Advances in Nursing Science
Vol. 44, No. 3, pp. 224–237

Moral Injury in Veterans
Application of the Roy Adaptation Model to Improve Coping

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The objective of this article is to provide validation, application, and understanding of the concept of moral injury and build provider awareness to reduce veteran self-harm. Two focus groups were conducted: one to identify characteristics of moral injury and the other to refine the concepts and generate clinical approaches that address maladaptive coping strategies. The focus group sessions verified moral injury's existence, and focus group consensus centered on loss of role identity and shattering of the veteran's core integrity. The veteran's inability to self-reflect is identified as a significant contributor to the maladaptive thought process, creating internal triggers based on violations of deeply held beliefs. A Supplemental Digital Content video abstract is available at http://links.lww.com/ANS/A33. **Key words:** *battle buddies*, *group identity*, *moral injury*, *role function*, *Roy Adaptation Model*, *self-harm*, *self-reflection*, *suicide*, *veteran*

THE EXTENDED wars of the 20th and 21st centuries have forced clinicians to look at mental and emotional trauma in a new light. Suicide among US military personnel has doubled since 2002, and in 2008, the military suicide rate topped the general population rate for the first time in history.[1] Despite Congress appropriating more than $1 billion to fund Department of Defense and Veteran Administration suicide prevention programs, and mandatory screening for veterans and active-duty military, the suicide rate continues to climb. Between 2005 and 2016, the suicide rate for veterans, 18 to 34 years of age, rose a staggering 80%, and the overall rate across all ages is 1.5 times higher than nonveterans.[2] It appears that efforts to date are not working, necessitating the need for innovative and forward-thinking approaches to mitigate this crisis.

The authors believe that the harm created by the moral transgressions of war may be a significant but overlooked factor in the rise of veteran suicide. Therefore, the purpose of this study was to build a definitional understanding and awareness of the concept of moral injury (MI) (Table), as it relates to veteran self-harm. In addition, the project was designed to help diminish the shame associated with veteran mental health and prompt the creation of improved therapies. The authors hope that definitional clarity will encourage all clinicians to incorporate MI into their therapeutic milieu.

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The authors thank the veterans and stakeholders for sharing their expertise and experience in each focus group discussion. Their struggles and sacrifices fostered the development of this study.

The authors have disclosed that they have no significant relationships with, or financial interest in, any commercial companies pertaining to this article.

Supplemental digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal's Web site (www.advancesinnursingscience.com).

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DOI: 10.1097/ANS.0000000000000348

Statements of Significance

What is known or assumed to be true about this topic?

Between 2005 and 2016, the suicide rate for veterans, 18 to 34 years of age, rose a staggering 80%, resulting in the veteran suicide rate topping the general population rate for the first time in history. We believe that moral injury is a contributing factor to this crisis. Moral injury explains the emotional wounds that combat veterans incur when required to perform actions outside of their moral and ethical boundaries. These perceived transgressive behaviors result in lasting harm to the veteran's social, psychological, and biological well-being.

What this article adds:

This article provides a comprehensive review of the moral injury concept and offers insight into the challenges faced by veteran health providers. We recognized that the lack of a robust clinical designation is primarily due to the complexity of the phenomenon, which requires a holistic approach beyond any one discipline. The Roy Adaptation Framework allowed us to explore moral injury using a bio-psycho-social-spiritual-paradigm. This model clearly delineates the lack of social reintegration and highlights specific examples of why veterans withdraw from their social networks.

LITERATURE REVIEW

The concept that one's morally transgressive behavior results in lasting harm to the individual's social, psychological, and biological well-being is well documented. The struggle for redemption and efforts to repair the damage created by these transgressions is captured in the fables and tales that chronicle the human story. However, only recently has the clinical relevance of this age-old struggle been examined.[9] Jonathon Shay[10] developed the term "moral injury" (MI) to describe the emotional and physical wounds that combat veterans incur when required to perform actions outside of their moral and ethical boundaries. These moral infractions cause the individual to assess perceived violations of ethical judgment as "wrong," creating a sense of guilt.[1]

Table. Definition of Terms

Term	Definition
Moral Injury	A trauma or series of traumatic events, psychological, behavioral, or existential, that creates intrapersonal and interpersonal issue for the individual.[3]
Moral agency	Broadly defined as the capacity and willingness to act on behalf of the community and display actions that maintain a positive moral identity.[4]
Spirituality	All-encompassing and refers to the way individuals find and extract meaning and develop a purpose in life.[5]
Soul	The bearer of moral significance, which is manifested via the thoughts and feelings of a person's interior life.[6]
Coping	The ability or inability to adapt to stressful situations in a positive manner that protects the well-being of the individual.[7]
Environment	Encompasses all the stimuli that affect the individual; these stimuli can create both positive and negative responses.[8]
Awareness	In MI, relates to the shame associated with mental health and the reluctance of veterans to seek help and treatment.
Self-harm	Equates to self-injury, self-mutilation, self-abuse, suicidal ideation, suicide attempts, or suicide.

Abbreviation: MI, moral injury.

In 2016, Jeremy Jinkerson[3] provided an updated and comprehensive definition of MI that accounts for trauma or a series of traumatic events, psychological, behavioral, or existential, that creates interpersonal and intrapersonal issues for the individual. Moral injury occurs because of the purported violation of moral principles by oneself or those of trusted individuals. These traumatic experiences generate substantial moral discord, which, left untreated, leads to anger, depression, sorrow, regret, shame, and alienation.[1] By including the existential component of this trauma, Jinkerson[3] made the definition of MI suitable to everyone, regardless of their deistic beliefs or spiritual identity.[11]

The crux of the MI concept is the injury sustained by violating one's ethical principles, making it impossible to ignore the influence of spirituality. Whether it is humanistic, cultural, or religious spirituality, each contributes to developing moral ideologies. The definition of spirituality in MI is all-encompassing and refers to the way individuals find and extract meaning and develop a purpose in life.[5] It affects what the individual holds sacred and transcendent. Without this influence in the development of a moral compass, there would be no moral discord, and the emotional wounds of MI would not exist.[5]

Moral injury attributes are fluid, as researchers and subject matter experts work to delineate the condition's foundations. The literature reviewed concentrates the defining attributes into 6 areas: (*a*) betrayal, (*b*) breach of trust, (*c*) spiritual/existential loss, (*d*) social problems, (*e*) self-depreciation, and (*f*) psychological symptoms. The individuals often describe a feeling of betrayal by someone in authority or believe that they have committed an act of betrayal. They experience a loss of trust in themselves, a deity, and others. In the sense of spiritual/existential loss of meaning, the individuals begin to question their morality. Social problems exist where the individuals withdraw from society, experience isolation, and describe difficulties fitting-in. Self-depreciation describes the feeling of guilt, loss of self-worth, and shame. Finally, psychological indicators represent a broad domain, including depression, emotional difficulties, anger, and other mental issues, leading to personal, occupational, and self-depreciative problems.[3,5,12-14] In the literature reviewed for this study, it appears that the concept of MI is based principally on the psychological indicators, along with accompanying attributes from the other 5 areas.

As researchers and clinicians continue to debate the existence and potential treatment options related to MI, they appear to be creating an almost infinite assortment of symptoms, which overlap other trauma-related conditions. In fact, some researchers and organizations outright reject the term MI and believe that stress associated with moral damage is better captured by the existing psychological term of "inner conflict," defined as stress arising because of moral damage from violating one's deeply held beliefs.[5] Hodgson and Carey[5] suggest that the lack of definitional clarity leads researchers to focus more on the effects of MI, rather than attempting to provide a decisive definition. Since the medical condition of MI is still being explored, the authors believe that the best approach for a new study is one that helps identify the key indicators and defining characteristics, which distinguish MI from other trauma-associated syndromes. Based on the literature reviewed, the concepts identified for this study include moral agency, spirituality, coping, environment, and awareness. Although the concepts are independent in meaning, they appear codependent and often synergistic in their influence on the individual suffering from MI.

MORAL AGENCY

Moral agency requires a sense of ethical principle and an obligation to operate by spiritual and cultural values.[4,15] Military members are expected to act within specified moral boundaries, but the demands and pressures faced in combat frequently require actions that exceed these boundaries. Moral injury occurs when the individual assumes moral responsibility for the act, even though

contextual factors distort the ethical decision-making process, and real or perceived constraints lead to effects which the service member recognizes as wrongdoing.[9,13] The individual's inability to maintain moral agency leads to a profound sense of betrayal and shame.[14,16]

SPIRITUALITY

The concept of spirituality is typically tied to theology and religious affiliation and describes the institution of religious expression.[5] However, when using the term associated with MI, it has a much broader meaning. Spirituality is how individuals find connectedness with others and to their environment.[5,17] Since MI impacts the individual's biological, social, psychological, and spiritual well-being, a holistic approach to treatment is required.[18] The component of spirituality can act as a source of strength, helping the individual cope with morally transgressive events. It can also create anxiety when the individual's actions become emotionally exhausting, leading to moral distress or injury.[19]

COPING

Coping strategies require the individual to continually adapt to changing internal and external stimuli, as these stimuli exceed one's moral contextual framework.[20] In other words, coping allows the individual to mitigate the effects of morally egregious events. The literature identifies 2 forms of adaptive strategies, problem-focused and emotional-focused. People who suffer physical or emotional trauma, as seen in MI, tend to use emotional-focused or maladaptive mechanisms, such as withdrawal/isolation, to shield themselves from confronting the issue directly.[20-22] Veterans who have survived suicide attempts describe loneliness or "feeling alone" as the top reason they considered suicide.[2]

ENVIRONMENT

The environment consists of both internal and external stimuli, which act as stressors that influence the development and behavior of the individual or group. Therefore, everything the person encounters is part of the environment. Thus, changes small or large require the individual to expend energy to adapt to the changing situation.[7,23] This directly affects the person's ability to cope, and since the individual suffering cannot be separated from the environment, this interaction may work to alleviate or worsen MI symptoms.

AWARENESS

The linkage between the concept of awareness and MI is complex and dual purposed. It serves to highlight one's self-awareness regarding the stigma of mental health but it also encompasses the aspects of societal recognition to ensure the proper identification and treatment of MI. The armed forces reward those who sacrifice and incur physical injuries. The Purple Heart Medal is awarded to members of the armed forces who are wounded by the instruments of war. However, there is no award for psychological injuries. In the military culture, mental injuries are seen as a sign of weakness and are often career-ending. The stigma associated with mental health issues consciously and subconsciously creates reluctance in veterans to acknowledge early symptoms.[24,25] Therefore, a significant proportion of veterans who suffer mental health issues do not access, repeatedly delay, or fail to complete mental health treatment.[25] The education component of awareness is essential in creating a trusting atmosphere where veterans can openly discuss mental health. Evidence shows that education plans that improve coping skills can influence the veteran's ability to adapt and reduce tension, lessening the impact of stressful situations. Therapies that address appropriate coping strategies

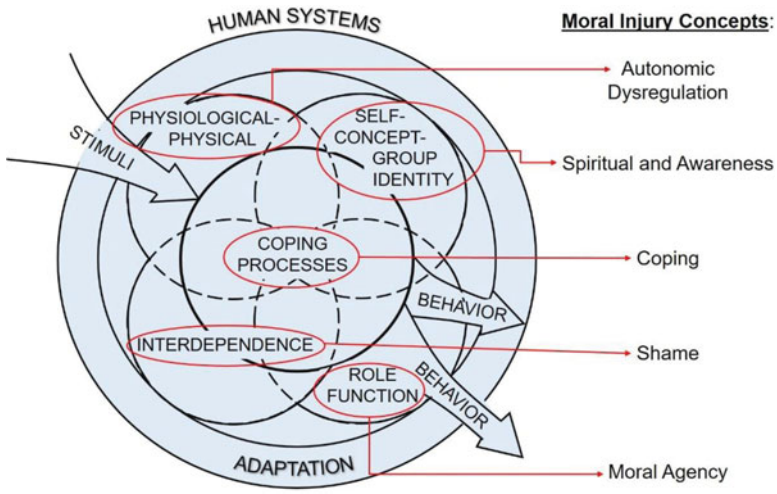

Figure 1. Diagrammatic representation of human adaptive systems.[8] Adaptation Model, modified to apply concepts of moral injury. This figure is available in color online (www.advancesinnursingscience.com).

may lead to greater adaptability of veterans experiencing the effects of moral discord induced by battlefield stress.[26]

Framework

This study is guided by the Roy Adaptation Model (RAM). The theoretical framework appears to be well suited for this study since it focuses on the coping processes and the external and internal stimuli that enable or prevent the person from successfully maintaining psychological, physiological, and social integrity in his or her current environment.[8] The RAM's adaptive modes, which were modified to include MI concepts, guided the researchers through the discovery process (Figure 1). The accessibility and generalizability of the concepts of person, environment, and adaptation in the RAM allowed the researchers to contextualize the veteran's emotional responses to MI.[23,26]

The RAM fully supports the concepts identified and facilitates the formation of strategies to assist veterans with MI. The idea of moral agency is captured in the model under the mode of role function. The principles of obligation and social integration act to define the role one occupies in society and how he or she should behave.[23,27,28] Degradation within the role function mode leads to the feeling of mistrust, betrayal, and guilt. The RAM helps the clinician identify these maladaptive emotions, which allows focused treatment and recovery programs.

The self-concept group identity mode in the RAM deals with the spiritual component identified by the authors. The RAM directs the assessment of the physical, moral, ethical, and spiritual well-being of the individual. In essence, it explores the individual's sense of purpose in the universe.[7,27] Veterans with MI experience feelings of guilt, loss of self-worth, and shame impacting self-concept and group identity.[3,5,12-14]

Interdependence adaptation of the RAM model includes the social, behavioral, and relational aspects, which determines the individual's ability to form close relationships and to benefit from these relationships.[28] The veteran's perception of mental illness degrades his or her relational integrity and role function within the group. This interferes with self and group identification, decreasing the perceived need for mental health intervention.[24] These negative views induce a sense of shame, jeopardizing the close relationships that military service and combat experience cultivate. Since veterans often perceive mental illness as a weakness and

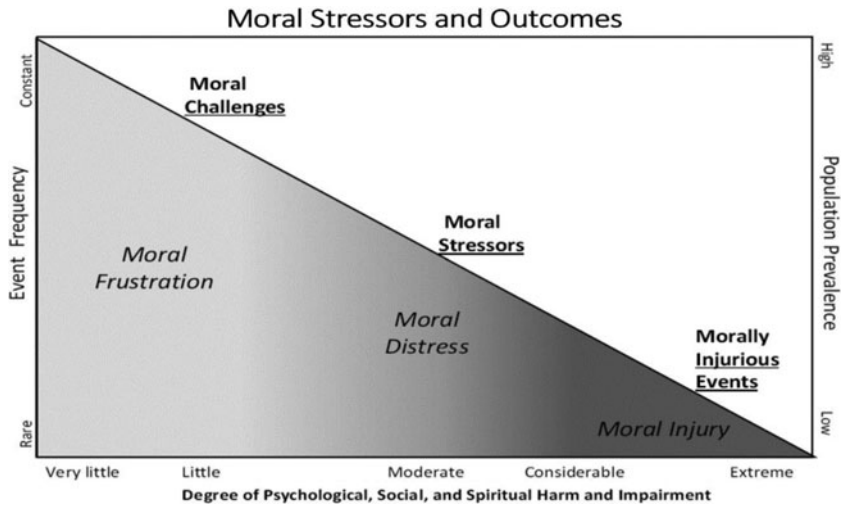

Figure 2. Heuristic Continuum Model of Moral Stressors.[9]

potential detriment to performing in the role of a soldier, they are reluctant to seek assistance.

In the RAM, coping strategies are critically important in determining whether stressful stimuli result in adaptive or maladaptive behavior.[28] The individual who develops appropriate coping strategies reduces the effects of stress on mental and physical health, leading to greater adaptability.[26] Veterans who use emotion-focused coping strategies avoid their issues rather than confronting them, creating a higher incidence of depression and anxiety.[20-22] This leads to physiological changes in the sympathetic and parasympathetic systems, causing autonomic dysregulation.[29] The dysregulation is characterized by a decrease in parasympathetic activity, creating a pathogenic mechanism in the treatment and maintenance of those suffering posttraumatic stress disorder (PTSD) and MI.[30] The overlap between PTSD and MI physiological symptoms complicates the diagnostic process. The RAM captures these changes in the physiologic regulator subsystem response of the model.

The environment consists of all positive and negative circumstances and conditions that affect the individual's ability to adapt.[27] The RAM considers these changes as the stimulus that drives the adaptive response.[8] For the clinician, establishing a safe and trusting environment is a crucial step in convincing veterans to participate in an outreach program.

Since the concept of awareness serves a dual purpose, its components are captured in the self-concept mode and in the control processes under the cognator subsystem.[27] The RAM allows the provider to explore the stigma associated with mental health through a moral-ethical-spiritual lens, thus allowing for the creation of interventions that best fit the person's needs.[8,27] The RAM person as an adaptive system, combined with the hypothetical Heuristic Continuum Model of Moral Stressors (Figure 2), can guide education and help both providers and veterans better understand how improving the individual's control process can enhance self-concept, role function, and interdependence, and enhance the adaptation response.[7,9]

METHODS

Participants

The authors conducted 2 focus group sessions with a variety of health care and religious professionals who work with

veterans in a college community. The majority of participants are veterans, as well as subject matter experts. They all have knowledge and experience with military service personnel and war zone veterans and exposure to veterans from the current wars. The groups comprised members from the Veteran Administration, veteran education systems, Veteran Court, veteran rehabilitation programs, mental health profession, and chaplaincy. One focus group participant disclosed that he is currently receiving treatment related to MI. These subject matter experts are individuals who have a personal or professional interest in helping define MI and how it affects veterans. The purpose of engaging stakeholders was to improve understanding of MI, thus generating relevant conclusions regarding this condition pertinent to practice.

Procedures

The study protocol was given expedited approval by the university institutional review board, which included an information sheet notifying members that attendance implies consent. To recruit relevant stakeholders, the selection process included both recommendations from the study team and snowball sampling, ensuring a diverse representation of focus group participants. These methods helped identify members of special populations who frequently engaged veterans in programs that promote veteran welfare. Investigators generated a list of potential contacts, and a member of the study team sent an e-mail requesting that the individuals read the information about the project and respond if they were willing to participate in the focus group sessions. Additional contacts were generated through recommendations from the focus group volunteers. In the invitation e-mail, potential focus group members were informed that their participation was voluntary and that they could withdraw from the study at any point. Participants received no compensation for their participation, and no focus group members were previously known by any members of the research team.

Recognizing that veteran mental health is an intense topic, the investigators created a safety protocol for focus group participants. Members were advised, if they needed to take a break or step out, to notify the moderators by signaling if they were okay, by giving a "thumbs-up," or if not okay, provide a discreet "thumbs-down" so that the team could follow up. The college behavioral intervention team was available for assistance if required. No members of the focus group signaled a need for support during these sessions.

The authors led 2 focus group discussions utilizing a dual-moderator methodology to establish critical issues and elicit recommendations from the stakeholders. The dual-moderator approach uses 2 moderators to guide the conversation. One moderator is in charge of asking the questions, and the other ensures that questions provoke informative answers.[31] This method ensures that important themes are not overlooked, and participants stay on task, enhancing knowledge and understanding of MI. The first session provided an open forum to discuss the presence or absence of the concept, beginning with a single question: "What do you know about MI?" This open-ended question prompted dialogue regarding the topic, allowing the study team to engage stakeholders and determine their perceptions regarding the concept of MI. In the second session, themes were reintroduced to refine the concepts and screening criteria. This information was used to determine the best methods for increasing awareness and develop procedures for interventions. Summaries of the main themes were reviewed with the focus group participants at the end of each session to validate understanding, contributing to the findings' trustworthiness.

The study team used a formative assessment design to gain an in-depth understanding of subject matter expert views on mental health within the veteran community. A formative thematic focus group methodology allows the development of an operational

definition and the identification of salient issues raised by the stakeholders.[32] The transcripts for the focus groups were analyzed utilizing 2 stages. In the first stage, the investigators categorized the participants' comments into maladaptive behavior categories, out of which the following themes emerged. These include the thought process, self-reflection, boundaries, internal and external triggers, and barriers to treatment. In stage 2, the investigators recategorized the identified themes within the RAM modes of physiological, self-concept, interdependence, and role function. The principal investigators reviewed all analysis, and discrepancies were resolved through discussion and consensus.

RESULTS

Stage 1 analysis

Early in the first focus group session, it became evident that most focus group members had not been exposed to the concept of MI. However, the members were well acquainted with the struggles veterans face after leaving military service. The focus group members were less concerned with creating definitional clarity regarding the concept and preferred to focus on the harmful behaviors utilized by veterans to effectively cope with their environment. Therefore, the interview quickly evolved into categorizing behaviors rather than creating an operational definition of MI. From this discussion, 5 maladaptive themes emerged, representing veterans' reactions to morally injurious situations.

Thought process

The identified changes to the thought process capture the transformation of the veteran's worldview. The focus group unanimously agreed that the individual suffering moral discord experiences a betrayal of his or her moral integrity. They find themselves searching for their postwar identity and retreat into self-deprecating guilt about the person they believe they have become. The loss of confidence creates a wedge of distrust, disrupting their ability to reengage with society.

Self-reflection

The discomfort of self-reflection further hinders the reintegration process since many veterans are unaware or unprepared for the self-reflective state. The focus groups concluded that most of their clients lack the ability to perform a self-appraisal. Their opinion of themselves is captured in the positive or negative comments collected on social media. Therefore, the individual's online persona tends to be overly optimistic, as he or she strives to capture "likes" rather than face the true nature of his or her situation. The younger veterans struggle to understand the value of self-reflection and are left without context to explain their negative thoughts and feelings.

Boundaries

Adding to the problem, the boundaries within a war zone are contextual and fluid, often building moral discord. In combat, the veteran's sense of right and wrong becomes skewed, creating ambiguity in his or her core beliefs. As the veterans transition back to society, they may find themselves doing things that are dangerous or hurtful to themselves or others. Once the boundaries are breached, it becomes easier to engage in self-deprecating acts, leading to suicidal ideation or suicide.

Internal and external triggers

Internal and external triggers speak to the agony that veterans suffering MI experience because of an inner struggle between their perceptions of right and wrong. The focus group agreed that the separation between PTSD and MI is the mental versus physical triggers. Posttraumatic stress disorder is categorized by physical triggers such as smell, noise, or a crowd, whereas MI is related to inappropriate thoughts, which control the reaction.

Barriers to treatment

Unexpectedly, only 50% of focus group members were acquainted with the concept of MI before the first session, pointing to the lack of awareness regarding this topic. The group believes that this lack of awareness and the stigma associated with PTSD are creating barriers to treatment.

Stage 2 analysis: the RAM adaptive modes

Physiological mode

"Is there a difference between moral injury and posttraumatic disorder?" was a question verbalized by many members of the focus groups. Based upon group consensus, the autonomic dysregulation seen in PTSD is derived from the high baseline state of hyperarousal and the sympathetic nervous system's increased activation. It is usually accompanied by physical symptoms of increased blood pressure, heart rate, and respiration, which are easily observed by the veteran and the provider. However, the physiologic response to MI is subdued and often not immediately recognizable. Negative cognitions and mood affect the individual's well-being but are often overlooked until symptoms become severe. The focus group members believed that screening criteria based on physical versus emotional factors might provide differentiation between MI and PTSD. One member of the group provided this explanation:

> The easiest way for me to classify MI is that it is more of a mental thing. It doesn't mean that stress doesn't affect your body, but you can probably walk into a crowded parking lot or a store, and it's not going to affect you the same.

Another added:

> One thing that separates MI is the type of triggers. PTSD, you have physical triggers. On the moral side, if you keep everything full, there is no space for the guilt or shame to come in. When you do happen to pause, you allow that space, and I think that is when the problems arise with people suffering from MI.

Self-concept mode

The aspects of spirituality, awareness, and self-reflection are illuminated by the responses captured in the self-concept mode.

Spirituality

The focus group discussions revealed the critical role of religion and chaplains in the identification and treatment of MI. Understanding that the mind and the soul are closely related, it seems logical that mental health professionals work in a realm that creates interaction between these elements. This is a new territory, and religious leaders and mental health professionals in the group acknowledge that societal restraints impede the clinicians' ability to fully assess the moral, ethical, and spiritual well-being of the veteran. A health care provider admitted:

> Psychiatrists and psychologists in government are probably not going to be comfortable talking about souls.

The need for collaboration is further highlighted in the comments of a combat veteran group member:

> I think veterans would be able to say that there is a part of them that has a problem spiritually, even if they don't fully understand the meaning. When you have religion, faith, belief, it directs how you act every day; every choice is tied to the soul.

Mental health providers in the focus group identified the ineffectiveness of the current treatment methodologies when PTSD and MI are combined as a single diagnosis.

> We are not fixing the soul in PTSD.

Awareness

The concept of MI is still in its infancy, evidenced by the unfamiliarity of the term among group participants. Although PTSD is widely recognized, and treatment options do not currently include a spiritual component, the group is divided regarding MI as an individual diagnosis. Approximately half of the focus group believe:

If we have a better framework, then we can talk about MI within the rubric of PTSD; we can talk about it as a subtype.

Participants who preferred leaving MI under the PTSD umbrella provide clinicians flexibility in treatment. Surprisingly, the chaplain group was most concerned about separating MI and PTSD into separate conditions. A chaplain commented:

PTSD is already widely recognized, and people need help now, figuring out how to combine clinical and theological practice is more important than the diagnostic code.

The discussion on PTSD and MI creates a dichotomy for the clinician and the researcher. A few participants verbalized concerns that treating MI within the realm of PTSD may continue to create barriers to treatment. One participant with no previous knowledge about MI believes that the separation is necessary because:

The stigma is not there for MI like it is for PTSD. I think when you start looking for jobs, people start to judge and ask questions; "Does he own a gun?" but with MI, they may not ask or question. I believe veterans would get treatment earlier if they were able to identify that their problems were associated with MI.

Self-reflection

In stage 1 analysis, the group identified the lack of self-reflection as a detriment in defining the individual's moral-ethical-spiritual-self. The veterans find themselves lost in self-punishing thoughts and behaviors since their image is based on environmental feedback rather than their own internal reflective guidance. This leaves them unable to rectify the dissonance between their perceived moral transgressions and current thoughts and feelings. A focus group member who served in Iraq and Afghanistan suggested:

Veterans are reluctant to see how ugly it looks, but they must deal with it. Even if it's really big, they need the reflective process. Maybe, they just can't deal with it all at once.

The combat veteran also mentioned:

I think it, but I don't act upon it because I don't want those things to define me.

A health care provider added:

General society is not taught self-reflection, so many times, they do not understand the reflective process and are left without an anchor.

Interdependence mode

Connectedness and a strong sense of belonging dominate the veteran's military experience, until violations of one's moral integrity create a sense of shame, leaving the veteran unable to give or receive support. All group participants described interactions with veterans who purposely withdrew from their social networks. During the discussion, 2 themes evolved: (1) veterans who isolate themselves because they do not want to be reminded of the morally injurious events, and (2) those who isolate themselves, believing a need to protect others from harm. In describing those who wish to escape the experience, a provider commented:

Veterans avoid connecting, they don't want anything to do with it anymore, but they must belong to something.

In describing those who fear harming others, a group member with combat experience suggested that the veterans may recognize a change in their fundamental identity.

They have adjusted themselves to behave because of their combat environment, which is no longer acceptable in their current environment. They understand right and wrong, but their switch is stuck in the wrong direction.

Role function mode

Throughout the interview process, there was consensus among the group that transition from military service to civilian life is difficult for veterans. The group recognized that events viewed as normal and acceptable during combat do not align with civilian societal expectations. A mental health provider surmised:

The fear of being judged and ostracized impedes the veterans' social integrity leading them to feel that prior actions are irredeemable.

Inefficient coping methods due to the role change were described this way by focus group participant, who served in both Afghanistan and Iraq:

They have core beliefs that they feel have been breached. The consequences of betraying these fundamental principles have hallmarks like resentment, shame, and regret.

The group concluded that the shame experienced by the veterans prevents them from reentering their predeployment role. They no longer feel capable of being a nurturing and loving individual.

The morally injurious events change the veteran's fundamental identity making it difficult to fit back into the role they occupied prior to deployment.

Another group member with combat experience described it this way:

It is a thought process based on moral boundaries. Once the boundaries are breached, it is easier for others to breach the boundaries.

DISCUSSION

The focus group discussions revealed the military culture as a complicating factor in recognizing and treating veteran mental health. Themes of betrayal, breach of trust, spiritual/existential loss, social problems, self-depreciation, and psychological symptoms were captured in reactions to morally injurious events, as the veterans search for purpose/meaning and struggle to reconcile their thoughts/behaviors. Although the participants preferred to concentrate on the observed maladaptive behaviors and mitigation of the effects of these behaviors, the voices from the group clearly established how MI is defined from the veteran perspective.

This study describes the struggle veterans face as they reassemble their lives postwar. While multiple themes emerged, the group's consensus centered on the loss of role identity and a shattering of the veteran's core integrity. In combat, it is common to witness atrocities daily, desensitizing the individual and redefining what is considered morally acceptable. Using the RAM's adaptive modes, the authors asked chaplains, mental health clinicians, and veteran service professionals to critically evaluate the constructs of MI. Using a semistructured interview process, the authors conducted a thematic analysis of the focus group sessions, validating the link between autonomic dysregulation, which is commonly described in the diagnostic criteria for PTSD (the fight or flight response) versus the self-deprecating thoughts that prevent the veteran's reintegration into society.

The focus group discussions suggest that there are uniquely and morally injurious experiences in war, and these experiences create an array of psychological, spiritual, social, and behavioral problems. There was unanimous agreement that clarification of MI is needed, and that it may provide a better construct for addressing the complex consequences of combat. Based on the analysis, the authors believe that the altered thought patterns may represent a defining characteristic of MI. In addition, the group universally agreed that the PTSD diagnostic criteria do not fully encompass the construct. More research is needed to delineate the conditions and symptoms that describe MI.

Although there is increasing literature examining MI, the concept remains explorative. The group determined that the lack of a robust clinical designation is primarily due to the complexity of the phenomenon, requiring a holistic approach beyond any one discipline. Early in the study, the authors realized the need for a plan that included the interaction of the veteran within both the combat and civilian environments. The RAM framework was adopted because it consists of a holistic bio-psycho-social-spiritual-paradigm.

Historically, minimal attention was paid to the effects of spirituality on mental health in the veteran population. In addition,

clinicians in the group communicated their reluctance to address this subject in a clinical setting. Nevertheless, the focus group overwhelmingly supported the connection between spirituality and the veterans' sense of self-worth and the ability to reintegrate with the community. The group recommends that health care providers and chaplains collaborate and share their understanding of the whole person as they explore spiritual interventions.

Throughout the literature, the symptoms of social/interpersonal functioning are poorly described.[3] However, the RAM in its interdependence and role function mode clearly delineates the lack of social reintegration and highlights specific examples of why veterans withdraw from their social networks. It appears that the "fear of burdening others with their story" and the desire to protect those within their social network promote self-isolation. The veterans demonstrate a willingness to disconnect themselves from both their military and civilian families, not wanting to relive the morally injurious event(s). They also wish to avoid judgment for acts they believe are irredeemable. The incongruence between societal expectations and the individual's perceived moral transgressions hinders their ability to self-forgive. A great example from the group is captured in the interdependence mode "I don't deserve this, but I did this, I don't deserve help, and I am ashamed. How did I become this monster?" Once a person reaches this point, he or she becomes susceptible to the idea of suicide. Even if the veteran accepts that his or her perception and worldview have changed, the people within his or her circle may never fully understand these changes. The focus group acknowledged that both mental health and spiritual guidance are necessary to help veterans accept this new reality.

The self-isolation and fear of judgment create a significant barrier to treatment since it is unlikely that the individual will seek mental health assistance. Recognizing this fact and that veterans are much more accepting of support from fellow veterans, the focus group suggested a push approach to care. The discussion prompted the creation of a "Battle Buddies for Life" campaign. All military service members are familiar with the term "battle buddy," which was first used in the 1970s, at the beginning of the all-volunteer force, in an effort to mitigate the social and behavioral factors affecting attrition. Every veteran understands the connectedness captured in this term and the strength it communicates. Regardless of the context, knowing that you have at least 1 person to talk to, who understands your experiences, may help get the veteran out of the darkness. A single voice in a crowd can decrease the alarming number of self-inflicted deaths. All group members believe that community engagement, education, and reconnection are necessary to reduce the untoward effects of self-isolation.

It can be challenging for veterans to find purpose and perspective after ending their military service. The battle buddy system lays the groundwork in keeping fellow veterans safe by allowing them to share their struggles and recognizing that their life may never look the same. Throughout the process, they are building a new community, which fosters a sense of purpose, hope, and perspective. The use of a battle buddy is proven to save lives in combat. It is comforting to know that someone always has your back, even after your service has ended.

SUMMARY

The issue of moral pain and injury inflicted during a war is not new, and many survivors incur both physical and mental wounds, which affect their understanding of humanity. They are affected by these experiences, and their own moral compass is badly damaged. While the concept of MI offers a starting point for understanding warrior and veteran suffering, it is vital to understand predisposing factors leading to moral trauma and not just treat the symptoms. By viewing the issues and themes, the clinician and the

veteran bring to the table a better understanding of the issue, allowing them to address the despair that leads to suicidal ideation.

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The author and planners have disclosed no potential conflicts of interest, financial or otherwise.