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Spiritual Wellness as a Predictor for Moral Injury in Combat Veterans

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Walden University
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Abstract

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MA, Marymount University, 2010

MS, Command and General Staff College, 1993

BS, United States Military Academy, 1981

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Abstract

Many combat veterans face difficulties coping with their personal lives, relationships, and families when they leave the service and return to civilian life. Most studies examining the effects of combat on veterans focus on posttraumatic stress disorder (PTSD) as well as a collection of related consequences. Interest in the term *moral injury* of military veterans as a related mental health construct has grown. Researchers have investigated the effects of spiritual wellness of combat veterans. However, there is a paucity of counseling literature on the relationship between spiritual wellness and moral injury when combat veterans return to civilian life. Investigating the relationship between spiritual wellness and moral injury as based in existential theory could offer insights to improve quality of life of veterans, families, and society. This study examined the connection between spiritual wellness and moral injury among combat veterans using a quantitative survey with a cross-sectional, correlational analysis and incorporating demographic variables. Results showed that the relationship of spiritual wellness on moral injury is statistically significant. Participants with low spiritual well-being were likely to have an elevated level of moral injury. Those with strong levels of life meaning and purpose were less likely to experience moral injury. These findings can be used to help combat veterans heal from the wounds of war. Clinical interventions associated with life meaning and purpose could enable successful reintegration of combat veterans into society. Results could be used to identify and test specific treatment options. Outcomes could also be used to explore the relationship of combat veterans to other professions subject to moral injury and further explore the relationship of moral injury to PTSD.

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Dedication

This research is dedicated to all veterans, families, and those in our society who suffer from the consequences of combat trauma and need help. May the merits of this investigation serve to benefit all people everywhere and offer insights, direction, and implications for current treatment and future study. I also dedicate this effort to all clinical mental health clinicians so that they can expand their own knowledge and skills needed to treat individuals healing from moral injury, post-traumatic stress and addictions.

Acknowledgments

I acknowledge my family and close friends for all their love and support through my own transition in this healing and education process. I wish to acknowledge my many close spiritual teachers that have given me the wisdom and courage to know what I can change and what I cannot. I am grateful that my dissertation committee was a role model of professional leadership. Most importantly, my committee practices what they teach. This allowed me to learn by seeing first-hand how to approach and cope with this effort and life with care, kindness, and compassion. They displayed the delicate balance of how to meet our own needs while considering those of others. Their patience, willingness, and dedication to help me grow was a true blessing in every respect. Dr. Haddock's trust and support helped me build confidence in my abilities and improve as a professional in the counseling education and supervision field.

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Chapter 1: Introduction to the Study

There are approximately 22 million veterans of the U.S. Armed Forces in our country today (U.S. Census Bureau, 2011; Manzo, Director, Bruno, & Duncan, 2016; Smith et al., 2016; U.S. Department of Veterans Affairs [VA], 2014). According to these sources, approximately 2.8 million service members returned from Iraq and Afghanistan over the last 15 years. Forty-six percent of these members sought assistance through the VA and almost half of them were diagnosed with a mental health illness (Smith, Goldstein, & Grant, 2016; Tsai, Pietrzak, Hoff, & Harpaz-Rotem, 2016). Further, according to the VA Office of Public Health and Environmental Hazards (2017), mental health conditions could affect the emotional and psychological well-being of veterans and their ability to use their cognitive and emotional capabilities, function in society, and meet the ordinary demands of everyday life (VA, 2014). In 2015, over 8,000 veterans committed suicide maintaining a rate of 22 incidents of veteran suicide daily, a rate that has persisted for the past several years (Bryan et al., 2015; Smith et al. 2016; U.S. Department of Veterans Affairs, 2014).

The vast research on combat veteran reintegration shows that the impact of veterans' mental health on society varies widely (Cesur, Sabia, & Tekin, 2013; Currier, Drescher, Holland, Lisman, & Foy, 2015; Hoge, 2010; Hoge et al., 2004; U.S. Department of Veterans Affairs, 2014). Between 2014 and 2015, the number of veterans receiving disability benefits increased from 3.9 million to 4.5 million (VA, 2014; U.S. Census Bureau, 2011). Of those 4.5 million, approximately one million veterans have a

service-connected disability rating of at least 70%, which is an objective system of the severity of the injury or diagnosis (U.S. Census Bureau, 2011).

The causes, issues, and diagnoses of the mental health of veterans have been expansively studied over the last several years (Steenkamp, Litz, Hoge, & Marmar, 2015; U.S. Department of Veterans Affairs, Office of Public Health and Environmental Hazards, (2017). Within the last few years, a pronounced number of mental health studies clearly concluded that there is a critical need to examine the impact of veterans' mental health and disability (Bobrow, 2015; Currier et al., 2015; Hoge, 2010). Further, the studies indicated that the effective integration and coping skills of veterans' mental health vary greatly and depend on many factors including preexisting wellness, strengths, values, beliefs, coping skills, and habits (Currier et al., 2015; Harris, Park, Currier, Usset, & Voecks, 2015; Hoge, 2010).

When values and beliefs are used as the foundation of spirituality and religious preferences, spiritual wellness could impact veterans' mental health before and after they transition to society (Currier et al., 2015; Harris et al., 2015; Hoge, 2010; Litz et al., 2009; Johnson, Bormann, & Glaser, 2015; U.S. Department of Veterans Affairs, 2014). The spiritual dimension of wellness is often viewed as seeking meaning and purpose in human existence (Johnson et al., 2015). These authors defined spiritual wellness as the continuous growth of the appreciation for the depth and meaning of life and natural forces that exist in the universe.

Historically, the more strength and devotion to spirituality and religion a society has, the more they are willing to fight wars and sacrifice their lives and those of others

(Böhm, Rusch, & Gürerk, 2016). Military members have cited using religion and spiritual wellness as rationale to perform their duties and conversely not to perform their duties (Böhm et al., 2016). Therefore, an injury or challenge to veterans' spiritual beliefs could also affect their emotional and psychological well-being and their ability to function in society (Currier et al., 2015; Harris et al., 2015; Hoge, 2010; Litz et al., 2009).

In Chapter 1, I present an overview of the study with an explanation of the problem, gaps in the literature, and the research question and hypotheses I used in the study. I introduce the theoretical framework of existential psychology and how this theory could provide a lens for examining the relationship between moral injury and spiritual wellness. Finally, I delineate the terms and variables and provide the research design and the nature of the study, including a discussion of the limitations, delimitations, assumptions, and significance of the study, as well as the implications for social change.

Background of the Problem

Throughout the last several decades, the American military and the U.S. Department of Defense have made significant changes in the strategy for interacting in a changing world environment (Baylis & Gray, 2015; Brodie, 2015; Freedman, 2015). Freedman (2015) claimed that the general direction of military operations, which are necessary for our overall political and military objectives, changes and has longer lasting effects than ever before. This monumental shift is causing a great deal of pressure and stress on the nature of war and the shape of society (Baylis & Gray, 2015; Brodie, 2015).

Today many combat veterans face difficulties coping with their personal lives, relationships, and families when they leave the service and return to life as a civilian

(Currier et al., 2015; Hoge, 2010; Hoge et al., 2004; VA, 2014). The VA (2014) stated that the transition of combat veterans into families and communities is a priority, but efforts to reintegrate many combat veterans into civilian life have not been successful, perhaps due to combat experiences (Currier et al., 2015; Harris et al., 2015; Hoge, 2010). A comprehensive literature review revealed that the deficiency of effective transition and reintegration of combat veterans continues to grow (U.S. Department of Veterans Affairs, 2014; Harris et al., 2015; Vargas, Hanson, Kraus, Drescher, & Foy, 2013). Most studies examining the effects of combat on veterans focused on the negative symptoms such as anger, frustration, anxiety, depression, shame, and guilt as well as a collection of related consequences such as violent crime, suicide, aggression, spousal abuse, and driving under the influence of alcohol or other substances (Currier et al., 2015; Hoge, 2010; Nash et al., 2013).

Reviews of professional literature indicated a growing interest in the term *moral injury* (Johnson et al., 2015; Hoge, 2010; Hoge et al., 2004). Recent studies have defined moral injury of military veterans as a construct related to the mental health of those veterans who have witnessed or perpetrated an act in combat that contradicted their deeply held beliefs and values pertaining to justice and personal integrity (Bormann, Liu, Thorp, & Lang, 2012; Currier et al., 2015; Nash et al., 2013). The concept of moral injury refers to the pattern of inappropriate guilt, shame, anger, self-handicapping behaviors, relational and spiritual/existential problems, and social alienation that emerges after witnessing and/or participating in warzone events that challenge one's basic sense of humanity (Litz et al., 2009; Nash et al., 2013; Vargas et al., 2013).

Researchers highlighted that the degree of spiritual wellness of combat veterans affected the reintegration and transition of combat veterans back to society (Bormann et al., 2012; Currier et al., 2015; Johnson et al., 2015). Further, evidence exists that existential constructs and theory could be effectively used to test the relationship of moral injury and spiritual wellness (Bormann et al., 2012; Fleming, 2015; Iacovou, 2016). Bormann et al. (2012) studied existential well-being factors to reduce the severity of PTSD and related moral injury symptoms in veterans with military trauma. The researchers reported that spiritual interventions related to purpose, meaning, and faith were useful (Bormann et al., 2012). The ability, facilitated by such interventions, to redirect attention and initiate relaxation to decrease symptom severity resulted in significant and positive decreases in trauma symptoms (Bormann et al., 2012). The study supports the framework for this research and relates well to the Functional Assessment of Chronic Illness Therapy - Spiritual Well-Being Scale (FACIT-Sp; Canada, Murphy, Fitchett, Peterman, & Schoover, 2008).

However, an exhaustive review of the literature identified a paucity of counseling literature related to the relationship between spiritual wellness and moral injury once combat veterans return to civilian life (Barr, Sullivan, Kintzle, & Castro, 2016; Bormann et al., 2012; U.S. Department of Veterans Affairs, 2014; Harris et al., 2015). While researchers are addressing many of the factors mentioned in the previous paragraphs, gaps remain regarding the potential relationship between moral injury and spiritual wellness of combat veterans. Therefore, in this study, I addressed the lack of research available to examine the relationship between moral injury and spiritual wellness. There

is a lack of knowledge about the factors that could impact the ability of combat veterans to return to society.

Problem Statement

While moral injury is not formally labeled a mental disorder, research studies reveal that combat veterans are experiencing moral injury (Bormann et al., 2012; Brown, Stanulis, & McElroy, 2016; Harris et al., 2015; Nacasch, Rachamim, & Foa, 2015). The study of spiritual wellness is closely related to many aspects of human wellness (Kim & Jamal, 2007; Reynolds, 2014; Yalom, 1980). Both concepts are associated with the principles related to life meaning and purpose in human existence and the deep appreciation for the depth of life (Bormann et al. 2012; Canada et al., 2008; Kim & Jamal, 2007; Reynolds, 2014; Yalom, 1980). Bormann et al. (2012) highlighted that a lack of spiritual wellness is related to an increase in symptoms associated with psychological stress, maladaptive coping behaviors, and physical pain. While moral injury could be related to these elements, it is not known if spiritual wellness is significantly related to moral injury as defined in the literature. Researchers have recently demonstrated the possibility that having a lack of spiritual wellness increases vulnerability to moral injury (Bormann et al., 2012; Kim & Jamal, 2007; Reynolds, 2014). A review and synthesis of the research exposes a gap in the study of the relationship between spiritual wellness and moral injury and warrants this study (Bormann et al., 2012; Currier et al., 2015; Harris et al., 2015; Nacasch et al., 2015; Nash et al., 2013). The relationship between spiritual wellness and moral injury could be

discovered by examining veterans who have experienced combat (Bormann et al., 2012; Sayer et al., 2010; Nash et al., 2013).

The field of counseling needs this analysis to minimize the negative impact of moral injury and successfully reintegrate combat veterans back into society. The results could lead to effective treatment development (Currier et al., 2015; Nash et al., 2013) as well as have implications for counselor training. Research findings and conclusions could offer useful information to bring attention to combat veterans as a unique and specific culture (Currier et al., 2015; Doyle & Peterson, 2005; Sayer et al., 2010; Sayers, 2011; Schwartz, 2012). A greater understanding of combat veterans as a culture could contribute to the counseling field by influencing social change related to counselor education curriculums and community-based trauma-related programs and treatment. The gap this study addresses is the lack of investigation concerning the relationship between moral injury and spiritual wellness. The lack of data concerning the impact of the factors of spiritual wellness and moral injury prevents an effective understanding and assessment of the successful reintegration of combat veterans into society.

Purpose of Study

The purpose of this study is to investigate the potential relationship between the independent variable of spiritual wellness as measured by the FACIT-Sp and the dependent variable of moral injury as measured by the Moral Injury Events Scale (MIES) among combat veterans. Understanding the relationship between the factors and characteristics could impact or predict the effects of spiritual wellness on moral injury and could lead to significant changes in how combat veterans return to society. While

PTSD in combat veterans has been expansively researched and studied over the last several years, the potential relationship of spiritual wellness to moral injury has not (Barr et al., 2016; Currier et al., 2015). Examining the relationship of spiritual wellness to moral injury could result in a theory of moral injury separate from that of PTSD (Barr et al., 2016; Currier et al., 2015; Hoge, 2010; Nacasch et al., 2015; Nash et al., 2013).

Though the relationship between spiritual wellness and moral injury is not clearly understood or defined in the literature, researchers identified gender, branch of service, component of service, military rank, and religion as important variables for future study (Barr et al., 2016; Currier et al., 2015; U.S. Department of Veterans Affairs, 2014; Harris et al., 2015; Nacasch et al., 2015; Nash et al., 2013). The inclusion of these variables could help further define any statistically significant relationships that are representative of veterans and could influence the potential relationship between moral injury and spiritual wellness (Barr et al., 2016; Currier et al., 2015; Nacasch et al., 2015; Nash et al., 2013).

Nature of the Study

For this study, I used a quantitative survey with a cross-sectional, correlational analysis to help me evaluate the connection between spiritual wellness and moral injury among combat veterans. I used a deductive approach to investigate the relationship between spiritual wellness and moral injury among combat veterans while incorporating the demographic variables identified within the literature review as potentially significant. I used regression analysis to estimate the conditional expectation of moral injury scores given spiritual wellness scores in addition to the demographic variables. In

this manner the demographic variables are incorporated into the regression analysis to see how much more predictive power could be realized when adding spiritual wellness.

To advance empirical research on the problem, I investigated whether the independent variable of spiritual wellness, as measured by the FACIT-Sp (Canada et al., 2008), could be used to predict the dependent variable of moral injury, as measured by the MIES (Nash et al., 2013), while integrating the demographic variables for gender, branch of service, component of service, military rank, and religion. Addressing criterion-related validity, the researchers for these scales concluded that strong psychometric properties could be used to measure the variables as an indicator of specific traits or behaviors (Canada et al., 2008; Nash et al., 2013). The quantitative survey research is designed to discover trends and develop explanations about the potential relationship between spiritual wellness and moral injury for combat veterans while integrating the demographic variables (Grove et al., 2009). The focus for the research is based on the implications of previous research that a lack of spiritual wellness in combat veterans leads to moral injury (Bormann et al., 2012; Currier et al., 2015; Doyle & Peterson, 2005; Harris et al., 2015; Nacasch et al., 2015; Nash et al., 2013; Sayers, 2011; Sayer et al., 2010; Schwartz, 2012).

The analytical strategy includes descriptive statistics, correlation analyses, and multiple regression analyses. I used correlation analysis to test the statistical significance of the relationships between spiritual wellness and the demographic variables (Field, 2013; Green & Salkind, 2014; Creswell, 2009; Hair, Black, Babin, & Anderson, 2010). Regression analysis was used to estimate the conditional expectation of moral injury

scores given spiritual wellness scores after integrating the demographic variables (Field, 2013; Green & Salkind, 2014; Hair et al., 2010). More specifically, regression analyses predicted how measurements of moral injury changed when scores of spiritual wellness are varied while accounting for the impact of the demographic variables (Simon, 2011). The regression analyses involved identifying the relationship between one or more of the independent variables (spiritual wellness, demographic variables) and the dependent variable (moral injury). A convenience sampling method was used to collect the data.

Research Question

To advance empirical research on the problem, I investigated if a statistically significant relationship exists between the factors of spiritual wellness as measured by the FACIT-Sp and demographic variables (independent variables) on moral injury (dependent variable) as measured by MIES. I developed explanations concerning the potential relationship between spiritual wellness and moral injury for returning combat veterans.

The following research question (RQ) guided my dissertation research: Does spiritual wellness, as measured by the FACIT-Sp, predict moral injury, as measured by MIES, among combat veterans beyond the predictive power of the demographic variables of gender, branch of service, component of service, military rank, and religion?

Hypotheses

Null Hypothesis (H_0): There is no statistically significant relationship between spiritual wellness as measured by the FACIT-Sp and moral injury as measured by MIES

on combat veterans beyond the possible predictive power of the demographic variables of gender, branch of service, component of service, military rank, and religion.

Alternative Hypothesis (H_a): There is a statistically significant relationship between spiritual wellness as measured by the FACIT-Sp and moral injury as measured by MIES on combat veterans beyond the possible predictive power of the demographic variables of gender, branch of service, component of service, military rank, and religion.

Theoretical Framework

Researchers have found that many of the consequences and symptoms related to moral injury as a result of combat experiences are associated with conflicts of deeply held beliefs and elements associated with life meaning, value, and fulfillment of life purpose (Bormann et al., 2012; Kim & Jamal, 2007; Nash et al., 2013; Sayer et al., 2010). These constructs could be understood and are often related to the same foundations and elements aligned with existential psychology (May & Yalom, 2005; Reynolds, 2014). The hypothesis of this study is based on the concepts used in existential psychology. Existentially based theories have received a great deal of research and support from the counseling field over years of practice (Bormann et al., 2012; Canada et al., 2008; Drescher et al., 2011; Harris et al., 2015; Kim & Jamal, 2007). Existential theory was established by philosophers in the 1800s and has evolved to include the integration of psychological wellness and spiritual balance (May & Yalom, 2005). The unified theoretical framework is based on the belief that even though we are essentially alone in the world, humans desire to be connected to others (May & Yalom, 2005; Reynolds, 2014). May and Yalom (2005) stated that if a person's connection to other humans is at

risk, as can be experienced in combat, they can become dependent on others for their own validation. May and Yalom (2005) also concluded that this conflict between self-validation and reliance on others could be repaired when patients become comfortable with their own fundamental aloneness. Once this internal validation occurs, they could connect more genuinely to others (Yalom, 2005). These constructs are important to this study because a relationship between spiritual wellness and moral injury could be discovered though the combat experiences associated with conflicts of deeply held beliefs associated with life meaning, value, and fulfillment of life purpose (Bormann, et al., 2012; Kim & Jamal, 2007; Sayer et al., 2010; Nash et al., 2013).

Operational Definitions

Spirituality and *religion:* These terms are often conflated. However, Vieten (2016) stated that the difference between religion and spirituality is simply that most religions offer a specific set of beliefs and structures to help people attune to their innate spirituality, whereas spirituality is a more general term that encompasses religion but also the general human impulse to reach out towards the greater whole of which we are a part. In this study of moral injury, spiritual wellness refers to this concept of spirituality versus alignment or membership with specific religious tradition. As established in studies by Cashwell et al. (2013); and Meredith et al. (2012), integration of spirituality or elements of spirituality in clinical counseling practices is linked to psychological functioning.

Veterans: There are varying definitions of veterans and combat veterans. A study by Allen (2007) found significant developments in veterans' law and defined a veteran as any person who served honorably on active duty in the armed forces of the United States.

Therefore, active duty members will not be included as veterans in this study. Other states have their own definitions of veteran that often include the number of days of regular active duty service and an honorable discharge at the time of last discharge or release but does not require wartime service (U.S. Department of Veterans Affairs, 2014; Allen, 2007). Conversely, the U.S. Department of Defense and the VA define a combat veteran by service in a combat theater (U.S. Department of Defense, 2015). According to the VA, other definitions of veterans revolve around length of time in combat, type of unit, and position served (U.S. Department of Veterans Affairs, 2014; Allen, 2007). In this study, I will use the definition from federal law that states that a combat veteran is a person who served honorably on active duty in a combat theater (U.S. Department of Veterans Affairs, 2014; Allen, 2007).

Moral injury: Moral injury is an emerging construct developed to more fully capture the psychological, ethical, and potential spiritual/existential challenges that could arise for veterans (Brown et al., 2016; Drescher et al., 2011; Frankfurt & Frazier, 2016; Maguen & Litz, 2014). Recent studies define moral injury of military veterans as a construct related to the mental health of those veterans who have witnessed or perpetrated an act in combat that contradicted their deeply held beliefs and values pertaining to justice and personal integrity (Bormann et al. 2012; Currier et al., 2015; Nash et al., 2013). Moral injury is mainly viewed as a collection of symptoms that can include shame, anger, demoralization, self-minimization, poor self-care, and guilt (Gray et al., 2012; Maguen & Litz, 2014). Although little formal research exists on moral injury, a wide range of cognitive, behavioral, and affective symptoms are associated with moral

injury (Currier et al., 2015; Frankfurt & Frazier, 2016; Maguen & Litz, 2014; Nash et al., 2013). Researchers have concluded that the results of moral injury could occur from actions, inactions, or witnessing of events that challenge moral beliefs or values (Currier et al., 2015; Litz et al., 2009; Maguen & Litz, 2014).

Spiritual elements connected with moral injury could include guilt, shame, inability to forgive, loss of meaning or purpose, and difficulties in relationships (Litz et al., 2009; Maercker & Perkonigg, 2013; Maguen & Litz, 2014). Traumatic stress is more related to a fear-victim reaction to danger and has identifiable trauma symptoms such as flashbacks, nightmares, hyper-vigilance, and dissociation (Maercker & Perkonigg, 2013). In this study, I use the term *moral injury* to describe an inner conflict based on a moral evaluation of having inflicted harm and a judgment based in a sense of personal activity (Litz et al., 2009; Maguen & Litz, 2014). It should also be noted that moral injury could affect all people of any profession and age (Gilligan, 2014).

Spiritual wellness: As with the term *spirituality*, some researchers take a more religious view of spiritual wellness to comprise the inclusion of specific rituals, beliefs, dogma, and commandments (Canada et al., 2008; Mueller, 2015; Vieten, 2016). These religious elements and specific principles are included as main factors in some spiritual wellness measures and scales (Childs, 2014; Gill, Barrio, Minton, & Myers, 2015). For this study, the term *spiritual wellness* will refer mainly to spiritual constructs related to finding meaning, peace, and faith in relationship to all beings (Meredith et al., 2012; Vieten, 2016; Whitford & Olver, 2012; Wilson, 2015). Many researchers have defined spiritual wellness as the characteristic of human wellness that studies principles and

theories associated with meaning and purpose in human existence and the deep appreciation for the depth of life (Bormann et al., 2012; Canada et al., 2008; Kim & Jamal, 2007; Reynolds, 2014; Yalom, 1980).

Reintegration and redeployment: In a study on military families' perceptions of neighborhood characteristics affecting reintegration, Beehler, Ahern, Balmer, and Kuhlman (2017), defined reintegration as the process of service members resuming participation in their family and society. While there are common elements and issues associated with reintegration and redeployment of military members back home after combat, the term *reintegration* mainly refers to combat veterans leaving active duty service and returning to society (Brenner et al. 2015; Castro, Kintzle, & Hassan, 2015). Redeployment of combat veterans is often viewed as phases military members undergo as they return to the United States from the theater of operation (Currie, Day, & Kelloway, 2011). Brenner et al. (2015) pointed out that during redeployment, military members could be reunited with family and society for a limited time and then re-assigned to follow-on units. Although each branch of military service uses different terminology to describe the phases of the deployment cycle, they all recognize the importance of providing support throughout the redeployment cycle for service members and their families (Castro et al., 2015).

An enormous amount of recent literature accentuated the need to study the reintegration of combat veterans as they transition back into personal and organizational roles after leaving active duty and returning home to society and families (Brenner et al., 2015; Castro et al., 2015; Currie et al., 2011). Issues associated with increased personal,

family, and work tension were significantly associated with reintegration difficulties (Bolton et al., 2008). Assessing the relationship of spiritual wellness and moral injury could offer insights into what could be done to improve reintegration of combat veterans back into families and society.

Limitations and Assumptions

One of the main limitations of this study is the inconsistency within the literature of the definition of a combat veteran (U.S. Department of Veterans Affairs, 2014; Schwartz, 2012). Searching for definitions of a military veteran and combat veteran produced a wide variety of explanations and interpretations amongst the general U.S. population as well as in the military itself (Schwartz, 2012). The federal definition of a veteran is any person who served honorably on active duty in the U.S. armed forces and received an honorable discharge (U.S. Department of Veterans Affairs, 2014). The number of veterans and combat veterans also greatly differs depending on the source of context. A combat veteran is defined as a military member ordered to foreign soil or waters to participate in direct or support activity against an enemy (U.S. Department of Veterans Affairs, 2014). The same source identifies a combat veteran as a military member who experiences any level of hostility for any duration resulting from offensive, defensive, or friendly fire military action involving a real or perceived enemy in any foreign theater. The definition of combat veteran also varies between the Armed Services (Army, Air Force, Navy, Coast Guard, Reserves) as well as the levels associated to the services including persons that serve as active duty, reserve, guard, and civilian members (Castro et al., 2015; U.S. Department of Veterans Affairs, 2014; Schwartz, 2012). Using

time in a combat theater to define combat veteran addressed the issue; however, examining these differences in definition could be useful in a future study. Further, while access to the population was not anticipated to be a problem, finding qualified participants based upon this definition could have been a limitation. There are also many subjective variables that could affect the definition of combat veteran such as type of mission in a combat zone or duration and length of deployment in a combat role.

Reliability and internal consistency could have been a limitation if the sample was not representative of the population (Creswell, 2009; Hair et al., 2010; Simon, 2011). Without adequate representation, the extent to which the instrument yields the same results on repeated measures could have produced less than reliable results (Currier et al., 2015; Simon, 2011). Unaccounted for variables associated with participants' religious (spiritual) values, moral attitudes, family influences, urban or rural setting, and cultural background could impact the study scores.

The quantitative survey design and data collection could be a limitation if study participants communicate and interact with each other (Creswell, 2009; Hair et al., 2010; Simon, 2011). Additionally, participants could have experienced some mental health risk if they were currently undergoing treatment for another mental health disorder. Survey questions could have triggered other mental health related symptoms considering the stage of treatment of the study participants. Potential triggering of these symptoms could also account for higher scores that could otherwise be expected or cause others to question if participants were subject to this disorder. These risks are addressed and accounted for in the informed consent through nondisclosure and confidentiality.

Further limitations are associated with site administrator's and participant's lack of knowledge and acceptance of moral injury as a DSM-5 related issue or disorder. It was also noted that participants personal agendas or interests related to the definition of moral injury that could skew the scores. Another potential restriction could result from participants' desires to over emphasize the value of religion over spirituality. A great majority of the military identifies with a specific religious tradition (Park et al., 2016). However, the study and acceptance of spiritual constructs as valid measures are limitations to be considered.

Additionally, my own bias could have been a constraint. As a combat veteran, I have firsthand experience of the results of moral injury and spiritual wellness that could have influenced how I selected combat veterans and wrote the results. As a clinical counselor in the field, I also have previous knowledge of the treatment and successful strategies for treatment. To address this bias, I established parameters in the study design that allowed other decision makers to be involved in the participant selection process. The data collection also included clinicians who were not combat veterans.

The reluctance of combat veterans to receive mental health treatment may also limit this study's results. The George W. Bush Institute's Military Service Initiative (2015) conducted a survey that found that a majority of veterans believe combat-related mental health conditions are legitimate war wounds (Phelps, 2016). However, Phelps (2016) discovered that 80% of veterans claim that embarrassment or shame is a barrier to reporting and seeking treatment. According to this report and other related research, less than half of veterans who experience these invisible wounds of war are seeking care

(Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2015). The stigma of reporting and being treated for mental health for returning veterans complicates the reporting of the numbers (Phelps, 2016). Concerns for future employment also stop veterans from getting medical treatment and therapy for these conditions (U.S. Department of Veterans Affairs, 2014).

Studies conducted by Frankfurt and Frazier (2016) and Park et al. (2016) support an important assumption that being trained in the armed forces causes members to undergo direct or indirect actions that could cause harm to others. The mission of the armed forces is to perform combat operations and undertake a range of military tasks (Park et al., 2016; Powell, 1992). Park et al. provided recent evidence that training causes members to perform military missions that involve physical and emotional destruction and injury to other human beings. As such, this training could also cause experiences of acting against one's personal values, ethics, and moral beliefs (Frankfurt & Frazier, 2016; Iacovou, 2016; Park et al., 2016).

In a recent review of moral injury studies, Frankfurt and Frazier (2016) discovered that a violation of moral beliefs and values is related to a distinct set of consequences and symptoms being labeled as moral injury. Efforts to research moral injury of combat veterans are just now receiving greater attention from the VA and society as a whole (Frankfurt & Frazier, 2016; Iacovou, 2016; Park et al., 2016). The implications of these findings could also lead to assumptions that moral injury causes mental health issues (Iacovou, 2016; Park et al., 2016). While it can be assumed that participants will have varying degrees of spiritual wellness before they enter service, the

impact of spiritual wellness on moral injury after military combat veterans leave active duty is not well known.

Assumptions for this analysis are associated with using a multiple regression. A multiple regression was used to learn more about the relationship between moral injury and spiritual wellness. The regression helped to determine which factors of spiritual wellness can predict moral injury and determines the validity of the results (Field, 2013; Green & Salkind, 2014). The underlying assumptions of this statistical test are that there must be a linear relationship between moral injury as the dependent variable and moral injury and demographics as the independent variables (Field, 2013

To be considered statistically significant, the data will need to pass eight assumptions required for multiple regressions to give valid results (Creswell, 2009; Frankfort-Nachmias & Nachmias, 2008; Green & Salkind, 2014). These eight assumptions are as follows: (a) the dependent variable is measured on a continuous scale (i.e., it is an interval or ratio variable), (b) two or more independent variables are continuous or categorical, (c) observations are independent, (d) there is a linear relationship between the dependent variable and each of the independent variables (to check for the linear relationships, scatterplots and partial regression plots using SPSS as well as a visual inspection of the scatterplots and partial regression plots to check for linearity), (e) data show homoscedasticity, which is when the variances along the line of best fit remain similar as you move along the line, (f) data show multicollinearity, which occurs when you have two or more independent variables that are highly correlated with each other, (g) there are no significant outliers, high leverage points, or highly influential

points, and (h) there is a check to ensure that the residuals (errors) are approximately and normally distributed. This check will be accomplished using a histogram and a Normal P-P Plot or a Normal Q-Q Plot. Further assumptions and details will be discussed in Chapter 3.

Scope and Delimitations

Past studies (Currier et al., 2015; Nash et al., 2013) focused primarily on combat marines and did not include other military services, branches, and demographics that were used in this study. The scope of the study was expected to improve reliability and validity of the findings. I recruited participants from local military hospitals (inpatient, partial hospitalization, and outpatient), intensive outpatient programs, local veteran treatment programs (government and private), and distribution lists that serve military populations across all the services in the local area and nationwide. I have access to these sites as offered by previous employment and my current work with Ft. Belvoir and the Walter Reed military communities. As a veteran and working with veterans, I anticipated access to populations that could be useful for this study. The convenience sampling approach (Creswell, 2009; Leedy & Ormrod, 2010) was used to document the specific demographics for the study. I anticipated that participants would be combat veterans with moral injury based on their combat experience and admission to existing programs.

To address the research purpose, hypotheses, and question, I used purposive sampling to ensure representation across different demographic groups (see Creswell, 2009). Previous research conducted by Nash et al. (2013) concluded that demographics associated with gender, branch of service, component of service, military rank, and

religion could have a significant relationship with combat veterans who identify with moral injury. Efforts to include a random selection of participants from the demographic groups could improve the validity of the study (Groves, 2009).

Researchers investigating veterans have been consistent in accounting for gender, branch of service, component of service, military rank, and religion in study results (Huang & Kashubeck-West, 2015). However, the use and categories of gender has not been constant (Nash et al., 2013). Understanding social environmental factors specifically related to transgender veterans' health outcomes is essential for developing prevention and intervention strategies to improve the lives of transgender individuals (Blosnich et al., 2016). The gender variable is reported as whether the participant identifies as a male, female, transgender male to female, transgender female to male, other, and/or do not wish to say. The researchers tested indicators of community- and state-level LGBT equality with transgender veterans' mental health. The authors concluded that nearly half (47.3%) of the sample lived in states with employment discrimination protection and 44.8% lived in states with hate crimes protection. Protection was associated with a significant decrease of having a mental health disorder. Therefore, a more detailed examination of gender related to moral injury and spiritual wellness needs to be conducted to know about this relationship to protections, stigma, and mental health in general across the country for veterans.

The delimitations of this study included the research question, variables, theoretical perspectives, and population. Delimitations set limits to the scope and defined the study boundaries (Creswell, 2009. The purpose is to investigate the possible

relationship between spiritual wellness and moral injury. Studying the quality of life, reintegration, other mental health issues, and specific treatment options for combat veterans is not specifically covered in this study. Specific elements associated with these issues are related to the study purpose but are not covered in their entirety.

Although military personnel enter the service with their own specific culture, values, and beliefs, it is assumed that each individual is trained to use strength, force, aggression, and cause some level of harm to meet military objectives (Cesur et al., 2013; Fleming, 2015; Freedman, 2015). The nature of warfare assumed by Cesur et al. (2013) could be generalized to veterans who are from any part of the country and have different ranks and time in service. Although the scope of the research centers on treatment programs in the Washington, D.C. metropolitan area, the survey was also distributed to other regions of the United States. Only data from combat veterans were used. Generalizability could be affected by the sample size and therefore viewed as a constraint to this study. However, these limitations could result in opportunities for future research.

Significance of the Study

Investigation of the effects of spiritual wellness on moral injury could be used to inform the development of new interventions, which could help combat veterans receive treatment that they could not otherwise obtain (Gray et al., 2012; Hoge et al., 2004; Karlin et al., 2010; Maguen & Litz, 2014). Other researchers (Doyle & Peterson, 2005; Sayer et al., 2010; Sayers, 2011) have highlighted the need for advocacy and leadership that could help recognize veterans as a specific culture. Considering the professional counseling literature, there is a lack of advocacy to consider veterans as a separate culture

(Currier et al., 2015; Schwartz, 2012). Currier et al. (2015) and Schwartz (2012) highlighted that this lack of advocacy weakens the attention for mental health treatment of combat veterans and is an issue that must be addressed. Recommendations from this study could offer guidance for developing policies and procedures for providing culturally sensitive treatment for those within the military.

Sayers et al. (2011) and Schwartz (2012) revealed that significant implications could be realized by recognizing the need to provide trained clinicians to treat this population. The VA estimated that 40% of veterans are not treated by trained professionals (VA, 2014). The research is important to the counselor education and supervision profession to better understand and serve the veteran population as counselors, educators, consultants, advocates, leaders, and researchers (American Counseling Association, 2014; Arredondo et al., 1996; Council for the Accreditation of Counseling Relayed Education Programs [CACREP], 2009; Doyle & Peterson, 2005).

Highly competent counselors will continue to be required to treat returning combat veterans (Doyle & Peterson, 2005). This study could suggest changes to the CACREP standards for counseling programs in the United States and provide program expectations, quality, and credibility. Study findings may be integrated and used to ensure that counselors are trained to meet specific and defined standards through proven educational and competency requirements (Schweiger et al., 2012). For example, combat veteran culture could be added as a standard in culture-related courses to gain CACREP accreditation.

Implications for Social Change

In this research, I investigated whether a statistically significant relationship exists between spiritual wellness by the FACIT-Sp and demographic variables and moral injury as measured by MIES. I developed explanations concerning the potential relationship between spiritual wellness and moral injury for returning combat veterans. Examining how spiritual wellness relates to moral injury could lead to theories and interventions that will address the negative impact of moral injury on veterans (Currier et al., 2015).

Investigating the potential relationship between spiritual wellness and moral injury could also bring clarity regarding how moral injury develops. Developing a theory of moral injury could contribute to the counseling field by influencing social change related to community-based trauma-related programs and treatment (Nash et al., 2013). Herzberg (2006) emphasized that social change should be viewed as a professional responsibility of clinical mental health counselors. As such, this study is critically important to add to the data needed to support social change that could allow veterans to be identified as a culture and to address the issues associated with moral injury and spiritual wellness.

According to the American Counseling Association (2014), efforts to incorporate combat veterans' cultural considerations and education standards into counselor education and supervision programs could help new clinicians become more effective in working with this population. These considerations and education standards could offer possible mental health advocacy related to moral injury symptoms and consequences related to family violence, spousal abuse, traffic accidents due to road rage, alcohol and

drug related incidents, and driving while intoxicated arrests. Advocacy for the veteran population could have a direct social change impact. Results of the study could also be used to reveal and test specific treatment options to improve quality of life and well-being of veterans (Ando et al., 2009; Johnson et al., 2015). Other implications for clinicians and researchers could be to explore the relationship of combat veterans to other professions, such as police and firefighters, subject to moral injury (Gray et al., 2012). Studying effective treatments for moral injury could be of benefit to others in society and support social change.

Summary

After an exhaustive search of the literature, I found only one researcher who discussed a comparison between spiritual wellness and moral injury (Nash et al., 2014). In this study, I researched and addressed the potential relationship between moral injury and spiritual wellness among combat veterans. The results could aid in the discovery of more creative ways to treat combat veterans with moral injury. Ideally, there will be an improved chance for successful integration of combat veterans back home to families and society. Moral injury and spiritual wellness concepts contain important clinical mental health constructs that are critical to understand, study, and help veterans' transition back to society (Currier et al., 2015). The overall methodology and design described in this study could be used to test if there is a statistically significant relationship between the factors of spiritual wellness and demographic variables on moral injury.

Gaps in existing professional literature drive the need and importance to move the research on this topic forward. Research on the effects of moral injury on spiritual

wellness has not been identified. Researchers at the National Center for PTSD (2014) stated that with moral injury, a sense of normal is affected and ways to relate to and react to fear are changed, often forever. Upon veterans' return home, a large number of combat veterans and families are unable to cope with the invisible wounds of war (U.S. Department of Veterans Affairs, 2014). In summary, with this study I hope to spread new knowledge to inform policy makers, military leaders, scholars, and educators of further possibilities for discussion and creativity about how to help combat veterans heal from the wounds of war.

Chapter 2: Literature Review

Introduction

The need to define and understand the difficulties faced by combat veterans who return home from war is growing (Currier et al., 2013; Frankfurt & Frazier, 2016; Maguen & Litz, 2014; Nash et al., 2013). Research on the impact of mental health on veterans has received a great deal of attention over the last few years (Barr et al., 2016; Bormann et al., 2012; Currier et al., 2013; U.S. Department of Veterans Affairs, 2015). Mental health researchers found that the identification and lack of understanding of moral injury and spiritual wellness, as well as their impact on mental health, have not been sufficiently studied. The purpose of this study is to achieve a better understanding of the relationship between moral injury and spiritual wellness of combat veterans.

Attaining a better comprehension of this relationship could help identify, define, and reduce the many issues confronted by families and society when veterans return home (Barr et al., 2016; Currier et al., 2013; Maguen & Litz, 2014; Nash et al., 2013). Barr et al. (2016), Currier et al. (2013), Maguen and Litz, (2014), and Nash et al. (2013) concluded that understanding the relationship is critical for reducing the negative symptoms and consequences experienced by the veteran. Results of the study could offer insights into further study for the treatment of veterans with moral injury and to advocate for the importance of seeing combat veterans as a unique culture.

Overview

The purpose of this literature review is to examine the current research related to the relationship between moral injury and spiritual wellness. In this chapter, I examine

the research on moral injury, spiritual wellness, and the proposed research topic. I also present an overview of relevant literature and the synopsis of the current literature that establishes the history and relevance of the problem. I intend to support the establishment of the need, value, and benefits of researching the potential relationship between spiritual wellness and moral injury. Understanding a relationship between spiritual wellness and moral injury could lead to better treatment for veterans and have positive benefits for society.

I discuss the study of moral injury and spiritual wellness by outlining its history and the need for more research, as well as the benefits and significance of establishing a relationship between the two. Because this study focuses primarily on moral injury, a background is provided for a clearer understanding of its history. Identification and explanation of key terms, theory, and methodologies are reviewed. I also explore how researchers have used existentialism as a theoretical framework as it contributes to how spiritual wellness relates to moral injury. An explanation of search strategies, key variables, and concepts is followed by a summary and conclusion.

Literature Search Strategies

The following sections include previous research on moral injury and spiritual wellness and how this research supports the study, compares methodologies and theoretical frameworks, and identifies gaps in the professional literature. Identified and discussed below is a list of accessed databases, search engines, key search terms, and scope of literature review. A comprehensive review of the current research on spiritual wellness and moral injury could help identify previous discoveries by leading researchers

in the field (Creswell, 2009). Creswell (2009) evaluated, assessed, and synthesized information to address the most effective methods and steps for this study to advance and effectively address the problem (Green & Salkind, 2014).

Obtaining a thorough understanding of the relationship between spiritual wellness and moral injury could lead to effective interventions to address unique issues that arise for veterans who have committed or been exposed to moral injury and to successfully integrate combat veterans back into society (Currier et al., 2013; Frankfurt & Frazier, 2016; Maguen & Litz, 2014; Nash et al., 2013). Studying previous results, implications for future research, theoretical frameworks, and methodologies of leading researchers provided insights on how to best further the research on moral injury and spiritual wellness (Creswell, 2009).

A thorough search, review, analysis, and synthesis of the literature indicate a need to study the relationship between moral injury and spiritual wellness. I primarily focused on research published within the last 5 years and used research older than 10 years only to help provide key findings. I conducted multiple searches using the following databases: Walden University's Academic Search Premier, Dissertations and Theses, Health and Psychosocial Instruments, ProQuest Central, PsycARTICLES, PsychINFO, PsychNET, SAGE, and Google Scholar.

Key search words used for this study included *moral injury, soul injury, PTSD, spirituality, spiritual wellness, combat veterans,* and *combat veteran reintegration*. I searched for research and empirical studies without restriction on the type of research and number of participants. The search produced 120 studies. Using the most recent research

articles dealing with moral injury and spiritual wellness produced only three related studies. Two studies were quantitative and one was qualitative (Currier et al., 2013; Frankfurt & Frazier, 2016; Maguen & Litz, 2014; Nash et al., 2013). These researchers discovered strong support to further understand the relationship between moral injury and spiritual wellness. However, there is a lack of empirical research and evidence from peer-reviewed journals and other sources regarding specific investigations of spiritual wellness and moral injury. To address this, an empirical based review of the history of moral injury and spiritual wellness related to comparable studies and themes helped to identify the need, opportunities, and value to this specific study.

Frankfurt and Frazier (2016) highlighted that the study of moral injury is relatively young and requires greater development to benefit veterans. Previous researchers concluded that there is a significant deficiency in the research on moral injury (Currier et al., 2013; Frankfurt & Frazier, 2016; Maguen & Litz, 2014; Nash et al., 2013). There is a limited amount of research to define moral injury and identify the differences of moral injury and PTSD (Frankfurt & Frazier 2016; Kinghorn, 2012). There is also an abundance of empirical research on relationships between spiritual wellness and issues related to moral injury such as PTSD (Manzaneque et al., 2011; Smith et al., 2016; Steenkamp et al., 2015; Tsai et al., 2016; Rapgay, Bystritsky, Dafter, & Spearman, 2012; Williams, McManus, Muse, & Williams, 2008). Figure 1 illustrates the relationship of moral injury to PTSD. In the following section, I identify and define the elements related to symptoms, outcomes, and characteristics. Considering the lack of studies related directly to moral injury and spiritual wellness, I also reviewed the studies related to

spiritual wellness and PTSD to examine research methodologies, theoretical framework, effects on maladaptive coping, and the gap associated with spiritual wellness and moral injury.

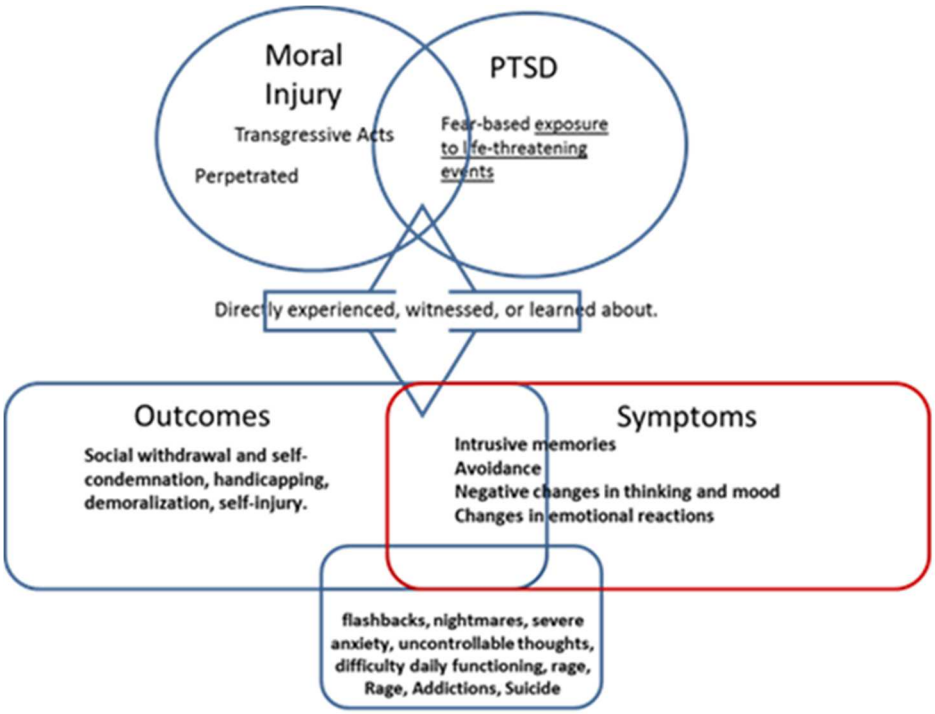

Figure 1. Overlap of terms, categories, labels, and symptoms

Key Variables, Concepts, and Themes

In this section, I review the studies related to the elements and constructs of moral injury, spiritual wellness, related quantitative methodologies, and existentialism theory within the scope of the study. Also examined are methods researchers have used to approach the problem and the strengths and weaknesses inherent in their approaches. Examination of the history of moral injury, the role of spiritual wellness on symptoms, the consequences of moral injury, and the related disorders is the basis for selecting to

study the relationship of moral injury and spiritual wellness as the key dependent and independent variables for the study. Understanding the history and background could help to make deductions concerning their relationship.

I also examine the role of existentialism as the theoretical framework and methodologies related to the research question. I conducted the review and synthesis of the key independent and dependent variables to determine and explain what is known about the variables, what is debated, and what the implications for further study are. Provided below is an exhaustive review of the current literature on moral injury, spiritual wellness, and their related research methods and theoretical frameworks.

Moral Injury

The definition and elements of moral injury are important for examining the relationship of moral injury to spiritual wellness. I found very few statistics and little research on the prevalence of moral injury elements in veterans prior to the Vietnam War. It is important to provide a brief review of the early moral injury research to understand the support and credibility of viewing moral injury differently than the trauma-based characteristics associated with PTSD (Haley, 1974; Horowitz & Solomon, 1975; Shatan, 1973; Shay, 2003).

In studies on the grief of Vietnam combat veterans, Shatan (1973) concluded that acts that violated the moral and ethical beliefs of veterans over a period of time were likely to cause behavioral issues and difficulty returning to life back home. Another prominent study by Horowitz and Solomon (1975) predicted delayed stress response syndromes in Vietnam veterans. These early researchers concluded that combat veterans

exposed to repeated violations to their consciences will likely experience difficulties coping with life once they return home to families (Horowitz & Solomon, 1975; Haley, 1974; Shatan, 1973).

Shatan (1973) concluded that the government claimed few "psychiatric casualties" among Vietnam War veterans. The author reported that delayed symptoms and culture and training that discourage grief and intimacy made a difference in reporting (Shatan, 1973). It is important to note the historical nature of the stigma of this issue and hesitancy of the VA and others to provide assistance. Shatan identifies initiatives that are needed to assist mental health professionals in coping with inadequacy of the traditional therapist-patient relationship. For several decades, clinicians have noted the psychological impact on veterans of engaging in killing, committing atrocities, and violating the rules of engagement.

A great deal of research on the present-day concept of moral injury is credited to clinical psychiatrist Dr. Jonathan Shay (U.S. Department of Veterans Affairs, 2014). Shay (2003; 2010; 2014) defined moral injury as stemming from the “betrayal of ‘what’s right’ in a high-stakes situation by someone who holds power”. According to Shay (2014), the process of recovery should consist of purification through joining with life purpose in a creative way. Shay’s view on the importance of life meaning begins to show the significance to connecting existential theory and spiritual wellness to the relationship of moral injury.

Since 1994, there have been numerous studies on this topic that take into account military conflicts and similar exposure to moral injury. However, the review of the

recent studies related to the present-day war in Iraq and Afghanistan could be useful for examining the latest studies as they relate to our current culture and needs. Approximately 930,000 military personnel (Army, Navy, Marine, Air Force) deployed to Iraq and Afghanistan between 2001 and 2011 for at least one year; at least 50,000 personnel deployed for four or more years (Baiocchi, 2013).

A majority of the research on veterans has focused on PTSD as a fear and trauma-based disorder that results from exposure to life-threatening events rather than the consequences of active participation in warfare (Currier et al., 2013; Frankfurt & Frazier 2016; Maguen & Litz, 2014; Nash et al., 2013; Litz et al., 2009; Drescher et al., 2011). According to these leading researchers, most moral injury researchers studied factors and themes related to transgressive acts and betrayal that impact and contribute to moral injury. The researchers studied the elements initially thought to be important to moral injury and paved the way to explore other elements, such as spiritual wellness, as a possible relationship on moral injury. The researchers discovered themes of moral injury that relate to acts of transgression, betrayal, justification, and rules of engagement as identified and detailed below.

Acts of transgression and betrayal. A review of the present research of moral injury in combat veterans found that most of the present-day researchers view the construct of moral injury as acts of transgression and betrayal (Currier et al., 2013; Drescher et al., 2011; Frankfurt & Frazier 2016; Litz et al., 2009; Maguen & Litz, 2014; Nash et al., 2013). These studies reveal acts of transgression as injuries separate from PTSD and uncover how they relate to spiritual wellness. The transgressive acts theme

was investigated in studies by Currier et al. (2013) and Drescher et al. (2011). The studies describe the experiences that involve the violation or transgression of accepted boundaries of behavior. A study by Litz et al. (2009) proposed that like traumatic events, as defined in the criteria for PTSD, transgressive acts could be directly witnessed and experienced. The experiences are often referred to as morally injurious experiences (MIEs) or moral injury (Litz et al., 2009; Farnsworth et al., 2014). Figure 2 illustrates the connection of these concepts to both definitions by Litz et al. (2009) and Drescher et al. (2011).

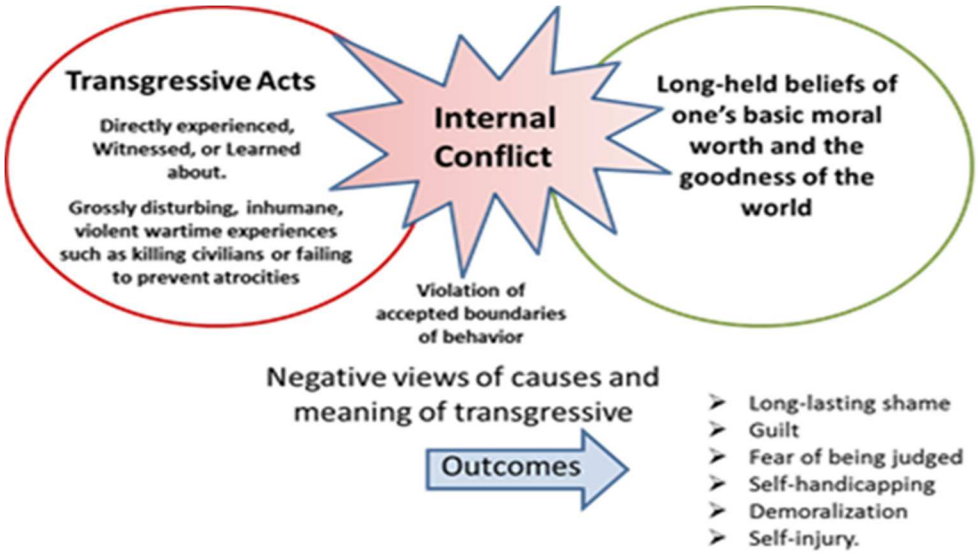

Figure 2. Illustration of the basic premise of Moral Injury by Litz, et al (2009); Drescher, et al (2011)

Figure 2. Basic premise of moral injury by Litz et al. (2009) and Drescher et al. (2011)

The moral injury syndrome was proposed by Litz et al. (2009) to result from the conflict generated between transgressive acts and long-held beliefs about one's basic moral worth and the goodness of the world. According to Litz et al. (2009) if this

internal moral conflict gives rise to negative acknowledgments about the causes and meaning of a transgressive act then these attributions can lead to long-lasting shame, guilt, and a fear of being judged. The researchers highlighted key findings that individual's life meaning and purpose has an important impact on these outcomes. This is significant to draw the connection to the value of studying the impact of the existential framework used for this study. Understanding the relationship of an individual's life meaning and purpose, as a factor of spiritual wellness, is important to study the relationship on moral injury.

Recent reviews and studies by Frankfurt and Frazier (2016) and Vargas et al. (2013) proposed that moral injury is the suffering some veterans experience when they engage in acts during combat that violate their beliefs about their own goodness or the goodness of the world. The researchers concluded these experiences are labeled transgressive acts to identify them as potentially traumatic experiences distinct from the fear-based trauma associated with PTSD. Litz et al. (2009) identified moral injury as a result of grossly disturbing violent wartime experiences such as killing civilians or failing to prevent atrocities. These authors offered this preliminary definition of morally injurious experiences (or transgressive acts): "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply help moral beliefs and expectations" (p. 700). Drescher et al. (2011) defined transgressive acts as "inhumane, cruel, depraved, or violent, bringing about pain, suffering, or death of others" (p. 9). Drescher et al. (2011) defined betrayal by a trusted authority figure, such as a commanding officer, as a transgressive act.

A new research study by Currier et al. (2015) examined whether exposure to MIES contributes to mental health issues in the transition of combat veterans to families and society. Findings provided evidence moral injury events increase the risk for adjustment problems. This is important finding because it helped to understand the relationship of moral emotions and fear of being judged impact sympathetic interactions and spiritually oriented wellness factors. Examining supportive interactions related to spiritual wellness could help discover relationships to moral in jury outcomes related to shame and guilt-based beliefs of being unforgivable. Understanding this could also highlight self-condemnation outcomes related to life purpose characteristics of spiritual wellness. Few studies have examined the relationship between transgressive acts to shame, guilt-based beliefs, forgiveness, and self-condemnation. Therefore, discovering a relationship of spiritual wellness to moral injury can help to uncover data needed to further explore how transgressive acts may relate to the outcomes of moral injury.

Other researchers have reported a relation between transgressive acts to guilt, shame, and increased social problems (Barr et al., 2016; Beckham et al., 1997; Fontana, Rosenheck, & Brett, 1992; King, King, Fairbank, Keane, & Adams, 1998). Results of these studies established a strong association between exposure to atrocities and feelings of guilt, shame, and the re-experiencing and avoidance symptoms of trauma related injuries. However, research is lacking to test the relationship of transgressive acts to overall spiritual wellness (King et al., 1998). Suggestions for further research concluded the need to study associations with moral injury and the effects of life meaning, purpose, peace, and faith that are directly related to spiritual wellness.

Justified transgressive acts or outside rules of engagement. Other themes and perspectives associated with the definition of moral injury are important to understand and study the relationship of moral injury to spiritual wellness. There is ongoing debate about what particular acts should be considered transgressive (Farnsworth et al., 2014; Frankfurt & Frazier, 2016; Litz et al., 2009). For example, shooting and attempting to kill an enemy combatant who is shooting at you may fall within the rules of engagement in a theater of combat, but continuing to shoot at an enemy combatant who has fallen to the ground falls outside the rules of engagement. The risk, type, and exact nature of transgressive acts are varied between wars, theaters of combat, branches of military service, and particular acts assessed (Smith et al., 2016; Tsai et al., 2016; Steenkamp et al., 2015). There are not any current studies that investigate the same transgressive act across military branches of service and wars. This makes comparisons unreliable and the exact number of acknowledged transgressive acts, such as witnessing transgressive acts, betrayal by a commanding officer, or participation in a friendly fire incident, not yet assessed. However, researchers generally agreed those acts considered transgressive as justified in war (killing an enemy combatant) or outside the rules of engagement (atrocities, war crimes) are still potentially morally injurious (Farnsworth et al., 2014; Frankfurt & Frazier, 2016; Litz et al., 2009). Further, these authors concluded research is needed to connect philosophy, psychology, and military studies to explore what are transgressive acts and how they should be defined. Drawing from this desire to link these categories, the research of spirituality and spiritual wellness is viewed as an expansion of these areas.

The need to understand the relationship and impact of moral injury on spiritual wellness is expected to help comprehend moral injury. A study by Smith et al. (2016) concluded a recent cohort of veterans from Operation Iraqi Freedom (OIF) in Iraq and Operation Enduring Freedom (OEF) in Afghanistan were reported to run a high risk of having engaged in or been exposed transgressive acts. This risk was likely heightened because combat was against insurgent forces using guerilla tactics in urban/close quarters. Approximately 40%–50% of OIF soldiers and 65% of OIF Marines reported killing an enemy combatant (Hoge, 2010; Hoge et al., 2004; Maguen et al., 2010). Additionally, 12%–15% of OIF combat infantry soldiers and 28% of OIF combat infantry Marines reported killing a noncombatant (Hoge et al., 2004). A Rand Corporation survey of all deployed OIF and OEF veterans, including both active duty and Reserve/National Guard Army, Marine Corps, Navy, and Air Force personnel, found that 9.5% reported participating in hand-to-hand combat, 5% reported being directly responsible for deaths of civilians, and 5% reported witnessing brutality toward civilians (Schell & Marshal, 2008). These percentages supported in literature reveal the need to address moral injury and factors such as spiritual wellness that could help us better understand moral injury.

Moral injury scales and measures. In research by Litz et al. (2009), moral injury was described as the collection of shame and guilt-based disturbances that some combat veterans experience after engaging in wartime acts of commission (killing) or omission (failing to prevent atrocities). As a result of this, researchers suggested further study to develop measures to assess engagement in and exposure to transgressive acts (Litz et al., 2009; Smith et al., 2016; Tsai et al., 2016; Steenkamp et al., 2015). The

MIES (Nash et al., 2013) and the Moral Injury Questionnaire - Military version (MIQ–M) (Currier et al., 2015) were developed. Both the MIES and the MIQ–M assess committed or witnessed transgressive acts and perceived betrayal by others.

The MIQ–M assesses both causes and effects of moral injury development. The MIQ–M also assesses events that violate the rules of engagement and events that do not violate those rules. Using a regression analyses MIQ-M scores were associated with greater suicide risk controlling for other factors, but the bivariate correlation was not significant (Currier et al., 2015). In a study of the relation between transgressive acts and suicidality, Air Force and Army personnel with a lifetime history of suicide attempts (n 11) had significantly higher MIES scores than did personnel with no history of suicidality (n 106; Bryan et al., 2014). As identified in the description of the MIQ–M, a total score combined items assessing causes (14 items) and effects (six items). The MIES also assesses both causes ("I saw things that were morally wrong") and effects ("I am troubled by having witnessed others' immoral acts") on the same items. Assessing causes and effects on the same items implies connections between the two that may not be present. Addressing the relationship of spiritual wellness could provide connections to both causes and effects that could help us to better understand moral injury.

The MIES, developed by Nash et al. (2013), offers an 11-item, self-report survey to measure exposure to events and assess effect on deeply held moral beliefs. The reliability and psychometric properties of MIES showed good internal consistency reliability. The Cronbach's alpha for the nine-item scale was 0.90 and the item-total correlations ranged from 0.52 to 0.75. Indices suggested a good model fit (c2 (36) =

83.06, $p < 0.001$; SRMR = 0.04; RMSEA = 0.08; CFI = 0.96; TLI = 0.93). MIES was positively correlated with the Revised Beck Depression Inventory ($r = 0.40$), the Beck Anxiety Inventory ($r = 0.28$), and the PTSD Checklist ($r = 0.28$). The instrument used includes transgressive acts and components of moral injury that include acts that fall both within (e.g., killing an enemy combatant) and outside (e.g., committing atrocities) the rules of engagement. Additional research is needed to establish MIES validity in the context of others military services and components and gender.

Initial psychometric testing of both the MIES and MIQ–M demonstrated adequate psychometric properties of scores in samples of active duty military personnel, recently returned veterans, and treatment-seeking veterans (Currier et al., 2015; Nash et al., 2013). For example, scores on the MIES demonstrated good internal consistency, and the two-factor structure (i.e., perceived transgressions by self or others and perceived betrayal by others) was cross-validated in a separate sample (Nash et al., 2013). Scores on the MIES and MIQ–M were significantly positively correlated with measures of distress, supporting convergent validity.

A shortfall of the MIES and the MIQ–M is the inability to compare the exposure of transgressive acts to the effects of exposure (Frankfurt & Frazier, 2016). In the same manner, comparing the factors of transgressive acts to the outcomes of transgressive acts (or both) is unclear (Frankfurt & Frazier, 2016). Conducting a study to address the relationship of moral injury to spiritual wellness is expected to help address the relationship of exposure of transgressions to consequences of exposure. Understanding the relationship of spiritual wellness associated with life meaning, life purpose, peace,

and faith on moral injury is further reviewed below to address specific outcomes and consequences (addictions, suicide, rage, violence, crimes, trauma and other mental health disorders). Litz et al. (2009) suggested the use of empirical based quantitative research to moderate the relation between transgressive acts and moral injury and other existential factors related to spiritual wellness such as life purpose and self-esteem. Examining spiritual wellness on moral injury could help discover and understand this important relationship.

Moral injury and spiritual constructs. This section further reviews and details the relationship between spiritual constructs and moral injury to advance the value of studying the relationship between spiritual wellness to moral injury as further examined in latter sections. Understanding the history, value, and close association of spiritual constructs to spiritual wellness and moral injury connects the two variables and to understand the interaction of existentialism as the theoretical framework for the study.

Sher, Braquehais, and Casas (2012) and Weber and Pargament (2014) examined the effects of spiritual factors of veterans on overall well-being and motivation. The researchers concluded that spiritual wellness is related to suicidal ideation and behavior, depression, and resilience. In both studies, study participants overwhelmingly identified the value of seeking meaning and purpose in human existence. It includes the development of a deep appreciation for the depth and expanse of life and natural forces and peace that exist in the universe. The definition of moral injury effects, outcomes, and symptoms vary greatly and conflict with the development of these characteristics (Bormann et al., 2012; Currier et al., 2015; Drescher et al., 2011; Foa, 2010; Harris, 2015,

Kinghorn, 2012; Maguen & Litz, 2014; Litz et al., 2009; Nash et al., 2013). Frankfurt and Frazier (2016) concluded moral injury outcomes related to demoralization, self-injury, self-condemnation, withdrawal, and numbing oppose the value of developing a strong sense of self. Studying a relationship between a strong sense of self and moral injury, as offered through an investigation of spiritual wellness on moral injury, could offer a much deeper appreciation and understanding of this connection.

Examining the history and development of the spiritual wellness concept, Miller (2016) traced its development as it moved through various transformations. As provided by Miller (2014), the National Wellness Institute describes spiritual wellness as the search for meaning and purpose in human existence, leading one to strive for a state of harmony with oneself and others while working to balance inner needs with the rest of the world. Without life meaning and connection with others a disruption in life harmony and balance may occur. Comparing this to moral injury, leading researchers of combat veterans, Currier et al. (2015) and Nash et al. (2013) concluded isolation, disconnection, and lack of harmony was a major effect of moral injury.

Earlier pioneers of spiritual growth and development, such as Carl Jung, Ken Wilber, Eric Erickson, and others, concluded significant findings on the value and effects of spirituality (Clements, Kaklauskas, Hocoy, & Hoffman, 2016). However, some researchers conclude that spirituality lies beyond the material world of proof, beyond what can be measured or counted (Sessanna et al., 2011). Many of those that challenge the value of measuring spirituality also agree that there is a relationship of stress, anxiety, and depression to inner calm, life meaning, and peace (Clements et al., 2016; Miller,

2014; Underhill, 2015). These researchers conclude that the characteristics of inner calm, peace, and meaning are those often used in definitions of spirituality. Clements et al. (2016) and Kaminker and Lukoff (2013) stated that meaning and purpose are the foundation of our most closely held values, and the base of our trust and hope. Kaminker and Lukoff, in their all-encompassing study of transpersonal perspectives on mental health and mental illness, pointed out spiritual wellness brings purpose and meaning to life. As we develop spiritual wellness, we evolve and grow.

A propensity of recent research of the spiritual impact on moral injury is taking place at the Soul Repair Center at Brite Divinity School (Brock & Lettini, 2012). U.S. Army chaplains are currently addressing the spiritual aspects of moral injury and their role in assisting the healing process. Drs. Rita Nakashima Brock and Gabriella Lettini are conducting research at the school to address moral injury from a spiritual perspective. These researchers emphasize moral injury as "…souls in anguish, not a psychological disorder" (Brock & Lettini, 2012). The researchers concluded that this occurs when veterans struggle with a lost sense of humanity after transgressing deeply held moral beliefs.

The moral injury syndrome was proposed to result from the cascading effects of social withdrawal and self-condemnation following the guilt and shame veterans experience after transgressive acts (Litz et al., 2009). Further, leading researchers discovered that differences related to moral injury were more often related to elements associated with the transgressions of moral and ethical factors often associated with spiritual wellness (Bormann et al., 2012; Currier et al., 2015; Drescher et al., 2011; Foa,

2010; Frankfurt & Frazier 2016; Harris, 2015, Kinghorn, 2012; Maguen & Litz, 2014; Litz et al., 2009; Nash et al., 2013). All of these researchers concluded that moral and ethical factors of spiritual wellness could affect onset, symptoms, and consequences of moral injury differently than PTSD.

Identifying a lost sense of humanity, as an outcome of transgressing deeply held beliefs, provides the opportunity to assess spiritual wellness outcomes in relationship to the MIES moral injury survey. The MIES survey as described above addresses both transgression acts and outcomes. Understanding moral injury as an outcome and a transgression may also help to satisfy the limitations in the MIES survey. For instance, it is not clear if factors, such as anger, are factors for transgressive acts or outcomes of transgressive acts or both. The study of moral injury is further complicated by including symptoms of intrusive memories, emotional numbing, and avoidance, as well as the collateral effects such as self-injury, demoralization, and self-handicapping which are stem from PTSD diagnosis (Currier et al., 2015; Frankfurt & Frazier 2016; Litz, 2009; Maguen & Litz, 2014; Nash et al., 2013). I found that these researchers also include constructs and effects of moral injury such as guilt, shame, withdrawal, self-condemnation that overlap with the collateral outcomes of self-handicapping, demoralization, and self-injury.

Review of the literature revealed it is difficult to validate moral injury models that theorize links between transgressive acts and guilt if the measures of transgressive acts also measure guilt. It would also be useful to identify measures of transgressive acts that distinguish between different kinds of exposures. This is important because these

different types of exposures may be associated with different outcomes (Farnsworth et al., 2014). Exploring the relationship of spiritual wellness and moral injury could help to address this limitation in the research. As a further example, substance abuse can be conceptualized as self-injury or as self-handicapping. Frankfurt and Frazier (2016) revealed the need for strong research designs and quantitative methods to clearly define the relationship of the categories. Investigating the effects of spiritual wellness on moral injury could help to understand and define these relationships. Researchers concluded that analyses that separate the causes versus effects items on moral injury surveys or new measures of transgressive acts that are not confounded with outcomes could be useful (Currier et al., 2015; Farnsworth et al., 2014; 2013; Frankfurt & Frazier, 2016; Litz, 2009; Maguen & Litz, 2014; Nash et al., 2013). Investigating the impact of spiritual wellness on moral injury as a measure that separately assesses these experiences could be useful.

Another highly researched topic that uses similar causes, outcomes, and effects is the reintegration and quality of life measurements of returning combat veteran back to society and family (Wallace, 2016). Recent combat veteran reintegration and quality of life studies were examined to understand the intersection of causes, outcome, and effects of moral injury and trauma (U.S. Department of Veteran Affairs, 2014; Sherman, Larsen, & Borden, 2015; Vargas, 2013; Wallace, 2016). Sherman et al. (2015) identified spiritual wellness as one of the six key domains to broaden the focus in supporting reintegrating Iraq and Afghanistan veterans. There is ample research of trauma and reintegration issues of combat veterans in relationship to alternative health, integrated medicine, and

holistic approaches using elements of spiritual wellness and moral injury (Barr et al., 2016; Brenner et al., 2015; Bryan et al., 2015).

As provided, this review also revealed a large number of related topics (combat veteran reintegration, quality of life, and overall mental health) that studied the relationship of spiritual wellness on the causes, effects, and outcomes of moral injury and their elements as well as other trauma related issues such as PTSD. The research indicated significant relationships concerning the effects of spiritual wellness and the value in studying the effects of spiritual wellness. Many of these researchers identified in this review concluded the difficulties faced by veterans and the need to understand the relationship of spiritual wellness and related moral and traumatic injuries.

Spiritual Wellness

There is a fair amount of clinical and empirical work to identify the effects of spiritual elements on transgressive acts (Currier et al., 2013; Frankfurt & Frazier 2016; Litz, 2009; Maguen & Litz, 2014; Nash et al., 2013; Vogt & Johnson, 2011). A study of 154 combat veterans by Bormann et al. (2012) on the relationship of forgiveness and life meaning found compelling evidence that transgressive acts are associated with loss of life purpose even after controlling for combat exposure. This study suggests a relationship may also exist in the spiritual wellness of combat veterans. However, limitations in recent studies center on understanding the direction of characteristics associated with transgressive acts and outcomes. Studying the relationship of spiritual wellness to moral injury can add to an understanding of that relationship. Bormann et al. (2012) also concluded factors to influence the likelihood of negative moral injury outcomes and

collateral effects related to battlefield ethics, and positive leadership to offer a sense of faith, hope, and peace.

Most of the latest research on transgressive acts centers on whether killing and/or contributing to atrocities predicts PTSD different then traumas that involve general combat exposure. Several studies have shown that killing in combat significantly predicted PTSD symptoms after controlling for combat exposure in samples from the Vietnam, Gulf War, and the Iraq War (Fontana & Rosenheck, 1998; Maguen et al., 2010, 2009; Maguen et al., 2011). However, the separation of moral injury is not clear. Finding a relationship of spiritual wellness on moral injury can also help to understand moral injury as separate from PTSD. For example, a low score on the life purpose factor of spiritual wellness may results in a low moral injury score. In this case less spiritual wellness results in less moral injury. Comparing the relationship of spiritual wellness to moral injury and PTSD separately could help to separate the differences in moral injury from PTSD. Moreover, the review revealed a need to further understand the wellness factors that could both reduce the risk of transgressive acts and help clinicians identify combat veterans that could be at risk of moral injury. Assessing the relationship of moral injury and spiritual wellness addresses this shortcoming.

The review revealed a shortage of recent studies that test the relationships between transgressive acts and relevant outcomes associated with guilt, shame, and social withdrawal in one model (Beckham et al., 1998; Fontana & Rosenheck, 1999; Maguen et al., 2010, 2009; Maguen, Vogt et al., 2011). Using a spiritual wellness and existentialist model could account for these differences. Maguen et al. (2010, 2009) and Maguen,

Vogt et al. (2011) concluded participation in transgressive acts is also associated with increased risk of suicide and self-handicapping and is shown to be influenced by life meaning, peace, faith, shame, guilt, and moral spirituality. Considering the implications of past research and effects identified in the moral injury model, there is the strong support for the importance of knowing more about the relationship between moral injury and spiritual wellness. In reviewing a number of spiritual wellness instruments, three surveys with strong psychometrics were carefully considered for this study: the Spiritual Assessment Inventory (SAI) (Hall & Edwards, 2002); the Spirituality Index of Well-Being (SIWB) (Daaleman & Frey, 2004); and the Functional Assessment of Chronic Illness Therapy—FACIT-Sp (Canada et al., 2008).

The SAI is a 49-item self-report questionnaire designed to assess five aspects of spirituality based on a theistic model for assessing spiritual development. The SIWB is a 12-item instrument that measures one's perceptions of their spiritual quality of life and defines spirituality as a sense of meaning or purpose from a transcendent source (Daaleman & Frey, 2004). Canada et al. (2008) developed a 12-item FACIT-Sp as a measure of the religious/spiritual (R/S) components of quality of life. The Canada et al. (2008) was favored because it included the elements of moral injury and existential framework most often referred to in the literature.

The FACIT-Sp is 2-item assessment that measures the religious/spiritual (R/S) components of quality of life (Canada et al., 2008). The significance of this instrument is that it offers a 3-factor solution that includes the elements: meaning, peace, and faith. These elements are the same ones used in recent research to test spiritual constructs to

other disorders. Examining these elements to moral injury can reveal a useful relationship. Cronbach's α (0.85) for the FACIT-sp suggests that the test is reliable and item-to-total correlations were all significant (0.34 to 0.73). Moderate to strong correlations among subscales suggest validity. The common elements of the FACIT-Sp and moral injury literature included: life meaning and purpose, faith, peace, and forgiveness. FACIT-Sp also identifies the value of the here and now present moment awareness associated with mindfulness, kindness, and compassion. These constructs were often studied to test the significance and efficacy associated with shame, suicide, depression, anxiety, guilt, and self-minimizing (Canada et al.; Daaleman & Frey, 2004; Hall & Edwards, 2002).

This review also resulted in a vast number of qualitative and quantitative researches that investigated the relationship between spiritual wellness and other trauma related disorders and maladaptive coping behaviors. Recent studies found relationships of spiritual wellness factors of life purpose, meaning, forgiveness, peace, faith in higher power on anxiety and adaptive coping behaviors. Oman and Bormann (2015) designed an experiment to measure the relationship between spiritual wellness and self-efficacy in veterans for managing PTSD. The researchers concluded a significant relationship between spiritual components and PTSD in diverse types of health care interventions. This study investigated the effects of the peace and faith through use of a mantra repetition program (MRP) on self-efficacy for managing PTSD symptoms. Outpatient veterans with PTSD (n = 132) and participants were randomized. Results revealed that spiritual group showed that spiritual elements and wellness had a significant effect on

PTSD ($p < .01$). Authors concluded that the MRP fosters self-efficacy for managing PTSD symptoms, improves well-being, and merits investigation.

Walker et al. (2015) conducted a feasibility study promoting spiritual well-being for behavior change. The researchers concluded that faith-based programs have shown beneficial effects for health and behaviours. The study was a quasi-experimental one group, pretest–posttest design. This study provided support for the design and further testing of the theoretical components of the spiritual framework for coping with stress (Walker et al., 2015). A further review of the research helped to identify and understand the relationship of moral injury to PTSD. Research shows a strong connection of moral injury to spiritual related wellness factors. As discovered by Currier et al. (2015) the growing problem of moral injury has resulted in significant issues for combat veterans related to the consequences and symptoms of shame and guilt more often associated spiritual wellness (Worthington & Langberg, 2012).

The review of the literature revealed little research concerning the direct relationship of moral injury and spiritual wellness. However, the literature revealed several studies related to elements of spiritual wellness and moral injury as well as the cognitive, behavioral, and affective symptoms associated with moral injury different than PTSD (Currier et al., 2013; Maguen & Litz, 2014; Nash et al., 2013). The authors also pointed out the value of studying specific targeted treatment approaches that could significantly reduce the onset and specific moral injury symptoms and consequences. Therefore, given the importance of spiritual elements and constructs in the definition and

development of moral injury studying spiritual related wellness and approaches could be beneficial.

The review on spiritual wellness and moral injury also produced a great deal of information concerning the value of spiritual programs and interventions related to changes in moral injury and its elements (Harris et al., 2015). Some of the spiritual wellness and moral injury based programs related to faith based settings such as Building Spiritual Strength (BSS) and Mindfulness Based Stress Reduction (MBSR). These studies concluded significant results related to understanding the impact of killing on psychiatric symptoms. Several of these studies support the need for additional studies to understand moral injury and spiritual wellness as an important next step in delivering adequate care to combat veterans (Owens, Walter, Chard, & Davis, 2012; Raes, DeWulf, Van Heeringen, & Williams, 2009; Rapgay et al., 2011; Taylor et al., 2011; Williams et al., 2011; Yook et al., 2008).

To build on the spiritual wellness and moral injury research review related to methodology and theoretical framework, examining studies associated to mindfulness reveals strong connections to the relationship of spiritual wellness and moral injury of combat veterans (Rapgay et al., 2011; Taylor et al., 2011; Williams et al., 2008; Williams et al., 2011; Yook et al., 2008). Examining the research of the related moral injury symptoms revealed the importance of researching spiritual wellness and moral injury (Ando et al., 2009; Craigie, Rees, Marsh, & Nathan, 2008; Evans et al., 2008; Finucane & Mercer, 2006; Kim et al., 2010; Manzaneque et al., 2011; Raes et al., 2009; Rapgay et al., 2011; Williams et al., 2008). These researchers have concluded that there is a

relationship between spiritual wellness and outcomes and consequences of other metal disorders such as PTSD and anxiety.

In the majority of these studies, subjects were treated with spiritual and mindfulness related constructs such as life meaning, purpose, faith, peace, forgiveness, and kindness. According to studies (Evans et al., 2008; Finucane & Mercer, 2006; Kim et al., 2009; Manzaneque et al., 2011), as spiritual wellbeing improved, and consequences and symptoms of moral injury and PTSD decreased. These researchers concluded that although Cognitive Behavior Therapy (CBT) is considered an effective treatment for PTSD, a significant number of patients continue to experience symptoms unrelated to PTSD (Evans et al., 2008). Study results often predicted significant results for those treatments associated with elements of spiritual wellness. These studies also suggested that those who had a strong spiritual wellbeing score tended to have less symptoms and consequences related to PTSD (anxiety, addictions, anger, etc.).

Existentialism Theory

The hypothesis of this study is based on the concepts used in existential psychology. Existentially based theories have received a great deal of support and validation from the counseling field over many years of research and practice (Bormann et al., 2012; Canada et al., 2008; Drescher et al., 2011; Harris et al., 2015; Kim & Jamal, 2007; Bormann et al., 2012; Sayer et al., 2010; Nash et al., 2013). Several researchers concluded the consequences and symptoms of moral injury related to combat veterans are associated with conflicts of deeply held beliefs most often associated with life meaning, value, and fulfillment of life purpose (Bormann et al., 2012; Castro et al.,2015; Kim &

Jamal, 2007; Sayer et al., 2010; Nash et al., 2013). These constructs can be understood and are often related to the same foundations and elements aligned with existential psychology (May & Yalom, 2005; Reynolds, 2014).

Existential theory and models have evolved over many years to include the integration of psychological wellness and spiritual balance (May & Yalom, 2005). The framework is based on the belief that even though we are essentially alone in the world, humans desire life meaning, purpose, and to be connected to others (May & Yalom, 2005; Reynolds, 2014). May and Yalom (2005) stated that if a person's connection to other humans is at risk, as experienced in combat, they can become dependent on others for their own validation. The relationship of existential theory and models to this study is important because it endorses and validates the study of spiritual wellness and moral injury as operational variables (Creswell, 2009).

Researchers have concluded that the conflict between self-validation and dependence on others can be restored when patients become comfortable with their own fundamental aloneness (Bormann et al., 2012; Canada et al., 2008; Drescher et al., 2011; Harris et al., 2015; Kim & Jamal, 2007; May & Yalom, 2005; Reynolds, 2014; Sayer et al., 2010; Nash et al., 2013). Once this internal validation occurs they can connect more genuinely to others (Yalom, 1980). Figure 3 illustrates that these constructs are important to this study because a relationship between spiritual wellness on moral injury could be discovered though the combat experiences associated with conflicts of deeply held beliefs associated with relationship with others, life meaning, value, and fulfillment

of life purpose (Bormann et al., 2012; Kim & Jamal, 2007; Sayer et al., 2010; Nash et al., 2013).

Figure 3. Relationship of Spiritual Wellness and Existential Theory to Moral Injury

Bormann et al. (2012) studied the value of using existential spiritual well-being (ESWB) to reduce the severity of PTSD and related moral injury symptoms in veterans with military trauma. The researchers reported that the intervention redirects attention and initiates relaxation to decrease symptom severity and resulted in significant and positive decreases in trauma symptoms. The study supports the framework for this research and relates well to the FACIT-Sp survey instrument scale. The research cited above reveals a connection and value of spiritual wellness in moral injury but it is just beginning to be identified, defined, and validated in the mental health community. Acceptance by the culture is just beginning and a systems approach is needed to

implement change and the new constructs (Senge, 2006). As latter in latter chapter a systems approach by leaders can help improve advocacy needed to choose specific interventions and address study results.

Several quantitative studies that researched the relationship of spiritual wellness and elements of moral injury predicted the importance of this relationship (Kuo, Gallo, & Eaton, 2004; Bormann et al., 2012; Kim & Jamal, 2007; Parson, 1990; Sayer et al., 2010; Nash et al., 2013). The studies tested the relationship of spiritual wellness to moral injury and found significant relationships and outcomes related to demoralization, inability to cope, and hopelessness. These researchers concluded a demoralized person descends into existential despair and meaninglessness. This important finding validates the value and validity of an existentialist model.

Kuo et al. (2004) predicted that demoralization is often experienced concurrently with depression; demoralization could have unique consequences as ties to moral injury. This research may help to understand whether demoralization and/or other outcomes are related to moral injury and be used as a mechanism to predict factors that increase the risk of other collateral outcomes such as self-injury rather than as an independent outcome. For example, hopelessness as a component of demoralization is also a risk marker for suicidality among veterans with direct combat exposure (Bryan et al., 2014). Comparing spiritual wellness to moral injury could provide insights into being unable understand whether demoralization and/or other outcomes are related to moral injury.

As pointed out in this review the connection of the spiritual constructs related to moral injury make the investigation of spiritual wellness and moral injury valuable.

There are a large number of studies examining the relationship of spiritual wellness factors used in the FACIT-Sp such as purpose, faith, forgiveness to factors of moral injury dealing with transgression, betrayal, fear, anxiety, and related behavioral and emotional consequences. This review confirms the value and credibility of studying the relationship of spiritual wellness to moral injury. It also demonstrates the value of the study methodology and validates the use framework, and design connected to the study variables.

Summary and Conclusions

Despite the known benefits of studying the causes and effects of moral injury, there are few efforts to understand and study the relationship between spiritual wellness and moral injury. Understanding the effects of transgression on moral injury and the benefit of separating it from PTSD is not enough to completely understand moral injury and its causes. Researchers have indicated that certain spiritual wellness factors could affect the effect of moral injury and its impact on society. If a clear connection could be made with regard to this relationship, determining the relationships between these characteristics could give justification for enhanced treatment of combat veterans. The enhanced treatment could lead to less stress on families and society when combat veterans transition back home from war. Treatment could also lessen monetary costs and demand to society as a result of consequences of moral injury. Understanding veterans as a distinct culture could also help train clinicians to treat combat veterans once they return back to society.

Looking through the lens of existentialism theory, it is expected that research could demonstrate how spiritual wellness could benefit combat veterans in the early steps of their training and before they deploy for war and are exposed to moral injury. A major theme in the literature is that many elements of moral injury are also common to PTSD and have similar effects, outcomes, and consequences. Many themes related to moral injury and spiritual wellness are also inherent in issues related to reintegration and transition of combat veterans back to society and families.

What is well known in the literature is the significance and value of defining moral injury separate from PTSD and other trauma related disorders. Also known is the value of spiritual wellness and trauma related disorders and value of meaning, purpose, faith and peace in helping heal from moral injuries. What is not known as well or lacking is the relationship of spiritual wellness to moral injury. It is not clear if a high spiritual wellness relates to a risk of more or less moral injury. Additional research is needed on the proposed collateral effects of exposure to transgressive acts beyond PTSD symptoms. Little research has examined the collateral effects in relation to transgressive acts. Other aspects of moral injury such as spiritual/existential problems and loss of faith were not included in the original works of Litz et al., (2009). According to Drescher et al. (2011) and Farnsworth et al. (2014), these aspects of moral injury need to be examined.

There is also a strong need to define the definition of transgressive acts and their relationship to effects and outcomes as they relate to measuring moral injury. Research concluded the implication of needing to further define if killing an enemy combatant could be considered a transgressive act and the differences between transgressive acts

associated with rules of engagement or atrocities. This research could also be used to help define the boundaries of what should be considered a transgressive act.

More research is needed on risk and protective factors for transgressive act exposure. Although combat exposure is perhaps inevitable, better spiritual training could help protect against some transgressive acts (e.g., killing enemy combatants or noncombatants) that accompany combat exposure. Disentangling the causes and effects of transgressive acts could be useful for gathering data on risk and protective factors for transgressive acts and moral injury outcomes prior to deployment. Studies that comprehensively assess the collateral effects related to spiritual wellness could allow for further clarification regarding the interrelatedness of the manifestations of moral injury.

Studies that test more complex models that include mediators and moderators of the relations between transgressive acts and the collateral effects of moral injury and PTSD symptoms are needed. Studies that assess mediation should be designed to provide strong tests of implied claims of causality in mediation models (e.g., by collecting data longitudinally pre- and post-deployment). This study fills at least one of the gaps in the literature and extends knowledge in the discipline. This research could help to bridge the gap between psychology, philosophy, ethics, and military studies. Examining elements of moral injury against spiritual wellness could help to develop assumptions of the moral injury concept and to define the boundaries between expected existential reckoning and moral injury. This review helps to establish the need to address the unique issues that arise for veterans who have committed or been exposed to transgressive acts. Further, this research could also help to explore, compare and predict the relationship of moral

injury and spiritual wellness. Results could be used to compare the impact of spiritual wellness to PTSD and help define the difference between PTSD and moral injury.

Connecting the gap of spiritual wellness to moral injury by offering an empirically based quantitative approach is lacking in the literature. Using a quantitative approach to predict a connection using a factor analysis could help draw direct conclusions as supported by a majority of the recommendations of the researchers in this review. This research is a quantitative survey and uses correlational analytical strategies and multiple regression analyses to address the question. Chapter 3 addresses the research design and plan, including specific information about sampling, statistical analysis, and limitations.

Chapter 3: Methodology

Introduction

In Chapter 3, I address the research methodology I used to evaluate the relationships between moral injury and spiritual wellness. The purpose of this study was to investigate the potential relationship between the independent variable of spiritual wellness as measured by the FACIT-Sp (Canada et al., 2008) and the dependent variable of moral injury as measured by the MIES (Nash et al., 2013) among combat veterans. In this chapter, I present the methodology, research question, and a discussion of the research design.

Methodology and Analytical Strategies

In this study, I used a quantitative design and a deductive approach to examine spiritual wellness to predict a relationship with moral injury of combat veterans in addition to related demographic variables identified within the literature review (Creswell, 2009; Groves et al., 2009). To advance empirical research on the problem, I investigated whether the independent variable of spiritual wellness as measured by the FACIT-Sp (Canada et al., 2008) could be used to predict the dependent variable of moral injury in combat veterans as measured by MIES (Nash et al., 2013), incorporating the demographic variables of gender, branch of service, component of service, military rank, and religion. The quantitative survey research is designed to discover trends and develop explanations about the potential relationship between spiritual wellness and moral injury for combat veterans (Groves et al., 2009). Both of these scales have been used to

discover statistically significant outcomes of military populations to assess trauma related issues and disorders (Bryan et al., 2014; Nash et al., 2013).

The analytical strategy included tests of means, correlation, and multiple regression analyses. Tests of means and correlation analysis were used to test the statistical significance of the relationships between spiritual wellness and the demographic variables (see Creswell, 2009). I then used regression analysis to estimate the conditional expectation of moral injury scores given spiritual wellness scores in addition to the demographic variables identified as significant. More specifically, results of a regression analysis could predict how measurements of moral injury change when any of the scores of spiritual wellness are varied beyond the impact of the demographic variables. The regression analysis involved identifying the relationship between one or more independent variables (spiritual wellness, demographic variables) and the dependent variable (moral injury). Regression analysis allows for discovery of a relationship between dependent and explanatory variables (Field, 2013; Green & Salkind, 2014). Field (2013) and Green and Salkind (2014) highlighted that the analysis does not predict that the explanatory variables cause the dependent variable but could determine some statistically significant association in the data (Montgomery, Peck, & Vining, 2015; Cohen, Cohen, West, & Aiken, 2013).

In similar studies, Lan et al. (2016) and Nieuwsma et al. (2014) used regression analysis to test veterans with mental health problems and readiness to seek treatment. The independent variables and dependent variables in both studies closely align with characteristics associated with moral injury and spiritual wellness. These authors

concluded that there could be a relationship that might not have been understood between these variables. Using an ex post facto design as a competing analytical strategy, Bakken-Gillen et al. (2015) predicted dependent variables of mental health and independent variables of wellness and demographics. The ex post facto design is used to study results that have already occurred (Campbell & Stanley, 1963). Instead of examining groups that are equivalent and subjecting them to different treatments, an ex post facto experiment takes groups that are already different in some respect and searches for factors that brought about those differences (Lord, 1973; Cohen, Manion, & Morison, 2000; Vogt & Johnson, 2011). The ex post facto study could be used to determine why one person has high moral injury scores and another does not. If an investigation reveals that people who are exposed to moral injury at a particular rank tend to have more symptoms, the investigator could hypothesize that exposure to moral injury at that rank is a factor in moral injury. Examining already present spiritual wellness could be assessed in much the same way. However, using ex post facto research would not address the research question for this investigation: Does spiritual wellness predict moral injury among combat veterans? The causal-comparative design method could also be appropriate if it was not possible to select, control, and manipulate the factors necessary to directly study cause and effect relations of moral injury and spiritual wellness. (Lord, 1973; Cohen et al., 2000; Vogt & Johnson, 2011).

Research Question and Hypotheses

RQ: Does spiritual wellness, as measured by FACIT-Sp, predict moral injury, as measured by MIES, among combat veterans beyond the predictive power of the

demographic variables of gender, branch of service, component of service, military rank, and religion?

H_0: There is no statistically significant relationship between spiritual wellness as measured by FACIT-Sp and moral injury as measured by MIES on combat veterans beyond the possible predictive power of the demographic variables of gender, branch of service, component of service, military rank, and religion.

H_a: There is a statistically significant relationship between spiritual wellness as measured by FACIT-Sp and moral injury as measured by MIES on combat veterans beyond the possible predictive power of the demographic variables of gender, branch of service, component of service, military rank, and religion.

Population and Sample

The unit of analysis is the individual combat veteran. Definitions of a military veteran and combat veteran vary widely amongst the general U.S. population as well as in the military itself (Schwartz, 2012). The federal definition of a veteran is any person who served honorably on active duty in the armed forces of the U.S. and received a general discharge and under honorable conditions (U.S. Department of Veterans Affairs, 2015). The number of veterans and combat veterans differs greatly depending on the source. According to the U.S. Census Bureau (2014), there are 22.6 million veterans in the U.S. armed forces as of 2014 in comparison to 319.2 million Americans (U.S. Department of Veterans Affairs, 2015).

A war veteran is defined as a military member ordered to foreign soil or waters to participate in direct or support activity against an enemy (U.S. Department of Veterans

Affairs, 2015). The VA (2015) identified a combat veteran as a military member who experiences any level of hostility for any duration resulting from offensive, defensive, or friendly fire military action involving a real or perceived enemy in any foreign theater. The definition of combat veteran is inconsistent among the Armed Services (Army, Air Force, Navy, Coast Guard, Reserves) as well as among active duty, reserve, guard, and civilian members. Those who enter a theater of operation are brought on active duty, but much of their training and experience could be from a Reserve or National Guard component (Department of Veterans Affairs, 2015). The survey instructions will ask those who have multiple tours or have served in different services or components to record their last tour of combat duty. A number of variables could affect the definition of combat veterans, such as type of mission in a combat zone, duration, and length. These variables were not addressed in this survey and are normalized by having at least one tour of duty that meets the requirement for being a study participant. Other variations of variables could be appropriate for a future study.

I used purposive sampling to ensure representation across different demographic groups (Creswell, 2009) to gain the best access to the most relevant data (Montgomery et al., 2015) and limit the study to a specific population (Frankfort-Nachmias & Nachmias, 2008). Purposive sampling supports previous research conducted by Nash et al. (2013) in which the authors concluded that the demographics associated with gender, branch of service, component of service, military rank, and religion could have a significant relationship with combat veterans who identify with moral injury. Efforts to include a random selection of participants from the demographic groups could improve the validity

of the study. It was necessary to ascertain a purposeful sample by determining which participant could meet the criteria of moral injury for the study.

I chose purposive sampling of participants because it could provide the most informative and appropriate data (Frankfort-Nachmias & Nachmias, 2008). Purposive sampling allowed for choosing combat veterans within the population to use for this study. Unlike random studies, which deliberately include a diverse cross section of ages, backgrounds, and cultures (Groves et al., 2009), this purposive sampling allowed for concentration on people with combat experience needed for this experiment.

The purposive sampling technique allowed for the gathering of large amounts of information by using a range of different techniques and a better cross-section of information (Montgomery et al., 2015). These authors also highlighted that the disadvantages of researcher bias and the nonprobability nature of purposive sampling could make it difficult for a researcher to mount a solid defense (Montgomery et al., 2015). A critic could argue that if different selections had been made during the purposive sampling, a different result could have been achieved. However, the selection of participants according to accepted definitions of combat veterans could help to address this limitation. Other researchers (Cesur et al., 2013; Hoge, 2010) using purposive sampling of combat veterans for PTSD, found purposeful sampling was valid and reliable.

Frankfort-Nachmias and Nachmias (2008) concluded that taking a sample from a particular population, analyzing it, and then applying the results to the whole population is the main idea when conducting quantitative research. Green and Salkind (2014)

suggested the use of nonrandom sampling methods, called purposive sampling, in studies in which the population is identified, willing, and available. According to Creswell (2009), purposive sampling lends itself to greater depth of information, especially when a smaller amount of data is involved. This type of sampling affords the maximum opportunity for comparable analysis and supports the accuracy needed to enhance the validity of findings obtained from employing nonprobability sampling procedures (Creswell, 2009).

I used a G*Power analysis (Faul, Erdfelder, Lang, & Buchner, 2007) to estimate the appropriate sample size, and my calculation indicated that I needed a minimum sample size of 148 with five predictors because it could easily detect medium to large effects (Creswell, 2009; Field, 2013). The analysis was conducted for this multiple regression based on a two-tail test, five variables, effect size of .50, 80% power, and an alpha of .05 (Faul et al., 2007; Field, 2013). Initially, an informal estimate suggested that significantly fewer participants were available, which could have presented a constraint to the sample size. However, after further review of the literature, I discovered and became a member of distribution lists and list serves that allowed me to solicit participants I had not previously recognized.

Data Collection Procedures

While examining possible types and sources of data, I recruited participants from local military hospitals (inpatient, partial hospitalization, outpatient), intensive outpatient programs, local veteran treatment programs (government and private), and distribution lists that serve military populations in the local area and worldwide. Requests for study

participants were sent to a large population; however, only those who self-report as combat veterans were included in the study. Some participants were expected to have an increased chance of moral injury based on their combat experience and admission to existing programs. I have access to several military related treatment and internet sites as offered by previous employment and working relationships with Washington, D.C. based military community. As a veteran and working with veterans, I anticipated access to populations that could be useful for this study. I identified many of these organizations and programs from my personal experience and during my research on this topic. Research led me to organizations that work specifically with trauma related veterans.

Organizations and participants were invited to participate in the study (Appendices C and D) according to the Walden IRB criteria and outlined further below in the ethical section. The IRB approved the study in May 2017 (05-01-17-0518810). I used a self-administered electronic survey format (Survey Monkey) via the Internet. The invitation to participate in this survey was sent to organizations and individuals across the country (Appendix C). Organizations and individuals were selected as recommended by program directors of selected Department of Defense and Department of Veterans Affairs treatment facilities in the Washington D.C. community. An invitation to participate in the survey was sent to the site and/or directly to the individual (Appendix D). The invitation directed participants to a website that contained the agreements, informed consent, and protection of rights needed to administer the survey. Permission and agreements from these organizations to distribute surveys to the list serves and centers were documented prior to the start of the research.

An online survey is a questionnaire that the target audience can complete over the internet. Surveys can be created as web forms and the answers stored on a database (Cobanoglu & Cobanoglu, 2003; Creswell, 2009). The online survey questionnaire was controlled through database and web site management (Harmon, Morgan, & Harmon, 2001; Roztocki, 2001). Use of paper copies was considered but was not used for this research. The choice of an online survey data collection was influenced by the research design of the study (Cobanoglu & Cobanoglu, 2003). The authors highlighted the importance of the research design, research questions, and variables to best determine the data collection method. Considering the links between spiritual wellness and moral injury, the online survey offers a more flexible and reliable data collection method to study the problem. Reduced complexity of both the MIES and FACIT-Sp questionnaire obviates issues related to education and literacy concerns (Canada et al., 2008; Nash et al., 2013). Harmon et al. (2001) concluded the online method works well as an inexpensive method that is useful where the respondents are co-operative. The strength of this survey method is that it could be used to compare numerically based correct responses (Creswell, 2009). A weakness of this method is related to response-shift bias when the frame of reference for the participant could change over time (Harmon et al. (2001). The authors pointed out that methods using perception could be open to bias. A combat veteran could rate different numbers on the survey at different points in their career. To account for this, previous research found that the current scores of combat veterans are significant indicators of their current status and mainly influenced by their last combat tour (Currier et al., 2015; Hoge, 2010; Steenkamp et al., 2015).

Veterans were encouraged to complete online surveys with the incentive of helping further research in the field. Online surveys offer efficiency, speed, and low cost (Roztocki 2001; Cobanoglu & Cobanoglu, 2003). The authors also pointed out that use of web-based surveys reduces mailing costs and improves accuracy of analyzing the respondents' data. Online surveys are efficient, reduce the possibility of human error, and effectively reach respondents in different geographical areas effectively (Roztocki, 2001). It is not certain if all the study participants and members of the population have access to the internet and responses could be received from unintended recipients. Examining demographic variables related to each respondent could help identify characteristics that minimize duplication of responses. With the increasing use of technology, the need for ethical considerations is also important (Roztocki, 2001). Roztocki (2001) discussed the ethical considerations regarding privacy and consistent laws involving web-based surveys. States and jurisdictions have different laws governing the use of the internet for the type of research being conducted (Roztocki, 2001).

Interviews and direct observations were considered; however, good co-operation, literacy, and simplicity of overall questions supported the survey method selected. It was also less expensive and improved consistency and standardization not offered by interviews. The informed consent and the Walden IRB process included procedures for gaining permission to work within the center, contacting participants, securing informed consent, and ensuring protection of the rights of the participants (Walden IRB). Data integrity and confidentiality were maintained by storing study data in different secured filing cabinets and access by personnel not involved in the study was restricted.

Variables

The final selection of variables for this study came from realizing the gap in the literature between moral injury and spiritual wellness. Working as a clinical mental health provider primarily to veterans for over eight years, I diagnosed and treated numerous combat veterans with PTSD and related behavioral and emotional issues and consequences. As I began efforts to understand the differences between PTSD and moral injury, I quickly became aware of the *soul injury* terminology related to moral injury. This allowed me to question the relationship to spiritual wellness and review the current literature. However, as I began to understand more about moral injury, I realized that there is a need to explore the relationship of spiritual wellness to moral injury. The selected variables for this study are defined below.

Moral Injury

As highlighted in the literature review, several researchers have studied moral injury to know more about its relationship to behavioral and emotional issues among combat veterans (Bryan et al., 2014). Bryan et al. (2014) also point out current interest and efforts to understand the impact of a variety of influences on moral injury. The relationship between moral injury and spiritual wellness needs further evaluation. The MIES measures psychological distress associated with moral injury across three interrelated factors (Bryan et al., 2014; Nash et al., 2013). Exploratory and confirmatory factor analyses supported a three-factor solution: transgressions-others, transgressions-self, and betrayal (Bryan et al., 2014; Nash et al., 2013). Transgressions-others contains two items that assess distress due to witnessing or learning about others' actions that are

perceived to be morally wrong (e.g., "I am troubled by having witnessed others' immoral acts"). Transgressions-self includes four items that assess distress due to committing acts or making decisions that are perceived to be morally wrong (e.g., "I am troubled by having acted in ways that violated my own morals or values"). Betrayal involves three items that assess distress due to perceived deception or treachery by others (e.g., "I feel betrayed by fellow service members who I once trusted").

Each item is rated on a 6-point Likert scale ranging from 1 (strongly disagree) to 6 (strongly agree). All three scales have good internal consistency (.79) and differentially correlate with other indicators of psychopathology consistent with theoretical conceptualizations (Nash et al., 2013). The Transgressions-Other and Betrayal scales can differentiate between military personnel with and without a likely PTSD diagnosis, although the Transgressions-Other scale has a relatively stronger relationship with PTSD (Bryan et al., 2014). The MIES provides researchers and clinicians a tool to measure moral conflicts experienced by persons that have experienced a military context that conflicts with their moral values. This assessment tool could be used to evaluate the prevalence and perceived intensity of such war-zone experiences, which is a necessary precursor to evaluating the biological, psychological, social, and spiritual consequences of moral injury (Nash et al., 2013). These researchers cited that additional testing is needed to establish the validity of the MIES in the context of the existential and spiritual distress and impairment as a result of moral challenges in war. Investigating moral injury as it relates to existential and spiritual wellness will add to the research concerning the validity of the MIES in this context.

Spiritual Wellness

While there are many widely used spirituality instruments, the FACIT-Sp is used for a variety of research studies measuring both chronic diseases and mental health related populations (Canada et al., 2008; www.FACIT.org). Canada et al. (2008) developed the the FACIT-Sp to measure spiritual well-being to examine a personal search for faith, meaning, and purpose in life through connections with others and nature. Using 12-items the instrument measures perceptions of their religious/spiritual (R/S) components of quality of life (Haugan, 2015; Daaleman & Frey, 2004). The scale relates to existential framework that human spirituality is expressed and experienced in the context of meaning and caring connections with oneself, others, nature and a life force or God (Haugan, 2015). It is not limited to any one religious or spiritual tradition (Canada et al., 2008).

The FACIT-Sp is part of the larger FACIT measurement system and the FACIT.org website (www.FACIT.org). The FACIT-Sp consists of 12 items (Appendix-A) rated on a 5-point Likert type scale (0 = *Not at all*; 1 = *A little bit*; 2 = *Somewhat*; 3 = *Quite a bit*; and 4 = *Very much*). Previous researchers demonstrated that the FACIT-Sp-12 is a psychometrically sound measure of spiritual wellbeing (Canada et al., 2008). In a recent review of instruments measuring spirituality in clinical research, Monod (2011) reported that the FACIT-Sp-12 emerged as a well-validated instrument for the assessment of a patient's current spiritual state.

FACIT-Sp correlates with mental health issues such as depression, anxiety, and trauma related symptoms (Bormann, Thorp, Wetherell, Golshan, & Lang, 2013; Buttner

et al., 2016; Johnson et al., 2015). According to a study by Bekelman et al. (2010), the FACIT-Sp Meaning/Peace subscale consistently correlated with depression (r = -0.50, p<0.0001) and quality of life (r = 0.41, p = 0.001). The FACIT-sp is often used in research involving chronic illness; however, these studies show a strong correlation to mental health related issues in respect to the FACIT-sp factors of meaning, peace, and faith. This is valuable to understand and further test the relationship of FACIT-sp to moral injury. Examining the factors of FACIT-sp to moral injury may also predict relationships to physical issues (Park et al., 2016). Recent studies by Park et al. (2016) support the significant impact of religiousness and spirituality in the prevention and amelioration of sickness and illness. Outcomes of moral injury related to addictions, compulsive behaviors, and impulse control are also classified as chronic, progressive, and can often be fatal (Hall, Carter, & Forlini, 2015). The FACIT-Sp was used to predict other chronic behavioral and mental health related conditions and overall quality of life (Bormann et al., 2013; Buttner et al., 2016; Johnson et al., 2015). Further research is needed to better understand life meaning, faith, and purpose (spirituality) of combat veterans with moral injury.

Gender

The role and effect of gender in the military is a significant factor in investigating the impact of war on combat veterans (Brenner, 2015; Castro, Kintzle, & Hassan, 2015; Barr, Sullivan, Kintzle, & Castro, 2016; Bormann et al., 2012; U.S. Department of Veterans Affairs, 2014; Harris et al., 2015). In the last five years gender labels beyond male and female are being considered to fully understand the complete impact of gender

on veterans (Blosnich, 2016; Hatzenbuehler, 2014). In the scope of recent studies, few if any researchers have found significant indicators of lesbian, gay, bisexual and transgender (LGBT) social environmental context among transgender veterans or how social factors are associated with mental health diagnoses (Blosnich, 2016; Hatzenbuehler, 2014). Therefore, this gap in the research can be studied to understand the role of moral injury and spiritual wellness on specific gender identity. The gender variable is reported as whether the participant identifies as a male, female, transgender male to female, transgender female to male, other, and/or do not wish to say. Other researchers account for the importance of incorporating these categories and including the category to not wish to say (Reisner et al., 2015). Reisner et al. (2015) concluded the importance of counting transgender and gender-nonconforming adults in health research recommendations. The researchers concluded the omission of these gender categories presents a shortcoming needed to understand the wellbeing of transgender and gender-nonconforming people and understand more about sex and gender differences that may be applicable for the health of veterans and all people.

Branch of Service

The branch of service refers to Army, Air Force, Marines, or Navy as reported by the study participant. Each branch of military service performs a distinct and separate mission and is often associated with a specific and unique culture (U.S. Department of Defense, 2016). According to the U.S. Department of Defense each service performs combat operations more closely aligned specific boundaries. For example, the Army aligns with ground missions, Air Force with air and space, Navy/Marines the sea, and

Coast Guard with coastal areas. Each military service also includes specialties and unique missions for combat related forces and units such as special operating forces, direct, and indirect combat forces. While there are many similarities and differences in combat units across the service missions, moral injury can affect anyone in the theater of operations (Currier et al., 2015; Harris, Park, Currier, Usset, & Voecks, 2015; Hoge, 2010). These researchers reported a focus on only one branch of service and few studies have examined a more inclusive cross section of services. To address the lack of research on service level studies I investigated possible relationships to moral injury across these services. I solicited participants from military installations associated with different branches of service. Study participants were combat veterans. Separating each of the services to individual combat specialties could be useful for future study.

Component of Service

This variable refers to the Active, Reserve, or National Guard component of the United States military prior to being called to theater of operations for combat duty. Military members that are mobilized and enter a theater of operation are brought on active duty even though their training and experience could be from a Reserve or National Guard component (U.S. Department of Veterans Affairs, 2014). This could have an impact on moral injury and spiritual wellness as identified in past studies (Currier et al., 2013; Frankfurt & Frazier, 2016; Maguen & Litz, 2014; Nash et al., 2013).

Military Rank

The military rank was the military pay grade of the participant at the time of service in the last combat zone served. The culture of the military services is to identify

enlisted, warrant officer, and enlisted personnel by a name associated with a particular rank (U.S. Department of Veterans Affairs, 2014). However, these names are not consistent across the services and it could be confusing to compare and address relationships. For example, a Captain in the Army, Marine Corps, and Air Force is equivalent to a Lieutenant in the Navy/Coast Guard). All of these ranks are pay grade 0-3 and carry the same rank status (U.S. Department of Defense, 2017). This consistency holds true for enlisted ranks. While some could be unfamiliar with pay grade in the military rank system, pay grades are consistent across the services and components (U.S. Department of Defense, 2017). Pay grades are officer (O) and enlisted (E) designations. While the names of the rank are different, the pay grades are equivalent. The term rank is often used because it is more familiar to those outside the military culture (Currier et al., 2013; Frankfurt & Frazier, 2016; Maguen & Litz, 2014; Nash et al., 2013). To avoid confusion, the code of pay grade was used with respect to the service and an explanation of rank to pay grade was included in the results section of the research. Military rank and accumulated wartime could closely align to a participant's age and number of years in service (Kessler et al., 2014; LeardMann et al., 2013).

Religion

In recent studies, researchers identified spirituality as having a significant impact on moral injury, anxiety, mental health, and trauma (Currier, Smith, & Kuhlman, 2017; Robbins, 2016; Currier et al., 2016; Harris, Erbes, Winskowski, Engdahl, & Nguyen, 2014). Each of these researchers examined and discussed the role of spirituality but did not include religion directly as a distinct variable. While all of these researchers agree

and acknowledge that both concepts are interrelated, very few, if any, empirical studies address specific religions as factors influencing moral injury, anxiety, or PTSD. There is agreement among these researchers for the need to continue research with religion as an important demographic variable.

While it has been generally accepted that spiritual/religious beliefs could reduce anxiety and bring meaning to traumatic experiences (Shiah, Chang, Chiang, Lin, & Tam, 2015), others find these beliefs hurtful and could abandon their religion after experiencing trauma (Fontana & Rosenheck, 1998). Therefore, religion as a distinct and separate variable in this study could help to explain divergent findings. In this way both religious beliefs and religious pressures could be assessed in comparison to spirituality. Maoz & Henderson (2013) studied and introduced data on world religions using and expanding on the latest statistics contained in the 2010 U.S. Census figures. The World Religion Project systematically developed classification of major world religions and religious families within major world religions based on scriptures, institutions, historical evolution, and a common class of beliefs, rituals, and practices. These authors stated the most popular religions are associated with Christianity, Judaism, Islam, Buddhism, Hinduism, Agnostic, and Atheist. These categories were used for this study along with a category for other.

Data Analysis

The data analysis included descriptive statistics, correlation, and multiple regression analyses.

Descriptive Statistics

I reported descriptive statistics to assess the quality of the data. The statistics in this study included the mean, mode, median, standard deviation, and percentages of the variables. The descriptive data defined how combat veterans are classified and categorized according to the demographic variables. In addition, skewness and kurtosis of FACIT-sp and MIES scores was calculated both in total and within each of the demographic groups to confirm that the data is normally distributed. Should skewness or kurtosis of either FACIT-sp or MIES fall outside of the range of -1.0 to +1.0, the data will be transformed to bring it into a normal distribution. The exact method of transformation was selected based on the direction of the distortion with an intention to transform the data as conservatively as possible.

Correlation and Regression Analysis

Correlation analysis was used to test the statistical significance of the relationships between moral injury, rank, and spiritual wellness. This was done to preliminarily identify relationships between moral injury and spiritual wellness and if rank correlates with these two variables. The correlation analysis indicated the strengths of the relationships between these variables. I then used a multiple regression analysis to estimate the conditional expectation of moral injury scores given spiritual wellness scores on top of the predictive value provided by the demographic variables identified as significant in the tests of means and correlational analyses (Creswell, 2009; Frankfort-Nachmias, & Nachmias, 2008; Montgomery et al., 2012). The regression analysis identified which variables are statistically significant predictors of moral injury and if the

addition of spiritual wellness significantly increases the ability to predict moral injury beyond the predictive power, if any, of the demographic variables.

A hierarchical regression allowed multiple steps of predictor variables to be entered into the regression equation to see if each new step significantly improves the predictive power of the model (Montgomery et al., 2012). The first step was the demographic variables and the second step was spiritual wellness. I then checked to see if adding spiritual wellness significantly increased the predictive power of the equation. A statistically significant change in the R-squared variable would determine if the addition of spiritual wellness does indeed increase the predictive power of the model. Investigating spiritual wellness, moral injury, and demographics in this analysis served to control, elaborate, and predict the relationship. Frankfort-Nachmias and Nachmias (2008) provided that multivariate analysis could be viewed when a less relevant variable (perhaps gender) is examined between an independent variable (spiritual wellness) and a dependent variable (moral injury) to ensure that a correlation between the two main variables is correct. Therefore, a multiple regression analysis was used to predict how moral injury changes when scores of spiritual wellness are varied while accounting for the impact of the demographic variables (Creswell, 2009; Field, 2013; Frankfort-Nachmias & Nachmias, 2008). The regression analysis involved identifying the relationship between one or more independent variables (spiritual wellness, demographic variables) and the dependent variable (moral injury).

Creswell (2009), Field (2013), and Frankfort-Nachmias and Nachmias (2008) hypothesized a model of the relationship and estimated the parameter values used to

develop an estimated regression equation (Creswell, 2009; Field, 2013; Frankfort-Nachmias & Nachmias, 2008). Tests were then conducted to determine if the model is satisfactory. According to Montgomery et al. (2012), if the model is deemed satisfactory, the estimated regression equation could be used to predict the value of the dependent variable given the values of the independent variables. An initial examination of existentialist theory and study variables does not suggest a clear significance for the order of predictor variables. This analysis also supports the research question and set of assumptions for the test that are most applicable.

Statistically Significant Thresholds, Confidence Intervals, and Effect Sizes

To be considered statistically significant the data needed to pass eight assumptions that are required for multiple regressions to give valid results (Creswell, 2009; Frankfort-Nachmias & Nachmias, 2008; Green & Salkind, 2014). These eight assumptions are: (a) the dependent variable is measured on a continuous scale (i.e., it is either an interval or ratio variable), (b) two or more independent variables are continuous or categorical, (c) independence of observations, (d) linear relationship between the dependent variable and each of the independent variables (to check for the linear relationships, scatterplots and partial regression plots using SPSS, as well as visual inspection of the scatterplots and partial regression plots to check for linearity), (e) data shows homoscedasticity, which is when the variances along the line of best fit remain similar as you move along the line, (f) data shows multicollinearity, which occurs when you have two or more independent variables that are highly correlated with each other, (g) no significant outliers, high leverage points, or highly influential points, and (h) a

check to ensure that the residuals (errors) are approximately and normally distributed. This check was accomplished using a histogram and a Normal P-P Plot or a Normal Q-Q Plot.

The results of this analysis typically assess the "statistical significance" of the estimated relationships, that is, the degree of confidence that the true relationship is close to the estimated relationship (Field, 2013). I estimated the extent of change produced in moral injury by spiritual wellness and demographics, holding other relevant independent variables constant. The multiple correlation coefficient, R^2, was used to measure the amount of variance in moral injury variable explained by spiritual wellness and demographics (Frankfort-Nachmias & Nachmias, 2008).

An omnibus F-test for a one-way ANOVA for the regression analysis, unlike the test prior to the regression analysis, was used. This investigation could demonstrate if the effect of spiritual wellness was statistically significant (Field, 2013; Green & Salkind, 2014) and according to these authors using a post hoc analysis to test if moral injury was statistically significantly lower for any of the demographics. The two-way interaction of moral injury and spiritual wellness could prove to be statistically significant. The correlation coefficients (effect sizes) could reveal relationships between the variables and explain a portion of the moral injury score variance (Field, 2013; Green & Salkind, 2014). The results of the regression will indicate level of spiritual wellness to explain a percentage of the variance of the moral injury.

Using statistical analyses, the research study looked for a statistically significant value measurement (*p* value) that indicates if the relationship measured happened by

chance. In most social science studies, *p* values of .05 are used to determine statistical significance and the threshold that was used in this study (Field, 2013; Green & Salkind, 2014). The variables used could demonstrate the strength of the relationship between the different characteristics that all combat veterans have in common. Finding whether there is statistical significance for each of these variables could help decide which ones could offer the best variables to use within the study. According to Green and Salkind (2014), confidence intervals (CI) are used to make an educated guess about the characteristics of a certain population. Using the given margin of error of <.05, CI's determine the relationships found between two or more variables in a certain population. If they fall under the given alpha level, it means that the null hypothesis needs to be rejected in order to avoid a type II error (Field, 2013). I used 95% confidence intervals, which relates to using a p value of 0.05 to identify the significance of coefficients. Effect sizes address the importance of the effect obtained from the data analysis. An effect size of 0.5 is used in order to determine the strength the relationship between the variables.

Ethical Concerns

Because human subjects are used for this study, formal application and approval from the Walden University Institutional Review Board (IRB) are required. The IRB governs ethical considerations for all data collection (Walden IRB, 2017; Walden, 2014; 2015). Procedures for gaining permission to work within an organization, contacting participants, securing informed consent, and ensuring protection of the rights of participants are all ethical concerns addressed in the IRB.

In collecting data online, the informed consent was the first page and participants checked a box that they read and understood the informed consent and agreed to participate. Once participants signed an informed consent statement, they were informed that the study involved research, provided an explanation why they were selected and disclosed the identity and all relevant roles of researcher, provided an understandable explanation of the research purpose, and a description of the procedures and duration of participation (Walden IRB application). Participants were also informed that participation is voluntary and they will not be penalized for refusing or discontinuing participation. A description of foreseeable risks or discomforts, anticipated benefits to subjects, compensation for participation, and how confidentiality will be maintained was also provided (Walden IRB). Using a protected class of individuals in the study was not anticipated.

The Walden IRB process provided that participants will receive contact information for questions, a copy of the informed consent form, and a list of potential conflicts of interest (Walden 2014; 2015). The consent process and documentation was in language understandable to the participant. This process ensured subjects were not subjected to waive his/her legal rights. Using a self-report test could produce some conflicts for participants. To minimize the risks, informed consent included contact with mental health providers and additional information about the study. Cultural considerations, including socioeconomic class, gender, ethnic, and religious backgrounds, could influence subject participation and affect the study results. These variables were captured and examined separately. Issues of confidentiality related to identifying

information to an institution or connected to specific results were upheld and outlined in the participants' informed consent.

Conclusions

Major challenges for the methodology research of this study were the collection of data from institutions, participants that were not combat veterans, and valid representation of the different demographics. To address this problem, a definition for combat veterans accompanied the informed consent and participants' instructions for the survey. Identified demographics were expected to have an impact on the differences among combat veterans.

The analysis was conducted for this multiple regression based on a two tail test, five variables, effect size of .50, 80% power, and an alpha of .05 (Faul et al., 2007; Field, 2013). Descriptive statistics, t-test analyses, and logistic regression analysis was used to determine the predictive relationships between the independent and dependent variables.

In Chapter 4, I discuss the data collection process and summarize the research results and their impacts on the hypotheses. I present the analysis results including statistical assumptions. Finally, I provide a summary in which I answer my research question based on results of the analysis.

Chapter 4: Results

Introduction

The purpose of this study was to investigate the potential relationship between spiritual wellness as measured by the FACIT-Sp and the dependent variable of moral injury as measured by the MIES among combat veterans. It was hypothesized that spiritual wellness would predict the level of moral injury. Understanding the relationship of spiritual wellness to moral injury could result in a theory of moral injury separate from that of PTSD (Barr et al., 2016; Currier et al., 2015; Hoge, 2010; Nacasch et al., 2015; Nash et al., 2013). The research question that addressed and guided my dissertation research was as follows: Does spiritual wellness, as measured by the FACIT-Sp, predict moral injury, as measured by MIES, among combat veterans beyond the predictive power of the demographic variables of gender, branch of service, component of service, military rank, and religion? The null hypothesis (*Ho*) was that there is no statistically significant relationship between spiritual wellness as measured by the FACIT-Sp and moral injury as measured by MIES on combat veterans beyond the possible predictive power of the demographic variables of gender, branch of service, and component of service, military rank, and religion. The alternative hypothesis (*Ha*) was that there is a statistically significant relationship between spiritual wellness as measured by the FACIT-Sp and moral injury as measured by MIES on combat veterans beyond the possible predictive power of the demographic variables of gender, branch of service, component of service, military rank, and religion.

In this chapter, I describe the data collection process, review the research questions and hypotheses, and discuss the results of the study. This section also contains the details of the data collection to include discrepancies in data collection, descriptive and demographic characteristics, and validity of the sample.

Data Collection

The data collection period took place for 25 weeks from May 23 to December 5, 2017. Following approval of the proposal and IRB, on May 1, 2017, I finalized the participation letter and fliers and distributed them over the next 2 weeks. I contacted organizations to inform them that the promotional fliers and invitation letters were being sent to them (see Appendices C and D). All sites agreed to follow up on the original agreement to distribute the fliers and letters to their sites and organizations. The recruitment from military programs, treatment centers, and distribution lists associated with veteran populations were willing to support the requests. The surveys were then posted on SurveyMonkey where they were also provided the informed consent and any national and local resources they might need (see Appendix F). A debriefing appendix was included (see Appendix H). The G*power analysis determined a sample size of 148. After 3 months, 58 survey responses were received (38% of the total needed). To ensure that the additional surveys were completed, I made follow-up phone calls and on-site visits to the site administrators to request support and offer further information. In some cases, meetings were held with the site program director. As a result of this effort, I discovered some miscommunication concerning the definition of combat veteran and the defined demographics. Clarifying the definition of combat veteran and service

components, as detailed in this paper, allowed program directors and administrators to further distribute the surveys with the organizations. In the last week of October 2017, 113 surveys were received (88%). Another call to sites and the addition of another study site resulted in a total of 153 surveys. This effort resulted in five more surveys than needed and the survey site was closed. However, during data analysis and cleansing, I discovered that eight surveys were incomplete and not useable. With approval of the dissertation chair, the site was reopened and five more useable surveys were received. The final number of collected surveys was 158 and a total of eight were not useable. This resulted in an addition of two more surveys than the minimum anticipated (148). The survey site was then closed on December 5, 1017. Other than having to visit sites and offer additional information, the data collection plan went according to expectations.

Descriptive and Demographic Results

A total of 150 surveys were used in the data analysis. Demographic information for this sample is presented in Table 1. All participants were combat veterans. A majority of the sample was Army veterans who had recently been on active duty service. The majority identified as Christian. Over 85% of the sample identified as male. Many participants left the service with the rank of officer. To address the representativeness of the sample, the Department of Veteran's Affairs has offered detailed reports and statistics over the last 5 years (https://va.gov/vetdata). Many of these reports differ from state to state. Further, the categories do not match the ones used for this study. The makeup of combat veterans nationwide roughly matches the demographics associated with Religion and Gender. However, the percentages of Branch (Army), Component (Active Duty) and

Rank (officer) are much higher than the national average and not a representative sample. These differences will be explained and their implications discussed in Chapter 5.

Table 1

Sample Demographics

Demographic category		*n*	%
Branch of the military	Army	115	76.7
	Marine Corps	20	13.3
	Navy	10	6.7
	Air Force	4	2.7
	Coast Guard	1	0.7
Component of service	Active	121	80.7
	National Guard	8	5.3
	Reserve	21	14.0
Religion	Christianity	105	70.0
	Judaism	1	0.7
	Agnostic	9	6.0
	Atheist	6	4.0
	None	19	12.7
	Prefer not To say	10	6.7
Gender	Female	20	13.3
	Male	129	86.0
	Prefer not to say	1	0.7
Military rank	E1 - E4	9	6.0
	E5 - E7	47	31.3
	E8 - E9	12	8.0
	01 - 03	16	10.7
	04 - 06	47	31.3
	07 - 08	16	10.7
	09 - 10	2	1.3
	W1 - W2	1	0.7

Note. Total $N = 150$. All participants identified as combat veterans. Missing values for all categories < 0.01%.

Statistical Tests

This section contains the statistical tests of hypotheses that emerged from the analysis of the main hypotheses, as appropriate for the study. The included tables illustrate results and evaluate the statistical assumptions.

Table 2 presents the means and standard deviations for the MIES and FACIT-Sp and subscales. The MIES scale had an average of 30.86 out of a possible maximum score of 54, indicating a moderate level of moral injury. The FACIT-Sp Total Score had an average of 29.31 out of a possible maximum score of 48, indicating a moderate level of spiritual well-being. Of the subscales, Faith had the lowest average score of 8.58, indicating a relatively low level of faith. Meaning had the highest average score of 11.29, indicating a moderate level of meaning. The skew of all scales was acceptable, ranging from -1.21 to -0.51.

Table 2

Means and Standard Deviations for Moral Injury Events Scale and Spiritual Well-Being Scales

Measure	*M*	*SD*
MIES Total Score	30.86	13.19
FACIT-Sp-12 - Meaning	11.26	3.99
FACIT-Sp-12 - Peace	9.47	4.21
FACIT-Sp-12 - Faith	8.58	5.29
FACIT-Sp-12 Total Score	29.31	12.05

Note. All scales: Total $N = 150$, MIES Likert Scale: 1 = *Strongly Disagree*, 2 = *Moderately Disagree*, 3 = *Slightly Disagree*, 4 = *Slightly Agree*, 5 = *Moderately Agree*, 6 = *Strongly Agree*. FACIT-Sp-12 Likert Scale: 0 = *Not at all*, 1 = *A little bit*, 2 = *Somewhat*, 3 = *Quite a bit*, 4 = *Very much*. MIES Total Score: Range = 9 – 54. FACIT-Sp-12 - Meaning: Range = 0 – 16. FACIT-SP-12 - Peace: Range = 1 – 16. FACIT-Sp-12 - Faith: Range = 0 – 16. FACIT-Sp-12 Total Score: Range = 4 – 48.

In order to better understand moral injury prior to testing the hypothesis, I compared scores on the MIES between the demographic groups using an ANOVA for variables with more than two categories and a *t* test for variables with two categories. The results of these comparisons are shown in Tables 3 through 7. In order to conduct post-hoc tests, some variables in the categories were removed or collapsed into the Other category.

Moral injury was found to significantly differ between Army and Navy veterans (see Table 3). To conduct post-hoc tests for rank of service, the Coast Guard ($n = 1$) and Air Force ($n = 4$) categories were collapsed into the Other category. Participants who were Army veterans reported significantly higher levels of moral injury ($M = 33.92$, $SD = 12.60$) than participants who were Navy veterans, $M = 19.80$, $SD = 11.85$, $F(3, 146) = 6.60$, $p < 0.01$.

Table 3

Means, Standard Deviations, and ANOVA Results for Moral Injury Events Scale

Measure	Variables	*M*	*SD*	*F*	*p*
MIES					
Branch of Service	Army*	33.92	12.60	6.60	0.00
	Marine Corps	27.60	12.83		
	Navy*	19.80	11.85		
	Other	18.60	13.76		

Note. $N = 150$, Army $n = 115$, Marine Corps $n = 20$, Navy $n = 10$, Other $n = 5$. $df = 3, 146$. Likert Scale: 1 = *Strongly Disagree*, 2 = *Moderately Disagree*, 3 = *Slightly Disagree*, 4 = *Slightly Agree*, 5 = *Moderately Agree*, 6 = *Strongly Agree*. *$p < 0.05$

Moral injury was not found to differ between participants from the three branches of service (Table 4). The Branch of Service variable did not require removal or

collapsing of any categories. However, the overall ANOVA was not significant, $F(2, 147) = 1.00$, $p = 0.37$, indicating no significant differences in moral injury between veterans of the three different branches.

Table 4

Means, Standard Deviations, and ANOVA Results for Moral Injury Events Scale

Measure	Variables	*M*	*SD*	*F*	*p*
MIES					
Component of service	Active	31.58	13.55	1.00	0.37
	National Guard	29.38	12.07		
	Reserve	11.25	11.25		

Note. $N = 150$, Active $n = 121$, National Guard $n = 8$, Reserve $n = 21$. $df = 2, 147$. Likert Scale: 1 = Strongly Disagree, 2 = Moderately Disagree, 3 = Slightly Disagree, 4 = Slightly Agree, 5 = Moderately Agree, 6 = Strongly Agree.

Moral injury was found to significantly differ between participants who identified as Christian and participants who selected *None* as their religion (see Table 5). In order to conduct post-hoc tests, the category of Judaism ($n = 1$) was removed from analysis. Participants who identified as Christian reported significantly lower levels of moral injury ($M = 28.43$, $SD = 13.03$) than participants who selected None as their religion, $M = 37.37$, $SD = 14.30$, $F(4, 144) = 3.39$, $p < .05$.

Table 5

Means, Standard Deviations, and ANOVA Results for Moral Injury Events Scale

Measure		Variables	*M*	*SD*	*F*	*p*
MIES						
	Religion	Christianity*	28.43	13.03	3.39	0.01
		Agnostic	34.67	12.27		
		Atheist	31.83	11.44		
		None*	37.37	14.30		
		Prefer Not to Say	39.00	6.62		

Note. *N* = 149, Christianity *n* = 105, Agnostic *n* = 9, Atheist *n* = 6, None *n* = 19, Prefer Not to Say *n* = 10. *df* = 4, 144. Likert Scale: 1 = Strongly Disagree, 2 = Moderately Disagree, 3 = Slightly Disagree, 4 = Slightly Agree, 5 = Moderately Agree, 6 = Strongly Agree. *$p < 0.05$

Moral injury was found to significantly differ between participants who identified as male and participants who identified as female (Table 6). In order to compare means, the Prefer Not to Say (n = 1) category was removed from the analysis. Participants who identified as male reported significantly higher levels of moral injury (M = 31.95, SD = 12.57) than participants who identified as female (M = 23.10, SD = 12.57, t = -2.86, p < .05).

Table 6

Means, Standard Deviations, and t-test Results for Moral Injury Events Scale

Measure		Variables	*M*	*SD*	*t*	*p*	95% CI *LL*	95% CI *UL*
MIES								
	Gender	Female	23.10	12.57	-2.86	.01	-14.956	-2.736
		Male	31.95	12.91				

Note. *N* = 149, Female *n* = 20, Male *n* = 129. *df* = 147. Likert Scale: 1 = Strongly Disagree, 2 = Moderately Disagree, 3 = Slightly Disagree, 4 = Slightly Agree, 5 = Moderately Agree, 6 = Strongly Agree.

Moral injury was found to significantly differ between participants who left the service with a rank of 01 - 03 and those who left the service with a rank of 07 – 10 (Table 7). In order to conduct post hoc tests, the category of W1 - W2 (n = 1) was removed from analysis and the categories of 07 - 08 (n = 16) and 09 - 10 (n = 1) were collapsed into a category of 07 - 10. Participants who left the service with a rank of 01 - 03 reported significantly higher levels of moral injury (M = 39.25, SD = 2.51) than participants who left the service with a rank of 07 - 10 (M = 25.83, SD = 3.31, $F(5, 143) = 2.45$, $p < .05$).

Table 7

Means, Standard Deviations, and ANOVA Results for Moral Injury Events Scale

Measure	Variables	*M*	*SD*	*F*	*p*
MIES					
Military Rank	E1 - E4	26.44	3.85	2.46	0.04
	E5 - E7	32.00	1.87		
	E8 - E9	33.67	4.49		
	01 - 03*	39.25	2.51		
	04 - 06	29.26	1.86		
	07 - 10*	25.83	3.31		

Note. $N = 149$, E1 - E4 $n = 9$, E5 - E7 $n = 47$, E8 - E9 $n = 12$, 01 - 03 $n = 16$, 04 - 06 $n = 47$, 07 - 10 $n = 18$. $df = 5, 143$. Likert Scale: 1 = Strongly Disagree, 2 = Moderately Disagree, 3 = Slightly Disagree, 4 = Slightly Agree, 5 = Moderately Agree, 6 = Strongly Agree. $^*p < 0.05$

Table 8 presents correlation coefficients between the MIES and FACIT-Sp scales. All scales were significantly related to each other, with the strength of the relationships ranging from moderate to strong. The relationship between the MIES and the FACIT-Sp Total score was a strong negative one, indicating that participants with low spiritual well-being are likely to have a high level of moral injury. The relationships between the FACIT-Sp subscales and Total score were all positive, indicating that the scales all measured some part of a similar concept, yet they were separate constructs.

The Pearson Correlation Coefficient (r) was used to study the relationships between two variables, among three or more variables, or when comparing sets of variables (Green & Salkind, 2011). It can help determine the extent to which a relationship exists through statistical values (Green & Salkind, 2011). To determine whether or not the relationship exists, a significance test for r was completed for this

research (Green & Salkind, 2011). Two assumptions are made for r: the variables are bivariately, normally distributed and the cases represent a random sample from the population and the scores on variables for one case are independent of scores on these variables for other cases (Green & Salkind, 2011). The values range from -1 to +1 and result in a negative, a positive, or no correlation (Green & Salkind, 2011). The demographic variables were entered into block 1. The FACIT-Sp Total scores were entered into block 2. It was expected that the regression analysis would identify a significant increase in predictive power when including the FACIT-Sp Total scores to the demographic variables.

Table 8

Correlations Between Moral Injury Event Scale and Spiritual Well-Being Scales

	MIES Total Score	FACIT-SP-12 - Meaning	FACIT-SP-12 - Peace	FACIT-SP-12 - Faith
FACIT-SP-12 - Meaning	-0.65***			
FACIT-SP-12 - Peace	-0.71***	0.78***		
FACIT-SP-12 - Faith	-0.57***	0.59***	0.73***	
FACIT-SP-12 Total Score	-0.71***	0.86***	0.93***	0.89***

Note. $N = 150$. Moral Injury Event Scale: Higher scores indicated more of the construct. Spiritual Well-Being Scales: Higher scores indicated more of the construct. All correlations calculated using Pearson Product-Moment Correlation. ***$p < .001$

Because the remaining variables were all nominal with more than two levels, they were recoded into dummy variables. For Component of Service, the Active category was used as the base as it had the largest number of participants. Branch of Service was recoded using the collapsed categories from the ANOVA. The Army Category was used

as the base as it had been identified as being significantly different from one of the other categories in the ANOVA and had the largest number of participants.

Since the recoded Religion variable from the ANOVA contained more than four levels, it was further collapsed prior to the dummy coding in order to maximize the degrees of freedom. The Atheist and Agnostic categories were collapsed into Atheist-Agnostic category as they were deemed to be the most conceptually similar categories. Christianity was used as the base as it had been identified as being significantly different from one of the other categories in the ANOVA and had the most participants.

The recoded Rank of Service variable from the ANOVA also contained more than four levels and was further collapsed prior to the dummy coding in order to maximize the degrees of freedom. It was decided to keep the 01 - 03 and 07 - 10 categories as they had been found to be significantly different. Because the 04 - 06 fell between these levels, it was kept as it was. The E01 – E03 level was kept as it represents a distinct class of enlisted service members than the E04 – E 09 ranks. The E5 – E7 and E8 – E9 groups were collapsed into one E5 – E9 group as these groups represent similar classes of enlisted service members and it was desired to keep the total number of groups as small as possible to maximize the degrees of freedom. The 07 - 10 category was used as the base as it was identified as being significantly different from one of the other categories in the ANOVA and it was the larger of the two significantly different categories.

Hypothesis 1 stated that there would be a statistically significant relationship between spiritual wellness as measured by FACIT-Sp and moral injury as measured by MIES on combat veterans beyond the predictive power of the demographic variables of

gender, branch of service, component of service, and military rank. Specifically, it was expected that lower scores on the FACIT-Sp would predict significantly higher scores on the MIES.

Results

Prior to conducting the regression analysis, the assumptions of homoscedasticity and non-multicollinearity were assessed. Figure 1 contains the scatterplot used to check the homoscedasticity assumption. The shape of the plot confirms that the assumption of homoscedasticity was roughly met. Non-multicollinearity was assessed with the Durbin-Watson statistic, tolerance scores, and VIF scores. The Durbin-Watson score of 1.84 fell within the allowable range of 1.5 to 2.5. Tolerance scores for the regressed variables were all above 0.1. VIF scores for the regressed variables were all under 10. Together, these variables indicate that the assumption of non-multicollinearity was met. As these two assumptions were met, analysis proceeded with the regression analysis.

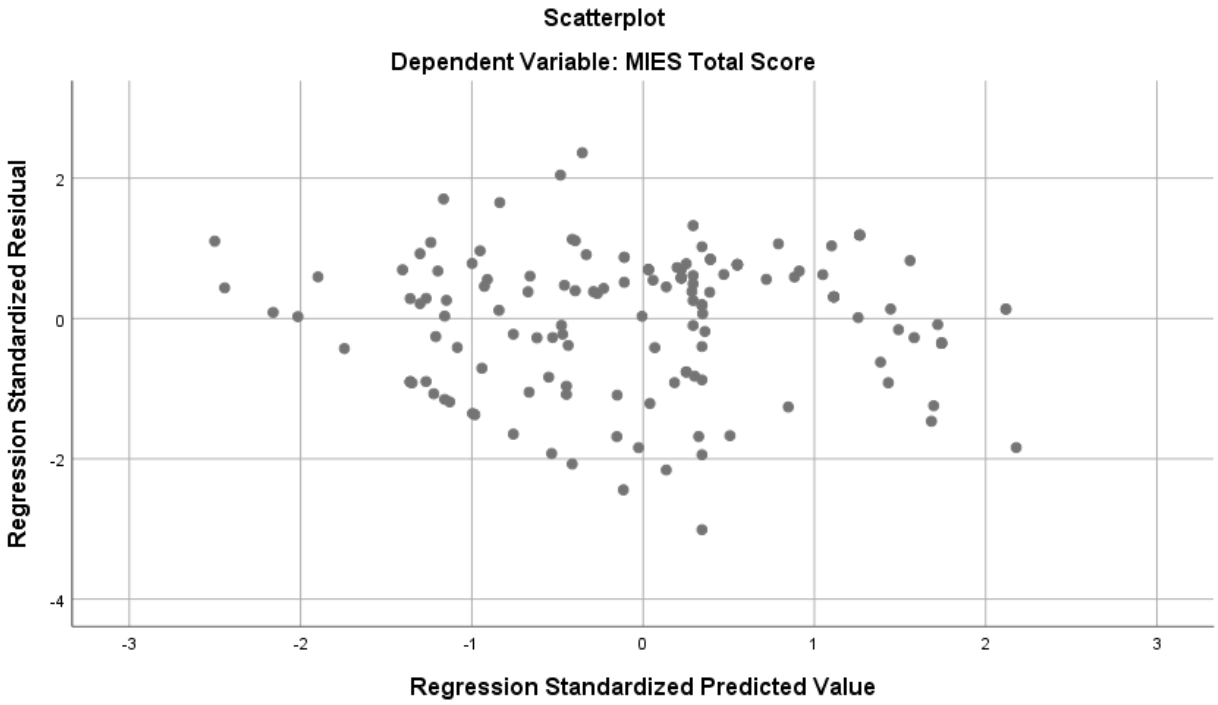

Figure 4. Homoscedasiticy scatterplot.

The result of the regression analysis is shown in table 9. Religion: Christianity vs. Prefer Not to Say, gender, Rank of Service: 07 - 10 vs. 01 - 03, and the FACIT-Sp-12 Total were found to significantly predict moral injury. Religion: Christianity vs. Prefer Not to Say had a significant positive relationship with MIES scores ($\beta = 0.17$, $t = 2.89$, $p < 0.01$); participants who preferred not to say what their religion was had significantly higher moral injury than did participants who identified as Christian. Gender had a significant positive relationship with MIES scores ($\beta = 0.20$, $t = 3.42$, $p < 0.01$); participants who identified as male had significantly higher moral injury than did participants who identified as female. Rank of Service: 07 - 10 vs. 01 - 03 had a significant positive relationship with MIES scores ($\beta = 0.16$, $t = 2.54$, $p < 0.05$); participants who reported holding a rank of 01 - 03 had significantly higher moral injury

than did participants who reporting holding a rank of 07 - 10. FACIT-Sp-12 Total scores had a significant negative relationship with MIES scores ($\beta = -0.66$, $t = -11.19$, $p < 0.001$); participants who reported higher levels of spiritual well-being had significantly lower moral injury.

The overall model F test was significant, $F(14, 132) = 15.85$, $p < 0.001$, with Block 1 predicting 63% of the MIES scores. Adding the FACIT-Sp-12 Total scores in Block 2 significantly increased the predictive power of the model to predict MIES scores (F-test Δ (1, 132) = 125.14, $p < 0.001$) by an additional 35%. Consequently, the hypothesis was supported.

Table 9

Regression Analysis for Spiritual Well-Being Predicting Moral Injury Event Scale Scores

Variable	B	*t*	95% CI *LL*	95% CI *UL*
Component of Service: Active vs. National Guard	-0.01	-0.11	-7.13	6.38
Component of Service: Active vs. Reserves	0.00	0.07	-4.31	4.64
Branch of Service: Army vs. Marine Corps.	-0.08	-1.38	-7.42	1.33
Branch of Service: Army vs. Navy	-.009	-1.58	-10.70	1.22
Branch of Service: Army vs. Other	-0.02	-0.31	-9.48	6.90
Religion: Christianity vs. Atheist-Agnostic	0.06	1.06	-2.40	7.90
Religion: Christianity vs. None	0.07	1.28	-1.62	7.56
Religion: Christianity vs. Prefer Not to Say	0.17	2.86**	2.65	14.59
Gender	0.20	3.42**	3.23	12.12
Military Rank: 07 - 10 vs. E1 – E4	-0.05	-0.74	-10.30	4.69
Military Rank: 07 - 10 vs. E5 – E9	-0.08	-0.82	-6.92	2.87
Military Rank: 07 - 10 vs. 01 - 03	0.16	2.54*	1.52	12.34
Military Rank: 07 - 10 vs. 04 -06	-0.06	-0.65	-6.44	3.26
FACIT-Sp Total Score	-0.66	-11.19***	-0.84	-0.59

Note. $N = 147$. Gender: 1 = Female, 2 = Male. All other demographic variables: 0 = Base, 1 = Comparison Category. FACIT-SP Total Score: Higher scores indicate greater spiritual well-being. Demographic variables were entered into Block 1. FACIT-Sp Total Scores were entered into Block 2. CI = Confidence Interval, *LL* = Lower Limit, *UL* = Upper Limit. Overall model F-test (14, 132) = 15.85, $p < .001$, Total $R^2 = .59$, $R^2\Delta = .35$, F-test Δ (1, 132) = 125.14, $p < .001$. *$p < .05$, **$p < .01$, ***$p<.001$

Summary

Invitation letters and fliers were sent electronically via email to 14 different veteran sites, organizations, and individual combat veterans across the country. The goal for sample size was a minimum of 148 and 150 surveys were completed for use in the data analysis. The completed analyses were tests of means, a Pearson correlation, and a multiple linear regression. The alternative hypotheses failed to be rejected (HA) due to lack of statistical significance, and Null hypothesis was rejected (H0) due to statistical significance, $p < .05$. These results show that the prediction of spiritual wellness on moral injury is statistically significant. These results provide questions, answers, and more direction based on the data and the data collection procedure. The overall relationship was a strong negative one, indicating that participants with low spiritual well-being were likely to have a high level of moral injury. Research revealed that spiritual wellness, as measured by the FACIT-Sp, can predict moral injury, as measured by MIES, among combat veterans beyond the predictive power of the demographic variables of gender, branch of service, component of service, military rank, and religion. In Chapter 5, the interpretations of the findings, the limitations of the study, and the recommendations for future research are presented. Implications for social change and the potential impact for positive social change at the individual, family, organizational, and societal/policy are discussed.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to investigate the potential relationship between spiritual wellness as measured by the FACIT-Sp and moral injury as measured by the MIES among combat veterans. The research question investigated was as follows: Does spiritual wellness (as measured by the FACIT-Sp) predict moral injury (as measured by the MIES) among combat veterans beyond the predictive power of the demographic variables of gender, branch of service, component of service, military rank, and religion? I anticipated that understanding the relationship between the factors and characteristics assessed in these measures could impact or predict the effects of spiritual wellness on moral injury and suggest significant changes in how combat veterans return into society. I also examined moral injury separate from PTSD to investigate whether the relationship of spiritual wellness to moral injury could result in a theory of moral injury separate from that of PTSD (Barr et al., 2016; Currier et al., 2015; Hoge, 2010; Nacasch et al., 2015; Nash et al., 2013).

The study was based on a quantitative survey with a cross-sectional, correlational analysis to help me evaluate the connection between spiritual wellness and moral injury among combat veterans. I used a deductive approach to the evaluation while incorporating the demographic variables that I had identified within the literature as potentially significant. A regression analysis helped estimate the conditional expectation of moral injury scores given spiritual wellness scores in addition to the demographic variables. In this manner the demographic variables are incorporated into the regression

analysis to see how much more predictive power could be realized when adding spiritual wellness.

As noted above, to advance empirical research on the problem, I investigated whether the independent variable of spiritual wellness, as measured by the FACIT-Sp (Canada et al., 2008), could be used to predict the dependent variable of moral injury, as measured by the MIES (Nash et al., 2013) while integrating the demographic variables for gender, branch of service, component of service, military rank, and religion. Addressing criterion-related validity, the researchers for these scales concluded that strong psychometric properties could be used to measure the variables as an indicator of specific traits or behaviors (Canada et al., 2008; Nash et al., 2013). My quantitative survey research is designed to discover trends and develop explanations about the potential relationship between spiritual wellness and moral injury for combat veterans while integrating demographic variables (Grove et al., 2009). The focus for the research is based on the implications of previous research that a lack of spiritual wellness in combat veterans leads to moral injury (Bormann et al., 2012; Currier et al., 2015; Doyle & Peterson, 2005; Harris et al., 2015; Nacasch et al., 2015; Nash et al., 2013; Sayers, 2011; Sayer et al., 2010; Schwartz, 2012).

The analytical strategy for the study includes descriptive statistics, correlation analyses, and multiple regression analyses. Correlation analyses were used to test the statistical significance of the relationships between spiritual wellness and the demographic variables (Creswell, 2009; Field, 2013; Green & Salkind, 2014; Hair et al., 2010). Regression analyses were used to estimate the conditional expectation of moral

injury scores given spiritual wellness scores after integrating the demographic variables (Field, 2013; Green & Salkind, 2014; Hair et al., 2010). More specifically, regression analyses helped predict how measurements of moral injury change when any of the scores of spiritual wellness are varied while accounting for the impact of the demographic variables (Simon, 2011). The regression analyses involved identifying the relationship between one or more of the independent variables (spiritual wellness, demographic variables) and the dependent variable (moral injury). I used a convenience sampling method to collect the data.

Interpretation of the Findings

This study extends current knowledge in the counseling profession. The overall finding is that the alternative hypothesis was accepted and proved that the prediction of spiritual wellness on moral injury is statistically significant. The alternative hypothesis stated that there would be a statistically significant relationship between spiritual wellness as measured by FACIT-Sp and moral injury as measured by MIES on combat veterans beyond the predictive power of the demographic variables of gender, branch of service, component of service, and military rank.

The strong negative relationship found in this study indicated that participants with low levels of spiritual well-being are more likely to have an elevated level of moral injury. Specifically, I expected that lower scores on the FACIT-Sp would predict significantly higher scores on the MIES. This research revealed that spiritual wellness (as measured by the FACIT-Sp) can predict moral injury (as measured by MIES) among combat veterans beyond the predictive power of the demographic variables. This is an

important finding because this information can be used to help reduce the consequences and symptoms of moral injury among combat veterans.

As presented in the literature review in Chapter 2, explorations of the relationship of spiritual wellness to moral injury using an empirically based approach was lacking in the literature. This study's use of a quantitative approach helped predict a connection to draw direct conclusions as supported by many of the recommendations of the researchers cited in this review. Many of the findings were confirmed, and knowledge was extended to combat veterans in respect to demographics. The effect of moral injury on spiritual wellness confirmed the conclusions of Barr et al. (2016), Currier et al. (2013), Maguen and Litz (2014), and Nash et al. (2013) of the importance of moral injury on transgressions. These findings also extend the knowledge that there is a statistically significant relationship between spirituality and moral injury. Even with the known benefits of studying the causes and effects of moral injury, there have been few efforts to understand this relationship.

Study findings indicate that a high level of spiritual wellness relates to less moral injury compared to a risk of increased moral injury. These results can also be used the help predict the collateral effects of exposure to transgressive acts beyond PTSD symptoms. Research examining the collateral effects in relation to transgressive acts as defined in the MIES is lacking in current literature. For example, aspects of moral injury such as spiritual/existential problems and loss of faith were not included in the original works of Litz et al. (2009). According to Drescher et al. (2011) and Farnsworth et al. (2014), these aspects of moral injury needed to be examined.

Statistical tests in the study illustrated the results necessary to evaluate the statistical assumptions. As discussed in Chapter 4, the means and standard deviations for the MIES and FACIT-Sp and subscales supported the alternative hypothesis. The correlation coefficients between the MIES and FACIT-Sp scales demonstrated that all scales were significantly related to each other, with the strength of the relationships ranging from moderate to strong. The relationship between the MIES and the FACIT-Sp total score was a strong negative. This indicates that participants with low spiritual well-being are likely to have a high level of moral injury. The relationships between the FACIT-Sp subscales and total score were all positive, indicating that the scales all measured some part of a similar concept, yet they were separate constructs.

Assessment Subscales and Demographics

The findings associated with the subscales of FACIT-Sp also produced useful results. Assessments associated with subscales related to faith, meaning, and purpose can be used to prioritize training and assistance offered to combat veterans. Of the subscales, faith had the lowest average score of 8.58, indicating a relatively low level of faith. Meaning had the highest average score of 11.29, indicating a moderate level of meaning. The skew of all scales was acceptable, ranging from -1.21 to -0.51. This suggests that meaning would have the biggest impact on moral injury. Further testing the characteristics and impact of this subscale would be beneficial for future study to minimize the effects of moral injury.

The examination and interpretation of the demographics also provided discoveries and conclusions beyond the scope of this research. Moral injury was found to

significantly differ between participants who identified as Christian and participants who selected *none* as their religion. Christianity *v.* Prefer Not to Say had a significant positive relationship with MIES scores ($\beta = 0.17$, $t = 2.89$, $p < 0.01$); participants who preferred not to say what their religion was had significantly higher moral injury than did participants who identified as Christian.

Moral injury was found to differ significantly between participants who identified as male and those who identified as female. Participants who identified as male reported significantly higher levels of moral injury ($M = 31.95$, $SD = 12.57$) than participants who identified as female ($M = 23.10$, $SD = 12.57$, $t = -2.86$, $p < .05$). Moral injury was found to differ significantly between participants who left the service with a rank of 01 to 03 and those who left the service with a rank of 07 to 10. Gender also had a significant positive relationship with MIES scores ($\beta = 0.20$, $t = 3.42$, $p < 0.01$); participants who identified as male had significantly higher moral injury than did participants who identified as female.

As shown in Table 9, results associated with religion and rank were found to significantly predict moral injury. Examining Rank of Service O7 to 10 versus O1 to O3 showed a significant positive relationship with MIES scores ($\beta = 0.16$, $t = 2.54$, $p < 0.05$); participants who reported holding a rank of O1 to O3 had significantly higher moral injury than did participants who reported holding a rank of O7 to 10. FACIT-Sp-12. Total scores had a significant negative relationship with MIES scores ($\beta = -0.66$, $t = -11.19$, $p < 0.001$); participants who reported higher levels of spiritual well-being had significantly lower moral injury.

Demographics were consistent with the overall scores and conclusion that higher spiritual awareness lower moral injury. The overall model F-test was significant ($F(14, 132) = 15.85$, $p < 0.001$), with Block 1 predicting 63% of the MIES scores. Adding the FACIT-Sp-12 Total scores in Block 2 significantly increased the predictive power of the model to predict MIES scores (F-test Δ $(1, 132) = 125.14$, $p < 0.001$) by an additional 35%. Consequently, the hypothesis was supported. An enhanced understanding of the relationship of religion, gender, and rank on moral injury can be used to help train these specific groups to reduce moral injury. Following is an interpretation of the findings in the context of the theoretical framework.

Existentialism Theory

The hypothesis of this study is based on the concepts used in existential psychology. Through this research, I identified that the existential model fit well with the FACIT-sp instrument. The factors of faith, purpose, and meaning associated with the FACIT-sp lined up with the life meaning and purpose associated with existential theory (Bormann et al., 2012; Canada et al., 2008; Drescher et al., 2011; Harris et al., 2015; Kim & Jamal, 2007; Bormann et al., 2012; Sayer et al., 2010; Nash et al., 2013).

Existential theory and models include the integration of psychological wellness and spiritual balance (May & Yalom, 2005; Reynolds, 2014). The framework is based on the belief that, even though we are essentially alone in the world, humans desire life meaning, purpose, and to be connected to others (May & Yalom, 2005; Reynolds, 2014). Each of these factors is measured in the FACT-sp instrument. Understanding the value and close association of spiritual constructs to spiritual wellness and moral injury

connects the two variables and the interaction of existentialism as the theoretical framework for the study.

Showing that spiritual wellness influences moral injury also supports May and Yalom's (2005) contention that if a person's connection to themselves or other humans is at risk, as is experienced in combat, there is an increased chance of injury to their overall wellness and ability to function. There also is an elevated risk to become dependent on others for their own validation. The relationship of existential theory and models to this study is important in that it endorses and validates the study of spiritual wellness and moral injury as operational variables (Creswell, 2009). Identifying a lost sense of humanity as an outcome of transgressing deeply held beliefs provides the opportunity to assess spiritual wellness outcomes in relationship to the MIES moral injury survey.

The existential theory presented in Chapter 2 was valuable for this research and created an appropriate theoretical lens for the research. The findings extended existing research for both theories by confirming existing expectations and values of the theories and expanding the known importance of using a consistent model that integrated multicultural components necessary in clinical mental health counseling.

Summary

The implications of these results center on being able to predict moral injury based on spiritual wellness. The research, based on the data and the data collection procedure, provides detailed results concerning spiritual wellness, moral injury, and relevant demographics that address questions and provide direction to help treat and prevent moral injury among combat veterans. The alternative hypotheses failed to be

rejected (HA) due to lack of statistical significance, and Null hypothesis was rejected (H0) due to statistical significance ($p < .05$). These results show that the prediction of spiritual wellness on moral injury is statistically significant. Limitations of the study, recommendations for future research, and implications for social change are discussed below.

Limitations of the Study

Delimitations of this study included the research question, variables, theoretical perspectives, and population. For this research, the delimitations set limits to the scope and defined study boundaries. The study's purpose was to investigate the possible relationship between spiritual wellness and moral injury. Topics such as quality of life, reintegration, other mental health issues, and specific treatment options for combat veterans were not specifically included. Although specific elements associated with these issues are related to the study purpose, they are not covered in their entirety.

One of the main limitations of the study is the inconsistency within the literature of the definition of a "combat veteran" (U.S. Department of Veterans Affairs, 2014; Schwartz, 2012). Reliability and internal consistency could be a limitation if the sample is not representative of the population (Creswell, 2009; Hair et al., 2010; Simon, 2011). Military veterans were an appropriate group from whom to gather information related to the variables and instruments in this research. To narrow the research group, participants were limited to combat veterans to assess the relationships explored in this study. However, as discussed in Chapter 2, definitions of a military veteran and combat veteran

produced a wide variety of descriptions and interpretations among the general U.S. population as well as in the military itself (Schwartz, 2012).

Further, while access to the population was not anticipated to be a problem, finding qualified participants based on this definition could have been a limitation. Distributing the survey to organizations and people who were identified as combat veterans to be included in programs offered by those organizations helped address this limitation. While there were differences among the services, all services considered combat veterans as serving in a theater of operations. Also, care was taken in the instructions and distribution of the surveys to control for combat veterans. Follow on discussions and debriefings on site also helped to insure the trustworthiness of the data.

Other study limitations center on the lack of participation within some demographic categories. Although some categories were combined, there was still less representation from demographics associated with services, religions, and gender. However, the number of participants was consistent with the overall percentages that could be expected for the veteran population across the military (VA census 2016). This was also consistent with previous studies where these were included (Currier et al., 2015; Nash et al., 2013). In future studies, in would be useful to have a higher representation of other services, components, and genders.

Anticipating a lack of certain demographic groups, purposive sampling was used to ensure representation across different demographic groups (Creswell, 2009). Previous research conducted by Nash et al. (2013) concluded that demographics associated with gender, branch of service, component of service, military rank, and religion could have a

significant relationship with combat veterans who identify with moral injury. Efforts to include a random selection of participants from the demographic groups could improve the validity of the study (Groves, 2009).

The trustworthiness and validity of the data was maintained mainly based on the reliability associated with the organizations and programs that were asked to participate and distribute the surveys. It took six months to gather the number of responses needed. While the short number of questions associated with the surveys helped improve the response rate, reports from administrators revealed that most veterans found the on-line survey process overwhelming. The expected survey time was 10 minutes for both surveys. Most organizations and programs had the ability to connect and access veterans to follow up and ask them to participate. Additionally, most administrators who received the letter were able to access the leadership of the organizations they worked with to increase support and improve a response rate. I had to visit several sites post announcements and redistribute the request letter to most of the sites to get the appropriate number of responses.

Other potential limitations were associated with availability of demographic groups and were mitigated by my status as a veteran and a therapist working with veterans. Past studies focused primarily on combat marines and did not include other military services, branches, and the demographics that were used in this study (Currier et al., 2015; Nash et al., 2013). The enhanced scope of this research was expected to improve reliability and validity of the findings. I had access to a wide variety of sites as offered by previous employment and my current work with Ft. Belvoir and the Walter

Reed military communities. As a veteran and working with veterans, I anticipated access to populations that could be useful for this study.

The study included participants contacted by public and privately-funded organizations as well as those in treatment and not in treatment programs, which helped improve generalization across the population. Based on the sampling technique, it was not possible to determine how many participants were in treatment or other types of programs. I had predicted that most of the participant would come from treatment programs. However, most participants were found though distribution lists of veterans that were not associated with or participating in an active treatment program. Not knowing if a veteran had some new experience at improving their spiritual wellness prior to taking the survey might have impacted the validity and reliability of the results.

Further, those responding from treatment programs or in programs that emphasize spiritual wellness may have been better able to cope with the effects of moral injury transgressions. It was not possible to determine participants who were or currently receiving support and treatment. Considering this as a variable in future studies could help assess the impact of specific or other treatment modalities.

The quantitative survey design and data collection also may have limited participants if they were currently undergoing treatment for another mental health disorder. Survey questions may have triggered other mental health related symptoms considering the stage of treatment of the study participants. Triggering these symptoms could also account for higher scores that could otherwise be expected or cause others to question if they are subject to this disorder. For additional studies of this type, it could

prove useful to use a more specific combat veteran population such as those not in treatment to gain more representation from some sources.

The self-report format, with little to no assistance, may potentially have also led to some issues regarding trustworthiness and validity. Without adequate representation, the extent to which the instrument yields the same results on repeated measures could have produced less than reliable results (Currier et al., 2015; Simon, 2011). Unaccounted for variables associated with participants' religious (spiritual) values, moral attitudes, family influences, urban or rural setting, and cultural background could impact the study scores. I anticipated that participants would be combat veterans with moral injury based on their combat experience and admission to existing programs.

Regarding specific findings, research investigating categories of gender have not been consistent (Nash et al., 2013). A lack of understanding the social environmental factors for this study related to transgender veterans prevents a full understanding of the gender demographic. In the future, a more detailed sampling and understanding of the gender demographic would improve sampling and reliability of the gender category.

Although military personnel enter the service with their own specific culture, values, and beliefs, for this study it was assumed that, once in the service, each are trained to use strength, force, aggression, and to cause some level of harm to meet military objectives (Cesur et al., 2013; Fleming, 2015; Freedman, 2015). The nature of warfare assumed by previous researchers could be generalized to veterans who are from any part of the country and have different ranks and time in service. While the scope of the research centers on treatment programs in the Washington, D.C. metropolitan area,

the survey was also distributed to other regions in the United States. As noted, only the data from "combat veterans" was used. It is also possible generalizability could be affected by the study's sample size and that could be viewed as a constraint to this study. These limitations are opportunities for future research.

Further limitations could involve a participant's lack of acceptance of moral injury as a DSM-5 and ICD-10 related issue or disorder. Participants could have a personal agenda or interests related to the definition of moral injury that could skew the scores. Another potential restriction could result from participants' desires to over–emphasize the value of religion over spirituality. A clear majority of the military identifies with a specific religious tradition (Park et al., 2016). However, the study and acceptance of spiritual constructs as valid measures could be a limitation in the study.

Finally, to limit my bias as a combat veteran and a clinician, I involved administrators in organizations who were not all combat veterans in the participant selection process. The data collection also included clinicians who are not combat veterans.

Recommendations

An examination of the strengths and limitations associated with the data, in combination with a comprehensives review of existing literature and the theoretical constructs guiding this study, suggest several key recommendations. Because study findings indicate a relationship between spiritual wellness and moral injury, efforts to validate, update, and replace existing programs in the system can be considered and implemented. Results of the study also have relevance for elements related to clinical

counseling and psychological theories, orientations, policy, training, and education. Below is a discussion of recommendations that are within the scope of the study.

Further Study

Including spiritual wellness related constructs in military training related systems can be used to help combat veterans mitigate or alleviate consequences and symptoms related to moral injuries experienced in combat environments. Specific elements and factors associated with items in the subscales assessing spiritual wellness of faith, purpose, and meaning can improve spiritual wellness and prevent moral injury. While there may be some difficulty with the term 'spiritual wellness', the subscales and elements related to the term can be integrated into programming and counseling without negative stigma.

For maximum benefit, training in each military component should include entry, mid, and senior level schools and programs associated within each service. Military related programs on leadership, wellbeing, and performance counseling education programs can be updated to include these key elements. Knowledge of the importance of these elements can also help define and understand the difficulties faced by combat veterans who return home from war (Currier et al., 2013; Frankfurt & Frazier, 2016; Maguen & Litz, 2014; Nash et al., 2013).

Focusing on assessment instruments, this study identified some challenges with the MIES moral injury scale. Interpreting the findings related to spiritual wellness revealed questions concerning the link between transgressive acts and life meaning and purpose if the measures of transgressive acts also measure purpose. Studies that can

identify and distinguish between various kinds of exposures to transgressive acts could improve the validity of moral injury scores. This would be an important contribution, since diverse types of exposures may be associated with different outcomes (Farnsworth et al., 2014). Frankfurt and Frazier (2016) also revealed the need for strong research designs and quantitative methods to clearly define the relationship of the categories.

Understanding moral injury as an outcome and a transgression may also help to address some limitations in the MIES survey. For instance, it is not clear if factors, such as anger, are factors for transgressive acts or outcomes of transgressive acts or both. The study of moral injury is further complicated by including symptoms of intrusive memories, emotional numbing, and avoidance, as well as the collateral effects such as self-injury, demoralization, and self-handicapping that stem from PTSD (Currier et al., 2015; Frankfurt & Frazier 2016; Litz, 2009; Maguen & Litz, 2014; Nash et al., 2013). Constructs and effects of moral injury — such as guilt, shame, withdrawal, and self-condemnation — overlap with the collateral outcomes of self-handicapping, demoralization, and self-injury.

Future research may also explore different data collection instruments and techniques, for example, using one on one interviews to measure the relationship of moral injury and spiritual wellness. A PTSD scale such as the Clinician Administered PTSD scale (CAPS-5) and PTSD checklist (PCL-5) could also be useful to control for variables and improve the limitation of generalization associated with the study. Additionally, partnership with other Veteran organizations to gather data would be very useful in presenting the topic to military leadership. Involving mental health

professionals at the start of the research could also help with distribute surveys and collecting accurate data. It would also be useful to include those that have identified as demographics. Qualitative data also would be a useful addition to gathering empirical data to ensure that the data are relevant to the variables indicated and/or modifications to the FACIT-sp or MIES.

Military Settings

The most direct implications of study findings would be for settings where veterans serve. For example, including spiritual wellness related constructs in military training related systems can be used to help combat veterans mitigate or alleviate consequences and symptoms related to moral injuries experienced in combat environments. Specific elements and factors associated with items in the subscales assessing spiritual wellness of faith, purpose, and meaning can improve spiritual wellness and prevent moral injury. While there may be some difficulty with the term 'spiritual wellness', the subscales and elements related to the term can be integrated into programming and counseling without negative stigma.

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Finally, there continues to be a lack of knowledge about the factors that impact the ability of combat veterans to successfully reintegrate into civilian society. Other recommendations are described below related to implications for positive social change. This research establishes strong ties to individuals and families, interventions, counseling advocacy and leadership, and social policy. Acceptance of these new constructs is just beginning in our societal culture and a systems approach is needed to implement change and the new paradigms (Senge, 2006). The following section offers a description of the potential impact for application of the findings and positive social change.

Implications

Findings from this study indicate that certain spiritual wellness factors affect moral injury and its impact on individuals and on society. A connection between this relationship and its characteristics may enhance treatment of and other responses to combat veterans. This research shows the areas most effected are individual and family, interventions, counseling advocacy and leadership, and social policy.

Clinical Treatment for Practice (Individual, Group, and Family)

Results of this research also can impact social change by helping individuals, groups, and families heal and grow from moral injury wounds. Mental health counseling interventions and treatment can be developed and adjusted to incorporate spiritual wellness factors and alleviate negative symptoms and consequences for combat veterans (Gray et al., 2012; Hoge et al., 2004; Karlin et al., 2010; Maguen & Litz, 2014). The results could lead to an enhanced effectiveness of treatment and development of new and more effective psychotherapy approaches (Currier et al., 2015; Nash et al., 2013). The

addition of spiritual constructs in counseling interventions may lessen negative impacts on society due to the consequences of moral injury.

Interventions associated with life meaning, purpose, and faith also could enable more successful reintegration of combat veterans back into society. To accomplish this, efforts to further study the most effective elements of life purpose, meaning, and purpose will impact social change. Life purpose, meaning, and faith are currently embedded in preexisting theories and orientations that could now be prioritized and supported. Empirically based and best practice clinical mental health theories that use present moment awareness and here and now orientations all incorporate elements associated with meaning, purpose, and faith. These theories postulate that being in the present allows an individual to let go of faulty beliefs and behaviors associated with these elements and explore and find their true and authentic self. A stronger sense of self can lead to a more positive and healthy sense of wellbeing and reduce the risk of harmful coping habits.

Mindfulness and somatic based theories such as MBCT, DBT, ACT, and others that focus on the here and now emotions and feelings are often used in this manner. In addition to illogical and faulty beliefs, these theories help to examine behavior habits that are not working well. Old strategies and habits to attain purpose and meaning can be examined and adjusted. This all leads to helping a client address old thoughts and behaviors in a way that enables them to slow down reaction times so that new healthier patterns can be identified and developed.

Results can be expanded to examine if spiritual wellness is related to suicidal ideation and behavior, depression, and resilience. Studies by Sher, Braquehais, and Casas (2012) and Weber and Pargament (2014) examined the effects of spiritual factors of veterans on overall well-being and motivation. In both studies, study participants overwhelmingly identified the value of seeking individual meaning and purpose in human existence.

Other societal implications could be realized through increased attention to moral injury symptoms and consequences. Factors associated with demoralization, hopelessness, self-injury, and depression have often been associated with moral injury (Kuo et al., 2004). These characteristics relate to the study and examination of the numerous societal issues related suicide of combat veterans. Findings from this research supports Kuo et al.'s (2004) prediction that steps to highlight and raise attention to spiritual wellness could lead to a decreased number of suicides and their related negative impacts on society. Incorporating spiritual wellness treatment interventions into counseling programs and materials is needed to support this outcome.

Further social change implications related to treatment center on identification and integration of other spiritual wellness constructs. For example, as identified in the literature review, forgiveness has been well studied as a spiritual construct and has been shown to have a positive effect on wellbeing. Understanding how forgiveness relates to spiritual wellness can have a positive effect in the treatment of moral injury symptoms. Research also supports the value of integrating spiritual wellness approaches into mental health training and counseling. Enhanced understanding of the treatment implications

related to acts of transgression, betrayal, fear, and anxiety highlights the value of adding spiritual wellness as an impact on other behavioral and emotional consequences.

Treatment related to the existential framework also have social change implications. Offering opportunities to develop an improved sense of life meaning, purpose, and faith in treatment can support a combat veteran's ability to become comfortable with their own fundamental sense of aloneness (Bormann et al., 2012; Canada et al., 2008; Drescher et al., 2011; Harris et al., 2015; Kim & Jamal, 2007; May & Yalom, 2005; Reynolds, 2014; Sayer et al., 2010; Nash et al., 2013). Offering this treatment could then restore wellbeing by repairing the conflict between self-validation and dependence on others as concluded in existentialist theory. This internal validation can allow veterans to connect more genuinely to others (Yalom, 1980; Bormann et al., 2012; Kim & Jamal, 2007; Sayer et al., 2010; Nash et al., 2013). Treatment in this manner could also increase a veteran's ability to develop more positive coping mechanisms and habits.

Treating the patterns of inappropriate guilt, shame, anger, self-handicapping behaviors, relational and spiritual/existential problems, and social alienation that emerge after witnessing and/or participating in warzone events that challenge a combat veteran's basic sense of humanity can be used to alleviate the consequences of moral injury (Litz et al., 2009; Nash et al., 2013; Vargas et al., 2013). Integrating these outcomes into clinical treatment would then have a positive impact on families, other individuals directly affected by the veteran, and society.

Societal Advocacy, Leadership, and Policy

These findings and conclusions provide useful information to bring attention to combat veterans as a unique and specific culture, as supported by Currier et al. (2015); Schwartz (2012); Doyle & Peterson (2005); Sayer et al. (2010) and Sayers, (2011). Recommendations from this study could offer guidance for developing policies and procedures for providing culturally sensitive treatment for combat veterans and others within the military. Further, these results support and add to the strong need to advocate for Veterans as a specific culture.

Even in the professional counseling literature, there is a lack of advocacy to consider veterans as a separate culture (Currier et al., 2015; Schwartz, 2012). Enhanced recognition will bring increased attention to combat veterans and encourage others to prioritize assistance to combat veterans and the organizations that support them. It is my hope as a researcher, veteran, and clinician that this priority will help spark a call to action for increased treatment, resources, and assistance. Action will help reduce the financial, emotional, and physical drain on the system caused by the consequences and symptoms of moral injury.

Results of this study support the American Counseling Association's (2014) suggestion that increased efforts to incorporate combat veterans' cultural considerations and education standards into counselor education and supervision programs could help new clinicians become more effective in their work with this population. These considerations and education standards could then encourage increased mental health advocacy related to moral injury symptoms and consequences related to family violence,

spousal abuse, traffic accidents due to road rage, alcohol and drug related incidents, and driving while intoxicated arrests among this population. In these ways, advocacy for the veteran population would have a direct and positive social change impact.

This supports related research efforts that also highlight the need for advocacy and leadership to recognize veterans as a specific culture (Doyle & Peterson, 2005; Sayer et al., 2010; Sayers, 2011). For example, Currier et al. (2015) and Schwartz (2012) noted that this lack of advocacy weakens the attention for mental health treatment of combat veterans and is an issue that must be addressed. A systems approach by leaders in counseling and education can help improve the advocacy needed to choose specific interventions informed by research and address the results of this study.

To improve advocacy, results of this study can also be used to support increased promotional materials, additional presentations at conferences and universities, workshops, annual association events, and other clinical theory related forums in the clinical counseling community. Connecting with national clinical counseling association (mental health, school, rehabilitative) and other related professions (psychology, social work, psychiatry, etc.) with sub groups that specialize in spiritual integration into counseling would be useful.

Other implications could be realized by recognizing the need to provide trained clinicians to treat combat veterans. The Department of Veterans Affairs estimated that 40% of veterans are not treated by trained professionals (U.S. Department of Veterans Affairs, 2014). The addition of this research is important to the counselor education and supervision profession to better understand and serve the veteran population as

counselors, educators, consultants, advocates, leaders, and researchers (American Counseling Association, 2014; Arredondo et al., 1996; CACREP, 2009; Doyle & Peterson, 2005).

Increasing numbers of highly competent counselors will continue to be required by society to treat our returning combat veterans (Doyle & Peterson, 2005). A greater understanding of combat veterans as a culture could contribute to the counseling field by influencing social change related to counselor education curriculums and community-based trauma-related programs and treatment. Findings from this study also suggests changes to the CACREP standards to include spiritual wellness as a core competency and combat veterans as a unique culture to provide program quality and credibility. Results from this study could be integrated and used to ensure counselors are trained to meet specific and defined standards through proven educational and competency requirements (Schweiger et al., 2012). For example, combat veteran culture could be added as a standard in culture related courses to gain CACREP accreditation.

Expanding the results of this study to other veterans, professions, and civilians exposed to moral injury could be beneficial to society in much the same way. Exploring the relationship of moral injury to other career fields such as police and firefighters, also subject to moral injury, could benefit others in society and support social change.

Conclusion

In conclusion, this study's purpose was to determine what relationships, if any, existed between spiritual wellness and moral injury. The study fills at least one of the gaps in the literature and extends knowledge in the discipline. The gap this study

addressed is the lack of investigation concerning the relationship between moral injury and spiritual wellness. The lack of data concerning the impact of the factors of spiritual wellness and moral injury prevents an effective understanding and assessment of the successful reintegration of combat veterans back into society. Study results also suggested that veterans who incorporate spiritual wellness as part of their life can protect themselves from the at least some of the negative effects of committing or been exposed to transgressive acts. Incorporating counseling interventions that build on and enhance a combat veterans life purpose, meaning, and faith can help heal combat veterans heal. In future research, results from this study could be used to compare the impact of spiritual wellness to PTSD and help define the difference between PTSD and moral injury.

Study findings also support the need to incorporate spiritual wellness to benefit combat veterans in the early steps of their training, before they deploy for war, when they are exposed to moral injury, and when they return from exposure. All these interventions have inherent implications for the reintegration and transition of combat veterans. Results of this study support the need for the education, training, and treatment of combat veterans, and emphasizes a need to add spiritual wellness to policy and training as well to ensure that veterans' treatment and transition needs are more fully met. Changes in training, treatment, awareness, support, and education related to these study findings could be a part of effective efforts to help combat veterans reintegrate into society and back home to their families more effectively. It is hoped that, with the enhanced application of multicultural concepts, a sizable percentage of combat veterans who are marginalized due to SES, ethnicity, gender, or other cultural factors will receive greater

attention and effective treatment. This research could further help to bridge the gap between psychology, philosophy, ethics, and military studies.

Considering the study methodology, the study validates the use framework and design connected to the study variables. Adding to the mental health research, these results enhance the understanding, identification, and impact of moral injury and spiritual wellness of combat veterans. An improved understanding of this relationship can help identify, define, and reduce the many issues confronted by families and society when veterans return home. The treatment of veterans with moral injury is also important to recognize combat veterans as a unique culture. As highlighted throughout this effort, this new knowledge can inform policy makers, military leaders, scholars, and educators of further possibilities for discussion on how to help combat veterans heal from the wounds of war.

References

Allen, M. P. (2007). Significant developments in veterans' law (2004-2006) and what they reveal about the U.S. Court of Appeals for the Federal Circuit. *University of Michigan Journal of Law Reform*, 37(1), 55-61(3).

American Counseling Association. (2005). https://global.oup.com/academic/product/strategy-9780199325153

American Counseling Association. (2014). Family Reintegration Difficulties and Couples Therapy for Military Veterans and Their Spouses. *Cognitive and Behavioral Practice*, *18*(1), 108-119. Retrieved from https://www.counseling.org/search-results?q=military+veterans and their spouses.

Ando, M., Morita, T., Akechi, T., Ito, S., Tanaka, M., Ifuku, Y., & Nakayama, T. (2009). The efficacy of mindfulness-based meditation therapy on anxiety, depression, and spirituality in Japanese patients with cancer. *Journal of Palliative Medicine, 12*(12), 1091-1094. doi:10.1089/jpm.2009.0143

Arredondo, P., Toporek, M. S., Brown, S., Jones, J., Locke, D. C., Sanchez, J. & Stadler, H. (1996). Operationalization of the Multicultural Counseling Competencies. AMCD: Alexandria, VA. Retrieved from https://www.counseling.org/resources /competencies/multcultural_competencies.pdf

Bakken-Gillen, S. K., Berven, N. L., Chan, F., Brooks, J., & Resnick, S. G. (2015). Prediction of employment outcomes among veterans with substance use disorders: A chi-squared interaction detector analysis. *Journal of Vocational Rehabilitation*, *43*(2), 113-127.

Retrieved from https://www.rehab.research.va.gov/jrrd/

Barr, N. U., Sullivan, K., Kintzle, S., Castro, C. A., Barr, N. U., Sullivan, K., Kintzle, S., ... Castro, C. A. (September 02, 2016). PTSD symptoms, suicidality and non-suicidal risk to life behavior in a mixed sample of pre- and post-9/11 veterans. *Social Work in Mental Health, 14,* 5, 465-473.

Baiocchi, D. (2013). *Measuring army deployments to Iraq and Afghanistan* (Research Report No. RR145-A). Retrieved from RAND Corporation website: http://www.rand.org/pubs/research_reports/ RR145.html

Baylis, J., & Gray, C. S. (2015). *Strategy in the contemporary world: an introduction to strategic studies*. Oxfordshire, England. Oxford University Press.

Beckham, J. C., Feldman, M. E., Kirby, A. C., Hertzberg, M. A., & Moore, S. D. (1997). Interpersonal violence and its correlates in Vietnam veterans with chronic posttraumatic stress disorder. *Journal of Clinical Psychology*, *53*(8), 859-869.

Beehler, S., Ahern, J., Balmer, B., & Kuhlman, J. (2017). Military families' perceptions of neighborhood characteristics affecting reintegration: Development of an aggregate measure. *Military Behavioral Health*, *5*(1), 43-50.

Bekelman, D. B., Parry, C., Curlin, F. A., Yamashita, T. E., Fairclough, D. L., & Wamboldt, F. S. (2010). A comparison of two spirituality instruments and their relationship with depression and quality of life in chronic heart failure. *Journal of Pain and Symptom Management, 39*(3), 515-526.

Blais, A. R., Thompson, M. M., & McCreary, D. R. (2009). The development and validation of the Army Post-Deployment Reintegration Scale. *Military*

Psychology, *21*(3), 365.

Blosnich, J. R., Marsiglio, M. C., Gao, S., Gordon, A. J., Shipherd, J. C., Kauth, M., . . . Fine, M. J. (2016). Mental health of transgender veterans in US with and without discrimination and hate crime legal protection. *American Journal of Public Health*, *106*(3), 534-540

Blotcher, E., ... & Wischenka, D. M. (2016). Advancing our understanding of religion and spirituality in the context of behavioral medicine. *Journal of Behavioral Medicine, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5183527/*

Bobrow, J. (2015). *Waking up from war: A better way home for veterans and nations*. Pitchstone Publishing (US&CA).

Böhm, R., Rusch, H., & Gürerk, Ö. (2016). What makes people go to war? Defensive intentions motivate retaliatory and preemptive intergroup aggression. *Evolution and Human Behavior*, *37*(1), 29-34.

Bormann, J. E., Thorp, S. R., Wetherell, J. L., Golshan, S., & Lang, A. J. (2013). Meditation-based mantram intervention for veterans with posttraumatic stress disorder: a randomized trial. *Psychological Trauma: Theory, Research, Practice, and Policy*, *5*(3), 259.

Bormann, J. E., Liu, L., Thorp, S. R., & Lang, A. J. (2012). Spiritual wellbeing mediates PTSD change in veterans with military-related PTSD. *International journal of behavioral medicine*, *19*(4), 496-502.

Bradley, R., Greene, J., Russ, E., Dutra, L., & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *American Journal of Psychiatry, 162,*

214–227. http://dx.doi .org/10.1176/appi.ajp.162.2.214

Brenner, L. A., Betthauser, L. M., Bahraini, N., Lusk, J. L., Terrio, H., Scher, A. I., & Schwab, K. A. (2015). Soldiers returning from deployment: A qualitative study regarding exposure, coping, and reintegration. DOI:10.1037/rep0000048

Brock, R. N., & Lettini, G. (2012). *Soul repair: Recovering from moral injury after war.* (Boston: Beacon Press, 2012).

Brodie, B. (2015). *Strategy in the missile age*. Princeton University Press.

Brown, W. B., Stanulis, R., & McElroy, G. (2016). Moral Injury as a Collateral Damage Artifact of War in American Society: Serving in war to serving time in jail and prison.

Bryan, C. J., Griffith, J. E., Pace, B. T., Hinkson, K., Bryan, A. O., Clemans, T. A., & Imel, Z. E. (2015). Combat exposure and risk for suicidal thoughts and behaviors among military personnel and veterans: A systematic review and meta-analysis. *Suicide and Life-Threatening Behavior*, *45*(5), 633-649.

Bryan, A. O., Bryan, C. J., Morrow, C. E., Etienne, N., & Ray-Sannerud, B. (2014). Moral injury, suicidal ideation, and suicide attempts in a military sample. *Traumatology, 20*(3), 154.

Bush, G. W. Institute's Military Service Initiative (2015). Retrieved from http://www.bushcenter.org/explore-our-work/index.html

Buttner, M. M., Bormann, J. E., Weingart, K., Andrews, T., Ferguson, M., & Afari, N. (2016). Multi-site evaluation of a complementary, spiritually-based intervention for Veterans: The Mantram Repetition Program. *Complementary Therapies in*

Clinical Practice, *22*, 74-79.

Campbell, D. T., & Stanley, J. C. (1963). *Experimental and quasi-experimental designs for research.* Boston, MA: Houghton Mifflin.

Canada, A. L., Murphy, P. E., Fitchett, G., Peterman, A. H., & Schover, L. R. (2008). A 3-factor model for the FACIT-Sp. Psycho-Oncology, 17(9), 908-916.

Cashwell, C. S., Young, J. S., Fulton, C. L., Willis, B. T., Giordano, A., Daniel, L. W., ... & Welch, M. L. (2013). Clinical behaviors for addressing religious/spiritual issues: do we practice what we preach? *Counseling and Values*, *58*(1), 45-58.

Castro, C. A., Kintzle, S., & Hassan, A. M. (2015). The combat veteran paradox: Paradoxes and dilemmas encountered with reintegrating combat veterans and the agencies that support them. *Traumatology*, *21*(4), 299.

Cesur, R., Sabia, J. J., & Tekin, E. (2013). The psychological costs of war: military combat and mental health. *Journal of Health Economics*, *32*(1), 51-65.

Childs, C. Y. (2014). Exploratory Factor Analysis of the Spiritual Wellness Inventory. Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine*, *351*(1), 13-22.

Clements, C. J., Kaklauskas, F. J., Hocoy, D., & Hoffman, L. (2016). History, Development, and Contemporary Perspectives of Transpersonal Psychology. *Shadows & Light (Volume 1: Principles & Practices): Theory, Research, & Practice in Transpersonal Psychology*.

Cobanoglu, C., & Cobanoglu, N. (2003). The effect of incentives in web surveys: application and ethical considerations. *International Journal of Market*

Research, *45*(4), 475-488.

Cohen, J., Cohen, P., West, S. G., & Aiken, L. S. (2013). *Applied multiple regression/correlation analysis for the behavioral sciences*. Routledge.

Cohen, L., Manion, L., & Morrison, K. (2000). Research Methods in Education [5th ed.] London: Routledge Falmer. *Teaching in Higher Education*, *41*.

Council for Accreditation of Counseling and Related Educational Programs (CACREP). (2008). *Journal of Counseling and Development*, *86*(2), 240+. Retrieved from http://link.galegroup.com.ezp.waldenulibrary.org/apps/doc

Craigie, M. A., Rees, C. S., Marsh, A., & Nathan, P. (2008). Mindfulness-based cognitive therapy for generalized anxiety disorder: A preliminary evaluation. *Behavioural and Cognitive Psychotherapy, 36*(5), 553-568. doi: 10.1017/S135246580800458X

Creswell, J.W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches.* (Laureate Education, Inc., custom ed.). Thousand Oaks, CA: Sage Publications.

Currie, S. L., Day, A., & Kelloway, E. K. (2011). Bringing the troops back home: Modeling the postdeployment reintegration experience. *Journal of occupational health psychology*, *16*(1), 38.

Currier, J. M., Drescher, K. D., Holland, J. M., Lisman, R., & Foy, D. W. (2015). Spirituality, forgiveness, and quality of life: Testing a mediational model with military veterans with PTSD. *The International Journal for the Psychology of Religion*, 1-28.

Currier, J. M., Holland, J. M., & Malott, J. (2015). Moral injury, meaning making, and

mental health in returning veterans. *Journal of clinical psychology*, *71*(3), 229-240.

Currier, J. M., Drescher, K. D., Holland J. M., Lisman, R., and Foy, D. W. (2016). Spirituality, forgiveness, and quality of life: Testing a mediational model with military veterans with PTSD. *The International Journal for the Psychology of Religion* 26(2), 167-179.

Currier, J. M., Smith, P. N., & Kuhlman, S. (2017). Assessing the unique role of religious coping in suicidal behavior among US Iraq and Afghanistan veterans. *Psychology of Religion and Spirituality*, *9*(1), 118.

Daaleman, T. P. & Frey, B. B. (2004). The Spirituality Index of Well-Being: A new instrument for health-related quality of life research. *Annals of Family Medicine*, 2, 499-503.

Doyle, L. M. E., & Peterson, L. K. A. (2005). Re-entry and reintegration: Returning home after combat. *Psychiatric Quarterly*, *76*(4), 361-370.

Drescher, K. D., Foy, D. W., Kelly, C., Leshner, A., Schutz, K., & Litz, B. (2011). An exploration of the viability and usefulness of the construct of moral injury in war veterans. *Traumatology*, 1534765610395615.

Endicott, L. (2010). *Institutional Review Board (IRB) frequently asked questions* [Online tutorial]. Retrieved from http://academicguides.waldenu.edu/researchcenter/orec

Evans, S., Ferrando, S., Findler, M., Stowell, C., Smart, C., & Haglin, D. (2008). Mindfulness-based cognitive therapy for generalized anxiety disorder. *Journal of Anxiety Disorders, 22*(4), 716-721. doi: 10.1016/j.janxdis.2007.07.005

Exline, J. J., Hall, T. W., Pargament, K. I., & Harriott, V. A. (2016). Predictors of growth from spiritual struggle among Christian undergraduates: Religious coping and perceptions of helpful action by God are both important. *The Journal of Positive Psychology*, 1-8.

Farnsworth, J. K., Drescher, K. D., Evans, W., & Walser, R. D. (2017). A functional approach to understanding and treating military-related moral injury. *Journal of Contextual Behavioral Science*, *6*(4), 391. doi:10.1016/j.jcbs.2017.07.003

Faul, F., Erdfelder, E., Lang, A. G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods*, *39*, 175-191.

Field, A. (2013). *Discovering statistics using IBM SPSS Statistics* (4th ed.). London: Sage.

Finucane, A., & Mercer, S. W. (2006). An exploratory mixed methods study of the acceptability and effectiveness of mindfulness-based cognitive therapy for patients with active depression and anxiety in primary care. *BMC Psychiatry, 6* doi: 10.1186/1471-244X-6-14

Fleming, W. H. (2015). The Warrior Journey: A Hope Enhancement Intervention for Veterans with Combat-Related PTSD.

Foa, E. B. (2010). Dissemination of evidence-based psychological treatments for posttraumatic stress disorder in the Veterans Health Administration. *Journal of traumatic stress*, *23*(6), 663-673.

Fontana, A., & Rosenheck, R. (1998). Psychological benefits and liabilities of traumatic

exposure in the war zone. *Journal of Traumatic stress*, *11*(3), 485-503.

Frankfort-Nachmias, C. & Nachmias, D. (2008). *Research methods in the social sciences* (7th ed.). New York: Worth.

Frankfurt, S., & Frazier, P. (2016). A Review of Research on Moral Injury in Combat Veterans. *Military Psychology*, *28*(4), 000.

Freedman, L. (2015). *Strategy: a history*. Oxford University Press.

Gill, C. S., Barrio Minton, C., & Myers, J. (2015). Poor, Rural Women: Spirituality, Religion, and Wellness Across the Life Span. *Adultspan Journal*, *14*(2), 66-76.

Gilligan, C. (2014). Moral injury and the ethic of care: Reframing the conversation about differences. *Journal of Social Philosophy*, *45*(1), 89-106.

Gray, M. J., Schorr, Y., Nash, W., Lebowitz, L., Amidon, A., Lansing, A.,. Litz, B. T. (2012). Adaptive disclosure: An open trial of a novel exposure-based intervention for service members with combat-related psychological stress injuries. *Behavior Therapy, 43,* 407–415. http://dx.doi.org/ 10.1016/j.beth.2011.09.001

Green, S. B., & Salkind, N. J. (2014). *Using SPSS for Windows and Macintosh: Analyzing and sciences* (7th ed.). New York: Worth.

Groves, R. M., Fowler, F. J. Jr., Couper, M. P., Lepkowski, J. M., Singer, E., & Tourangeau, R. (2009). *Survey methodology* (2nd ed.). Hoboken, NJ: John Wiley & Sons.

Hair, J. F., Jr.; Black, W. C.; Babin, B. J.; and Anderson, R. E. (2010). *Multivariate Data Analysis, 7th Edition.* Upper Saddle River, NJ: Prentice Hall.

Haley, S. A. (1974). When the patient reports atrocities: Specific treatment considerations

of the Vietnam veteran. *Archives of General Psychiatry*, *30*(2), 191-196.

Hall, T. W. & Edwards, K. J. (2002). The spiritual Assessment Inventory: A theistic model and measure for assessing spiritual development. *Journal for the Scientific Study of Religion,* 41, 341-357.

Hall, W., Carter, A., & Forlini, C. (2015). The brain disease model of addiction: is it supported by the evidence and has it delivered on its promises? The Lancet Psychiatry, 2(1), 105-110.

Harmon, R. J., Morgan, G. A., & Harmon, R. J. (2001). Data collection techniques. *Journal of the American Academy of Child & Adolescent Psychiatry*, *40*(8), 973-976.

Harris, J. I., Park, C. L., Currier, J. M., Usset, T. J., & Voecks, C. D. (2015). Moral injury and psycho-spiritual development: Considering the developmental context. *Spirituality in Clinical Practice*.

Harris, J. I., Erbes, C. R., Winskowski, A. M., Engdahl, B. E., & Nguyen, X. V. (2014). Social support as a mediator in the relationship between religious comforts and strains and trauma symptoms. *Psychology of Religion and Spirituality*, *6*(3), 223.

Hatzenbuehler, M. L. (2014). Structural stigma and the health of lesbian, gay, and bisexual populations. *Current Directions in Psychological Science*, *23*(2), 127-132.

Haugan, G. (2015). The FACIT-Sp spiritual well-being scale: an investigation of the dimensionality, reliability and construct validity in a cognitive intact nursing home population. Scandinavian journal of caring sciences, 29(1). 152-164.

Herzberg, H. (2006). Learning habitus and the dynamics of lifelong learning. *Studies In The Education Of Adults*, *38*(1), 37.

Hoge, C. (2010). *Once a warrior--Always a warrior: Navigating the transition from combat to home--including combat stress, PTSD, and mTBI*. Rowman & Littlefield.

Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). http://academicguides.waldenu.edu/researchcenter/orec/application

Horowitz, M. J., & Solomon, G. F. (1975). A prediction of delayed stress response syndromes in Vietnam veterans. *Journal of Social Issues*, *31*(4), 67-80.

Huang, H. H., & Kashubeck-West, S. (2015). Exposure, agency, perceived threat, and guilt as predictors of posttraumatic stress disorder in veterans. *Journal of Counseling & Development*, *93*(1), 3-13.

Iacovou, S. L. (2016). *The impact of active service on the intimate relationships of ex-servicemen: an existential-phenomenological study* (Doctoral dissertation, Middlesex University/New School of Psychotherapy and Counselling).

Jacob K., F., Kent D., D., Jason A., N., Robyn B., W., & Joseph M., C. (2014). The Role of Moral Emotions in Military Trauma: Implications for the Study and Treatment of Moral Injury. *Review of General Psychology*, (4), 249. doi:10.1037/gpr0000018

Johnson, B. D., Bormann, J. E., & Glaser, D. (2015). Validation of the Functional Assessment of Chronic Illness Therapy–Spiritual Well-Being Scale in veterans with PTSD. *Spirituality in Clinical Practice*, *2*(1), 25.

Kaminker, J., & Lukoff, D. (2013). Transpersonal perspectives on mental health and mental illness. *The Wiley-Blackwell handbook of transpersonal psychology*, 419.

Karlin, B. E., Ruzek, J. I., Chard, K. M., Eftekhari, A., Monson, C. M., Hembree, E. A., ... & Foa, E. B. (2010). Dissemination of evidence-based psychological treatments for posttraumatic stress disorder in the Veterans Health Administration. *Journal of traumatic stress*, *23*(6), 663-673.

Kessler, R. C., Heeringa, S. G., Stein, M. B., Colpe, L. J., Fullerton, C. S., Hwang, I., ... & Schoenbaum, M. (2014). Thirty-day prevalence of DSM-IV mental disorders among nondeployed soldiers in the US Army: results from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS). *JAMA psychiatry*, *71*(5), 504-513.

Kim, B., Lee, S., Kim, Y. W., Choi, T. K., Yook, K., Suh, S. Y., . . . Yook, K. (2010). Effectiveness of a mindfulness-based cognitive therapy program as an adjunct to pharmacotherapy in patients with panic disorder. *Journal of Anxiety Disorders, 24*(6), 590-595. doi: 10.1016/j.janxdis.2010.03.019

Kim, H., & Jamal, T. (2007). Touristic quest for existential authenticity. *Annals of Tourism Research*, *34*(1), 181-201.

Kinghorn, W. (2012). Combat trauma and moral fragmentation: A theological account of moral injury. *Journal of the Society of Christian Ethics*, *32*(2), 57-74.

Kuo, W. H., Gallo, J. J., & Eaton, W. W. (2004). Hopelessness, depression, substance disorder, and suicidality. *Social psychiatry and psychiatric epidemiology*, *39*(6), 497-501.

Lan, C. W., Fiellin, D. A., Barry, D. T., Bryant, K. J., Gordon, A. J., Edelman, E. J., ... & Marshall, B. D. (2016). The epidemiology of substance use disorders in US Veterans: A systematic review and analysis of assessment methods. *The American journal on addictions*, *25*(1), 7-24.

LeardMann, C. A., Powell, T. M., Smith, T. C., Bell, M. R., Smith, B., Boyko, E. J., ... & Hoge, C. W. (2013). Risk factors associated with suicide in current and former US military personnel. *Jama*, *310*(5), 496-506.

Leedy, P.D. & Ormrod, J. E. (2010). Practical Research: Planning and Design, Ninth Edition. NYC: Merril.

Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C., & Maguen, S. (2009). Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical Psychology Review*,*29*(8), 695-706.

Lord, H. G. (1973). Ex Post Facto Studies as a Research Method. Special Report No. 7320

Maercker, A. & and Perkonigg. A. (2013). "Applying an international perspective in defining PTSD and related disorders: Comment on Friedman." *Journal of traumatic stress* 26.5 (2013): 560-562.

Maguen, S., & Litz, B. T. (2014). Moral injury in the context of war. Retrieved from http://www.ptsd.va .gov/professional/co-occurring/moral_injury_at_ war.asp

Manzaneque, J. M., Vera, F. M., Ramos, N. S., Godoy, Y. A., Rodriguez, F. M., Blanca, M. J.,... Enguix, A. (2011). Psychobiological modulation in anxious and depressed patients after a mindfulness meditation programme: A pilot study.

Stress and Health: Journal of the International Society for the Investigation of Stress, 27(3), 216-222. doi: 10.1002/smi.1334

Manzo IV, F., Director, M. P., Bruno, R., & Duncan, K. (2016). The Impact of Prevailing Wage Laws on Military Veterans.

Maoz, Z., & Henderson, E. A. (2013). The world religion dataset, 1945–2010: Logic, estimates, and trends. *International Interactions*, *39*(3), 265-291.

May, R. & Yalom, I. (2005). Existential psychotherapy. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (pp. 269-298). Belmont, CA: Thompson.

Meredith, P., Murray, J., Wilson, T., Mitchell, G., & Hutch, R. (2012). Can spirituality be taught to health care professionals? *Journal of religion and health*, *51*(3), 879-889.

Miller, C. (2016). 'Spiritual but not religious': rethinking the legal definition of religion. *Virginia Law Review*, *102*833.

Monod, S., Brennan, M., Rochat, E., Martin, E., Rochat, S., & Büla, C. J. (2011). Instruments measuring spirituality in clinical research: a systematic review. Journal of General Medicine, 26(11), 1345-1357.

Montgomery, D. C., Peck, E. A., & Vining, G. G. (2015). *Introduction to linear regression analysis*. John Wiley & Sons.

Mueller, J. R. (2015). Spiritual Well-being, Faith, Hope, Anxiety and Loneliness in Oncology Patients: A Descriptive Correlational Study.

Nacasch, N., Rachamim, L., & Foa, E. B. (2015). Case Presentation of a Chronic Combat PTSD Veteran. In *Future Directions in Post-Traumatic Stress Disorder* (pp. 391-

409). Springer US.

Nash, W. P., & Litz, B. T. (2013). Moral injury: A mechanism for war-related psychological trauma in military family members. *Clinical child and family psychology review*, *16*(4), 365-375.

Nash, W. P., Marino Carper, T. L., Mills, M. A., Au, T., Goldsmith, A., & Litz, B. T. (2013). Psychometric evaluation of the moral injury events scale. *Military Medicine*, *178*(6), 646-652.

Nieuwsma, J. A., Fortune-Greeley, A. K., Jackson, G. L., Meador, K. G., Beckham, J. C., & Elbogen, E. B. (2014). Pastoral care use among post-9/11 veterans who screen positive for mental health problems. *Psychological services*, *11*(3), 300.

Oman, D., & Bormann, J. E. (2015). Mantram repetition fosters self-efficacy in veterans for managing PTSD: A randomized trial. *Psychology of Religion and Spirituality*, *7*(1), 34.

Owens, G. P., Walter, K. H., Chard, K. M., & Davis, P. A. (2012). Changes in mindfulness skills and treatment response among veterans in residential PTSD treatment. *Psychological Trauma: Theory, Research, Practice, and Policy*, *4*(2), 221.

Park, C. L., Masters, K. S., Salsman, J. M., Wachholtz, A., Clements, A. D., Salmoirago-Blotcher, E., ... & Wischenka, D. M. (2016). Advancing our understanding of religion and spirituality in the context of behavioral medicine. *Journal of Behavioral Medicine*, 1-13.

Park, C. L., Smith, P. H., Lee, S. Y., Mazure, C. M., McKee, S. A., & Hoff, R. (2016).

Positive and Negative Religious/Spiritual Coping and Combat Exposure as Predictors of Posttraumatic Stress and Perceived Growth in Iraq and Afghanistan Veterans.

Parson, E. R. (1990). Post-traumatic demoralization syndrome (PTDS). Journal of Contemporary Psychotherapy, 20, 17–33. http://dx.doi.org/10.1007/ BF00946017

Phelps, M. L. (2016). Supporting the Troops. *The Routledge Research Companion to Security Outsourcing*.

Pietrzak, R. H., Johnson, D. C., Goldstein, M. B., Malley, J. C., & Southwick, S. M. (2015). Perceived stigma and barriers to mental health care utilization among OEF-OIF veterans. *Psychiatric services*.

Powell, C. L. (1992). US forces: Challenges ahead. *Foreign Affairs*, 32-45.

Reintegration problems and treatment interests among Iraq and Afghanistan combat veterans receiving VA medical care. *Psychiatric Services*, *61*(6), 589-597.

Raes, F., Dewulf, D., Van Heeringen, C., & Williams, J. M. (2009). Mindfulness and reduced cognitive reactivity to sad mood: Evidence from a correlational study and a non-randomized waiting list in a controlled study. *Behaviour Research and Therapy, 47*(7), 623-627. doi: 10.1016/j.brat.2009.03.007

Rapgay, L., Bystritsky, A., Dafter, R. E., & Spearman, M. (2011). New strategies for combining mindfulness with integrative cognitive behavioral therapy for the treatment of generalized anxiety disorder. *Journal of Rational-Emotive & Cognitive Behavior Therapy, 29*(2), 92-119. doi: 10.1007/s10942-009-0095-z

Reisner, S. L., Conron, K. J., Baker, K., Herman, J. L., Lombardi, E., Greytak, E. A., ...

& Matthews, A. K. (2015). “Counting” transgender and gender-nonconforming adults in health research recommendations from the Gender Identity in US Surveillance Group. *TSQ: Transgender Studies Quarterly*, *2*(1), 34-57.

Reynolds, J. (2014). Understanding existentialism. Routledge.

Robbins, A. T. (2016). *Association between combat, morally injurious experiences, spiritual injury, and alcohol use among active duty military personnel and veterans’* Doctoral dissertation, Old Dominion University).

Roztocki, N. (2001). Using internet-based surveys for academic research: opportunities and problems. In *Proceedings of the 2001 American Society for Engineering Management (ASEM) National Conference* (pp. 290-295).

Sammons, M. e., & Batten, S. e. (2008). Treating Combat Veterans and Their Families /. *Journal Of Clinical Psychology*, *64*(8), 921-1013.

Sayer, N. A., Noorbaloochi, S., Frazier, P., Carlson, K., Gravely, A., & Murdoch, M. (2010). Reintegration problems and treatment interests among Iraq and Afghanistan combat veterans receiving VA medical care. *Psychiatric Services*, *61*(6), 589-597.

Sayers, S. L. (2011). Family reintegration difficulties and couples therapy for military veterans and their spouses. *Cognitive and Behavioral Practice*, *18*(1), 108-119.

Schwartz, H. J. (2012). *Psychotherapy of the Combat Veteran*. Dordrecht: Springer Netherlands.

Senge, P. M. (2006). *The fifth discipline: The art and practice of the learning organization*. New York: Doubleday.

Sessanna, L., Finnell, D. S., Underhill, M., Chang, Y., & Peng, H. (2011). Measures assessing spirituality as more than religiosity: a methodological review of nursing and health-related literature. *Journal of Advanced Nursing*, *67*(8), 1677-1694. doi:10.1111/j.1365-2648.2010.05596.x

Shatan, C. F. (1973). The grief of soldiers: Vietnam combat veterans' self-help movement. *American Journal of Orthopsychiatry*, *43*(4), 640.

Shay, J. (2003). *Odysseus in America: Combat trauma and the trials of homecoming*. Simon and Schuster.

Shay, J. (2010). *Achilles in Vietnam: Combat trauma and the undoing of character*. Simon and Schuster

Shay, J. (2014). Moral injury. *Psychoanalytic Psychology*, *31*(2), 182.

Sher, L., Braquehais, M. D., & Casas, M. (2012). Posttraumatic stress disorder, depression, and suicide in veterans. *Cleve Clin J Med*, *79*(2), 92-7.

Sherman, M. D., Larsen, J., & Borden, L. M. (2015). Broadening the focus in supporting reintegrating Iraq and Afghanistan veterans: Six key domains of functioning.

Shiah, Y. J., Chang, F., Chiang, S. K., Lin, I. M., & Tam, W. C. C. (2015). Religion and health: anxiety, religiosity, meaning of life and mental health. *Journal of religion and health*, *54*(1), 35-45.

Simon, M. K. (2011). Dissertation and scholarly research: Recipes for success (2011 Ed.). Seattle, WA, Dissertation Success, LLC.

Smith, J. (2015). Explorative Study of Barriers to Care for Post-Traumatic Stress Disorder Among Combat Veterans from Operation Iraqi Freedom and Operation

Enduring Freedom.

Smith, N. B., Mota, N., Tsai, J., Monteith, L., Harpaz-Rotem, I., Southwick, S. M., & Pietrzak, R. H. (2016). Nature and determinants of suicidal ideation among US veterans: Results from the national health and resilience in veterans' study. *Journal of affective disorders*, *197*, 66-73.

Smith, S. M., Goldstein, R. B., & Grant, B. F. (2016). The association between post-traumatic stress disorder and lifetime DSM-5 psychiatric disorders among veterans: Data from the National Epidemiologic Survey on Alcohol and Related Conditions-III (NESARC-III). *Journal of Psychiatric Research*, *82*, 16-22.

Steenkamp, M. M., Litz, B. T., Hoge, C. W., & Marmar, C. R. (2015). Psychotherapy for military-related PTSD: a review of randomized clinical trials. *Jama*, *314*(5), 489-500.

Steenkamp, M. M., Marmar, C. R., Litz, B. T., & Hoge, C. W. (January 01, 2015). Psychotherapy for military-related PTSD: A review of randomized clinical trials. *Jama - Journal of the American Medical Association, 314,* 5, 489-500.

Taylor, V., Grant, J., Daneault, V., Scavone, G., Breton, E., Roffe-Vidal, S., . . . Beauregard, M. (2011). Impact of mindfulness on the neural responses to emotional pictures in experienced and beginner meditators. *NeuroImage, 57*(4), 1524-1533. doi: 10.1016/j.neuroimage.2011.06.001

Tsai, J., Pietrzak, R. H., Hoff, R. A., & Harpaz-Rotem, I. (2016). Accuracy of screening for posttraumatic stress disorder in specialty mental health clinics in the US Veterans Affairs Healthcare System. *Psychiatry research*, *240*, 157-162.

U.S. Census Bureau (2011). US Veterans, *American Community Survey 2007 – 2011.* U.S. Census Bureau's American Community Survey Office, 2011. Web. 1 January 2016.

U. S. Census Bureau. (2014). Retrieved from http://www.census.gov/newsroom/facts-for-features/2014/cb14-ff24.html

U.S. Department of Defense. (2015, 2016, 2017). *About department of defense, definitions, branches, and ranks*. Retrieved from: https://www.defense.gov/.

U. S. Department of Veterans Affairs. (2014). *National Center for PTSD*. (2014). Retrieved from: http://www.ptsd.va.gov/professional/assessment/adult-int/caps.asp.

U. S. Department of Veteran Affairs. (2017). Retrieved from http://www.va.gov/

Vargas, J. A. (2013). *Preparation and Reintegration of Military Reservists: What Reservists Expect from their Civilian Employers* (Doctoral dissertation, Texas State University-San Marcos).

Vargas, A. F., Hanson, T., Kraus, D., Drescher, K., & Foy, D. (2013). Moral injury themes in combat veterans' narrative responses from the National Vietnam Veterans' Readjustment Study. *Traumatology*, 1534765613476099.

Vieten, C. (2016). How Spirituality and Religion Are Linked to Psychological Functioning. *Science*.

Vogt, W. P., & Johnson, R. B. (2011). *Dictionary of statistics & methodology: A nontechnical guide for the social sciences*. Sage.

Walden University. (2014). *PhD dissertation*. Retrieved

from: http://academicguides.waldenu.edu/writingcenter/capstone/phd

Walden University. (2015). *Dissertation prospectus guide*. Retrieved from: http://academicguides.waldenu.edu/researchcenter/osra/phd

Walden University. (2017). Institutional Review Board (IRB). Retrieved from: http://academicguides.waldenu.edu/researchcenter/osra/phd

Walker, J., Ainsworth, B., Hooker, S., Keller, C., Fleury, J., Chisum, J., & Swan, P. (2015). Optimal health (spirit, mind, and body): A feasibility study promoting well-being for health behavior change. *Journal of religion and health*, *54*(5), 1681-1698.

Wallace, L. T. (2016). Creating A Veteran Centered Wellness Treatment Model For Successful Reintegration.

Weber, S. R., & Pargament, K. I. (2014). The role of religion and spirituality in mental health. *Current opinion in psychiatry*, *27*(5), 358-363.

Whitford, H. S., & Olver, I. N. (2012). The multidimensionality of spiritual wellbeing: peace, meaning, and faith and their association with quality of life and coping in oncology. Psycho-Oncology, 21(6), 602-610.

Williams, M. J., McManus, F., Muse, K., & Williams, J. M. (2011). Mindfulness-based cognitive therapy for severe health anxiety (hypochondriasis): An interpretative phenomenological analysis of patients' experiences. *British Journal of Clinical Psychology, 50*(4), 379-397. doi: 10.1111/j.2044-8260.2010.02000.x

Worthington, E. L., & Langberg, D. (2012). Religious Considerations and Self-Forgiveness in Treating Complex Trauma and Moral Injury in Present and Former

Soldiers. *Journal of Psychology & Theology*, *40*(4).

Yalom, I. D. (1980). Existential psychotherapy. New York, NY: Basic Books.

Yook, K., Lee, S., Ryu, M., Kim, K., Choi, T. K., Suh, S. Y., . . . Kim, M. (2008). Usefulness of mindfulness-based cognitive therapy for treating insomnia in patients with anxiety disorders: A pilot study. *Journal of Nervous and Mental Disease, 19(6), 501-5*

Appendix A: FACIT-sp Survey

FUNCTIONAL ASSESSMENT OF CHRONIC ILLNESS THERAPY (FACIT) LICENSING AGREEMENT

January 13, 2017

The Functional Assessment of Chronic Illness Therapy system of Quality of Life questionnaires and all related subscales, translations, and adaptations ("FACIT System") are owned and copyrighted by David Cella, Ph.D. The ownership and copyright of the FACIT System - resides strictly with Dr. Cella. Dr. Cella has granted FACIT.org (Licensor) the right to license usage of the FACIT System to other parties. Licensor represents and warrants that it has the right to grant the License contemplated by this agreement. Licensor provides to ***Steve Zappalla***
the licensing agreement outlined below.

This letter serves notice that **Steve Zappalla** ("INDIVIDUAL") is granted license to use the **English** version of the **FACIT-Sp** in one study.

This current license extends to (INDIVIDUAL) subject to the following terms:

1) (INDIVIDUAL) agrees to provide Licensor with copies of any publications which come about as the result of collecting data with any FACIT questionnaire.

2) Due to the ongoing nature of cross-cultural linguistic research, Licensor reserves the right to make adaptations or revisions to wording in the FACIT, and/or related translations as necessary. If such changes occur, (INDIVIDUAL) will have the option of using either previous or updated versions according to its own research objectives.

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4) In all publications and on every page of the FACIT used in data collection, Licensor requires the copyright information be listed precisely as it is listed on the questionnaire itself.

5) Licensor reserves the right to withdraw this license if (INDIVIDUAL) engages in scientific or copyright misuse of the FACIT system of questionnaires.

6) There are no fees associated with this license.

Appendix B: MIES

Instructions: Please circle a number to indicate how much you agree or disagree with each of the following statements about your experiences at any time since joining the military.

		Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
1.	I saw things that were morally wrong.	1	2	3	4	5	6
2.	I am troubled by having witnessed others' immoral acts.	1	2	3	4	5	6
3.	I acted in ways that violated my own moral code or values.	1	2	3	4	5	6
4.	I am troubled by having acted in ways that violated my own morals or values.	1	2	3	4	5	6
5.	I violated my own morals by failing to do something that I felt I should have done.	1	2	3	4	5	6
6.	I am troubled because I violated my morals by failing to do something I felt I should have done.	1	2	3	4	5	6
7.	I feel betrayed by leaders who I once trusted.	1	2	3	4	5	6
8.	I feel betrayed by fellow service members who I once trusted.	1	2	3	4	5	6
9.	I feel betrayed by others outside the U.S. military who I once trusted.	1	2	3	4	5	6

Source: William P. Nash, Brett T. Litz. Public Domain

Scoring instructions:

The original 11-item Moral Injury Events Scale shown in the Appendix of Nash et al. (2013) shows **response choices from 1 to 6 corresponding to labels of "strongly agree" to "strongly disagree,"** such that, using the 9 items included in the final scale, **higher scores on the MIES would correspond to lower intensity of Moral Injury Events.**

The correct response choice labels are shown in the table above and described accurately in the text of Nash et al. (2013). The response choices from 1 to 6 correspond to labels of "strongly disagree" to "strongly agree," such that higher scores on the MIES correspond to higher intensity of Moral Injury Events.

Reference: Nash, W. P., Marino Carper, T. L., Mills, M. A., Au, T., Goldsmith, A., & Litz, B. T. (2013). Psychometric evaluation of the moral injury events scale. Military medicine, 178(6), 646-652.

Appendix C: Advertisement for Participation

Combat Veterans Wanted

Are you a Combat Veteran of the United States Armed Forces?

Would you like to help us learn how your experiences may have affected your return home, your wellbeing, and quality of life?

Research is being conducted to explore the relationship of moral injury and spiritual wellness. Participation may improve reintegration of combat veterans back home to families and society.

All that is needed are answers to two very brief surveys (18 questions total – 5 minutes)

Surveys and eligibility questionnaires located at:

https://www.surveymonkey.com/user/sign-in/

If you are interested or would like more information, please contact Steve Zappalla *
Phone:
Email:

*Steve Zappalla is a Doctoral Candidate at Walden University. This study is being conducted to meet partial fulfillment of the requirements for the degree of PhD Counselor Education and Supervision.

Appendix D: Request letters (As needed)

Dear Program Administrator:

My name is Steve Zappalla and I am a fourth year doctoral student at Walden University. I am writing to request your assistance with my dissertation. As a retired Army Combat veteran I am interested in identifying ways to minimize consequences and symptoms of returning combat veterans to help improve their overall wellness and quality of life. (Detailed description attached to this note).

The attached advertisement contains the link to the survey. I am hoping you would consider distributing the advertisement to your public distribution lists of veterans and others that might be interested for possible participation in this study.

The surveys will be administered electronically and is a one-time administration of two surveys totaling 20 questions plus a demographic questionnaire to combat veterans. Both surveys take 5 minutes, the research is confidential, and participating veterans or organizations will not be identified either by name or through identifying information published in the final manuscript. To further protect confidentiality, results will not be analyzed as individual participants or agencies. Results will be aggregated and analyzed based on branch of service, gender, component of service, pay grade, religion, and other participant level characteristics. I am dedicated to preserving the confidentiality of participating organizations, agencies and their employees.

There is minimal risk to participants and the two surveys are well-accepted instruments that have been specifically normed for use with human services staff. I am not collecting information regarding clients.

I have received IRB approval (when appropriate) to begin data collection, however, as part of the recruitment process, I request your assistance to reach out to veterans you have assisted or you think could also benefit. Please pass this along to others in your organization that might be to able assist or participate. If I should contact others directly or you would like to discuss the study further, please email or call me at your earliest convenience.

Thank you for your consideration and I hope to hear from you.

Sincerely,

Steve Zappalla, LPC, ACS, NCC
Doctoral Candidate

Appendix D: Continued (Request letter attachment – as needed)

Examination of Spiritual Wellness as a Predictor for Moral Injury in Combat Veterans

I am examining spiritual wellness as a predictor for moral injury in combat veterans under the guidance of my dissertation chair, Dr. Laura Haddock. Researchers found that while moral injury is not formally labeled a mental disorder, combat veterans are experiencing moral injury. Further research on spiritual well-being discovered significant connections associated with psychological stress, maladaptive coping behaviors, and physical pain.

While moral injury could be related to these elements, it is not known if spiritual wellness is significantly related to moral injury. Researchers have recently demonstrated the possibility that having a lack of spiritual wellness increases vulnerability to moral injury. Investigating the relationship between spiritual wellness and moral injury could offer insights to improve quality of life and well-being of veterans, families, and society.

Appendix E: National and Local Resources

National:

Veterans Crisis Line Website

1-800-273-8255 (Press 1, chat online, or send a text message to 838255)

Confidential support 24 hours a day, 7 days a week, 365 days a year. The Veterans Crisis Line connects veterans in crisis and their families and friends with qualified, caring Department of Veterans Affairs responders.

TAPS

800-959-TAPS (8277)

Talk with someone on our survivor care team if you want more information about helpful services and programs or just need someone to talk to, please call us any time at 1.800.959.TAPS (8277). Our resource and information helpline is available 24 hours a day, 7 days a week, 365 days a year.

Suicide & Crisis Hotline

1-800-999-9999

The Lifeline provides 24/7, free, and confidential support for people in distress, prevention and crisis resources for you or your loved ones, and best practices for professionals.

Local

Community Services Board Emergency Services

Crisis Hotline: 703-573-5679, TTY 711 (24 hours, 7 days/week)

For people in crisis with a mental health, intellectual disability or alcohol or other drug emergency. Services include crisis intervention and stabilization, and evaluation for referrals to crisis care facilities, emergency shelters, and hospitals.

Appendix F: Applicant Demographic Data and Eligibility Sheet

Combat Veteran: Yes or No

Gender: Male, Female, Transgender male to female, Transgender female to male, other, and/or do not wish to say.

Brach of Service: Army, AF, Navy, Marine, Coast Guard

Component of Service: Active, Reserve, National Guard

Religious Preference: Christianity, Judaism, Islam, Buddhism, Hinduism, Agnostic, Atheist, Other

Appendix G: Debriefing Handout

Thank you for participating in this study. Your participation is much appreciated, and I am grateful for your willingness to share your experiences with me. Your contribution will help add important information to the counseling profession.

Sharing your military experiences and importance of spirituality in your life could cause you some distress and pain. Common stress responses could include anger, anxiety, worry, sadness, trouble sleeping, and impatience. Other responses could be associated an increase in behaviors and actions that you are normally able to control.

If you notice that you are having these responses and they do not subside within a short time frame, you may need additional help to address them. You may refer to your insurance plan's directory for counselors in your network or use the local resources included in the consent form.

Thank you again for your participation,

Steve Zappalla
Doctoral Candidate, Doctor of Philosophy in Counselor Education & Supervision
Walden University