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Christian U.S. Army Female Combat Veterans Diagnosed with PTSD Experiencing a Moral Injury of War

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Kathaleen Graham-Young

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Walden University
November 2022

Abstract

Christian U.S. Army Female Combat Veterans Diagnosed with PTSD Experiencing a

Moral Injury of War

by

Kathaleen Graham-Young

MA, Liberty University, 2015

BS, Alabama State University, 1988

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health & Human Services

Walden University

November 2022

Abstract

Warzone exposure potentially impacts the mental and physical health of veterans who received a diagnosis of PTSD. There is limited research addressing the adjustments of the potentially morally injurious event(s) (PMIEs) experienced by Christian U.S. Army female combat veterans diagnosed with PTSD who returned home from Iraq and Afghanistan warzones post - 9/11. To better understand the impact of PMIEs experienced by the target population, a study of the integration of the transpersonal-existential meaning-based model was used. A general qualitative research design was selected to understand the complex social phenomena. In-depth telephone interviews were conducted to gather viable data. These data were audio-recorded, transcribed, and coded for emergent themes. The themes were: internal conflict leads to emotional distress and doubt in decision making; long-term combat and operational stress injuries prompt both mental and physical health outcomes; adjustment experiences can birth lifestyle changes; combat zone experiences can create challenges when transitioning back to civilian life; holding onto Christian principles and practices to embrace and resolve moral conflict generated by a moral injury of war; a safe place to share/talk/and be heard is still needed. This study yielded greater awareness of the impact PMIE has on women and served to inform helping professionals and spiritual leaders on how to identify and treat this unique population.

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“For with God nothing shall be impossible” (Luke 1:37)

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Chapter 1: Introduction

An increasing number of women continue to enlist in the United States armed services, and many of these female soldiers choose to serve in combat roles (Brunner et al., 2019; Ganzer, 2016; Muirhead et al., 2017; National Center for Veterans Analysis and Statistics, 2011). This population is now recognized as the fastest growing among military veterans post-9/11 (Brunner et al., 2019; Muirhead et al., 2017). By 2030, women veterans are projected to represent approximately 14 % of the veteran population, an increase of 5% compared to women veterans who are not in combat positions (Brunner et al., 2019; Muirhead et al., 2017). The risk factors associated with the exposure of combat positions in war conflict zones continue to be a rising concern regarding the physical and mental health of active-duty female soldiers and female veterans (Daphna-Tekoah & Harel-Shalev, 2017; Muirhead et al., 2017).

Much research literature on female veterans focused on the symptoms of war trauma, such as posttraumatic stress disorder (PTSD), depression, alcohol abuse, sexual trauma, suicide, and deployment-related mental health (Curry et al., 2014; Daphna-Tekoah & Harel-Shalev, 2017; Ganzer, 2016). Limited research addressed the concerns of Christian United States Army female combat veterans diagnosed with PTSD experiencing a moral injury of war. I researched this topic to understand better the impact of a potentially morally injurious event (PMIE) experienced by Christian U.S. Army female combat veterans diagnosed with PTSD post-9/11.

This research study continued to fill the gap in knowledge regarding how PMIEs affect the adjustment experiences of Christian U.S. Army female combat veterans who returned home from the Iraq or Afghanistan wars post-9/11 diagnosed with PTSD. The interrelated concerns associated with PTSD and PMIE to facilitate further conversation and collaboration were warranted (Shay, 2014). PMIE awareness positions service alliances such as faith-based and religious support groups, healthcare practitioners, clinical or mental health professionals, and the military to identify the signs and symptoms associated with PTSD and PMIE (Maguen & Litz, 2012; Shay, 2014; Wortmann et al., 2017).

Background

Smith-MacDonald et al. (2017) acknowledged mental health is an increasing concern of combat soldiers' post deployment. Approximately 40% of these combat veterans have experienced moderate to extreme mental health issues when returning home from the Iraq or Afghanistan wars post 9/11 (Smith-MacDonald et al., 2017). The necessity existed to gain a more in-depth understanding of the implications associated with the exposure to PMEIs and the psychological distress (PTSD) experienced by United States active-duty soldiers and veterans (Evans et al., 2018; Litz et al., 2009; Maguen & Litz, 2012; Nash et al., 2013). Litz et al. (2009) acknowledged that morally injurious experiences of combat war veterans were unaddressed too often in literature. The findings in both dated and current research warrant a deeper exploration regarding the different atrocities associated with potentially morally injurious acts. Gaining a better

understanding of the impact of these acts (physical or mental) can aid in the development of specific treatment and intervention strategies to address moral injury and moral repair of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) women combat war veterans (Litz et al., 2009; Shay, 2014; Wortmann et al., 2017). The phenomenon of moral injury (i.e., internal conflict) continues to evolve rapidly among combat soldiers with PTSD (Nash et al., 2013).

Research on the military population was predominantly limited to male service members. The experiences of female combat veterans are understudied in the mental health field and this population is underserved (Haun et al., 2016). Female combat veterans with combat-related PTSD are underdiagnosed and are more likely to experience lifetime PTSD issues as a result of exposure to trauma than their male counterparts (Pereira, 2002). This gap in the literature warranted further research to more fully understand the impact of PMIEs among this population diagnosed with PTSD. There is a demand for more mental health practitioners, spiritual care programs and chaplaincy services as long as military combat personnel and veterans face challenges regarding self-condemnation and complex trauma (Cary et al., 2016; Chang et al., 2015; Worthington & Langberg, 2012).

Problem Statement

During 2001-2013, the United States Army deployed approximately 1.5 million soldiers to OEF, OIF, and Iraq - Operation New Dawn, (OND) wars (Baiocchi, 2013). Of that number, approximately 200,000 (14.3%) represented active-duty female soldiers

(National Center for Veterans Analysis and Statistics, 2015; Rivera & Johnson, 2014). Approximately 1,000 Army female combat soldiers have suffered injuries, 161 of those females died during combat operations, and at least 83% represent female veterans enrolled in the Veteran Affairs health care services (National Center for Veterans Analysis and Statistics, 2015; Patterson, 2016). In April 2018, the Military reported 170,000 females were serving in the Army and 600 of these females accounted for infantry and armor jobs (infantry, armor, artillery battalion, or single brigade combat team) (Swick & Moore, 2018). Some of these female soldiers faced or continue to face posttraumatic stressors as well as moral injuries of war caused by OEF and OIF wars (Battles et.al, 2018; Donoho et al., 2017; Ferrell, 2017; Street, Vogt, & Dutra, 2009). Female veterans are more than likely to experience greater levels of PTSD compared with male veterans; therefore, female-specific care and rehabilitation are needed to adequately support this population (Haun et al., 2016).

The psychological state of United States military combat soldiers returning from OIF, OEF, or OND wars continues to be to a long-standing problem (Buttner et al., 2017; Ganzer, 2016). Some of the long-term mental health challenges emerged from the aftermath of PMIEs (Frankfurt & Frazier, 2016; Jinkerson, 2016; Litz et al., 2009). These events attributed to conflicting thoughts, attitudes, beliefs and betrayal caused by the psychological stress associated with PMIEs (Evans et al., 2018; Hodgson & Carey, 2017: Litz et al.; 2009; Suzuki & Kawakami, 2016). Litz et al. (2009) defined moral injury as a "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress

deeply held moral beliefs and expectations" (p. 697). Service members who perceived an event (witnessed or participated) to be morally injurious presented to counseling often with posttraumatic symptomologies such as feelings of guilt, shame, anger, social withdrawal, and spiritual distress (Battles et al., 2018; Litz et al., 2009; Maguen & Litz, 2012; Wortmann et al., 2017). These characteristics related to moral wounds of war resulted in conflict and internal struggles (Battles et al., 2018; National Center for PTSD, 2012), which is an increasing concern regarding service members (post deployment) and veterans (Hufford, Fritts, & Rhodes, 2010; Smith-MacDonald, Norris, Raffin-Bouchal, & Sinclair, 2017).

Increasing awareness within the health care and mental health profession regarding these internal conflicts and struggles is important (Battles et al., 2018; Shay, 2014). Adequately describing these struggles provided greater insight regarding the context of the phenomenon articulated by service members and veterans diagnosed with PTSD who experienced or is experiencing PMIEs (Bryan et al., 2018). The descriptive and interpretive descriptions (Kahlke, 2014) of the experiences gave depth regarding the context of the PMIE (Yin, 2009).

Shay (2014) established three specific criteria associated with moral injury "a betrayal of what's right; by someone who holds legitimate authority (military-leader); and a high stakes situation" (p.183). Shay believed the mental health field has a critical need to establish and train a trustworthy clinical community who understands why moral injury destroys the trust factor among morally injured combat soldiers and veterans. Shay

advocated for a better diagnostic and statistical guide that addressed the symptomatic characteristics of moral injury. He acknowledged the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) which is the authoritative guide for health care professionals (American Psychiatric Association, 2018) did not adequately make a distinction between the presenting symptoms of PTSD and moral injury (Shay, 2014). Many researchers have argued that health care practitioners and mental health professionals have an essential duty to address spiritual conflict (positive or negative) among combat veterans with PTSD in treatment settings (Smith-MacDonald et al., 2017).

Previous researchers acknowledged essential findings relative to the perceived effects of moral injury on United States Army combat and veterans diagnosed with PTSD. I have found no research that explores the adjustment experiences of Christian United States Army female combat veterans diagnosed with PTSD who have experienced or experiencing PMIEs. Researchers have acknowledged that one's spirituality can serve as a positive coping mechanism for service members and veterans who receive a diagnosis of PTSD who have also experienced PMIEs, and the influence of spirituality on their ability to cope with PMIEs (Chang et al., 2015; Smith-MacDonald et al., 2017). This gap in the literature warrants further research to better understand the impact of PMIEs among this population who receive PTSD diagnosis.

Purpose of the Study

The purpose of the general qualitative study was to explore how PMIEs (i.e., complex issue) affect the adjustment experiences of Christian U.S. Army female combat veterans who returned home from the Iraq or Afghanistan wars post-9/11 who received a diagnosis of PTSD (social issue) (Percy et al., 2015). The collected descriptive and interpretive descriptions (Kahlke, 2014) of the adjustment experiences provided a better explanation of conflicting thoughts, attitudes, and beliefs (Suzuki & Kawakami, 2016) caused by the psychological stress associated with PMIEs (Evans et al., 2018). Sharing their stories allowed this targeted population to share adjustment experiences from a stream of consciousness (Seidman, 2012) and add to the knowledge base of this understudied population. Their stories showed an interrelatedness of spirituality, PMIEs, and military soldiers' mental health (Chang et al., 2015; Smith-MacDonald et al., 2017). A need still exists for collaboration among combat veteran patients (perspective or experiences), health care or clinical practitioners (gaining knowledge), researchers (exploration or discovery), and spiritual leaders (Maguen & Litz, 2012; Wortmann et al., 2017).

Research Question

How do PMIEs affect the adjustment experiences of Christian U.S. Army female combat veterans who returned home from the Iraq or Afghanistan wars post-9/11 diagnosed with PTSD?

Conceptual Framework

In this study, I used the transpersonal-existential meaning-based model. Screenivasan, Semen and Weinberger (2014) used the context from Frankl's logotherapy (meaning described by war trauma experiences) and Tillich's systematic theology (existential experiences) as a framework to develop the transpersonal-existential meaning-based model. This meaning-based model explicitly focused on combat veterans who returned home from the Iraq or Afghanistan wars battling a moral injury of war. There are four constructs addressed in the model. Constructs one and two of the model identified the signature strengths from the combat stories and the event meaning in a more substantial context (Screenivasan et al., 2014). Construct three addressed the spiritual context and the resolution to overcome cynicism (Screenivasan et al., 2014). The fourth construct identified the pitfalls caused by anger and resentment, which opened the door to promote resilience (Screenivasan et al., 2014). Therefore, I used the transpersonal-existential meaning-based model as a pathway to explain the impact of PMIEs (phenomena) experienced or are experiencing by Christian U.S. Army female combat veterans who returned home from Iraq or Afghanistan wars post-9/11 and received a diagnosis of PTSD (Screenivasan et al., 2014).

Nature of the Study

A general qualitative research design served as the blueprint (Grant & Osanloo, 2014; Percy et al., 2015) to better understand the complex social phenomena (Yin, 2015, 2009). This approach allowed the empirical researcher to explore the real-life events

while intentionally retaining the holistic and meaningful characteristics of the experience (Yin, 2015). The research design aided in gathering viable data to support the construct validity, confirmability, and reliability regarding the contextual parameters of the stated case conditions (Yin, 2015; Patton, 2015). A critical part of the research process was to produce rich textual descriptions (Yin, 2014), which served as the voice of the Christian United States Army female field combat operation veterans diagnosed with PTSD experiencing a moral injury of war. A general qualitative inquiry allowed the researcher to investigate the "how" of the lived experience (Percy et al., 2015). The experience became the focus. The researcher explored the experience, probed what happened, and understood the belief points perceived in the outer world (Percy et al., 2015). This approach aligned with the research question. It afforded the emergence of data that gave insight into the impact of PMIEs experienced by the target population.

I used a general inductive approach that guided the procedure of the study (Liu, 2016; Thomas, 2006). This approach was a practical method to explore themes and patterns of observations and develop meaningful descriptions from the target population's perspective (Liu, 2016; Thomas, 2006). Liu (2016), Thomas (2006), and Strauss and Corbin (1998) agreed that an inductive approach establishes an opportunity for the researcher to start with a particular area of study so the data can emerge accordingly. I recruited qualified participants using purposeful sampling and gathered data through in-depth interviews (Liu, 2016; Yob & Brewer, 2015). Integrating this method allowed for

the collection of rich data from the target population (individuals) which is strategic to the context of the research (Yob & Brewer, 2015).

The interviews naturally captured the inner perspectives about what is happening or what has happened within the context that yielded the phenomenon the study sought to describe (Flyvbjerg, 2006; Patton, 2015; Yin, 2014; 2009). Using this approach allowed the empirical inquiry to investigate the real-life events while intentionally retaining the holistic and meaningful characteristics of the experience (Crowe et al., 2011; Yazan, 2015; Yin, 2015). The qualitative inquiry focused on a relatively small sample, such as five to permit in-depth analysis and understanding of the contemporary phenomenon (Yin, 2015). This general qualitative study purposefully focused on a particular and unique population within the phenomena (Yin, 2014; 2009). Using this methodological approach potentially filled the gap in literature focusing on the specific conditions associated with the phenomena. The primary condition builds on the reality, validity, and understanding and knowledge of circumstances and experiences of the individual investigated in the general qualitative study (Merriam, 1998; Stake, 1995; Yazan, 2015; Yin, 2002). The other conditions of the general qualitative study are contingent upon the defining characteristics of the qualitative inquiry such as holistic, empirical, interpretive, and empathic (Stake, 1995). The general qualitative study design answered the how and why questions regarding the phenomenon of interest (Yazan, 2015; Yin, 2015) Christian U.S. Army female combat veteran who received a diagnosis of PTSD and experienced a moral injury of war.

The recruited participants participated in a 90-minute telephone semi-structured qualitative interview (Duke University, 2018). I asked the participants a series of open-ended questions regarding their perceived views of experiences caused by PMIEs. The research process elements were both reflexive and flexible (Patton, 2015) so that the research developed naturally (Patton, 2015). I understood the importance of interviewing eligible recruited participants (Liu, 2016; Ravitch & Carl, 2016; Thomas, 2006). I prepared for the interview, conducted the interview, and had the interviews transcribed (verbatim) (Liu, 2016). The responses from the interview presented an opportunity to investigate and interpret PMIEs for relevance (Fusch & Ness, 2015; Simon, 2011). A necessity existed to allow for a prolonged and intense engagement with participants to gather rich and descriptive data (Baxter & Jack, 2008).

Definitions

Christian: a person who is a believer in Christianity (teachings of Jesus Christ) and governs his or her life based upon faith, and deeply held and practiced beliefs (Shaler, 2016; Worthington et al., 2011). Some of these practiced beliefs include prayer, scripture, and Christian values (Worthington et al., 2011).

Moral injury (MI): "a betrayal of what's right; by someone who holds legitimate authority (military-leader); and a high stakes situation" (Shay, 2014, p.183). The "perpetuating, failing to prevent or bearing witness to acts that transgress deeply held morals beliefs and expectations" (Carey et al., 2016, p, 1219 cited Litz et al. (2009)). For example, a soldier in the war zone who has to make a quick and rational (or not) decision

to shoot an approaching person who appears to be an enemy or threat (i.e., Battles et al., 2018; Drescher et al., 2011; Frankfurt & Frazier, 2016; Jinkerson, 2016; Maguen & Litz, 2012). MI takes on two distinct characteristics such as guilt and shame (Buechner & Jinkerson, 2016).

Moral injurious event (MIE): is the “morally questionable or ethically ambiguous situations” experienced by soldiers deployed to war zones (Drescher et al., 2011; Litz et al., 2009). Characteristics of MIEs include “committing harmful acts, witnessing harmful acts, and failing to stop the harmful actions of others” (Drescher et al., 2011). These events often trigger psychological problems such as PTSD, depression, and suicide (Williams & Berenbaum, 2019).

Morally ambiguous situation: describes the struggle service members encounter when there is an uncertainty to act or respond to a potential threat (Brayan et al., 2018). For example, to kill a person (innocent child) or to bomb an approaching vehicle or to seek revenge for justice (Brayan et al., 2018).

Spirituality: refers to the way a person intentionally expresses meaning and purpose regarding nature, music, family, community beliefs, and values (Puchalski et al., 2009). Carey et al. (2016) build on the definition by connecting faith, purpose and experience to God, self, or the significant or sacred.

Spiritual injury: presents as a condition when a person’s spiritual identity is in question, and, struggles with the understanding or accepting of one’s belief system when coping with a traumatic experience witnessed or participated (Fuson, 2013).

Spiritual distress: develops from spiritual or religious struggles when a person finds it difficult to deal with realities associated with the meaning of life, death, a superior being, or one's belief system (Exline et al., 2014; Harris et al., 2018). Spiritual distress is a characteristic of moral injury (Harris et al., 2018).

Assumptions

An initial assumption in this inquiry was that the recruited participants of the study would respond to the interview questions truthfully because they control the content of the data (i.e., story and experiences). Another assumption was that female combat veterans' input would be considered when assessing the effectiveness of broad-based treatment plans and programs for PTSD and PMIE, thus, demanding specific gender differences assessments (Afari et al., 2015; Battles et al., 2018; Brunner et al., 2019; Chanfreau et al., 2018). These assumptions were necessary to acknowledge because doing so brings awareness regarding the physical and mental health concerns of this understudied population; thus, continuing the conversation regarding the need to develop more gender-specific assessments and interventions to treat PMIE (Afari et al., 2015; Battles et al., 2018; Brunner et al., 2019; Chanfreau et al., 2018).

Scope and Delimitations

The premise of this study was to understand better how PMIEs affect the adjustment experiences of Christian U.S. Army female combat veterans who returned home from the Iraq or Afghanistan wars post-9/11 and received a diagnosis of PTSD. Because more women are serving in the military in combat roles, a critical need is to be

aware of the physical and mental symptoms associated with PTSD and MIE that emerged from combat zone deployment (s) and experiences (witnessed or participated) (Afari et al., 2015; Bryan and et al., 2018). The study's boundaries are limited to Christian U.S. Army female combat veterans who received a PTSD diagnosis and experienced a moral injury of war.

Limitations

Two limitations could potentially affect the general qualitative study. The first limitation involved the transparency of shared information by the participants. The data collected was from the participants' recollection regarding the perception of the circumstances and context of the phenomenon (Baxter & Jack, 2008; Stake, 1995). In other words, the participants had control over the content, which put the researcher at a disadvantage in verifying the information objectively (Baxter & Jack, 2008). Therefore, prolonged exposure to the context of the phenomenon was necessary (Baxter & Jack, 2008). The second limitation involved the time to gather and accurately transcribe the data (Baxter & Jack, 2008). As the researcher, it was essential to maintain the integrity and accuracy of the collected data, which was critical to the process of establishing a rapport with respondents to discuss and clarify interpretations and meanings of the contemporary context of the phenomenon (Baxter & Jack, 2008; Daniel & Onwuegbuzie, 2002; Yin, 2015). I have no prior military experience. So, incorporating methods such as bracketing or epochéé and journaling (interviewing the interviewer) helped me to be aware of my own biases, thus, validating the trustworthiness of the qualitative data

(Chenail, 2011; Daniel & Onwuegbuzie, 2002; Patton, 2015). Sharing my discoveries with my Chair was essential during the data collection process (Chenail, 2011; Daniel & Onwuegbuzie, 2002). As the research instrument, I risked the study's trustworthiness if I failed to prepare appropriately and address concerns and biases such as pre-study thoughts and assumptions of how participants might respond to questions asked (Chenail, 2011; Daniel & Onwuegbuzie, 2002). Additionally, I used reflexivity as a self-reflective accountability tool to address my prejudices (Karagiozis, 2018; Patton, 2015; Roulston & Shelton, 2015).

Significance

Many women have joined the United States military and are entering combat positions (Swick & Moore, 2018). As of January 2018, the Army positioned itself to add three additional posts for women assigned to combat roles (Swick & Moore, 2018). On average, women veterans were more likely to experience combat-related PTSD than male veterans after being exposed to traumatic events (Haun et al., 2016; Pereira, 2002). Pereira (2002) found that female combat soldiers typically received a diagnosis of a depressive disorder or borderline personality disorder, compared with male soldiers who were mainly diagnosed with schizophrenia or antisocial personality disorder. The Department of Veterans Affairs Women's Health (2013) reported female veterans who served in OIF and OEF wars accounted for one in five who receive a PTSD diagnosis.

The gap in the literature warranted additional research regarding quality assessments, tools, and treatments for female veterans who experienced or are

experiencing a moral injury of war (Battles et al., 2018; Farnsworth et al., 2017; Frankfurt & Frazier, 2016). Bryan et al. (2018) argued that PTSD and MI are different in terms of their distinct symptoms. These symptoms developed from the transgressive acts of war (Frankfurt & Frazier, 2016). Therefore, a need exists to create MI-specific interventions that target both combat-related and PMIE symptoms (Brayan et al., 2018). Carey et al. (2016) and Chang et al. (2015) argued that consideration warrants spiritual care and chaplain advocacy to be a part of the intervention plan to help service members and veterans work through issues caused by MI. Bridging the gap regarding the critical need for greater collaboration of services between healthcare professionals, mental health clinicians, and chaplains or spiritual leaders is necessary when treating a moral injury of war (Cary et al., 2016; Hodgson & Carey, 2017; Kopacz, 2017; Shay, 2014). Because gender differences exist in the manifestation of PTSD and MI symptoms post combat exposure, researches have suggested it is necessary to develop gender-specific screening assessments and treatment plans (Luxton et al., 2010; Street et al., 2009).

These new interventions potentially could help U.S. Army female field combat veterans who receive a PTSD diagnosis and who lived through or presently experiencing PMIEs, to work through and resolve issues caused by transgressive acts of war (moral injury). Filling the gap may give us a fuller understanding of the distinctions between signs and symptoms of PTSD versus MI among female U.S. Army service members. This study yielded greater awareness of the impact PMIE has on women and serve to inform

helping professionals and spiritual leaders on how to identify and treat this unique population.

Summary

In Chapter 1, I highlighted the ever-rising physical and mental health concerns of Christian U.S. Army female combat veterans who returned home from the Iraq or Afghanistan wars post-9/11 and received a diagnosis of PTSD and experienced a moral injury of war. Combat war exposure affects both men and women differently. However, more women are serving in combat roles, putting them at a higher risk of combat trauma such as PTSD and moral injury (Daphna-Tekoah & Helmsley, 2017; Muirhead et al., 2017). By 2030, women veterans will represent approximately 14 % of the veteran population, increasing five percent (Brunner et al., 2019; Muirhead et al., 2017). Because Christian U.S. Army female combat veterans' war experiences are understudied, it warranted an inquiry to understand the impact of a moral injury among this population who receive PTSD diagnosis.

The researcher proposed a general qualitative study research design to investigate the social concern. Incorporating in-depth telephone interviews was the most appropriate strategy to probe and answer the research question. This approach aided in filling the gap of knowledge while evaluating other studies that addressed the implications and symptoms of PTSD and MI among combatant veterans. I explained the impact of PMIEs (phenomena) experienced by Christian U.S. Army female combat veterans who returned home from the Iraq or Afghanistan wars post-9/11 diagnosed with PTSD, incorporating

the transpersonal-existential meaning-based model as a conceptual framework (Sreenivasan et al., 2014).

Chapter 2, the literature review, justified why the proposed research study warranted further investigation. This chapter discussed the specific methodology, using a general qualitative inquiry and the transpersonal-existential meaning-based model as a conceptual framework.

Chapter 2: Literature Review

Introduction

This literature review articulated the physical and mental health concerns and implications of war-zone exposure regarding United States military combat soldiers and veterans returning from OIF, OEF, or OND wars (Buttner et al., 2017; Ganzer, 2016). The United States Army has deployed approximately 1.5 million soldiers who served in these wars (Baiocchi, 2013). The active-duty female population of the United States military represents 14.3% (National Center for Veterans Analysis and Statistics, 2015; Rivera & Johnson, 2014). The risk factors associated with the exposure to combat positions in war conflict zones continue to be a rising concern regarding women soldiers and veterans' physical and mental health (Daphna-Tekoah & Harel-Shalev, 2017; Muirhead et al., 2017).

The literature critique showed the knowledge gap. This gap presented an opportunity for the researcher to investigate the phenomena. I incorporated a general qualitative design strategy to provide understanding regarding the impact of potentially morally injurious events (complex issue) experienced by Christian U.S. Army female veterans who received PTSD diagnosis post - 911 (context of the case) (Yin, 2009). The experiences of female combat veterans remain understudied in the mental health field, and this unique population is underserved (Haun et al., 2016). Adequately capturing these struggles provided greater insight regarding the experiences of this population diagnosed with PTSD who experienced or is experiencing PMIEs (Bryan et al., 2018). Therefore, a

collaboration among combat veteran patients, health care/clinical practitioners, researchers, and spiritual leaders can potentially provide solutions to address the implications associated with these PMIEs (Haun et al., 2016; Maguen & Litz, 2012; Wortmann et al., 2017).

Literature Search Strategy

The literature search strategy was primarily limited to peer-reviewed articles published within the last five years. However, the necessity exists to review the dated materials of researchers who developed specific theories and methodologies about moral injury and posttraumatic stress disorder. I used the following databases to search for relevant articles to support the proposed inquiry: ProQuest Central, Military and Government Collection, Google Scholar, Thoreau Multi-Database Search. Another resource is the Veteran Affairs website.

I used the following key or combination search terms to conduct an in-depth literature search: *moral injury, moral injury of war, military, veterans, Iraq, Iraqi, Afghanistan, women, veterans, female, combat, war zone, potentially morally injurious events, spirituality, spiritual distress, posttraumatic stress disorder, mental health, combat trauma, deployment, post-deployment, combat exposure, PTSD symptoms, moral injury symptoms, trauma, chaplain, pastoral care, religion, spiritual care, interventions, chaplaincy, implications, quality care, health care, mental health, morally ambiguous situation, spiritual injury, VA, Veterans Administration, Veterans Affairs, Army, field combat operation, women soldiers, gender differences, women veterans, combatants,*

conflict, war,, models, PTSD, MI, PMIEs, morality, killing, shame, guilt, anger, transgressive acts, warzone-deployed, psychological, gender, Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), diagnosis, empirical studies, theodicy, female veterans, case study, prolonged exposure, assessments, ethical, moral, moral wounds of war, vulnerable population, service members, and omission.

Conceptual Framework: Transpersonal-Existential Meaning-Based Model

I used the transpersonal-existential meaning-based model (Sreenivasan et al., 2014) as a pathway to explain the impact of PMIEs (phenomena) experienced or are experiencing by Christian U.S. Army female combat veterans who received a PTSD diagnosis post-9/11. The meaning-based model focused explicitly on combat veterans who returned home from the Iraq or Afghanistan wars and experienced a moral injury of war. The conceptual framework potentially established the basis to more fully understand the meaning described by the war trauma experiences and the existential experiences (Sreenivasan et al., 2014).

Soren Kierkegaard, Friedrich Nietzsche, and Jean-Paul Sartre were post-World War II philosophers who shared different concepts to more fully understand the atrocities of war and the implications of the perceived truth regarding those experiences of being in the world (Capuzzi & Stauffer, 2016). The philosophers acknowledged how some people struggled with reality or the inconsistencies of truth regarding the ideals of loneliness, guilt, and anxiety (Capuzzi & Stauffer, 2016). The premise for the theory was the individual choosing from a subjective perspective (influences/consequences; Capuzzi &

Stauffer, 2016). For example, Kierkegaard (1944) believed people were capable of making a choice, and that choice aligned with faith (Capuzzi & Stauffer, 2016). The context of the truth included the subject and the observation (Capuzzi & Stauffer, 2016).

Conversely, Nietzsche (1889) did not support the theory of a living God – "God is dead" (Capuzzi & Stauffer, 2016). He voiced his opinions regarding European views about religion and morality (Anderson, 2017). His critique aimed "to undermine not just religious faith or philosophical, moral theory, but ordinary moral consciousness" (Anderson, 2017, p.3). However, Sartre embraced the concept that a person's life (existence) happens before consciousness (meaning), and the outcome is contingent on actions are taken (do or act), freedoms that the individual has committed to in terms of the role in life (The Noble Prize, 2019). The context of the truth included the subject and the observation (Capuzzi & Stauffer, 2016).

The existential theory continued to evolve as Victor Frankl used his personal experiences (survivor of four Nazi concentration camps during - WWII) (Capuzzi & Stauffer, 2016). He contributed to the literature by solidifying existential psychoanalysis. This approach focused on meaning, human existence, and the search for meaning to understand life purposes no matter what empirical support for the basis of Frankl's logotherapy (Capuzzi & Stauffer, 2016; Sreenivasan et al., 2014). Frankl's work demonstrated how he used mistreatment as an opportunity to find a real meaning that empowered the human spirit, which created a will to survive (Capuzzi & Stauffer, 2016;

Sreenivasan et al., 2014). Logotherapy provided a spiritual pathway for humanity (Sreenivasan et al., 2014).

The war experiences displayed the good (uplift the soul in terms of courage and duty). Also, it demonstrated the bad (disbelief in goodness because of cruelty) regarding the human spirit (Screenivasan et al., 2014). The knowledge builds upon Frankl's perspective regarding existential experiences. It takes a more in-depth probe to give a fuller understanding of making meaning out of warzone events and personal values from an injurious moral viewpoint (Screenivasan et al., 2014). "Understanding moral combat-based conflicts within a meaning-based perspective addresses core existential issues omitted by a psychopathological framework" (Screenivasan et al., 2014, p. 26).

The transpersonal-existential meaning-based model design helped OIF/OEF veterans work through combat-related issues such as shame, guilt, forgiveness, and emptiness (Screenivasan et al., 2014). Screenivasan et al. (2014) acknowledged it was critical to find answers that gave understanding regarding the loss of existential meaning (Screenivasan et al., 2014). For example, how would a combat soldier start to make meaning from a horrific witnessed or participated battlefield event? Additionally, how does a female combat veteran begin to overcome existential anxiety? (Screenivasan et al., 2014). The researchers developed this conceptual framework by adding to the knowledge of other scholars such as Litz et al. (2009) and Nash et al. (2013). They, from their perspectives, defined and gave meaning to moral injury and its interrelatedness to a spiritual construct (Screenivasan et al., 2014). The model included four fundamental

concepts: (a) identify signature strengths, the combat veteran story (meaningful context); (b) identify event's meaning in larger context, purpose of the veteran's role; (c) address the spiritual context, spiritual anxiety and forgiveness (self/others); religious beliefs; and (d) promote resilience, integrating techniques and strategies to avoid traps such as anger resentment, or guilt (Screenivasan et al, 2014).

Cognitive models such as cognitive behavioral therapy are worth noting to have successfully provided explanations regarding stress-related transgression; however, they cannot give answers regarding the emptiness of meaning and spiritual context of moral injury experienced by warzone veterans (Screenivasan et al., 2014). This conceptual framework helped the researcher understand the meaning described by the war trauma experiences and the existential experiences of Christian U.S. Army female combat veterans who received PTSD diagnosis and experienced a moral injury of war.

Literature Review of Key Concepts

The premise for conducting empirical research was to observe and measure the phenomena in their context expressed by the subject regarding actual experiences (Penn State University, 2019). Haight et al. (2016) acknowledged how empirical studies provided a more in-depth understanding of the experiences and impact of moral injury. Using a qualitative approach allowed them to develop and assess appropriate instruments to address moral injury from a social work perspective (Haight et al., 2016). The researchers argued that it is essential to the field of study to address the implications of moral injury to help clients work through issues such as guilt, shame, and moral

confusion (Haight et al., 2016). Screenivasan et al. (2014) acknowledged that "moral injury, therefore, can be viewed as a healthy reaction - reflecting a contact with conscience as well as process offering the opportunity to find meaning in terrible events" (p. 29). Moral injury as a psychological trauma that emerged from violating an individual's moral belief, and the aftermath reflects intense guilt, shame, and spiritual crisis (Jinkerson, 2016).

It is necessary to distinguish between moral injury (internal conflict) and PTSD behaviors (avoidance or numbing). There is a need for greater collaboration among combat veteran patients (perspective or experiences), health care or clinical practitioners (gaining knowledge), researchers (exploration or discovery), and spiritual leaders (Maguen & Litz, 2012).

Combat Exposure - Women Veterans

Literature continues to expand as more women join the United States military and enter into combat roles. This population accounted for the increase of veteran women previously deployed to Afghanistan or Iraq and are now patients of the Veteran Affairs health care system (Brunner et al., 2019; Creech et al., 2016). Butter et al. (2019) acknowledged in their research that there is a significant occurrence of combat exposure (CE) among male (82%) and female (73%) veterans previously deployed to OEF/OIF war zones. CE is linked to psychological trauma and physical health issues (pain-related) (Butter et al., 2019). Compared to their male counterparts, the scores conveyed how female veterans were profoundly impacted (Butter et al., 2019). There is a need to

employ gender-specific models to understand better CE regarding women veterans deployed to Afghanistan or Iraq post 9/11 (Butter et al., 2019).

Women and females respond differently to trauma exposures. Daphna-Tekoah and Harel-Shaely (2017) articulated the importance of learning from women combatants' exposures to traumatic events in the war theatre. From their perspective, these women shared the impact of life-threatening war trauma and how it affected their minds and bodies, which caused both physical and psychological injury (Daphna-Tekoah & Harel-Shaely, 2017). One significant takeaway from their research study is the need to have prolonged and engaging conversations with women combatants (Daphna-Tekoah & Harel-Shaely, 2017). This kind of dialogue potentially opens the door to a complete understanding of the impact of war trauma and aid in the contribution to advancing gender-specific literature regarding women soldiers and women veterans who served in a combat zone. (Daphna-Tekoah & Harel-Shaely, 2017).

The researchers noted literature addressing war trauma mainly focused on men combatants' war symptoms and experiences (Daphna-Tekoah & Harel-Shaely, 2017). Daphna-Tekoah and Harel-Shaely (2017) cited Pineles et al.'s (2013) definition of potentially traumatic events (PTEs) that "are those events that involve exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence" (p. 945).

Daphna-Tekoah and Harel-Shalev (2017) referenced how trauma studies focused on the body and why it was necessary to pay attention to the body's reactions during war

theatre. Also, security studies of war emphasized why it was essential to understand what happens to the body and how it functions during CE (Daphna-Tekoah & Harel-Shalev, 2017). One common theme described during interviews was that both men and women must act like a man and not falter in emotions during combat (Daphna-Tekoah & Harel-Shalev, 2017). More research is needed to adequately address the concerns associated with trauma and distress (psychological or physical) regarding women combatants during PTEs (Daphna-Tekoah & Harel-Shalev, 2017).

Though this Daphna-Tekoah and Harel-Shalev (2017) study is an important and innovative look at the experiences of female combat veterans, previous researchers had begun to address the issue. Yan et al. (2013), for example, conducted a longitudinal observational cohort study, also known as the HEROES Project (Yan et al., 2013). The framework of the HEROES Project centered around the pre-deployment and early post-deployment predictors (psychosocial and physiological) of physical symptoms and health care utilization (Yan et al., 2013). The results of the survey identified six significant stressors. Yan et al. categorized these stressors as interpersonal, deployment-related and military-related, health concerns, death of a loved one, daily needs, and employment or school-related concerns. The most common stressor identified from the four phases of the research process was interpersonal stressors (Yan et al., 2013). Some examples of these interpersonal stressors include the inability to communicate with significant others, consistent interaction with close friends and family members, and the engagement in a marital affair (Yan et al., 2013). The Coping Response Inventory (CRI) coded these

stressors (Yan et al., 2013). It was challenging to address and resolve interpersonal stressors during combat deployment because of the geographical distance and limitation of time regarding personal contact (Yan et al., 2013). It is worth noting that the unresolved stressor can negatively affect and prevent the individual from carrying out combat mission duties. Long-term unresolved stressors can potentially interfere with the veteran's ability to reintegrate into civilian life (Yan et al., 2013).

Yan et al. (2013) acknowledged that women veterans self-reported deployment-related or military stressors were of the highest frequency before and immediately after deployment. Some of the stressors included getting mobilized for an immediate deployment (2 days), being deployed with a unit of strangers, experiencing different methods of attacks (rocket fire), and serving alongside the enemy (Yan et al., 2013). Compared to previous wars, the researchers acknowledged that women veterans of OEF/OIF wars post 9/11 have experienced more significant exposure to stress-related difficulties because of combat-supported positions. Yan et al. stated more research warrants to address these concerns further. Also, more tailored programs are needed to address the daily needs of veteran women to minimize the negative impact of chronic combat-related stressors (Yan et al., 2013). The Veteran must continue to establish cross-collaboration efforts with the local community and religious groups with readily available resources that cater to the specific needs of women veterans' health and wellness (Yan et al., 2013).

Creech et al. (2016) aimed to explore the associations of warzone exposure to combat and how it impacted mental health, post-deployment relationships, and family functioning (parenting) among 134 women veterans deployed to Afghanistan or Iraq wars post 9/11. The researchers were interested in understanding the impact of PTSD symptoms and trauma-related stressors experienced by these women veterans (Creech et al., 2016). Also, Creech et al. wanted to explore if there was a correlation between alcohol misuse and post-deployment family and intimate relationship functioning problems (Creech et al., 2016). The researchers acknowledged their study was the first to examine associations between warzone exposures to combat post-deployment and family functioning problems veteran women face returning from OEF or OIF wars post 9/11. Therefore, their research identified a gap in the literature relating to women veterans facing different challenges adjusting to family functioning returning from the OEF or OIF wars post 9/11 (Creech et al., 2016).

The study participants resided in New England and were selected from the OEF, OEF, and OND databases (Creech et al., 2016). The Veterans Health Administration Office of Public Health Post-Deployment Epidemiology Program maintained the listing of veteran women (Creech et al., 2016). Initially, 600 participants were randomly selected to participate in the study who were residing in Veterans Integrated Service Network 1 (VSIN1) (Creech et al., 2016). All participants were required to complete a global measure of family functioning after deployment. However, if the participant acknowledged she was in a current relationship (romantic), she completed an intimate

relationship satisfaction survey (Creech et al., 2016). The Combat Experiences scale – Deployment Risk and Resilience Inventory-2 (DRRI-2) appropriately assessed exposure to combat experiences (most recently) (Creech et al., 2016; Vogt et al., 2013). The PTSD Checklist (PCL) was a tool used to measure symptoms of PTSD experienced by the participants in the last month (Creech et al., 2016). The outcome of research brought greater awareness that there is an association between combat exposure, PTSD, and relationship and family functioning among veteran women who served in Iraq or Afghanistan wars post 9/11 (Creech et al., 2016). Moreover, the research findings indicated that women veterans exposed to combat have higher PTSD symptoms and can potentially benefit from the relationship and family-focused services (Creech et al., 2016).

Female Veterans Health

Women and females may comprise a small portion of the overall group of combat veterans, but they do have unique needs. Rivera and Johnson (2014) articulated that female combat veterans account for 12% of the United States armed services, and this number continues to increase because of military opportunities for women. Because of this, adding to knowledge of addressing how female soldiers responded to war trauma (OIF, OEF, or OND) and the health care (mental or physical) of female veterans was critical (Rivera & Johnson, 2014). Unfortunately, supporting evidence to mandate better and gender-specific treatment for this understudied population was lacking (Rivera & Johnson, 2014). Crompvoets (2011) acknowledged “there is a gender bias in the

diagnosis of PTSD within the U.S. Veterans Affairs (V.A.) healthcare system, while male veterans are receiving a higher rate of diagnosis than women" (p. 6).

During the Vietnam war, women with CE self-reported physical and reproductive health challenges (Rivera & Johnson, 2014). Subsequent studies regarding OIF, OEF, or OND female veterans linked mental health diagnosis and reproductive health challenges to CE (Rivera & Johnson, 2014). Current studies that addressed PTSD showed female veterans were at a higher risk of receiving a psychological diagnosis stemming from exposure to death and accidents than male veterans who served in the same wars (OIF, OEF, or OND) (Rivera & Johnson, 2014). Rivera and Johnson (2014) noted mental health issues (psychiatric pathology) were and continue to be one of the primary reasons female soldiers evacuated from war theatre. Additional research is warranted to provide female combat veterans with adequate health care and resources (Rivera & Johnson, 2014).

In addition, there are differences in outpatient services. More female veterans are patients of outpatient mental health services (Runnals et al., 2014). Female veterans aged 45-64 who served in the Afghanistan or Iraqi wars sought mental health services more than younger females (Runnals et al., 2014). Also worth noting is that mental health will continue to increase and impact the women veterans' lifespan (Mattocks et al., 2010).

Spiritual Wellbeing, Spiritual Care

Spiritual care and wellbeing are important elements to dealing with trauma from a religious perspective. Literature continues to articulate how experiences of war-related

trauma are associated with altering an individual's religious or spiritual beliefs regarding the meaning and purpose of life (Bormann, Liu, Thorp, & Lang, 2012; Sherman, Usset, Voecks, & Harris, 2018). Although limited empirical studies have addressed spiritually-based intervention for PTSD treatment, religious or spiritual programs integrated into treatment can be positive coping tools (Bormann et al., 2012).

Often, combat veterans faced spiritual challenges while experiencing MI of war that included spiritual distress (Sherman et al., 2018). In their study, Sherman et al. (2018) addressed the role of religion and spirituality (R/S) and how both impacted warzone trauma among veterans who received a PTSD diagnosis. An increase of positive outcomes, including a sense of meaning, resiliency, and satisfaction was linked to R/S coping strategies (Sherman et al., 2018). The framework of the study focused on the following four themes: "(a) impact of trauma/PTSD on veterans' spirituality, (b) role of R/S in veterans coping with trauma/PTSD, (c) role of R/S in partners' responding to veterans' trauma/PTSD, and (d) the role of the couple's spiritual connection in coping with trauma/PTSD" (Sherman et al., 2018, p. 369).

The sample included 11 male veterans who received PTSD diagnoses and nine female partners living with a male veteran who received PTSD diagnosis; all were interviewed at the VA hospital by a psychology technician (Sherman et al., 2018). They conducted interviews using eight open-ended interviewing questions (Sherman et al., 2018). The research outcome showed that incorporating religion and spirituality as culturally competent care for veterans who received PTSD diagnoses and survivors of

war trauma is necessary (Sherman et al., 2018). Also, worth noting and; that from their perspective, the success of spiritual interventions emerged from both Western and Eastern religious worldviews (Sherman et al., 2018). Moreover, the demand for more mental health practitioners, spiritual care programs, and chaplaincy services is necessary as long as military combat personnel and veterans face challenges regarding self-condemnation and complex trauma (Cary et al., 2016; Chang, Stein, & Skarf, 2015; Worthington and Langberg, 2012; Wortmann et al., 2017).

Hufford et al. (2010) participated in a spiritual fitness workgroup pre-conference (Defining Total Force Fitness for the 21st Century). The collaboration allowed exploring how spiritual fitness applications could impact the Department of Defense (DoD) overarching goals such as “performance, preparation, resilience, and unit cohesion” (p. 73). The cross-disciplined workgroup included “academic experts, chaplains (each service branch), and authorities from the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE)” (pp. 73-74).

Data collected during the preconference workgroup served to aid the conference regarding its efforts to develop a more strategic conceptual framework and metrics. The workgroup concluded a substantial need exists for new policies and programs regarding spiritual fitness interventions. Also, considerations warranted adding chaplains to the treatment process because they are valuable resources for developing leadership and support personnel training programs.

Spiritual Distress

Spiritual distress is also an element to take into consideration when assessing moral injury. Chang et al. (2015) incorporated a qualitative research method and used the ground theory as the theoretical lens to guide the pilot research process. The premise for the research was to gain a fuller understanding of spiritual distress (spiritual needs/care) experienced by military veterans of combat wars (Vietnam or World War II (WWII) from the perspective of military chaplains. Five chaplains (all Christians) of the Veteran Affairs health care system participated in 30 minutes of face-to-face interviews. The experiences of these chaplains involved working with veterans (at the end of their lives) who struggled with undisclosed spiritual distresses caused by traumatic events experienced during their military career. The research analysis concluded that "it is important to train health professionals to identify psychological symptoms rooted in religion or spirituality and to work with chaplains in helping veterans experiencing spiritual distress" (Chang et al., 2015, p. 638). Future research is relative to considering the end-of-life services (chaplain or mental health) for combat veterans experiencing spiritual distress.

In another study, Tran et al.'s (2012) framework design aimed to understand how traumatic events experienced by veterans during warzone operations impacted or interfered with their religious beliefs. These participants received a PTSD diagnosis, and; the outcomes of their mental health linked to religious beliefs and faith practices (Tran et al., 2012). The study participants included 449 male, and 395 female veterans enrolled in

a Veteran Affairs PTSD residential treatment program (Tran et al., 2012). All study participants were required to fill out a battery of questionnaires and consent to the researchers to use their data before and after the program (Tran et al., 2012). Each participant had to be non-psychotic, substance-free for 14 days (minimum) before admission, previously participated in an outpatient PTSD treatment program, and currently showed signs of continuous struggles regarding military-related trauma (Moreira-Almeida et al., 2006; Tran et al., 2012).

Tran et al. (2012) framed a working definition for religiosity, which served as a fundamental concept to help guide the research study. The researchers used domains such as religious beliefs (affiliation), motivation, behavior, and coping to describe the different characteristics of religiosity (Tran et al., 2012). These religious characteristics centered around religion and spirituality and an individual's concept of God (Tran et al., 2012). Eleven primary God concept analysis factors are associated with different psychological health outcomes (Schaefer & Gorsuch, 1992). These concept factors were benevolent, wrathful, Omni, guiding, false, stable, deistic, worthless, powerful, condemning, and caring (Schaefer & Gorsuch, 1992). The religious motivation was determined by the intrinsic or extrinsic reasons for religious commitments (Gorsuch & McPherson, 1989). Intrinsic religious motivation is guided by an individual's belief (doing good - spiritual principle).

In contrast, extrinsic religious motivation was based on personal gain and social benefits (solace through spiritual prayer or attendance; see Gorsuch & McPherson, 1989).

However, religious behaviors involve actual activities (service attendance and prayer) that engage religiosity (Tran et al., 2012). For example, religious coping was engaged behavior that incorporated religious beliefs to problem-solve or alleviate negative emotional consequences caused by life's stressful circumstances or situations (Koenig, Pargament, & Nielsen, 1998).

It is worth noting that both positive and negative religious coping strategies have been associated with positive and negative psychological adjustments to stress (Ano & Vasconcelles, 2005). In treatment, religious attributions and coping mechanisms were strategies veterans used to reframe their view of the traumatic experience, framed by the individual's concept of God or another universal spirit (Tran et al., 2012). The veteran struggling in his faith tried to make meaning out of the traumatic experience (moral transgression; Litz et al., 2009; Tran et al., 2012).

The analysis of Tran et al.'s (2012) research study gave a better understanding of the relationship between PTSD and religiosity. The researchers acknowledged the outcome of the study was more complicated when examining other traumatic experiences (Tran et al., 2012). Findings (data collected from 2000 to 2003) gave more in-depth insight into religiosity in mental health functioning related to religious beliefs, motivation, and behavior, which could be beneficial to recovery (Tran et al., 2012). Tran et al. (2012) advocated that more research was needed to address the need for religiosity in PTSD and depression treatment. More research is required to bring awareness about religiosity's influences on personal emotional and psychological functioning (Tran et al.,

2012). Also, addressing veterans' religious and spirituality (r/s) struggles and convictions after PMIE exposure can yield more significant reductions in suffering for those with MI (Evan et al., 2018).

PTSD: Prevalence Among Military Community

Literature confirmed that receiving a PTSD diagnosis in the military community- produces adverse emotional reactions and the fear of stigma (see Gaudet et al., 2016; Hundt et al., 2019). PTSD is prevalent among service members and veterans, and the diagnosis of PTSD continues to rise as they return from combat deployment operations (Hundt et al., 2019; Kessler et al., 1995; Koening, 2018; Kulka et al., 1990; Tran et al., 2012). For example, 15% represented males, and 8% represented females of the Vietnam War (Kulka et al., 1990), 12% represented Gulf War veterans (Kang et al., 2003), and 22% described veterans of the OEF and OIF wars (Seal et al., 2009).

PTSD among military personnel and veterans is more challenging to treat when the diagnosis is chronic (Steenkamp et al., 2015). Only 20-30% of those individuals with a chronic PTSD diagnosis receive complete remission of symptoms (Steenkamp et al., 2015). Often these symptoms are associated with psychiatric comorbidities such as depression, anxiety, substance abuse, and relationship problems (Ginzburg et al., 2010; Pietrzak et al., 2011). Ramsawh et al. (2014) acknowledged PTSD and depressive illnesses continue to increase concurrently among United States Army personnel. Also, PTSD is associated with a significant risk of suicide among active-duty personnel and veterans (Elbogen et al., 2017; Koenig, 2018; McKinney et al., 2017; Ramsawh et al.,

2014). Historically, suicide rates were considerably low among the United States Army personnel (2001-2007) (Black et al., 2011) compared to civilian suicide rates (Eaton et al., 2011). Since the start of the OEF and OIF wars (2001 to 2009), suicide rates within the Army increased from 9 to 22 per 100,000 (Black et al., 2011). Therefore, the prevalence of PTSD has established itself as a mental and physical health concern that increased and continues to rise after combat-related stress (Hoge et al., 2004).

Effects of PTSD

The American Psychiatric Association (APA) established the term PTSD in 1980. They added it in the third edition of the DSM-III. The National Center for PTSD (United States Department of Veterans Affairs, 2020) describes PTSD as a mental health condition of an individual who has experienced or witnessed a life-threatening event (combat), a natural disaster, or sexual assault. Sochenko (2017) defined PTSD as a severe psychiatric disorder that potentially occurs due to an emotionally traumatic experience. It is worth noting that early theories of PTSD viewed symptoms as an inherent individual weakness (Sochenko, 2017).

PTSD continues to be an increasing health concern for the United States veteran population returning from OEF, OIF, or OND warzone operations (Department of Veterans Affairs [VA], 2015; Hoge et al., 2004; Sripada et al., 2020). Combat veterans who received a PTSD diagnosis post-9/11 can potentially experience intrusive thoughts of trauma, avoidance of reminders related to the injury, irrational mood swings, irritability, and anxiety with distorted perceptions (American Psychiatric Association,

2013). Also, apart from PTSD, combat-related stress leads to ethical dilemmas (consequences of decisions) such as the moral injury of war (Blum, 2008; Gaudet et al., 2016). In 2013, the VA Health System reported there was an increase of veterans (249%) seeking care for PTSD from 2002 to 2012 (Department of Veterans Affairs [VA], 2013). Gaudet et al. (2016) acknowledged the military does not adequately train or prepare personnel for the complexities of war, such as self-judgment and shame.

Past and present research studies provided evidence that it is necessary to examine the prevalence of lifetime combat exposure and its association with PTSD (see Reger et al., 2019; Koenen et al., 2017). For example, Hoge et al.'s (2004) research study explored the impact of combat operations (ground combat and hazardous security duty) on United States military personnel deployed to OEF and OIF wars. They surveyed staff (2,530) from four United States combat infantry units, including three Army units and one Marine Corps unit (Hoge et al., 2004). Participation in the survey occurred before military personnel deployed to Iraq or three to four months after staff returned from OEF or OIF combat zones (Hoge et al., 2004). The outcome of the study confirmed those soldiers deployed to Iraq experienced significant exposure to combat (15.6 to 17.1 percent) than those soldiers deployed to Afghanistan (11.2 percent) (Hoge et al., 2004). Many of these individuals experienced mental health problems, such as major depression, generalized anxiety, and PTSD (Hoge et al., 2004). There was a significant difference in the rate of PTSD and barriers to the negative stigma that prevented many of these individuals from seeking adequate mental health services (Hoge et al., 2004). The study's

outcome positioned the researchers to advocate for further studies to address the problem of stigma regarding military personnel seeking mental health care services in the United States military (Hoge et al., 2004).

Gender Differences and Prolonged Exposure to PTSD Among Veterans

Research on gender effects of combat post-deployment symptoms among Iraq and Afghanistan veterans is limited or inconsistent (see Afari et al., 2015; Goldstein et al., 2017). While conducting their research study, Afari et al. (2015) discovered there is no literature to show how the role of PTSD, depression, substance use, and other mental health symptoms is linked to anger and aggression in female veterans. However, some studies showed the link between combat experience and aggression in male veterans who served in the OEF or OIF wars post – 9/11 (Afari et al., 2015). The findings of their research advocated for further exploration regarding the complex contributions of experiences (military and deployment) in both men and women to understand better how to treat symptoms in multiple domains in OEF and OIF veterans. Combat exposure (male - 82%, female - 73%), physical and mental health problems and pain are high prevalence outcomes experienced by or being experienced by OEF and OIF veterans post - 9/11 (Buttner et al., 2017).

There is a critical need to understand better the nature and extent of potential gender differences associated with PTSD (mental and physical impairment) experienced by OEF and OIF veterans who returned post – 9/11 (see Fang et al., 2015). Moreover, there is a need to address military trauma exposures (stressors) in female veterans who

returned from OEF or OIF wars post – 9/11 (Goldstein et al., 2017). Addressing gender differences in this area can potentially improve the quality of trauma exposure treatments and assessments for this special population (Goldstein et al., 2017). Other military related-trauma, such as the effect of enemy combat tactics on PTSD (Green et al., 2016), psychosocial functioning, and health-related quality of life (HRQOL; Fang et al., 2015; Haun et al., 2016). The risk and protective factors associated with PTSD (Kline et al., 2013) warrant further discovery to understand better how OEF and OIF female veterans post - 9/11 adjust to these stressors, which potentially cause mental and physical health problems (Goldstein et al., 217). Moreover, too few healthcare providers are aware of war-zone exposure's significant impact on female veterans (Muirhead et al., 2017).

Since 2013, more published literature has focused on the experiences (role) and mental health of male combat soldiers or veterans post - 9/11 than their female counterparts. Mouilso et al.’s (2016) research study addressed the gender gap regarding prolonged exposure (PE) for PTSD in veterans. The premise of the research was to address the concern because more women are joining the United States military and being diagnosed with PTSD at a higher rate than male veterans (Mouilso et al., 2016). The researchers established the study framework by exploring PTSD, "characterized by intrusive reexperiencing symptoms, avoidance, behaviors, and elevated phycological arousal" (Mouilso et al., 2016, p. 308). The Veterans Affairs (VA); first-line treatment for both male and female veterans diagnosed with PTSD is Prolonged Exposure (PE) therapy (Mouilso et al., 2016).

Mouilso et al. (2016) study examined 292 male (90%) and 33 female (10 %) veterans who received a PTSD diagnosis and who received PE treatment from October 31, 2007-August 20, 2013 (Mouilso et al., 2016). Participants sampled were referrals and had worked with the PTSD Clinical Team (PCT) (Mouilso et al., 2016. The PCT consisted of "29 mental health service providers, clinical psychologists, social workers (VA trained or PE Certified), and predoctoral psychology interns (extensive cognitive-behavioral therapy training)" (Mouilso et al., 2016, p.311). The PE protocol maintained the integrity of the 90-minute weekly supervised group session (8 - 15 weeks) (Mouilso et al., 2016).

The sessions covered the following constructs: psychoeducation, repeated in vivo exposures (safe situations to avoid stress), repeated prolonged imaginal exposure with eyes closed (memories of trauma) and processing imaginal exposures (Mouilso et al., 2016). In total, 202 participants (62%) completed the treatment process (Mouilso et al., 2016). No significant differences were reported between males and females who completed the process regarding the effectiveness of PE treated by VA clinicians (routine clinical practice) (Mouilso et al., 2016). However, the researchers admitted more studies are necessary to further explore PE among female veterans (Mouilso et al., 2016).

Moral Injury

Moral injury (MI) is becoming a more common term among active-duty military (ADM) and veterans of warzone exposure (Dombo et al., 2013; Koenig, 2017; Koenig et al., 2019; Koening et al., 2019; Dombo et al., 2013; Koenig, 2017; Koenig et al., 2019;

Koening et al., 2019). For example, >50% of ADM with PTSD symptoms have four or more symptoms of MI, and approximately 60% of veterans with PTSD have five or more MI symptoms (Koenig et al., 2019). During the study, the researchers used the Moral Injury Symptoms Scale Military Version (MISS-M) (Koenig, 2017). The first multidimensional scale assessed MI's psychological and spiritual/religious symptoms among veterans and ADM (Koenig, 2017). MISS-M is a 45-item scale designed to evaluate veterans and ADM with PTSD (Koenig, 2017). This scale consisted of 10 grounded subscales (theoretical) that assessed MI's psychological and spiritual/religious symptoms (Koenig, 2017). Some of these MI symptoms included guilt, shame, betrayal, moral concerns, difficulty forgiving, loss of religious faith/hope, and the loss of trust (Koenig, 2017). The three outcome factors associated with this assessment scale included: high internal reliability, high test-retest reliability, and factor structure replicate (Koenig, 2017).

MI (military perspective) involves the emotional, spiritual, and moral consequences of a soldier committing a transgression or witnessing a violation committed by others (Dombo et al., 20132; Koenig et al., 2019). The rationale for these transgresses acts interferes with the deeply held moral values of the soldier during combat or military-related operations (Koenig et al., 2019; Koenig et al., 2019). For example, ADM or veterans who struggled with MI issues experienced the betrayal of what is right by a superior of authority. This act forced the individual to transgress moral boundaries (Koenig et al., 2019). Literature (past and current) suggest PTSD and MI are different

with some overlapping conditions (Koenig, 2017; Koenig et al., 2019). Therefore, it is necessary to understand, recognize and address MI to maximize successful treatments of PTSD (American Psychiatric Association, 2013; Dombo et al., 2013; Koenig et al., 2019; Koenig et al., 2019).

Exposure of Potentially Morally Injurious Events and Psychological Distress

More research studies are purposefully addressing concerns regarding the exposure of PMIEs, and have concluded it may have a direct impact on military veterans' mental health (Evans et al., 2018). Evans et al. (2018) research study focused on the implications of exposure to PMIEs and the psychological distress (PTSD) experienced by United States military veterans in war zones. The researchers incorporated religious and spiritual struggles (r/s) as a mediating role in establishing the framework.

The sample included 155 veterans. Most participants were males (85.9%), Army veterans (57%), and 23% represented those who served in the OEF/OIF/OND wars. The specific measures of the research included "PMIEs, r/s struggles, PTSD symptoms, depressive symptoms, and anxiety symptoms" (Evans et al., 2018, p. 363). Data analysis confirmed the conceptual understanding of r/s struggles were a direct outcome of PMIE exposure and psychological distresses. Incorporating a mediation model that focused on religious and spiritual struggles (conceptualized process) proved advantageous in working alongside military veterans who experienced a moral injury of war (Evans et al., 2018; Harris, Park, Currier, Usset, & Voecks, 2015). The context of the experiences accounted for the psychological and spiritual functioning of the veteran (Evans et al.,

2018; Harris et al., 2015). The collected data showed the associations between psycho-spiritual factors and psychological distress symptoms (Evans et al., 2018). The researchers concluded it is critical to the intervention (treatment) process that clinical/mental health practitioners become more aware of moral injury healing among military veterans (Evans et al., 2018).

Psychological distress is more prevalent among war veterans involved in the direct or indirect killing of the enemy and its civilians (Maguen et al., 2010). Forty-eight to 65% of OIF combat infantry personnel acknowledged they were responsible for the death of an enemy combatant (Maguen et al., 2010). Fourteen to 28% stated they killed noncombatants (Maguen et al., 2010). Killing in the warzone is a risk factor for combat-related psychiatric and social disturbances (Maguen et al., 2010). Killing is a significant predictor of the development of mental health and psychosocial challenges (Maguen et al., 2010). These challenges present a more significant problem when the individual finds it difficult to reintegrate and readjust post-military (Maguen et al., 2010). Psychological stress caused by combat-related events links to MI (Ferrell, Huyser, & Dykas, 2017). Intrusion, avoidance, and hyperarousal are characteristic features of trauma responses associated with MI (Ferrell, Huyser, & Dykas, 2017). Intrusion is the re-experiencing of events (thoughts, repeated dreams, flashbacks (Ferrell, Huyser, & Dykas, 2017). Avoidance is the attempt not to remember the event's activities (Ferrell, Huyser, & Dykas, 2017). Hyperarousal is the physical reactions to the event, such as short-tempered behaviors and difficulty concentrating (Ferrell, Huyser, & Dykas, 2017).

Symptoms Associated with Moral Injury Syndrome

Jinkerson (2016) purposely drew a distinction between MI and PTSD from a syndrome perspective. He used a definition collaborated by a group of professionals (clinicians, researchers, and clergy) to develop the symptom profile (Jinkerson, 2016). He expanded the literature by incorporating past studies (e.g.., Drescher et al., 2011; Litz et al., 2009; Shay, 1994, 2003) to validate the MI syndrome. The researchers had similar findings that most MI descriptions included guilt, shame, and loss of trust in self. Other MI explanations included a superior being, spiritual crisis, psychological problems (i.e., depression and intrusive thoughts or images), isolation, and moral disgust and moral contempt (Drescher et al., 2011; Famsworth et al., 2014; Jinkerson, 2016; Litz et al., 2009; Stein et al., 2012).

Moral injury is a direct outcome of profound demoralization experienced by war-zone soldiers who perceived their moral integrity was compromised by self or someone of authority (Shay, 2003). Moral dissonance, when unresolved, leads to the development of core and secondary symptomatic features that affect the mental and physical health of those who experienced or are experiencing a moral injury of war (Dombo et al., 2013; Jinkerson, 2016; Koenig, 2017; Koenig et al., 2019). Some examples of core characteristic features include guilt, shame, spiritual conflict, and loss of trust (Dombo et al., 2013; Jinkerson, 2016; Koenig, 2017; Koenig et al., 2019; Shay, 2003). Secondary symptomatic features included depression, anxiety, anger, re-experiencing the moral conflict, self-harm, and social problems (Dombo et al., 2013; Jinkerson, 2016; Koenig,

2017; Koenig et al., 2019; Shay, 2003). Mental health clinicians, clergy, and local communities must understand MI and the characteristic features associated with MI.

When assessing a patient for clinical diagnosis and treatment, it is necessary to consider (like PTSD) two components: MI history (has the patient experienced PMIEs) and MI symptoms. (Jinkerson, 2016). Jinkerson (2016) suggested clinicians should strategically use inventories based on symptom relevance. Jinkerson (2016) concluded his study by stating, "the proposed syndrome definition honors existing treatment models by emphasizing the theoretical and empirical centrality of guilt in moral injury's identification and development" (p. 128). Understanding that MI differs from PTSD can aid in incorporating the most appropriate treatment plan for the individual (Jinkerson, 2016; Koenig, 2017; Koenig et al., 2019). Therefore, it is critical to address the concerns of a moral injury – traumatic guilt caused by an injury of war (Jinkerson, 2016; Jordan, Eisen, Bolton, Nash, & Litz, 2017; Litz et al., 2009; Maguen & Litz, 2012; Shay, 2014).

Nash et al. (2013) conducted a psychometric evaluation by administering the Moral Injury Events Scale (MIES) to address and evaluate combat stress among United States active-duty Marines after they returned home from a war zone. The researchers developed a measure that targeted potentially morally injurious events to validate the research. The research analysis suggested the phenomenon of MI (internal conflict) continues to evolve rapidly among combat soldiers with PTSD (stress injuries). Internal strife (life threat, loss, wear, and tear) is a characteristic of moral damage that arises from the carrying out or being a witness to acts and failures that interfere with a deeply held

belief system (Nash et al., 2013; Worthington & Langberg, 2012). Internal conflict can lead to self-condemnation (criticism and condemnation of oneself) caused by wrongdoing and moral failure (Worthington & Langberg 2012). As a result, combat soldiers faced moral and ethical challenges (Drescher et al., 2011; Litz et al., 2009), affecting physical health, mental health, relationships, and spiritual beliefs (Worthington & Langberg, 2012). These soldiers often experience emotions such as guilt, shame, rage, anger, feelings of betrayal, and anxiety which are characteristics of self-condemnation (Worthington & Langberg, 2012; Wortmann et al., 2017; Youssef et al., 2018). Internal conflict/moral injury (ICMI) experienced by veterans while deployed to combat zones continues to be widespread and disabling (Youssef et al., 2018).

The treatment plan to help minimize moral damage's long-term effect should include forgiveness as a coping mechanism (Worthington & Langberg, 2012). The concept of forgiveness addresses a decision to forgive and the emotional neutralization of negative unforgiving emotions to a perceived injustice (Worthington & Langberg, 2012). Positive coping mechanisms are both personal and psychological, which allows the individual to reach out to a friend, family member, chaplain, or counselor to talk about the experienced or experiencing emotions (Worthington & Langberg, 2012). The researchers incorporated spiritually-oriented therapy (SOT) into treatment plans for treating ICMI caused by combat-related stressors and experiences (Youssef et al., 2018). SOT is a potentially helpful approach for treating ICMI in the setting of PTSD (Youssef et al., 2018). One-third of patients diagnosed with PTSD do not respond successfully to

care, such as trauma-based therapies, prolonged exposure therapy, and cognitive processing therapy (Youssef et al., 2018). However, data supported the theory that SOT could reduce PTSD symptoms, but the individual must be receptive to or interested in participating in such a therapy (Youssef et al., 2018).

Acts of Omission, Worldviews, and Psychological Problems

Researchers continue to address concerns that men and women respond to and process trauma and injury differently (Rivera & Johnson, 2014). Christian Williams and Howard Berenbaum (2019) conducted a study to explore and investigate the implications associated with the acts of omission or commission and the interpretations and meanings (guilt or shame) of those acts experienced by OIF/OEF military veterans. The researchers articulated further investigation is necessary regarding the actions of omission to gain a fuller understanding of how these experiences affect an army veteran's worldview.

Williams and Berenbaum (2019) sampled 50 Iraqi and Afghanistan military veterans, and four represented the number of women veterans who completed the questionnaire regarding inactions, meanings, and interpretations. The other survey administered focused on measuring symptoms of war stresses such as PTSD, depression, suicides (attempts or contemplated), and combat and post-combat experiences. The researchers acknowledged other studies that addressed the characteristics of MI (e.g.., Famsworth, Drescher, Nieuwsma, Walser, & Currier, 2014. Williams and Berenbaum (2019) observed how they explored and provided moral injury of war explanations regarding inactions that caused guilt and shame (emotions) from a commission

perception; however, a need exists to investigate these interpretations and meanings from an omission perception.

Williams and Berenbaum (2019) had similar findings to Frankfurt and Frazier (2016) that veterans' worldviews altered as a direct result of breaking the rules (personal) of right and wrong, which played a critical role within the context of emotions such as guilt or shame. As a result, these emotions are linked to psychological problems experienced by combat veterans (Williams & Berenbaum, 2019). In their research study, Williams and Berenbaum (2019) articulated how the acts of omission during warzone events (witnessed or participated) significantly impacted the mental state of veterans while deployed and after post-deployment (Litz et al., 2009; Williams & Berenbaum, 2019). It is necessary to address the underlying moral injuries experienced by veterans and ADM who received a diagnosis of PTSD post 9/11 returning from OEF or OIF wars (Koening et al., 2019).

Literature expands on the mental and physical implications of PMIEs, which caused military combat soldiers and combat veterans to struggle with internal conflicts related to moral beliefs and expectations (Molendijk, 2018). Therefore, the most appropriate interventions and treatments are critical for combat veterans' physical and mental health, specifically for Christian U.S. Army female combat veterans who received a PTSD diagnosis and experienced a MI of war.

Interventions to Treat Moral Injury

Most studies regarding interventions and treatments for military combat veterans have focused on PTSD and males who served in the Iraqi or Afghanistan wars post- 9/11. Bormann, Thorp, & Golshan (2008) articulated in their research that limited investigations regarding spiritual-based approaches for managing PTSD symptoms among combat veterans are available. Bormann et al. (2008) advocated why spiritually-based interventions (holistic therapies) warrant positive treatment plans to aid Iraq and Afghanistan combat soldiers and veterans exposed to war-zone trauma. The researchers developed a spiritually-based group intervention that integrated teaching strategies using mantra repetition (relaxation response) to support their case (Bormann et al., 2008).

Twenty-nine men of the sample population completed the study, including white, black, Hispanic, and others (Bormann et al., 2008). The inclusion criteria included combat veterans at least 18 years or older, English-literate, Veteran Affairs health care services, and a combat-related PTSD diagnosis (Bormann et al., 2008). The participants served in the Vietnam, Korean, and first Gulf Wars. However, the exclusion criteria of the research included: the presence of psychotic symptoms and severe suicidality (Bormann et al., 2008). Bormann et al. (2008) collected data from preintervention and postintervention assessments.

The Mantra intervention consisted of a 6-week, 90-minute weekly session (Bormann et al., 2008). The therapy strategy included educational lectures on PTSD symptoms and techniques regarding choosing and silently repeating a word with spiritual

associations (Bormann et al., 2008). The researchers concluded that the spiritual intervention proved feasible for veterans who received a PTSD diagnosis after returning from combat deployment (Bormann et al., 2008). The spiritual intervention helped veterans find satisfaction; however, there is a need for additional research regarding symptom improvement (Bormann et al., 2008).

Farnsworth, Drescher, Evans, and Walser (2017) argued PTSD and MI are similar. Still, symptom's function is what distinguishes MI (morally-injurious stressors) from PTSD (threat-based trauma)—understanding the profound difference between the two constructs allowed for the proper diagnosis and treatment of military combat soldiers and veterans experiencing MI. Farnsworth and colleagues (2017) used a functional approach, Acceptance and Commitment Therapy (ACT), an evidence-based behavioral intervention, to treat military-related MI. Using this intervention helped them understand and purposefully examine particular characteristics associated with behavioral and social functioning (Hayes et al., 1996).

There were 49 male participants, and the sampled population included white and Hispanic veterans (Famsworth et al., (2017). Most of the participants had received service-based disability ratings for PTSD, and other diagnoses included depression or substance use disorder (Famsworth et al., 2017). Each male participated in a 6-week, 75-minute session facilitated by three therapists trained in ACT intervention and moral injury (Farnworth et al., 2017). Farnsworth and colleagues (2017) concluded the research

by acknowledging ACT was a feasible functional approach that can conceptualize and treat moral injury experienced by combat veterans of war.

Chaplaincy

Literature acknowledged that "chaplains have the longest institutional memory related to MI issues and have dealt with the associated psychological morbidity since the beginning of armed warfare" (Carey et al., 2016). Some characteristics associated with chaplains are values, ethical principles, and morality (Carey et al., 2016). Their work includes supporting roles in counseling and education and performing rituals and rites of passage (Carey et al., 2016). For decades, chaplains used and continue to use educational services to provide spiritual and leadership support to United States armed services (Carey et al., 2016). This commitment proved beneficial to military branches and local communities (Carey et al., 2016).

During previous research studies, some military personnel and combat veterans admitted they preferred counseling services from chaplains rather than mental health practitioners because of the stigma associated with seeking mental health professional services (Carey et al., 2016). The primary reason was because of confidentiality by chaplaincy (Carey et al., 2016). Schreiber (2015) argued that working alongside and treating combat veterans experiencing MI takes a different skill set. He established his case based on chaplains' ability to "offer words of healing, comfort, and absolution from all bloodletting slaughter of war, to penetrate, cleanse and restore the conscience of the warrior from the battlefield" (Schreiber, 2015, p. 22).

Assessment and screenings showed an increased need for treatment plans to include chaplaincy services as a plan of care, leading to the triage care services between professionals (Carey et al., 2016; Kopacz et al., 2015; Nieuwsma et al., 2013b). Minimal empirical research focuses on the role of clergy, chaplains, and MI regarding the implications of mental health, spiritual distress, and traumatic stress (Carey et al., 2016; Kopacz et al., 2015; Nieuwsma et al., 2013b). Carey et al. (2016) and Kopacz, Ducharme, Ani, & Atlig (2017) advocated against the marginalization of spiritual, pastoral care, or chaplaincy regarding MI care and treatment plans for combat veterans.

Harris et al. (2018) addressed the role of chaplaincy in their research study. The study goals were to test a spiritual-oriented intervention called Building Spiritual Strength (BSS), facilitated by trained chaplains (Harris et al., 2018). Harris et al. (2011) articulated that BSS "is a manualized, spiritually integrated, group counseling intervention designed to reduce symptoms of PTSD by facilitating the resolution of spiritual distress, thus helping individuals make new, more adaptive, and global meanings of traumatic experiences" (p. 421). The chaplains served as group facilitators. The sessions took place in the community and religious settings rather than mental health treatment facilities to minimize the stigma associated with mental health services (Harris et al., 2018).

Three chaplains were trained (Harris et al., 2018). The first chaplain was a white male with a Divinity and Marriage and Family Therapy background (Harris et al., 2018). His spiritual affiliation was the United Church of Christ, and; he served as a chaplain in

the Army Reserve (Harris et al., 2018). Chaplain two of the study was a white female. Her belief was non-denominational Christianity. She was a youth ministry leader and a marriage and family, therapist. The last chaplain was a white male with a degree in Divinity and Psychology (Harris et al., 2018). His faith affiliation was the Evangelical Lutheran Church of America, and he was an Army National Guard Family Life chaplain (Harris et al., 2018).

The study participants attended an 8-hour curriculum training to facilitate BSS and Present Centered Group Therapy (PCGT) (Harris et al., 2018). The BSS training consisted of reading, learning intervention techniques, reviewing videos, and supervised role-playing (Harris et al., 2018). The PCGT 8- hour training involved reading background PTSD information, group therapy strategies, rationale and manualized techniques for PCGT live instruction, and supervised role-playing (Harris et al., 2018). Doctoral-level psychologists conducted all training at religious facilities (Harris et al., 2018). The study outcome demonstrated BSS was a more effective treatment intervention than PCGT (Harris et al., 2018). A need exists for additional research to investigate the implications of incorporating psychospiritual interventions (Harris et al., 2018) to treat traumatic experiences of veterans who receive PTSD diagnosis and who experienced a MI of war.

Summary of the Literature Review

The literature review provided empirical knowledge regarding the physical, spiritual, and mental health concerns of traumatic war-zone exposure experienced by

United States military combat service personnel and veterans returning from OIF, OEF, or OND wars. The review examined critical contexts that support the premise of the proposed research study. The contexts include defining moral injury, exposure to PMIEs and psychological distress, and gender gaps regarding PE and PTSD among veterans. The literature review acknowledged how other research studies expand knowledge by intentionally addressing contexts such as the acts of omission or commission, worldviews, identifying MI or PSTD symptoms, combat exposure regarding women veterans, and spiritual distress. Diverse backgrounds of the literature review included spiritual well-being, spiritual care, the role of chaplaincy, female veterans' health, and interventions and treatments.

Moreover, the review gave in-depth insight regarding the gap in knowledge and justification to further the research regarding the understudied population of Christian United States Army female combat veterans who returned home from the Iraq or Afghanistan wars post – 9/11 who received a PTSD diagnosis experiencing a MI of war. Supporting evidence is lacking to mandate better and gender-specific treatment for this understudied population (Rivera & Johnson, 2014). Therefore, adding to the knowledge of how female soldiers responded to war trauma (OIF, OEF, or OND) and the health care (mental or physical) of female veterans is critical (Rivera & Johnson, 2014).

Chapter 3 of the study detailed how the researcher incorporated a general qualitative design to capture how a PMIE impacted Christian United States Army female combat veterans who returned home from Iraq or Afghanistan wars post – 9/11 who

received a PTSD diagnosis and experienced experiencing a MI of war. This approach allowed the empirical inquiry to explore the real-life events while intentionally retaining the holistic and meaningful characteristics of the experience (Yin, 2015). The research design aided in gathering potential viable data to support the construct validity, confirmability, and reliability regarding the contextual parameters of the stated case conditions (Yin, 2015; Patton, 2015).

Chapter 3: Methodology

Introduction

This study aimed to understand better how PMIEs affect the adjustment experiences of Christian United States Army female combat veterans who returned home from the Iraq or Afghanistan wars post - 9/11 and received a diagnosis of PTSD. Researchers projected by 2030, female veterans will be the fastest-growing among military veterans post - 9/11 (Brunner et al., 2019; Muirhead et al., 2017). This increase is due to the number of female veterans exposed to war-zone trauma (Brunner et al., 2019; Muirhead et al., 2017).

Because limited research is available addressing concerns of this understudied population, PMIE awareness could serve as a means to address risk factors associated with combat war zone exposure (Daphna-Tekoah & Harel-Shalev, 2017; Muirhead et al., 2017). Moreover, PMIE awareness can potentially highlight rising concerns regarding combat women soldiers and women veterans (Daphna-Tekoah & Harel-Shalev, 2017; Muirhead et al., 2017). Nash et al. (2013) observed the phenomenon of MI (internal conflict) continues to evolve rapidly among combat soldiers with PTSD (stress injuries).

In this investigative study, I probed deeper to understand the context of the phenomenon. Doing so provided explanations to fill the gap in knowledge regarding the potential impact of PMIEs experienced or being experienced by Christian U.S. Army female combat veterans who returned home from the Iraq or Afghanistan wars post - 9/11 and received a PTSD diagnosis. The research study framework positioned me to describe

particular learning articulated by a Christian United States Army female combat veteran who received a PTSD diagnosis and has experienced or is experiencing PMIEs. The discovery of adjustment experiences and mental and physical health struggles provided greater insight into the impact of combat zone exposure and the internal strife generated by a moral injury of war experienced by these understudied United States veterans.

Research Design and Rationale

How do PMIEs affect the adjustment experiences of Christian United States Army female combat veterans who returned home from Iraq or Afghanistan wars post - 9/11 and received a PTSD diagnosis? Incorporating a general qualitative study research design was the most appropriate qualitative method to answer the research question (see Merriam, 1998; Stake, 1995, 2006; Yazan, 2015; Yin, 2015). The design captured the impact of PMIEs experienced (experiencing) by a Christian United States Army female combat veteran who received a PTSD diagnosis and served in Afghanistan or Iraqi wars. This platform was suited to explore the subject's human behavior and social interactions studied (Harrison et al., 2017; Yin, 2015). I conducted 90-minute telephone interviews. I asked open-ended questions and made follow-up calls to clarify and discover viable data (Duke University, 2018; Watts, 2011).

A general qualitative research method (Merriam, 1998; Stake, 1995; Yazan, 2015; Yin, 2015; Percy et al., 2015) allowed me to conduct an investigative inquiry by applying a general qualitative study tradition (Harrison et al., 2017; Stake, 1995, 2006; Merriam, 2009; Yin 2015). The study's tradition focused on two constructs: relativist-constructivist

and interpretivist - meaning and understanding (Stake, 1995, 2006). Using this approach helped me focus on the situation (impact of PMIE) from a natural position. I discovered and generated interpretive meanings (understanding) associated with the positive paradigm of the phenomenon (Golafshani 2003). In contrast, quantitative research methods test the hypothesis of the interrelated set of variables (independent/dependent). Therefore, a critical aspect of the research process maximized the quality of the inquiry (Yin, 2015). Ensuring the trustworthiness of the research study throughout the process helped eliminate bias and increased the proposition regarding the social phenomenon (Golafshani, 2003; Yin, 2015).

Role of the Researcher

My role as the researcher was two-fold, participant and observer (Watts, 2011). First, I conducted five in-depth 90-minute telephone interviews using semi-structured open-ended questions to probe and discover descriptive and interpretive descriptions of behaviors caused by PMIEs (see Fusch & Ness, 2015; Kahlke, 2014; Liu, 2016; Simon, 2011; Watts, 2011). Secondly, I listened with interest to the context of the participant's feelings, experiences, and perceptions caused by PMIEs (see Yin, 2009). Bracketing helped me set aside as well as withdraw personal preconceptions and judgments, beliefs, and ideologies to maximize the research experience (Glaser, 1978; 1992; Tufford & Newman, 2010), which allowed the phenomenon to develop naturally (see Grant & Osanloo, 2014; Watts, 2011). For example, I wrote a narrative to describe the procedures used during the methodology, which gave validity to the study (Tufford & Newman,

2010). As the research instrument, a critical aspect of the inquiry was avoiding personal bias, including accusations (manipulating the participant's responses) and prejudice (Roulston & Shelton, 2015). Roulston and Shelton (2015) argued that avoiding assumptions such as foundationalist assumptions will eliminate the researcher's bias in qualitative research. Foundationalist assumptions attempt to answer the research question by establishing justifications using theories of knowledge and the position of one's belief (Roulston & Shelton, 2015). The researcher's role was critical when it came to bias as a threat to trustworthiness (Roulston & Shelton, 2015).

To better manage the researcher's bias, I incorporated reflexivity as a self-reflective accountability tool (Karagiozis, 2018; Patton, 2015; Roulston & Shelton, 2015). Reflexivity positioned me to intentionally think about my thoughts, perceptions, and beliefs regarding the topic of study (Karagiozis, 2018; Patton, 2015; Roulston & Shelton, 2015). The disclosure of self-discover provided a pathway for me to journal my experiences, which gave me a narrative account throughout the research process (Bishop & Shepard, 2011; Creswell & Miller, 2000; Engward & Davis, 2015; Karagiozis, 2018).

I maintained the study's integrity by incorporating four criteria: creditability, transferability, dependability, and confirmability (see Lincoln & Guba, 1985). This investigative standard demonstrates how the collected data supports the research findings regarding the researcher's position. I maintained an ethical position throughout the inquiry process and respected the rights and disclosures of the participant (see Watts, 2011). As the researcher, it was essential to consider ethical issues, including privacy,

confidentiality, transparency, and communication (see Kuper, Lingard, & Levinson, 2008).

Also, I integrated five foundational principles to ensure the integrity of the research study. I minimized the risk of harm, obtained informed consent, protected confidentiality, avoided deceptive practices, and allowed participant (s) to withdraw from the study (Laerd Dissertation, 2012). It was critical for the researcher not to transfer the study's outcome to fit personal contexts. Reflexivity underpinned my ethical conduct throughout the research process (Watts, 2011).

As the researcher, I acknowledge that I maintained a professional relationship with the research study participants. I adhered to Walden University's Institutional Review Board (IRB) protocol. I minimized the potential influence over the participants as I followed ethical code practices, which gave credibility to the study (Grady & Fauci, 2016). Research participants did not receive any incentive or monetary compensation. The rationale was to recruit volunteers to participate in the study without being coerced by incentives (see Ethics Guidebook, 2019; Sheffield Hallam University, 2015). A critical aspect of the data collection process was that participants answered questions truthfully based on their experiences of PTSD and PMIE (see Ethics Guidebook, 2019; Sheffield Hallam University, 2015). Not giving an incentive avoided controversy regarding compensation (Ethics Guidebook, 2019; Sheffield Hallam University, 2015).

Participant Selection Logic

I recruited Christian United States Army female combat veterans who returned home from Iraq and Afghanistan wars post – 9/11. These female veterans were diagnosed with PTSD and knew MI. Their perspective on how PMIEs affected them added to the richness of the data collected (Liu, 2016; Palinkas et al., 2015; Thomas, 2006). This nonprobability strategy created the possibility of exploring purposeful random sampling characteristics that allowed the researcher to validate the participant's selection (Martinez-Mesa et al., 2016; Patton, 2015). I solicited participants from the women veterans support groups and churches. The purposeful random sampling included five female veterans who met the criteria (Babbie, 2015; Ghaljaie et al., 2017; Ravitch & Carl, 2016).

It was essential to identify and recruit individuals who met the criteria and could answer the research question. I recruited and selected participants who qualified based on the established inclusion criteria. The selection inclusion criteria helped the researcher identify potential subjects to participate in the research study (Velasco, 2012). Ethical principles and methodological standards guided the inclusion criteria (Velasco, 2012; Watts, 2011). According to Velasco (2012), "inclusion criteria must be selected carefully based on a review of the literature, in-depth knowledge of the theoretical framework, and the feasibility and logistic applicability of the criteria" (p. 2). The inclusion criteria included specific qualifications. They are United States Army veterans, deployed to Iraq or Afghanistan (at least 12 - 18 months), female, Christian (self-described), combat

exposure, has received PTSD diagnosis, and has experienced or are experiencing PMIEs post-9/11, and have access to a pastor or counselor (without needing to seek one). Three exclusion criteria included - male veterans, veterans of other military war zones, and veterans of other countries who received a PTSD diagnosis and have experienced PMIEs. The participants followed the established and required guidelines of Walden University's Independent Review Board. The recruiting phase of data collection included:

- An invitation to participate.
- The Independent Review Board Electronic Informed Consent form.

90-minute telephone interviews that were audio-recorded and transcribed by REV.com. The participants were adults and not a part of a protected population (children, prisoners, residents of any facility, or mentally or emotionally disabled individuals) (Laureate Education, n.d.).

Snowball sampling served as an approach for the researcher to recruit and interview referrals who met the criteria (Babbie, 2015; Ghaljaie et al., 2017; Ravitch & Carl, 2016). This approach captured the essence of the experiences of the target population of persons who received a PTSD diagnosis and who experienced or are experiencing a potentially morally injurious event (impact). Patton (2015) argued that small samples of random sampling could increase the credibility of the collected and presented data.

This general qualitative study purposefully focused on reporting the individual’s subjective beliefs, attitudes, or experiences (Percy et al., 2015). When the research

question is focused-specific, and the data collection is purposeful, saturation will occur faster (Fusch & Ness, 2015; Sargeant, 2012; Simon, 2011; Suri, 2011). In other words, I reached saturation when additional interviews did not produce any new concepts or themes (Sargeant, 2012). I understood it is not just about exhausting the resources but gaining the depth of the data that is rich (quality) and thick (quantity) and is contingent upon the sample size (Fusch & Ness, 2015). Qualitative research authors such as Morse, Bernard, Creswell, Guest, Bunce, and Johnson (see Mason, 2010) suggested specific factors determine the appropriate sampling size in qualitative studies. In 2006, Guest et al. conducted a qualitative research study on reproductive health care in Africa. The researchers interviewed 60 women and reached data saturation by the sixth interview. The findings concluded studies with a high level of homogeneity among the target population permitted the development of themes and practical interpretations (by the 12th interview) (see Mason, 2010).

Instrumentation

As the researcher, I was the primary instrument who conducted five in-depth 90-minute telephone interviews. Simon (2011), Seidman (2012), and Jacob and Furgerson (2012) acknowledged in-depth interviews (IDI) provide a more engaging way to collect data. Incorporating IDI, I heard first-hand the stories of the individual, which allowed for investigating and analyzing meaning and themes. However, narrative interviews focused on the participant summarizing their experience of a particular event (phenomena) and telling that story to the researcher (IB Psychology, 2018; Jovchelovitch & Bauer, 2000). I

developed open-ended interview questions (see Appendix A). These questions emerged from the research question, scholarly literature, experiences, unanswered questions, and the need to provide probing questions that allow the participant the opportunity to give more details (Jacob & Furgerson, 2012; Maguen & Litz, 2012). Harvard Sociology (n.d.) suggested that asking one question at a time is best, and then using a probing question that invites the respondent to give additional details (see also Jacob & Furgerson, 2012).

During the interview phase, I used research tools such as the interview protocol guide and an audio-recorder to ensure I accurately captured the essence of the participant's perspective and experiences (Jacob & Furgerson, 2012). Using the interview guide aided me in starting the process with a fundamental open-ended question such as - *tell me about yourself* which allowed the participant the opportunity to answer a straightforward question while providing detailed information (Jacob & Furgerson, 2012 (see Appendix A)

I used MAXQDA, a software designed for qualitative and mixed methods research, to organize and code transcribed interviews (MAXQDA, 2019). Researchers in more than 150 countries and renowned universities have used this comprehensive software for approximately 30 years (MAXQDA, 2019). MAXQDA's visual tools allowed me to see the progression of the research from - data transcription to data analysis (MAXQDA, 2019). The software Code Matrix Browser aided me in coding the text appropriately, which enriched the analysis with evidence and plausibility (MAXQDA, 2019).

Data Collection

I used purposeful sampling to recruit participants and collect raw data (Babbie, 2015; Ghaljaie et al., 2017; Ravitch & Carl, 2016). This technique is often used for exploratory purposes, revealing part of the inquiry (Babbie, 2015; Ghaljaie et al., 2017; Ravitch & Carl, 2016). The screening and recruitment process involved internet posting of flyers on military social media platforms and email Listserv (women organizations and churches). All screening information collected was kept confidential and secured (UCLA Office of the Human Research Protection Program, 2019).

I used a telephone script to conduct initial screening calls (UCLA Office of the Human Research Protection Program, 2019). The screening guide included my name and telephone number as the person conducting the study. The script referenced Walden University as well as described interview questions. The screening template informed potential participants of the approximate length of the interview; and the question asking if the individual wanted to participate or not in the study (UCLA Office of the Human Research Protection Program, 2019). I included a statement on the electronic consent form asking the participant to consent to a 30-minute post interview call if needed to verify or clarify their response. The script included the IRB telephone number if potential participants had questions regarding their right to participate in the study (UCLA Office of the Human Research Protection Program, 2019). I received IRB approval regarding the informed electronic consent (Walden University, 2019).

After the screening process, I scheduled interviews with participants who met the study's criteria. Participants participated in an in-depth 90-minute telephone interview, answering semi-structured open-ended questions (Duke University, 2018; Jacob & Furgerson, 2012; Maguen & Litz, 2012). The interview took place in a quiet setting with minimal noise and distractions (Patton, 2015; Rubin & Rubin, 2012). Novick (2008) argued that telephone interviews are often secondary in qualitative research to face-to-face interviews. Although telephone interviews minimize the cost and travel, this method's risk included losing data regarding contextual and verbal clues (Novick, 2008). An obligation existed to maintain the confidentiality and anonymity of the participant unless there was a threat to another person and the researcher considered removing the participant from the study (ASA Ethics, 2014).

Interviewing as a data collection method allowed me to conduct an in-depth investigation regarding the real-life context of the contemporary phenomenon of PMIEs (Patton, 2015; Yin, 2014; 2009). The general qualitative study described the personal perspectives of what is or what has happened and promoted the data validation and holistic coherence of the empirical inquiry (Yazan, 2015; Percy et al., 2015). Seidman (2012) acknowledged storytelling reflects the individual’s consciousness that gives access to complexities associated with social and educational issues, thus, offering descriptions and explanations. I audio-record the interviews, and Rev.com transcribed (verbatim) them. This process demonstrated the transparency of the study (Duke

University, 2018). I informed the participants of the protocol for reporting data and that I would send them a summary of the results.

Data Analysis Plan

A general qualitative study concept provided a suitable context for the research study (see Simon, 2011; Thomas, 2003; Percy et al., 2015). This inductive analysis better positioned the researcher to analyze, organize, search for patterns, and synthesize data (Simon, 2011; Thomas, 2003). Social science researchers often use inductive analysis (Simon, 2011; Thomas, 2003). The raw data (rich) collected answered the research question: How does PMIEs affect the adjustment experiences of Christian U.S. Army female combat veterans who returned home from the Iraq or Afghanistan wars post – 9/11 who received a PTSD diagnosis? Thomas (2003) acknowledged at least five possible vital features of coding. The first three include a label for category (word or short phrase); description of the category (meaning or characteristics); and text or data category (meanings, associations, or perspectives) (Thomas, 2003). The last two are links (relationship with other categories); and the type of model with the category embedded (model, theory, or framework (Thomas, 2003). I used MAXQDA to code the raw text, which helped me strategically interpret the experiences, ideas, concepts, relationships, and meanings collected from the interview (see MAXQDA, 2019; Ravitch & Carl, 2016; Rubin & Rubin, 2012; Saldaña, 2016).

During the data analysis process, I remained trustworthy with respondents when listening to their perspectives from a spoken word to a written word (Sutton & Austin,

2015). The verbatim transcripts captured the interaction during the interview experience (Sutton & Austin, 2015). Transcription in qualitative research aids in interpreting data which allows the interviewer (researcher) to read, analyze and interpret the text that is precise, concise, and easily understood (Davidson, 2009; Sutton & Austin, 2015). I avoided concluding the qualitative analysis, which prevented questions regarding the trustworthiness of the research (Davidson, 2009). As the interviewer, I took notes during the interview to not leave out critical pieces of information shared. Word-for-word transcription proved more reliable when listening and interpreting what the respondent said (Davidson, 2009; Rubin & Rubin, 2012; Sutton & Austin, 2015)

Issues of Trustworthiness

Nowell, Norris, White, and Moules (2017) acknowledged that for a research study to be trustworthy, the data analysis conducted must demonstrate the credibility *o*f the research process to the reader. The research process of this inquiry showed a thorough and methodical approach that yielded meaning and valuable results regarding the phenomenon (Nowell et al., 2017). Lincoln and Guba (1985) articulated five domains of trustworthiness that establish the criteria for good and valuable research, which is deemed incentives3necessary for the stakeholder. The domains are creditability, transferability, dependability, confirmability, and audit trails (Lincoln & Guba, 1985). These five domains validated independent replication, comparison of previous findings, triangulation, participant feedback, and observations from other researchers who expanded the knowledge (Thomas, 2003).

Lincoln and Guba (1985) acknowledged how the *creditability* of a qualitative research study is determined. They believed that the credibility of the research happens when the reader and other researchers can identify research strategies such as persistent observation, data collection triangulation, prolonged contact and researcher triangulation, and reflexivity (Lincoln and Guba (1985). They advocated that creditability establishes through member checking, which allows for the testing of the findings and interpretations with the study participants (Lincoln & Guba, 1985). Creditability emerged from the data quality, ensuring the research results are accurate (Carter, Bryant-Lukosius, DiCenso Blythe, & Neville, 2014; Shenton, 2004; Thomas, 2003).

The data analysis showed how the *transferability* of the research could be transferred and compared with other contexts and settings (Lincoln & Guba, 1985). An essential component of the process is that the researcher gives readers detailed descriptions of the research situation and methods (Nowell et al., 2017; Shenton, 2003; Thomas, 2003). The person reading the data generalizes the degree of transferability (Shenton, 2004).

Lincoln and Guba (1985) stated the research establishes *dependability* when details of the process are analyzed. The information collected for this inquiry was consistent, credible to repeat, and documented (Nowell et al., 2017; Shenton, 2004; Tobin & Begley, 2004). The dependability of the analysis allowed the researcher to understand the scope of the data, methods, and effectiveness (Shenton, 2004). This particular domain opened the door for the researcher to use the reported data and build on it for further

discussions (Shenton, 2004; Thomas, 2003). For example, the audit trail is essential because it enables the reader to review each research process step, including decisions and methodology (Shenton. 2004).

The researcher established *confirmability* when the inquiry demonstrated creditability, transferability, and dependability (Lincoln & Guba, 1985). Confirmability is the process that questions how the collected information supports the research findings regarding the researcher's position (Nowell et al., 2017; Shenton, 2004; Tobin & Begley, 2004). It was critical to the outcome of the study that I (the researcher) remained unbiased to allow the phenomenon (impact of PMIEs) to develop naturally (Ravitch & Carl, 2016). Reflexibility was an essential component of the audit trail that enabled the researcher to document the logistics of the research process, which included methodological decisions, personal reflections (values), and discovered insights about self (Lincoln & Guba, 1985; Tobin & Begley, 2004).

To be transparent with stakeholders regarding the findings of the research, I used a research journal (audit trail) to illustrate and describe the participant’s responses, narratives accurately, and themes collected during the interviewing process (Carcary, 2009; Lincoln & Guba, 1985; Tobin & Begley, 2004). I uploaded the raw text into a table, which showed the analytical (decisions and tracking of those decisions, data analysis, activities) and followed a logical and strategic path solely dependent on the responses of the participant (Carcary, 2009; Lincoln & Guba, 1985; Tobin & Begley, 2004).

Ethical Procedures

As the research instrument, I considered ethical concerns such as privacy, confidentiality, transparency, and communication (Kuper, Lingard, & Levinson, 2008). To ensure the study's integrity, I: (a) minimized the risk of harm; (b) obtained a verbal informed consent; (c) protected confidentiality; (d) avoided deceptive practices; and (e) allowed participant (s) to withdraw from the study at any point (Laerd Dissertation, 2012). I understood the implications and ramifications if I elected to transfer the study's outcome to fit my context (Kuper et al., 2008). I informed participants that participating in the study was voluntary and there was no compensation.

I know there are different types of harm when a participant participates in a research study. This type of detriment includes psychological harm, physical harm, legal harm, social harm, and economic harm (National Institutes of Health, 2018). I incorporated a statement on the electronic consent form that participants need to be of legal age (aged $\geq$18 years) and capable of choosing whether to participate in the study (Nijhawan et al., 2013). As the researcher, I maintained my obligation of confidentiality to the participant, and the participants communicated no threats of harm. (ASA Ethics, 2014). Before each interview, I provided a list of counseling resources. Providing the list was essential if sharing triggered an unpleasant memory during or post interview.

Rubin and Rubin (2012) articulated that when a researcher learns something illegal or potentially harmful during the interview unrelated to the topic of study, that information can become problematic, especially if the researcher notified the authorities.

Reported information can ruin the research study, which indicates to the respondent that the researcher is not reliable (Rubin & Rubin, 2012). For that stated reason, I informed the participants of the disadvantages of sharing illegal or harmful information, which forfeits confidentiality (Rubin & Rubin, 2012). I adhered to Walden University's ethics guidelines and completed the Institutional Review Board (IRB) application. I received IRB approval to conduct the study: 04-09-21-0721098.

Summary

Chapter 3 provided a pathway to understanding the phenomenon (impact of PMIEs) experienced by the target population post - 9/11. The rationale for the research design validated this method and answered the research question, which added knowledge and helped fill the literature gap. The suggested methodology explicitly outlined the processes and procedures of the research study, inclusive of the role of the researcher, participant selection, data collection instrument, data analysis plan, issues of trustworthiness, and ethical considerations. Chapter 4 provided a detailed analysis of the data collected and describes the interpretations of meaning from the participants' perspectives.

Chapter 4: Data Collection and Analysis

Introduction

The risk factors associated with the exposure of combat positions in war zones continue to be a rising concern regarding active-duty female soldiers and female veterans (Daphna-Tekoah & Harel-Shalev, 2017; Muirhead et al., 2017). Some of these female soldiers faced or continue to face posttraumatic stressors, as well as moral injuries of war caused by OEF and OIF wars (Battles et al., 2018; Donoho et al., 2017; Ferrell et al., 2017; Street et al., 2009). Female veterans are more likely to experience greater levels of PTSD compared with male veterans. Therefore, female-specific care and rehabilitation are needed to adequately support this population (Haun et al., 2016).

This generic qualitative study aimed to investigate how PMIEs affected this target population. The research question that guided the study was the following: How do PMIEs affect the adjustment experiences of Christian, U.S. Army, female combat veterans who returned home from the Iraq or Afghanistan wars post -9/11, who received a diagnosis of PTSD? This chapter includes a description and summary of analyzed data from the sampled population.

Setting

Each open-ended interview was conducted over the telephone. The participant and I agreed upon a mutual quiet setting where she could freely share her story without interruptions and distractions. The setting was conducive for probing. This made it easy to gather information rapidly and to audio record with minimal background noise. Most

of the interviews were conducted within the 90 minutes as stated in the electronic consent form. I completed five interviews before reaching data saturation. The data collected are further discussed in the results section.

Demographics

Purposeful sampling was the selected method to recruit participants of the target population (see Ravitch & Carl, 2016; Rudestam & Newton, 2015). This nonprobability recruitment technique proved effective, even though it could be subject to bias and error. This sampling provided a pathway for recruited participants of the study to refer to those who met the criteria without violating the individual's privacy. For example, each participant of the study shared the following characteristics: U.S. Army female veteran, deployed to Iraq or Afghanistan post 9/11, Christian (self-described), combat zone exposure, received a PTSD diagnosis, experienced or experiencing a moral injury of war, already sought treatment for PMIE and have access to a counselor or pastor. I replaced names with unique identifiers (e.g., V1, V2, V3) to ensure confidentiality in data and reporting. See Table 1 for participant demographics relating to the study sample.

Table 1

Participant Demographics

Participant	Sex	Marital Status	PTSD Diagnosis	Education
V1	Female	Married (divorcing)	2012	College
V2	Female	Married	2015	College
V3	Female	Divorced	2021	College
V4	Female	Single	2016	College
V5	Female	Single (engaged)	2011	College

Data Collection

Initially, the goal was to interview between six to12 potential participants who met the screening criteria. I reached data saturation by the fifth interview (see Boyd, 2011; Creswell, 1998; Dworkin, 2012; Fusch & Ness, 2015; Sargeant, 2012; Simon, 2011; Suri, 2011). I worked to identify codes, categories, and themes. The interviews were audio-recorded and transcribed verbatim. Open-ended interviews allowed me to probe the real-life context of the contemporary phenomenon of PMIEs. The individual stories shared during the interview showed an interrelatedness of spirituality, PMIEs, and the soldiers' mental and physical health before, during, and after war-zone deployment. The interviews naturally captured the inner perspectives about what is happening or what has happened within the context that yields to the phenomenon the study sought to describe (see Flyvbjerg, 2006; Patton, 2015; Yin, 2014; 2009).

Initial interviews varied in length from 60 to 120 minutes. However, I made follow-up calls with two participants to verify some of the responses about adjustment

experiences and PTSD diagnosis dates. Although I conducted interviews via telephone, the participant and I agreed upon a quiet setting, with minimal noise and distractions. I used notes, transcripts, and an audio recorder to capture the rich data during the collection phase.

I encountered several challenges when recruiting potential participants to participate in the study. For example, I scheduled telephone interviews with potential participants who met the screening criteria, but three elected not to complete the interviewing process. I would follow up to reschedule with a call or email. The second challenge I encountered was dealing with individuals who agreed to be a point of contact to post my invitational flyer on their social media platforms. They did not carry out the request. The third challenge was Covid-19 restrictions and Independent Review Board's guidance; I transitioned from face-to-face interviews to telephone interviews.

Data Analysis

After each in-depth telephone interview, I sent the audio-recorded data to Rev.com via an encrypted file for transcription services. Subsequently, I uploaded the transcripts into a MAXQDA document and code system platform. I labeled codes within the work platform using words or phrases that represented the recurring themes and descriptions from the respondents' perception and their connections (see Liu, 2016; Ravitch & Carl, 2016; Rubin & Rubin, 2012; Saldaña, 2016; Thomas, 2006).

The initial phase of inductive coding was too detailed, warranting reorganization and recoding. It was critical to identify broader codes that described the context extracted

from the data that would help me answer the research question specifically. Once I reorganized and recoded the words and phrases, I established the categories. Line-by-line coding allowed me to review the data further and assign additional codes to each line that captured rich and specific text (meaning or characteristics). Once I completed this process, I identified themes within the data set (see Thomas, 2003). I drew meaning from the codes, categorization, and themes that produced the narrative for answering the research question regarding meanings, associations, and perspectives.

I identified and labeled 19 inductive codes. These codes were specific as they recurred in all five interviews conducted. For example, the codes described excerpts of text that reflected the following: trauma and experiences, trust/betrayal, erratic behaviors, being Christian, moral injury, coping, triggers, re-entry into society, confidential support, making right choices, military chaplains, Veteran Affairs experiences, mental health, spiritual leaders, internal conflict, stress injuries, and exercise.

Eight categories emerged from the list of codes, which produced descriptions of meaning and characteristics. For instance, some categories included the following: coping tactics, faith/spirituality/practices (prayer, Scripture, godly counsel), moral injury, moral code of conduct, gender-specific assessments/treatments, war zone experienced mental health/spiritual practitioners, physical/mental health outcomes, and a safe place for sharing.

Each of the six themes emerged after I grouped the coding and categorization data. See Table 2 for descriptive labels and related content.

Table 2

Data Coding

Code	Category	Theme
Christian/believer	Coping Tactics **Grouping**: Coping Exercise	1. Internal conflict leads to emotional distress and doubt in decision making. Paralyzed and overwhelmed by the weight of decisions.
Combat zone trauma/experiences	Faith/Spirituality/Practices (prayer, Scripture, godly counsel) **Grouping**: Christian/believer Shattered faith	2. Long-term combat and operational stress injuries prompt both mental and physical health outcomes.
Erratic behaviors	Moral Injury **Grouping**: Moral injury Re-entry into society Internal conflict Stress injuries	3. Adjustment experiences validating the integration of positive coping strategies Female veterans integrating positive coping strategies to maintain focus, balance, and control.
Trust/betrayal	Moral Code of Conduct **Grouping**: Trust/betrayal Doing what's right - choices	4. Internal struggles generated by a moral injury of war. Combat zone experiences can create challenges when transitioning back to civilian life.

Moral injury	Gender-specific Assessments/Treatments	5.Relying on Christian principles and practices to resolve a moral injury of war
	Grouping:	
	VA experiences	
Re-entry into society	War Zone Experienced Mental Health Practitioners/Spiritual Leaders	6. A safe place to share/talk/and be heard is still needed
	Grouping:	
	Support – mental health practitioners	
	Support – military chaplains	
	Support – church/spiritual leaders	
Coping	Physical and Mental Health Outcomes	
	Groupings:	
	Erratic behaviors	
Confidential support	Triggers	
Doing what's right - choices	Safe place	
	Groupings:	
	Confidential support	
Support – mental health practitioners		
Support – military chaplains		
Support – church/spiritual leaders		
VA experiences		
Internal conflict		
Stress injuries		
Shattered faith		
Exercise		

Evidence of Trustworthiness

The data analysis conducted in this qualitative study demonstrates the credibility of the research process (see Nowell et al., 2017). The process showed a

methodical approach that yielded meaning and valuable results about the phenomenon (Nowell et al., 2017). I interviewed participants who were knowledgeable of PMIEs and shared their interpretations, beliefs, and perspectives. As a result of the participants sharing their adjustment experiences triggered by a moral injury, I was able to identify and extract from transcribed data themes that answered the research question. The reader can use the audit trail to review the research process, including decisions and methodology (Shenton, 2004).

The reader reviewing the findings described in the data analysis can see how the codes and categories grouped produced a narrative that can potentially be transferred and compared with other contexts and settings (Lincoln & Guba, 1985). The detailed descriptions stated in the analysis give readers a more profound insight into the research situation and methods (Nowell et al., 2017; Shenton, 2004; Thomas, 2003). *T*ransferability happened when themes identified about the adjustment experiences triggered by moral injury can be compared with other contexts and settings.

The data in this study build on dependability, which ensures the information is consistent, credible to repeat, and documented (Nowell et al., 2017; Shenton, 2004; Tobin & Begley, 2004). The extracted data showed recurring perspectives and themes about moral injury and coping tactics. The reader can review the audit trail for detailed and strategic steps regarding the data analysis process, including recruiting potential participants, challenges, and research results.

The confirmability of the analysis process showed how the collected data supports the research findings regarding the researcher's position (Nowell et al., 2017; Shenton, 2004; Tobin & Begley, 2004). Throughout the data analysis process, it was necessary to remain unbiased to allow the phenomenon (impact of PMIEs) to develop naturally (see Ravitch & Carl, 2016). During this phase of the research, I reflected, took notes, and thought about the female veterans' shared experiences/challenges while remaining unbiased. I was able to write the research narrative solely based on raw and rich data collected during the interview process.

Results

Theme 1: Internal Conflict Leads To Emotional Distress And Doubt In Decision-Making

It is necessary to better understand the context of internal conflict by viewing it through the lens of cognitive dissonance. Cognitive dissonance is a term that describes a psychologically uncomfortable state that occurs when there is a developing consequence of contrasting cognitions - having two or more inconsistent attitudes, beliefs, or thoughts in the human mind (Festinger, 1957): the acts of omission and commission (Litz et al., 2009). Disharmony is a direct result when a new condition and a previously held belief create contradictions in the mind – cognitive dissonance (Festinger, 1957). Individuals who experience this internal conflict of inconsistencies regarding beliefs, thoughts, and attitudes are psychologically uncomfortable. They struggle to find ways to reduce the cognitive dissonance to regain a state of consonance (Festinger, 1957). Therefore, internal

conflict is the experience of having contradicting psychological impulses, feelings, or beliefs.

It was essential to gain a perspective on how this population dealt with internal conflict relating to appropriate human conduct. V5 stated that she experienced internal conflict when she had to decide how to treat a prisoner of war like he was a human being.

> It felt horrible and it felt extremely conflicting. I don't think that there could have been any repercussion that would've held me back from being a decent human being to him, because I felt strongly that that's what God would've wanted me to do in that moment is to show compassion for even the enemy. It was very conflicting because my job required me to be cold and ruthless, but I just didn't have it in me. It was very conflicting to feel that I had to choose between my job and being a decent human being to someone.

Emotional distress is often an experience when a person feels overwhelmed and helpless, and who has difficulty thinking or remembering or has feelings of guilt without a clear cause. V2's adjustment experiences confirmed how internal conflict led to her emotional distress and doubt in decision making when two cognitions contradicted each other – presenting the military as a great opportunity and witnessing the death of former students in combat. When asked to share her story, she responded, “I don't take a critical tongue to anyone or anything but tell the truth about my experiences” (V2). She shared a particular story stating, “I went to war, and I took six of my students with me, and I lost two. I introduced them to the service in the 11th grade. And they were early, commitments”

Paralyzed and overwhelmed by the weight of her decision, she “did carry a failed sense of commitment” (V2). She voiced,

> I had to grapple with that, particularly, for those soldiers that I'm responsible for. I suggested to them, and made a case for this being a- a great opportunity for them. And they walked into the opportunity for them. I made a commitment to those kids. And so, I felt personally responsible. One of these kids lost their mind. And so now, I'm less likely to recommend any of these services. I really just let people come up of their own decisions. If you have a faith stance, you should put that in the equation.

Theme 1 is a lens to view how PMIEs affected the adjustment experiences of Christian, United States Army female combat veterans who had to find ways or are still trying to deal with internal conflict triggered by a moral injury of war. Participants of the study stated the following: “I still think about it” (V2) and “I feel conflict regularly, and I am unable to put myself in situations where I have to face this conflict again. I don’t want to put myself in a situation again where I have to choose” (V5). Those combat soldiers who experienced a conflict between the impulses toward aggression and compassion generated by war-zone exposure can lead to an identity crisis of significant proportions, which can be emotionally destabilizing and potentially life-threatening (Matsakis, 2007). Schwartz (2016) acknowledged how the result of indecision can become debilitating when making significant decisions that directly impact the lives of others. Therefore, for

the safety of the soldier and other soldiers, indecisions have no place in the combat zone – a costly action (Matsakis, 2007).

Theme 2: Long-Term Combat And Operational Stress Injuries Prompt Mental And Physical Health Outcomes

It is necessary to consider how these injuries are subtle physical changes in the brain (Zero to Three, 2016). These injuries are experienced by veterans when stress is too intense or last too long. As a result, the brain cannot “handle and adapt stress, sights, sounds, movements, and memories” (Zero to Three, 2016). *The Department of Defense Dictionary of Military and Associated Terms* (2001) defined combat and operational stress as

> The expected and predictable emotional, intellectual, physical, and/or behavioral reactions of Service members who have been exposed to stressful events in war or military operations other than war. Combat stress reactions vary in quality and severity as a function of operational conditions, such as intensity, duration, rules of engagement, leadership, effective communication, unit morale, unit cohesion, and perceived importance of the mission (JP 4-02).

In combat duty, regardless of the individual's military occupational specialty (MOS), the work performed involves physical stress that can potentially have lifelong psychological and physical consequences (Matsakis, 2007).

Understanding how this population adjusted in the warzone even though their MOS was different was essential. V3 shared that she was deployed to the war zone even

though her MOS was a paralegal. V4 stated, "I served as an Army engineer, then transitioned to HR. V3 claimed, "On active duty, you are a soldier, regardless of your job, especially in the Army. Unless you're an actual lawyer, a doctor, or a chaplain or a nurse, you know, everyone is trained to understand that they are a solider first." She reflected on how her "job description became different - making claims for a war-torn country" and "assessing whether our engaging this country caused this damage" (V3). Also, V3 described the mental stress she experienced when determining who was responsible (the military or the enemy) for what she had witnessed in terms of accidents, blown up buildings, and people dying. She acknowledged, "my eyes were opened, and I became exposed to so much" (V3). V3 remembered asking herself, "Why do I have to do all this?" The participants had no outward evidence of the injury, just the changes in behavior triggered by a traumatic event(s) or the build-up of low-level stress over time.

The unspoken fear is another example of mental stress experienced by this unique population of female veterans deployed to the combat zone. It is essential to consider the meaning of unspoken and fear. V1 stated, "I wasn't happy about being deployed, but I've always known that was part of the job description." V3 stated, "I didn't know anything about war. I didn't know if we were prepared. My leadership didn't look prepared. They look as scared as I was. I can still recollect us getting off the plane, sitting there on a bus, waiting to be transported to our camp; just so much uncertainty." When asked how she would describe her combat zone experience, V3 stated, "you pretty much stayed on edge. An unspoken fear unravels you – lost friends, friends who got shot or almost got shot – so

many instances where that could be the day.” Unspoken fear contributed to the mental stress of this special population.

War zone exposure presented many uncertainties to these Christian, United States Army, female, combat veterans diagnosed with PTSD experiencing a moral injury of war. The reality of the possibility of death trigged unspoken fear, most horrifically both mentally and physically. V3 stated, "One night, we were watching TV, and suddenly, an IED hits the building next door to ours - immediate shock. How close could that have been? That could've easily been me.” V3 articulated the daily question that became so profound: "Will this be the day that I don't come back or that we don't come back?" V4 stated, "I remembered when I first got to Iraq and when they put that flight vest on us, it became real, and I started crying.” Another intense moment shared was, "When we were on those roads, you know, you're in upper armor, suburban, and in full gear - that was like the scariest part for me “expressed V4. V2 acknowledged, “The fragility of life became real when you are on a “peacekeeping mission in Iraq, and your compound is attacked, and a choice had to be made, kill or be killed.”

> Even today, I go back and relive that incident of taking a life. I wasn’t able to leave it there. It took a toll on me, and I relived the experience over and over again for quite some time. I’m at a point in my PTSD routine and medical regimen now that things are where they are. They are in memory, not in recurring memory, not reliving everything – because when I do that, I’m chipping away at my mental stability. And it drains me. You know, whenever I’m mentally drained,

> I'm physically fatigued. (V2) The possibility of death triggered mental stress and anxiety for this special female population serving in the warzone.

This target population experienced physical duress during combat, resulting in combat fatigue and combat exhaustion. Not all physical stresses are life-threatening, yet they "can tax the immune system, thus making soldiers more vulnerable to more serious illnesses on the field or later in life" (Matsakis, 2007, p. 27). In the words of V2, "you are trained to work and operate on minimal hours of sleep. We worked about 18 hours out of 24; tedious, and it was a hustle and bustle environment, and my mentality was to do or die. The reality was we tore our bodies down." V5 stated, "You don't sleep, at least in my position. I didn't eat much. I was exhausted all the time." Sharing her experience, V3 recalled

> The stress level caused me to bleed extensively when I got over there. I had heat rashes. A lot of things going on in my body pushed me to a place I had never been before. There became a period where I wasn't sleeping. I developed a stutter, and I think the antidepressants they gave me caused the stuttering.

Theme 2 supported the argument that a more in-depth study of moral injury, and not just PTSD symptoms, is a consideration when addressing long-term combat and stress injuries that prompt mental and physical health outcomes. It is reasonable to consider the perspective and meaning supported by the whole experience and its impact on the person's body, mind, and spirit (Smith, 2015). Sreenivasan et al. (2014) argued that the accurate meaning of MI could not be fully captured by integrating most psychological

theories and constructs. Therefore, it warrants a closer examination of spiritual anxiety – emptiness and loss of meaning experienced by the soldier (Sreenivasan et al., 2014). This population returned home to find ways to deal with severe physical injuries and psychological health problems. Shattered faith resulted from environmental conditions and the individual experiences encountered while in combat (Blaisure et al., 2016). Even today, the discussion of morally injurious experiences in war remains chiefly unaddressed (Litz et al., 2009).

Theme 3: Adjustment Experiences Validating The Integration Of Positive Coping Strategies

Specific incidents happened to these Christian, United States Army, female, combat veterans diagnosed with PTSD experiencing a MI. Consequently, it was necessary to understand better the theme through the lens of moral injury from the cause of action perspective. Moral injury can be experienced or witnessed within various life scenarios such as "betrayal by leaders, peers, or trusted civilians, failure to uphold one's own moral principles, mistreating the enemy combatants, destroying civilian property; sexual assault; and friendly fire" (Blaisure et al., 2016, p. 172). Too often, officers chose to ignore or cover up the physical and emotional abuse of female soldiers in their units, which meant those in the chain of command supported perpetrators instead of the soldier who reported her assault (Mathers, 2021). V1 stated,

> Another soldier sexually assaulted me in leadership, and no one did anything about it. When reported, nothing happened. My First Sergeant (female) tried to

> give me an article 15. She made sure that everyone in the company knew that I was sexually assaulted. Her actions hurt me to my core. It was like no one cared, and they found a way to turn it around on me. It impacted my life that I lost one husband, pushed people away, and became closed in, an introvert. I didn't trust anyone, not even my own family. I didn't believe that there was a God anymore. And it also crept into my second marriage (sexual relations); currently going through a divorce. It damaged my psyche. Whatever I had going for myself, the moral conflict affected all of that. I had the same offense happened to me when I was 14 years old.

The impact of sexual assault in the military can initiate emotional pain and medical and physical challenges (Matsakis, 2007). To work through her MI experience while deployed, V1 acknowledged, "I did something called shadow work – writing down and documenting my experiences." When I asked how often she did shadow work, she replied,

> It depended on how the day went. If the day went well, I would shadow journal before I went to bed. But if it was a rough day, I would sit down any time and write. I always carried my journal with me. (V1)

V2 acknowledged that her adjustment experiences birthed intentional lifestyle changes because she is combat-injured and lives with the trilogy of unseen combat injuries consisting of cognitive disorder, PTSD, and irreversible traumatic brain injury (TBI). Researchers have recognized TBI as the signature injury for soldiers (22% to 35%)

who served in the Iraq or Afghanistan wars (Blaisure et al., 2016). Veterans from either OIF/OEF wars with TBI and PTSD injuries can potentially experience issues associated with emotion regulation. V2 described three separate incidents she experienced during her combat deployments: (a) she was blown out of a building; her school was bombed, and the impact of the rocket-propelled grenade (RPG) pushed her; (b) she had to avert not to hit an improvised explosive device (IED) and rolled a Humvee; and (c) she was in a building that was bombed and collapsed. She said, “I don’t know which deployment I received the injury. I know that every deployment takes a little bit out of you” (V2). V2 described her life today as "I live differently; I live with a trilogy." She articulated that before her diagnosis, she was acting erratic - saying and doing things and blaming others for her decisions or actions at home, and work. For example, she experienced difficulty driving home from work, broke all the dishes in the house, gave away furniture because she felt as though her family was unappreciative, and became combative. She performed on "speed high" all day and became obsessed with work at the office. She averaged 2-3 hours of sleep nightly." V2 recalled, "In combat, you’re on speed high. It requires you to be on speed high because you'll lose your life if you go low. You've got to be hypervigilant." Subsequently, it took the intervention from her husband to bring awareness that something was wrong and problematic. V2 stated, “I was just unraveling.” Blaisure et al. (2016) acknowledged that when physical and psychological health is compromised, the complexity of maintaining resilience impacts both the personal and family levels.

The lifestyle adjustments became V2's reality after allowing her anger to run its course and after receiving the diagnosis. In the words of V2, "when I received this diagnosis, it was gloom and doom. I was like, 'This can't be. "While sharing this part of her story, V2 admitted that she was adamant about not becoming chemically dependent on pills: "there are things I can do for myself to prolong life and better my health." Initially, she followed a prescribed medical regiment every day. It was January before she started a different prescription cocktail. Subsequently, she took 60 days off work to cleanse mentally and physically, and she prayed and fasted. She instituted her action plan by incorporating a cleaner diet, exercise, stress-relieving hobbies, and a sleep routine. V2 admitted that establishing a sleep routine was problematic because "most folks with PTSD also suffer from insomnia." When I asked her what mechanism, she used to achieve this goal, she replied a sleep journal. She was determined to go through the process by adding music (instrumental/nature sounds), replacing mattress/pillows, stopping the consumption of caffeine before bedtime, and listening to health/wellness motivation speakers whose message was to invest in sleep. Today, she averages at least 6 hours of sleep nightly and has learned how to sleep in late on Saturdays. These adjustments have prompted her to "live a very organized life" (V2).

It is just as important to cross-reference the emotional and physical outcomes with the morally injurious event(s) that occur in war and combat (Blaisure et al., 2016; Litz et al., 2009). Doing so will give descriptive meanings and perceptions regarding the MI

construct. War-zone experiences can significantly impact and lead to an existential crisis, a crisis of meaning (Sreenivasan et al., 2014). V2 stated,

> I had a choice to rely on my training and live another day. Soldiers who are moms -that mom tag keeps you alive because it won't let you second guess. After all, your personal goal is to return to your children whole bodily. I started rationalizing that this was a war. This is what happens in war, some fatalities. Let me make sure I'm not one of them. So, you know, I went through that and then, at the end of the day, I was like, they breached this compound. I didn't go out looking for them. They came looking for us. I said stand down multiple times. They didn't. I said, "Oh, all right. Maybe they had a death wish because they had the opportunity to go a different direction. I'm boxed in, so I had to shoot my way out. The impact of MI events experienced or witnessed during combat resulted in long-term emotional and physical outcomes.

Female soldiers (14%) on operational deployment to either OEF or OIF performed duties in combat zones and were exposed to hostile situations and military attacks (Luxton et al., 2010). In the words of V5, being in the war zone was traumatizing as well as paralyzing. V5 witnessed people doing "atrocious" things, and "it was not even just the people that we were fighting in the war, the things that you see us doing to each other were just as horrendous." For example, V5 cared for an enemy prisoner (monitored his vitals) who tried to blow himself up in a car and was unsuccessful. The prisoner was dying; her unit charged her with the task to keep him alive so that they give him back to

the requesting government. The military police (MP) instructed her not to talk to the prisoner unless it was essential. The prisoner became even more hysterical. He knew death was upon him because he failed to carry out the mission successfully. V5 stated, “I didn't know what else to do but hold his hand.” The level of combat stress created a conflict between moral and ethical beliefs regarding actions taken on the battlefield (Sreenivasan et al., 2014). In the words of V5, being in combat with limited resources, especially for female soldiers, “felt paralyzing – it felt like you had no way out, no way to talk about it, you had to swallow a lot.” V5 acknowledged that she relied on prayer as a tool for her mental health, reminding herself that this deployment was not a permanent situation. The question was now a reality, how does a combat soldier recapture meaning from disturbing war events? (Sreenivasan et al., 2014). Combat stress became one of the realities for this particular population who battled with ethical and moral beliefs.

Theme 3 provided a pathway to further the discussion by integrating the MI lens to understand better the adjustment experiences of this population who had to make lifestyle changes so that they could continue to incorporate coping strategies to maintain focus, balance, and control. Considering a construct such as a syndrome perspective (Jinkerson, 2016) could produce more descriptive meanings regarding MI symptoms. Subject matter experts have concluded “that loss of trust/betrayal, spiritual/existential issues, psychological symptoms, social problems, and self-deprecation were significant moral injury outcomes” (Jinkerson, 2016, p. 124). MI and PTSD share features. However, the primary symptomological differences are that MI does not involve

physiological arousal, and PTSD may not necessarily involve guilt and shame (Jinkerson, 2016). However, the same theaters or events can produce PTSD and moral injury responses – a dual syndrome (Fontana & Rosenheck, 2004; Jinkerson, 2016). Nonetheless, MI is a separate syndrome accompanying military-related PTSD (Koenig, 2017).

Theme 4: Internal Struggles Generated By A Moral Injury Of War

These female combat veterans experienced emotional turbulence (Sreenivasan et al., 2014) due to combat exposure and moral injury. V1 expressed, "she continued to have difficulty controlling her feelings and emotions when she thought about her perpetrator or sees someone chewing and spitting tobacco." As a result of the assault, she could not separate the perpetrator from his race; now, she sees "them all the same and does not want to be around his particular race" (V1). Military sexual trauma (MST) continues to be pervasive among military personnel (Kameg and Fradkin, 2021). Approximately 50% of female soldiers have experienced MST (Kameg and Fradkin, 2021). US female soldiers who served in Iraq and Afghanistan experienced deployment stressors related to sexual assault (Mattock et al., 2012). Long-term effects of a sexual assault can develop over time. Such sexual outcomes included emotional dysregulation, insomnia, disassociation, destructive coping mechanism, and relationship issues (National Veterans Foundation, 2020). The crime of sexual assault is still underreported in both the military and civilian life (Matsakis, 2007). V3 stated,

> I brought home scars from the combat zone. Before going to war, I was already an introvert, and once I came back, I became more… sheltered to the point where it was unhealthy. Internally, I was angry. I was having social issues, and I didn't want to be around anyone. I quit talking and had very few conversations with people; I became very closed off.

When service members identify with a morally injurious event(s), the outcome of the moral injury significantly predicted anger as a symptom (Jinkerson, 2016).

Soldiers needed to suppress their grief, fears, homesickness, self-doubts, and many other emotions on the battlefield. Anger, however, was one of the few emotions they felt to express, and it was often the expression of a wide range of feelings, especially grief and guilt. For many soldiers, anger became a "catch-all" emotion. "For most combat veterans, such feelings are unacceptable in that they undermine the image of soldiers as brave, demanding people who can successfully handle almost any situation" (Matsakis, 2007, p.168). In the words of V5, "I isolated myself because I didn't trust anybody anymore." I didn't associate with many people except my immediate family," stated V5. V4 shared that she struggled with going places, and she didn't like when a person got too close to her. V4 stated,

> I still isolated myself once I retired and had to start working a civilian job; I hadn't worked in 15 years, and I was in a bad slump. I tried to pull myself out. I still grieve my brother's death, who died in 2018, this too was traumatic, and I isolated again.

Theme 4 challenged the politics of combat trauma regarding the narratives and the experiences of potentially traumatic events (PTEs) experienced by this population who understood the perceptions of their realities (Daphna-Tekoah & Harel-Shalev, 2017). Therefore, it would prove beneficial to further the discussion by "engaging with and listening to the diverse narrative of women combatants to contribute to the gendered literature on trauma" (Daphna-Tekoah & Harel-Shalev, 2017, p. 946). V5 stated, "I felt conflict regularly. I had a regular job working at the prison, but I'm no longer able to do that because I cannot put myself in situations where I have to face conflict with another human being. I work from home." These statements of meaning and perception give reason to incorporate a MI construct as a direct pathway to understanding better the challenges experienced when transitioning back to civilian life. The data collected during this study showed that using only PTSD symptoms as the primary source to interpret the meaning for this specific population returning home from the war zone is inadequate. Understanding both MI and potentially morally injurious events of OEF and OIF combat deployments is necessary and needs to be addressed further (Litz et al., 2009; Street et al., 2009; Jinkerson, 2016).

Theme 5: Relying On Christian Principles And Practices To Resolve A Moral Injury Of War

The female veterans interviewed for this study struggled with their Christian faith when trying to make sense of what they once believed before deployment, witnessed, experienced, or participated in during combat. According to the transpersonal-existential

meaning-based model, the outcome of war zone trauma can lead to “loss of existential meaning: disillusionment about the goodness of human nature, and guilt or shame for one’s actions or lack of actions” (Sreenivasan et al., 2014, p. 28). The context behind the conflict potentially stems from two perspectives that now question God’s existence or God’s benevolence (Matsakis, 2007). Perspective one described soldiers who went to war with a firm belief in God, and perspective two described faith established in childhood (Kick & McNitt, 2016; Matsakis, 2007). Some studies have found that many veterans have shown that if they “witnessed or participated in atrocities, the war greatly conflicted with the spiritual or religious values they once held” (Matsakis, 2007, p. 46). The stories of these combat soldiers provided raw and rich data that interpreted their experiences through description and meaning (Yob & Brewer, 2015). The effects of war can potentially push the service member toward faith or to abandon it (Kick & McNitt, 2016). V1 stated,

> Before my assault, I believed in the Creator, and my faith was strong. After the incident, I just forgot about God and His light. I didn’t pray out to Him as I would usually because I felt He could have stopped the situation from happening. So, it shattered my faith a lot. I was angry, and I had to carry this burden on my shoulders and the anger in my heart. It left me faithless – because why would God allow such bad things to happen to people.

Even though she was traumatized by the assault, V1 still valued her personal moral of conduct. She believed in treating people right whether they have done something wrong

to her or not. V1 stated, “When it comes to the foundation of being a Christian, your belief system has to be strong in wanting to do the right thing even in a hostile universe.” This population proved that holding on to faith principles and beliefs was essential for working through moral conflict.

V4 stated she is a Christian and believed being connected to the body of believers is essential. She believes in the Word of God, and its Biblical principles, such as “you reap what you sow.” She stated that she is grounded in servant-leadership and hospitality, which were her grandmother’s teachings. She believes in treating people fairly and wants to experience the same. Also, she believes in being there for people and showing empathy. However, while in the war zone, she struggled with deeply held faith practices. She stated that she would often ask herself: should we have been there? How many soldiers are we losing? According to V4, the war zone impacted her because she spent a lot of time thinking she would die, which caused her to stress about having her affairs in order, especially at home. She was the eldest child, and her mom depended on her. V4 stated,

> I struggled and kept many things inside, which wasn’t necessarily good. We saw many soldiers committing suicide and murder-suicide, and it was hard to decompress the impact of the experience. So, I would try to rely on the Word of God, trying to go back to knowing I have faith so that I didn’t make crazy decisions. In the war zone, it was always this wasn’t right or is this right. I had to make sure that on the outside, I looked like I had it all together when on the

> inside, it wasn't. Sometimes, I just had to let God work it out; He would put people in my path, even though I mistrusted some people. I didn't go to church much in the combat zone, but I had enough tools to help me. I would call home for words of encouragement. I had my Bible and read it. Read spiritual books, and I talked to myself a lot. I prayed, and those things brought me peace and comfort when challenged. I'm feeling the effects of that now that I'm retired and learning how to cope. Now, I'm back in church regularly and standing firm in my beliefs.

This unique population acknowledged how faith proved to be a rooted source for working through MI stressors.

V5 shared that she was in the medical unit working in the level one trauma center, which provided the highest level of trauma care to ill or injured soldiers – military and, in this case, the enemy. She described her work as being traumatizing, which forced her to block things out, almost becoming robotic so that she would not feel emotional. She voiced, "When I was in moral conflict in the warzone, I had to get through it. But once I returned home from work, almost immediately, I unraveled." She relied on the tool of prayer to remind her that this situation she was in was not permanent. However, her moral code of conduct was challenged when she had to care for an enemy base prisoner who tried to blow himself up. She recalled four people in the back of the ambulance, the prisoner, the MP, the interpreter, and herself. While monitoring the prisoner's vitals, she was instructed not to talk to him, who was hysterical and dying. The only thing she knew she could do to soothe and comfort the prisoner was hold his hand. V5 stated,

> I felt like that was the right thing to do. I couldn’t do anything to protect the prisoner. I couldn’t save his life. But at least at a minimum, I could hold his hand and comfort and pray for him. Let him know that a least one person was there that cared about his life, regardless if he tried to kill other soldiers or not. I felt horrible, and it felt highly conflicting. I don’t think there could have been any repercussion that would’ve held me back from being a decent human being to him. I feel strongly that’s what God would’ve wanted me to do at that moment, to show compassion for even the enemy. What was very conflicting was my job required me to be cold and ruthless, but I could not mistreat him in the name of duty.

As a result of her actions, she was reprimanded and written up as unprofessional. Nonetheless, she expressed compassionately, "I would do it again. But it was very conflicting to feel that you have to choose between your job and being a decent human being to someone." She admitted that experiencing this spiritual conflict has strengthened her and made her a better person. V5 stated, "I feel my relationship with God is just that, and it is just mine and God's. I don't feel like I have to explain that to anybody. And I learned to embrace that during my deployment. “These female veterans expressed that being grounded in faith became their weapon to combat MI generated by warzone exposure.

On the other hand, V5's spirituality weakened. She witnessed many people "mistreating other people or doing degrading things to others in the name of

Christianity." She admitted that she struggled with comprehending how anybody would call themselves a Christian yet do horrible things to others. Their actions made her question many things about Christianity and its practices. She added that seeing the cruel things people do to each other in the name of religion has changed her life and perspective. Also, her moral code of conduct encouraged her to provide anybody with basic human decency that will not alter because of what she went through.

Theme 5 supported the argument that a MI construct provides a more specific pathway to understand better how combat soldiers struggling with emptiness and the loss of meaning experience spiritual anxiety (Sreenivasan et al., 2014). It was necessary to interpret the meanings and descriptions of the offenses that violated the soldier’s beliefs about right/wrong and good/evil, which produced moral dissonance (Sreenivasan et al., 2014). Integrating the MI syndrome definition into the discussion gave greater insight into the construct’s dynamic (Jinkerson, 2016) The description stated the essence of MI; it empirically described MI symptoms and tells of the theoretical distinction from PTSD (Jinkerson, 2016). It is important to note,

> While cognitive models (as those traditionally used in Cognitive Behavioral Therapy) can explain distress related to the dissonance (negative self-appraisal, attributions of transgression), they cannot address the emptiness of meaning and the attendant spiritual anxiety associated with the moral injury (Sreenivasan et al., 2014, p. 30). To fully understand the emptiness of meaning, the descriptions and the accounts of the soldier's offenses must be reverenced and not minimized.

Theme 6: A Safe Place To Share, Talk, and be Heard is Still Needed

This theme resonated with conviction from each female veteran interviewed because they articulated a need for personal and genuine care and support in private counseling, the church, and the VA. The context supporting the theme is where these female soldiers can go to be vulnerable and receive adequate resources? V2 stated, “We need a space to step in naked with all of our true/wrong feelings and vulnerabilities exposed; a place to be free.” V3 expressed, "I wasn't even allowed to talk about my experiences in Iraq during my counseling session." She acknowledged that she was not sleeping in Iraq and was experiencing some mental health issues (angry/withdrawn/feelings of going crazy). So, she sought counseling, which did not help her because she did not have adequate time to commit to the sessions because of work duties. The military and its counseling practices pushed meds. They put her on antidepressants, which she believed caused her to start stuttering. After taking the medication, she started feeling suicidal and shared with the doctor that she had not had those feelings before taking the drug. She quit taking the pills at the doctor's advice, who then prescribed Ambien, sleep meds. The sleep meds had her in a "zombie state" as she worked 8 hours daily; she had no idea what was going on around her. For example, her roommate would say to her, "Did you remember so and so came here and you were talking to them?" She had no recollection of the visit or conversation; she stopped taking the pills.

V3 resumed counseling when she reentered civilian life. She recalled a negative experience when she met with her therapist, a Black man, who stated, “You look pretty today.” His statement triggered something in her, and she stopped going to counseling for a long time. She voiced that she was going to counseling to work through some social issues because she was internally angry and felt like a ticking bomb. She admitted that she was feeling this way because she brought scars home. She recalled that from 2004 to 2016, she became her support person to work through her issues. She started going to counseling actively in 2016. She felt like she would have a nervous breakdown because she had no emotional control. She shared that she became emotionally unstable, where she could not have conversations without crying or getting upset. V3 stated, "Things just began to go sideways, and I couldn't pinpoint anything." In 2017, she received a referral to see a mental health practitioner. This practitioner attributed her experiences to PTSD (actually seeing dead bodies or being shot at directly or getting injured). She was not pleased with her diagnosis because she believed she did not fall into any checked categories. She voiced that the practitioner did not diagnose her based on the injuries one cannot see, the invisible scars from the war zone. The MI she was experiencing was never a diagnostic consideration. V3 acknowledged,

> People always talk about having gone to war, but they never talk about those who work behind, who supported the war back here on US soil. I worked in Army Casualty and Mortuary Affairs for three years. I was able to do the job by the

> grace of God. When female soldiers report to counseling, they want their stories heard and want to receive respect as individuals who experienced trauma.

The consensus of the Army female combat veterans interviewed for this study was that every case and war trauma experience are different. Therefore, practitioners need to "Listen more so that they can fully understand with empathy; rather than being judgmental, respect the story of the traumatized female soldier, and protect her" (V1). Another acknowledgment was, "They need to stop checking the boxes because every case is not the same, and what may have triggered one person may not trigger another; be open-minded and care" (V3). Another admission was,

> I needed to see someone who looked like me to understand me and be genuine and authentic. It's not just about black and white; it's about culture. I needed to feel comfortable. It was about diversity, equity, and inclusion. I'm battling therapy; I have not found the right person yet (V4). She needed a therapist who could relate to and experience her concerns from a cultural perspective.

Additionally, the agreement among the female veterans interviewed was there is a need for the VA counselors to serve women veterans better by being intentional regarding the services they provide. For example, V4 expressed,

> My experience was bad with the counselor I went to; she never followed up with me. And, sometimes, when I went to my counseling sessions, I felt like I was rushing against the clock. The counselor never suggested any other resources such as the employee assistance program (EAP).

V2 stated, that the VA should staff competent and humanistic counselors; they needed to revamp their process to include time for people. V3 expressed culture plays a part in counseling, and there was a desire to have a counselor who was "genuine and authentic" and culturally aware. She said she went to a counseling appointment with a female Indian doctor. The doctor told her, "Oh, there's nothing wrong with you because you didn't see death, and you were not in the line of fire, so you'll be fine." And since she did not fit into any of the other categories, the doctor went back to her original diagnosis and said, "you do not have a MI." V5 shared her counseling experience by voicing, I wish the VA would focus on hiring counselors who have experienced war zone trauma who could relate to the challenges associated with the effects of war. It felt a little condescending to try to hear a perspective from somebody who had no idea about the effects of war trauma or appropriate treatments. For instance, I tried to do a treatment called Eye Movement Desensitization and Processing (EMDR) and the VA disagreed with this particular treatment for me. I was like, okay, well, surely there has to be something else. And the answer was, well, this is what’s effective for all veterans. And, I was like, okay, it was not. Well, how about we try and talk it through. It felt like what they were talking about had no relevance to what veterans go through. I believe a person can only read so much about the war in a book, and all war experiences are different. These counselors needed to undergo specialized training with war veterans. Trained health practitioners with warzone exposure

need to come alongside and work with active duty and veterans who experienced combat-generated trauma.

Another experience shared by this unique population is how the VA practitioners are quick to medicate and give the wrong diagnosis. For example, V1 acknowledged,

> Not everyone needed medication. Treat those individuals with meds that needed them, but for those who didn't give them appropriate counseling, a shoulder to cry on, and a word of encouragement to let them know they are the victim and they too can overcome the moral injury.

In the words of V2, "Fought against taking a pill to feel a certain way. I'm not anti-medicine, but I believe there are things I could do to prolong life and to better my health." To adequately serve this special population, healthcare practitioners must make the proper diagnosis and incorporate a treatment plan that addresses these traumatic issues.

The study participants acknowledged the Veteran Affairs could be a safer place if they would incorporate more gender-specific assessments. V5 expressed, "I think the VA was so focused on sexual assault that they completely forgot that women experience things besides sexual assault while in the military; they believed that women are incapable of experiencing war trauma as men do." V5 believed the VA needs to create programs to help other female veterans who have similar stories to hers.

OEF and OIF deployments are a type of insurgency warfare in which there is no front line, and enemy attacks can come in many forms (Street et al., 2009). Combat

exposure rates are lower for women compared to their counterparts. However, they may be experiencing substantial levels of combat exposure (Street et al., 2009). Additional research can further discuss the association between combat exposure and psychological health outcomes for this population deployed to OIF and OEF (Lippa et al., 2015).

When soldiers report to counseling for war trauma, a spiritual assessment is critical to incorporate the appropriate treatments and interventions (Kick & McNitt, 2016). The evaluation should include information about the soldier's spiritual beliefs, religious affiliations, and relationship to God. Literature contends some clients have spiritual expectations when seeing a therapist. Harris et al. (2016) acknowledged some clients' counseling preferences included addressing religion and spirituality issues extensively. However, counselors or practitioners should not coerce their own spiritual beliefs or religious affiliations on the client (Kick & McNitt, 2016).

Shoemaker (2012) concluded how local religious organizations play a significant role in assimilating and reintegrating combat duty soldiers into United States society when returning home from combat deployment. Shoemaker argued that there is a necessity for relational support services provided by religious organizations and affiliations. Kick and McNitt (2016) argued that an informed faith community concerned about the dimensions of the suffering of veterans can become a partner in the transformation of both the veteran and their families. The effects of war trauma can potentially pose a threat and have soldiers questioning their faith and spirituality, leading to mental health issues. Kopacz et al. (2017) suggested that taking a spiritual history as

part of the clinical-therapy process could recognize unmet spiritual and pastoral care (SPC) needs.

The church became a safe place for V5 after she contemplated abortion and suicide. She admitted

> I found out that I was pregnant with my daughter, and I was terrified because I did not want to bring a child into a world like ours, so I thought of an abortion. I felt strongly about killing myself. I didn't want to be a mother. I didn't want to bring a child into a world where you have seen the things I have seen. I have a different understanding of how cruel people can genuinely be to each other; I was so afraid to bring somebody into a world that could endure that. I went as far as making a plan to kill myself. I went to an ultrasound appointment and heard my daughter's heartbeat, then I went to church and fell apart. I couldn't do it. I knew that I needed to get help. I struggled with opening myself back up emotionally or confiding in anybody. The church's role proved significant for this female veteran who dealt with an internal conflict deemed detrimental.

For V2, the church she attended at that time was not a safe place returning home from the war zone. V2 stated, "If people were under your tutelage, give them a space and let them speak about their experiences; don't minimize it." She expressed that the church had no fundamental understanding of postwar trauma and did not know how to recognize it. She recalled a time when a man volunteered to pray for her without understanding her experiences. She asked him, "but what else are you going to do?" The parishioners

around her became uncomfortable; they thought she might have an episode. She expressed hurt by the parishioners' actions when they stopped inviting her to events; "the people of God, no wonder people are not coming to church." She felt that for the church to be effective as a safe place for female veterans to come and share and be vulnerable, spiritual leaders must become equipped by taking courses and learning about PTSD and MI and creating alliances with local mental health facilities. However, "There's so much more to it than that" expressed V2. She believed churches must be willing to position themselves to want to understand the potential effects of war-zone trauma. With firm conviction, V2 expressed that the church must be ready to engage in courageous conversations and get uncomfortable talking about being a Christian in the war zone. She admitted that she stopped talking to her spiritual leaders when she first got her diagnosis.

It is critical to conduct additional research to understand better the impact and effects of mutual protecting roles between congregations and soldiers who deploy and return home with a spiritual crisis (Shoemaker, 2012). V4 stated that if the assembly is full of female veterans, spiritual leaders must understand how to gravitate toward them and be their community; their lives depended on that spiritual connection. V4 stated, "The church cannot be isolated, and I've seen it. We get stuck on ourselves when at the end of the day, the church is there to help people, to bring in the loss, right?" The church can have a more significant impact on helping veterans and active-duty personnel experiencing war trauma. However, churches must invest in PTSD and MI training to better serve this population.

For over 200 years, military chaplains, qualified clergy ordained by their religious denomination or faith group, have provided care and spiritual support services to service members and their families (Blaisure et al., 2016). Chaplains have a role and duty to advise commanders on upholding the free exercise right of religion, unit morale, and ethics. The care and support they provided include spiritual issues, personal challenges, deployment stress, reintegration challenges, and moral and ethical concerns (Blaisure et al., 2016). Chaplains are to guide those seeking care and support to the resources needed and should not leave individuals alone when they or others are at risk (Blaisure et al., 2016).

The Army female veterans of this qualitative study did not have a good experience with military chaplains. These veterans agreed that speaking with a chaplain was not considered a safe place to share and express their stories freely. They experienced mental health issues and sought care and support from their chaplains. V3 stated, "There is a stigma attached to mental health, and there is a stigma attached to being Christian." V1 expressed, "chaplains should be more empathetic toward female soldiers. They should believe and respect their stories of sexual assault, even if they have had more than one partner, and meet clients where they are, a place of shattered faith. V2 suggested that chaplains should "help fellow soldiers who are going through combat exposure crisis." She advocated that when it comes to the role of chaplains, the military needs to amend protocol, policy, and procedures. V2 expressed that when she tried to share her story of wrestling with a moral conflict with the chaplain, she was not free to

speak honestly about her experiences and therefore could not say, “I'm morally conflicted by our military's decision." V2 stated,

> Chaplains were not free to deal with an individual's reflections of struggling with a moral issue because, at that moment, he was no longer a chaplain but rather a person in uniform who could lose his job. As a result, I could only talk about things on the surface, leaving the session with no help or support to help me unravel my moral issue.

Theme 6 advocated for why there is a need for readily available safe places such as counseling, the church, and the Veteran Affairs for women veterans to go to when deployed/return home to share their stories and experiences without judgment. This population expressed a problem throughout the data collection process because there was a lack of concern and empathy for women veterans in a male-dominated occupation called the military. Street et al. (2009) acknowledged it is essential to understand gender-specific issues in the post-employment mental health readjustments of service members who served in Iraq and Afghanistan. The understanding can create a pathway to design and implement gender-specific services to aid the practitioner(s) in making the proper diagnosis and treatment of women veterans experiencing or have experienced MI and PTSD or other war exposure trauma. Women in combat do not receive the respect or demonstration of gratitude for their service in the military. Blaisure et al. (2016) cited how the nation and the Veteran Affairs have been slow to acknowledge women veterans. The VA still struggles to provide the most appropriate, adequate, and accessible services

to women veterans. Also, Blaisure et al. (2016) cited, "approximately 11% of women veterans use VA medical facilities for some or all of their health care, and women veterans account for only about 5% of all users at VA facilities" (p. 226). Some women veterans refuse to use Veteran Affairs service facilities because of the perception that there is partiality for male veterans in the Veteran Affairs system (Blaisure et al., 2016).

Summary

Chapter 4 described the qualitative data analysis process. The process included the audio recording of five participants, which was later transcribed (verbatim). I reviewed each transcript at least three times, which created initial codes. At first, my code list was too broad. I had to narrow down the list to capture the essence of the raw data that would provide text for the narrative. Once I narrowed the list, I combined the codes. I created the categories that produced the themes: the analysis delivered a detailed description, perspective, meaning, and interpretation to answer the research question. Chapter 5 intentionally connected the pieces that answered the research question. The information in this chapter included a summary of the findings, recommendations for research, and a conclusion.

Chapter 5: Summary, Discussion and Recommendation

Introduction

This chapter presented the research findings, conclusions, and recommendations. The general qualitative study aimed to learn how PMIEs, the complex issue, affect the adjustment experiences of Christian U.S. Army female combat veterans who returned home from the Iraq or Afghanistan wars post - 9/11 who received a diagnosis of PTSD. The study focused on the rich data collected via audio-recorded telephone interviews of the stories this unique population described as their emotional interpretations of the adjustments they had to make due to combat exposure.

The adjustment process included learning there was a need to address the MI that disrupted their lives: physical health, psychological comfort, work efficiency, social acceptance (Sharma, 2016), and spirituality (Hodgson & Carey, 2017). The five female veterans interviewed for the study had to incorporate assimilation and accommodation (Sharma, 2016) into the adjustment process to adjust to this new way of life post deployment.

The principal findings of the study captured the adjustments the female combat veterans made or are making. The first theme described how internal conflicts led to emotional distress and doubt in decision making, paralyzing and overwhelming by the weight of decisions. The second theme showed how operational stress injuries prompt mental and physical health outcomes. The third theme accounted for the adjustment experiences that birthed lifestyle changes to cope with maintaining focus, balance, and

control. The fourth theme described other challenges transitioning back to civilian life and the accompanying internal conflicts. The fifth theme recounted how they had to hold on to Christian principles and practices to resolve moral differences generated by war's moral injury. And the last theme addressed the continuous need for a safe place where women veterans can go to be heard and be vulnerable.

Interpretation of the Findings

The research question that guided this study was the following: How do PMIEs affect the adjustment experiences of Christian United States Army female combat veterans who returned home from the Iraq or Afghanistan wars post - 9/11 diagnosed with PTSD? Empirical research provided a more in-depth pathway to understand better the phenomenon of the actual experiences and the impact of moral injury experienced by the target population (Haight et al., 2016; Jamieson et al., 2020; Maguen & Litz, 2012). Women veterans of OEF/OIF wars post -9/11 have experienced more significant exposure to stress-related difficulties because of supported positions (Held et al., 2017; Yan et al., 2013). The women interviewed for this study were in support positions that promoted internal conflict, leading to emotional distress and decision-making doubts.

Research has supported a need to address military trauma (stressors), such as the internal conflict in female veterans who returned home from OEF/OIF wars post - 9/11 (Goldstein et al., 2017). In this study, MI is the dissonance and internal conflict, and the outcome behavior is paralyzing and overwhelming by the weight of the decisions. Combat-related stress, apart from PTSD, leads to ethical dilemmas (consequences of

decisions) such as moral injury of war (Blum, 2008; Gaudet et al., 2016; Held et al., 2017). Therefore, more research warrants distinguishing between moral injury and behaviors beyond PTSD (Held, et al., 2017; Maguen et al., 2020; Maguen & Litz, 2012). Addressing this concern is critical because more women are joining the United States military and being diagnosed with PTSD at a higher rate than male veterans (Mouilso et al., 2016). The argument continues to expand the literature that moral injury is not PTSD (Jinkerson, 2016).

This study has similar findings to that of Daphna-Tekoah and Harel-Shalev's findings (2017) that expanding the literature from the perspective of women combatants' exposures to traumatic events in the war theatre is critical. Their stories provided a pathway to learning and understanding the long-term operational stress injuries that prompted mental and physical health outcomes. For example, the health outcome of women veterans who deployed to OIF, OEF, or OND wars showed a link between mental health diagnosis and reproductive health challenges resulting from combat exposure (Han et al., 2019; Maguen et al., 2020; Rivera & Johnson, 2014). The primary reason female soldiers evacuated from the war zone was because of mental health issues (psychiatric pathology; Rivera & Johnson, 2014; Waszak & Holmes, 2017), and it will continue to increase and impact the women veteran's lifespan (Mattocks et al., 2010; Monteith et al., 2022). Their study showed that the overall outcome of combat exposure experienced by male (82%) and female (73%) soldiers deployed to OEF or OIF post - 9/11 are physical

and mental health (Buttner et al., 2017). Previous research studies primarily focused on men combatants' symptoms and experiences (Daphna-Tekoah & Harel-Shalev, 2017).

There is a need to understand better long-term combat and operational stress injuries that prompt physical health outcomes experienced by OEF and OIF veterans who returned post – 9/11 (Fang et al., 2015; Waszak & Holmes, 2017). For instance, the women veterans in this study expressed their experience of extreme combat fatigue and exhaustion. Past studies cite how women veterans of all age groups have a high rate of musculoskeletal conditions and joints disorders (Frayne et al., 2014). Findings showed that strenuous physical training, heavy loads, combat injury and exposure, and increased risk for stress fractures can contribute to these conditions (Good et al., 2020; Haskell et al., 2012; Strong, et al., 2018; & Waszak & Holmes, 2017). Also, Haskell et al. (2012) argued that it is vital to assess women veterans for physical injury and, musculoskeletal disorders because of associated chronic pain. According to Daphna-Tekoah and Harel-Shalev (2017), exploring gender practices of experiences of combatants in the military is necessary to understand the body and mind's responses to potentially traumatic events (PTEs). One of the most critical outcomes of Daphna-Tekoah and Harel-Shalev's (2017) study was that it "brings the body in" to studies of combat trauma, particularly women's traumatic experience. These researchers referenced how trauma studies focused on the body and why it was necessary to pay attention to the body's reactions during war theatre.

Also, Daphna-Tekoah and Harel-Shalev (2017) acknowledged learning more about the nature of trauma among women, confirming a study comparing women in

combat to women of sexual assaults can provide a narrative for understanding female trauma. However, there is little research that adequately addressed the integration between the body and mind in the context of women combatants in conflict zones who experienced war and potential trauma events PTEs (Daphna-Tekoah & Harel-Shalev, 2017). It is worth noting that military training aims to control and alter a soldier's body limits to endure fatigue, stress, injury, and pain (Brintz et al., 2020; Groeller, Burley, Orchard et al., 2015; Shilling, 2012; Woodward & Jenkings, 2013). As a result of this training, long-term psychiatric disorders and symptoms of distress are direct outcomes of armed conflict and combat exposure experiences (Solomon et al., 2013).

The population interviewed for this study continues to be understudied regarding how men and women in the military respond to and process trauma and injury differently (Rivera & Johnson, 2014). The increase of veteran women previously deployed to the Afghanistan and Iraq wars are now patients of the Veteran Affairs healthcare system (Brumer et al., 2019; Creech et al., 2016). Specifically, there is a need to address how these female combat veterans' adjustment experiences birthed lifestyle changes by integrating positive coping strategies to maintain focus, balance, and control. However, limited research addressed what tools or techniques they combined with coping during and after post deployment. The voices of this understudied population provided a pathway to better understanding these adjustment experiences. Current studies continue to document that women veteran of OIF, OEF, or OND with combat exposure experience higher physical and mental health challenges (Rivera & Johnson, 2014), but none report

actual adjustment experiences. Thus, making the argument that additional research warrants providing female combat veterans with adequate healthcare and resources (Rivera & Johnson, 2014). Also, expanding the learning builds on the purposeful examination of particular characteristics associated with behavioral and social functioning (Hayes et al., 1996). Men and women in combat theatre must act and cope like a man and not falter to emotions (Daphna-Tekoah & Harel-Shalev, 2017). Thus, confirming why a MI construct serves as a springboard to further the discussion to discover the adjustment experiences of female combat veterans.

Recovering and exploring the experiences of women combatants returning home and transitioning back to civilian life and trying to create new normalcy is understudied (Daphna-Tekoah & Harel-Shalev, 2017; Street et al., 2009). For the past two decades, research has focused on the wives of enlisted men, women in civilian posts within the military, or servicewomen in non-combat-related roles (Daphna-Tekoah & Harel-Shalev, 2017). The argument for further research builds on how vital it is to engage with and listen to the diverse narrative of this population to contribute to the gendered literature on combat trauma adequately (Daphna-Tekoah & Harel-Shalev, 2017). These women reintegrated into civilian life often without a plan of action, such as appropriate referrals and access to specialized resources (Murihead et al., 2017) and spiritual assessments and care (Carey et al., 2016; Hodgson & Carey, 2017; Kopacz et al., 2015). Rivera and Johnson (2014) argued that supporting evidence is lacking to mandate better gender-specific treatments for this understudied population. Rivera and Johnson (2014)

advocated that expanding the knowledge of how female combat veterans respond to OIF, OEF, or OND war trauma once they return home is critical. It was essential to integrate two components in the study, such as MIE history (person experienced PMIEs) and MI symptoms (Jinkerson, 2016), to better understand how combat zone experiences create challenges when female veterans transition back to civilian life (Jinkerson, 2016).

Literature continues to bridge the gap by addressing how war-related experiences alter an individual's religious or spiritual belief about the meaning and purpose of life (Bormann et al.,2012; Sherman et al., 2018). Reports described how combat veterans faced spiritual challenges while experiencing MI of war that produced spiritual distress (Sherman et al., 2018). Evans et al.'s (2018) data reflecting the majority of male veterans (82%) from the OEF, OEF, or OND wars confirmed the conceptual understanding that religious and spiritual struggles (r/s) were a direct outcome of PMIEs exposure and psychological distresses. Sherman et al. (2018) sample included 11 male veterans and nine female veterans with PTSD diagnoses in their study. The research outcome showed that incorporating religion and spirituality as culturally competent care (Western/Eastern religion worldviews) for veterans who are survivors of war trauma is necessary. Most research focused on PTSD interventions and treatments for male combat veterans who served in the Iraq or Afghanistan wars post-9/11 (Bormann et al., 2008; Mobbs & Bonanno, 2018; Stefanovis & Rosenheck, 2020).

On the other hand, Farnsworth et al. (2017) argued that although PTSD and MI are similar, MI (morally-injurious stressors) differs from PTSD (threat-based trauma).

Learning and understanding the difference between the two constructs allowed for the proper diagnosis and treatment of military combat soldiers and veterans experiencing MI. Additional research warrants explicitly addressing how female veterans hold onto their Christian principles and practices to embrace and resolve moral conflict generated by a moral injury of war.

Research confirmed that there continues to be a demand for more comprehensive services to assist military combat soldiers and veterans who face challenges regarding self-condemnation and complex trauma (Carey et al., 2016; Chang et al., 2015; Worthington & Langberg, 2012; Yano & Hamilton, 2017). These services include mental health care (practitioners), spiritual care programs, and chaplaincy services (Carey et al., 2016; Chang et al., 2015; Jinkerson, 2016; Pebole et al., 2021; Worthington & Langberg, 2012). Evans et al. (2018) argued that when considering intervention and treatment for military personnel and veterans, clinical and mental health practitioners should consider the context of moral injury in the healing process. Jinkerson (2016) proposed clinicians should purposefully use inventories based on symptoms relevance when assessing a patient for clinical diagnosis and treatment. Nash et al. (2013) added to the discussion by incorporating the Moral Injury Events Scale (MIES) to evaluate the stress of combat targeting PMIEs. There is a need to change policies and programs to integrate spiritual fitness interventions during the treatment process (Bremault-Phillips et al., 2019; Hufford et al., 2010; Smith-MacDonald, et al., 2018).

It is critical to train health care professionals to identify psychological symptoms rooted in religion or spirituality; and work alongside chaplains to help veterans who are experiencing spiritual distress (Chang et al., 2015). Hufford et al. (2010) argued that it is essential to consider chaplains as a part of the treatment process because they are a valuable resource. Carey et al. (2016) acknowledged that chaplains relate to MI issues because of dealing with the associated psychological morbidity since the beginning of armed warfare. Some military personnel and combat veterans conveyed they prefer counseling services from chaplains rather than mental health practitioners because of the stigma associated with mental health services (Carey et al., 2016).

Expanding the knowledge regarding the role of clergy, chaplains, and MI regarding the implications of mental health, spiritual distress, and traumatic stress is vital to administering the appropriate services (Carey et al., 2016; Carey & Hodgson, 2018; Kopacz et al., 2015; Nieuwsma et al., 2013b; Pyne et al., 2021). This understudied population is looking for a safe place to share and talk openly about their combat exposure and MI experiences. The women veterans in this study voiced that they would like to feel secure and safe in places such as the Veteran Affairs, private-sector counseling, and the church. Carey et al. (2016) and Kopacz et al. (2017) agreed against the marginalization of spiritual, pastoral care, or chaplaincy regarding MI care and treatment plans for combat veterans. Female veterans between 45 and 64 years who deployed to the Afghanistan and Iraqi wars sought mental health services more alarmingly than younger females (Doehring, 2018; Runnals et al., 2014).

Findings in Relation to the Conceptual Framework

This conceptual transpersonal-existential meaning-based model builds off the work of the personal story of Victor Frankl (survivor of four Nazi concentrations camps during - WWII). He contributed to the literature by demonstrating how he used mistreatment as an opportunity to find a real meaning that empowered the human spirit; thus, the foundation for logotherapy (Capuzzi & Stauffer, 2016; Screenivasan et al., 2014). Logotherapy provided a spiritual pathway for humanity (Screenivasan et al., 2014; Wong, 2020; Wong, 2016).

The transpersonal-existential meaning-based model's conceptual framework bridged a pathway to answer the research question - How do PMIEs affect the adjustment experiences of Christian United States Army female combat veterans who returned home from the Iraq or Afghanistan wars post - 9/11 diagnosed with PTSD? This model focused on combat veterans who returned home from the OEF and OIF wars, specifically battling a moral injury of war. The model's objective was to consider the effects of war (battlefield) without an established frontline of the war (Sreenivasan et al., 2014).

The research findings identified meaningful text according to the first two constructs of the model; signature strengths from the combat stories and the event meaning in a more substantial context (Sreenivasan et al., 2014). The interview process allowed for in-depth probing, which allowed sharing their stories from a war zone and moral injury perspective. These shared stories described internal conflict and emotional distress that generated decision-making challenges because of the weight of those

decisions. Some of the other stories addressed adjustments experiences that birthed lifestyle changes that they incorporated to maintain focus, balance, and control. Moreover, their stories advocated for respect for female veterans, a safe place to receive appropriate services where they can be free to talk and share without judgment. The findings of the research articulated that the understudied population's voices added to knowledge, potentially advocating for better gendered-specific programs and treatments.

The third construct of the model focused on the spiritual context and the resolution to overcome cynicism (Sreenivasan et al., 2014). Throughout the interview process, this population emphasized the critical value of human life from a spiritual perspective. These female combat veterans related to the ideal of the loss of existential meaning - disillusionment about the goodness of human nature and guilt and shame for their actions or lack thereof (Sreenivasan et al., 2014) due to battlefield trauma experienced. To survive combat deployment and the reentry to civilian life, they had to hold onto Christian (as best as they could) principles and practices to embrace and resolve moral conflict generated by a moral injury of war. According to the spiritual context of the model, soldiers of war trauma are experiencing an internal conflict regarding spiritual anxiety and forgiveness toward others and self, placing the offense within the soldier's spiritual or religious beliefs (Sreenivasan et al., 2014). This population still struggles to find meaning because of the adverse events witnessed in combat and returning home to civilian life. Sreenivasan et al. (2014) argued that moral injury is despair, suffering without meaning, and capturing meaning is critical to

repairing MI. For example, the researchers expressed it is essential to help soldiers transition from disengagement (alienation) to engagement and from emptiness to fulfillment (Sreenivasan et al., 2014). The findings of this study articulated how this unique population was alienated often and felt empty, seeking a spiritual depth (Sreenivasan et al., 2014) to understand and resolve internal conflicts generated by MI.

The fourth construct of the transpersonal-existential meaning-based model identified the pitfalls caused by anger and resentment, which opened the door to promoting resilience (Sreenivasan et al., 2014). This understudied population communicated how it was challenging not to hold resentment against military leadership, male counterparts, the church (clergy/chaplains), and the Veteran Affairs. They had to learn how to channel their anger, and become robotic at what they witnessed, participated in, or endured during a combat deployment to Iraq or Afghanistan. Some of these female veterans expressed they realized this robotic-type response was not healthy, so they relied on faith practices and principles to resolve moral conflict generated by a MI of war. They admitted doing so helped them refocus and commit to treating others fairly and justly no matter who they are, soldier or enemy. Each participant of the study shared how exposure to combat shattered their faith on many levels. Still, their faith eventually brought them peace and the determination to keep moving forward regarding their adjustment experiences. These female veterans searched, and some continue to do so for meaning and purpose as it relates to their traumatic events (Sreenivasan et al., 2014). The study's findings aligned with the conceptual framework describing how MI generated in combat

contributed to moral dissonance, violating assumptions and beliefs about right/wrong, good/evil, which leads to a crisis in meaning (Meador & Nieuwsma, 2017; Sreenivasan et al., 2014). The framework builds on the characteristics of MI which warrants additional research on how combat veterans find meaning after experiencing transgressive acts. Frankfurt and Frazier (2017) argued actions during combat that violated a soldier's beliefs of his goodness identify with transgressive acts. These acts are potentially traumatic and differ from fear-based traumas associated with PTSD.

Limitations of the Study

I expressed two potential limitations that could affect this general qualitative study: transparency of shared information by the participants and data collected from the participants' recollection regarding the perception and context of the phenomenon (see Baxter & Jack, 2008; Kapiszewski & Karcher, 2020; Stake, 1995). The second limitation acknowledged the length of time collecting and transcribing the data accurately (see Barrett & Twycross, 2018; Baxter & Jack, 2008). I established a rapport with each participant during the screening process to minimize any bias from me (see Chenail, 2011; Daniel & Onwuegbuzie, 2002; Grant, Wolf & Nebeker, 2019), which provided an opportunity to discuss and clarify interpretations and meanings of the context of the phenomenon during the interview (see Baxter & Jack, 2008; Daniel & Onwuegbuzie, 2002; Grant et al., 2019; Tuffour, 2017; Yin, 2015).

The stories voiced by each participant described the adjustment experiences they faced and resolved or still trying to resolve regarding a MI of war. They were willing to

share their stories even if recollecting caused emotional distress; they told their stories, hoping it would make a difference regarding fair treatment for female combat soldiers, more gendered-specific therapies and programs, and a safe place to share their stories feel safe. The adjustments experiences of female combat veterans are limited in mental health research, and this unique population is underserved (Haun et al., 2016). I adequately captured the experiences articulated by this target population diagnosed with PTSD who experienced or are experiencing PMIEs (Bryan et al., 2018). Furthermore, I used reflexivity and self-reflection to address potential prejudices (Karagiozis, 2018; Patton, 2015; Roulston & Shelton, 2015).

The uniqueness of the population presented limitations to recruiting, which prolonged the length of time to collect data and transcribe. The study's objective was to interview Christian, United States Army female veterans, diagnosed with PTSD, experiencing a moral injury of war, who deployed to Iraq or Afghanistan post – 9/11, and had combat zone exposure. It took almost ten months to identify and select the sample (Velasco, 2012). I interviewed participants knowledgeable of PMIEs who could share their interpretations, beliefs, and perspectives (see Nowell et al., 2017) about their combat zone experiences and their transition to civilian life. Once I collected the data, I sent each audio-recorded interview to Rev.com via encrypted email for transcription services. I received each verbatim transcript within 24-48 hours.

Recommendations

Future recommendations for further research on how PMIEs affect the adjustment experiences of Christian United States Army female combat veterans who returned home from the Iraq or Afghanistan wars post - 9/11 are essential to understanding their plight and providing better healthcare and treatment. Mouilso et al. (2016) admitted that more studies are necessary to further explore the prolonged PTSD among female veterans. Male and female soldiers process and respond differently to trauma and injury (Rivera & Johnson, 2014). Researchers concluded that additional research would provide a better understanding of the implications of the acts of omission or commission, worldviews, and psychological problems experienced by OEF and OIF military veterans (Williams & Berenbaum, 2019), specifically female veterans. The female veterans of this study have a PTSD diagnosis and a MI generated by combat exposure. The complexity of this trauma-duo makes the argument for expanding the literature that MI is not PTSD, and consideration for both constructs is critical when diagnosing the patient for treatment (Famsworth et al., 2017; Jinkerson, 2016; Litz et al., 2009; & Shay, 2014).

There is a vital need to employ gender-specific models to gain more in-depth insight into combat exposure experienced by women veterans deployed to Afghanistan or Iraq wars post- 9/11 (Butter et al., 2019). Also, there is gender bias in diagnosing PTSD within the VA healthcare system (Crompvoets, 2011). Furthermore, recommendations for spiritually-based interventions (holistic therapies) warrant a positive treatment plan to aid

OEF/OIF combat soldiers and veterans exposed to war-zone trauma (Bormann et al., 2008), specifically female combat soldiers.

Implications

Positive Social Change

The outcome of this general qualitative study can impact active-duty female soldiers and women veterans, the military, healthcare practitioners (clinicians/therapists), the Veteran Affairs, the church (clergy/chaplains), and the local community. The findings of the study advocated for the awareness of moral injury and PTSD as a dual-threat that affects the adjustment experiences of women in combat. Understanding the difference and the similarities between the two constructs presents the opportunity for better diagnosis for interventions and treatment programs.

This population continues to be understudied and underserved even though more women join the United States military and are assigned to combat support roles. Discovering and learning the long-term effects of moral injury (operational stress injuries) and how it impacts the transitioning back to civilian life can add to the knowledge of developing gendered-specific treatments. Expanding the understanding could reduce more women veterans or active-duty female soldiers becoming isolated from family and friends, contemplating suicide, questioning their faith, and not feeling safe and secure about mental health referrals at the Veteran Affairs or private sector.

Transitioning home from the combat zone was complex and challenging for this target population. These female combat veterans incorporated coping tools to help them

adjust to family life. Initially, the selected coping strategies did not allow them to focus, maintain control, or balance family life, which generated turmoil within the home and relationships. The family members witnessed behavior they could not explain or understand, which left them helpless and confused. This qualitative study voiced the reasons for expanding the knowledge to develop family-oriented programs specifically addressing moral injury and its impact on female combat veterans.

There needs to be a collaboration of professional services between the military, mental health practitioners, clinical or mental health professionals, and spiritual leaders (Maguen & Litz, 2012; Shay, 2014; Wortmann et al., 2017). This unique population depends on such services to help them work through adjustment experiences generated by the moral injury of war. OEF and OIF post-deployment data show mental health is an increasing concern and approximately 40% of combat veterans experience moderate to severe mental health issues returning home (Smith-MacDonald et al., 2017). Too often in literature, morally injurious experiences of combat war remain unaddressed (Lancaster, 2018; Litz et al., 2009; Maguen et al., 2020).

Social change promotes a positive outcome for this special population who remains understudied and underserved. Change happens when the focal point is on the adjustment experiences of female combat veterans with a PTSD diagnosis experiencing a MI of war. Change occurs when female combat soldiers feel respected by their counterparts. Change results in gendered-specific assessments and treatments. Change is

a reality when this population feels safe and secure in clinical, health care, church, and Veteran Affairs settings.

Theoretical Implications

The findings of this research study aligned with the contextual meaning described in Frankl's logotherapy - meaning perceived from war trauma experiences and Tillich's systematic theology, existential experiences (Screenivasan et al., 2014). These two contexts interconnected, serving as the framework for the transpersonal-existential meaning-based model used to answer the research question. The six themes identified from the data confirmed how these five female combat veterans tried to make meaning out of the adjustment experiences generated from a moral injury of war. The meanings of their experiences aligned with the four constructs of the model, which provided a pathway to explain and describe the impact of PMIEs (phenomenon) experienced by Christian United States Army female combat veterans diagnosed with PTSD post - 9/11; thus, answering the research question. These findings are consistent with past and limited research, which confirmed this unique population is understudied and underserved (Haun et al., 2016).

Recommendation for Practice

More women continue to join the military. They represent approximately 83% of the female veterans enrolled in the VA health care system (Rivera & Johnson, 2014). Research has cited that some of these female soldiers faced and continue to face challenges of posttraumatic stressors and a moral injury of war generated by combat

exposure during OEF or OIF wars, respectively (Battles et al., 2018; Donoho et al., 2017; Ferrell, 2017; Lawrence et al., 2021, & Street et al., 2009). The psychological state of the United States military combat soldiers returning from OIF, OEF, and OND wars is still a long-standing problem (Buttner et al., 2017; Ganzer, 2016); long-term mental health challenges emerging from the aftermath of PMIEs (Frankfurt & Frazier, 2016; Jinkerson, 2016; & Litz et al., 2009; Lawrence et al., 2021). These internal moral wounds of conflict increase concern for service members and veterans post-deployment (Hufford et al., 2010; Lawrence et al., 2021 & Smith-MacDonald, et al., 2017).

I recommend increasing the awareness of the effects of combat exposure and how it generates PTSD and MI, a dual mental health threat to service personnel returning home from the war zone. Awareness of these internal conflicts and struggles are essential (Battles et al., 2018; Shay, 2014), especially for this understudied and underserved population (Haun et al., 2016). The analysis of this qualitative study adequately captured these struggles, which provided more insight into the lived-experienced articulated by these Army combat female veterans.

I recommend more gender-specific programs regarding interventions and rehabilitation based on the analysis. Women and men respond to war trauma differently, and assessments need to capture her experiences to make the proper diagnosis and treatment plan. Therefore, there needs to be a collaboration of professional services between the military, mental health practitioners, clinical or mental health professionals, and spiritual leaders (Maguen & Litz, 2012; Shay, 2014; Wortmann et al., 2017).

Lastly, I recommend incorporating spiritual assessments during the initial intake and throughout the treatment process. Literature acknowledged how experiences of war-related trauma alter an individual's perception of religious or spiritual beliefs regarding the meaning and purpose of life (Bormann et al., 2012; Sherman et al., 2018). Thus, integrating spiritually-based programs as part of the treatment plan can be a positive coping tool (Bormann et al., 2012).

Conclusion

The United States Army deployed approximately 1.5 million soldiers to either OEF, OIF, or OND wars between 2001 and 2013 (Baiocchi, 2013). Of that number, 200,000 (14.3%) represented active-duty female soldiers (Rivera & Johnson, 2014). In 2018, the military reported 170,000 females served in the Army, and 600 performed infantry and armor jobs (infantry, armor, artillery battalion, or single brigade combat team) (Swick & Moore, 2018). Female soldiers/veterans are more than likely to experience greater levels of PTSD than their male counterparts. This concern advocates for more female-gendered care and rehabilitation services to adequately support this target population (Haun et al., 2016).

The long-standing issue military combat soldiers face returning home from the war zone is psychological (Buttner et al., 2017; Ganzer, 2016). This long-term mental health problem emerges after PMIEs (Frankfurt & Frazier, 2016; Jinkerson, 2016; Lawrence et al., 2021 & Litz et al., 2009). Many service members who perceived an event (witnessed or participated) to be morally dangerous have experienced posttraumatic

symptoms such as feelings of guilt, shame, anger, social withdrawal, and spiritual distress (Battles et al., 2018; Litz et al., 2009; Maguen & Litz, 2012; Wortmann et al., 2017). Shay (2014) advocated for a better diagnostic and statistical guide that addressed the symptomatic characteristics of moral injury. MI is bearing witness to or learning about acts of transgressing that conflict with deeply held moral beliefs and expectations (Frankfurt & Frazier, 2017 & Litz et al., 2009).

The general qualitative inquiry aimed to discover and describe how PMIEs, the complex issue, affect the adjustment experiences of Christian United States Army female combat veterans who returned home from Iraq or Afghanistan wars post-9/11 and received a diagnosis of PTSD. The research design allowed for collecting vital data to confirm the validity, confirmability, and reliability of the contextual parameters of the social phenomenon (Percy et al., 2015; Yin, 2015, 2009). The data collected produced rich and detailed textual descriptions that serve as a voice for the Christian United States Army female combat veterans diagnosed with PTSD experiencing a moral injury of war.

The design approach aligned with the research question, which affords the emergence of data that give in-depth meaning to the impact of PMIEs experienced by the target population. A generic inductive approach guided the procedure, which established an opportunity to explore themes and patterns of observations and develop descriptions of meaning from the target population (Liu, 2016; Thomas, 2006).

The study's data analysis captured six themes that described the detailed context of the adjustment experiences of the female combat veterans who have a PTSD diagnosis

and are experiencing a moral injury of war. Theme 1 answered the research question by suggesting it was necessary to understand the context of internal conflict better by viewing it through the lens of cognitive dissonance. Cognitive dissonance is a term that describes a psychologically uncomfortable state that occurs when there is a developing consequence of contrasting cognitions - having two or more inconsistent attitudes, beliefs, or thoughts in the human mind (Festinger, 1957); the acts of omission and commission (Litz et al., 2009). Therefore, for the safety of the soldier and other soldiers, indecisions have no place in the combat zone – a costly action (Matsakis, 2007).

Theme 2 answered the research question, explicitly addressing the long-term combat and operational stress injuries; necessary to consider how these injuries are subtle physical changes in the brain (Zero to Three, 2016). These injuries are experienced by veterans when stress is too intense or last too long. As a result, the brain cannot "handle and adapt stress, sights, sounds, movements, and memories" (Zero to Three, 2016). Unfortunately, this population returned home to find ways to deal with severe physical injuries and psychological health problems. Even today, the discussion of morally injurious experiences in war remains chiefly unaddressed (Litz et al., 2009).

Theme 3 answered the research question. It recommended that it is necessary to better understand this target population's adjustment experiences through the lens of moral injury from the cause of action perspective. MI can be experienced or witnessed within various life scenarios such as "betrayal by leaders, peers, or trusted civilians, failure to uphold one's own moral principles, mistreating the enemy combatants,

destroying civilian property; sexual assault; and friendly fire" (Blaisure et al., 2016, p. 172). The same theaters or events can produce PTSD and moral injury responses – a dual syndrome (Fontana & Rosenheck, 2004; Jinkerson, 2016). Nonetheless, moral injury is a separate syndrome accompanying military-related PTSD (Koenig, 2018).

Theme 4 answered the research question. This theme described how exposure to combat creates challenges when transitioning back to civilian life. These female combat veterans faced such problems as "disturbing memories or nightmares, numbness, feeling isolated from others, anger or irritability, and problems with sleeping, which can develop many years later (U.S. Department of Veterans Affairs, 2013d). Understanding both moral injury and potentially morally injurious events of OEF and OIF combat deployments is necessary and needs to be addressed further (Jinkerson, 2016; Litz et al., 2009; & Street et al., 2009).

Theme 5 answered the research question by describing how these female combat veterans tried to make spiritual sense out of what they once believed before deployment, witnessed, experienced, or participated in during combat. Some studies have found that many veterans have shown that if they "witnessed or participated in atrocities, the war greatly conflicted with the spiritual or religious values they once held" (Matsakis, 2007, p. 46). The description of the experiences stated the essence of MI; it empirically described MI symptoms and tells of the theoretical distinction from PTSD (Jinkerson, 2016).

Theme 6 answered the research question in hopes of finding a safe place to share and talk; personal and genuine care and support in private sector counseling, the church, and the Veteran Affairs. Research findings suggested that when soldiers report to counseling for war trauma, a spiritual assessment is critical to incorporate the appropriate treatments and interventions (Kick & McNitt, 2016). Kopacz (2017) suggested that taking a spiritual history as part of the clinical-therapy process could recognize unmet spiritual and pastoral care (SPC) needs. Street et al. (2009) acknowledged it is essential to understand gender-specific issues in the post-deployment mental health readjustments of service members who served in Iraq and Afghanistan. The Veteran Affairs still struggles to provide the most appropriate, adequate, and accessible services to women veterans (Blaisure et al., 2016). Some women veterans refuse to use Veteran Affairs service facilities because of the perception that there is partiality for male veterans in the Veteran Affairs system (Blaisure et al., 2016). The research is clear about expanding the knowledge to understand better the adjustment experiences of this unique understudied and underserved population with a diagnosis of PTSD and experiencing a MI of war.

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Appendix A: Interview Guide

Introductory Statement

Good morning/Afternoon _____________,

My name is Kathaleen Young, and I am a Ph.D. student at Walden University. I appreciate your willingness to participate in this study. As I shared with you during the initial screening, today's interview aims to talk about your experiences as a Christian U.S. Army female combat veteran who received a PTSD diagnosis and is experiencing or has experienced a moral injury of war. Sharing your story presents an opportunity to capture the meaning and themes of your experiences. The data collected can potentially help mental health, clinical, and health care practitioners develop more efficient and gender-specific treatment plans addressing a moral injury caused by warzone exposure. Also, this data can bridge the gap between spiritual leaders, chaplains, health care providers, the military, social workers, and mental health advocates to work as collaborative teams to address the psychological and physical health concerns of PMIEs experienced by women combat veterans diagnosed with PTSD. Please feel free to share your experiences without any judgments or biases from me.

Before we begin the interview, I would like to discuss the electronic consent form and the procedures of the process.

Now that we have gone over the consent form and procedures, do you have any questions or concerns? If not, let's begin the interview.

Interview

1) Tell me about yourself (veteran/mother/wife/single/married/partner/divorced).
2) What do you consider are your foundational principles for being a Christian?
3) How did you use your belief system and deeply held faith practices to cope with your war zone experiences?
4) How would you describe your combat zone experience?
5) Describe your mental health during your combat zone experience.
6) Describe your physical health during your combat zone experience.
7) What tools or techniques did you use to help you work through those experiences?
8) What stories come to mind regarding your encounter with potentially morally injurious events?
9) How has this moral injury of war impacted your life?
10) Describe how these morally injurious events have impacted your worldview on Christianity.
11) Tell me how this PMIE affected your re-entry into civilian society?
12) Who became your confidential support person to share your feelings or thoughts regarding your exposure to this PMIE?
13) What triggers of your war zone experiences helped you to decide you needed to seek medical and mental health support services?
14) Today, how would you describe your moral code of conduct? Please explain.

15) In your opinion, how can mental health and clinical health practitioners, better serve combat veteran women with PTSD who identity with moral injury?
16) In your opinion, how can the military and its chaplains better serve combat veteran women with PTSD who identity with moral injury?
17) In your opinion, how can spiritual leaders better serve combat veteran women with PTSD who identity with moral injury?
18) In your opinion, how can the VA better serve combat veteran women with PTSD who identity with moral injury?

Closing Statement

Thank you for participating in the interview. Is there anything more you want to add or share? Sharing your story and experiences are appreciated. I will analyze the data for reporting; however, your anonymity remains confidential. Copies of the interview recording and transcript are available upon request. Again, thank you.