perceived meaningfulness of military work or the extent to which finding meaning in one's work buffers against the detrimental effects of deployment stressors (p. 2169).
>
> "Although exploratory, a clearer understanding of gender differences in the extent to which military meaning buffers deployment stress (how the military determines what deployment stressors are most predominate and what can be done to reduce or resolve them), is essential for improving the structure of support services for all recent-era veterans" (p. 2169).

The group concluded that: “These findings have meaningful implications for researchers and clinicians alike; in working with recently deployed veterans, it is essential to consider multiple levels of gender differences in stress and meaning systems, including extra-and intra-unit stressor exposure and individual differences in MME as they vary across contexts.

These findings serve as a reminder that personal meaning systems emerge as a product of social structures and individual differences in life experience and cognitions. As healthcare systems continue to respond to the needs of diverse female and male servicemembers returning from long, stressful deployments, providers must consider the unique contexts in which individuals make sense of their time in the military (p. 2183). Kelley et al. (2019) state “Whether MIEs confer greater risk for female veterans, however, is not known. Alcohol abuse rates are higher among male veterans (Hoggatt et al., 2015), whereas combat has stronger associations with depression for female veterans (Luxton, Skopp, & Maguen, 2010)” (p. 338).

Guilt

According to Moon (2019), there exists a range of moral emotions. Research shows guilt as the primary emotional factor when a person experiences a PMIE. Guilt coincides with a person’s actions or inactions and debates with the self as to whether something is right or wrong. A person who experiences guilt due to MI must reconcile from within themselves, reviewing and self-evaluating actions taken especially those not taken. Due to the debilitating nature of guilt, practitioners must be aware and trained to help military personnel and veterans overcome this powerful and overwhelming emotion. Meade et al. (2022) determined that guilt cognitions involve insufficient justification (i.e., believing there was no or poor justification for the actions chosen during the time of the trauma) and wrongdoing (i.e., believing to have purposefully done something that violated one’s values or moral code).

Jinkerson (2016) asserts that for practitioners or therapists to diagnose MI, the following criteria must be met: history of MIE or exposure to an MIE and emotions presented concerning guilt. Symptomatic criteria which are either core or secondary are as follows: core symptomatic are guilt, shame, spiritual/existential, and loss of trust in self and others. Core secondary is depression, anxiety, anger, reexperiencing moral conflict, self-harm, and social problems (p. 126). Smigelsky et al. (2019) found it important to determine where guilt is placed. For example, if blame is attributed to oneself, then the experience of guilt can lead to other behaviors, such as being apologetic and wanting to seek others' forgiveness. Emotions such as guilt are often accompanied by other feelings, such as shame for what was witnessed, or an act directly or indirectly participated in.

Shame

From the early times such as when Christ was on earth, shame has been a powerful emotion. The Bible recounts that Christ was hung to die on a Roman cross. He was displayed and stripped naked, the most embarrassing, humiliating, and shameful way to die during this time, according to the King James Version (KJV) of the Bible. As Nillni et al. (2020) state: Potential consequences of traumatic experiences, such as Military Sexual Trauma (MST) and combat, along with nontraumatic experiences which include leadership failures, betrayals by peers and the military/ government served, may lead to an overwhelming sense of guilt and shame and could be a factor in the combat experience element, and problems may be exacerbated. Military sexual assault and sexual harassment have been a severe problem in the military ranks for many years. Suris and Lind (2008) suggest:

That MST was recognized in the early 1990s as occurring frequently enough that the VA was directed by Congress to provide counseling for veterans who experienced sexual trauma or

sexual harassment while on active duty (Veterans Health Care Act of 1992, Public Law 102-585), research related to MST is still in its infancy more than a decade later (p. 252).

Also, Suris and Lind (2008) note that "The VA in a 2002 national report; reported MST surveillance data from approximately 1.7 million VA patients indicated that 22% of women and 1% of men have experienced MST (Department of VA, 2004). Although women are twenty times more likely to be victimized during their military duty than men, there are twenty times more men in the military than women in the VA system. Therefore, because 22% of female and 1% of male VA users screen positive for MST, the actual numbers of men and women are about equal (Department of VA, 2004) (p. 251).

Military sexual assault and sexual harassment fall within the category of MI. Williamson et al. (2019) determined the negative impact of MI on veterans' mental health with key common symptoms that include shame. Military men and women are proud individuals, protective of and extremely loyal to their branch of service. Shame, however, is not considered a leadership trait or principle, nor is it readily discussed amongst the ranks. To keep from "shaming" their units or organization, many servicewomen and men hide their feelings of guilt and shame related to MIEs, PTSD, and other mental health disorders (Stebnicki, 2020). Though shame is a critical element to consider with a person working through a moral issue, anger can be a driving and influential emotion as well.

Anger

Hertz et al. (2022) discuss the stress that killing puts on an individual's morals, no matter if it is justified by combat and the persons killed were enemy combatants. The feelings of guilt, shame, and anger can become debilitating, causing great stressors, and leading to other injurious and destructive behaviors. As many authors have noted, emotions can become unstable and hard

to manage. Bravo et al. (2020) have studied individuals who have committed acts or witnessed an act that disrupts their own moral consciousness and moral fiber. Their study revealed that veterans who act against what they believe morally tend to experience more self-blame as well as shame, guilt, and loss of love for themselves. Those who witnessed such acts and did not report the incident or decided to ignore the act experienced more mistrust, anger, and hostility.

Trust

Trust is multifaceted concerning MI and emotions. According to Sullivan and Starnino (2019), the psycho-social consequences resulting from MIEs may include guilt, shame, or a loss of trust, meaning, or purpose. This can be associated with other emotional irregularities, such as guilt (Smigelsky et al., 2019), especially if a veteran or military member has lost trust in their leadership or the command with which they serve. As noted, MI can impact individuals' emotional states and frequently damage their social trust. According to Cahill et al. (2023), a betrayal of what is right by others, especially a person with authority, such as a combatant commander or platoon leader, can make it difficult, even impossible, for the person witnessing this wrong to derive any good from it. Therefore, the problematic act impacts the military member's or veteran's capacity to trust themselves or others in their society and environment. Bravo et al. (2020), also note that:

> One structure for understanding MI is whether the individual perpetrated an act, versus witnessed an act that may violate their sense of humanity. When veterans perpetrate transgressive acts, this self-directed MI may result in feelings of shame, guilt, social isolation, and the perception that one is fundamentally flawed and incapable of being loved. In contrast, in instances of witnessing morally injurious experiences, other-directed MI may result in feelings of mistrust, anger, and hostility toward others or those

> in authority positions. Not being able to trust oneself can lead to other mental health disorders (p. 52).

Trust in the chain of command or, for a veteran, trust in the VA is paramount, and MIEs that occurred during service or that transpire after leaving the service, such as the betrayal of peers, authorities, and the veterans' support and care system, can have serious effects on individuals.

Betrayal

Hollis et al. (2023) state that before the exploration of MI, Shay (2014) and others classified MI as a "socially inflicted wound of betrayal" (p. 86). Betrayal on any level has negative and often long-lasting effects on individuals, and people will respond differently, with some not affected at all. Shay also defined MI as a "betrayal of what's right, by someone who holds legitimate authority, in a high stakes situation" (p. 87). This warrants further investigation into the impact of leaders' and peers' wrong decisions in a combat (or any high-stakes) situation that can cause the subordinate or peer to feel betrayed.

Fleming (2022) states that the "predominate view" (p. 1027) in the current literature on MI derives from acts of transgression and/or betrayal that occur during an MIE. Fleming uses 12 key definitions taken from 124 articles that "provided definitions of MI or potentially morally injurious experiences/events in the context of military experiences", the majority of the twelve definitions describe MI as a response to a violation of moral beliefs by culpable acts of transgression (omission/commission) and/or betrayal (p. 1024). Fleming defined the subject of the 124 articles by identifying: perpetrations by self-omission/commission, perpetrations by other than self–betrayals/witnessing, and non-perpetration by self or others based on events. Being betrayed, or having believed they have been betrayed by leadership in the military can diminish discipline within the ranks and can lead to other betrayals of self. Studies have

indicated that self-worth can be inherently damaged and affected by the impact of betrayal resulting from MI.

Self-Worth

Those who experience MIEs that are potential precursors to MI must be willing or able to understand themselves and not harbor any ill will or hold themselves as unforgiven or worthless. Farnsworth et al. (2019) argue that it is natural for a person who experiences an MIE to experience moral pain, which they define as "the experience of dysphoric moral emotions and cognitions (e.g., self-condemnation) in response to MIEs" (p. 633). Purcell et al. (2018a) found that veterans and their therapists work to determine what forgiveness means to the veteran and evaluate the standards they apply to themselves as they do to others they forgive. A central aspect of this learning exercise is to identify any barriers (p. 652) there may be in the veterans forgiving themselves.

Thus, self-worth correlates with forgiveness. Pernicano et al. (2022) determined the benefits of forgiveness for self and others when dealing with MI. They concluded that "rumination, common in MI, undercuts forgiveness and keeps the offender on the offense, and emotions of hatred, revenge alive, and emotional forgiveness affects cognition and has a strong influence on a victim's subsequent attributions" (p. S60). However, there is minimal research concerning active-duty service members and self-worth. Being concerned with self is incredibly important, but just as important is social well-being.

Social Well-Being

Those who leave the service must go through another transition, which could be considered a metamorphosis, such as that undergone when they entered the service. However, leaving the service can be even more stressful and burdensome than joining the military. Grimell

(2017) states that “at a point no matter the length of time they have served, everyone must “transition and reintegrate back into civilian life.” Grimell (2017) finds that exiting service members face personal, social, familial, and financial challenges. Service members’ “self-identity” can be problematic because they must reinvent their character to who they are now as civilians (p. 833). Also, stated is that: “self-identity work may also implicate coping with experiences of an existentially burdensome or even traumatic character which could be formulated as existential concerns or MI” (p. 833).

Chesnut et al. (2020) developed two theoretical perspectives on how MI might impact military members’ or veterans’ Social Well Being (SWB). “One perspective, based within a social-functionalist or biological approach to morality, suggests that different moral emotions may ultimately lead to the same SWB outcome: withdrawal or disengagement from social life” (p. 588).

> An alternative perspective, based within the disciplines of philosophy, ethics, and anthropology, asserts that the social aspects of MI are related to other-directed transgressions and moral emotions and not necessarily to self-directed transgressions. This second theoretical argument focuses on a sense of betrayal and asserts that moral emotions, such as blame, can erode social bonds (p. 588).

The author’s second argument focuses on betrayal and contends that moral emotions i.e., blame, can erode social bonds. Another researcher such as Shay discussed this issue with the concern of service members' betrayal of what they viewed their leaders doing as right or wrong morally in a high-stakes situation. Collectively, the findings from these studies indicate that other-directed MI reactions rather than self-directed MI reactions are associated with the targeted social risk factors for suicidality (p. 588).

Spirituality

Gaining momentum in the study of MI are the effects and support of religion and a person's spiritual belief system. Koenig and VanderWeekle (2020) found that the relationship between religion and mental health is becoming an increasing focus for research. They discuss how the studies between counseling and mental health therapy, when conjoined or paired with a person's spiritual beliefs, seem to show there are positive, obtainable, and sustainable goals to set for individuals who are suffering from MI and that using religion to support mental health has a positive impact on persons suffering with or from an MIE or MI.

According to Brémault-Phillips et al. (2019), military service members and veterans who were exposed to MIEs during their service find the events to be mentally and spiritually distressing. These MIE experiences are often in direct conflict with the service member's or veteran's personal and moral beliefs, which leaves the person struggling to reconcile the event and their lived experiences, beliefs, values, and worldview. The authors noted that service members and veterans affected by an MIE can be deeply affected, experiencing doubt or a change in their being and spirit. Therefore, spirituality is a principal factor for practitioners to consider when determining the treatment approach to MI.

Suitt (2021) researched military trauma and military chaplains' support, along with other pastoral and spiritual support, for military members and veterans who suffer from MIEs. The Christian faith was consistently and seemingly "guiding" (p. 182) recovery from moral traumas and other MIs.

> People join the military with expectations about their relationship with the divine, its presence in their lives and the world. Unfortunately, the realities of war may upend these expectations. Broadly, psychologists and military chaplains have described "spiritual

> injury" as the unease with one's beliefs, one's relationship with God, and difficulty in participating in religious communities due to cognitive stress (p. 182).

The authors concluded there were many positive, impactful ways in which religion and spirituality contribute to therapeutic and "healing" (p. 197) processes when working with MI clients. However, Currier et al. (2019a) state that "in the initial stage and theory of scientific research, the role of religious faith and spirituality in MI has not been examined explicitly" (p. 393). Currier et al. (2019b) determined that given a well-documented synergy between religion and morality, many uniquely painful events, memories, or other triggers incurred by veterans during combat situations; are more than likely to view these events as a violation of their morals and beliefs (p. 383).

Smigelsky et al. (2020) determined that a religious or spiritual framework assists the person with MI symptoms and provides for the diagnosis and building a solid treatment plan towards achieving forgiveness. Pernicano et al. (2022) state that "the violation of spiritual, religious, military, or personal values results in a syndrome of shame, self-handicapping, anger, and demoralization" (p. S57); which any or a combination of all can lead to suicide attempts and or successful execution of a suicidal plan amongst combat experienced veterans.

Forgiveness

Forgiveness is a basic yet complicated emotion, which is biblically, socially, and individually a key element in the healing process for many individuals suffering from mental health problems, including MI. As Matthew 6:15 (KJV) reads, "But if ye forgive not men their trespasses, neither will your Father forgive your trespasses." In this passage, "men" refers to everyone. Moreover, self-forgiveness is just as important as forgiving others and is difficult for

many. Purcell et al. (2018b) discuss forgiveness and military personnel, noting that moral guilt can impact service members' ability to forgive themselves and others.

Forgiveness, and self-forgiveness in particular, bears some explanation. When it comes to killing and the violence of war, it is not clear who is authorized to forgive or whose forgiveness is needed and meaningful. In place of forgiveness from those killed in the war, soldiers tend to hear words of absolution from their own loved ones—those who tell them that they did what they had to do to stay alive or urge them not to judge themselves for difficult choices made in the heat of battle. For veterans struggling with MI, these reassuring words often feel insufficient (p. 648): and can cause further negative emotions.

Military service members on active duty and veterans can often be consumed and destroyed by their negativity toward themselves. Negative emotions, and negative thoughts about oneself can and often do lead to even more severe emotional distress and actions such as suicide.

Suicide

According to the National Veteran Suicide Prevention Annual Report (2022), "in 2020, there were 6,146 veteran suicides, and the suicide rate was 57.3% greater for Veterans than for non-veteran U.S. adults." The report states that on average, 16.8 veterans took their lives per day in 2020. In the same year, the "unadjusted suicide rate for males was 33.7 per 100,000, and for women veterans in the same year, was 13.8 per 100,000." According to Houtsma et al. (2017), it may be possible from what experiences servicemembers face during deployment, and other such acts of moral transgressions can affect the development of suicidal ideations and suicidal desire by way of self-decrease and the sense of belonging (Houtsma et al., 2017, Introduction). Bryan et al. (2014) as cited in Houtsma et al. (2017) determined that experiencing an MIE is a risk factor

for suicidal ideation and behaviors among military personnel, which determines a correlation of relevancy between MI and suicidal desires and actions.

Selby et al. (2010) and Bryan et al. (2013) as cited in Houtsma et al. (2017) discuss how military personnel face extreme difficulties once leaving the military, including coping with the effects of moral transgression, when separated from the military culture, which may act as a contextual aid to make these experiences more comprehensible. In a way returning home may worsen the effect of moral transgression due to perceived or actual lack of understanding on the part of civilian social support (Houtsma et al., 2017, Introduction). Post-deployment transitioning, when servicemembers go from being active duty to veterans, can be extremely difficult and create or increase mental health concerns for that individual and their families. According to Brenner et al. (2008) as cited in Houtsma et al. (2017), "Veterans indicated that strong bonds are formed with other military personnel during service, but an individual's connection to civilian life decreases" (Houtsma et al., 2017, Introduction).

Summary

The literature review explores the topic of MI and how it affects male service members and the situations or environments that most contribute to a person having to live and cope with MI specifically members and veterans of the U.S. military, encompassing all branches of service. Though only two-thirds of American military forces participate in global and domestic war conflicts, everyone in the military functions as one interlocking unit providing skills to support the "boots-on-the-ground" troops fighting on the front line. MI is a serious condition that, while not yet recognized as a mental health disorder, profoundly affects the emotions, behavior, and even spirituality of those who suffer from it. However, there remains a large gap in the literature, and that is the effect and impact MI has on women servicemembers and veterans. Ninety-eight

percent of the existing literature focuses on men. Therefore, little is known about the emotions and behaviors of women after they have been exposed to combat conditions, mainly because there is limited female participation in research from the military and veteran communities. The purpose of the current study and the design of the data collection method is to decrease the gap in the literature. I will collect data by gathering responses through an anonymous questionnaire. My research goals are to recruit female active-duty military and veterans who have deployed and have been in combat environments and situations. The purpose is to inform and, I hope, engage military and civilian counseling practitioners to be more prepared to assist and treat individuals affected by MI.

CHAPTER THREE: METHODS

Overview

This chapter discusses the research method and design I have chosen for this study, which is a quantitative descriptive statistics design study—a type of study that identifies and describes individuals or events as they are in the present time or their environment. The researcher does not manipulate any of the variables the data results provide. I selected a quantitative descriptive design to explore the multiple variables. I will review and analyze data collected from questionnaires to close the gap in research on the topic of women service members and veterans affected by MI. The overall intent is to present empirical information for researchers and mental health practitioners from both the civilian and military communities so they may provide the most current practices to treat our brave women in uniform and women veterans who suffer from MI. This chapter will discuss the measurement instrument I have selected to collect the data and how participants were selected to participate in this study.

Design

The method of design I selected is a descriptive quantitative design method, which according to Baker (2017) collects information concerning variables without changing or manipulating the variables. Descriptive designs are different from observational methods because they do not include comparison groups. Grove et al. (2013) define descriptive quantitative designs as a design used to develop a theory, identify problems for a topic, justify a current practice, make judgments, or determine what others in the same field of research have done or accomplished thus far. The variables from the statistical data are not manipulated, and treatment plans are not suggested or prescribed. I selected the descriptive design method to assist in answering the following research questions.

Research Questions

RQ1: What are the experiences related to death for MI participants while in combat?

RQ2: What were the emotional experiences related to MIEs for MI participants while in combat?

RQ3: Are there gender differences in MI percentages in the military?

Hypotheses

A hypothesis is not required for a descriptive quantitative design method.

Participants and Setting

The population for this research consists of women from the active duty and reserve ranks of the U.S. military and those veterans who meet the criteria to participate in this study. This study consists of 45 female active-duty and veterans, from the various branches of the American armed forces. For this study, convenience sampling is the best sampling method. Concerning the field and study sample the use of convenience or snowball sampling is applied because the

> "use of nonrandom sampling methods such as convenience sampling, in which individuals who fit the criteria of a study are identified in any way possible, or snowball sampling, in which researchers ask the participants they have identified to tell their friends and acquaintances about the study. These methods might help researchers obtain the number of participants they desire, but the way the participants are gathered can easily influence the results by introducing unexpected or uncontrolled factors. In both convenience and snowball sampling, all the resultant participants will be from the same geographical area. They may also have similar socioeconomic statuses or ethnic backgrounds. Any of these factors might have an impact on what the study is

investigating"(Robert, 2015, p. 164).

Instrumentation

Data was collected using the MI Survey for Military and Veteran Combatants (MIS-MVC v.1). This survey is a three-part research questionnaire Parts 1 & 2 were developed by the researcher and screened for approval by Liberty University: Institutional Review Board (IRB), (see Appendix A). Part 1 (Demographics) is a 9-question evaluation to determine if the individual completing the survey is eligible for the study. Questions 1 and 2 of Part I, Demographics, will trigger questions embedded in the survey and eliminate those who do not meet the criteria.

Part 2 was developed by me, and I conducted a piloted field test which the results are discussed later in this chapter; all questions were developed to answer the five proposed research questions (RQs). Part 2 of the Survey comprises 29 questions designed by the researcher to answer this study's RQs. Table 5 (see Appendix C) lists this study's five RQs. The survey questions (SQ) listed in the second column correspond to the RQs and will provide empirical and statistical data that answers the RQs.

Part 3 is the MI Event Scale (MIES), which consists of 11 questions and the participant only answers questions about traumatic moral events that occurred while on active or reserve duty. I selected this instrument based on the following reasons. Nash et al. (2013) developed the MIES based on: "Following a literature review, a team of experts generated a pool of items generically describing events involving perpetrating, failing to prevent, bearing witness to, learning about, or being the victim of acts that contradict deeply held beliefs and expectations. Of eleven items selected by consensus, nine addressed perceived violation of moral beliefs or betrayal by self or others: the remaining two addressed perceptions of trust. Instructions asked

participants to “indicate how much you agree or disagree with each of the following statements regarding your experiences at any time since joining the military.” Response options were Likert type, ranging from 1 (strongly disagree) to 6 (strongly agree). An even number of response options was chosen to preclude neutral responses. The resulting scale is the MI Events Scale (MIES)” (p. 647).

Procedures

Before getting approval for this study from the Institutional Review Board (IRB) at Liberty University, I developed a questionnaire to capture the data needed to evaluate female military and veteran personnel who may have suffered an MIE and may be suffering from MI. The information provided by the participants was received and screened anonymously. The name of the measurement tool is the MI Survey for Military and Veteran Combatants (MIS-MVC v.1) Part 1-3 (see Appendix A and B). Part 1 is a demographic survey, Part 2 is a survey of questions, and Part 3 is Nash et al. (2013) version of the MIES. I have had the instrument reviewed several times for readability, comprehension, grammar, spelling, relative question content, redundancy, and value of the questions as they relate to the research questions proposed in Chapters 1 and 3.

I also surveyed and field-tested the questionnaire. I sent the draft survey to twelve individuals, both male and female. Active-duty and veteran servicemembers were asked to review the questionnaires for a two-week trial field test. Eight of the twelve individuals made comments and suggestions to make the questionnaire more effective from their professional military experience and viewpoint. Five men and seven women who were either active-duty military, or veterans responded, and each respondent provided valuable feedback. One participant, a veteran (female), filled the questionnaire out using their experiences while in the military service. One of the most notable suggestions made by participants was to consider an

eliminating question. This suggestion was reviewed, discussed with Liberty University Professors, and adopted so that persons whose questionnaire contained data that does not apply empirically to the study could be discarded and not counted. After further discussion, the professors and I determined in Part 1, Demographics, if the participants answered “No” to question #1: Have you deployed or been in combat actions either directly or indirectly? Or question #2 are you male or female, if the participants' answer is “No”, then their survey was disqualified.

Surveys were distributed to people using the IRB’s recruitment document and received if accepted when participants were being solicited. Recruited participants are comprised of military personnel and veterans with whom I have discussed the study. Many have shown interest and would like to pass the questionnaire to other female active-duty and veteran persons who are interested in participating in the study. A consent statement before beginning the questionnaire was provided with all the instructions. This link: https://liberty.co1.qualtrics.com/jfe/form/SV_dnDp80Lj1iWCay2 is provided by Qualtrics; this website is available for all the participant's surveys to be returned anonymously. I formatted the parameters using Qualtrics to provide the survey results data, using figures, tables and cleaned statistical data so that the answers derived from the questionnaires can be analyzed, assessed, and screened appropriately.

Data Analysis

Before analyzing the data, I screened all questionnaires and reviewed all the data collected so it was “cleaned” for accuracy and validity. Martin and Bridgmon (2012) describe the data screening process in their book as: the initial step taken by the researcher/s will be the data screening process. The importance of this step is so the researcher/s can conduct or “clean” the

data after the data has been collected. Data may have been entered into an electronic source by hand or imported through a downloaded file from another source, and all other methods of data compilation i.e., questionnaires, have the potential for various degrees of errors such as outliers or skewed data. Data cleaning is vital and a vital role in all research. Kim et al. (2018), discuss in their research, how participants who use surveys are often more objective and attentive to the survey questions, however, this is very inaccurate. In all severity and real-world scenarios most participants respond carelessly according to Kim et al. Also, participants decided often to choose a path of least resistance and just reply to questions in a random haphazard way not making a concerted effort to make a notification at all.

Data collected from approved questionnaire surveys concerning MI and military combat-related MIE was received anonymously using Qualtrics. The survey will then be analyzed by the Qualtrics tool provided by Liberty University. I have chosen a quantitative descriptive design method to assess and screen the data. The assessment using Qualtrics was screened for disqualifiers for those participants whose surveys will not be assessed; screened and assessed for errors, such as outliers and incorrect data, including but not limited to false answers, skewed data, missing information, and so forth; and screened for data found in error. For example, if a questionnaire is determined to have been haphazardly or inaccurately answered, I will discard it, reset the parameters, and have it resubmitted. I will not set parameters for individual questions. This is to allow participants the choice to not answer a question they may not feel comfortable answering. I will use Qualtrics to accomplish the following: Qualtrics is purposeful for both data collection and analysis of the data. Once the data has been cleaned the information from the data collected from the questionnaires should be able to provide me with the answers to the proposed research questions. Qualtrics will format and store the questionnaires for those that are accepted

and submitted. Qualtrics will assist in the designing and distribution of the questionnaires and will create a web link in which all questionnaires can be submitted anonymously to the participants. After collecting the questionnaires, Qualtrics will format and create graphs, histograms, and charts also, will provide detailed reports so that the data and statistics can be easily reported on more.

As noted earlier the sample size is 45. Considering all factors including potential errors from the data results: 6 of the 45 respondents did not meet the selection criteria of Part 1 demographics of my questionnaire. The participants answered No to the question: had they ever been in or deployed to a combat environment during their term in service? I manually added a response for each of the 6 to each question for Parts 2 and 3 of the questionnaires as either, N/A where applicable, or No, if the response was Yes or No. For questions in Part 3, the selected answer for a manual 0 was recorded as Strongly Disagree.

Summary

I selected the descriptive statistics method of design to provide critical information for practitioners, educators, and military leadership to better understand MI and its effects on individuals and groups in myriad military communities. The problem is the lack of information on the effects of MI on active-duty women and women veterans who experienced MIEs and whether these effects impact them more than their male counterparts. Previous research could not include women due to the restriction on women serving in combat roles. However, in the past decade, the American armed forces have allowed women to perform their duties in combat. , along with the creation of measurement and instrumentation tools. I have identified the procedures by which I will assess the data. As has been identified there is not enough empirical data to determine just how MI is affecting today's female military combatants or those female

veterans who have served during conflicts and are suffering with or from MI. Providing this data, there are 8,844 female service members and veterans who have been wounded while participating in a combat environment; while there are more than 62,028 female military service members or veterans who have been assigned to duty in a combat environment. See Table 1. These numbers provide evidence that the subject of MI and how it affects female combatants is and will become more critical in the future.

CHAPTER FOUR: FINDINGS

Overview

Chapter 4 consists of a detailed descriptive analysis of data collected and reviewed from 45 received participants answering my MIS-MVC v.1 questionnaire. These questionnaires were anonymously completed by female active, reserve, or veteran American military service members. All questionnaires were submitted using the Qualtrics—Surveys & Analysis Tool. Qualtrics is a Liberty University-approved web-based survey software tool. It allows users to create, edit, share, and send surveys and provides reports based on the results. The purpose of this descriptive study is to analyze data collected from a convenience sampled group providing answers to the proposed RQs presented in this dissertation. The following questions were answered by the data collected:

RQ1: What are the experiences related to death for MI participants while in combat?

RQ2: What were the emotional experiences related to MIEs for MI participants while in combat?

RQ3: Are there gender differences in MI percentages in the military?

The variables will not be changed or manipulated during or after analysis. The statistical data reported in this chapter has not been manipulated, and treatment plans will not be discussed or determined as best practices for treating MI.

Siedlecki (2020) discussed analytic options for descriptive analysis using observations or surveys. The data is described using measures of central tendency, mean, median, mode, and standard deviations; the data can also be reported as frequencies and percentages to describe results. The following tables and figures are the data and descriptive information analyzed from

the results of the data collected from the 45 questionnaires completed and submitted via the anonymous link provided in the electronic recruiting letter.

Descriptive Statistics

In this analysis, 45 represents the total number of female service members or veterans who completed questionnaires. The following data has been analyzed and reported from Part 1 demographics of the questionnaire. Table 2 provides the mean score for the various age groups of female military or veterans who answered the survey. As shown in Table 2: the two age groups of 31–36 and over 50 have the higher mean score for the 45 participants. This data suggests, as does forthcoming data, that of the convenience sampling those who responded with a higher mean score are more likely to be career-oriented servicewomen or veterans who serve 8 or more years of service on active duty or in the reserved forces.

Table 2

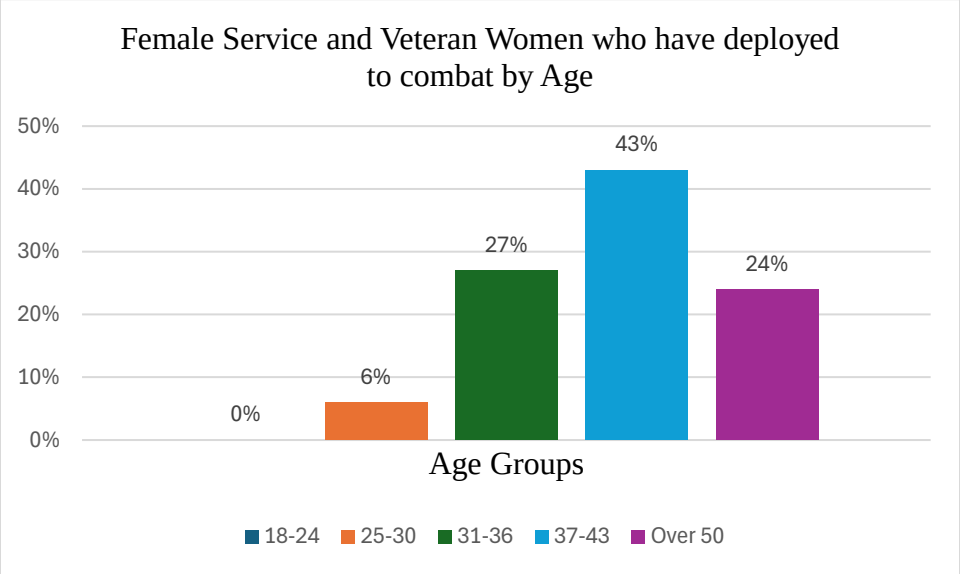
Age Range of Surveys Completed

Age	Mean	Std deviation	Variance	# of females
25–30	2.00	0.00	0.00	3
31–36	4.00	0.00	0.00	13
37–43	2.00	0.00	0.00	19
Over 50	5.00	0.00	0.00	10

Figure 2 displays the age breakdown for females who have deployed to combat. As the data shows, 43% of females participated or deployed to a combat environment ranging in age from 37–43. For the 18–24 age group, there were no responses, and for the 25–30 age group, the remaining value of 6% is listed in Table 2 based on the 3 responses recorded.

Figure 2

Age Breakdown Female Service Members or Veterans Who Deployed to Combat



As displayed in Figure 3, the data suggests only 2.5% of female participants served more than 35 years in the armed forces, whereas only 5% have served for 1–4 years. Most participants, at 17.5%, served from 8–25 more years of service. This information and the mean score from Table 2, suggest the larger percentage of participants are career servicewomen. This being understood, the following data is provided to answer the RQs this dissertation proposes; the data sustains more validity than if the percentages were greater in the 1–4: 4–8 service times, due to the longevity and more experienced warfighters being career servicewomen.

Figure 3

How Many Years Have You Served in the Military?

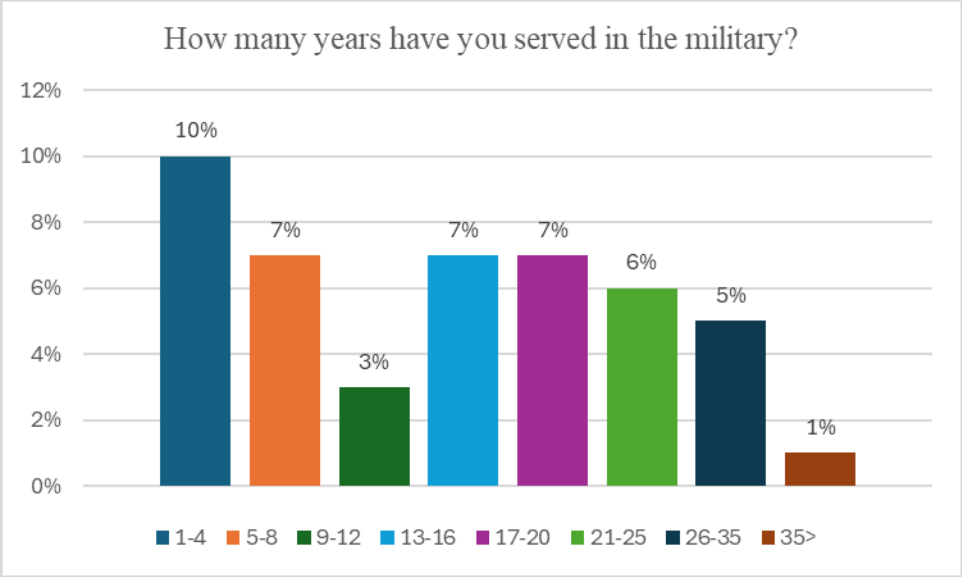
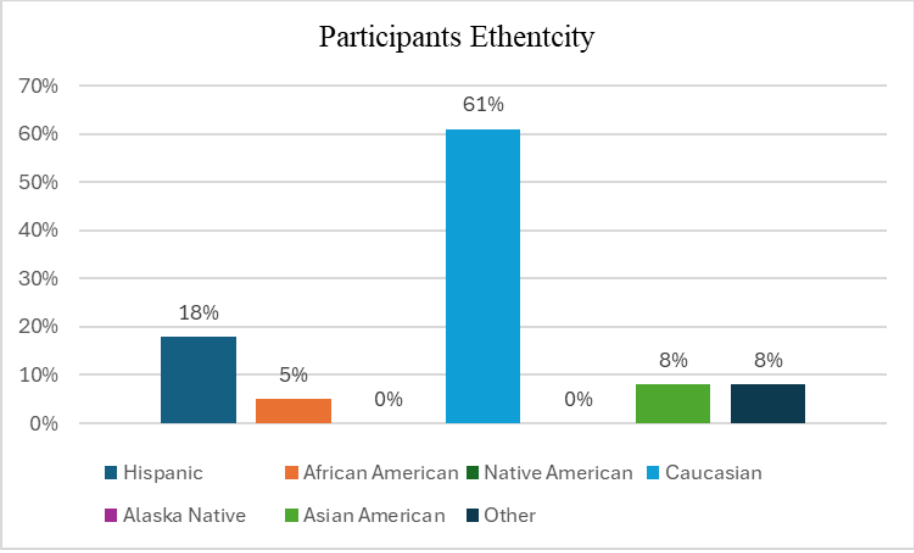


Figure 4 is a statistical breakdown by group and percentage comprised of different ethnicities that form the American armed forces. As shown in Figure 4, the majority ethnic group for female servicewomen or veterans who responded to the questionnaire is 63% Caucasian, whereas the second largest ethnicity is Hispanic females at 18%.

Figure 4

What is Your Ethnicity?



The following information is the data screened that provides an answer to the corresponding RQ per participant.

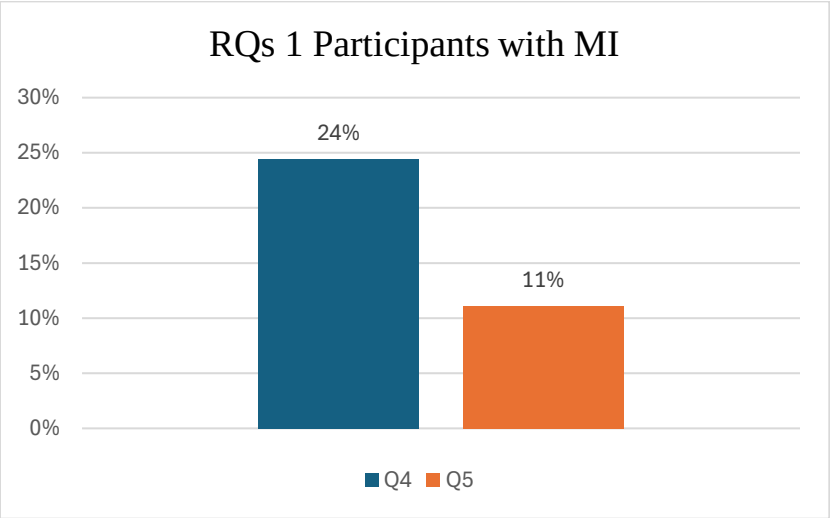
Results

Figure 5 represents RQ1: What are the experiences related to death for MI participants while in combat? Figure 5 shows participants' responses to questions from Part 2 of the questionnaire in Appendix A. Figure 5 lists MIEs experienced by female servicemembers (with a level of MI). As displayed in Figure 5: 11% to 24% of female warfighters with MI responded either yes or both to an experience or event that related or could have related to the death of a person or animal. Q4: Have you witnessed enemy or friendly military personnel being killed? Q5: Have you witnessed civilians or animals being killed during combat operations? The responses provide data that 21 of the 45 participants have some level of MI and identify MI

events that have impacted female servicewomen and veterans. Having provided data support and answers to RQ1, the results and data screening for RQ2 are recorded next.

Figure 5

Experiences While Deployed in a Combat Environment Related to Death



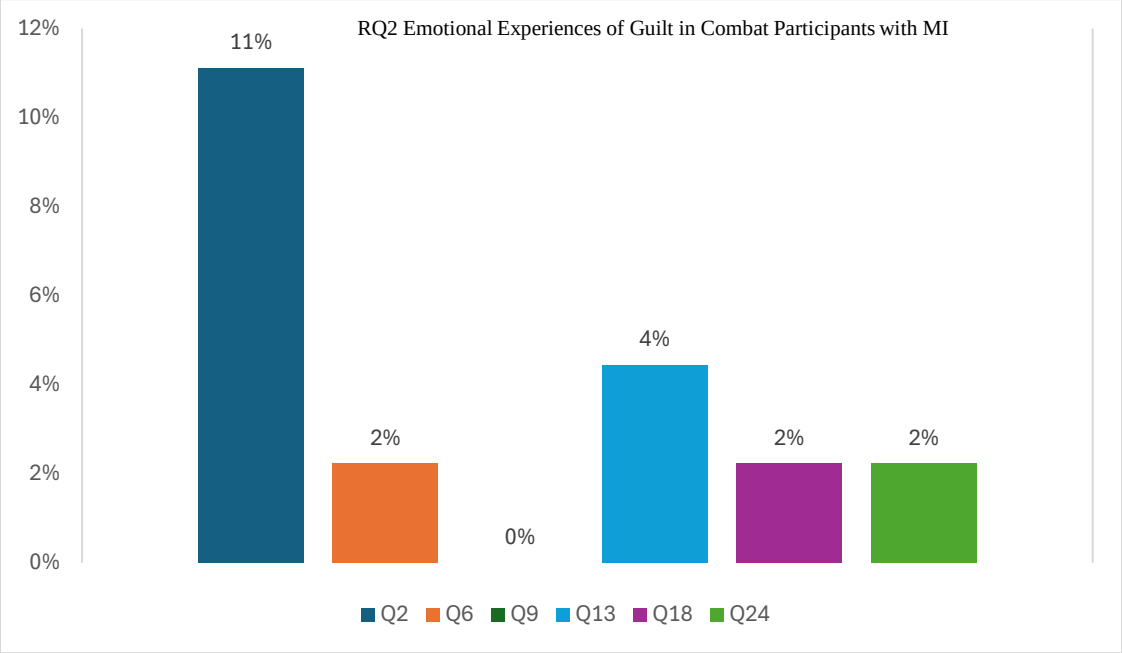
RQ2: What were the emotional experiences related to MIEs for MI participants while in combat? Figures 6–8 provide data as to each percentage of MI experienced by servicewomen or veterans separately for guilt, shame, and betrayal.

RQ2: concerning experiences by which female servicemembers or veterans feel guilty about experiencing MIEs and have a level of MI are shown in Figure 6. RQ2: Do you feel guilt for any events you witnessed or participated in? A total of 11% of female servicewomen or veterans responded felt guilty for an MIE they witnessed or participated in. Q6: When in combat situations, if any, did you feel guilt from not taking any action to assist or prevent an event of harm or damage being done? Only 2% of 21 participants with MI reported they felt guilty for not taking action to assist in an MIE to prevent harm or damage being done. Q9: Do you feel guilty for not killing someone in combat, either face to face, during a firefight, or remotely, when

ordered, or if it was necessary to do so, (e.g., drone operators or aircraft fighter pilots)? A null guilty response was scored for this question by participants with MI. Q13: Do you have any feelings of guilt that you have knowingly killed, planned killing, or witnessed families with children who have been killed during combat operations? A total of 4% of the participants with MI responded to question Q13 by either answering they felt guilty for killing others, guilty for planning to kill others, or felt guilty for witnessing the killing of others. Q18: Do you feel guilty that you survived your deployment and other service members did not? A total of 2% of female service members or veterans with a level of MI answered yes, they feel guilty about Q18. Q24: As a commander, have you felt guilty for sending others into battle? A total of 2% of the sample participants answered yes, they felt guilty as a commander. These participants who are or were in the position of a commander had sent soldiers into and onto the battlefield under her orders and command. She had sole responsibilities and accountability for their lives, and the accomplishment of her entire unit's mission in combat. The follow-on data pertains to those sample participants with MI who experienced shame after an MIE experience.

Figure 6

Emotional Experiences of Guilt with MI

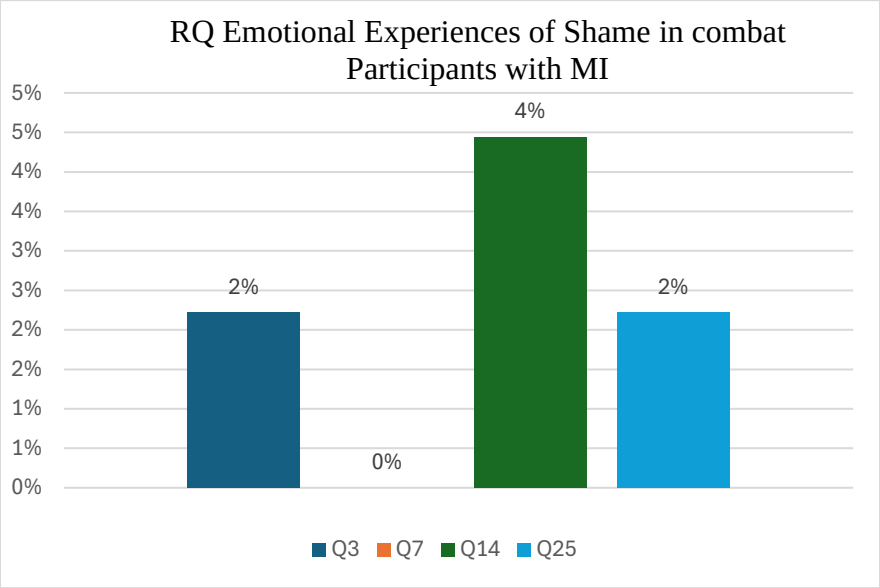


RQ2 data screened for shame felt while deployed or operating in a combat environment by participants. Figure 7 displays data results collected from participants concerning experiences by which female service members or veterans feel shame from MIEs experience and have a level of MI. Q3: Do you feel shame for any events(s) you witnessed or participated in? Of 21 participants with MI, 2% of the sampled participants felt shame for what they witnessed or participated in during combat operations or while deployed to a combat environment. Q7: When in combat situations, did you feel shame for not taking any action to assist or prevent an event of harm or damage being done? A null shame response was scored for this question by participants with MI. Q14: Do you have any feelings of shame that you have knowingly killed, planned killing, or witnessed families with children who have been killed during combat operations? A total of 4% of the sample population answered yes, for the killing of others, shame for the

planning of killing, and yes shame for witnessing the killing of others. Q25: As a commander, have you felt shame for sending others into battle? A total of 2% of the sampled participants selected yes, they felt shame for sending others into battle. Figure 9 depicts the data screened for those servicewomen or veterans who felt betrayed during their deployment in a combat environment or when they were participating in combat operations.

Figure 7

Emotional Experiences of Shame with MI

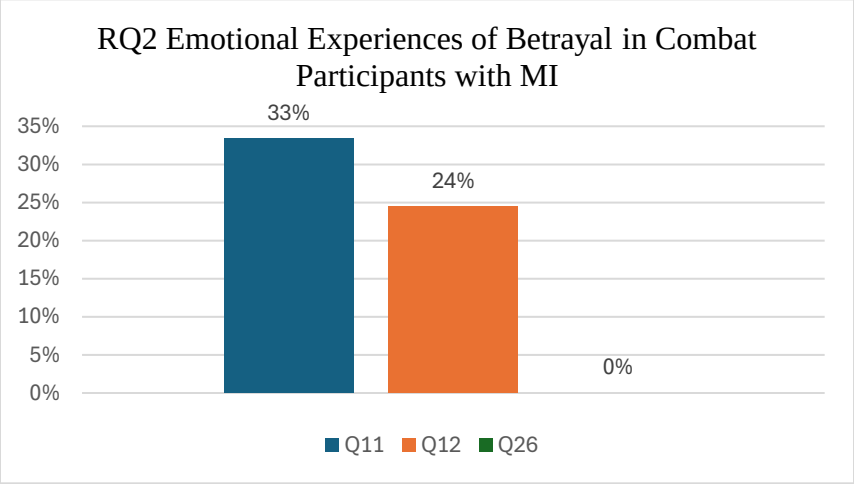


RQ2: element of betrayal and a level of MI in participants according to the data collected by their answers to the voluntary questionnaire. Figure 8 is the data screened for experiences in combat that produce a level of MI due to the emotional feeling of betrayal in service women and veterans who served in combat environments. Q11: Do you or have you ever felt betrayed by your fellow peers? A total of 33% of the sample answered yes, they felt betrayed by their fellow service members: Q12: Do you feel betrayed by your chain of command because of witnessed actions or inactions that go against your morals? A total of 24% answered yes, they felt betrayed

by persons in the chain of command who were leading them in combat. As discussed in Shay (2014), betrayal can be especially critical concerning MI when a person is betrayed by another person in a higher position of authority when exposed or in a high-stakes environment (i.e., combat). Q26: While a commander, did you ever feel betrayed by your fellow service members or peers because of the command you made during combat operations? Participants provided a null response to this question. I reviewed and screened the data to determine if there were any variances between men and women concerning MI.

Figure 8

Emotional Experiences of Betrayal with MI



RQ3: Are there gender differences in MI percentages in the military? Figure 9 represents 21 of 45 participants' responses that resulted in percentages they have some level of MI according to the MIES (M1-M11Part 3 of Appendix A) was scored using Likert scale scoring. Of the 45 participants 47% of the sample (21 participants), have some level of MI. 53% of participants did not present any level of MI. The next data figure and the table will display the results of this study's determination of female combatants who have a level of MI compared to

another study in which participants were veteran servicemembers. Both male and female participants filled out questionnaires.

Figure 9

Total MI Score for 21 of the 45 Female Participants

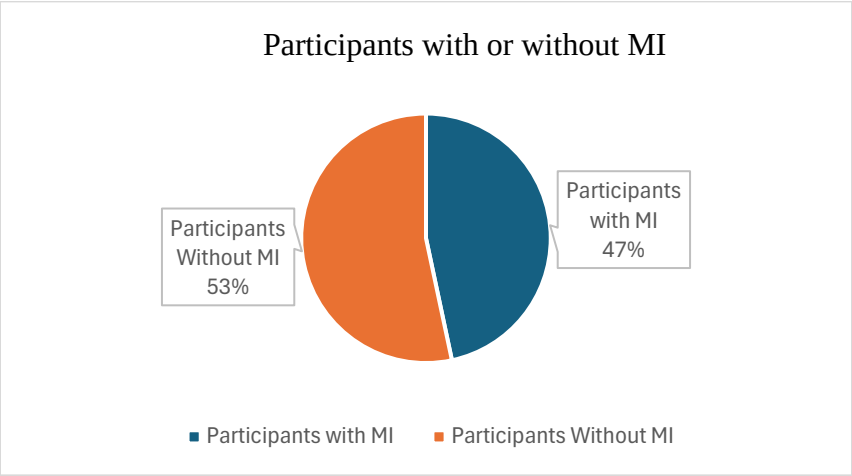


Table 3 shows the results of a mixed-gender MIES, of which all the participants were post-9/11 veterans transitioning from military to civilian life. The study was conducted by Maguen et al. (2020, p. 100). As seen in Table 3, the results determined that the values of the scores are remarkably similar between genders. Whereas the Maguen et al. study had over 7,000 participants (p. 98), my study can be compared in Table 4 of which only 45 participants responded to my questionnaires. Table 4 is a representation of female military and veteran responses to the (MIS-MVC-v.1) Part 3 VS Maguen et al. (2020). Q10 and Q11 from the original version of the MIEs constructed by Nash et al. (2013) were purposely omitted to match the study in Maguen et al. (2020).

Q7: I feel betrayed by leaders I once trusted. Q8: I feel betrayed by fellow servicemembers I once trusted. Q9: I feel betrayed by others outside of the U. S. military I once trusted are displayed in Table 4. Both surveys represent the element of betrayal from an MIE.

My study results showed that 33% to 52% of female participants combatants agreed they experienced some kind of betrayal from an MIE while deployed or participating in a combat environment. Maguen et al. (2020) revealed that 19% to 33% of men and 22% to 45% of females (unknown if they have been to combat or experienced MIE during combat) agreed they experienced some level of betrayal due to an MIE. The percentage of females from both studies is similar; however, the 45 female participants from my study had been in a combat environment or had participated in combat operations when their MIE occurred.

Table 3

Weighted Item-Level Responses to the MIE Scale Items by Gender

Item	Women %	Men %	$\chi 2$	*p*	OR Female	95% CI
I saw things that were morally wrong.						
Agree	54.5	42.8	365.05	<.001	1.60	1.53–1.68
Disagree	45.5	57.2			1.00	
I am troubled by having witnessed others' immoral acts.						
Agree	35.3	26.5	255.00	<.001	1.52	1.44–1.60
Disagree	64.7	73.5			1.00	
I acted in ways that violated my moral code or values.						
Agree	15.9	16	0.03	.858	.99	0.93–1.06
Disagree	84.1	84			1.00	
I am troubled by having acted in ways that violated my morals or values.						
Agree	15	14.6	0.91	.341	1.08	1.01–1.15
Disagree	85	84.4			1.00	
I violated my morals by failing to do something that I felt I should have done.						
Agree	15.8	14.8	4.59	.032	1.04	0.97–1.12
Disagree	84.2	85.2			1.00	
I am troubled because I violated my morals by failing to do something that I felt I should have done.						
Agree	14	13.5	1.47	.225	1.68	1.60–1.76
Disagree	86	86.5			1.00	
I feel betrayed by leaders I once trusted.						
Agree	44.8	32.6	433.02	<.001	1.68	1.60–1.76

Item	Women %	Men %	$\chi 2$	*p*	OR Female	95% CI
Disagree	55.2	67.4			1.00	
I feel betrayed by fellow service members I once trusted.						
Agree	40.2	25.4	830.60	<.001	2.08	1.98–2.19
Disagree	59.8	75.6			1.00	
I feel betrayed by others outside the U.S. military I once trusted.						
Agree	22.3	19	43.33	<.001	1.22	1.15–1.29
Disagree	77.7	81				

Note. Abbreviations include Odds Ratio (OR), Adjusted Odds Ratio (AOR), and 95% Confidence Interval (95% CI). Bolding indicates an Odds Ratio of at least a small effect size (OR ≥ 1.52 or ≤ 0.66).

Source: Maguen et al. (2020).

Table 4

Combatants (MIS-MVC v.1) Part 3 VS Maguen et al. (2020)

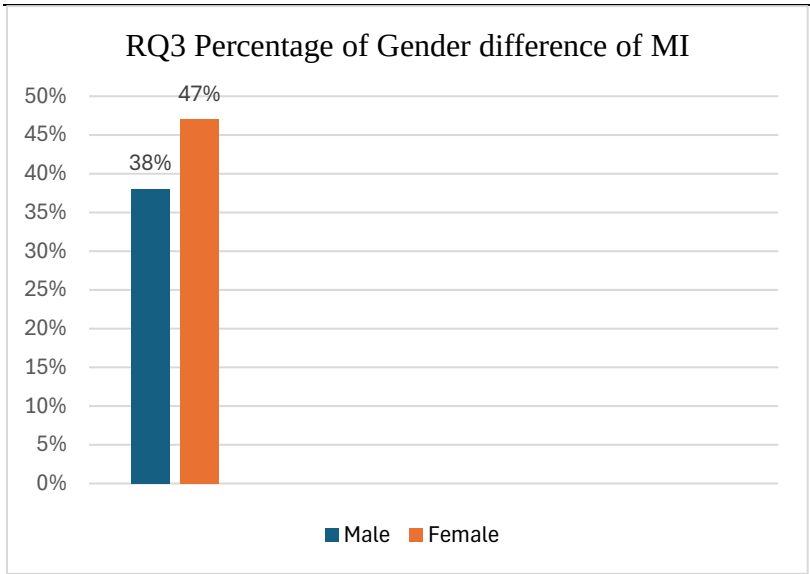
Item	(MIS-MVC v.1) Part 3	Maguen et al. (2020)
	Women %	Men %
I saw things that were morally wrong.		
Agree	62	42.8
Disagree	38	57.2
I am troubled by having witnessed others' immoral acts.		
Agree	23	26.5
Disagree	76	73.5
I acted in ways that violated my moral code or values.		
Agree	38	16
Disagree	62	84
I am troubled by having acted in ways that violated my moral code or values.		
Agree	14	14.6
Disagree	86	85.4
I violated my morals by failing to do something that I felt I should have done.		
Agree	24	14.8

Item	(MIS-MVC v.1) Part 3	Maguen et al. (2020)
Disagree	76	85.2
I am troubled because I violated my morals by failing to do something that I felt I should have done.		
Agree	14	13.5
Disagree	86	86.5
I feel betrayed by leaders I once trusted.		
Agree	52	32.6
Disagree	48	67.4
I feel betrayed by fellow service members I once trusted.		
Agree	38	25.4
Disagree	62	75.6
I feel betrayed by others outside the U.S. military I once trusted.		
Agree	33	19
Disagree	67	81

Figure 10 displays the results from which 47% [MC1] [NCWCJ2] of the 45 participants from my study reported some level of MI. Compare this to the 38% of men only, from the study conducted by Jordan et al. (2017). This group of researchers only included veteran males and did not include a female sample from the population group.

Figure 10

Percentage of 45 Participants with Some Level of MI Compared to a Separate MI Study Included Participants with Men



Summary

In Chapter 1, the problem this dissertation addresses is the lack of information found in previous and current resources published; that addresses female service women and veterans concerning MI. Those servicewomen and veterans have deployed to or operated in combat environments. Currently, there is extremely limited information on these servicewomen and veterans who possibly suffer more or equal to their male counterparts from MI. The goal and purpose of this study are to take the data collected herein and to expand and examine the problem based on the existing information, using questionnaires and descriptive statistics. This dissertation notes and reports from the information contained in this Chapter that there is a possibility of gender differences in the military population and provides statistical information in a descriptive format.

RQ1: What are the experiences related to death for MI participants while in combat? A total of 11% to 24% of participants had some level of MI due to experiencing an MIE that either resulted or could have resulted in death while in a combat environment. This result is discussed in the next Chapter, however, does provide evidence that fills a gap in the literature. RQ2: What were the emotional experiences related to MIEs for MI participants while in combat? Participants whose scores have an MI value have deployed, participated, or witnessed an MIE that impacted or affected their emotions when participating in combat operations or while deployed in a combat environment. Emotions: female warfighters who experienced an MIE related to guilt made up 2% to 11% of the 45 participants. Those who experienced shame made up 2% to 4% and related to betrayal (the highest scored MI element) was 24% to 33% of female warfighters. These three elements define almost all PMIE-experienced military personnel. The Tables and Figures listed in this Chapter provide information that resulted in 47% of 21 of the 45 female warfighters in the sampling answering the questionnaire in Appendix A having some level of MI similar findings to their male counterparts. RQ3: Are there gender differences in MI percentages in the military? According to the results in Figures 9 and 10, there are gender differences for MI and MIEs. Chapter 5 discusses the information from this Chapter and provides comparisons for the reported data. The discussion relates to the information contained in the literary review of this dissertation.

CHAPTER 5: CONCLUSIONS

Overview

Chapter 5 discusses the findings from the literature review concerning MI and female combatants and compares the information reported in the data I have collected, screened, and discussed in the previous chapter. This chapter primarily contrasts the information between the literature-reviewed materials and discusses the evidence from the data collected. Information provided by the descriptive data recorded may in the future assist persons working in the mental health field for private community practice or mental health practice for the military community to conclude there is a foundation of evidence concerning MI in female combatants. Continuing research is needed to ensure care is provided for our sisters, daughters, wives, etc… in serving our country and supporting our way of life.

Discussion

The problem is there is minimal statistical, descriptive, and empirical research dedicated to servicewomen and women veterans who have participated in combat operations and who have or are reported to have MI due to experiences involving MIES. The purpose of this study is to expound on the limited existing information concerning female service members and veterans. I used a descriptive statistical research design and determined there may be a difference between genders in the military and veteran population and that female service members and veterans possibly suffer more than their male counterparts due to MIEs.

Comparing information recorded in Chapter 4 to the Literature found in Chapter 2, there are similarities and differences which are noteworthy for further discussion. Between an all-male and all-female population, the population groups are from three different samples. Maguen et al. (2020) studied and evaluated both genders with a sample of veterans, whereas Jordan et al.’s

(2017) population consisted of all male veterans. This dissertation study is comprised of all female military members and veterans who have deployed to combat or a combat environment. The following discussion is the data reviewed and compared to the population of all female participants answering an anonymous online survey, in comparison to mixed-gender or all-male studies. Let us examine RQs 1–3 and their results.

RQ1: What are the experiences related to death for MI participants while in combat? Q4: have you witnessed enemy or friendly military personnel being killed? Q5: Have you witnessed civilians or animals being killed during combat operations? Figure 5 displays the results of 11% to 24% of 21 participants with MI experienced by witnessing enemy and friendly forces and animals killed during combat operations. Moral injury event surveys and measurement tools in the literature currently do not address questions concerning death and killing. Whereas the questionnaire I created associated emotional feelings with killing and events that can or do cause death. Also, Table 1 in Chapter 1 provides supporting data I requested concerning the number of Purple Hearts and CAAs issued or presented to females in the last 24 years. It is a well-known fact that the only way a servicemember receives a Purple Heart is if they are wounded or killed in combat operations. To be awarded the CAA the service member must have participated in combat actions. What then are the emotional aspects of MI?

RQ2: What were the emotional experiences related to MIEs for MI participants while in combat? Similarities are most notable in the output about the questions related to betrayal. Griffin et al. (2019) suggested aggravated traumatic events such as MIEs service members are exposed to and experience have behavioral associations; Guilt and self-blame, often triggered or mediated by anger, are consistent with evidence that exposure to MIEs is influenced by or results from betrayal. The highest scored percentages for betrayal for females compared to males was

between 22.3% and 59.8%, whereas my study reviewed answers using the same MIEs after answers were scored/paired for comparisons to the same type of questions in Part 2 of Appendix A. For questions related to betrayal in Figure 9, my study revealed that of 21 of the participants with MI 24% to 33% answered yes about emotional feelings of betrayal, which can be compared and found within the same sampling as Maguen et al. (2020). However, as mentioned in Chapter 4, this study had 45 participants, whereas their study had over 7,000 participants (Maguen et al., 2020, p. 98). I also measured emotions of guilt and shame. The following are the results and comparisons related to guilt.

As discussed in Chapter 2, guilt can lead to a loss of trust in self and others: according to Jinkerson (2016), "The decision to make guilt a necessary criterion was made because of the demonstrative empirical associations between guilt and the secondary symptoms found in individuals with MIE history and/or PTSD diagnoses" (p. 126). According to Moon (2019), research shows guilt is the primary emotional factor when a person experiences a PMIE. Guilt coincides with a person's actions or inactions and debates with the self as to whether something is right or wrong. However, in Chapter 2 no articles were reviewed that directly addressed the element emotion of guilt and MI. Yet, in the current study, we can see in Figure 7 that 2% to 11% of 21 participants with MI have guilty feelings from an experience of an MIE. I conducted research reviewing current literature (within the last 5 years) for publications that discuss or compare guilt and MI. None were found that directly examined the comparison of guilt and MI for female, male, or mixed genders. Shame, which can contribute to the emotions of guilt and betrayal, was included in my data collection.

Continuing discussion of RQ2, shame in Chapter 2 of the literary review was most associated with MST events. None of the articles reviewed for Chapter 2 directly addressed or

discussed shame as an emotional experience associated with MI and the population groups surveyed, which consisted of both genders. I once again reviewed current literature (from the last 5 years) for other publications discussing MI and shame; no current publications were directly related to shame and the direct association with MI. Authors such as Litz, Maguen, Shay, and Jordan, to name just a few referenced in this dissertation, include shame as one of the main characterizations for persons who suffer from or with MI. Litz et al. (2009) discussed moral conflict and determined that pre- and post-MIEs often cause emotional distress, such as shame, which can cause reflection and motivation and serve as constant reminders of the MIE experienced. Maguen et al. (2017) discussed shame as contributing to maladaptive cognitions that can act as mediators working in conjunction with other psychological distresses which can lead to functional impairment. Jordan et al. (2017) hypothesized that when PMIEs are perpetrated, guilt precipitates, such as an event my study questioned: "As a commander, have you felt shame for sending others into battle?" Jordan et al. (2017) referred to shame as the "negative global evaluation of the core self."

RQ3: Are there gender differences in MI percentages in the military? Table 3 displays the differences in MI related to gender. Maguen et al. (2020) scored the percentages shown between men's and women's responses to MIEs. My study exclusively targeted female servicewomen and veterans who are serving or have served in a combat environment. The data screened from Figure 11 represents data from the Maguen et al. (2020) study displaying data that 38% of male veterans scored a level of MI, as found in Table 2, and 47% of 21 female combatant participants who answered this study scored some level of MI. How could these results contribute to the community counseling field?

Implications

The results of the data reviewed and discussed in this study highlight the probability that current and future female service member veterans do and will suffer from MIEs. Those who have experienced an MST or have deployed to combat may especially need primary mental health care. Not only will mental health practitioners need this type of knowledge and training, but practitioners of faith such as military chaplains and civilian clergy need to be aware of MI and the implications concerning spirituality.

Guilt, shame, and betrayal tie directly to Christianity and Biblical teaching and prophecy. Consider, for example, the crucifixion of Jesus Christ. Christ was shamed, humiliated, and betrayed during his trial and crucifixion. Matthew 27:28 in the King James Version (KJV) reads, "And they stripped him, and put on him a scarlet robe." The Gospel of John 19:4 reported, "They said therefore among themselves, Let us not rend it, but cast lots for it, whose it shall be: that the scripture might be fulfilled, which saith, They parted my raiment among them, and for my vesture they did cast lots. These things therefore the soldiers did" (KJV). Jesus hung on the cross naked for the world to see, which had to be excruciating MI. Lastly, he suffered the betrayal of his chosen disciple Judas, the Jewish nation of Israel, and the world He came to save: Matthew 17:22 reads, "and while they abode in Galilee, Jesus said unto them, The Son of man shall be betrayed into the hands of men" (KJV). The military and civilian mental health and religious communities should take heed of the data presented, initiate training, and develop methods of treatment for future military members and veterans returning to their communities.

Limitations

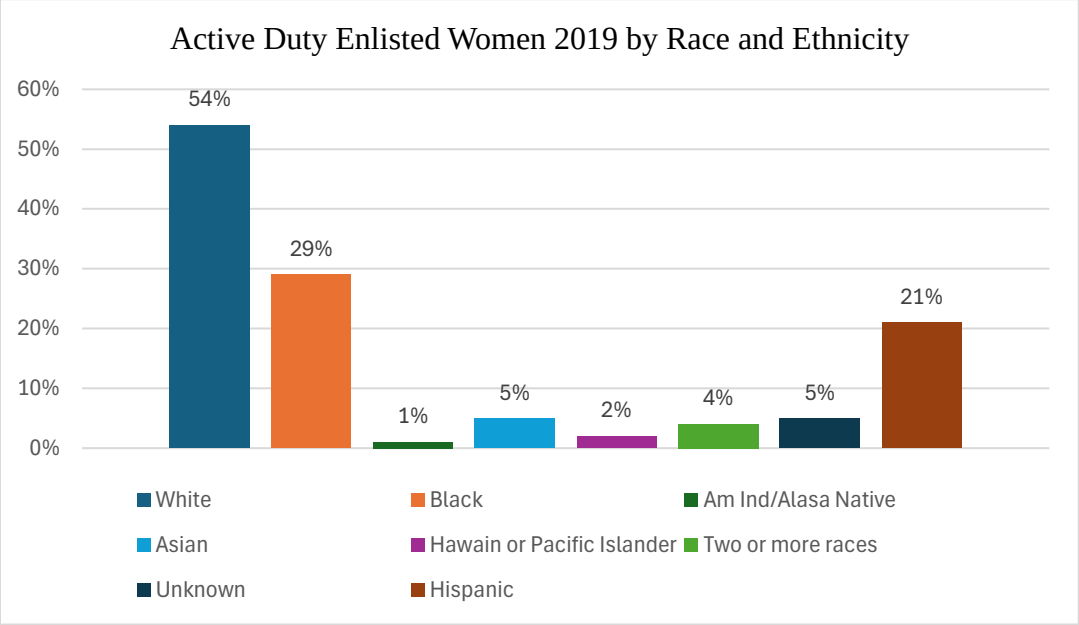
This study identified several limitations that could be explored in future research. Though I had access to a Marine Corps Installation, and I am a retired Marine, many limitations furthered

the need to collect more data. One limitation is having access to the active-duty personnel from all branches of service during data collection. Once I electronically sent my recruitment fliers, Headquarters Marine Corps Education personnel made me aware that the Marine Corps has an Internal Review Board (IRB) that considers studies that solicit active duty or active reserve Marines (even for voluntary or anonymous purposes) and that the Commandant of the Marine Corps has the final say as to if active duty and reserve Marines can participate. I expect the other service departments to also have an IRB or something similar.

The convenience sampling is small compared to the more than 70,000 female service members listed in Table 1; the convenience sampling limits the generalization of the results listed. Figure 4 displays the race percentages of the participants who answered the questionnaire. As shown in Figure 4, most respondents were Caucasian, and the second largest population by race was Hispanic. African American and Asian participants comprised only 5% and 8% of the 45 participants. Figure 11 displays results from a 2019 gender population survey, comparing the number of active-duty military women and their percentages compared to men on active duty (Statista Research Department, 2023).

Figure 11

Percentage of Active-Duty Women by Race and Ethnicity 2019



The 3-part questionnaire in Appendix A is self-reporting. As with any self-reporting measurement, the data could be in error because a participant who feels negative or has an emotional response to questions may answer them out of fear, anger, regret, or simply not answer the survey at all. Also, this is a questionnaire where the participants are or were in a branch of the U.S. military. Prejudices concerning data collection, the total anonymity of the questionnaires, and the respondent's concern about retaliation for exposure could cause more errors in their responses.

Recommendations for Future Research

Future research concerning MI should increase, if possible, in sampling size. The population should include females from all branches of military service. There is also a need to develop and field-test more accurate instruments that measure the levels of moral injury based on

experiences of morally injurious events and the defining characteristics of guilt, shame, and betrayal.

Another key factor to consider is the impact of killing and death witnessed or participated in while deployed in a combat environment. Killing and death play key defining roles when considering if a service member or veteran suffers from MI. Maguen et al. (2017) suggested "There is mounting evidence that Veterans from multiple eras who kill in war are at increased risk for posttraumatic stress disorder (PTSD), alcohol abuse, suicide, and functional difficulties after returning home" (p. 997). Killing another person must carry enormous weight. Purcell et al. (2018a) found that "When veterans are invited to share their thoughts and feelings after combat, many describe killing as a transformative experience that altered their perception of themselves and their world in sometimes devastating way" (p. 646). The moral injury events vary in form surveys, and other MIE surveys in the literature do not directly address killing by asking questions such as: Do you feel guilt, shame, or unforgiven for killing someone in combat?

I identified specialized or specially formed units consisting only of female warfighters from previous wars (e.g., wars in Iraq and Afghanistan). These specially formed units such as Female Engagement Teams (FETs) or members of the Lioness program the Marine Corps employed could provide beneficial data that could be collected from units such as these. Future research should explore which counseling theories and methods should be applied for the diagnosis and treatment of MI and develop more rigorous and fact-finding intake assessments for mental health and clergy persons to use. Ames et al. (2021) discussed future research concerning the treatment of MI. "While other, novel treatments for moral injury have been developed, it is still a burgeoning area of research. Treatments that are chaplain-led or at least considerate of the

spiritual aspects of moral injury are still in their infancy" (p. 3058). Lastly, future research could develop measures of MI exposure and symptomatology that would bridge MI with PTSD.

Summary

MIEs military persons witness cause guilt, shame, and betrayal, and can lead to other mental health problems, such as suicidal thoughts and actions, spiritual confusion and conflict, and MI can affect a person's social interactions and well-being. The overarching problem is that the literature published in the last 5 years omits statistical, descriptive, and quantitative research that focuses on the population of servicewomen in the active or reserve armed forces of America, and female veterans who have served in combat or combat environments.

The purpose and intent of this dissertation is to expound on the gaps and limited information found in the literature and, using a descriptive statistical research design, discuss the results from a sample population of female military and veterans who served in combat environments or participated in combat operations. Ames et al. (2019) discussed the reliability and concerns for self-reporting MI. As discussed in this study, no parameters were set for participants to answer each question on the questionnaire. Many participants either did not answer or negatively answered certain questions with a probability they felt the questionnaire may not be anonymous as announced due to prejudice in the military community and the fear of being retaliated against. Female servicemembers and veterans today, according to the convenience sample results in this study, have some level of MI.

Table 4 displays the results of two surveys concerning MIEs. In my study and Maguen et al. (2020) females had equivalent results, with 33% to 52% of female participants in my study agreeing they experienced an MIE related to betrayal and 22% to 45% of females (unknown if they have been to combat or experienced MIE during combat) agreed to the same question in

Maguen et al.'s study. To determine if there are differences between genders, 33% of females in my study agreed they experienced betrayal, whereas only 19% of males from the Maguen et al. (2020) study agreed. However, literature from the previous five years excludes or includes few female servicewomen in their studies. Inclusive with the number of female servicewomen and veterans who have received the Purple Heart or CAA the population sample should be in the 1000s to assess the overall population of female servicewomen and veterans more accurately.

Future research should include variables such as have fought in combat, have led men and women in combat, and whether they feel guilt for surviving an IED blast when others did not. Questions such as these and those dealing with killing should result in more instances of military servicewomen having greater percentages of MI. The men and women deserve the best America has to offer for their dedication and commitment to our country and our neighbors, brothers, sisters, and friends. In conclusion, MI is a prolonged emotional rollercoaster for the unlucky man or woman who serves voluntarily to keep us and our country safe and secure from enemies both foreign and domestic.

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APPENDIX A

Questionnaire Part I:

Moral Injury Survey for Military and Veteran

Combatants (MIS-MVC v.1)

Part 1 Demographics

1. Have you deployed or been in combat actions either directly or indirectly?	Yes / No
2. What is your age?	18–24 25–30 31–36 37–43 Over 50
3. What is your gender assigned at birth?	Male Female Prefer not to answer
4. What is your ethnicity?	Hispanic African American Caucasian Native American Alaska Native Asian American Other
5. Relationship Status?	Single Married Divorced Separated Cohabitating Widowed
6. Highest level of education completed Primary	(K–8) Secondary (9–12) College (2–4 Years) Masters or PhD
7. Do you have children?	Yes / No
8. How many years have you served in the military?	1-4 5–8

9–12
13–16
17–20
20–24
25–30
30+

Questionnaire Part 2:

Moral Injury Survey for Military and Veteran

Combatants (MIS-MVC v.1)

Questionnaire

Instructions: Participants completing the questionnaire below should apply the questions to their time in the military only. If the questions apply to an event or situation that did not occur while you were actively serving in the military, then your response must be No or N/A

1. Have you committed any act(s) that violated your morals values?

    A) Yes

    B) No

    C) N/A

2. Do you feel guilt for any events you witnessed or participated in? CHECK ALL THAT APPLY.

    A) Witnessed and feel guilt

    B) Witnessed and do not feel guilt

    C) Participated in and feel guilt

    D) Participated in and do not feel guilt

    E) N/A

3. Do you feel shame for any events(s) you witnessed or participated in? CHECK ALL THAT APPLY.

    A) Witnessed and feel shame

    B) Witnessed AND do not feel shame

    C) Participated in and feel shame

    D) Participated in and do not feel shame

    E) N/A

4. Have you witnessed enemy or friendly military personnel being killed?

    A) Yes

    B) No

    C) Both

    D) Neither

    E) N/A

5. Have you witnessed civilians or animals being killed during combat operations?

    A) Yes

    B) No

    C) Both

    D) N/A

6. When in combat situations, if any, did you feel guilt from not taking any action to assist or prevent an event of harm or damage being done?

    A) Felt guilty

    B) Did not feel guilty

    C) N/A

7. When in combat situations, did you feel shame for not taking any action to assist or prevent an event of harm or damage being done?

    A) Felt shame

    B) Did not feel shame

    C) N/A

8. Do you feel unforgiven for things you did or did not do during combat operations?

    A) Feel unforgiven

    B) Do not feel unforgiven

    C) N/A

9. Do you feel guilty for not killing someone in combat, either face to face, during a firefight, or remotely when ordered or if it was necessary to do so, e.g., drone operators or aircraft fighter pilots?

    A) Yes

    B) No

    C) N/A

10. Do you feel guilty for failing to save someone's life in combat?

    A) Feel guilty

    B) Do not Feel Guilty

    C) N/A

11. Do you or have you ever felt betrayed by your fellow peers? (This question pertains to losing confidence or trust in other service members and/or leadership authority and their ability to lead you in combat.)

    A) Yes

    B) No

    C) N/A

12. Do you feel betrayed by your chain of command because of witnessed actions or inactions that go against your morals? (This question pertains to losing confidence or trust in your chain of command and in their ability to lead you or others.)

    A) Yes

    B) No

    C) N/A

13. Do you have any feelings of guilt that you have knowingly killed, planned killing, or witnessed families with children who have been killed during combat operations? CHECK ALL THAT APPLY.

    A) Yes, guilt for killing others

    B) No guilt for killing others

    C) Yes Guilt for the planning of killing others

    D) No guilt for the planning of killing others

    E) Yes, guilt for witnessing the killing of others

    F) No guilt for witnessing of the killing of others

14. Do you have any feelings of shame that you have knowingly killed, planned killing, or witnessed families with children who have been killed during combat operations? CHECK ALL THAT APPLY.

    A) Yes, shame for killing others

    B) No shame for killing others

    C) Shame for the planning of killing others

    D) No shame for the planning of killing others

    E) Yes, shame for witnessing the killing of others

    F) No shame for witnessing the killing of others

15. Have you seen dead bodies, which have caused you to question your moral beliefs?

    A) Yes

    B) No

    C) N/A

16. Do you now doubt your ability to make decisions based on your moral beliefs after your combat experiences?

    A) Yes, I doubt my moral decision-making abilities

    B) No, I do not doubt my moral decision-making abilities

    C) N/A

17. If you experienced a MI Event (MIE), specifically witnessing families that had been slain while you were deployed in combat or in a non-combat environment, did that event affect your moral beliefs?

    A) Yes

    B) No

    C) N/A

18. Do you feel guilty that you survived your deployment and other service members did not?

    A) Yes, I feel guilt

    B) No, I do not feel guilt

    C) N/A

19. Do you have thoughts of negative self-worth because of event(s) or actions you did or did not take during combat operations?

    A) Yes

    B) No

    C) N/A

20. Do you have thoughts or ideas that you endangered anyone because of your moral beliefs during your combat deployments?

    A) Yes, because of my morals or beliefs, I endangered someone

    B) No, because of my morals or beliefs, I did not endanger anyone

    C) N/A

21. Have you ever been a platoon commander?

A) Yes

B) No

C) N/A

22. Have you been a company commander?

A) Yes

B) No

C) N/A

23. Have you been a battalion commander?

A) Yes

B) No

C) N/A

24. As a commander, have you felt guilty for sending others into battle?

A) Yes, felt guilty

B) No, did not feel guilty

C) N/A

25. As a commander, have you felt shame for sending others into battle?

A) Yes, felt shame

B) No, did not feel shame

C) N/A

26. While a commander, did you ever feel betrayed by your fellow service members or peers because of the command you made during combat operations?

    A) Yes, I felt betrayed

    B) No, I never felt betrayed

    C) N/A

27. If you are a veteran, were you discharged because of the way you performed in combat?

    A) Yes

    B) No

    C) N/A

28. Are you a spiritual person?

    A) Yes

    B) No

    C) N/A

IF NO, SKIP THE NEXT QUESTION.

29. After serving in a combat environment, have your faith and spiritual beliefs changed or remained the same because of moral events that you witnessed?

    A) Changed

    B) Remained the same

Questionnaire

Moral Injury Event Scale

Part 3

Instructions: Participants completing the Questionnaire below should apply the questions to their time in the military only. If the questions apply to an event or situation that did not occur while you were actively serving in the military, then your response must be No or N/A

1. I saw things that were morally wrong.

    1) Strongly Agree

    2) Moderately Agree

    3) Slightly Agree

    4) Slightly Disagree

    5) Moderately Disagree

    6) Strongly Disagree

2. I am troubled by having witnessed others' immoral acts.

    1) Strongly Agree

    2) Moderately Agree

    3) Slightly Agree

    4) Slightly Disagree

    5) Moderately Disagree

    6) Strongly Disagree

3. I acted in ways that violated my moral code or values.

1) Strongly Agree

2) Moderately Agree

3) Slightly Agree

4) Slightly Disagree

5) Moderately Disagree

6) Strongly Disagree

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

1) Strongly Agree

2) Moderately Agree

3) Slightly Agree

4) Slightly Disagree

5) Moderately Disagree

6) Strongly Disagree

5. I violated my morals by failing to do something I felt I should have done.

1) Strongly Agree

2) Moderately Agree

3) Slightly Agree

4) Slightly Disagree

5) Moderately Disagree

6) Strongly Disagree

6. I am troubled because I have violated my morals by failing to do something that I felt I should have done.

1) Strongly Agree

2) Moderately Agree

3) Slightly Agree

4) Slightly Disagree

5) Moderately Disagree

6) Strongly Disagree

7. I feel betrayed by leaders I once trusted.

1) Strongly Agree

2) Moderately Agree

3) Slightly Agree

4) Slightly Disagree

5) Moderately Disagree

6) Strongly Disagree

8. I feel betrayed by fellow service members I once trusted.

1) Strongly Agree

2) Moderately Agree

3) Slightly Agree

4) Slightly Disagree

5) Moderately Disagree

6) Strongly Disagree

9. I feel betrayed by others outside of the U. S. military I once trusted.

    1) Strongly Agree

    2) Moderately Agree

    3) Slightly Agree

    4) Slightly Disagree

    5) Moderately Disagree

    6) Strongly Disagree

10. I trust my leaders and fellow service members to always live up to their core values.

    1) Strongly Agree

    2) Moderately Agree

    3) Slightly Agree

    4) Slightly Disagree

    5) Moderately Disagree

    6) Strongly Disagree

11. I trust myself to always live up to my own moral code.

    1) Strongly Agree

    2) Moderately Agree

    3) Slightly Agree

    4) Slightly Disagree

    5) Moderately Disagree

    6) Strongly Disagree

APPENDIX B

Research Participants Needed

Moral Injury: FEMALE ACTIVE DUTY & VETERANS WHO HAVE EXPERIENCED COMBAT

1. Are you an active-duty member of the American armed forces?
2. Have you ever deployed or are you deployed to a very dangerous area or to a combat environment?
3. Are you a veteran of the American armed forces?
4. If you answered yes to the questions listed above, you may be eligible to participate in a research study.
5. This research study aims to deepen the understanding of whether American military (active, reserve, and veteran) women who experience combat in combat environments suffer from MI.
6. Participants are asked to read and anonymously answer all questions on the provided two-part questionnaire and submit it to the researcher via the provided web link.
7. There are no benefits to participating in this study.
8. Participants will not be compensated or receive any reimbursements for their participation.
9. If you want to participate in this study, please read and fill out Parts 1, 2, and 3 of the questionnaires. Once you have completed all parts, please use the link provided to return the questionnaire anonymously to the researcher.
10. A consent document is provided as the first page of the survey and will be attached. Please read the consent form once you begin the questionnaire your consent is given. Please submit the questionnaire back to the researcher using the same link provided.

William C. Neal, a doctoral candidate in the Education & Community Counseling academic department. The School of Behavioral Sciences at Liberty University is conducting this study.

Please contact William Neal for more information.

Liberty University IRB – 1971 University Blvd., Green Hall 2845, Lynchburg, VA 24515

APPENDIX C

Table 5

Research Questions & Questions Surveyed in Response

Research Question	Survey Question
RQ1: What are the experiences related to death for MI participants while in combat?	4. Have you witnessed enemy or friendly military personnel being killed? 5. Have you witnessed civilians or animals being killed during combat operations?
RQ2: What were the emotional experiences related to MIEs for MI participants while in combat?	2. Do you feel guilt for any events you witnessed or participated in? 3. Do you feel shame for any events(s) you witnessed or participated in? 6. When in combat situations, if any, did you feel guilt from not taking any action to assist or prevent an event of harm or damage being done? 7. When in combat situations, did you feel shame for not taking any action to assist or prevent an event of harm or damage being done? 9. Do you feel guilty for not killing someone in combat, either face to face, during a firefight, or remotely; when ordered, or if it was necessary to do so, e.g., i.e., drone operators or aircraft fighter pilots? 11. Do you or have you ever felt betrayed by your fellow peers? 12. Do you feel betrayed by your chain of command because of witnessed actions or inactions that go against your morals? 13. Do you have any feelings of guilt that you have knowingly killed, planned killing, or witnessed families with children who have been killed during combat operations? 14. Do you have any feelings of shame that you have knowingly killed, planned killing, or witnessed families with children who have been killed during combat operations? 18. Do you feel guilty that you survived your deployment and other service members did not? 24. As a commander, have you felt guilty for sending others into battle? 25. As a commander, have you felt shame for sending others into battle? 26. While a commander, did you ever feel betrayed by your fellow service members or peers because of the command you made during combat operations?
	MEIS Military Part 3: M1. I saw things that were morally wrong. M2. I am troubled by having witnessed others' immoral acts. M3. I acted in ways that violated my moral code or values. M4. I am troubled by having acted in ways that violated my morals or values. M5. I violated my morals by failing to do something I felt I should have done. M6. I am troubled because I have violated my morals by failing to do something that I felt I should have done. M7. I feel betrayed by leaders I once trusted. M8. I feel betrayed by fellow service members I once trusted. M9. I feel betrayed by others outside of the U. S. military who I once

	trusted. M10. I trust my leaders and fellow service members to always live up to their core values. M11. I trust myself to always live up to my own moral code
RQ3: Are there gender differences in MI percentages in the military?	