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The impact of clinical social workers' conceptualizations of moral injury on their treatment actions in work with veterans

Zachary P. Wigham

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Zach Wigham
The Impact of Clinical Social
Workers' Conceptualizations of
Moral Injury on their Treatment
Actions in work with Veterans

ABSTRACT

This exploratory study was designed to determine how clinical social workers' conceptualizations of Moral Injury impacted their treatment actions in work with veterans. Additionally, this study allowed insights into the clinical social workers' education and practice on Moral Injury.

Using semi-structured interviews with licensed clinical social workers who each held a Master of Social Work degree and held at least two years of experience working with veterans, this study gathered data from 7 participants. This study gathered data categorized under five major areas: demographics, conceptualizations and related data, sources of learning and frequency of contact, treatment actions, and perceived skill level and desired education.

This study found that clinical social workers largely feel unconfident in their ability to define and treat moral injury, and thus have little defined treatment strategies. Further, clinical social workers identified the high frequency of their contact with morally injured veterans and their perception that moral injury increases the clinical severity of the client. Clinical social workers conceptualizations were largely divided between those who understood moral injury to be a separate concept from posttraumatic stress disorder (PTSD), and those who believed it described a particular presentation of PTSD. Therefore, this study suggests further research on the role of trauma in the definition of moral injury, and alternatively, examination of the link between moral emotions such as guilt and shame and hyper- and hypo-arousal states.

Additionally, the development of educational and training opportunities on moral injury for clinical social workers is discussed toward more effective care for military veterans.

**The Impact of Clinical Social Workers' Conceptualizations of Moral Injury on their
Treatment Actions in work with Veterans**

A project based upon an independent investigation,
submitted in fulfillment of the requirements for the
degree of Master of Social Work.

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2016

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This thesis represents a landmark as I have attempted to find meaning in my military experience that took place from 2006 to 2012. It is a work that has unsettled, dislodged, challenged, and stirred me. If nothing else, my hope is that this work can benefit clinical social workers who may feel overwhelmed in the face of a problem that seems to elude psychiatric conceptualization alone.

However, this is also the product of the labor and time of the many clinical social workers who participated. I could not have completed this work without the support of my family, friends, and cohort. Specifically, I must thank my parents, Diana and William Wigham, for their early inspiration, Katie Nolan, for her constant, heedless support and energy, and Zoe Rudow, for taking this challenge up alongside me. I also owe thanks to Donald Hanover, professor of philosophy at Holyoke Community College, a man who taught me the value of rigorously examining my ethics and place in the world.

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CHAPTER I

Introduction

As service members return home from the wars in Iraq and Afghanistan, several common wounds return with them. While veterans often return with physical conditions and injuries, mental health conditions are widespread reactions to war. While the condition known as Post-Traumatic Stress Disorder (PTSD) represents a large proportion of mental health conditions related to our modern day responses to wartime experiences, we are now identifying other mental health issues that clinicians need to recognize in treating the complex clinical presentations of many veterans. One such development, known clinically as ‘moral injury’ is an emerging area of clinical presentation. Currently, studies are beginning to identify this condition. Moral injury can be described as the distress caused by one’s witnessing, or participation in an ethically troubling situation, such as killing a child wielding a rifle or being unable to rescue a wounded team member (Nash & Litz, 2009). Similarly, Drescher, et al., briefly describe moral injury as “acts of omission or commission in war that produce inner conflict” (2011). Yet, as moral injury is still being refined as a concept for clinical treatment, consistent, standard clinical conceptualization or treatment approaches have yet to be established. With little professional guidance, clinical social workers have few resources to aid in conceptualizing, diagnosing and approaching treatment for morally injured veterans.

In order to advance our understanding of moral injury in clinical practice, the proposed study aims to examine the question of: “How do clinical social workers conceptualizations of

moral injury effect their treatment actions with veteran clients?” A widely utilized definition of moral injury, and the one utilized here, is the “perpetration, failure to prevent, or having born witness to acts that transgress deeply held moral beliefs and expectations” (Nash & Litz, 2009). For the purposes of this study, a veteran client will be defined as any client who has served in the US Armed Forces, regardless of deployment status, era, branch, combat exposure, or discharge type.

Limited literature exists in terms of clarifying the concept of and treating the associated psychic distress of moral injury by clinicians working with veterans. However, preliminary work has been published which offers guidance on this emerging concept (Nash & Litz, 2009). Of interest, no mention of moral injury is made within the Council for Social Work Education’s Standards for Social Work Practice with Service-members, Veterans, and their Families (2010). As moral injury is not yet a recognized or available diagnosis in the Diagnostic and Statistical Manual (DSM), the phenomenon is still in a conceptual stage within the literature. Further study is warranted to advance our understanding of the psychic distress associated with moral injury in veterans. This study will help expand our understanding of moral injury from the perspectives of clinicians who have a firm understanding of this newly emerging condition, and how they address it in their clinical work with veteran clients.

In order to answer the research question noted above a qualitative study design is proposed in which data will be collected through semi-structured interviews with clinicians who self-identify as having an understanding of moral injury issues when treating veterans, and how they address it in their practice. Results will identify clinical social workers’ understanding of ‘moral injury’, and how those that do so incorporate this understanding in their practice. This

study will provide a conceptual as well as clinical understanding of moral injury issues while working with veteran clients.

Chapter II

Literature Review

Introduction

Many military mental health concerns have risen into public awareness since the invasion of Afghanistan in 2001. Often, the rise into public awareness is driven by the high social cost of war and the plight of returning veterans reintegrating to civilian life. Yet, determining exactly how many veterans suffer from specific mental health problems and mental health concerns in general is an ongoing area of focus by researchers funded by both Veteran's Administration (VA) and non-VA funded studies. A review of the literature associated with psychiatric disorder prevalence in veterans is presented below, focusing on post-traumatic responses, and some of the underlying issues relating to these responses. Of particular interest is how the notion of 'moral injury' relates to some presentations of PTSD and may lead to increased severity in PTSD symptoms and suicidality. Moral injury, often describing a shattering of self-concept following one's violation of their own ethics during military service, has been conceptualized similarly, with slight variations, by various authors. One common definition was offered by Nash and Litz (2009): "perpetration, failure to prevent, or having born witness to acts that transgress deeply held moral beliefs and expectations".

Various perspectives on Post-Traumatic Stress Disorder (PTSD) prevalence in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) populations are offered by the literature. Dursa, et al. (2014) found rates of PTSD in 15.8% of their OEF/OIF veteran sample, and 10.9% of OEF/OIF-era veteran sample (those veterans serving during the conflict period but

not deployed into the combat theatre). Of that sample, the combined average was of 13.5% when considering deployed and non-deployed veterans. Of further note is their finding that those within the “Missing” race category, or those veterans who’s racial identity was not encapsulated in the offered categories for their study, held higher rates of PTSD than other racial categories followed closely by African-Americans.

Fulton, et al. (2015) completed a meta-analysis of PTSD prevalence studies. The authors concluded that among OIF/OEF veterans in the studies reviewed, overall 23% of the samples suffered from PTSD. Similar to the above, Fulton et al. note that as the amount of white veterans increase in the sample pool, PTSD prevalence decreased. Results of their study indicate that “whiteness’ (traditionally described as Caucasian) may present as a protective factor in PTSD vulnerability among OEF/OIF veterans. Additionally, the authors note that many of the studies utilized in the meta-analysis take their sample populations from VA service users. Within the framework of the concept of ‘moral injury’, questions arise about the validity of these findings, as the theoretical basis of the notion of moral injury is that morally injured veterans may distance themselves from VA settings because these locations are felt to provoke associations to their military experience.

Green et al. (2015) also highlight the role of enemy combat tactics, and inevitability the unique setting of each conflict, on the development of PTSD. The authors describe the potential for higher PTSD rates in conflicts with asymmetrical enemy tactics; tactics which utilize unconventional means such as eschewing uniforms, conducting hit-and-run attacks, high use of “booby traps”, and a lack of interest in holding territory. Inherent in asymmetrical warfare are qualities of ambiguity, confusion, and situations that avoid conventional military framing. These situations may hold more potential for ethically-ambiguous or confusion events to trigger moral

injury. The Vietnam War and certain deployment phases of OIF/OEF are highlighted by the authors as examples of pervasive asymmetrical warfare.

PTSD prevalence data on Vietnam veterans shows another population impacted by the disorder. The National Vietnam Veterans' Readjustment Study (NVVRS) (Kulka, et al., 1990) demonstrated that of the veterans assessed, 830,000 male and female veterans experienced full or partial PTSD symptomology. Another study (Jordan, et al., 1992) suggested that 49% of the 1.7 million Vietnam War veterans suffered from “clinically significant distress” related to post-traumatic responses. Additionally, the NVVRS found that among male veterans the most common current and lifetime psychiatric disorders were Alcohol Abuse, Alcohol Dependence, and Generalized Anxiety Disorder. Among females the most common current and lifetime disorders were found to be Depression and Generalized Anxiety Disorder. Another assessment of psychiatric disorders other than PTSD found that both male and female veteran populations exposed to “war zone stress” held significantly higher rates of various disorders than civilian counterparts (Jordan, et al., 1991). Some of the disorders noted were depression, mania, obsessive-compulsive disorder, generalized anxiety, anti-social personality disorder, and panic disorder. The similarity in these presentations to various forms of traumatic responses may suggest a broader role of trauma than the relatively isolated diagnosis of PTSD.

The review to follow will focus on key areas that lead to and inform our understanding of PTSD, in particular to the root issues associated with ‘moral injury’, including literature reflective of unethical battlefield conduct, with a focus on dynamics leading to perpetration of unethical battlefield conduct and sequelae following killing in combat and involvement with unethical battlefield conduct; moral emotions (guilt and shame) and PTSD; and a final content

section focusing on the concept of moral injury itself. Finally, divergent points of view and needs for further study are presented.

Unethical Battlefield Conduct

While the previous section briefly highlighted the range and severity of mental health issues in US veterans serving in recent wars, a refined review led specifically to mental health responses to situations that could be commonly recognized as ethically-involved or challenging. These situations involve both legally-condoned acts, such as the killing of an enemy combatant, or acts considered by governments to be unethical conduct during war. Additionally, they account for ethically vague acts, such as the killing of a civilian by mistake or the killing of a person suspected but not proven to be an enemy combatant. A complex relationship exists between the mental health responses of service members to ethically challenging situations.

Studies reviewing the experiences of veterans involved in both OIF and Vietnam offer insight to the dynamics of unethical battlefield conduct. Data gained from the 2006 MHAT IV show responses by soldiers and Marines serving in Operation Iraqi Freedom (OIF) as it relates to battlefield ethics and conduct. Responses indicated (Castro & McGurk, 2007) a relationship between ethical conduct violations, anger, and mental health. Specifically, the MHAT-IV notes that those service members who screened positive for PTSD were doubly more likely to endorse engaging in unethical conduct than those who did not screen positive. Similarly, those who endorsed high levels of aggression were more likely to report unethical conduct as well. Further, the MHAT IV identified higher incidences of unethical conduct carried out by Marines who endorsed having experienced a member of their unit become a casualty or who handled human remains. The MHAT IV data displays specific consequences of soldiers and Marines exposed to

war trauma who in response find themselves as perpetrators of or bystanders to unethical conduct during war.

This cyclical dynamic has been identified in Vietnam veterans as well. A survey of Vietnam veterans (Nock, Kaufman, & Rosenheck, 2001) identified “increased combat exposure” as an important predictor of the veteran’s committing acts such as torturing or killing civilians, prisoners of war, and enemy combatants. However, while Castro and McGurk (2007) show a relationship between ethical conduct violations, anger, and mental health, PTSD may be less of a driver of one's committing ethical violations than witnessing war atrocities and a subsequent response of anger (Wilk et al., 2013). Still, PTSD appears to be a significant provoking factor for a service member's perpetration of unethical battlefield conduct. It appears that a combination of the existence of PTSD in a service member and the intensity of their aggression, interwoven with their having been bystanders to war atrocities, having engaged in direct combat, or having closely experienced loss due to war places a service member at the greatest risk to perpetrate unethical battlefield conduct. In short, the literature identifies that war trauma reproduces itself.

The literature reviewed below examines mental health responses to what may be ethically challenging events. Most studies focus on the impact of killing during war, with added focus on the killing of noncombatants. Data has been identified from Vietnam and OIF veterans.

The impact of killing, whether enemy combatants or noncombatants, is significant across a veteran's mental health and social functioning. PTSD is noted as more severe, with higher rates of dissociative experiences and self-harm, in those who have killed, made worse by having killed civilians or prisoners of war (MacNair, 2002; Maguen et al., 2009; Maguen et al., 2012). In addition to severe PTSD, higher rates of suicidal ideation than veterans who have not killed, Major Depressive Disorders (Maguen et al., 2012; Maguen et al., 2011), and alcohol abuse

(Maguen et al, 2010; 2011), are common among these veterans. Additionally, those who have killed were more significantly predicted to experience severely hindered psychosocial functioning characterized by anger, violence and relationship problems (Maguen et al., 2009; Maguen et al., 2010).

The wide range of responses to killing during war appear to be further complicated by the presence of moral emotions in the veteran. Guilt and shame emotions were shown to exist at a higher intensity among those veterans who endorsed suicidal ideation, though guilt has a stronger association between the two (Bryan, Ray-Sannerud, Morrow, & Etienne, 2013). The intensity of guilt and severity of PTSD symptoms have also been shown to share a positive correlation (Henning & Frueh, 1998). Further, research conducted with Vietnam veterans identified that among those exposed to combat, veterans who endorsed exposure to atrocities rated higher in PTSD symptom presentation and guilt intensity, similar to those who endorsed killing as noted above (Beckham, Feldman, & Kirby, 1998). Emerging from the complex reactions of veterans who endorsed killing or exposure to unethical battlefield conduct, the presence of guilt has been identified as a mediator between “combat-related abusive violence” and both PTSD and MDD (Marx et al., 2010). Guilt’s presence and intensity appears to play a large role in both the suffering of veterans and as a predictor of re-enacting trauma of their own.

The role of moral emotions in the traumatized veteran, particularly that of guilt, appears to have a series of impacts on their health and character. The influence of moral emotions on a veteran’s psyche has often, as demonstrated above, been examined in the context of PTSD. However, the concept of moral injury has often been promoted for its potential explanatory power, describing a form of mental suffering beyond the fear-based schema of PTSD. Divergent

points of view regarding the incorporation of moral emotions into, and therefore broadening of, the PTSD construct or of the distinct utility of the moral injury construct will be reviewed below.

Moral Emotions and PTSD

With the advent of DSM-5 came an uncommon opportunity to re-evaluate some of the DSM-IV's most controversial or important diagnoses (American Psychiatric Association [APA], 2013; APA, 2000). As the US engaged in war in several countries around the globe, the convergence of timing and relevance saw re-examining PTSD as an important task for the mental health field. Yet, questions around PTSD's biomedical construction and the role of the "social, political, and cultural" (Bracken, Giller, & Summerfield, 1995) context of the client began much earlier. The moral emotions of shame and guilt and their influence over survivors of trauma became salient to the ongoing review of PTSD as factors beyond the original criteria were highlighted.

DSM-IV's conception of PTSD as primarily fear-based anxiety, evidenced with its A2 criterion, has been examined and challenged prior to and since word of DSM-5's authoring arrived. Studies of the quality of dominant emotions in survivors of trauma and those diagnosed with PTSD have commonly identified non-fear based dominant emotions (Hathaway, Boals, & Banks, 2010; Rizvi, Kaysen, Gutner, Griffin, & Resnick, 2008). One sample population identified dominant emotions other than fear, such as guilt and shame, at higher rates than fear (Hathaway, Boals, & Banks, 2010). Further, in a study utilizing DSM-III-R criteria, some victims of violent crime who did not originally meet the emotional criteria for PTSD [fear, hopelessness, horror] did, at the time, report high levels of anger and shame (Andrews, Brewin, Rose, & Kirk, 2000). Similar to the information presented above, the dominance of guilt was found to be the most important factor in assessing for suicide risk in PTSD-diagnosed Vietnam

Veterans. The Department of Defense funded STRONG STAR Consortium (2012), appearing to acknowledge the importance of trauma variety, worked to identify several trauma categories within the military context. These categories, while titled in relation to the quality of the trauma event, utilize the intensity of peritraumatic and post-traumatic emotions as the base of their construction. Since DSM-III-R, future editions of the manual have increasingly widened their criteria for the quality of emotions, currently represented in DSM-5 as a “persistent negative emotional state” (APA, 2013). The DSM-5 offers example emotions such as persistent shame or guilt. PTSD has been forced to adapt to a wider range of experience, yet the role of moral emotions within the DSM have been simple additions allowing a larger acceptable pool of candidates for diagnosis. Moral emotions’ role in or relation to PTSD is still under assessment.

In considering the role of moral emotions in PTSD, the literature gravitated toward the impact of guilt and shame. A 2015 meta-review of literature on guilt’s relationship to PTSD (Pugh, Taylor, & Berry) identified four contrasting models. Two models focused on the demonstrated correlation between PTSD and guilt, hypothesizing opposing relationships in that guilt may be a causal driver of PTSD symptoms and vice versa. Additional insight to the relationship between the two was gained through PTSD treatments assessing for guilt intensity. A review of two wide-spread PTSD treatments utilized by the Department of Veterans Affairs, CPT and PE, displayed results suggesting different relationships between guilt and PTSD. The meta-review notes a study conducted with Cognitive Processing Therapy, a cognitive-behavioral manualized treatment, showed decreased guilt severity following program completion (Rizvi, Vogt, & Resick, 2009). However, guilt severity did not decrease following Prolonged Exposure treatment (Owens, Chard, & Ann Cox, 2008). While CPT is presented as a PTSD treatment, it may simultaneously address cognitions which promote feelings of guilt. However, both the CPT

and PE studies lend no direct insight into the relationship between guilt and PTSD. A final model was identified hypothesizing that no direct relationship, despite their common co-occurrence, exists. It is possible that while guilt exacerbates post-traumatic stress (Resnick, Nishith, Weaver, Astin, Feuer, 2002; Browne, Trim, Myers, & Norman, 2015), it does so independently. In reviewing the literature on guilt's relationship to PTSD, the proposed models appear to fall back to theoretical orientations of psychopathology as no conclusive empirical direction is yet clear.

Similar to guilt, explanations of the relationship between shame and PTSD are still forming. While evidence exists to show the presence of shame correlated positively with higher PTSD symptom acuity (Leskela, Dieperink, & Thuras, 2002), varying theoretical orientations offer differing hypotheses on shame's exact role. The literature primarily gravitated toward cognitive and explicitly social-psychological conceptions of shame's role. Harman and Lee (2010) suggest that shame's function of self-criticism maintains "current-threat", the primary cognitive state promoting PTSD psychopathology, and therefore shame shares a positive relationship with PTSD. Similarly, shame has been suggested to block one's "emotional processing" through "scheme congruence" or "schema incongruence" (Lee, Scragg, and Turner, 2001), therefore allowing the PTSD response to grow and persist unchecked. The role of shame and schema congruence in trauma serves to either confirm pre-existing self-concepts, or in the case of incongruence promote humiliation through one's then-damaged self-concept. Alternatively, Stone (1992) noted that feelings of shame may be derivatives of humiliation forming, in the moment of the trauma, as embarrassing "fear-terror". Stone then describes shame as a descendent or clue to the emotional experiencing of the trauma event.

However, in differentiating between the moral emotions authors across the literature have consistently sought to define guilt and shame. Differing from guilt, which appeared as more

personally intimate, shame was often defined within a social context. Both the cognitive investigations and Stone's are congruent with this perspective. Though, perhaps social explanations hold more utility in highlighting the role of the veteran's relational world. Further elaboration of a social lens has been offered by Troop and Hiskey (2013), as they demonstrate one's sense of "social defeat" as predictive of PTSD symptomatology. La Bash and Papa (2013) offer similar interpretations, concluding that shame is a response to threat, but unlike the fear-based model, the threat is to social standing. The issue of social standing was also noted by Budden (2009) in their proposal of a socio-emotional model of shame and PTSD. Budden notes the heavy impact of mental health stigma, changing social roles, and one's cultural expectations around emotional discourse and disclosure that promote PTSD symptoms. Budden highlights that shame stemming from one's actions in relation to their social expectations during the trauma and one's experiencing PTSD in a stigmatizing setting lead to isolation and higher symptom acuity.

When investigating the expansive role moral emotions have in altering the presentation and severity of PTSD questions of consistency arise. When conceptualizing the issues present in a traumatized veteran with relevant moral emotions the differing presentations lend to asking: "How much is PTSD representative of trauma?" The regular adaptations to the diagnostic criteria of PTSD noted above clearly show an imperfect diagnosis, but PTSD may not encapsulate a wide-enough range to capture responses to trauma alone. Moral injury has been promoted for its explanatory power in describing the moral suffering often experienced after trauma and may represent a more helpful conceptualization for some veterans than PTSD by itself.

Moral Injury

While moral injury is still an emerging construct, some literature exists to highlight the importance of the topic. As noted previously, moral emotions such as guilt and shame appear to be core to identifying moral injury. A 2015 review of literature examining the relationship to morality and moral emotions in veterans (Nazarov, et al.) concluded that one's "moral judgement" may predict their incurring a moral injury, which they appear to define as a morally-involving experience that triggers moral emotions and psychological stress. The authors recommend early intervention programs focused on reducing the intensity of moral emotions. Vargas et al. (2013), examined the National Vietnam Veterans Readjustment Study for themes of moral injury, looking to the past for further validation of the moral injury construct. The themes identified by Vargas et al. were consistent with common morally injurious events, such as involvement in civilian deaths and betrayal events. The identification of common morally injurious themes was correlated with higher severity of PTSD symptomology.

Morality shares a complex relationship to psychological distress. Examining the impact of morality outside of mental health, Burnell, Boyce, & Hunt (2011) investigated recent British veterans' "moral evaluation of deployment". Those veterans who morally affirmed their deployment experience were shown to endorse a more positive deployment experience and a stronger sense of community support upon homecoming. Through time, moral sentiments and guidelines developed from spiritual and social realms have been strongly implicated in the development of moral emotions. While these experiences may not necessarily result in a "comorbid" PTSD symptom presentation, they do appear to lend to varying forms of psychological distress.

A landmark study by Currier, McCormick, and Drescher (2015), investigated the precipitating factors which lead to moral injury through qualitative investigation with veterans involved in a residential PTSD treatment program. The study identified four major clusters of experience: organizational, environmental, cultural and relational, and psychological circumstances leading to or promoting moral injury. Within the four clusters are more specific themes that emerged. Themes under the organizational cluster often noted the rules of engagement, a distant or uncaring command, and poor intelligence or training as promoting factors. Coded under the environmental cluster, veterans spoke of asymmetrical/guerrilla warfare tactics used by the opposing force, constant threat, and the unpredictability of civilian behavior. When veterans spoke of cultural or relational factors, some noted their or their groups' internalization of the "capture or kill" attitude and the affirming emphasis on violence during their training, a lack of trust in their units, competition amongst individuals in a unit to demonstrate ruthlessness and violence as measures of value, and the dehumanization of the enemy. And, similar to the information discussed in the above unethical battlefield conduct section, psychological themes noted hopelessness, the conditioning and possible pleasure in aggression, emotional detachment, and desires for revenge among these veterans. This study offers a preliminary definition of how moral injuries occur, noting that the experiences are not necessarily derived from a PTSD criterion A event. This may serve to, at least partially, separate moral injury from PTSD.

In further efforts to describe the development of moral injury, Farnsworth, Drescher, Nieuwsma, Walser, & Currier (2014) take a social-functionalist approach, seeking to describe how morality promotes survival in groups. The authors emphasize the morality of the military that is inculcated in recruits through basic training, and the importance of the distinction between

friend and foe which creates strict moral rulings for a service-member. They note that while this morality often displays itself in relation to “friends”, or those within the same military, a larger evolutionary dynamic can still be enacted in consideration to the “team” of humanity when considering moral injury involving an opposing force. This account offers a broad and general explanation of moral injury that may be easily supplemented by more nuanced theories, however it offers less in examining the role of victim-victimizer-bystander dynamics explored above.

A purely cognitive model has also been promoted (Nash & Litz, 2009; Dombo, Gray, & Early, 2013) to explain moral injury. The cognitive explanation holds that morally injurious experiences create a dissonance between one’s experience and one’s moral-cognitive schema, and that this dissonance is the initiator of moral emotions and corresponding distress. This model highlights the individual variety of a sufferer’s morality and the breadth of experiences that may cause distress. However, it does so while paying less tribute to the influence of the social world in the development of personal morality – leaving preventions and solutions in the realm of the intrapsychic.

In correspondence with definitions of moral injury identified earlier, moral injury has been empirically divided into categories of “transgression-self”, “transgression-other”, and “betrayal” (Nash & Litz, 2009). These categories refer to morally injurious acts committed by oneself, by another, or the experience of a betrayal event from a trusted other onto oneself, respectively. Further exploration of these categories yielded insight to their relationship with suicidal ideation (Bryan, Bryan, Morrow, Etienne, & Ray-Sannerud, 2014). Of these categories, those veterans who noted experiencing a “transgression-other” and “transgression-self” also reported histories of suicidal ideation or attempts at higher rates than those who reported no morally injurious events. Of these, “transgression-self” was correlated with the highest suicidal

ideation, likely as it produced the most intense moral emotions of guilt and shame. This study, framing and interpreting distress within the frame of “moral injury”, is one of the only identified which demonstrated the unique impact of this construct. The results of this study may be integrated with the above review of the impact of moral emotions and PTSD, though cannot represent a holistic view of the impact of moral injury on mental health.

Treatment and Future Direction

Entering back to test the integrity of social connection after moral injury has been an important topic for both Sherman (2014) and Shay (1994; 2014). Sherman emphasizes building back the capacity for self-empathy, while Shay notes the importance of social connections in both military unit associations and in clinical healing communities – through groups and through the demonstrated bonds of clinical staff. Shay notes the wisdom of prior trauma theorists, highlighting that moral injury always occurs in the context of “an ecology of power” and that community building is an answer, an opposing force, to the trauma of moral injury. While manualized treatments such as Adapted Disclosure (Gray, et al, 2012) have been proposed for moral injury or moral emotion-laden PTSD, Shay describes the healing process as exactly a process or an organization instead of strict content.

However, despite the energetic advocacy of many authors, moral injury is still a relatively unknown topic. As Kopacz, Simons, & Chitaphong (2015) highlight, “moral injury” goes unmentioned in the Council for Social Work Education’s Advanced Social Work Practice in Military Social Work competency listing. Moral injury has little foothold in the cornerstones of preparatory social work education. The emerging construct of moral injury is still in utero, divided between multiple theoretical formulations and recognition outside of its mere descriptive abilities subsequent to a PTSD diagnosis. Social work, as a profession uniquely dedicated to the

vulnerable and marginalized, may offer relief to veterans who's experiences have wounded them beyond the psychological. These morally injured veterans carry wounds which may evidence more than trauma, but an indictment.

Thus, a study was conducted to further our understanding of how 'moral injury' is understood by practicing clinicians, and further, how they use the understanding to craft their clinical approach to the veterans they serve. In the next chapter, the study design and methodology are presented.

Chapter II

Methodology

Toward answering the question “How do clinical social worker’s conceptualizations of moral injury impact their treatment actions?” a qualitative, exploratory study has been designed. The literature review above detailed current discussion relevant to moral injury, but as shown, little information exists regarding clinical social worker’s relationship to the concept. To address this gap, this study has been designed to assess the current state of knowledge practicing clinical social workers utilize in work with morally injured veterans. Semi-structured interviews will function to gather this data. Description of the study components of the research methodology follow.

Sample

This study involves seven clinical social workers who participated in semi-structured interviews. Those clinical social workers met eligibility for participation as they self-identified as familiar with the term “moral injury”, hold both an MSW and clinical state licensure, have worked regularly with veterans of the US Armed Forces for at least two years, and were willing to be audio-recorded. These participants, meeting these criteria, confirmed their interest in participation. During interactions with these or other related professionals, this method used snowball sampling procedures to obtain referrals to potential participants. However, snowball sampling was preceded by direct referrals to potential participants by persons informed by my eligibility criteria. By utilizing direct referrals, my sample population skewed toward those

clinical social workers who are employed or gained their contact with veterans locally and those who are employed by local veterans' care organizations.

In addition to direct referrals and snowball sampling, this study sought participants from pre-identified online groups formed through various websites. Specifically, groups relevant to moral injury and veterans mental healthcare located on Facebook.com, LinkedIn.com, and Reddit.com were utilized. This approach was taken to expand the potential sample pool and incorporate perspectives from outside of the local area familiar to direct referees. Additionally, these online groups were utilized as they may have provided further access to non-dominant populations.

Ethics and Confidentiality

Safeguards were designed to protect the confidentiality of study participants. To assure privacy, all participants who expressed interest were communicated with via my password protected computer. Specifically, my e-mail address at zwhigham@smith.edu and my personal phone (also password protected). Potential participants were sent the Informed Consent form at the initial phone contact, with a request to review and contact me back with any questions prior to the interview, with instructions to send them back to me, or bring to the interview. If the subject brings the form to the interview, I signed it then, and gave a separate copy to the subject. If the subject was interviewed via phone, they could email the consent back to me with an electronic signature, or mail it to me in an envelope I provided, a copy for themselves. With the receipt of the consent form, and agreement to participate, data collection proceeded, each subject interview was organized by references to coded names or pseudonyms. Identifying information such as the signed consent forms is kept under locked protection as they are collected and for the

pre-determined length of time mandated before the records may be destroyed. Tape recordings and ICs were kept separate from other research materials.

In addition to confidentiality information, consent forms contained content important for the potential participant's decision-making process. The consent forms offered details of the study purpose, largely mirroring the introduction offered above, and the process of participating. Specifically, the form detailed the requirements for participation, namely: their participation in a 45 to 1 hour long semi-structured interview. Further information to guide their decision was included, such as the conceived risks and benefits of participation. No risks related to the participants' personal distress or other risks related to their financial, social, or legal standing were identified. While benefits for the field of clinical social work and veterans' mental health were identified, it was made clear that participants would not receive any direct personal benefit from this study. The consent form clearly articulated the voluntary nature of the study, including their right to withdraw at any time and, correspondingly, that any records related to their participation would be erased.

Finally, during data analysis, attention was paid to de-identify all subjects, in terms of their names, and their locations/agencies. Direct quotes used to illustrate specific findings were selected so as not to identify any individual. Results were organized in an aggregate, de-identified manner when presented in the final report.

Data Collection

Upon joining the participant for our scheduled interview, I conducted and recorded semi-structured interviews of 45 minutes to 1 hour in length. Participants were sent a sample of the intended questions alongside the consent form, prior to our interview, so that they had an opportunity to reflect on the responses they offered. Semi-structured rather than open interviews

were utilized due to the precise and otherwise niche quality of information this study seeks, in addition to the subtle nuances. The semi-structured interview design was developed to access targeted and efficient focus for our timeframe while allowing participants with unique, outlying perspectives the flexibility to expound on their perspectives. The interview questionnaire guide, was tailored to participant demographics and questions relevant to their conceptualization of moral injury. Demographics data was used to assist in informing the study and to describe the subject pool, in addition to other areas, on the representation, or lack, of non-dominant populations. Because of the limited number of subjects, diversity was not possible.

Data Analysis

Data collected from interviews was transcribed verbatim via a word processing program. Once transcribed, data was analyzed and coded for themes. Themes were designed based on content and are not pre-established, due to the exploratory nature of this study. Further, themes were constructed in the context of the research question. As themes emerged from data, they were sorted and applied to the research question toward the development of the discussion of the study results.

Discussion and Hypothesis

The development of this study was inspired by my service in the Massachusetts Air National Guard, my anecdotal experience of witnessing the importance of the moral injury concept for veterans, and the amorphous and variable attention and understanding seemingly common among clinical social workers who work with veterans.

These anecdotal factors, supplemented by the work of Kopacz, Simons, and Chitaphong (2015), highlight a potential gap in moral injury competency among clinical social workers. I hypothesized that this study would show a limited understanding of the moral injury concept

compared to the construct's complexity in professional literature. Further, I suspected participants may strongly associate moral injury with combat-related PTSD.

Chapter IV

Findings

This chapter documents the results of seven semi-structured interviews with licensed clinical social workers who have at least two years of experience working with veterans of the US Armed Forces. All participants self-identified as “familiar” with the concept of “moral injury”. Some of the most important data gathered was related to participant’s conceptualizations of moral injury, their understanding of the relationship between moral injury and PTSD, their sources of learning, frequency of clinician contact with a morally injured veteran, and perceived level of adequacy in treating moral injury. Results have been organized into five categories which detail the responses gathered from questions listed on the semi-structured interview guide. Responses to each question were organized into coded themes. Additional data borne from interview discussions is presented after those responses directly related to interview questions.

The semi-structured interview was composed of 12 specific questions, the first four addressing demographic data and comprising the first “Demographics” category. Following this, clinicians were asked to describe their conceptualization of moral injury, what experiences they believe may cause a moral injury, and their understandings of the relationship between moral injury and PTSD. Data related to their primary sources of learning about moral injury and their perception of their frequency of contact with a morally injured veteran were also categorized together. Clinicians’ treatment actions taken during work with a morally injured veteran and their perception of the treatment actions that were most useful were combined under the fourth major category of results. Finally, clinician’s perceived level of skill in treating moral injury and their

desired education or training for enhancing their practice related to treating moral injury are listed. Related data that was not directly gathered from interview questions follow.

Demographics

Seven licensed clinical social workers with at least two years of work experience with veterans comprised the sample population of this study. Four cisgendered females and three cisgendered males comprised the study. All participants identified as white and described European ethnicities. Five of the seven participants described having no religious or spiritual affiliation, while two described an identifiable affiliation. Of these two, one participant identified belonging to an organized religion.

Conceptualization and Related Data

The purpose of this study was to examine how clinical social workers' conceptualizations of moral injury impacted their treatment actions in work with veterans. However, while the data did illuminate the ways in which participants defined moral injury, the majority of participants confirmed a lack of certainty in their conceptualizations. Participant responses related to their conceptualization were coded into three themes. Themes identified included "Perpetrating Unethical Action", "Perpetrating or Bystanding Unethical Action", and "Morally Challenging Trauma". Coded under "Perpetrating Unethical Action", two participants described their conceptualizations in the context of specific actions a veteran may take which are incongruent with their individual morals. Another set of four participants described their conceptualizations as perpetration or bystander events and were coded under the "Perpetrating or Bystanding Unethical Action" theme. One participant described their conceptualization more openly and was coded as "Morally Challenging Trauma".

A wide range of responses related to the experiences participants believed could cause moral injury led to the developed of five coded themes. Four participants offered responses coded as “Moral Incongruence with the Mission or Conflict Itself”. Opposed to the concrete action/bystanding positioning of the conceptualizations described above, these participants described a political-moral dimension of a veteran’s experience leading to what they believed to be a moral injury. One participant described their belief as:

I mean, there have been some veterans that I’ve worked with that, uhm, let’s say enlisted and just the act of going to war in and of itself was, I think for a couple of individuals, even though there was no said “action” that took place, because from their perspective they were in a place that they felt they were not supposed to be. I had a couple of vets who joined before the war broke out and had a difficult time reconciling that when they were deployed they were, uhm, occupying an area where they felt they should not be and dictating terms of people’s lives they were not comfortable with, was not congruent with their morals, congruent with their beliefs of what we should do as a country.

Another set of three participants described examples coded under “Breaches in the Rules of Engagement”. Included in this code were examples in which participants described civilian deaths, such as with the killing of women or children, whether intentional or not. Individual participants each described what amounted to three outlying coded themes, those being a “Platoon-Wide Abandonment of Morals”, the “Veteran’s Spiritual or Religious Background”, and “Betrayal by Command Elements”.

Participants were also asked to describe their view of the relationship between moral injury and PTSD. A majority of participant responses were coded under the theme of “Moral

Injury Promotes the Persistence, Exacerbation, or is the Cause of PTSD Symptoms”. Participants here saw moral injury as an important factor which negatively, in some way, impacted PTSD symptoms. Importantly, two of these participants described that in the context of military trauma, they believed moral injury to be the underlying cause of PTSD in veterans. One participant offered the following:

From what I’ve read and what I’ve experienced in therapy, I think there’s a very clear relationship, that moral injury is likely to cause intense PTSD and prolong PTSD. I believe that, I believe that says it from both what I’ve read and what I’ve seen, what vets have shared in therapy.

One participant’s description was coded as “Moral Injury is a Version of PTSD with a Moral-Emotion Schema”. This was designed from their response elaborating their view that, in regards to psychiatric diagnosis, moral injury is simply a useful descriptor to a variant of PTSD that lacks the traditional fear-based schema. Further, two responses were coded under “May Exist Separately but Largely Interrelated”. These participants described two separable conditions which were often linked by a common PTSD criterion A-type traumatic event. Despite their differences, all participants described strong connections between moral injury and PTSD-quality trauma.

Sources of Learning and Frequency of Contact

Participants responses describing their most significant sources of learning about moral injury were divided into two relevant themes. The majority of participants offered that veterans themselves had been their most significant sources of learning, often noting in addition that veterans were their only source. Three participants described responses coded as “Specific

Authors or Researchers”, noting that their most significant sources of learning were shaped by other’s previous conceptualizations.

Related to participants’ frequency of contact with a morally injured veteran, six of the seven participants responses were coded as “Daily or Often”. The outlying participant’s response was coded as “Unknown”. The outlying clinician’s response was related to their uncertain conceptualization as they described lacking the ability to identify a morally injured veteran. No participants described working with a morally injured veteran on a less frequent basis.

Treatment Actions

Participants described a range of treatment actions they have taken in response to a morally injured veteran. A total of four coded themes were designed to encompass the variety of responses. A majority of participants, four total, described relying on “Basic Psychotherapeutic Skills” One participant described his approach to treatment actions as:

Uhm, and I’ve just allowed space for that... that weight, to be in the room and allowed myself to be in the room with them. I can’t say I’ve done anything more, you know, sophisticated than that. I mean, I guess I’ve relied on some basic principles of therapeutic intervention and holding and creating a safe space and a space where all that can be unpacked and it may not be specifically targeted at moral injury but I think, I hope, it all has positive value in terms of how they are experiencing it in the therapy room.

Reflecting their lack of confidence in treating moral injury, two participant responses were coded under “Referrals” as they noted making referrals to clinicians or spiritual leaders they perceived were more competent in treating moral injury. Another two responses, reflecting the clinicians’ beliefs that moral injury was significantly related to PTSD, were coded as “Manualized or Time-

Limited Treatments for PTSD”. One participant described their use of a specialized psychotherapeutic group, coded as “Targeted Group”.

Responses differed slightly when participants described what they believed were the most useful treatment actions they had taken in response to a moral injury. A majority of four participants offered comments coded as “Refraining from Premature Attempts to Assuage Guilt”. One participant detailed the following:

Really, I think the willingness to just be with it. To sort of in a way.... To join with them and resist that impulse to say “Well, you know you really couldn’t have effected that” or “you weren’t there”, again, just sort of saying, just being exactly where they are with how they’re experiencing it and validating that that feels terrible.

Similar to the above, two participants described “Referrals to a Spiritual Counselor or Other” and two offered details coded as “Manualized or Time-Limited PTSD Treatments”. One participant viewed their work as first tending with the reduction of PTSD symptoms and then to moral injury content. Another, advocating a manualized or time-limited PTSD treatment, saw the treatment they advocated as addressing moral injury concurrently.

Perceived Skill Level and Desired Education

Responses to clinicians’ self-reported sense of adequacy in treating moral injury were divided into two coded themes. Five participants who composed the majority denied adequate skill and were coded as such. Two clinicians’ responses were coded as “Endorses Basic Skill” and even as such, stated their desire for more specific training on treating moral injury. One participant described their adequacy as such:

No. No. I'm partway there. I'm glad that we're trying to offer help for it. I approach this problem with great humility; I don't have all the answers. I encourage them to tell their story with their peers and share the emotions connected with it, and eventually it'll bring them back to trying to do something constructive with the sadness and whatever remaining guilt/moral injury they carry.

However, participants were able to describe the opportunities they desire which they believe may better enable them to treat moral injury. Six participant responses were coded as "Trainings or Educational Opportunities" that may take the form of conference presentations or workshops, online continuing education courses, or other forms. One participant described their desire for clinical staff working groups at their employment location, whereas another participant described their desire for more exposure to research.

The findings listed above demonstrate how clinical social workers engaged in regular work with veterans are conceptualizing and treating moral injury. The findings indicate a range of positions on each question taken from the semi-structured interview. An analysis of the findings is presented below with recommendations for practice and future research included.

Chapter V

Discussion and Conclusion

The goal of this qualitative study was to examine how clinical social workers' conceptualizations of "moral injury" impacted their treatment actions in work with veterans. A widely utilized definition of moral injury, and the one utilized here, is the "perpetration, failure to prevent, or having born witness to acts that transgress deeply held moral beliefs and expectations" (Nash & Litz, 2009). Participants described a broad range of conceptualizations and ways in which they understood moral injury. Many of their responses found reflections in the literature whereas others may require further investigation. Participants described, despite their frequent work with veterans whom they identified through their current understanding to be morally injured, an uncertainty regarding their own conceptualizations. This uncertainty may be indicative of the relatively recent highlighting of the moral injury problem and still-developing literature.

Following are three areas of discussion that emerged from my study: 1.) major findings and their relationship to previous literature; 2.) implications of the findings for clinical social work practice and veterans' mental health care; and 3.) recommendations for future research. The chapter ends with the study conclusions, reflecting study limitations, implications for future research, implications for clinical social work practice, and a wrap up with a brief discussion about what I learned about the conduct of research in the course of doing this study.

Major Findings: Conceptualizations and Causes

Multiple themes representing a variety of responses to different interview questions connect to the literature reviewed on unethical battlefield conduct. “Conceptualization” themes coded as both “perpetrating unethical action” and “perpetrating or bystander unethical action” made up the majority of responses and those views are shared by the literature (Litz, et al., 2009; Drescher, et al., 2011). Notably, the responses given by participants to questions about both their conceptualizations and the experiences they believe could cause moral injury are similar. Specifically, the coded themes of, for example, “perpetrating unethical action” and “breaches in the rules of engagement” define the events of a moral injury. The responses do not describe the distress of in phenomenological terms. This could be accounted for given participants assumed, explicitly or otherwise, that the distress accrued is always that of traumatic response reactions. Yet, an outlying theme contradicts this and will be discussed further below.

Literature reviewed regarding unethical battlefield conduct suggests that war trauma reproduces cyclically, slung from perpetrator to victim and then from victim-perpetrator to victim in an ongoing fashion. What can be further interpreted from the literature and my study’s participant responses is that the lines of demarcation between victim and perpetrator bleed away during war. The theme of a “betrayal by command elements” that I found in my analysis demonstrates that moral injury can occur from roles aside from perpetrator and bystander. Not only does war trauma reproduce itself, but an analysis of responses suggests that a morally injured veteran can likely claim perpetrator, bystander, and victim positions either throughout their service or through a single trauma.

My study responses related to the experiences participants believed could cause moral injury were largely supported by the literature. However, the literature reviewed identified

provoking factors to moral injury related to internal military culture and training. Commonalities identified between literature and responses were: complications with the rules of engagement, the command leadership, and a break-down of platoon or group morals (Currier, McCormick, & Drescher, 2015). A significant difference between literature and responses was identified in the relative lack of emphasis among responses regarding the affirmation of violence in military culture. While the affirmation of violence and aggression within military culture should be less than surprising, its impact on the mental health of veterans is not widespread information. Responses did not point to themes from the literature such as the internalization of a “capture or kill” attitude, unit competition to demonstrate ruthlessness and violence, the conditioning and possible pleasure in violence, and desires for revenge (Currier, McCormick, & Drescher, 2015).

While reasoning for the lack of participant’s emphasis on these themes is unavailable, clinician self-concept and values may be implicated. Despite the common agreement that a veteran’s perpetration of an unethical action may lead to and define moral injury, the veteran’s presentation for care emphasizes their mental distress and suffering. Perpetration can be often seen in the context of a chaotic tragedy riddled with impossible decisions and further complicated by the “military-civilian divide” (Sherman, 2015) which promotes a narrative in which a civilian has no way of understanding or judging the experiences of a veteran. This narrative of perpetration may even be valuable for a clinician to maintain their therapeutic alliance. Despite the role in events which the veteran attributes to their distress, a clinician’s own sense of who they are treating – a victim, perpetrator, or bystander – is complicated by the ambiguous nature of military service. The clinician’s personal and institutional values, particularly those which mirror values found in military culture, may stand as a barrier to

identifying the negative impact of culturally-valued violence in the background of the veteran's narrative.

Emphasized by participant responses but absent within the literature was the impact of ethical incongruence with the mission or conflict itself. The majority of responses indicating this theme differ from other findings through the clear absence of PTSD-quality trauma. This outlying theme precedes a key theoretical problem made clear through the responses addressing the relationship between moral injury and PTSD.

Major Findings: The Relationship Between Moral Injury and PTSD

The divide between participants who described moral injury as a unique condition which either increases the severity or ultimately causes PTSD and those who believe moral injury to be a descriptive term for a variant of PTSD complicates the term's theoretical development. Further, the divide in how to conceptualize moral injury in the context of psychiatric care appears to be a keystone theoretical issue for treatment. The divide, perhaps best summarized between those who believe moral injury to be a unique concern and those who believe it to be a synonym, is only partially informed by the literature. Much literature appears to explicitly or implicitly frame moral injury within the context of combat or war experience, thus suggesting its connection to PTSD-quality trauma (Drescher et al., 2011; Litz et al., 2009; MacNair, 2002; Nash et al., 2013; Shay, 2014; Vargas, Hanson, Kraus, Drescher, & Foy, 2013). Including participant's connection between an ethical incongruence with the mission or conflict itself, a veteran's moral disillusionment with their duties, appears to depend upon conceptualizing moral injury as a phenomenon distinct from PTSD even if only as such in a minority of cases. Despite the general association between moral injury and PTSD-quality trauma, the "perpetration" role of those

veterans describing an ethical incongruence with the mission or conflict and related mental distress continues to fit within existing definitions.

At this time, “moral injury” appears to exist on a plane between definition as a medical-model psychiatric diagnosis and definition as a non-psychiatric qualitative descriptor. This ambiguous tension complicates the efforts of clinical social workers to identify and treat moral injury along with efforts to then educate themselves and their peers. To continue the process of further elucidating “moral injury” within a psychiatric frame may risk pathologizing morality, and in the case of the trauma-absent outlying theme, may risk at worst pathologizing dissent. The cases of Bowe Bergdahl and Chelsea Manning both allude to this pathologization of dissent as their legal defenses have both attempted to connect their actions to PTSD and Gender Dysphoria, respectively. Alternatively, maintaining moral injury as a non-psychiatric qualitative descriptor may distance “moral injury” from clinical legitimacy, risking developing efforts for training and education. As participants noted “often or daily” clinical interactions with morally injured veterans and clearly described its severity, “moral injury” cannot be considered a marginal issue and instead demands attention and resources for veterans’ care.

Any future attempts to elucidate “moral injury” will have to reconcile with the role and definition of trauma. If conceptions of moral injury continue to rely on PTSD-quality trauma, such as killing a child during combat, researchers and clinicians will be forced to justify their exclusion of “non-traumatic” acts of perpetration which shatter one’s self concept. The irresolution of this keystone theoretical tension may stand for some time but can be addressed through professional education highlighting the ambiguity and promoting the use of case studies toward resolution.

Major Findings: Clinical Education and Practice

The findings related to clinical practice and participant self-assessment dovetail with existing literature related to moral injury in social work education. Whereas the literature reviewed above (Kopacz, Simons, & Chitaphong, 2015) recommends additions to the CSWE's military social work educational policies, the findings presented here address the psychotherapeutic process with relevance to those uninvolved in targeted professional education. These findings complement existing literature by providing a pre-cursor to best practices for those already engaged in practice.

The overwhelming majority of participants described their uncertainty in how to treat moral injury, the lack of professional education they've received on moral injury, and the high frequency with which they conduct psychotherapy with morally injured veterans. For these participants, questions of a cohesive and comprehensive conception of moral injury – its range of causes, the varieties of its presentation, and the preliminary structure of prognostic assessment – still linger. The relatively bare-bones construction of moral injury as it currently stands leads to clinician uncertainty, furthered by their perception of a lack of organizational support. The ambiguity in practice may be reflective of the ambiguity surrounding the role of trauma, essentially one of diagnostic categorization, discussed above.

Whereas recommendations for formal social work education have been detailed, the development of professional education and best practices can be vaguely outlined based on the above responses. What is clear from the above findings is the desire of the participants for a more comprehensive understanding of a long-existing but newly recognized problem, either facilitated directly by their organizations or allowed space to develop a grass-roots peer

consultation space necessarily engaged with theory-building. A full discussion of the implications of these findings will be included below.

Conclusion

Study Limitations

Despite the notable findings described above, this study carried limitations that provide important context for judging its findings. The size and particular qualities of the sample pool along with the timeframe for data collection were identified as limitations. Recommendations for adjustments for study replication are also identified.

The sample pool gained for this study was limited to the extent that data saturation did not occur. The seven participants, despite the common similarities in their responses, limit this study as a holistic perspective on the topic was unachievable. Further, participants self-identified as “white” or “Caucasian”, self-identified as either “male” or “female”, and a majority of participants described no spiritual or religious affiliation. Other possible demographic data was not collected. Further, the strict requirements of this study defined a narrow potential sample population. As such, a small number of individuals were eligible for participation. Advertising for the study and the timeframe of data collection placed additional binds on the already small sample. Despite the methodology’s success in identifying eligible participants, this study’s methodology aided in the homogeneity of the resulting sample.

These limitations with the sample pool could be eased by a prolonged period of advertisement and data collection. Increased attention to demographic diversity and targeted recruitment of a wider array of social identities and spiritual or religious affiliations would likely add to the quality of data. Replications of this study may be served by including the perspectives

of non-US based clinical social workers in nations where an equivalent professional identification exists.

Implications for Clinical Practice

The findings presented above impact clinical practice by outlining the groundwork to develop professional education focused on moral injury for clinical social workers. Most of all, these findings act as a call to action for those involved in clinical social work and psychotherapy more generally. The role of moral-emotions and their reconciliation in the treatment of moral injury, the role of trauma in the conception of moral injury, and the facilitation of professional education are major points with actionable, though inter-dependent, opportunities.

The development of an introductory and explicitly non-definitive curricula may aid beginning practitioners and those with a history of veterans' care. By identifying the state of moral injury's theoretical and research development, including important tensions such as the role of trauma, clinical social workers may be able to ground their clinical work alongside colleagues'. Professional education should contextualize existing tensions and ambiguities within reviews of relevant literature as an expanding project. Ideally, organizations with the resources to connect clinicians and provide a forum for collaboration would provide the service. The development of prioritized techniques or treatments will clearly benefit from a blend of research and practitioner input, yet must grapple with the role of trauma. At this time, the inclusion of a Moral Injury "Z-diagnosis" (APA, 2013) or psychosocial stressor may benefit clinicians in coordinating care.

To fully meet the demands of clinicians faced with a frequent clinical issue with little exposure, implications of this research extend into professional training. Modifications to CSWE standards, such as recommended by Kopacz, Simons, and Chitaphong (2015), suffice for those

seeking particular accreditation through CSWE for work with veterans. However, a broader dissemination of moral injury theory and research, alongside any future competencies that may develop, should be included in formal degree programs and through continuing education programming.

Directions for Future Research

Multiple directions exist for future research on moral injury and clinical social worker's role in conceptualizing and treating morally injured veterans. From the highlights of the discussion, research related to the causes and conceptualizations of moral injury alongside education dissemination for clinicians are priorities for research.

The research relating to unethical battlefield conduct and the transmission of trauma, both between opposing forces and intra-combatant, was unable to clearly point to the beginning of these transmission chains. The chaos of military experiences, particularly war, obscures easy access to this information. However, the role of military culture in conditioning servicemembers toward violence, aggression, and revenge, was noted by the literature. Future research on the aspects of military culture or training that promote unethical battlefield conduct may identify areas for change that can decrease the transmission of intra-combatant trauma and moral injury.

Further research on the role of trauma in moral injury relates to both cause and conceptualization of presentation. Research on moral injury may benefit the field by examining how moral-emotional distress stemming from military experiences in veterans without a corresponding PTSD diagnosis manifests and is diagnosed. Alternatively, research redirected from moral injury to the current conceptualization of PTSD should focus on the connection between predominantly moral-emotional distress states and the hyper- and hypo-arousal states

indicative of traumatization. This research would serve to detail how emotions such as guilt or shame, as apart from fear, are justified in inclusion in PTSD diagnostic criteria.

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Appendix A

Informed Consent Agreement



SMITH COLLEGE

Appendix C

2015-2016

Consent to Participate in a Research Study

Smith College School for Social Work • Northampton, MA

.....

Title of Study: Clinician’s Approaches to Moral Injury

Investigator(s):

Zach Wigham, zwigham@smith.edu

.....

Introduction

- You are being asked to be in a research study of: How Clinical Social Worker’s conceptualization of Moral Injury effect their treatment actions.
- You were selected as a possible participant because: You have been identified as a Clinical Social Worker, who holds a Master’s of Social Work degree from an accredited institution, who self-identifies as familiar with “moral injury” and has worked regularly with veterans of the US Armed Forces for at least 2 years.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

As service members return home from the wars in Iraq and Afghanistan, several common wounds return with them. While veterans often return with physical conditions and injuries, mental health conditions are widespread reactions to war. While the condition known as Post-Traumatic Stress Disorder (PTSD) represents a large portion of mental health conditions related to our modern day responses to wartime experiences, alternative concepts have been formed that may be at odds with the explanations of some mental distress offered by the concept of PTSD. One alternative that has gained recent recognition is that of “moral injury”. In order to advance the understanding of how clinical social workers are making use of “moral injury” in their work with veterans, this study seeks to answer “How do clinical social workers conceptualizations of moral injury effect their treatment actions with veteran clients?” The results of this study will help to clarify how, and if, clinical social workers are using and advancing this concept through clinical practice.

This study is being conducted as a research requirement for: my master's in social work degree. Ultimately, this research may be published or presented at professional conferences. Demographic questions will be asked in order to better contextualize the opinions of each participant regarding moral injury.

Description of the Study Procedures

If you agree to be in this study, you will be asked to do the following things: Participate in a 45 minute to 1 hour semi-structured interview either in person with this researcher, over the phone, or over another electronic medium agreed upon for communication. The semi-structured interview will contain questions related to your demographics, such as gender, race, ethnicity, and religious or spiritual affiliation.

Risks/Discomforts of Being in this Study

Demographic questions will be asked in order to better contextualize the opinions of each participant regarding moral injury. Specifically, the interview proposes questions around your gender, race, ethnic, and religious or spiritual identity. Demographic questions are not mandatory for participation and you have the option to opt out of any or all demographic questions, or to have demographic information kept from the study's results.

Benefits of Being in the Study

- The benefits of participation are: The potential to positively impact the development of a new theoretical construct applicable to veterans' care. No other directly personal benefits will be offered or available to participants.
- The benefits to social work/society are: An examination of how clinical social workers understand and act to treat "moral injury", an often under-recognized clinical theoretical construct applicable to the veteran community.

Confidentiality

- Your participation will be kept confidential.
- Confidentiality will be protected by keeping identifiable and contact data separate from the contents of interviews. Interview meetings will occur either in person, at a mutually agreed upon meeting place, or through electronic means such as via phone or an internet communication platform such as Skype. The records will be kept confidential and only this researcher will have access to them.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/gift

- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up to the date noted below) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by March 1st, 2016. After that date, your information will be part of the thesis and unidentifiable, so withdrawing it will not be possible.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Zach Wigham at zwigham@smith.edu or by telephone at xxx-xxx-xxxx. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

.....

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

.....

[if using audio or video recording, use next section for signatures:]

1. I agree to be [audio] taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

Appendix B

Interview Guide

Interview Guide

Please describe

- 1.) How would you describe your gender identity?
- 2.) How would you describe your racial identity?
- 3.) How would you describe your ethnic identity?
- 4.) How would you describe your religious or spiritual identity or affiliation?
- 5.) What is your conceptualization of Moral Injury?
- 6.) What kinds of experiences do you believe may lead to a moral injury?
- 7.) What is your view of the relationship between moral injury and PTSD?
- 8.) What have been your most significant sources of learning about moral injury?
- 9.) How often do you believe you have encountered a moral injury in your work with veterans?
- 10.) What are the treatment actions you have taken in response to a moral injury (A referral, manualized treatments or workbooks, specific therapeutic techniques, talk therapy, etc)?
- 11.) What treatment actions do you believe have been most useful in responding to moral injury?
- 12.) Do you feel you have the knowledge, training, and experience to adequately treat the distress of moral injury at this time?

Appendix C

Eligibility Criteria Screening Form

RE: Pre-screening questionnaire for potential study participants.

- 1.) Do you currently hold a Master's of Social Work degree from an accredited institution?
- 2.) Are you currently a licensed clinical social worker?
- 3.) Have you regularly worked in a clinical social work capacity with veterans for at least 2 years?
- 4.) Do you believe yourself to be familiar with the concept of "moral injury" as it applies to veterans?
- 5.) Are you willing to be recorded on an audio recording device?

If you answer affirmatively to all four of the above questions, you are eligible to participate in the study. If you wish to participate, please contact me at: zwitham@smith.edu

The data collected from this study will be used to complete my master's of Social Work degree. The results of the study may also be used in publications and presentations.

If you do not meet the inclusion criteria above, thank you for your interest.

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Appendix D

HSR Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

December 15, 2015

Zachary Wigham

Dear Zachary,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in cursive script that reads 'Marsha Kline Pruett'.

Marsha Kline Pruett, Ph.D.
Co-Chair, Human Subjects Review Committee

CC: Elaine Kersten, Research Advisor

Appendix E

HSR Protocol Change Approval



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

January 14, 2016

Zachary Wigham

Dear Zach,

I have reviewed your amendment and it looks fine. The amendment to your study is therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink that reads 'Marsha Kline Pruett'.

Marsha Pruett, PhD
Co-Chair, Human Subjects Review Committee

CC: Elaine Kersten, Research Advisor