UNDERSTANDING CLINICIANS' PERSPECTIVES OF TREATING MORAL INJURY

A Dissertation

by

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ABSTRACT

Posttraumatic Stress Disorder (PTSD) has been widely researched and evidenced based treatment protocols have been developed to address the symptoms of the disorder (Shalev, Liberzon, & Marmar, 2017). This diagnosis covers four clusters of symptoms including intrusion, avoidance, negative cognitions/mood, and hyper arousal/reactivity. Recent research suggests that the diagnostic criteria for PTSD including the key symptoms, and the treatment protocols do not fully cover the emotional and existential impact of experienced events (Maguen & Litz, 2014). In 2009, Litz et al. published an article examining the concept of moral injury. This term described the arduous emotional experiences of individuals who witness or were involved in an event which deeply transgressed their personal feelings or beliefs of what is right, moral, or just. There is limited research of this presenting problem being effectively treated with existing evidenced based protocols for PTSD. Thus, the need to understand what clinicians have found to be effective when treating this is imperative for recovery of these individuals.

In this phenomenological qualitative study, clinicians who identified as having experience working with the concept of moral injury will be interviewed. The interview questions will be grounded in existentialism and inquire what the clinician's unique lived experience is, as well as their experience of what is effective when treating veteran clients presenting with moral injury. An additional focus group will be conducted to gain deeper insight and allow group members to clarify initial themes. Utilizing Giorgi's (2009) method of analysis, themes and units of meaning will be pulled out to develop an understanding of what is effective for alleviating the symptoms associated with the issue. Findings from this study may be useful in helping to develop an evidenced based treatment protocol for clinical use.

Keywords: moral injury, existentialism, PTSD

DEDICATION

To my husband, parents, family, friends, professors, classmates, and even strangers who offered kind words, encouraging messages, and supportive notes. I could never adequately express how much it meant to me.

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TABLE OF CONTENTS

CONTENTS PAGE

ABSTRACT v

DEDICATION vii

ACKNOWLEDGEMENTS viii

TABLE OF CONTENTS ix

LIST OF FIGURES xii

PART I: INTRODUCTION 1

Introduction 1

Statement of Problem 6

Purpose of Study 6

Research Questions 7

Significance 7

Methodology 10

Populaiton and Sample 11

Data Collection 11

Data Analysis 12

Terms 13

Researcher Background 14

Limitations 15

PART II: REVIEW OF THE LITERATURE 16

Foundation of Moral Injury 16

Changes to Conceptualization of Moral Injury 18

Leading Researchers on Moral Injury 21

Studies and Methodologies: Treating Moral Injury 23

Applications for Counseling 27

Conclusion 28

PART III: METHODOLOGY 29

Introduction 29

Methodology and Rationale 29

Research Questions 30

Trustworthiness and Qualitative Rigor 31

Sampling Procedures and Participant Characteristics 35

Context of Study 38

Data Collection 39

Data Analysis 41

Summary 42

PART IV: REFERENCES AND APPENDICES 44

REFERENCES 44

LIST OF APPENDICES 57

PART V: PROJECT REPORT 65

Changes to Research 65

Target Journal 68

Committee Suggestions and Candidate Response 70

Manuscript 73

TABLE 1 104

Participant Demographics 104

TABLE 2 105

Final Themes and Subthemes 105

LIST OF ANCILLARY APPENDICES 106

LIST OF FIGURES

FIGURES PAGE

Figure 1. Giorgi's Method of Analysis……...……42

PART I: INTRODUCTION

Prospectus

Introduction

Clinicians are trained to treat a myriad of presenting problems with various populations. The veteran population has garnered significant attention over the past 10 years for its increasing number of polytraumatic issues such as complex posttraumatic stress disorder, traumatic brain injury, and chronic pain (Lew et al., 2009; Wolf et al., 2015, Haskell et al., 2010 as cited in Yan, 2016). Military personnel may frequently encounter high stress, or traumatic experiences throughout their career. Posttraumatic Stress Disorder (PTSD) has been widely researched and a common psychological consequence from exposure to a traumatic event (Shalev, Liberzon, & Marmar, 2017; Van Hooff et al., 2009). A diagnosis of Posttraumatic Stress Disorder, however, does not always capture in totality, all the emotional implications of trauma that arise including the possibility of a with moral injury. Litz et al. (2009) identified moral injury as actions that transgress moral beliefs completed by self, or witnessed with failure to intervene, manifested by feelings of shame, guilt, or responsibility. The weight of these emotions can result in chronic mental health issues including anxiety, depression, relationship problems, or suicide (Schorr et al., 2017). Clinicians currently face a dilemma of how to treat moral injury for which there is no evidenced based protocol (Barnes, Hurley & Taber, 2019; Smigelsky et al., 2018). Perhaps understanding how clinicians are approaching this presenting problem can lead to developing a standardized effective treatment protocol.

In one of the seminal studies on moral injury, Litz et al. (2009) sought to further understand this concept and provide a definition. They stressed the importance of clarifying the

difference between moral injury and PTSD. For example, PTSD has a foundation in experiencing a traumatic or frightening event, while moral injury can happen in a non-threatening environment (Barnes et al., 2019). This is one of the key differences between these two concepts. The researchers assessed moral injury from a social-cognitive model by examining how personal attributions of transgressions or failures to act impact what one believes about the world and oneself. Jinkerson & Battles (2018) explained symptoms due to moral injury can include shame, guilt, avoidance, and re-experiencing a traumatic or witnessed traumatic event. The symptomology of moral injury and PTSD can be overlapping and separate. It is important for clinicians to understand moral injury and accurately distinguish its symptoms and how they are separate from PTSD. It may be challenging for clinicians to understand how moral injury affects perceptions of self and virtue, as these are subjective. Defining moral injury is important; understanding how to treat it is imperative.

From a counseling perspective, a problem is only a problem if the client deems it to be. It is therefore important to understand a problem from the client's perspective. Clinicians and researchers cannot fully understand how to conceptualize or treat a presenting problem without understanding it from the client's lens. Schorr et al. (2017) sought to determine sources of moral injury from experiences of service members. After speaking with service members who experienced these events firsthand, the researchers were able to understand how these injuries happen. Those first-hand experiences can help define moral injury from the client's perspective. Based on reports of service members, the researchers identified two categories of moral injury, based on locus of casualty: fault of oneself and fault of others. They further defined these into eight subcategories. Under personal responsibility they identified four subcategories of killing/injuring the enemy, disproportionate violence, harming civilians and civilian life, and

failing to prevent harm to others (Schorr et al., 2017). Under fault of others they identified the subcategories of disproportionate violence, harming civilians and civilian life, betrayal by trusted others, and betrayal by systems (Schorr et al., 2017). However, knowledge of a problem needs to be followed with identifying treatment modalities.

Measuring Moral Injury: Psychometric Assessment

While knowledge and understanding of moral injury is still growing, the concept has become so prevalent, there exists a need to measure this concept (Koenig et al., 2018). Nash et al. (2013) sought to develop a measure that could be used to identify potentially morally injurious events. In a study completed with Marines returning from a combat zone, Nash and colleagues (2013) were able to create the Moral Injury Events Scale (MIES) which is an 11-item scale measuring the severity of events that contribute to moral injury. Examples of events listed on the scale include "I saw things that were morally wrong" and "I feel betrayed by leaders who I once trusted" (Nash et al., 2013).

Another method of evaluation of moral injury is the Moral Injury Questionnaire- Military Version (MIQ-M), developed by Currier, Holland, Drescher, & Foy (2015). The MIQ-M can be used to assess for morally injurious experiences. The MIQ-M is a 20-item self-report assessment (Currier et al., 2015). The MIQ-M assesses both the causes of the morally injurious event as well as the subsequent effects of the event. Additionally, it assesses for events which violate the rules of engagement (Currier et al., 2015; Frankfurt & Frazier, 2016). This assessment can be useful for clinicians to administer with the veteran population to assess for the presence of moral injury.

The most recent attempt to create a measure which examines moral injury symptoms was conducted by Koenig et al. (2018). Koenig and colleagues created The Moral Injury Symptom Scale-Military Version which included both psychological and religious/spiritual dimensions in

the assessment. This assessment is comprised of 10 subscales which include feeling betrayal, guilt, shame, moral concern, religious struggle, loss of religious faith/hope, loss of trust, loss of meaning/purpose, difficulty forgiving, and self-condemnation (Koenig et al., 2018). This study brought attention to the spiritual and existential aspect of moral injury and expanded the understanding of the concept.

Attempts at Treating Moral Injury

The gold standard in treatment for PTSD has been Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) (Purcell et al., 2018). Cognitive Processing Therapy utilizes a trauma narrative in conjunction with cognitive therapy (Walter et al., 2014). This treatment modality assists patients in challenging dysfunctional thoughts and creating a more rational belief (Resick, Monson, & Chard, 2017). Prolonged Exposure therapy involved four main components in therapy, psychoeducation, in vivo exposure, emotional processing, and imaginal exposure (Rauch, Eftekhari, & Ruzek, 2012). Prolonged Exposure assist with confronting fear-based reactions (Griffin et al., 2019). Both of these treatment modalities address the symptoms of PTSD and the Criterion A stressor, which is the significant traumatic event; however, they fail to adequately address a moral injury.

Acceptance and Commitment Therapy (ACT) has some potential for addressing moral injury within PTSD treatment, however there are no empirical studies published that show outcomes for the use of ACT in treating individuals with moral injury (Griffin et al., 2019). Using ACT, and the six core processes addressed in treatment may offer some alleviation of symptoms as they focus on psychological flexibility and integration of values. Nieuwsma et al. (2015) outlined how the use of ACT may address some symptoms of moral injury including

addressing human suffering, issues of morality, and fostering forgiveness. Additional empirical research is needed to substantiate effectiveness.

Another potential treatment modality which can be used to target moral injury is Adaptive Disclosure, which was created by Litz, Lebowitz, Gray, and Nash (2016). This therapeutic treatment modality targets concepts including forgiveness, compassion, and moral repair. A preliminary study with 44 military personnel produced results where participants reported decreased symptoms of PTSD and depression, and increased posttraumatic growth (Griffin et al., 2019). There however is still a lack of sufficient conclusive research to definitively mark Adaptive Disclosure as the standard for treating individuals with moral injury. Continued research on acceptable and effective treatment approaches must be conducted before there can be a clear treatment modality identified for treating individuals with moral injury.

Summary of the Concept of Moral Injury

Moral injury is a term that has been used to describe the non-physical wound created when someone witnesses or engages in an act of violence or an otherwise disturbing experience (Barnes et al., 2019; Smigelsky et al., 2019; Frankfurt & Frazier, 2016; Litz et al., 2009). With symptoms including guilt, shame, and questioning of self-concept, moral injury can be easily associated with existentialism. A moral injury becomes problematic when someone cannot mediate the reality of his or her lived experience, and their personal beliefs and values (Currier, Holland, & Malott, 2015). A qualitative inquiry into the importance of treatment for moral injury, including an exploration of the importance of existentialism with treatment could provide immeasurable insight.

The concept of moral injury has been defined clinically through the work of many researchers including Litz et al., (2009) and Jinkerson & Battles (2018). Clients who have

experienced a moral injury have also been able to help identify events that cause moral injury (Schorr et al., 2017). Researchers have been able to define the construct well enough to develop an assessment (Nash et al., 2013). Additional research on this topic is critical, as practitioners are seeing this presenting issue more frequently in their clinics (Litz et al., 2009). The purpose of this study is to attempt to expand on the topic of moral injury by examining what clinicians deem important in treatment.

Statement of Problem

High rates of physical and emotional stress plague individuals working in the military (Killgore et al., 2008). Some of these experiences result in Post-Traumatic Stress Disorder (PTSD), while others however fall under this emerging concept of moral injury, which may be unrelated to fear for one's life or traumatic loss (Stein et al., 2012). Moral injury can include experiences where a person acts unethically or immorally or witnesses and fails to act in an unethical or immoral situation. (Litz et al., 2009). Acting unethically or failing to act can cause feelings of guilt or shame (Farnsworth, Drescher, Evans, & Walser, 2017; Barnes et al., 2019; Bryan et al., 2018) and are often accompanied by symptoms including feelings of isolation, depression, anxiety, social disconnection, or suicidal ideation or completion. There is an increasing number of individuals identifying as having a moral injury, demanding research that can help clinicians understand the important aspects of mitigating the problem (Jordan et al., 2017; Barnes et al., 2019; Frankfurt & Frazier, 2016). This qualitative study will attempt to address this issue.

Purpose of the Study

The purpose of this phenomenological study is to gain an understanding of the clinicians' treatment process when working with veteran clients who have or are currently experiencing

moral injury. This study will utilize individual interviews and one focus group to engage with clinicians who identified as having experience treating individuals with moral injury. At this stage in the research the term moral injury will be defined as an event a person experiences which they identify as an unethical or immoral act, causing feelings of guilt or shame (Litz et al., 2009). The concept of meaning and purpose from existential theory will be emphasized when interviewing clinicians on what treatment approaches they use to address the issue of moral injury.

Research Questions

The overarching question in this study is "What are the experiences of clinicians who identify as having treated or are currently treating a moral injury?". This question will be used to guide the understanding of how clinician's address the components of therapy including building a therapeutic relationship, as well as gathering information related to what has been helpful in successfully treating this problem.

Significance

Military personnel who are tasked with making difficult decisions often experience high levels of stress. Some of these experiences include orders or decisions that go against one's belief of what is right or ethical, leading to moral injury. Clinicians can be challenged when attempting to address these presenting problems, since there is a limited amount of information on treatment methods. Moral injury can cause one to experience questioning of self, the world around them, and leadership (Yandell, 2018). Clinicians must adjust how they approach a problem that perhaps was previously viewed as a symptom of PTSD. Although researchers have just begun to clearly define moral injury, there is agreement on the importance of delineating the

difference between moral injury and PTSD (Litz et al., 2009). Clinicians and researchers continue to add to the literature to help garner a better understanding of this concept.

Findings of the current study are significant for mental health providers as they treat moral injury. This investigation grounded in the voices of clinicians who are treating individuals experiencing a moral injury will perhaps add to the body of literature attempting to address this issue. Findings from this study can encourage future research on this topic.

This study seeks to understand the treatment processes of clinicians addressing moral injury. Moral injury can cause individuals to question their purpose in life, as well as how they relate to the world around them (Frankfurt & Frazier, 2016; Koenig et al., 2018). Due to the connection of moral injury to purpose, meaning, and relationships, examining this concept from an existential frame is plausible. The knowledge gained from discussing with clinicians how they address issues such as self-perception, meaning and purpose, and interpersonal relationships can be useful in understanding and treating this problem. Clinicians can perhaps modify their treatment protocol based upon findings of this investigation.

Moral injury and PTSD can be caused by a traumatic event; however, treatment approaches for PTSD do not fully address the complexities of treating moral injury (Purcell et al., 2018). Information from this study perhaps will be useful for helping clinicians identify when someone is experiencing a moral injury, which subsequently could lead to employing a different, or more appropriate treatment modality. Additionally, findings from this study could benefit those who have endured a moral injury.

Normalization, which is done by labeling presenting problems and assisting clients to see how symptoms are not unique to them, is important for clients experiencing mental health concerns. Creating a greater understanding of moral injury and potential treatment can help

normalize this concept. If veterans are able to better understand moral injury and share their experiences with others, feelings of isolation may subside, leading to a greater willingness to engage in treatment. An additional consideration of significance is the potential to apply the findings to other disciplines. An example of this could be sharing information how moral injury is not exclusive to this population but rather can be seen in a variety of work settings, and tailoring treatment to address symptoms.

In summary, findings from this study may guide clinicians in their choice of treatment for moral injury. In addition, published results from this study might foster a connectedness for those who have experienced morally injurious events and add to the growing body literature.

Theoretical Perspective

Moral injury has previously been studied from a social-cognitive model (Dombo, Gray, & Early, 2013). This approach focuses on how individuals construct their worldview based on their social surroundings and observations of other individuals. The goal of the present study is to examine how moral injury is treated from the lens of existentialism. Existentialism is a theory in which an individual is viewed as a whole with particular attention paid to the "Big Five" existential concerns of death, isolation, identity, freedom, and meaning (Koole, Greenberg, & Pyszczynski, 2006). This study will focus on how clinicians treating an individual with an identified moral injury conceptualize the client, and the treatment of symptoms. Existential concepts from major theorists Rollo May, Irvin Yalom, and Viktor Frankl, were examined in this study.

Rollo May examined the role of anxiety in relation to existentialism in his book, *Man's Search for Himself*. May (1953) explained man cannot live in a state of emptiness for too long before anxiety, depression, and other disorders set in. May (1953) discussed the importance of

fulfilment and purpose for healthy functioning. If an individual has experienced a moral injury, and begins to perceive themselves as immoral or unethical, the emptiness May described in his book could take over and affect one's mental health. In my study clinicians will be asked how they address the client's struggle with personal fulfillment, and self-perception after a moral injury, in an attempt to understand how clinicians address the client's sense of purpose after experiencing a morally injurious event.

Viktor Frankl explored the role of purpose and meaning in his book *Man's Search for Meaning* (1963). Frankl discussed the importance of understanding one's purpose, and how disillusionment can affect people. Individuals who have experienced a moral injury may experience the lack of purpose or joy Frankl described as disillusionment. The present study will examine this concept by inquiring about the clinician's perspective of importance of meaning making in the therapeutic process. Another aspect of existentialism is the relationship one has with others, including the importance of a therapeutic relationship.

Irvin Yalom discussed in many of his works the importance of the therapeutic relationship, and the importance of connectedness. He explained that purposeful relationships can bring meaning to one's life. This study will examine the importance of the therapeutic relationship when working with individuals who have experienced a moral injury. The impact of relationship on recovery will be discussed by clinicians who have experience treating a moral injury. This study will also inquire about the perceived conditions necessary for recovery. The clinician's perspective of the importance of the relationship when treating individual's moral injury will be explored.

Methodology

Phenomenological Approach

A phenomenological study aims at exploring the lived experiences of the participant (Groenewald, 2004; Padilla-Díaz, 2015). The use of descriptive phenomenology assists researchers in gathering rich information that can be used to gain a deeper understanding of human experience (Crowther et al., 2017). Because the purpose of this study is to gain a deeper understanding of how clinicians with experience treating people who have a moral injury view the therapeutic process, a phenomenological approach will be utilized. Participants in this study will be asked to describe their experience treating clients with moral injury, their perception of existential components in regard to a moral injury, and what they believe is helpful in the healing process. This phenomenological study will attempt to provide insight into the lived experiences of individuals treating moral injury.

Population and Sample

The nature of qualitative research sampling is purposeful, as it seeks to examine a specific population (Padilla-Díaz, 2015). This study will specifically examine the lived experience of clinicians treating moral injury. Participants in this study will be clinicians, identifying as either a licensed counselor, social worker, marriage and family therapist or psychologist, who are currently treating or have treated moral injury with veteran clients. Individuals who volunteer but do not have experience treating individuals moral injury will be thanked for the offer to participate and excluded from the study. The individuals involved in this study must meet criteria for participation. Recruiting first requires gathering a sample pool. Prior to the interview participants will be given information about the study. After a 1 week waiting period potential participants will be contacted again to inquire about interest.

Data Collection

If the participant agrees to the study, the consent form will be signed, and an interview will be scheduled. The participant will then complete a demographic survey, followed by an individual meeting to answer interview questions. These meetings will be recorded, transcribed, and coded for themes. After all individual meetings are completed, one focus group will be conducted with available participants. After the focus group participants will be involved in a debriefing session. As the primary researcher, I will ensure participants have contact information in case any questions arise.

Interviews

Interviews are open or semi-structured for qualitative inquiries (Padilla-Díaz, 2015). As primary researcher I will conduct semi-structured interviews for this study. Participants will be asked questions about their lived experience. Questions will be related to the clinicians' experience identifying the moral injury, addressing the therapeutic relationship, as well as what they have seen to be successful in treatment. To ensure trustworthy and quality interviews, questions will be developed before the interviews. Each question will also have additional prompts to help gather additional information as needed. Interviews are expected to last approximately forty-five minutes in length. After all individual interviews are completed, a focus group will be conducted. Group members will be given the opportunity to provide additional feedback or clarification. Participants will be informed during the informed consent, as well as before the interviews are conducted, that they can stop the interview or take a break when needed.

Data Analysis

Giorgi's method of data analysis will be used for this study. Giorgi (2012) stated prior to beginning data analysis the researcher focuses on the information as if it is new. This is done to

limit bias that may be present. Giorgi (2012) implored the researcher to focus on the phenomenon by only considering the information provided in the data collection. Giorgi's first step in data analysis is to read the data in whole, to gain a complete understanding of the information presented (2012). The holistic approach is important for the researchers understanding of the phenomena being studied. The second step in the Giorgi method of analysis is to reread the information and begin to make units of meaning throughout the transcript. The units of meaning are arbitrary and related to the attitude of the researcher (Giorgi, 2012). Consultation will be utilized during this step of the data analysis process to practice trustworthiness. The third step in the process is transforming the data into psychology-based words, however carefully maintaining the subjects' experience (Giorgi, 2012). The fourth step is to write an essential structure of the lived experience (Giorgi, 2012). The final phase of the analysis is to use the essential structure to clarify and understand the raw data (Giorgi, 2012). Giorgi's method of analysis is most appropriate as the focus of this study is to understand the lived experience of clinicians who have worked with this new concept.

Terms

existentialism- A theory grounded in universal human experience related to purpose, meaning of life, and personal responsibility.

clinician- A licensed practitioner who identifies as either a counselor (LPC), social worker, marriage and family therapist (LMFT), or psychologist.

veteran- A person who has served as a member of one of the branches of the Armed Forces (Army, Air Force, Navy, Marines, Coast Guard).

moral injury- Actions completed by oneself, observed of another person with failure of oneself to intervene, or witnessed events which transgress moral beliefs and cause symptoms including shame, guilt, and personal responsibility.

moral beliefs- Can be based on spirituality, societal norms, or psychological beliefs.

posttraumatic stress disorder (PTSD)- A diagnosable disorder characterized by the experience of a traumatic event or witnessing a traumatic event. Symptoms associated with this disorder include hyper vigilance, flashbacks, nightmares, irritability, isolation, psychomotor agitation, and many others. Full criteria can be found in the Diagnostic and Statistical Manual of Mental Health Disorders- 5 (DSM 5).

treatment protocol- A guideline for best treatment of a disorder. Generally developed from research and identified as an "evidenced based protocol" or EBP.

normalization- A process in counseling which validates the client's reaction to a specific experience.

psychological emptiness- Characterized by symptoms including isolation, lack of emotion, lack of connection to others, low mood, difficulty finding purpose, etc.

Researcher Background

In my current professional role, I work with combat veterans providing counseling services through the Veterans Health Administration. In working with veterans from various combat theaters I found a theme of guilt, and shame, related to service experiences and actions of war continuously came up. Upon further discussion with colleagues, it became clear this idea of "moral injury" was seemingly universal. My clinical practice is grounded in humanistic theory, specifically existentialism. The role of human relationships and sense of belonging cannot be overlooked when working with moral injury and should be examined more closely. Being that I

have my own personal experience, I recognize the potential for bias when conducting interviews and focus groups. To mitigate this risk, I will engage in consultation to account for potential bias. Additionally, I will keep a researcher journal throughout the process. I will also utilize the technique of bracketing as a form of managing bias. Bracketing is a practice that involves setting aside our knowledge about the phenomenon (Giorgi, 2009; Giorgi, 2012; Giorgi et al., 2017). By bracketing knowledge and preconceived notions, the potential for skewed data will be limited.

Limitations

By its nature, qualitative research has a limitation of potential researcher bias. Due to my involvement in the study, separation of bias can be difficult. One way this can be addressed is through the use of consultation, triangulation, and bracketing. In conducting this study, I will use these strategies to monitor for bias in research themes.

While not a limitation of the study, results of this study are not generalizable; however, they may be transferable to future studies. A more in-depth understanding of the concept could allow for application to other disciplines as well. It is important to continue to study the construct of moral injury throughout combat eras, and across various careers.

Another potential limitation to this study is participant responses. Due to being employed by a similar health care system as participants, participants may have given skewed responses. While there is no risk to responding to the questions, the participants may exaggerate experiences working with clients with moral injury to assist aid this study.

PART II: REVIEW OF THE LITERATURE

Introduction

Clinicians frequently encounter presenting issues that do not always fit the diagnostic criteria. These presenting concerns may not warrant the creation of a new diagnosis; however, there is a need to operationally define them. One of these constructs that has gained notoriety and increased interest in recent years is that of moral injury (Braitman et al., 2018; Drescher et al., 2011). What was once perhaps considered symptoms of PTSD is now being etched out as a deeper, more spiritual or ethical wound experienced by those who have engaged in or failed to act on a moral dilemma (Litz et al., 2009). With the development of a new construct comes the need to understand how to treat individuals with these experiences.

Foundation of Moral Injury

Moral injury is often co-occurring with PTSD (Barnes et al., 2019). Some clinicians believe these are be separate issues, while others suggest they are of the same silo. Smith et al. (as cited in Farnsworth et al., 2017) reported moral injury as not separate from PTSD, but instead another manifestation of traumatic stress response. Other researchers argue moral injury is distinctly different from PTSD (Shay, 2014; Maguen & Litz, 2012; Drescher et al., 2011). Barnes et al., (2019) believe moral injury is derived from the emotional part of trauma, and includes guilt, grief, self-blame, existential issues, and difficulty trusting.

There are breadcrumbs of PTSD throughout history before it was clearly defined in the Diagnostic and Statistical Manual in 1980. In these recollections of war, moral injury can also be found. Beginning with *The Iliad* of Homer, soldiers reported experiences of the trauma of war. Riddled with themes about doing what is right, grief for those lost, and committing of atrocities, *The Iliad* is the one of literature's first encounters with PTSD, and what would become moral

injury (Shay, 1991). Jonathan Shay related the themes in the poem to his work with Vietnam veterans, and later Iraq and Afghanistan veterans.

Posttraumatic Stress Disorder and issues of morality continue like a ribbon through history weaving in and out of wars and connecting those who have experienced the atrocities of combat. In the Post-Civil war era, people referred to the concept as the Soldier's Heart, described by British psychiatrist Charles Samuel Myers (Dombo et al., 2013). Leaping forward to World War I, terms including combat stress and shell shock are used to describe the symptoms that doctors and professionals cannot label. When World War II concluded psychiatrists noticed what they would label battle fatigue, combat exhaustion, or battle neurosis. In the ICD-6 this was labeled for the first time as Acute Situational Maladjustment (WHO, 1948). Even after years of seeing similar symptoms, researchers and clinicians struggled to fully comprehend and label this disorder.

The Vietnam war era brought increased attention to the emotional and perhaps spiritual effects of war. Survivor Syndrome was identified by Niederland (1968) who noticed the manifestation of symptoms including inability to tolerate stress, increased anxiety, and poor relationships. In 1968, The Diagnostic Statistical Manual-II provided the diagnosis for Adjustment Reaction of Adult Life, to account for reactions to trauma (American Psychological Association, 1968). Vietnam veterans returned home to a country that was unprepared to address the emotional, cognitive, and ethical repercussions of combat.

In 1980, the DSM-III identified the symptoms of trauma as Post-traumatic Stress Disorder, or PTSD (American Psychological Association, 1980). Adjustments were made to the diagnosis over the years; however, the general criteria of experiencing a traumatic event, and symptoms experienced after this event have remained largely the same. Variations of the

diagnosis, including terms such as compassion fatigue and burn out describe the emotional exhaustion of individuals who have not experienced the single Criterion A stressor. As wars continued, and veterans of the past sought treatment, a new construct began to surface among clinicians. The emotional pain reported by veterans related to doing what is perceived as wrong became identified as moral injury.

Jonathan Shay (1991; 2009) was the first clinician to outline moral injury. He tied his experiences working with Vietnam veterans to the themes of war in Homer's *The Iliad*, including the idea of moral injury. He identified specifically not just an emotional, cognitive, behavioral readjustment issue, but disturbances that were moral in nature. He identified a moral injury as a "high stakes violation of 'what's right'" by someone holding legitimate authority in a high-stakes situation (Shay, 2009). Shay (2009) continued to discuss the physiological piece of moral injury including the physical symptoms of panic or the sinking feeling in the stomach. His work in identifying the foundation of moral injury has led to several follow up studies and inquiries of the construct.

Changes of Conceptualization of Moral Injury

Jonathan Shay (1991) created the foundation of moral injury which clinicians have used to expound on the concept. Shay discussed the emotional turmoil that is experienced when individuals witness the betrayal of what is believed to be right and engagement in what is wrong (Haight et al., 2016). After Shay's first identification of the concept plaguing Vietnam veterans, clinicians became more adept in identifying moral injury, however the momentum was slow, and it took years before additional research and literature on the concept of moral injury was produced. As the topic gained notoriety, a greater understanding of the concept grew. With this came a deeper understanding of the psychological sequelae.

In practice, clinicians first connected moral injury to the feelings of survivor's guilt as identified by Litz et al. (2009). Veterans reported feelings of shame, responsibility, and unworthiness in relation to returning home while others died. While the emotions were reported to clinicians, the morally related thoughts and feelings were largely unaddressed. Litz et al. (2009) suggested this was due to clinician's efforts being focused on addressing the life-threatening traumas of combat and failing to acknowledge the deep emotions of shame and guilt. The traditional trauma focused treatments including Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Cognitive Processing Therapy (CPT) focus on mitigating the effects of traumatic events and do not address the moral aspect of this concept (Purcell et al., 2018). It was later identified that traumatic events were not necessary for moral injuries to develop, which is perhaps why they were previously overlooked (Barnes et al., 2019). The foundation of understanding moral injury lies in knowing how a moral injury occurs.

Morally injurious events have been defined by Litz et al., (2009) as situations in which a person acts, fails to act, or witnesses an action that transgresses moral beliefs or values. Researchers expanded on this as identifying the actions to be perceived as cruel, immoral, inhumane. Shay (1991) identified actions including failure to do what is right, dehumanizing the enemy, and partaking in actions like excessive killing as leading to moral injuries. The necessary piece to identifying a moral injury, however, is when the individual who committed, or witnessed the committing of these acts experiences a deep inner conflict involving questioning of self, and including one's moral, ethical, or philosophical beliefs (Litz, et al., 2009). Another explanation of how a moral injury is developed is through engaging in killing, excessive use of violence, and inability to assist wounded civilians (Dresher et al., 2011). Individuals who have these types of experiences may question their own morality and struggle to understand how they

can engage in these types of activities. The definition of moral injury and identification of morally injurious events continue to evolve. Understanding the foundation is not enough, and efforts have been turned towards comprehending the psychological sequelae of moral injury.

One of the most significant developments in the construct of moral injury is the identification of the lasting impact these events have on a person. After enduring a morally injurious event, someone may experience feelings of guilt, shame, remorse, or grief (Bica,1999; Cunningham et al., 2018; Dresher et al., 2011; Frankfurt, Fraizer, & Engdahl, 2017; Harris et al., 2015; Jordan et al., 2017). Isolation may occur, reiterating to the person who experienced the moral injury that what they did was unforgiveable, and they deserve to be shunned. This person may be trapped between the actions they committed or failed to intervene on, and a society which will no longer accept them. Dresher et al. (2011) found chronic mental health concerns to be associated with moral injury. Chronic conditions such as depression, anxiety, and suicidal thoughts brought attention to the significance of moral injury.

Individuals who have reported experiencing a moral injury also frequently report symptoms related to depression, anger, anxiety, and have a higher rate of suicidal ideation, attempts, or self-injurious behavior (Smigelsky et al., 2018; Nash et al., 2013). Maguen & Litz (2012) reported increased aggression, substance use, and withdrawal. A general theme of mistrust in others, institutions, and even self has been found with those experiencing moral injury (Dresher et al., 2011; Yandell, 2018). Individuals who experience these symptoms may report mistrust, isolation, anger, worry, and low mood, however the challenge comes in articulating deeper existential feelings such as shame or guilt.

Guilt and shame have haunted individuals throughout history. The inability to clearly identify and mitigate these feelings has sent individuals into spirals of depression, neuroses, or

even suicide. Bryan, Morrow, Etiene, and Ray-Sannerud (2013) found a strong association of suicidal ideation with feelings of guilt and shame in military personnel. The inability for a person to mediate their beliefs about themselves and their moral character with actions which greatly transgress their beliefs can trigger an existential crisis a person struggles to come back from (Currier, Holland, & Malott, 2015).These are experiences and emotions which trauma focused treatment cannot alleviate

Moral injury started as an observation of a pattern in presentation of symptoms of PTSD. While it has been mentioned as far back as Homer's *The Iliad* (Shay, 1991), it was not until recently the construct has been teased out from its trauma roots. While there has been great growth in the concept, clinicians and researchers must continue to examine the foundation, treatment, and understanding of moral injury.

Leading Researchers on Moral Injury

The first clinician to explore and report on the concept of moral injury was Dr. Jonathan Shay. Shay began his career as a psychiatrist for a community-based outpatient clinic near Boston (Shay, 2014). He began noticing issues of morality in the Vietnam veterans he was working with, and likened their struggle to those of Achilles, the lead in Homer's *The Iliad*. Shay's seminal piece on moral injury was published in 1991, and the concept expanded from there (Shay, 1991;2009). As the concept continues to grow more leaders in research emerge. Those who have been credited with the major growth of the concept include Brett Litz, Shira Maguen, William Nash, Kent Drescher, and Jacob Farnsworth.

Brett Litz, working with the National Center for PTSD in the VA, and teaching at the Boston University School of Medicine, has completed extensive research on moral injury and its ties to PTSD. In 2009, Litz, and colleagues published an article in the *Clinical Psychology*

Review which discussed their conceptualization of moral injury, the etiology of the problem, and the future research topics. Two of Litz's colleagues were Shira Maguen and William Nash, who would go on to produce additional research on the topic.

Shira Maguen, a VA psychologist out of the San Francisco VA Health Care System, continued research on moral injury, with a focus on the impact of killing. She led a team of clinicians in a study examining the mental health symptoms of those who killed an enemy in combat. The study stemmed from information from 1200 Vietnam veterans and the researchers found that killing was associated with PTSD, dissociation, and functional impairment (Maguen et al., 2009). Maguen continues to expand on research related to moral injury and is currently expected to start research on treatment of veterans with moral injury through the University of California, San Francisco, where she is a professor.

William Nash has worked extensively with both Maguen and Litz on their work with moral injury. Nash, an M.D who served in the Navy attached to a Marine unit, has a rich background in treating active duty personnel with moral injuries. Nash's work focused on creating and validating the Moral Injury Events Scale (Nash et al., 2013). The scale offers various morally injurious scenarios and asks the participants to rate whether this is something they experienced. Prior to the creation of this scale Nash enlisted the help of 23 professionals from various disciplines and asked them to discuss their experiences working with Iraq and Afghanistan veterans to understand what a moral injury is.

Kent Drescher was previously associated with the National Center for PTSD, and the VA Palo Alto Health Care System. Drescher's focus was primarily on the role of spirituality and trauma (Drescher & Foy, 2008). He researched the role of "God", and "right from wrong", and impact it had on those who experienced a moral injury. Drescher et al. (2011) conducted a

qualitative study to understand the concept of moral injury from the perspective of clinicians who were encountering it in their practice. Dresher et al. (2011) reported clinicians believed the concept was separate from PTSD, and the identification of the concept was necessary. Drescher worked closely with another clinician, Jacob Farnsworth who is also credited with expanding the construct of moral injury.

Jacob Farnsworth, a VA psychologist, has spent most of his career defining and critiquing the idea of moral injury. One of Farnsworth's most notable pieces was published in the *Review of General Psychology*, which focused on the role of moral emotions (Farnsworth et al., 2014). Farnsworth et al. (2014) summarized all literature to date on moral injury and offered direction for future research. Farnsworth et al. (2017) also worked towards understanding treatment options and specifically explored the potential for use of Acceptance and Commitment Therapy. Farnsworth continues to work with other clinicians on expanding the understanding of etiology and treatment of moral injury.

Studies and Methodologies: Treatment of Moral Injury

As the construct of moral injury gains momentum, attention must be paid to treatment. Past attempts to treat moral injury with trauma focused evidence-based practices have been proven unsuccessful. Purcell et al. (2018) identified Prolonged Exposure Therapy (PE), and Cognitive Processing Therapy (CPT) to be the hallmark of treatment for PTSD, particularly in the Veterans Health Administration. They concluded while these treatments may be successful for alleviating PTSD symptoms, they focus on addressing fear-based trauma and do not directly address the moral injury. One treatment that is being piloted to address moral injury is The Impact of Killing treatment (Purcell et al., 2018; Maguen et al., 2011). This treatment utilizes cognitive behavioral components to process the thoughts and feelings related to the act of killing

(Griffin et al., 2019). This treatment is still being researched; however, preliminary studies show potential for use in treating moral injury. Another manualized therapy which shows potential for treatment of moral injury is Adaptative Disclosure.

Adaptive Disclosure, named in a way to avoid the use of terms "therapy" or "treatment" to avoid negative labels with patients is a hybrid approach (Gray et al., 2012). This treatment consists of six weekly sessions, 90 minutes in length and is targeted specifically towards addressing life threating traumas, traumatic loss, and experiences that may create a moral injury (Gray et al., 2012). Adaptive Disclosure addresses some of the hallmark components of moral injury including shame, guilt, and feelings of being shunned. While there is still limited empirical research to prove Adaptive Disclosure is successful in treating individuals with moral injury, there is promising research being conducted. Evidence based treatment is the next block in the building process of constructing a full understanding of moral injury. One area that is not necessarily required of moral injury yet cannot be ignored is that of spirituality.

Another recent development in the construct of moral injury is the consideration of spirituality and religion in treatment. Psychology, counseling, and other social sciences tend to avoid spirituality or religious conceptualization of problems. These pose a potential ethical dilemma that clinicians and researchers are careful not to cross. Moral injury, however, does have some grounding in spirituality, philosophy, existentialism or religion, as at its core it examines right from wrong. Johnson (2014) explains that clinicians addressing moral injury while integrating religion or spirituality must be careful to identify boundaries and be aware of their clinical competency. The major emotions of shame and guilt experienced by those with moral injury are often grounded in spiritual or existential beliefs (Harris et al., 2015). In their

study examining psycho-spiritual development, Harris et al. (2015) found that for treatment to have optimal efficacy, it should possibly be based on a spiritual, cultural, or moral worldview.

As the concept of moral injury began to develop, most studies completed were qualitative in nature. Clinicians and researchers first identified the need to clearly define what they were encountering in practice. Drescher et al. (2011) worked to identify how clinicians described and conceptualized moral injury through their in-depth qualitative study. Other researchers conducted qualitative studies with veterans who had experienced moral injuries firsthand to gain an understanding of perspective (Purcell et al., 2016). Qualitative research laid the foundation for understanding the construct. Quantitative research and instrument development have allowed for testing the effects of moral injury and understanding how to measure it.

Four construct measurement tools have been developed to help quantify the moral injury construct. The first is the Moral Injury Events Scale (MIES) developed by Nash et al., 2013. Nash et al. (2013) began testing with an 11-item moral injury events scale. They administered this self-report scale to Marines at one week, and at three months post deployment. Eventually two items were dropped from the scale, and it is now a nine-item scale named the Moral Injury Event Scale. This instrument was proven to be conceptually valid (Nash et al., 2013). The researchers explain the scale can be used to evaluate occurrence and the severity of morally injurious events. Questions from this measurement include “I saw things that were morally wrong”, “I am troubled by having acted in ways that violated my own morals or values”, and “I feel betrayed by leaders who I once trusted” (Nash et al., 2013). This is useful for clinicians to administer to patients who are expressing some of the psychological symptoms of moral injury.

The second scale developed was the Moral Injury Questionnaire-Military version (MIQ-M) developed by Currier et al. (2015). The MIQ-M was developed to help practitioners assess

possible morally injurious experiences among individuals in the military (Currier et al. 2015). The questionnaire consists of 19 questions which inquire about the individual's experiences including items such as "I saw/was involved in the deaths of children" and "I made mistakes in the war zone that led to injury or death" (Currier et al., 2015). Currier et al. (2015) found that higher scores were associated with greater combat exposure, impairments in functioning, and depression.

The Expressions of Moral Injury Scale-Military was created by Currier et al. (2017) and is used to identify warning signs and major symptoms of moral injury. The instrument was tested on independent samples of veterans, all of whom served in a war zone (Currier et al., 2017). The instrument has been proven successful in research at identifying subtypes of moral injury, which are self-directed moral injury and other-directed moral injury. With additional testing and validation, this instrument could be beneficial for clinicians to utilize to help understand moral injury, its subtypes, and potentially lead to the development of more evidenced based treatment.

Koenig et al. (2018) developed the Moral Injury Symptom Scale-Military Version (MISS-M), a multi-dimensional tool which can be used to measure outcomes of interventions when treating moral injury (Koenig et al., 2018). This tool considers the importance of a spiritual/religions connection with moral injury (Koenig et al., 2018). This questionnaire consists of 45 questions which measure 10 domains including betrayal, guilt, shame, moral concerns, religious struggles, loss of religious faith/hope, loss of trust, loss of meaning, difficulty forgiving, and self-condemnation (Koenig et al., 2018). The results of this study demonstrated moral injury is also correlated with symptoms of PTSD, chronic pain, depression and anxiety, relationship problems, and social withdrawal (Koenig et al., 2018). This questionnaire is particularly useful,

as it also examines the religious and spiritual aspect of moral injury which are important components when considering moral injury from an existential viewpoint.

Applications for Counseling

Moral injury is a relatively new construct in the field of mental health, and researchers and clinicians continue to move towards a better understanding of its etiology, and how this problem is mitigated. Qualitative research has helped develop a foundation of understanding from a clinical perspective, as well as a first-hand account from those who have experienced these transgressions. The next step in research is applying what is known to clinical practice.

The concept of moral injury first had to be clearly defined before it could be treatable. The treatment of moral injury is a challenge facing clinicians and researchers. Researchers have suggested that traditional trauma treatments do not address the root of the moral injury (Purcell et al., 2018). Some clinicians suggest existing evidenced based treatments including ACT could be helpful; however, empirical research must be conducted (Nieuwsma et al., 2015). Other clinicians are working to develop new treatment approach such as the Impact of Killing protocol which is specifically designed to address the moral implications of war (Maguen et al., 2017). The next, and perhaps most important step in order for counselors to address moral injury is establishing a treatment protocol, or at minimum treatment guidelines that directly address this issue.

Moral injury has been conceptualized from a military or veteran experience (Jinkerson & Battles, 2018). As it has been more clearly defined over recent years, the possibility of applying the definition to various experiences continue to evolve. A medical provider who is unable to practice in a way they feel is most ethical due to constraints of insurance or clinic rules may also experience moral injury. A social worker investigating abuse or neglect cases may experience a

moral injury when they are unable to gather enough evidence to remove a child or vulnerable adult from an unsafe environment. Now that moral injury has been defined and empirical evidence is building, this concept will potentially become a prominent issue in counseling.

Conclusion

Clinicians encounter a variety of presenting issues in their day to day practices. Issues with extensive research such as depression or anxiety can be identified, diagnosed, and treated with evidence-based practices. However, moral injury has posed a new challenge to the counseling profession, as clinicians and researchers try to understand how this problem develops, and more importantly how it can be treated. Research focusing on moral injury, now that it has been defined, involves identifying the most effective methods of addressing this mental health issue.

PART III: METHODOLOGY

Introduction

In Chapter 3, the purpose of the study, as well as research method and data analysis will be reviewed. I will also discuss how I will work to achieve trustworthiness and rigor with using the qualitative process. I will also address the notions of dependability, confirmability, transferability and dependability with qualitative research. My chosen method of analysis, Giorgi's method, will be discussed, and I will identify the steps I will take to complete the analysis. Additionally, participant recruitment and inclusion criteria will be reviewed.

Methodology and Rationale

The concept of moral injury is relatively new to the field of mental health. Recent research has focused on veterans' experience with moral injury. A qualitative study was chosen to add depth to the understanding of how to treat moral injury, particularly from an existential framework. Additionally, a qualitative study is necessary to add breadth to the topic allowing for clinicians to gain an understanding of moral injury and treating this problem. The goal of a phenomenological qualitative study is to identify what is present by adding information that is not there (Applebaum, 2012). Researchers do not seek to quantify information, but rather garner an understanding of a phenomena. This study will be conducted using the descriptive phenomenological research approach of Amedeo Giorgi. Giorgi utilized a scientific approach, however maintaining respect for human characteristics (Giorgi, 2012). Interviews and a focus group will be utilized for data collection. Giorgi identified that due to the length of interviews used in this approach, as well as the arduous data analysis, few subjects are often used particularly in dissertations or theses (Giorgi, 2008). Additionally, he recommends at least three participants (Giorgi, 2008). This approach is the most appropriate choice for this study as the

purpose is to employ the use of interviews to gather information and summarize the lived experiences of the participants without attempting to give meaning to it.

Giorgi discussed the impact Husserl had on his own development as a phenomenological researcher and in his development of the descriptive phenomenological approach used in psychology, and which will be utilized in this study (Giorgi, 2012). One key concept of Husserl's that this study considered is intentionality. The definition of Husserl's intentionality is to be conscious of something, and that people's consciousness structures what they experience (Föllesdal, 1994; Giorgi et al., 2017). Husserl further explains that in order for one to understand the intentionality of others, certain procedures should be used. First, utilizing the phenomenological reduction attitude, the researcher must fully analyze the phenomena as it is and describe it, exactly how it is lived (Giorgi et al., 2017). Two additional Husserl-based practices important in Giorgi's research methods are scientific phenomenological reduction, a special sensitivity to the phenomenon wherein one seeks to access pure consciousness, and bracketing, which is setting aside our knowledge about the phenomenon (Giorgi, 2009; Giorgi, 2012; Giorgi et al., 2017). Once these attitudes are set and practices engaged in, the researcher can begin with analysis of data.

Research Questions

Qualitative research is framed in theory and research questions must be representative of this (Bigby, 2015). This study will examine the concept of moral injury from an existential theoretical perspective. The overarching research question is grounded in existentialism, and specifically examines the clinician's experiences when treating individuals with moral injury. Additionally, to expand upon existing research, the question about what may be important for the healing process will be explored.

The overarching research question is

What are the experiences of clinicians who identify as having treated or currently are treating a moral injury?

The goal of this question is to gain a deeper understanding of how clinicians experience the treatment of a moral injury, as well as what they believed to be essential to mitigating the problem. The question was developed with fidelity to the theoretical framework discussed in the purpose of the study section.

Role of the Researcher

As the primary researcher, I will take on various roles in this qualitative study. I will act as is the interviewer, transcriber, and identifier of themes. Above all the role of the researcher is to ensure production of quality research, which I will attempt to do by ensuring rigor and credibility in this study. While a researcher is completely encapsulated in the study, they also must work towards removing themselves to not allow biases to affect data analysis. Qualitative researchers are not as concerned with reliability and validity as quantitative researchers are, but rather work towards qualitative rigor to ensure trustworthy findings (Thomas & Magilvy, 2011). I will utilize multiple methods to ensure trustworthiness of this study.

Trustworthiness and Qualitative Rigor

Defining rigor in qualitative studies has long been debated; however, it is a critical component in research (Cypress, 2017). Rigor and trustworthiness of the study are key in qualitative research as they provide evidence of the strength of the research design (Cypress, 2017). Trustworthiness in qualitative studies refers to the reliability and validity of the study. In this study, I will utilize bracketing and maintained a researcher journal to keep track of audit trails. Bracketing and use of a researcher journal help to eliminate researcher bias, which could

affect the quality of the study (Giorgi, 1988). Additionally, to add to the trustworthiness of the study, I will ensure credibility, transferability, dependability, and confirmability were by using multiple methods (Cypress, 2017). By using these multiple methods, trustworthiness and rigor of the study can be assured.

One technique that will be used to ensure qualitative rigor is bracketing. By utilizing the technique of bracketing the effect of preconceived notions or ideas on results can be limited. Giorgi based his phenomenological approach on Husserl's work (Giorgi, 2012). Husserl, and subsequently Giorgi, discussed the use of bracketing to control for bias to enhance pure consciousness (Cypress, 2017; Giorgi, 1997). As I have professional experience working with a population who reports experiencing a moral injury, it is imperative I bracket my previous knowledge and experience when analyzing themes. In order to enhance the rigor of this study, I must work to prevent my experiences from skewing the data (Tufford & Newman, 2010). While it is impossible to completely eliminate my personal experiences with this concept, one way I will attempt to track and reflect on my experiences is by keeping the researcher journal.

I will use a researcher journal to keep track of audit trails which are used in qualitative research to demonstrate the authenticity and adequacy of the research process (Sharts-Hopko, 2002). The audit trail covers data collection from raw data, to analysis, to interpretation of findings (Sharts-Hopko, 2002). Tracking this information will allow me to be transparent in the process which enhances trustworthiness through confirmability. By showing the reader how the information was gathered, what sources will be used to conceptualize the information, and how the accuracy of the information was confirmed, I will enhance the trustworthiness of the study. Additionally, I will utilize the journal to keep record of my personal reflections in the data collection and analysis process. The use of this journal will also assist me with the

phenomenological reduction attitude, which Giorgi based on Husserl's epoché (Giorgi, 2012). Giorgi further explained this psychological reduction is adopted though the entire data analysis process (Giorgi, 2009). Assuming this attitude is imperative, so the researcher resists from applying non-given knowledge or views on the presented information, and accepts information as it is (Giorgi, 2012). The use of this journal will assist me in reflecting on personal biases or potential assumptions and ensure the use of the phenomenological reduction attitude. The final method I will use to demonstrate trustworthiness is the use of consultation with a methodologist to ensure dependability in the qualitative research process. In addition to the researcher journal, I will also consult with my dissertation chair and methodologist. By discussing my potential biases with my committee members, and tracking the research trail in my journal, I will be able to enhance the rigor of this qualitative study. Credibility, transferability, dependability, and confirmability will also be addressed as I conduct this study to further ensure trustworthiness.

Credibility is achieved by the researcher reviewing findings for similarities across participants, as well as repeatedly viewing transcripts. Credibility can also be gained by discussing themes with participants (Thomas & Magilvy, 2011). I will ensure my understanding of participant answers by engaging in reflective statements during the interview. Additionally, I will allow participants to provide reactions on identified themes during the focus group. I will be careful not to engage participants in evaluating the psychological interpretation of themes as Giorgi cautioned against this, but rather ask for general reactions (Beck, 1994). Allowing participants to discuss the themes and add additional information assists with building credibility of the study (Kornbluh, 2015). Credibility will be achieved in this study by eliciting feedback from participants, and repeatedly viewing transcripts. These techniques helped ensure confidence in the truthfulness of the findings reported.

Transferability in qualitative research is described as the ability to identify how the findings of the study may be applicable to another group (Thomas & Magilvy, 2011). One way this is achieved is by providing a rich description of the participants. In the present study, I will interview licensed clinicians (LPC, Social Work-LMSW, Psychologists, and LMFT) who reported having experience working with the concept of moral injury. This study could be repeated using other disciplines, such as unlicensed individuals or chaplains to compare results with. Additionally, the information gathered from this study will be reported in a way so that other clinicians may be able to apply these findings to their own work.

Dependability, similar to the quantitative concept of reliability, is the trail a researcher can follow to replicate a study (Thomas & Magilvy, 2011). A study must be clearly described so that replicability is ensured. A clear and thorough literature review, and methodology, as well as data analysis and results must be provided. I will fulfill this role by providing comprehensive descriptions of procedures and findings. Additionally, I will provide suggestions for future research for other researchers to consider. Demonstrating the ability to replicate the study enhances the reliability of the research design.

Confirmability is the counterpart to objectivity for quantitative research, which happens when credibility, transferability, and dependability are achieved (Thomas & Magilvy, 2011). The role of the researcher here is to continue to be flexible with the study and remain open to how the results may unfold (Thomas &Magilvy, 2011). The way I will complete this is by not directing interviews, but rather I will take on a follower approach to ensure the information being gathered reflects that of the participant (Thomas & Magilvy, 2011). I will also engage in reflection statements to check for understanding of the participant. Additionally, the use of bracketing and the researcher journal will assist with limiting my personal biases and the effect they could have

on the results. Ensuring confirmability, dependability, transferability, credibility and rigor will help enhance the trustworthiness of the study.

Triangulation

The purpose of triangulation in this qualitative study is to enhance the validity of the findings through the use of multiple data sources, and decrease the researcher's potential bias (Renz, Carrington, & Badger, 2018). Triangulation will be achieved through various ways. Data triangulation will be demonstrated by using at least two methods of data collection (Carter et al., 2014; Renz et al., 2018). Individual interviews will be conducted, and initial themes will be drawn. From there, a focus group with all available participants will be conducted to discuss initial themes and give the participants an opportunity to discuss offer additional feedback and reactions. By utilizing multiple data sources, data triangulation will be achieved, and the accuracy of the study will be improved (Carter et al., 2014). Qualitative research requires the researcher to be intricately involved in data collection and analysis. Due to the researcher's proximity to the study, a potential for researcher bias is present. The use of triangulation strategies enhances the validity of the study and increases the trustworthiness of the researcher.

Sampling Procedure and Participant Characteristics

Sampling procedure

This study will utilize two types of sampling procedures to gain the desirable number of participants (n = 6). First, homogeneous purposeful sampling will be used, as there is a specific group with similar characteristics being sought (Palinkas et al., 2013). The multicultural demographics do not need to be homogenous; however, all participants must report having treated or currently treating a moral injury. The purpose of a qualitative study is to gain

understanding of a specific group's experience and work towards saturation (Palinkas et al., 2013). The second type of sampling that will be used is snowball sampling.

Due to the professional connections between counselors, social workers and psychologists, it is likely participants will share their involvement in the study with peers. The snowball process is the accessing of potential participants through the spread of information from other participants (Noy, 2008). Snowball sampling is a widely utilized sampling procedure within social sciences and with use of qualitative research (Noy, 2008). This type of sampling method will be helpful and is expected to take place when trying to identify participants, as it is likely therapists have consulted with other clinicians who have worked with a moral injury.

Recruitment

I will utilize multiple recruitment methods. First, I will contact clinicians that I know work with the veteran population. I will inquire if these individuals have any experience treating moral injury. Additionally, I will send a request for participants in an email sent to a listserv. The listserv is a part of the Military and Government Counseling Association, a branch of the American Counseling Association, and a group of which I am a member.

Snowball sampling will likely occur as participants contact me for engagement. I will also encourage individuals who agree to participate in my study to share the study information with other clinicians who may be interested and meet criteria. Additionally, I will inquire if participants know of any other individuals who might be interested in participating and request contact information and permission to contact that individual.

Participants

The single criterion for selection is identifying as either a licensed professional counselor, marriage and family therapist, psychologist, or social worker who has worked with treating a

moral injury. There were no demographic restrictions to participation, all gender, race, ethnicity, sexual orientation, SES, etc. were eligible for participation, however a demographic questionnaire was included. Due to the lack of an absolute definition of moral injury, the Litz et al. (2009) definition was provided to the potential participants if they have questions.

Prescreening

A brief prescreening will be conducted to ensure appropriate participation selection. I will complete the prescreening either in person or by email depending on the location of the participant. I will start the prescreening by giving the Litz et al. (2009) definition to the individual if they are unsure about the concept and asked if they have experience working with this concept. Additionally, I will inquire if the clinician had heard of the term moral injury and if they have previously focused treatment specifically on addressing this issue. Additionally, participants will be provided with an informed consent during the pre-screening if they express interest in the partaking in the study. Participants will be given contact information for this writer in the event they have questions. At one week post prescreening participants will be contacted to confirm or deny interest in engaging in the study. Additionally, it will be explained to participants who were in the local area that information will be gathered at a private location on the Texas A&M University- Corpus Christi campus. For participants who are outside of this location, it will be explained information will be gathered either by telephone or video conference. Information about the study, use of data, and expectations and potential risks will be reviewed during the prescreening with participants. Participants will also be informed that a transcription service will be used to transcribe their interviews. Participants will be informed their personal information will not be compromised and recordings and transcripts will be coded.

Data Storage and Confidentiality

Participants will be given an informed consent, and an opportunity to discuss concerns and ask questions before starting the interview. All hard copy documents will be stored in the dissertation chair's office in a locked cabinet. To ensure confidentiality, participants will be coded by number and all data will be stored under the identifying number. All information related to the study will only be accessible by me and will be kept under password protected files. In accordance with Texas A&M University-Corpus Christi policy, the files will be deleted 3 years after completion of the study.

Context of the Study

The context of this study is considered when making interpretations of data. The location, culture, and time of the study were all considered as influential factors of the study (Levitt, et al., 2018). Post-traumatic stress disorder has gained notoriety and focus from professionals over the past 15+ years due to the surge in veteran population from Iraq and Afghanistan deployments. This focus on PTSD symptoms is how the concept of moral injury was developed. There had been previous mention of moral injury by Shay (1991) who likened it to the moral struggle in Homer's *The Iliad,* however until 2009 it was relatively unknown. The prevalence of the concept in current culture is one factor to consider, as it may have an effect on participant answers. Another cultural consideration is the location of the study, south Texas. Clinicians working in the same establishment may have similar or limited treatment modalities. The data will be collected at a private location on Texas A&M University-Corpus Christi's campus, or through telephone or video conference methods. This setting may be uncomfortable to some participants who are not familiar with the campus. Additionally, some data will be collected over the phone or through video conferences which may limit participants ability to be authentic or fully engaged.

For interviews completed through phone or video conference, an electronic consent form and demographic survey will be collected.

Data Collection

Data will be collected from participants on two separate occasions. First participants will complete an individual interview. Once initial themes are identified, a focus group will be conducted. In the event a participant cannot engage in the follow up focus group, a second individual meeting will be offered and conducted to discuss initial themes and provide an opportunity for the participant to respond and give feedback.

Interviews will last approximately 45-60 minutes. Interviews will be guided by a set of predetermined questions to keep the interview on track and avoid any additional irrelevant data. Participants will be informed they can end the interview at any time if it becomes too overwhelming. Initial themes will be extracted from interview data and used for the focus group.

The focus group will take place after initial themes are identified from individual interviews. The purpose of the group is to review the themes drawn out by the researcher and offer participants an opportunity to clarify or dispute data presented.

Preconstructed interview questions will be used to ensure necessary information is gathered. The individual interview questions are:

(a) Can you please describe as detailed as possible a situation in which you treated a client experiencing a moral injury?

(b) How did you address the therapeutic relationship with clients experiencing a moral injury?

(c) What is it like for you as a clinician to treat moral injury?

(d) How do these experiences currently affect your treatment protocol when counseling clients with a moral injury?

Focus Group Questions:

Please introduce yourself

(a) How familiar are you with moral injury?

(b) How often you have treated clients experiencing a moral injury?

(c) What is your recommended treatment protocol when counseling clients experiencing a moral injury?

After I summarize the focus groups answers, additional summary questions will be presented to the group (Krueger & Casey, 2000). The group summary questions are:

(a) Of all the treatment protocols that were discussed, which one was most important to you?

(b) Have I missed anything or is there anything you would like to add that has not been discussed?

(c) Did I correctly describe what was said?

(d) How well does that capture what was said here?

Data Analysis

The initial task in the data analysis phase is to ensure quality information has been obtained. The use of quality research questions, and thorough interview questions is imperative to obtaining the necessary information. The Giorgi method of analysis, consisting of five steps, will be used for data analysis in this study.

As the researcher, I must first assume the phenomenological approach in Giorgi's method (Giorgi et al., 2017). In this phase I will read the transcriptions of the interviews in a holistic way. I will also work to bracket prior knowledge, experience, or assumptions in order to view the interview in its entirety. After assuming the phenomenological approach, and reviewing the interviews holistically, the next step in the analysis process is to identify units of meaning.

Units of meaning are determined when the researcher experiences a transition in meaning when reviewing the transcription (Giorgi et al., 2017). Meaning units can be identified with slash marks through the interview (Giorgi, 2009). I will reread the same transcription and identify different start and end points for the meaning unit, however the focus is the results of the study and the quality of my analysis of the data (Giorgi, 2009). I will discuss units of meaning with the dissertation chair and methodologist as part of the triangulation and trustworthiness of the study. The next step is to transform the units of meaning into psychological terms.

The process of creating psychological meaning from the units is the scientific part of data analysis (Giorgi, 2009). I will transform the units of meaning into psychological, third person terms, while ensuring the meaning is not lost. From these transformations the final step in data analysis is completed. I will use these units as the basis for describing the whole lived experience, or the essential structure (Giorgi et al., 2017; Giorgi, 2009). This is the final process in the data analysis, which creates understanding of the phenomenon being observed.

The gathering of general structures and creation of essential structures of the experience is the last step in Giorgi's method of analysis. I will complete this by reviewing all the psychological transformations and extracting the essential transformations. This process takes pieces of the study and creates a whole, general understanding of the phenomenon (Broomé, 2011). The general structures from each participant are reviewed and combined to form the essential structure (Giorgi et al., 2017). In the final process in this study I will identify the essential structures of clinicians' experiences treating moral injury and report the results.

Figure 1. Giorgi's Method of Analysis

Summary

Chapter three reviewed the research design and the steps that will be taken to ensure trustworthiness and qualitative rigor. Additionally, I identified how this study will address other

concepts such as confirmability, transferability, dependability and credibility. This chapter also reviewed how participants will be recruited and selected. The purpose of using Giorgi's method of analysis was identified, and I outlined the steps I will take to complete the data analysis.

PART IV: REFERENCES AND APPENDICES

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LIST OF APPENDICES

APPENDIX PAGE

Appendix A. Invitation to Participate 58

Appendix B. Informed Consent 59

Appendix C. Demographic Questionnaire 63

Appendix D. Semi-Structured/Open-Ended Interview Guide 64

Appendix A: Invitation to Participate

Purpose of the Study

I am Kristyn Heins a doctoral candidate from the Department of Counseling and Educational Psychology at Texas A & M University-Corpus Christi. For my dissertation, I am conducting a qualitative study gathering information from clinicians who are treating moral injury in the veteran population. If you would like to participate in this study, you will be asked to complete a demographic form, take part in a 45-minute interview, and a 45 -minute focus group with five other clinicians like yourself. Your participation in this study is voluntary. The purpose of the study is to gain information regarding the experiences of clinicians who have or are treating moral injury clients. You were selected as a possible participant because you meet the criteria as a licensed clinician in good standing who reports having experience treating moral injury in the veteran population. To participate in the study and set up an interview please contact me at kheins@islander.tamucc.edu or 616-502-3635.

Duration and Location
The study will consist of completion of a demographic survey and participation in an individual and group interview. The demographic survey should take approximately 5 minutes. The individual interview should take approximately 45 minutes. The group interview will take approximately 45 minutes. If you agree to participate in this study, you will be provided with a consent form and demographic survey before participating in interviews. No distress is expected from participation in this study. However, if you experience any stress please stop and speak with me. If further help is needed, we have counseling services can be made available. You may withdraw from the study at any time with no risk.

Procedures
Procedures involve the completion of a demographic form and engaging in an individual and group interview. Accommodations will be made at your convenience.

Potential Risks, Discomforts and Anticipated Benefits
The questions in the interview will be related to experiences treating moral injury. If you decide to take part in the study but then change your mind, you are free to withdraw at any time. Again, participation is voluntary. If you ever have, any questions about this research, or are interested in participating please feel free to contact me, Kristyn Heins, Doctoral Candidate, kheins@islander.tamucc.edu or Dr. Robert L. Smith, Regents Professor, robert.smith@tamucc.edu. If you ever have any questions about your rights as a research participant or possible research-related injuries please feel free to contact the Research Compliance Officer, at (361) 825-2497.

Confidentiality
Your name will not appear in any publications or reports produced from this study. All information provided is confidential

Appendix B: Informed Consent

CONSENT TO PARTICIPATE IN A RESEARCH STUDY AT TEXAS A&M UNIVERSITY-CORPUS CHRISTI

Understanding Clinicians' Perspectives of Treating Moral Injury

WHO IS DOING THIS STUDY?

The study is being conducted by Kristyn Heins, Doctoral Candidate in Counselor Education in the Department of Counseling and Educational Psychology at Texas A&M University-Corpus Christi

We are asking you to be a part of this research study. Please read the information below and ask questions about anything that you do not understand before you make a choice.

WHY IS THIS STUDY BEING DONE?

The purpose of this research study is to explore the experiences of clinicians working with the concept of moral injury with the veteran population. This qualitative study specifically seeks to gain insight into how clinicians' approach and treat the presenting problem of moral injury. Objectives include 1. To gain an understanding of the important factors to consider when treating clients with a moral injury 2. To understand the kind of treatments used by clinicians who are, or have worked with, clients experiencing moral injury 3. To obtain recommendations from clinicians who are or have worked with clients' experiencing moral injury. 4. To understand how clinicians build the therapeutic relationship with individuals who have experienced a moral injury.

WHO CAN BE IN THIS STUDY?

To be a part of this research study you will need to be a clinician in good standing that has or is working with clients experiencing moral injury.

To be eligible to participate in this study, you

- must be 18 years of age or older
- need to hold a masters or doctoral degree in social work, clinical mental health counseling, marriage and family counseling, or psychology
- need to be currently licensed in good standing
- must have worked with clients experiencing moral injury

TEXAS A&M UNIVERSITY
CORPUS CHRISTI

WHAT WILL HAPPEN TO ME IN THIS STUDY?

Being in this study involves the completion of a one-page demographic paper, an individual interview, and focus group. The interview seeks to gain information on the treatment of moral injury. The focus group also gathers information on the treatment of moral injury.

If you agree to be in this study, you will be involved in completing a demographic sheet taking 5 minutes, one individual interview for 45 minutes, and a onetime focus group that will take 45 minutes. The individual interview and focus group will be recorded.

WHAT ARE THE RISKS OF THE STUDY?

There a minimal risk to being involved in this study. "Breach of Confidentiality." is a risk. Pseudonyms, are used in the study to protect the identification of participants.

WHAT ARE THE BENEFITS OF BEING IN THIS STUDY?

There may be no direct benefit to you from being in this study. Benefits to society could involve clinicians being able to use the information gathered in the focus group to learn more about the treatment of moral injury. Due to the recent increase in cases of moral injury, extant treatment modalities need to be explored.

WHAT ABOUT EXTRA COSTS?

Participation in this study will not result in any extra costs to you. You will not have to pay anything extra if you are in this study aside from the personal time and travel costs it will take to come to the study visits.

WHAT WILL I RECEIVE FOR BEING IN THIS STUDY?

You will not receive any payment for participating in this study.

WHAT ARE THE ALTERNATIVES TO BEING IN THIS STUDY?

Instead of being in this study, you may choose not to participate.

WHAT ARE MY RIGHTS AS A STUDY PARTICIPANT?

Being in a research study is voluntary. You do not have to be in this study. If you choose not to participate, there will be no penalty or loss of benefits to which you are otherwise entitled.

What if I change my mind?

You may withdraw from the study at any time without penalty.

WHO SHOULD I CALL IF I HAVE QUESTIONS OR PROBLEMS?

You may call Kristyn Heins (Doctoral Candidate Researcher) at 616-502-3635, or email Kristyn.heins@gmail.com with any questions.

You may also call Dr. Robert Smith TAMUCC Faculty member, at 361-825-2307, with questions at any time during the study, or email at robert.smith@tamucc.edu

You may also call Texas A&M University-Corpus Christi Institutional Review Board (IRB) with questions or complaints about this study at irb@tamucc.edu or 361-825-2497. The IRB is a committee of faculty members, statisticians, researchers, community advocates, and others that ensures that a research study is ethical and that the rights of study participants are protected.

CONSENT TO PARTICIPATE

The purposes, procedures, and risks of this research study have been explained to me. I have had a chance to read this form and ask questions about the study. Any questions I had have been answered to my satisfaction. A copy of this signed form will be given to me.

_____ _____

Signature of Participant Date

STUDY PERSONNEL

I have explained the purposes, procedures, and risks involved in this study in detail to:

_____

Print name of Participant

Any questions that have been raised have been answered to the individual's satisfaction.

_____ _____

Signature of Person Obtaining Consent Date Time

Print Name of Person Obtaining Consent _____

Appendix C: Demographic Questionnaire

Study Title: *Understanding Clinicians' Perspectives of Treating Moral Injury*

1. Full Name (Last, First):

   _____

2. Email Address:

   _____

3. Contact Number:

   _____

4. Gender

   - ○ Male
   - ○ Female
   - ○ Other

5. Race/Ethnicity
   - ○ African American
   - ○ American Indian
   - ○ Asian or Pacific Islander
   - ○ Caucasian
   - ○ Hispanic
   - ○ Other

6. Which field do you hold a graduate degree in?
   - ○ Counseling
   - ○ Marriage and Family Therapy
   - ○ Social Work
   - ○ Psychology

7. How many years of total experience do you have in your field?

   _____

8. How many years of experience do you have treating moral injury?

   _____

Appendix D: Semi-Structured/Open-Ended Interview Guide

Individual Interview Questions:

(a) Can you please describe as detailed as possible a situation in which you treated a client experiencing a moral injury?

(b) How did you address the therapeutic relationship with clients experiencing a moral injury?

(c) What is it like for you as a clinician to treat moral injury?

(d) How do these experiences currently affect your treatment protocol when counseling clients with a moral injury?

Focus Group Questions:

Please introduce yourself

(a) How familiar are you with moral injury?

(b) How often you have treated clients experiencing a moral injury?

(c) What is your recommended treatment protocol when counseling clients experiencing a moral injury?

(d) How has the recent pandemic affected your treatment of moral injury?

Focus Group Summary Questions:

(a) Of all the treatment protocols that were discussed, which one was most important to you?

(b) Have I missed anything or is there anything you would like to add that has not been discussed?

(c) Did I correctly describe what was said?

(d) How well does that capture what was said here?

PART V: PROJECT REPORT

Changes to Research

The general concept of the proposed study remained intact. There were some changes to the number of participants and recruitment and data collection, and minor changes to interview and focus group questions. The changes were made to accommodate the global pandemic which began during the Spring 2020 semester. The changes to the study, as well as the rationale for the changes are outlined in the following paragraphs.

Changes to recruitment and participants

On January 21, 2020 the first confirmed case of the SARS-CoV-2, better known as COVID-19 was reported in the state of Washington (Dehkordi et al., 2020). On March 11, 2020 the World Health Organization publicly declared COVID-19 as a pandemic (Khosrawipour et al., 2020). By April 5, 2020 there were 308,850 confirmed cases in the United states (Dehkordi et al., 2020). As identified in a COVID-19 Response plan released on March 23, 2020 by the Department of Veteran Affairs, the majority of outpatient services would be transferred to telehealth services as appropriate. The impact of COVID-19 is not limited to only physical health complications and stress on the medical health care system but impacts the state of mental health and treatment options.

Data collection for this study began January 21, 2020 when a recruitment request was sent to the Military and Government Counseling association, a copy of which can be found in the appendixes. When no response was received by January 29, 2020 a follow up email was sent requesting the script be included in the biweekly digital newsletter. Multiple follow up emails were sent until a response was received March 8, 2020. On March 20, 2020 the first script was sent in the biweekly newsletter, and second was sent April 3, 2020.

By early April the majority of counseling services had been transferred to telehealth. Clinicians were adjusting to working from home with short notice and many were underprepared for this quick transition. Individuals were also managing their own concerns with COVID-19. The division of the Military and Government Counseling Association is comprised of many government employees. There were no requests to participate from the email recruitment. I assumed with individuals managing the transition of work and personal stressors could have possibly created a barrier to participation.

Through snowball and convenience sampling additional participants were identified. Multiple attempts were made to contact individuals. Some individuals expressed interest in participating initially, however failed to return the demographic survey and consent form. Study recruitments were sent to other individuals with no response. There are a multitude of potential barriers with recruiting for research studies; however, I suspect attempting to recruit individuals who are transitioning work and clinical caseloads to telehealth, as well as managing personal complications with a pandemic was a significant barrier to successfully recruiting the target number of six participants for this study. The minimum participants of four was successfully met, and a focus group was conducted with these four participants.

The dissertation committee was informed of this alteration of participants. The dissertation committee was informed of the sampling difficulties and provided with additional literature about sample size in qualitative studies. The literature included one article by Boddy (2016) on sample sizes for qualitative studies ranging from 1 participant up to 12 participants. The other article from Fusch & Ness (2015) discussed the importance of depth of quality as well as rich and thick quality over the focus on sample size. On April 8, 2020 the committee approved the change in sample size and the focus group was scheduled.

Changes to Data Collection

Due to the previously mentioned pandemic of COVID-19, there was some adjustment to data collection as well. Initially interviews would take place in person if possible, however due to Center for Disease Control guidelines regarding social distancing, all interviews took place via telephone call. Interviews were also going to be conducted on campus at Texas A & M University- Corpus Christi; however, closure of the campus due to the pandemic also impacted this plan. Interviews were instead conducted in the residence of the primary researcher. Interviews were completed when no other person was in the home to ensure confidentiality. Additionally, all consent and demographic surveys were collected digitally and saved in secure files electronically.

When the focus group was conducted on April 18, 2020, all participants reported they had transitioned to telework and were completing appointments via telephone call and secure video connect. It would have been an egregious oversight to not include a question about managing telework related to the topic of moral injury in the focus group. The question was not included in the original creation of focus group questions; however, they were imperative to discuss and added depth to the conversation and topic of moral injury. The updated questions are included in the manuscript appendixes.

Summary

The unprecedented pandemic that first appeared in the United States in January created many barriers for clinical care and continuation of research. Recommended guidelines including transition to telework, engagement in social distancing, and avoidance of crowds complicated both the everyday work life of many, as well as the ability to maintain engagement in research.

Adjustments were made to this study to accommodate the public health crisis and adapt the study for continued movement towards completion.

Target Journal

The journal my manuscript is being written for is the Journal of Military and Government Counseling, a journal from the Military and Government Counseling Association, a division of the American Counseling Association.

The Journal of Military and Government Counseling (JMGC) is a peer reviewed journal. The journal is published multiple times a year, generally once quarterly. The focus of the articles is on counseling in military and government type settings. This journal is not exclusive to military and veteran research and includes topics on civilian employees of the Department of Defense and other government agencies, as well as first responders including EMT, firefighters, law enforcement and dispatchers. This journal is an appropriate fit for this manuscript as the topic is about treating moral injury with the veteran community; however, the participants and the firsthand experience comes from government employees. Additionally, information garnered from this study may be applicable in treating a similar presenting problem in other sample populations such as first responders.

The JMGC lists seven examples of submission topics. These include practice focused manuscripts which review innovative treatment approaches, ethical concerns, or supervision practices. These manuscripts are generally grounded in theory or empirical knowledge. Theory is another suggested focus with topics including new theoretical approaches or integrated approaches. Another listed suggestion is research where both qualitative and quantitative research is published and manuscripts are to include participant information, data analysis, results and implications. Assessment and diagnosis is another listed accepted topic for

manuscripts with an emphasis on practitioner relevance. Profiles on individuals who have helped to advance the counseling field through research or leadership are also accepted manuscripts. Additionally, JMGC suggests manuscript submissions on trends in counseling including implications to the trends. The final suggestion listed on the JMGC website for manuscripts is best practices, where the focus is separate from theory and more tailored to specific interventions with specified populations.

This qualitative research study and manuscript falls in line with JMGC's suggestions for submitted manuscripts. The present study is a completed phenomenological qualitative study inquiring about the lived experiences of clinicians treating moral injury, a relevant topic for clinicians. The manuscript will include an introduction, review of literature, overview of the study including sample selection, data gathering and analysis, results, limitations, and implications for the field and future research. The submitted manuscript will follow the specific guidelines listed by the JMGC.

The listed guidelines follow a general format for manuscripts. Manuscripts should follow direction of the Publication Manual of the American Psychological Association (7th ed). One exception to this is use of Department of Defense capitalization of words including Soldiers, Sailors, Marine, Airmen, Veterans, etc. A full list of these exempted words is listed on the JMGC website. A separate title page with the manuscript title, authors name, affiliation and contact information will be submitted with the manuscript. An abstract will also be submitted consisting of no more than 150 words. The manuscript in total should be no more than 25 pages with 1-inch margins; however, the page limit does not include title, abstract, and references. The manuscript will be submitted electronically attached as a word document to the email listed on the JMGC website.

The Journal of Military and Government Counseling is the most appropriate fit for submission of this manuscript as it fits the suggested manuscript types outlined by JMGC. Additionally, as the Journal of Military and Government Counseling is from a branch of the American Counseling Association, the manuscript is an appropriate submission from a counselor education program. The topic of treating moral injury arises frequently in the treatment of veterans and first responders. Some consumers of the journal will likely find the information relatable, and hopefully applicable to their current practice.

Committee Suggestions and Candidate Response

All members of my committee attended my dissertation proposal. At the end of my presentation committee members offered feedback and suggestions. Additionally, all committee members provided me with copies of my dissertation with comments and requests for changes. The major feedback and changes are included below.

Comments from Committee Members	Responses
1) Separate moral injury assessments under a separate heading. [Ricard]	I created a separate heading and revised the section in chapter one to clearly outline measurements for moral injury, and more clearly define attempts at treating.
2) Expand on attempts at treating moral injury in chapter 1. [Smith]	I created a separate heading for attempts at treating moral injury. Included information on Adaptive Disclosure as well. Additionally, I

	added a summary section for the concept of moral injury before the statement of problem.
3) Remove sub questions for dissertation and discuss the overarching research question. [Suggestion from committee during proposal]	Sub questions were removed from the dissertation.
4) Discuss treatment approaches in significance. [Smith]	I added additional information on treatment approaches
5) Expand on how normalization is part of significance. [Ricard]	Expanded on the importance of normalization and how it relates to the significance to the study
6) Update researcher background to first person. [Oliver]	Updated researcher background to first person
7) Update "leading scholars" title to be more informative. [Ricard]	Updated title to "Leading Researchers on Moral Injury"
8) Add content on Adaptive Disclosure to Studies and Methodologies: Treatment of Moral Injury section. [Smith]	Added information on Adaptive Disclosure. Also elaborated on other studies discussed.
9) Remove Purpose of Study from methodology chapter. [Oliver]	Removed Purpose of Study
10) Question as to what Giorgi says about data collection and sufficient data. [Oliver]	Added additional citations for Giorgi's discussion of participants and use of interviews.

11) Include information on consulting with critical others. [Oliver]	Included information on reviewing themes with methodologist and dissertation chair.
12) See epoché and attitude of phenomenological reduction. [Oliver]	Included additional information and citation of my use of phenomenological reduction attitude, Giorgi's description of Husserl's epoché and seeing information exactly as it is presented
13) Various grammatical and style suggestions. [Wolff-Murphy]	Changes made throughout dissertation.

UNDERSTANDING CLINICIANS' PERSPECTIVES OF TREATING MORAL INJURY

Abstract

The purpose of this study was to explore clinicians' experiences of treating moral injury. In this descriptive phenomenological qualitative study, clinicians who identified as having experience treating symptoms indicative of moral injury were interviewed. Preconstructed interview questions were developed to elicit clinicians' unique lived experiences and how those experiences impact their treatment of moral injury. A focus group was also conducted to gain deeper insight and to allow group members to review preliminary findings. Findings include themes of clinician personal experience treating individuals with moral injury, as well as what is useful in treatment. Findings from this study may be useful in future clinical practice as clinicians see increased frequency of this presenting problem. Additionally, some of the presented findings may be useful as clinicians begin to see medical personnel and other civilians who were frontline workers in treating COVID-19.

Keywords: Moral Injury, Qualitative, PTSD, Veteran

Understanding Clinicians' Perspective of Treating Moral Injury

Posttraumatic Stress Disorder, commonly known as PTSD has been widely researched and is the most common psychological consequence from exposure to a traumatic event (Shalev, Liberzon, & Marmar, 2017). This diagnosis covers a myriad of symptoms falling into four clusters – intrusion, avoidance, negative cognitions/mood, and hyper arousal/reactivity. The diagnosis of PTSD does not always cover the emotional implications of trauma. Litz et al. (2009) identified moral injury as actions that transgress moral beliefs completed by self, or witnessed with failure to intervene. It is a condition manifested by feelings of shame, guilt, or responsibility. Moral injury is a term used to describe the non-physical wound created when someone witnesses or engages in an act of violence or an otherwise disturbing experience (Barnes, et al., 2019; Smigelsky et al., 2019; Fankfurt & Frazier, 2016; Litz et al., 2009). A need exists to understand how clinicians are addressing this presenting problem in the therapy room, as well as their personal responses to treating this issue.

Moral injury can be caused by a traumatic event, such as a Diagnostic and Statistical Manual 5 Criterion A stressor used to diagnose PTSD. Gold standard treatment approaches for PTSD such as Cognitive Processing Therapy (CPT) or Prolonged Exposure (PE) however may not fully address the complexities of moral injury (Purcell et al., 2018). Evidenced based protocols (EBP) may not directly address the more deeply rooted issues tied to personal ethics and moral codes. Nieuwsma et al. (2015) outlined how the use of Acceptance and Commitment Therapy (ACT) may be useful in addressing symptoms of moral injury with its unique approach of increasing psychological flexibility and integrating values work. Recently, Litz, Lebowitz, Gray, and Nash (2016) developed a modality called Adaptative Disclosure which incorporates concepts including forgiveness, compassion, and moral repair. Additional empirical research is

needed on all the discussed treatment approaches prior to a clear delineation of a standard treatment approach to moral injury.

The purpose of this phenomenological study was to gain an understanding of clinicians' experiences of working with clients who have experienced a moral injury. This study utilized interviews and a focus group to engage clinicians with experience treating this concept. The framework of existentialism, specifically concepts of meaning, purpose, and connection was considered when discussing with clinicians what has been helpful in the treatment process. The overarching research question in this study was "What are the experiences of clinicians who identify as having treated or currently treating moral injury?" This question was used to guide the understanding of the unique lived experience of clinician's who had experience treating individuals with moral injury. This study was conducted with the goal of providing additional information as to what may be useful in treatment to other clinicians working with this presenting problem.

Method

A descriptive phenomenological method was used to conduct this present study. A phenomenological study aims to explore the lived experiences of the participant (Groenewald, 2004; Padilla-Díaz, 2015). A phenomenological qualitative study was most appropriate for the research question as it can provide insight into the lived experiences of clinician's treating individuals who identify as having a moral injury. Individual interviews as well as one focus group were utilized to gather data. Interviews were used to gather rich and thick data pertaining to participant's experiences. A focus group allowed for additional data to be garnered, as well as gave participants an opportunity to clarify and add to preliminary data. Giorgi's (2009) method

of analysis was implemented to identify units of meaning, engage in psychological reduction of units, and create an essential structure applicable to the data.

Researcher Description

In my professional work experience, I have worked in a clinical role with a variety of populations including Veterans. In working with Veterans of various combat eras I saw the presentation of guilt and shame related to experiences and actions engaged in during war. Upon discussion and consultation with colleagues, it became clear this idea of moral injury was presenting in any therapy sessions. My theoretical orientation is grounded in humanistic theory with attention to existentialism. Because I have my own personal experience working in this population, I recognized the potential for bias when conducting interviews, the focus group, and analyzing data.

To mitigate risk, I engaged in consultation to account for potential bias. Themes were reviewed and discussed with my dissertation chair and methodologist. Additionally, I kept a researcher's journal throughout the process. In keeping with Giorgi's method, I also utilized the technique of bracketing as a form of managing bias. Bracketing is a practice that involves setting aside our knowledge about the phenomenon, and viewing what is given (Giorgi, 2009; Giorgi, 2012; Giorgi et al., 2017). Bracketing knowledge and prior experience assists with limiting the potential for skewed data. Finally, reflective statements were used to ensure the correct information was being gathered during interviews, and some initial data was discussed during the focus group allowing participants to clarify information. By utilizing multiple techniques for checking personal bias, the trustworthiness can be enhanced.

Recruitment Process

The nature of qualitative research sampling is purposeful and seeks to examine a specific population. Giorgi (2008) identified that due to the length of interviews used for this approach, as well as the arduous data analysis, few subjects are often used particularly for dissertations of theses. The original target number of participants of this study was six, the minimum was four. Data collection for this study began January 21, 2020 when a recruitment request was sent to the Military and Government Counseling Association. Convenience sampling and snowball sampling also began at this time. By March 11, 2020 the World Health Organization (WHO) publicly declared COVID-19 to be a pandemic (Khsrawipour et al., 2020). During this time public health concern grew, and many agencies transitioned clinicians to telehealth. It became difficult to follow up with individuals and many potential participants stopped communication, assumedly due to the public health crisis. The dissertation committee was consulted and additional literature on appropriate sample size was provided to discuss the smaller than anticipated sample size (n =4). On April 8, 2020 the committee approved the change in sample size and the focus group was scheduled.

Participant Selection

The single criterion for selection was an individual identifying as a licensed professional counselor, marriage and family therapist, psychologist, or social worker who has worked with treating individuals with moral injury. There was no limit to length of time or number of patients, and no demographic restrictions. A demographic survey was completed by participants prior to conducting the interview. The demographic survey included personal demographics such as name age and identified gender, as well as professional data including discipline and number of years of experience working with moral injury.

Data Collection

Data was collected from participants on two separate occasions. Participants first engaged in an individual interview. After all interviews were completed a focus group was conducted. Due to distance between participants, as well as COVID-19 concerns, all interviews and the focus group were conducted via telephone call. One alteration made to data collection was the reduction in number of participants as previously discussed in this article. Interview lengths ranged from 29 minutes to 41 minutes with an average of 35 minutes. The focus group lasted 35 minutes. Interview questions were pre-constructed; however, follow up questions as well as reflective statements were used in each interview for clarification and gathering of rich data. Individual interview questions inquired about the clinician's lived experience when working with individuals who have experienced a moral injury and how these experiences impact therapy. The focus group questions were used to gain a deeper understanding of the clinicians' unique lived experience, as well as facilitate group discussion about the topic of treating clients who have experienced a moral injury. The interviews and focus group were recorded, transcribed, and saved to secure files.

Data Analysis

Giorgi's method of analysis was chosen for this study. Giorgi stated a researcher must first assume the correct attitude when working with a descriptive phenomenological method (Giorgi, 2012). This entails assuming the attitude of phenomenological reduction, which requires the researcher to view the information as new, without applying preconceived ideas or understanding, and only considering the data as it is (Giorgi, 2012). Additionally, the researcher must assume a psychological attitude and take into context sensitivity to the subject that is being researched (Giorgi, 2012). This attitude was assumed for this research study to ensure trustworthiness of data collected and utilized to bracket prior knowledge of the subject.

After assuming the appropriate attitude for this study, the first phase of data analysis after completing interviews and transcription was to read the entire transcription as a whole (Giorgi, 2012; Giorgi et al., 2017). This process was repeated for each individual interview as well as the focus group prior to the second step in analysis.

The second step in Giorgi's method of analysis is to begin identifying units of meaning (Giorgi, 2012). This process requires the researcher to again consider the topic being researched, as well as what may be meaningful. The units of meaning may differ based on the researcher, as they are correlated with the attitude of the researcher identifying units (Giorgi, 2012). These units were put into a chart and used for the third step which entails creating psychological meaning from units.

The third step in Giorgi's descriptive phenomenological analysis is to transform the units of meaning into psychological essence (Giorgi, 2009; Giorgi, 2012). When completing this step, the researcher takes the units of meaning and gives a more psychologically based value to them. It is important in this step for the researcher to still maintain the basis of what the participant said (Giorgi, 2012). The methodologist was consulted during this step to ensure accuracy of transformation and to ensure trustworthiness. From these psychological units, general structures and themes were developed.

In the fourth step, the general structure from each participant is combined to form the essential structure (Giorgi, 2012; Giorgi et al., 2017). Repetition of units are noted, and similarities are combined to create themes. From this process an essential structure was created and applied to the research as a whole to interpret the raw data (Giorgi, 2012). The data collected in this study resulted in two separate overarching themes, the first was the personal experience of

the clinician treating moral injury and the second was what clinicians found to be useful in treating the presenting problem.

Methodological Integrity

One technique that was used to ensure qualitative rigor and integrity of the study was the use of bracketing. This strategy was employed throughout the entire study process. Bracketing is a piece of what Giorgi identified as assuming the phenomenological and psychological attitude (Giorgi, 2012). The use of bracketing was essential to set aside previous experiences with the subject of moral injury and to approach the information gathered in interviews as new. While it is impossible to completely eliminate personal biases, the use of a researcher journal was also employed to help track and reflect on experiences when collecting and analyzing data.

A researcher journal was used to keep track of audit trails and is a commonly utilized practice in qualitative study to demonstrate authenticity (Sharts-Hopko, 2002). The audit trail covers the data process from raw data, to analysis, and interpretation of findings (Sharts-Hopko, 2002). Tracking this information allowed for transparency in the process which enhances trustworthiness of the study. This process assisted with checking personal biases as well. The methodologist was also consulted throughout the data collection and analysis process. Consulting with the methodologist ensured adherence to the qualitative research process.

Finally, the use of data triangulation through using at least two methods of data collection was used (Carter et al., 2014; Renz et al., 2018). After the initial interviews were completed the focus group was conducted. During the focus group some initial data was discussed. This allowed participants the opportunity to clarify or correct information from the interviews. By using at least two methods of data collection the trustworthiness of the study and validity of results was enhanced.

Results

Out of the 5 verbatim transcripts, 173 units of meaning were extracted. Through Giorgi's method of analysis, the 173 units were transformed into 68 initial psychological reductions. This process is demonstrated visually in Figure 1. In Giorgi's fourth step, the psychological reductions were combined to form themes of the essential structure. Two major themes were extracted from the data: (a) clinicians personal experience treating moral injury and (b) components for effective treatment. The clinician's personal experience treating moral injury theme included four subthemes: (a) feeling unprepared, (b) clinician flexibility, (c) experience of professional satisfaction, (d) awareness of biases. The theme of components for effective treatment included seven subthemes (a) therapeutic relationship, (b) utilizing a multifaceted approach, (c) addressing existentialism, (d) use of community, (e) addressing avoidance (f) identification of emotions and (g) use of telehealth. It is worth mentioning that had data been collected prior to the mass implementation of telehealth due to COVID-19, it is likely telehealth would not have been a major theme. However, since every clinician had transitioned to the use of telehealth during the focus group, multiple units of meaning were identified under this subtheme.

Clinicians Personal Experience Treating Moral Injury

During the interviews and focus group the participants discussed their personal experiences when treating moral injury. The participants discussed topics include feeling unprepared, the importance of flexibility, having awareness of personal biases, and feelings of professional satisfaction.

Feeling Unprepared

One theme expressed in both individual interviews as well as in the focus group was clinician's feeling unprepared or underprepared to address the presenting problem. This topic

was brought up in four of the five transcripts. When discussing feeling unprepared clinicians identified issues including the difficulty defining successful treatment, avoidance of addressing the topic, not having clear guidance or consultation, and difficult with transference. Multiple clinicians expressed the frequency of the problem presenting in therapy; however, they also reported feeling ill equipped to address the issue. When discussing preparedness Kelly stated:

> To be honest I struggle…with a lot and the honest reason as to why I feel I struggle with it is that there is no clear treatment process, and we haven't really accounted for it … For me sometimes it's a struggle to not have anyone, to go to professional that can help me deal with it.

Michael echoed similar frustration and expressed difficulty with addressing the presenting problem and explaining moral injury to clients. Michael explained:

> I think it's very different because it's very gray. It's not black and white. I mean, with PTSD we can explain the symptoms. We can explain the biological reasons why they're experiencing what they're experiencing along with a lot of different interventions to help them work through those symptoms to mitigate it or reduce it or just eliminate it completely.

During the focus group a similar frustration was expressed again as clinicians discussed their experiences treating this presenting problem with others. Michael stated, "I know a lot to do with PTSD, but when it comes to moral injury it's more difficult as far as 'ok how do you really work with this'."

One topic that arose under feeling unprepared was clinician's avoidance of the topic. Ann discussed how she is at times apprehensive to address the topic. She explained "even I sometimes hesitate because I don't want to ask too much, and I also don't want to engage in

avoiding this subject." All participants discussed how they have felt unprepared to address this presenting problem at some point in their career.

Clinician Flexibility

The importance of clinician flexibility was also addressed during the interviews and focus group. Two individuals discussed this, and the topic was brought up during the focus group as well. There was an expressed need for clinicians to understand and accept they will not have all the answers when working with moral injury, and the importance of clinician willingness to be flexible in the treatment process. Michael explained:

> I think for me personally, it's just accepting that's there and being ok with it. Just kind of understanding that, you know, the way I was taught in graduate school isn't really the reality of what happens when you really sit down in session with individuals . . .There's not going to be an answer for every single type of situation, you're going to have to be artistic in a way, with the unknown, the uncomfortable.

Ann discussed how for her it was important to be flexible with her practice and meet the client where they were at:

> It's very tempting to want to find out the algorithm, make up the manual, make it some science, but that's just not the way people work . . . and if that means deviating from a protocol, bringing other things, obviously we're going to do it with a certain amount of clinical judgement

During the focus group the importance of clinician flexibility was again discussed. During the focus group one participant stated "But really for me it's just been keeping on my game, trying to read as much as I can, being flexible, and being ok in not feeling like an expert at all."

Experience of Professional Satisfaction

Clinicians expressed frustration and challenges when treating individuals with moral injury due to lack of guidance or resources, and difficulty defining success. Clinicians also discussed experience of professional satisfaction when working with individuals who report having experienced a moral injury. Michael explained:

> So for me, as much as it has been a challenge, it's been absolutely rewarding and just, you know, kind of given me a whole new perspective on my own life or just life, in general. You know hearing the stories and what people have worked through or continue to work on and work through. So, I find for me personally and just professionally, it's just incredibly rewarding and stimulating.

Ann also expressed the challenges and also satisfaction that come professionally with treating this presenting problem. She stated:

> So, on one hand, it's really sad because it is real. And if I didn't see it as sad, I feel like I wouldn't really be in the room because you can't deny that. And on the same note, because I really like positive psychology and reading about gratitude and being empowered, feeling honored that these vets trust me enough to come in and talk to me about these things. And working with them is challenging and you don't always get the Hollywood ending, but some of them start doing better in their lives and that's really rewarding.

When discussing this complex topic, clinicians reported experiencing a myriad of personal reactions including frustration and satisfaction. Clinicians also expressed the need to be aware of their own biases when working with this as well.

Awareness of Biases

Some clinicians also discussed the importance of being aware of personal biases. Therapists are taught the importance of multicultural sensitivity in school and training programs;

however, a different type of bias may arise if a clinician is not engaged in personal awareness. Clinicians discussed how the topic of moral injury can trigger an emotional response from the therapist and stated it is important for the provider to be aware of their own reactions. Ann described this experience:

> By building safety, you know, really being human in this session and really monitoring my reactions because it is difficult to her about a child being killed and I really have to be present with the patient and monitor my reactions to that, and just be aware that that may bring up stuff for me but also considering the patients pain and making it more about them. So, in other words, just really making sure that I'm not showing any signs of judging or flinching, or you know, just really kind of remaining that calm stable person in the room…

This topic was brought up in the focus group as well. During the focus group it was stated "…but it's about having that nonjudgement, and being aware of my own biases, so I can hear what they want to bring in, and if they're even willing to bring it in the room."

Another focus group participant reported, ". . . and just really harping on the relationship, and really checking my biases. Especially when you read the chart and have all this information, and just allowing him the space." Therapists working with moral injury may hear stories or situations which they have a personal response to and have to continuously check personal biases.

Of the sub-themes that emerged in the theme of clinicians' personal experience treating individuals with moral injury, the expression of feeling unprepared or underprepared was the most frequently mentioned. Clinicians also discussed the importance of checking personal biases and being flexible in the treatment process, as well as being humble and comfortable knowing they are not experts on the topic. Some participants discussed the professional satisfaction they

experience when helping clients with this presenting issue. Multiple sub-themes were also identified in the other overarching theme of components for effective treatment.

Components for Effective Treatment

Clinicians discussed what they identified to be important components in the treatment of moral injury. The range of experience in working with moral injury varied between clinicians, however many themes were the same. One of the most frequently discussed components was the importance of the therapeutic relationship. Other subthemes included utilizing a multifaceted approach to treatment, addressing existential issues and the frequency of presentation of these issues in session, the use of community and normalization, addressing avoidance, and helping clients correctly identify emotion. Another subtheme that arose due to the pandemic was the use of telehealth in treating individuals with moral injury and barriers and successes related to this.

Therapeutic Relationship

The importance of building the therapeutic relationship was repeated multiple times in each individual interview as well as in the focus group. Topics associated with this subtheme included the importance of building safety and creating a safe environment, demonstrating acceptance, utilizing Rogerian techniques and core conditions, and meeting the client where they are at and encouraging autonomy. Every participant discussed how they address this in their practice as well as the building blocks to create the therapeutic relationship. Carol discussed how she addresses this relationship:

> So, as far as treating it, what I found is, I think the most important thing is just being honest and genuine and authentic with the patients and clients to give them a safe space to tell their story and try not to judge because sometimes the stories are very shocking, but you know, just listen to their stories . . . I think it starts with, really the therapeutic

> relationship that just being open and genuine and honest and normalizing some of the things they went through…

Kelly expressed a similar feeling of the importance in establishing a strong connection. She explained:

> I think that if I had not established a strong therapeutic relationship with him, I don't think he would have been able to disclose this thing that he was wrestling with, that he went through a [previous] course of treatment and didn't disclose.

Ann reported similar techniques in building the rapport. She expressed, "Just being really warm and welcoming and genuine and earing their trust and creating a sense of safety so they are even willing to discuss these things that they may never have discussed in therapy before."

Michael spoke about his theoretical orientation and how the traditional Rogerian approach assists with building this essential relationship. He reported:

> I'm just a big believer in more of the Rogerian type styles of empathy and unconditional positive regard and just meeting them where they're at, and meeting them with complete openness and compassion and, trying to, you know, provide a sense of safety.

The importance of the relationship was also discussed during the focus group. One particpant indicated, "I found that the relationship is kind of pivotal in the treatment process." Another stated, "I'd say nine times out of ten they always refer back to it was really about the relationship, the dynamics of the relationship, about them feeling safe to talk about what they were struggling with." Other statements included the importance of creating a safe environment for the client. Kelly explained:

> I think if I didn't work hard on establishing a safe environment where he felt it was ok to disclose this, I don't think I would have ever known about it and it would've just been another course of treatment that he went through.

Additionally, creating the environment, safety, and meeting the client where they are at were identified as being key in building a therapeutic relationship. Michael reported:

> Just meeting the situation with where it's at. I think sometimes you know it can be really uncomfortable between the therapist and client, just this expectation of right now, what do I do? And sometimes I think, or a lot of times I think there's a lot of power in just allowing this to just be right now, and let's see what's here.

In addition to building a therapeutic relationship, a multifaceted approach to treatment was discussed. Clinician identified various theories and techniques they work from, however the most important component for treatment expressed by all participants was the therapeutic relationship.

Multifaceted Approach to Treatment

The participants in the study discussed at length different techniques and theories they utilize when working with an individual with a moral injury. One sentiment repeated by all participants was the experience that utilizing one EBP does not fully address moral injury and incorporating a variety of techniques from various EBP's is seemingly more effective. Participants discussed using elements from Acceptance and Commitment Therapy, Cognitive Processing Therapy, Cognitive Behavioral Therapy, Psychodynamic theory, Dialectical Behavioral Therapy, as well as incorporating mindfulness exercises, compassion work, and psychoeducation. Ann explained in her individual work as well as in her group "we introduce topics, we bring in elements of CPT, PE and even Acceptance and Commitment Therapy, which is being looked at for treating moral injury." She continued, "I'm even bringing in elements of

DBT and radical acceptance, just being totally, radically genuine." Michael expressed "Adlerian, so always trying to look at you know, how is a person still kind of checked into life and meeting the tasks of life despite what they're going through."

This was discussed as well in the focus group. One participant reported "I know we recommend working with chaplains, we talk about Native American practices and how they heal. We looped in compassion exercises from ACT."

Another component of utilizing a multifaceted approach that was discussed was the importance of psychoeducation on moral injury. Carol discussed how she incorporates this with most if not all of her clients. She explained:

> So, I would explain to them in the most simplistic terms is, you know, everyone has a moral code about what they think is right and wrong. That something goes in your civil code and causes you psychological distress. That could be considered a moral injury. And then I would give them examples.

The use of multiple techniques and theories was reported by all participants and reiterated during the focus group. The clinicians in this study expressed the importance of combining approaches to most fully address the presenting problem of moral injury.

Prevalence and Treatment of Existential Issues

All clinicians reported the topic of existentialism arising when working with individuals who have experienced a moral injury. Reflective statements and follow up questions were asked to gain a better understanding of how they address this in session. Specifically discussed were the aspects of belonging, connection, purpose, values, and spirituality. Topics related to these that arose included relationships, connection, barriers to relating to others, finding meaning, questioning of self, feelings of worthiness, and experiences of shame and guilt. Ann reported:

> When things that you've done question who you are, question what you're about, makes you question everything about yourself. I think you know, really looking at the meaning of life, the meaning [of] what does this mean about me? What does this mean about where I might go?

Ann continued to say she addresses these existential concepts with ACT:

> Whether you believe in the afterlife or how you might be punished for your crimes, that's something that does come up, which is why bringing in ACT has been really important because we get people back in touch with their values.

Michael discussed how he utilizes existentialism to conceptualize moral injury. He explained:

> But moral injury is a whole different ballgame where there is no treatment and you're dealing with, you know, things very existential issues, and there's no manual for it. How do you deal with individuals who struggle with, you know, figuring out, did I do the right thing? . . . [There's] identity revolving around meaning and purpose one's life.

Difficulty with reconnection with others and maintaining relationships was also discussed. Participants also reported their clients struggle with feeling connected or as though they belong. Clinicians reported the use of groups and normalization to address these barriers.

Use of Community

Two of the participants reported they lead or co-lead a moral injury group. These individuals discussed using the group structure to help create connection and a sense of community to address some of the previously mentioned existential issues. These participants as well as others also discussed how normalizing the presenting problem of moral injury can be useful in helping their clients work through issues of isolation and loneliness. Carol discussed how group members create a support system when new members join. She reported:

> What I've noticed is for all these people who are typically, usually they have severe PTSD and severe moral injury, is they tend to one another and they care about each other and when a new person comes in they will say hey, essentially, "hey man, we all sat right there and this is like a road map. You'll find your way; it may take a long time, but you'll get better, but you've got to be honest.

Ann also discussed how her group helps with reconnection and building relationships. She explained:

> …having this group and having a place where other people get it, even if you're not sharing exactly what it is, knowing that we're all in this group because something has really affected the rest of my life. That's a very important component.

Michael discussed how he utilizes normalization to help address issue of isolation of feeling as though they don't belong. He stated:

> I think it helped him put a name and a label to kind of what was going on. And I think that was more of like him understanding okay, so this isn't because I'm really crazy, or this isn't something new. Or this isn't- I'm not the only one who's been struck with that. You know, this is something that could be named, and this is really maybe something that's normal because of what I experienced.

Using a community approach such as moral injury groups, and helping clients normalize the problems they are experiencing were reported to be key components in the treatment process.

Challenging Avoidance

The importance of addressing avoidance and underreporting was expressed by multiple individuals and discussed during the focus group. Clinicians in the study specifically discussed how having a strong therapeutic relationship with the individual allowed for gentle

confrontation. Kelly reported experiencing avoidance and importance of addressing it "I feel it's important to explore why, you know, what is so aversive about having this, where [do] his thought processes lie? For him it helps him stay in denial that these things did not happen." When the topic arose in the focus group one participant discussed use of the therapeutic relationship to address avoidance:

> Really grounding of my good basic therapy skills and strong clinical judgment and knowing that with that relationship I had the buy in to kind of push and not collude with the avoidance…sometimes we don't want to hurt our patients and sometimes that means we collude with avoidance and we don't push and press at times where they might need that. So just going back to the relationship gave me that buy in to be able to gently nudge…

Clinicians discussed how at times it is difficult to address avoidance; however, with the foundation of a strong therapeutic alliance this can be essential in the healing process. Assisting clients to understand the emotional process was also discussed as a key component to the therapeutic process.

Identification of Emotions

Assisting clients with appropriately recognizing and identifying emotions was a recurring subtheme during interviews and the focus group. Participants discussed how they help clients correctly identify the emotions and encouraging the client to allow themselves to fully experience the emotion. Additionally, clinicians reported they work to help clients understand the universality of emotions. Related to dealing with client's avoidance, Kelly explained "he minimizes the things that he's going through, because it's just like he shouldn't be going through it." Kelly discussed how one of her clients labeled every emotion as anxiety, and she worked

with him to correctly identify the emotions. Ann discussed working with individuals to acknowledge the presence of emotions. She explained:

> Because in a combat zone there is no place for your emotions, and now that we're in the therapy room, that's kind of what this is about. Kind of unpacking that and addressing everything that was kind of stowed away for later. Like we put the pieces back together with them.

Individuals who have experienced moral injury may incorrectly or completely avoid labeling emotions as it can cause an increase in emotional pain. Clinicians in this study discussed the prevalence of this in their practice as well as the importance of addressing this issue.

Use of Telehealth

As previously discussed, during data collection COVID-19 grew to a pandemic and professionals across the United States were required to adapt their approach to treatment. By the time the focus group was conducted all participants had transitioned to either completely teleworking, or very minimal in-person client contact. While telehealth was not a consideration in the creation of this study, it could not be left unaddressed as participants had to change their approach to treatment. Participants expressed both setbacks and successes with the transition to telehealth. Frustrations expressed in the focus group included the clinician's questioning their clinical effectiveness, difficulty approaching sensitive topics, inability to control the environment the client is in, and difficulty or no ability to read body language. One participant explained, "It's been challenging kind of maintaining all the new, trying to connect with them over the video, challenging the avoidance, knowing when to push and when to step back. It's just been a lot of learning."

Another participant reported "I feel very, for lack of a better word, limited, especially what I can do trying to establish these relationships with individuals over the phone, it's just been really frustrating." Many participants discussed feeling limited in their ability to connect, particularly with new clients. One clinician stated, "it's very awkward for me and for them." Due to the sensitive nature of moral injury some clinicians reported feeling hesitant to address the topic. One individual stated "well, let me just say it's client dependent, so if I've been doing the work with them, I'll continue because I know what their coping abilities are." It was repeated that if the clinician had a good working relationship with the client, they were more likely to continue work on moral injury. Individuals also expressed how this shift in treatment has been helpful for some clients.

Both participants with moral injury groups stated their groups were not currently meeting. One member reported "some people who didn't want treatment before, since we've taken a break from group, some of them seem more apt to engage in treatment individually now." Another participant reported a client expressed preference for phone meetings "because you know, you don't see me, and you can't judge me." All clinicians reported both positives and negatives to the transition. The pandemic created a new barrier to the treatment of moral injury; however, it was reiterated by participants the strong therapeutic relationship was still essential to continue treatment.

There were a number of additional findings in the study that did not qualify as themes. Participants discussed how there are some similarities to symptoms of PTSD, and how it can be difficult at times to separate the two. One participant specifically discussed how the symptoms may be similar, however the DSM-5 Criterion A stressor may not be the cause for maladjustment. Participants also discussed how they have used previous works including

Jonathan Shay's *Achilles in Vietnam* to conceptualize the presenting problem. Another topic discussed was the frequency in which clients are presenting to clinics with symptoms of moral injury, and how these can often go unrecognized.

Discussion

This phenomenological qualitative study was conducted to gain an understanding of clinicians' perspectives of treating moral injury. From results of the data analysis arose novel suggestions for addressing the presenting problem of moral injury, as well as a reiteration of what clinicians have always known to be true – the therapeutic relationship is key to effective treatment. Multiple subthemes arose in each major theme. The findings in this study offer broad guidance to professionals who are starting to treat this emerging presenting problem.

Clinicians reported the importance of using multiple theories and techniques in their treatment and stressed the importance of clinician flexibility. Perhaps the greatest takeaway from this study however is the repeated discussion of the importance of the therapeutic relationship. Throughout the history of psychology and counseling, theories ranging from psychodynamic to person-centered have identified the relationship as being a vital part of treatment (Horvath, 2018). The findings in this study reiterate what most clinicians learn in school, that the therapeutic relationship is central in the change process. Clinicians are often preoccupied with meeting standards and demonstrating what evidenced based protocol was offered that they may overlook the essential part of therapy, building rapport. Moral injury is not a presenting problem with a clearly outlined treatment protocol, yet with a strong foundation of a working relationship, clinicians in this study reported they have been able to tailor treatment to meet the needs of the client.

While not an original consideration in the development of this study, the use of telehealth was discussed at length in the focus group. With the current pandemic clinicians have had to restructure their practice and approach to treatment. The group discussed the challenges of addressing the sensitive topic of moral injury. Concerns included not being able to control where the client is for the appointment, and concerns about assessing for safety through phone call or telehealth. Participants also discussed the barrier of creating a strong relationship when the appointment is not conducted in person, which was previously discussed as an integral part of the therapy process. The future utilization of telehealth and digital treatment cannot be overlooked as the field transitions to keep up with the changing social climate.

An additional consideration with moral injury is how this concept will likely present with civilian healthcare workers. Professionals across the nation, and the world in whole, are being faced with difficult decisions, including determining which patient is in greater need of care. Counselors should not be surprised when other healthcare professionals seek services and present with the key indicators of moral injury. The suggestions for treatment are applicable not only in continued work with veterans, but also the healthcare professionals faced with the morally disparaging work treating COVID-19.

Implications for Counselors

Based on the findings of this study, some recommendations can be made for professionals who are starting to work with moral injury. First the importance of establishing a strong therapeutic relationship is central to treatment. While this is an integral piece of clinical training, it is possible a strong relationship is even more critical to treatment when working with moral injury. Due to the sensitive nature of moral injury and the likelihood these individuals are experiencing other existential issues including disconnect and isolation, the therapeutic

relationship can be utilized as both the framework of therapy as well as an intervention. Modeling acceptance, genuineness, positive regard, and safety could help the client challenge how they see themselves and others in the world. Upon establishing a strong therapeutic bond, the use of multiple interventions and theories is also important.

As previously discussed, and identified by participants, there is no gold standard of treatment for moral injury. Rather, previous research studies, like the clinicians in this study suggest an eclectic approach, and encourage, with clinical judgement, pulling interventions from a myriad of theories, including nontraditional therapeutic interventions. Moral injury presents differently in individuals, and the importance of clinician flexibility and tailoring treatment to meet the needs of the client is imperative.

Participants in this study reiterated the importance of normalization. Moral injuries are deeply personal and individuals who have experienced them may feel isolated in this experience. Similar to trauma, each injury may be unique; however, there are some similar presenting problems. Psychoeducation on the topic of moral injury and helping these individuals understand they are not alone with these feelings could help progress in treatment. Additionally, clinicians may consider creating groups focused on addressing moral injury. It is important to engage in standard group protocols including pre-screening and semi-structuring sessions to avoid any re-traumatization. Groups can assist clients with creating a community and work on reconnecting and increase their feeling of belonging.

Finally, as with a variety of clinical issues, the use of group or individual consultation should be considered. Clinicians in this study, both with a lot of experience and little experience with moral injury discussed the role of consultation with colleagues. Individuals with considerable experience discussed how they speak with peers and engage in consultation.

Participants with less experience expressed the desire to have consultation or clinical guidance to help improve their feelings of competence in working with moral injury.

Taken together, findings from this study as well as research from previous work on moral injury may assist new clinicians, or clinicians newly addressing moral injury to feel better equipped for addressing this complex presenting problem.

Limitations and Suggestions for Future Research

The major limitation to this study was the small sample size. The sample size proposed for this study was revised with the approval of the dissertation committee as recruitment became difficult during the pandemic. Future studies would benefit from an increased sample size to gather a wider range of responses. The use of a written component such as a free written journal, or journal prompts, may also add depth to the subject. Additionally, adding a quantitative component and utilizing a mixed method design may contribute additional information to what has been effective when treating moral injury.

One suggestion for future research is to expand the sample. Individuals who participated in this study were clinicians with experience working with veterans who have experienced moral injury. As previously mentioned, there are potentially other individuals who have experienced moral injury such has law enforcement or health care professionals, and the experiences of treating those individuals could further expand on the findings in this study.

Qualitative research does not seek to find generalizable results; however, the findings reported in this study may be applicable for other clinicians as they continue treating veterans presenting with moral injury and begin to address what will likely be the presentation of moral injury in other healthcare workers in a post-COVID-19 world.

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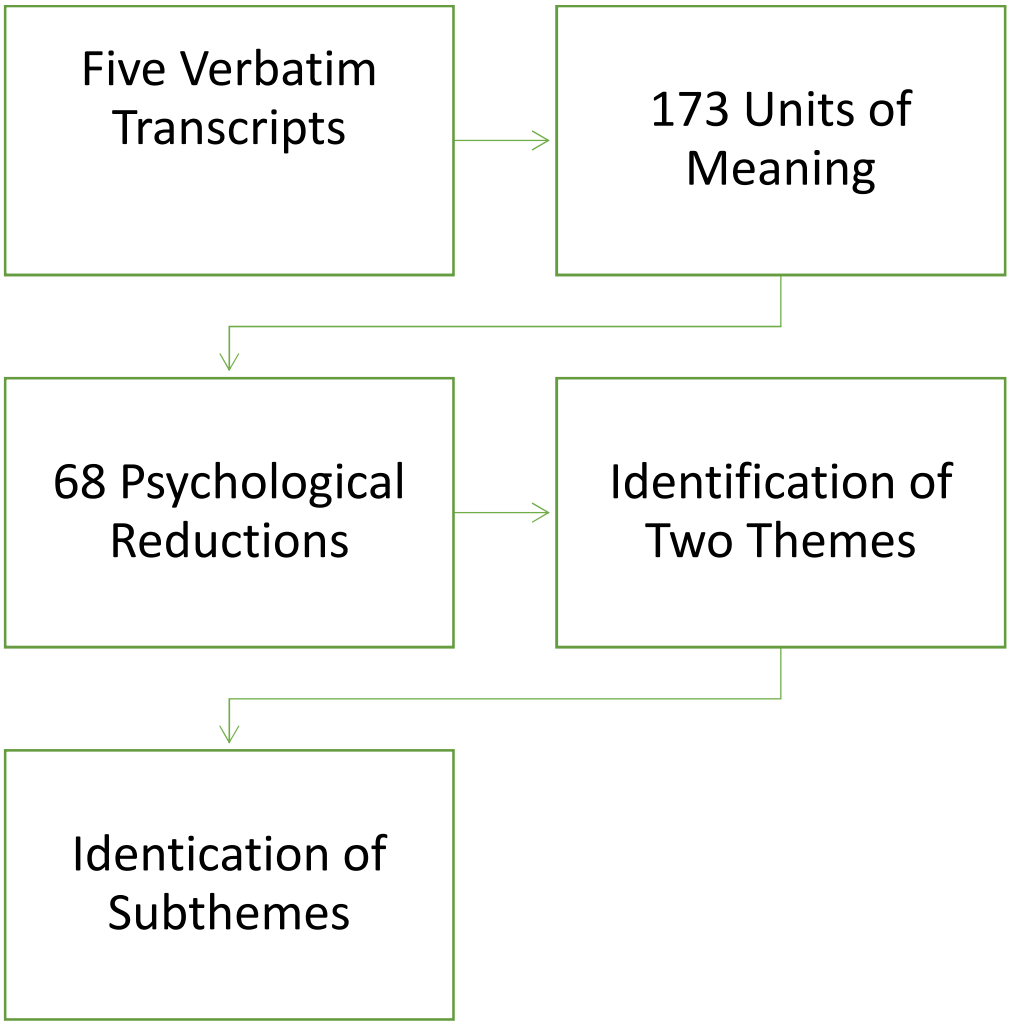


Figure 1. **Reduction Flow Chart**

Table 1.
Participant Demographics

Name	Profession	Gender	Ethnicity	Years of Professional Experience	Years of Experience with Moral Injury
Ann	Psychologist	Female	Caucasian	8	2
Kelly	Licensed Marriage and Family Therapist	Female	African American	6	1
Michael	Licensed Professional Counselor	Male	Caucasian	10	4
Carol	Social Worker	Female	Caucasian	31	6

Table 2.

Final Themes and Subthemes

Theme	Subthemes
Clinician's Personal Experience	a. Feeling unprepared b. Clinician flexibility c. Experience of professional satisfaction d. Awareness of biases
Components for Effective Treatment	a. Therapeutic Relationship b. Multifaceted approach c. Prevalence and treatment of existential issues d. Use of community e. Challenging avoidance f. Identification of emotions g. Use of telehealth

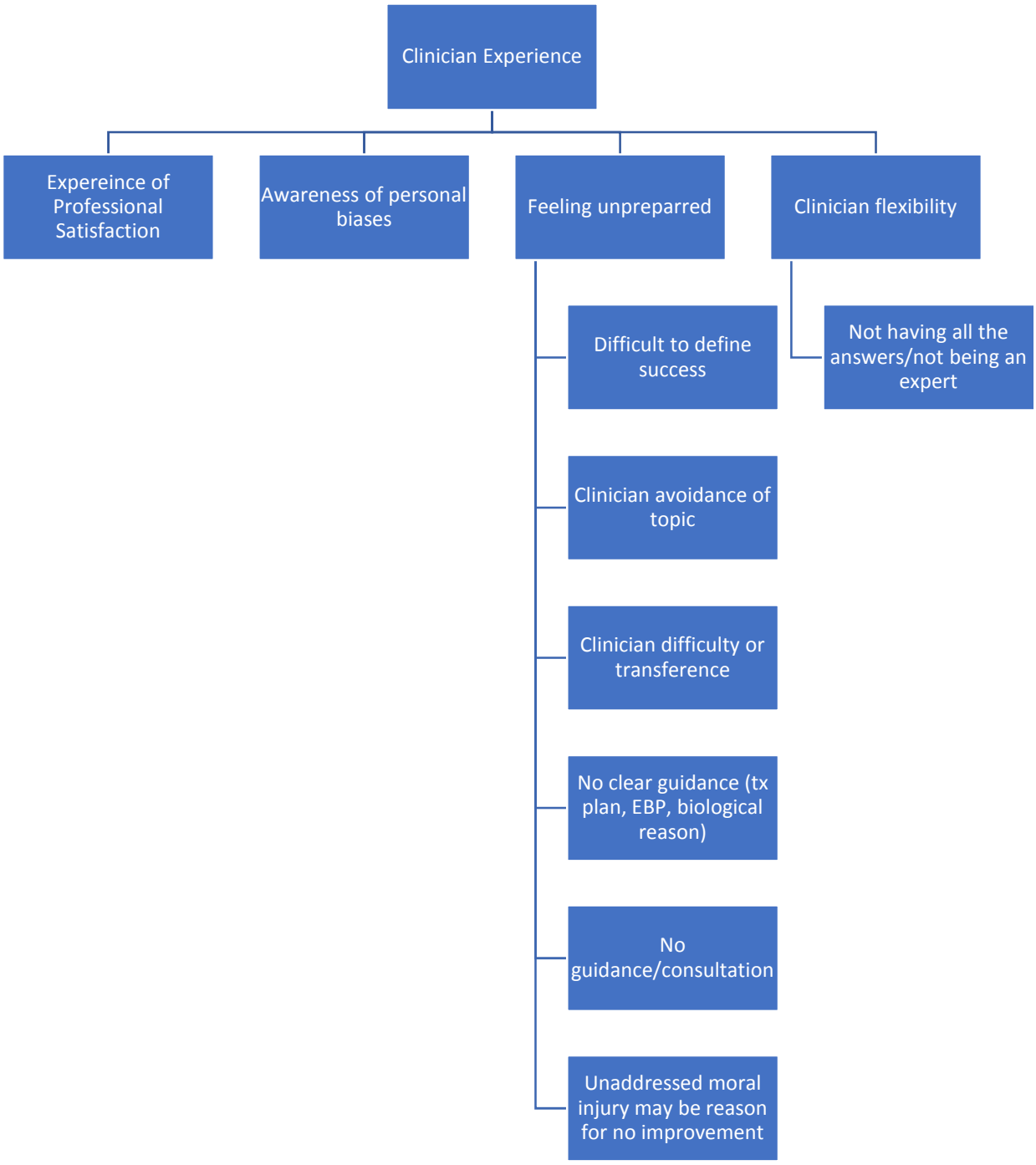
LIST OF ANCILLARY APPENDICES

APPENDICES PAGE

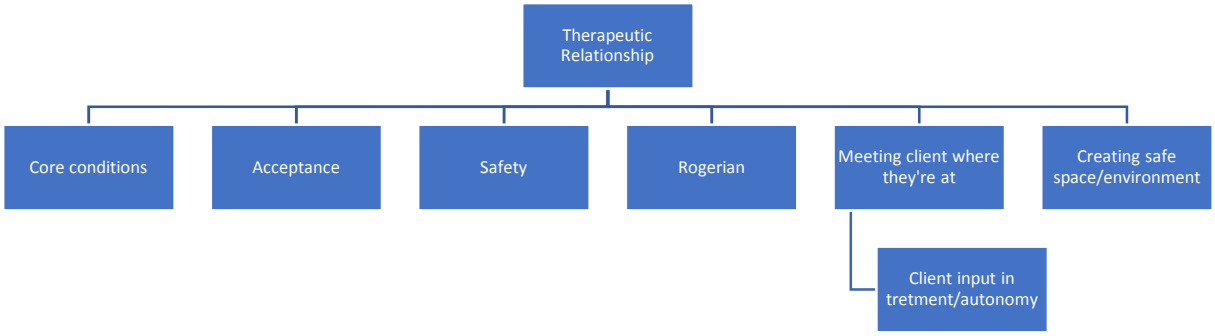
Appendix 1: Chart of clinician personal experience……104

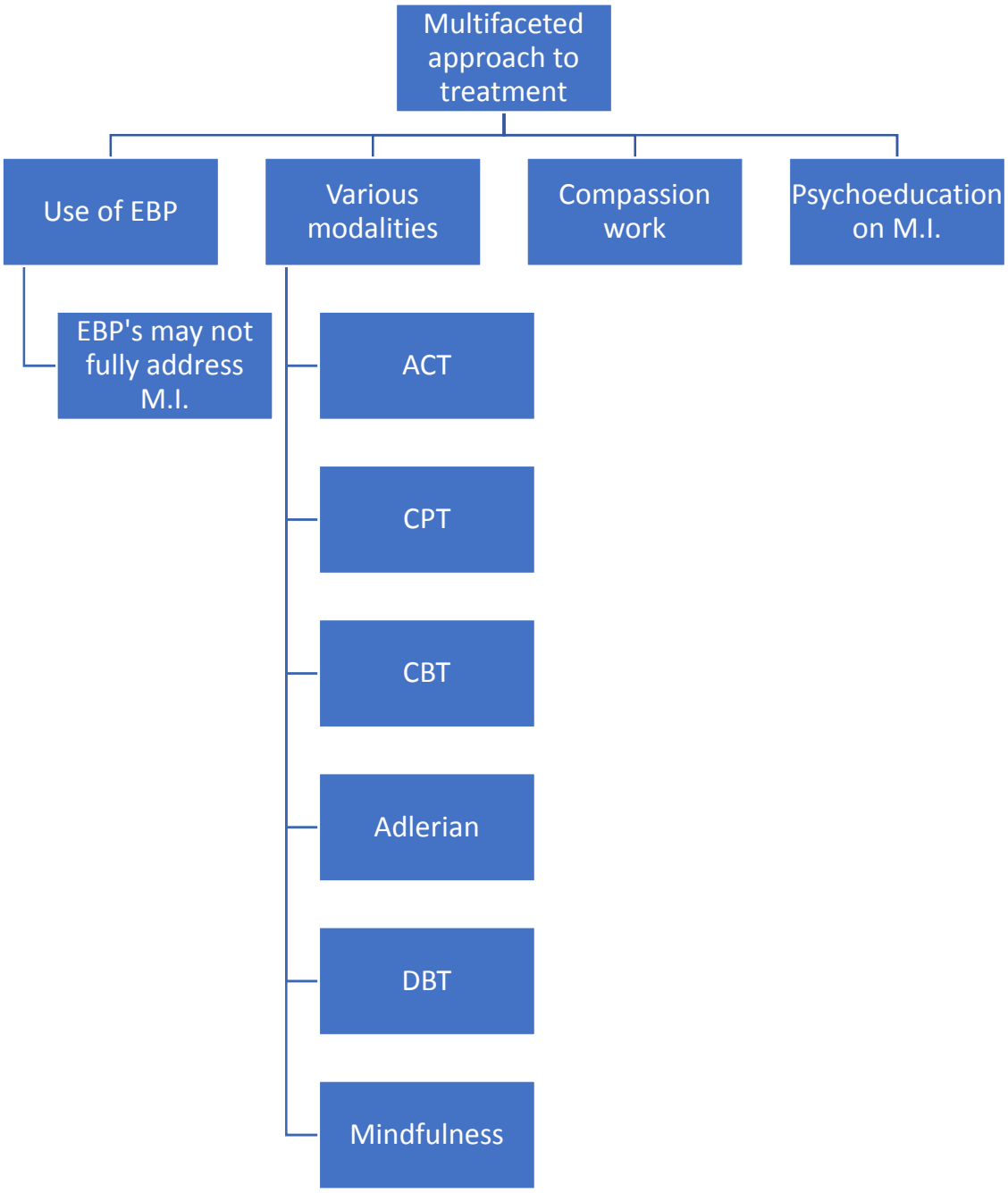
Appendix 2: Components for effective treatment……105

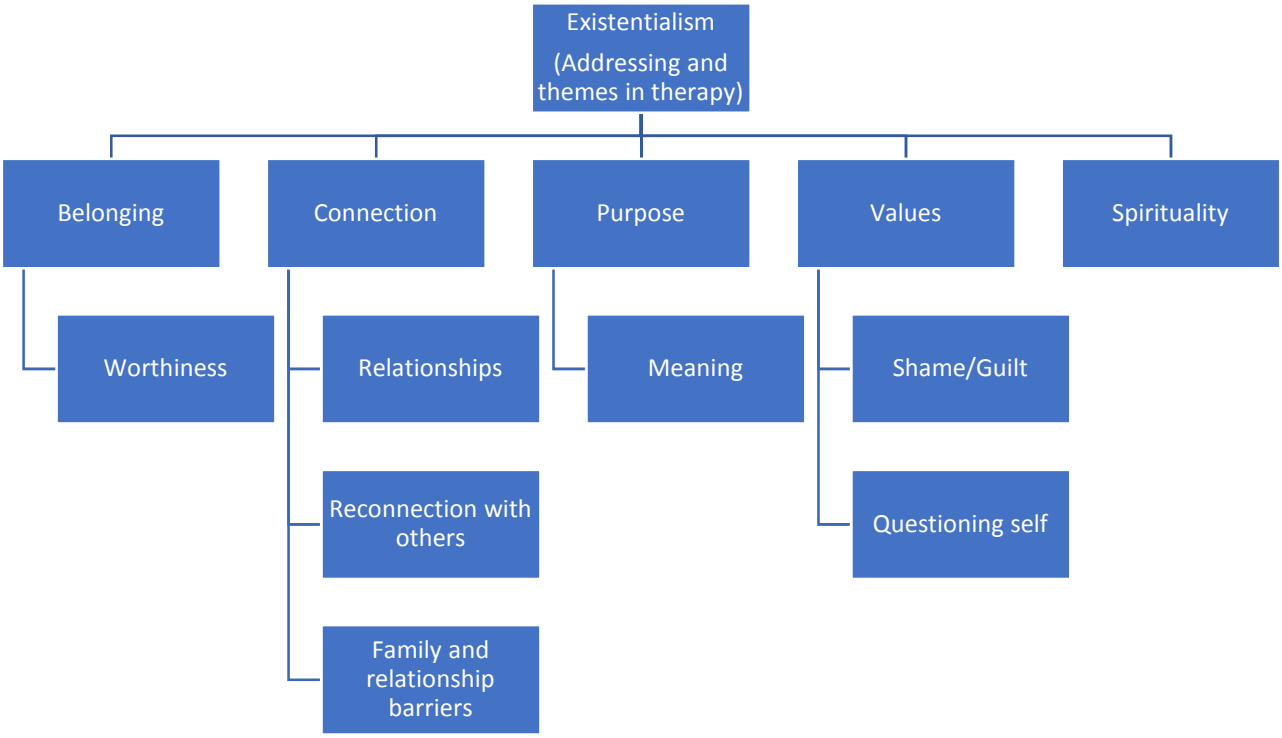
Appendix A: Chart of Clinician's Personal Experience

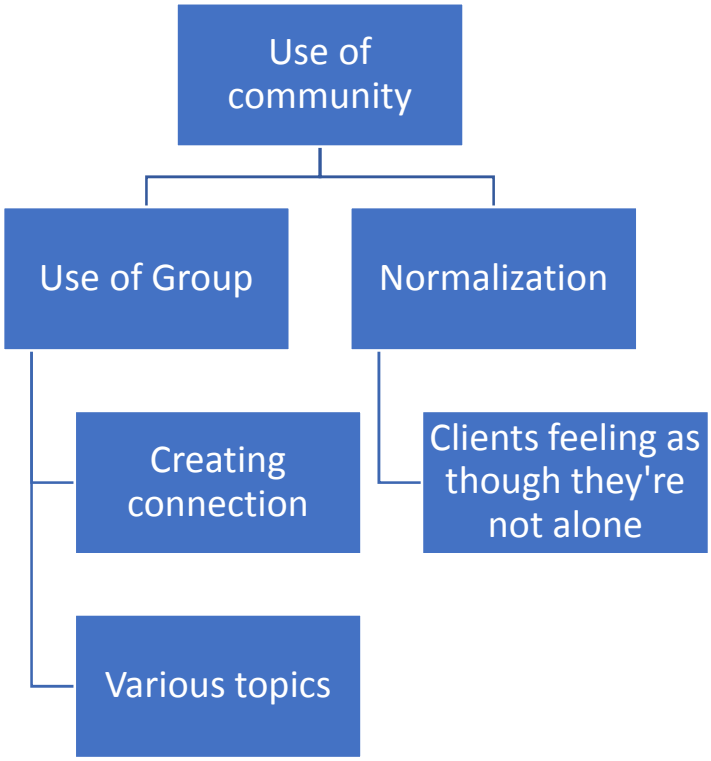


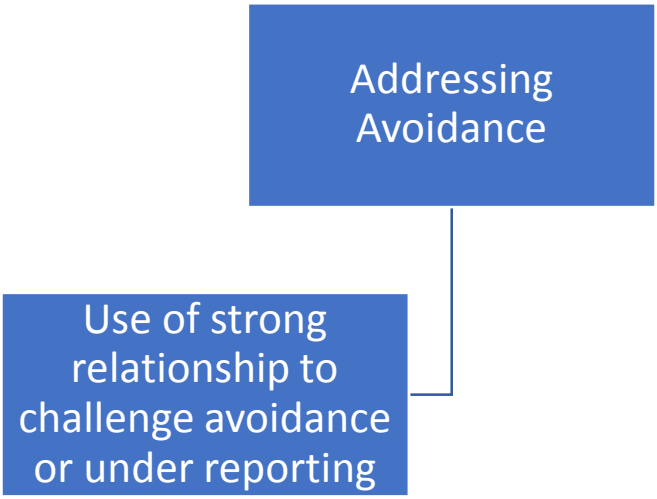
Appendix B: Components for Effective Treatment

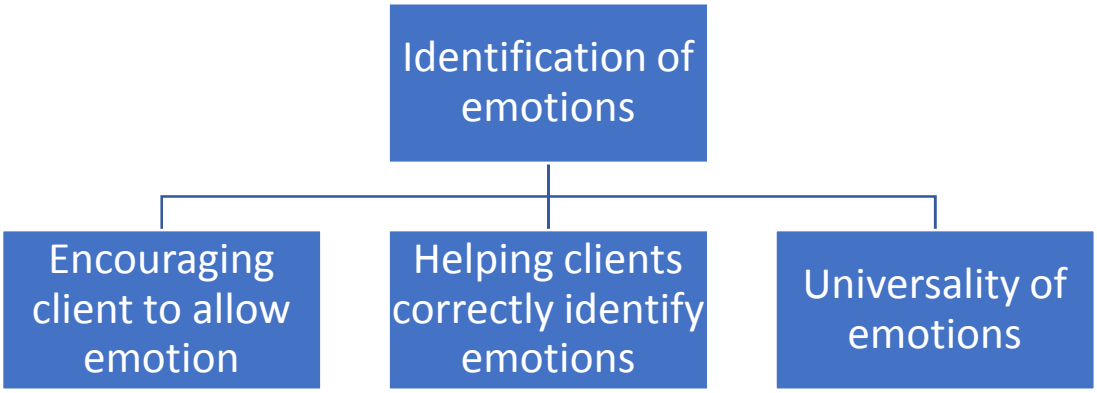


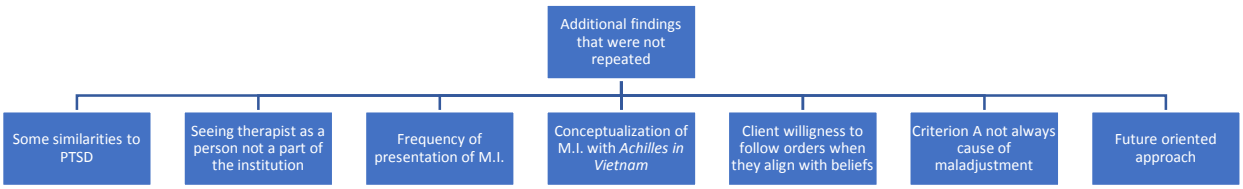

Multifaceted approach to treatment
Use of EBP
Various modalities
Compassion work
Psychoeducation on M.I.
EBP's may not fully address M.I.
ACT
CPT
CBT
Adlerian
DBT
Mindfulness

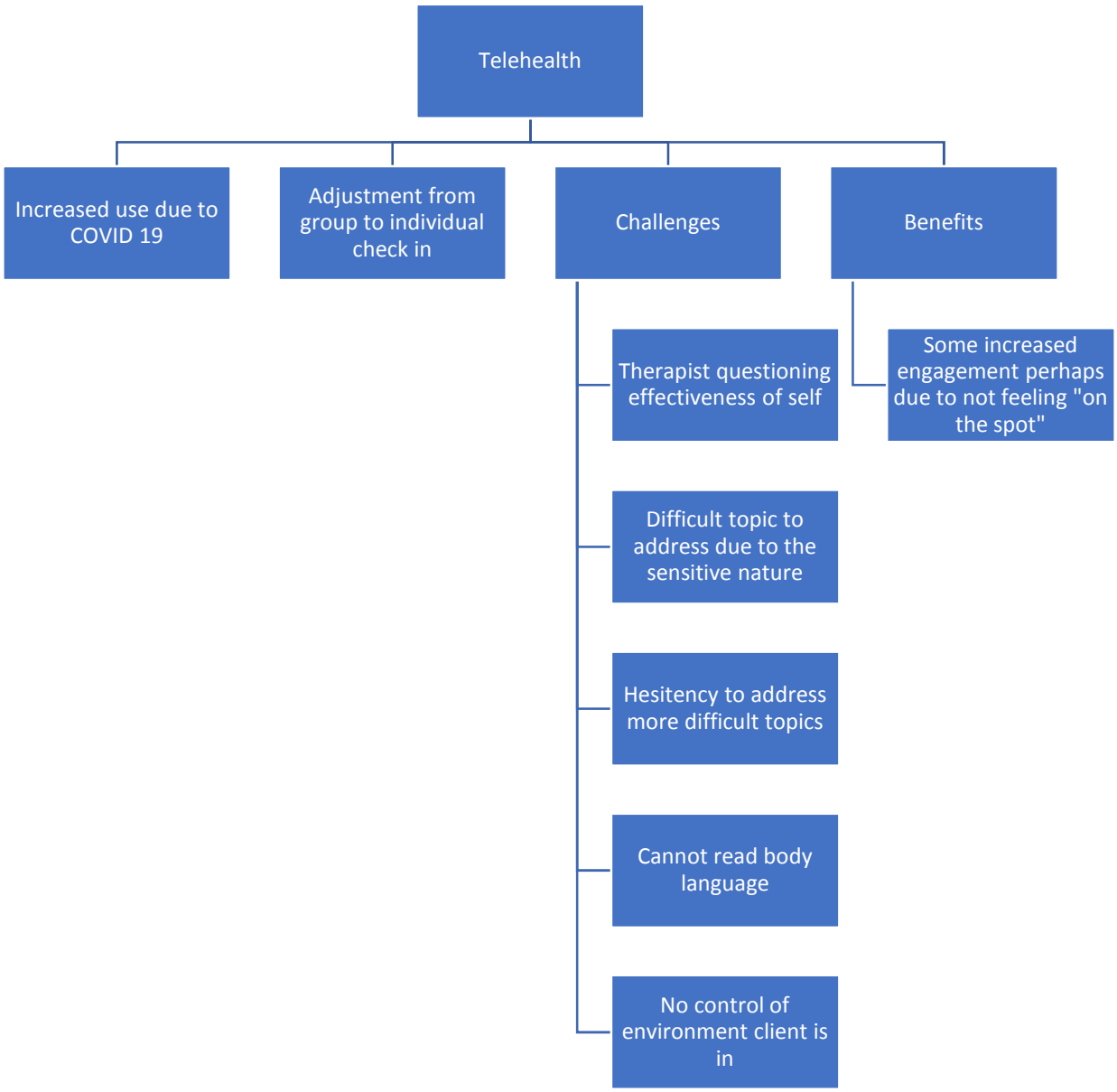

Existentialism
(Addressing and themes in therapy)
Belonging
Connection
Purpose
Values
Spirituality
Worthiness
Relationships
Meaning
Shame/Guilt
Reconnection with others
Questioning self
Family and relationship barriers


Use of community
Use of Group
Normalization
Creating connection
Various topics
Clients feeling as though they're not alone


Addressing Avoidance
Use of strong relationship to challenge avoidance or under reporting


Identification of emotions
Encouraging client to allow emotion
Helping clients correctly identify emotions
Universality of emotions


Additional findings that were not repeated
Some similarities to PTSD
Seeing therapist as a person not a part of the institution
Frequency of presentation of M.I.
Conceptualization of M.I. with *Achilles in Vietnam*
Client willingness to follow orders when they align with beliefs
Criterion A not always cause of maladjustment
Future oriented approach


Telehealth
Increased use due to COVID 19
Adjustment from group to individual check in
Challenges
Benefits
Therapist questioning effectiveness of self
Some increased engagement perhaps due to not feeling "on the spot"
Difficult topic to address due to the sensitive nature
Hesitency to address more difficult topics
Cannot read body language
No control of environment client is in