



Beyond PTSD: A Multi-Case Study Exploring Identity, Moral Injury, and Spiritual Injury

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RESEARCH

VIRGINIA TECH.
PUBLISHING

ABSTRACT

This multi-case study explored Swedish military veterans' experiences related to posttraumatic stress disorder, moral injury, and spiritual injury. Specifically, the present study focused on 4 domains (health care, veteran's administration, moral conflicts and injuries, and identities and existential dimensions) that emerged in participants' meaning making as they navigated everyday life. While these domains are distinct from each other, results show health care experiences are typically embedded within veteran's administration, while at times, moral injury and/or spiritual injury appear to be linked to identities and existential dimensions. Questions of identity (e.g., who am I?), morality (e.g., how do I become good?), and spirituality (e.g., does a higher being cause people to suffer?) are not pathological by nature, but can be viewed as fundamental to an individual's *raison d'être*.

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KEYWORDS:

identity; moral injury; spiritual injury; posttraumatic stress disorder; military veterans; Sweden

TO CITE THIS ARTICLE:

Grimell, J., & Atuel, H. R. (2023). Beyond PTSD: A Multi-Case Study Exploring Identity, Moral Injury, and Spiritual Injury. *Journal of Veterans Studies*, 9(3), pp. 9–22. DOI: <https://doi.org/10.21061/jvs.v9i3.436>

Post-Traumatic Stress Disorder (PTSD) is characterized by symptoms such as difficulty concentrating, nightmares, flashbacks, negative feelings about oneself or others, and avoidant behavior that persists after witnessing or witnessing a traumatic, violent, or threatening event according to the *DSM-5* (APA, 2013). Today, however, military PTSD is considered by many researchers and clinicians to be more complicated and contain more layers than the diagnostic description suggests (Grimell, 2016; Koenig et al., 2017; Shay, 2002, 2003).

In the last decade, the concept of moral injury (MI) has been established as an overlapping yet distinctive phenomenon in a North American context (Drescher et al., 2011; Litz et al., 2009; Shay, 2002, 2003). MI can occur if the moral compass or deeply held values are violated and/or betrayed during a military operation. A MI does not have the status of a clinical diagnosis, but can be integrated into a PTSD complex. This insight was already presented in the end of the 20th century by Shay and Munroe (1998) and Shay (2002, 2003) in light of their therapeutic work with Vietnam veterans. A MI can illustrate a life question complex that contains deep concerns about guilt, meaning, and identity.

The concept of identity has recently emerged as an important approach in understanding PTSD and MI (Atuel et al., 2021; Grimell, 2016; Tick, 2005). Both PTSD and MI may fragment and disintegrate the story of “who I am,” i.e., identity, and this confronts a person with identity struggles of an existential magnitude, which are expressed in basic identity questions such as: Who am I? Where am I going? Where is my place in the world? (Atuel et al., 2021; Grimell, 2022).

In light of the existential and moral depths of PTSD, and also spiritual/religious (S/R) layers, both researchers and clinicians today suggest that the S/R dimension may have a vital role to play and needs to be addressed to meet integrated yet distinct issues and potential needs of veterans (Atuel et al., 2020, 2021; Brock & Lettini, 2012; Drescher & Foy, 2008; Graham, 2017; Grimell, 2019, 2020a-b, 2021; Koenig et al., 2017; Smith-MacDonald et al., 2018).

For example, a recent study on Swedish military veterans diagnosed with clinical PTSD¹ investigated the complexity of their combat trauma from a qualitative approach (Grimell, 2022). Results showed that MI, identity issues, and spiritual injury (SI) were pressing, present, and distinct within the PTSD experience. However, these concepts were not addressed from a clinical perspective. To many of the participants, their MI and identity questions were among the hardest things to grapple and live with in the aftermath of PTSD and combat trauma. Hence, the present multi-case study aims to highlight the complexity of PTSD among Swedish veterans and discuss what the implications such layeredness may have for the conceptualization of PTSD and treatment. Broadly this exploratory research is guided by this overarching question: In what ways can clinical PTSD be described and understood through lenses such as MI, identity and SI?

CONCEPTUALIZATION OF MI, IDENTITY, AND SI

MI AND IDENTITY

Shay (2002, 2003) illustrated in his crucial work on Vietnam veterans that there could be additional layers in clinical PTSD. It was not only a matter of simple PTSD, i.e., the incapacity to shut down the biological survival combat mode due to deployment in war zones. Shay titled this as a MI, which made PTSD more complex. MI had to do with betrayal and malpractice leadership; and the conceptualization on MI pointed towards three important steps: (a) betrayal of what was considered morally right in the local culture, (b) by someone who had been legitimately granted authority within the social system, and (c) in a high-stakes situation(s). However, the concept of MI did not have much impact regarding treatment of veterans in the end of 20th century. Recent review by Atuel and colleagues (2020) found that before 2008, only eight scholarly works contained the term MI in the abstract. A search from 2009 to 2020 yielded 265 scholarly products with the same term (p. 3).

The interest in MI accelerated in the wake of the asymmetrical war on terror, which included combat situations against an enemy that did not necessarily carry the traditional identity markers of a soldier, i.e., a standardized military uniform including all the combat gear, which explicitly suggests that this is a combatant. Such asymmetrical warfare was—and continues to be—blurred and ambiguous. This in turn increased the risk of making transgressions against deeply held personal moral values during their efforts to solve the mission and survive alongside their battle buddies. The seminal article by Litz and colleagues (2009) marked the starting point for this newly individual turn on MI. Transgressive acts or morally injurious experiences were tailored to “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations” (p. 700).

From here on many research articles on MI have followed, and the concept continues to evolve in various ways. The most recent development is illustrated by Atuel and colleagues (2021) by connecting MI to identity. They suggest that MI arises when the experience of suffering caused by moral failure (i.e., the lack of human goodness) is reflected onto one’s character and identity. MI is defined as a less than virtuous state of being (in the Aristotelian context of character and identity) arising from suffering or even death brought about by one’s own or another person’s moral failure. This understanding of MI, as related to identity and the failure to uphold moral integrity, resonates to Swedish research on veterans diagnosed with PTSD (Grimell, 2022). From a Swedish stance, identity refers to a narrated military or veteran identity which become damaged due to MI.

Another current topic up for debate on MI is the actual treatment. The clinical treatment of MI so far has leaned against PTSD treatment (with cognitive reconstructing and exposure therapies), which has been shown to have high non-response rates (e.g., Steenkamp et al., 2015). This is because the appraisals of the morally injurious experience(s) may be accurate, which may make cognitive restructuring practices inutile or possibly even harmful. Moreover shame and guilt (the primary emotional reactions of MI) are fundamentally different than fear and anxiety (the primary emotional reactions of PTSD), which may make exposure techniques ineffective (Atuel et al., 2020, 2021).

In sum, MI is an evolving construct. Early conceptualizations suggest PTSD and MI as distinct but overlapping (Drescher et al., 2011; Shay, 2003), while recent considerations argue for PTSD and MI as dual processes arising from the same event but with different etiologies (Atuel et al., 2021; Barr et al., 2022). What is clear is that MI is a dimensional problem (i.e., there is no diagnostic threshold and instead severity is seen as varying widely for any given veteran with time and circumstance), which in and of itself is fully capable of deeply afflicting the lives of veterans who have experienced trauma amid military service and deployment (Drescher & Foy, 2008; Grimell & Nilsson, 2020; Shay, 2014; Vargas et al., 2013). MI can result in guilt, shame, anger, and sadness (Bryan et al., 2016; Litz et al., 2009; Wortmann et al., 2017). MI may also include alienation, loss of purpose, social instability, loss of social trust, withdrawal, self-condemnation, self-harming, and self-handicapping behavior (Frankfurt & Frazier, 2016; Maguen & Litz, 2012, 2018; Shay, 2002, 2003).

SPIRITUAL INJURY (SI)

SI is another distinct concept which may resonate to both MI and PTSD. SI and MI may occur due to transgressive acts and evolve in corresponding ways, but MI affects the ethical domain of individuals and their perceived violation of personal moral codes. SI, on the other hand, impacts the explicit S/R dimension such as God, divine beings, and explicit religious faith, among other things (Grimell, 2020a). In theory a veteran may be struggling with both SI in relation to God (e.g., a silent God, theodicy problem, loss of faith) and MI (e.g., perceived betrayal by a commanding officer in a high-stake situation), which may suggest different approaches to treatment, i.e., one related to the spiritual domain/counseling and one related to military ethics and culture/forgiveness.

Berg (2011), a forerunner and pioneer in the elaboration and development of the concept of SI, described it as the effect of an event that has damaged an individual's relationship with God, self, and/or others, and has alienated that person from that which gives meaning in

life. SI explicitly points to the S/R dimension of an inner injury inflicted upon the self and thus broadens the narrow bio-psycho-social model of understanding human experiences. This brings up the potential of a holistic bio-psycho-social-spiritual model robust enough to explain a variety of human experiences, including those specific to veterans (Berg, 2011; Grimell, 2019, 2020a; Smith-MacDonald et al., 2018). SI also closely relates to spiritual terms such as soul, soul wound, soul injury, and soul repair. These expressions are sometimes employed by researchers within both the field of MI and PTSD with varying rationales and conceptualizations (Atuel et al., 2021; Brock & Lettini, 2012; Grimell, 2018a, 2022; Tick, 2005).

THE PRESENT STUDY

The 4 (Rolf, David, Linda, and IP3) cases that comprise the current research are drawn from a larger study (project number KS 2020-0042) launched between October 2020 to January 2021 from the Unit for Research and Analysis within the Church of Sweden and approved by the Swedish Ethical Review Authority (2020-00056). Broadly, the study aimed to explore life experiences related to PTSD, including moral injuries (MI) and spiritual injuries (SI). Given the lack of research within a Swedish context, the use of a qualitative interview (e.g., Kvale & Brinkmann, 2009) was more appropriate to draw veterans' attitudes and experiences related to clinical and complex PTSD, including MI, SI, and identity concepts. Additionally, the status of this research field was such that there was no established consensus theory from which standardized categories could easily be deduced and employed within a Swedish context. The theoretical landscapes on MI, SI, and identity had to be contextually applied and developed qualitatively by gathering context-specific empirical knowledge. Hence, a qualitative approach using a semi-structured interview seemed most fitting (Verschuren & Doorewaard, 2010).

A qualitative and descriptive research study such as this does not focus on identifying generalizable and repeatable truths or events, but instead strives to describe storied experiences of veterans and to develop hypotheses for further testing. Concepts such as validity and reliability, which are often used to assess and guide quantitative research, require some rethinking from the perspective of this study. Here validity is more closely related to a meaningful analysis (Polkinghorne, 1988, 2005). Thus if an analysis includes an important finding, even as an individual occurrence, it can be described as a significant result since it offers new qualitative insights which can add to theory (Grimell, 2020b). Especially, since the Swedish field of qualitative research on veterans with PTSD is quite unexplored.

METHOD

SAMPLE

The intent during sample selection was to recruit former Swedish officers, soldiers, and seamen who lived a life in the aftermath of deployment with PTSD and/or struggled with existential issues. An additional intent was to find diversity among the participants in order to provide the investigation with a variety of broad and wide qualitative nuances. Hence recruitment of participants was designed as a purposeful sampling selection (Merriam, 2002) via a snowball sampling method (Noy, 2008; Polkinghorne, 2005). A research information letter was sent to the potential participants that described the background of the research project, purpose of the study, research ethics, anonymity, and related formalities including the approval by the Swedish Ethical Review Authority (SERA). Each potential participant had to reply via email in order to join the study and send the informed consent agreement via postal service.

Eight military veterans agreed to participate, 6 males and 2 females. Seven of the interviewees were clinically diagnosed with PTSD and/or were given treatment for symptoms and medical conditions (e.g., back and neck pain).

There was a wide variation among the participants regarding age (ranging from mid-30s to 60 years), number of deployments (ranging from 1 to 10), deployment contexts (ranging from the Middle East, former Yugoslavia to Afghanistan and Mali). The study included participants from the Army, the Air Force, and the Navy. The vast majority had served on the field in the various conflict/war zones.

Each participant decided a time and place for his/her interview, but due to the pandemic, all interviews were conducted virtually through Microsoft Teams. The individual interviews lasted from 60–120 minutes. A follow-up conversation (without any recordings) was offered the participants if they felt the need to address anything from the interviews, all participants declined. All interviews were transcribed verbatim in Swedish.

INTERVIEW DESIGN

Four specific interview topics were developed for the purpose of the larger study: (a) questions to explore the full trauma story (from the beginning till today); (b) questions related to relationships; (c) identity; (d) and personal beliefs, purpose, meaning, life-questions, and existential experiences. A semi-structured interview design was developed to cover these topics (Kvale & Brinkmann, 2009). Within each topic several follow-up probes allowed for greater exploration, allowing participants to provide answers in ways they found meaningful (Riessman, 1993; Webster & Mertova, 2007), as well as share their narrated experiences in their own ways (Clandinin, 2013; Clandinin & Connelly, 2000).

The researcher (JG) who conducted the interviews was also a military veteran. To the participants this person was both a researcher and a former military officer, and this shared military identity facilitated communication and, equally important, established a sense of trust throughout the interviews (Brunger et al., 2013; Mishler 1986, 2004).

ANALYSIS

The first step of the analysis included close relistening and rereading to summarize the content and abstract plot(s) or storyline(s), theme(s), and tone(s) of the interviews (Clandinin, 2013; Clandinin & Connelly, 2000; McAdams, 2013). This, as agreed upon in correspondence with Ganzevoort (1998), is described as global reading, which serves as the first step “to get a general picture of the text” (p. 28).

Participants were asked if they would like to participate in this summarizing analytical step to transform the interviews into short stories. Everyone agreed to this procedure. This process included correspondence between the researcher and participants as their lifeworld, as they would like to present it, was carved out and presented in a short life-story (in Swedish) consisting of approximately 2 pages. This coauthoring process strengthens the validity of their storied cases.

The second step was to transfer the transcripts into a qualitative data analysis program (called Atlas.ti), which functions as an organizer wherein the interview data were coded in different ways to explore the content. This analysis was based upon an inductive approach to build theory out of individual and experiences. The first step in this process was to code the content within the transcripts. The codes were developed in close relation to the content; for instance, if a participant narrated that “and suddenly I have these flashbacks and am back into the combat situation,” this was coded as flashbacks. The whole paragraph was then highlighted and connected to this code. This analytical process generated 239 codes, of which some were frequently expressed across many transcripts, whilst some were only expressed by one participant.

A cluster level analysis then needed to be developed in order to make meaning and sense of the first level analysis. Within Atlas.ti this level is called the family level since the codes become organized within families. The hermeneutical principle for the development of these clusters was that the codes could be understood in reference to the clusters and vice versa. This suggested a reciprocity between clusters and locally emergent parts or codes of the transcripts, as the clusters contributed to the interpretation of the codes, and then the codes contributed to the interpretation of the clusters as such (Grimell, 2018b; 2020b; Ricoeur, 1998). The clusters made it possible to organize the codes in a meaningful way, as it otherwise would have been quite a

challenge to meaningfully describe the narrated experiences among the participants in such an organized manner. Thirteen clusters were developed and presented below.

1. The military story
2. Military culture
3. Military identity
4. Transition from a military to a civilian life
5. To live with the implications of deployments
6. PTSD-symptoms and issues
7. Moral conflicts and injuries
8. Health care
9. The Swedish Armed Forces (veterans administration)
10. Authorities and society
11. The countryside, nature and dogs
12. Identities and existential dimensions
13. Interview responses

ILLUSTRATION OF ANALYTICAL RESULTS

Four cases were selected based on the diversity and complexity of their clinically diagnosed PTSD. The coauthored short story (translated into English) will be presented in parts to illustrate each case and the “big story” of a participant (McAdams, 2013). All clusters, however, cannot be presented here (for a full presentation see Grimell, 2022) and of main interest for the purpose of the current research are clusters 7, 8, 9, and 12, including narrative accounts.

The participants were also encouraged to select their own pseudonyms, which served to invite them into the research process, while also safeguarding their anonymity. Furthermore, and for the same reason, some details have been slightly altered or omitted from the interview accounts.

RESULTS

ROLF'S CASE

Rolf was involved in the Home Guard in his youth, did his conscription in the 1980s, and then deployed to Bosnia somewhat later. Rolf saw the ravages of war during the operation, comrades were wounded and injured, and he became numb. During post-deployment he thought that everything was continuing as usual, but his wife did not think so. Rolf's military mindset from the operation was still active and he had a high sensitivity to sound, to which his family reacted. He also had a very short temper. He experienced insomnia, memory difficulties, and difficulty concentrating. Rolf felt a rootlessness in the “civilian darkness.” He was at home but still not at home. Rolf felt insecure where he should have felt safe. The situation was so difficult that Rolf was losing his family. His wife issued an

ultimatum: “Either you seek help, or we cannot go on like this!” Rolf sought help even though it was far inland.

As the years moved on, both Rolf and the family recovered. Overtime Rolf felt stronger. When the possibility of a new deployment presented itself quite a few years later, Rolf felt ready. When he jumped into the combat vehicle after many years as a civilian, it felt like he had come home. Or in his own words: “Damn, I'm home now!”

From thereon Rolf deployed on many missions to new conflict zones. He was involved in combat many times; battle buddies were wounded and fell during the operations. Rolf was mission focused and tried to shut down all emotions that accumulated. However, even before he deployed on his very last mission, he felt that he was not really feeling well, but he admitted nothing.

At the end of his last effort, something happened that brought old memories back to life. Rolf felt that he had put so much in his backpack for so long and now suddenly the lid cracked. Everything came rushing in again: insomnia; daily flashbacks, sometimes several times a day in different situations; the anger returned. He fought his way through the last deployment and when he came home, he sought help. He received psychiatric support and therapeutic help for a long time. Rolf was diagnosed with PTSD, something he does not agree with. However, he has come to the realization that it can be good to be a little more open as it can help others.

Despite continuous PTSD symptoms, Rolf works; and it is very important and meaningful for him. He keeps his anxiety at a manageable level with the help of antianxiety medication. Other medications are used to help him calm down before nightfall. The most difficult aspects to deal with, for which there is no medicine, are the moral conflicts over guilt that Rolf is constantly forced to combat. Rolf recounted:

Today every morning begins with a clenched fist in the stomach before I go up and I try to get my mind on other things. I medicate now too, both antianxiety medication and to calm down and sleep in the evening. It helps to some extent but not all the way. I also have regular appointments with the Military Health Care. [...] But it is what it is, it is very difficult when those specific dates arrive and the guilt flushes over me. Well, I am the one who does that, puts all the guilt on myself. No one else says: “Hi, Rolf, it is your fault” —because they don't have the whole picture. This is a very difficult part to process. [...] The guilt of a fallen battle body is the hardest thing to live with. It is my fault; I have accepted that it is my fault. Because when I went to therapy, it was explicitly said: “But you must be able to say that it was not your fault.” But I cannot lie to myself and pretend that everything is peace and joy, I did that

before, but I cannot do that any longer. I don't have the energy to do that. It is easy to sit in the chair in front of me and say: "But you have to let this go, it is not your fault." Such a suggestion is not absorbed. [The guilt] is hard to handle, very hard to live with.

The military identity is constantly present and is deeply rooted in Rolf, even though today he wears civilian clothes. There is a military mindset that cannot really be turned off and it spills over into everything else. Rolf feels that the military bonds and the community are extremely strong, but also that they are connected to what they have experienced together. Some veteran colleagues have been particularly important to Rolf. They have supported each other in the deeper valleys of the moon and made it possible for each other to talk about themselves and share experiences, hardships and struggles just as they are.

DAVID'S CASE

David did his conscription in the early '90s and later deployed to a conflict zone in former Yugoslavia. The aftermath of the war, poverty, and ethnically segregated villages marked the context. David could see traces of the war everywhere and there were skeletal parts, skulls and shins a little everywhere in the forests. It was demanding to constantly live with the stress that if you took one step off the road, it could be the last thing you did due to the extensive presence of land mines. There were a few occasions during the operation when life hung on a fragile thread. David had never seen himself as a believer, but thought in a number of situations: "If there is a God, see to it that we come home unscathed." In connection with an incident during the deployment, David decided and acted upon what he knew resulted in the death of a very young person.

When David returned home, some unemployment followed, but he continued to work part-time as an instructor in the Armed Forces. However, the traces of the deployment were deep. Soon David began self-medicating to alleviate corrosive anxiety, nightmares, and flashbacks. Due to the fear of land mines, it took far more than a year before he dared to walk on lawns and soft ground. New Year's Eve with rockets created much stress. He was sensitive to smells, was on full alert all the time, aggressive, and irritable.

About a year after returning home, David sought medical help and came into contact with a psychiatrist. As a patient, he was met with the comment, "No, no, this cannot be posttraumatic stress because we do not have it in Sweden, it only exists in countries that have soldiers at war." In light of that attitude, David did not want any more help from health care, but instead began to think that he was abnormally sensitive and that it was him who was at fault. He buried his anxiety and his questions within himself. This

was followed by a very long dark and destructive period of partying and self-medication with alcohol and drugs.

A normal heavy week during this period could consist of 3–4 days without sleep. David only fell asleep when his body was so exhausted that it was not physically possible to stay awake. He was plagued by a lot of anxiety, nightmares, and suicidal thoughts. Several suicide attempts followed during this period. He wrestled with ethical and moral questions due to the death of the innocent young person. David recounted:

In my case it was thoughts like: *Could I have done anything different? Did I do the right thing? Did I do wrong?* During this period, I had become a parent myself. And I had reached a level that if I would have met the parent [of the dead young person], I am not convinced that I would not have given up my child to this parent if I thought it would help. This idea also became very strange and added to an already bad conscience which increased the anxiety. This is a complex and taxing question.

David needed to dull the pain. When it was at its worst, he had not a sober day in 6 months. There was not a single day without some type of medication in the body: tablets, cannabis, or marijuana. Strolling here and there could provide money for drugs to numb the anxiety. The contact with loved ones gradually ended. Civil relations ended. There were short-lived superficial relationships.

Just over 10 years after the first attempt seek health care, David tried to get medical support again, encouraged by the partner he then lived with. This time it started better thanks to a foreign psychologist with personal experience of war. However, the referral to psychiatry specialist and the treatment that followed was not very good. Sometime later David was in worse condition and the treatment was stopped.

It would take years to end the long destructive period that began after David's return from deployment. With the help of a veteran who supported him with care contacts and authorities combined with the opening of veteran clinic in Sweden, David got the help he needed. Today David is on sick leave despite his relatively young age. He takes his medication and does not have anxiety in the same way as before. He is bitter towards the Armed Forces and testified:

I can feel bitterness towards the Armed Forces because most of all they did not assist and support me. My situation and condition have been known to them, but they haven't given a damn and instead pushed everything to the health care sector. They said upon the return that, "The deployment is

not completed until you have participated in two organized reunites..." periodically scheduled. I was not present for either of them and the Armed Forces did not check up on me at all. Despite the fact that this was supposed to be mandatory, I haven't heard anything from them.

David feels that the healthcare is not equipped to deal with veterans with PTSD problems, with the exception of the veterans' clinic. In the aftermath of the deployment, David's approach to a transcendent dimension has also changed in contrast to the deployment:

This is a delicate and sensitive question. I have discussed this at some point with someone. The idea, if we should stick to God, is like this to me. No matter how all powerful One may be, a God which is all almighty and can affect everything and still let all these things happens is not worthy of my commitment.

David still has strong ties to the veteran community and the military identity is still very strong. The veteran collective is more his family—brothers and sisters—than the civilian family constellation. It is in the veteran collective that safety exists, not in civil society.

LINDA'S CASE

Linda began her military career in the Swedish Armed Forces' youth activities in the mid-1990s. She then did her conscription and continued to the officers' academy. A few years later, Linda graduated as an officer and worked in the Armed Forces in several different positions. During the 2000s, Linda participated in the deployment against the war on terror, which was characterized by danger, insecurity, and combat operations. Linda was exposed to both rocket fire and the imminent threat level in the form of mines and direct fire, which consistently characterized the task solution during this deployment paradigm.

When Linda came home, she had a hard time getting into ordinary life. She was very angry and could not walk on lawns or soft ground. She became extremely frustrated with the people who could not understand or share her deployment experience. She felt that there were no groups where she could get the support. And the culture of the Armed Forces, as she experienced it, meant that one should not show any vulnerabilities. So, it was not relevant to open up such a conversation.

In addition, there was another dimension. Linda was a woman and she did not want to expose herself because she was afraid that it would be ruinous for service members who were women. Linda was afraid that it would be a

confirmation of prejudice against women in the Armed Forces that she had previously encountered, "Yes, but you cannot do it." On the other hand, in various contexts, she sought to bring out a little of what she felt within herself in the light of what can be called personal development and maturity.

Privately, she and her partner stood in completely different places in life and the marriage fell apart. During this period Linda was diagnosed with PTSD, but she struggled, recovered, and continued to serve as an officer.

After a few years Linda met a new life partner and she also left the Armed Forces for a civilian job. Her leadership skills, creativity, and drive were well expressed in her new work. The years went by and with them also came private and professional challenges on various levels that Linda fought through. These challenges brought to the fore deep thoughts about life, life issues, and identities. Not least thoughts about the military identity have been articulated. Linda's military identity was and is built around achievement, forward thinking, duty, loyalty, morality, utility, community, collegiality, self-sacrifice, and other military ideals; a kind of military mindset. Despite many years as a civilian, Linda is still struggling with the "military Linda." Some things are very good, other things can cause problems and sometimes it becomes too much of the military. Linda testified:

It took three years to get back on your feet and also accept that the body is... that you need time, alone is not strong, you actually need to flash your vulnerabilities and ask for help. Because I could not handle it physically, it did not work. Also, as a thing, then came this big decision that I had to move to [a new place] without having an identity. Because I have always built my identity around work, studies, achievement. All of a sudden, I'm just a human being. Now I remember one thing too, I remember it so clearly when I met my husband [in a military context]. Then he asks the question like, "Who are you?" Then I start talking about everything I have delivered and he just, "Yes, it sounds very exciting, but that was not what I wanted to know." I just, "Huh?" "No, but who are you?" You know, I had no idea, because that was my way of being. So, this was a huge thing. [In light of a reflective therapy context later in life] But in this safe context then I allowed myself to feel, and then I could process, really, emotionally and also look at these mechanisms that I have to always perform, "What is behind achievement really? Why can I not just go out and walk two kilometres, why must it be ten kilometres? Where does all this come from?"

IP3'S CASE

IP3 did his conscription in the 1970s and embarked on his first deployment fairly immediately thereafter. Then he was stuck. It was not possible to just come home and think, "Now I have done this, now I go on." But instead it was, "When can I look for the next one?" Only after more than 10 years, with almost as many deployments in his backpack, did he finally come home for good. Yet whilst IP3 had come home physically, he still had not come home.

Emptiness always characterized the homecoming, both between the deployments and after the very last. Already after the second deployment in the Middle East, IP3 began to feel that something was wrong with him; he became more withdrawn. But it was one of IP3's parents who later put the finger on it by asking what had happened to him. IP3 wondered what the parent meant, and the parent replied:

That happy, playful, positive IP3 that you have always been, he does not exist, but now it is... now it is sad... and you knot your eyebrows and you are here, but you are not here in any way.

IP3 realized that something had happened, something lingered, and he had no idea what it was, but he could not have it like this. IP3 struggled with strong mood swings and had a short fuse. He struggled with both conscience issues and deep anxiety, relations and relationships dwindled due to his mood. IP3 went to the health care center and received a referral to the psychiatric ward where he received both medication and therapeutic support, but they never processed the military part. IP3 said that the deployments were the best he had done, which did not rule out that there could also be destructive layers. After, it was just out and trying to live and work in civil society with the help of medication and shock therapy that completely missed the military part of his life and trauma.

IP3's life was a roller coaster—the fluctuations in the mood were terribly hard and resulted in a sick leave combined with work. At first he enjoyed his civilian work, but over the years, as his condition deteriorated and anxiety worsened, he grew to dislike it.

Years later, a bit into the 2000s, IP3 contacted healthcare again and mentioned the possibility that he might have PTSD. He was then met with the comment, "That there was no PTSD among Swedish soldiers as they have not been out in any war."

The medication continued and IP3 struggled with life. Thoughts of suicide occurred from time to time, because periodically this was a "devilish time."

Finally, IP3 met an adequate specialist unit in Sweden that specialised in the area of crisis and trauma. After a new medical assessment, the specialist was furious that the medical staff and therapists who had met and treated

IP3 during all these years had not seen and understood that he had PTSD. The specialist said that IP3 had severe PTSD and that so many years had passed that there was simply nothing to do. He could not be cured. Only symptom relief was possible and IP3 must learn to live with PTSD. In light of the diagnosis and the process that then started, IP3 eventually became sick-retired.

Although this made him socially isolated, at the same time, it was a liberation. He moved to the countryside, which gave him self-chosen solitude, silence, and peace. Since childhood, nature had filled him with a kind of life energy. When the anxiety grew strong, IP3 fought his way out into nature, fished, hiked, listened to the birds and enjoyed the peace and quietness—the beauty of nature. He also stopped taking the medication when he came to the country in order to be present in nature. The medication left him in a bubble and floating away from life itself. Now he is present in life and with nature as a source of relief; IP3 seeks to manage his severe PTSD. However, it is not easy. In the yard, in his darker moments, he has already selected a solid branch that will hold his weight.

One of the most taxing moral issues that IP3 must live with relates to his perceived failure as a parent. He testified:

Well, it's like this, my son, he was born [a year], what will he be now... [in his mid-30s]. I have had one Christmas with him all these years and it has been because I have been away so much, I have gone and torn. I have talked to him about this in recent years, that I also have a bad conscience for it, such a terrible bad conscience because I have not been a good father, I have not fathered my son. It was never really planned, but it doesn't matter, because my son has always been welcome, but I have never had peace in my body. I do not say that I have thought of myself in the first place, but it has been this drive inside of me, "out, away, out, away, out." I have a god damn conscience for that.

His military identity will never leave IP3; he is marked for life. Inside his house he has a wall covered with military memorabilia and what concerns him is what will happen to all this when he dies:

I usually think about it when I sit and look at all my memorabilia, I usually think, "The day I die, I wonder what he [the son] does with this then. Does he throw it in the dump or what does he do?" Then I think he probably does not want to deal with this, because all the time I have been away from him. How he thinks about this, I do not know, I must ask him. On the other hand, when I'm gone, I hardly care where this goes.

DISCUSSION

Broadly, this multi-case study aimed to explore Swedish military veterans' experiences related to PTSD, moral injury (MI), and spiritual injury (SI). Specifically, the present study focused on 4 domains (health care, veteran's administration, moral conflicts and injuries, and identities and existential dimensions) that emerged in participants' meaning making as they navigated everyday life. While these domains are distinct from each other, results show health care experiences are typically embedded within veteran's administration, while at times, MI and/or SI appear to be linked to identities and existential dimensions. Hence, the discussion will be organized according to the interrelatedness of these various domains.

HEALTH CARE AND VETERAN'S ADMINISTRATION

In all 4 cases, receiving the PTSD diagnosis served as the gateway for treatment. Whether treatment proved to be beneficial or not varied between participants. In Linda's case she reported struggling through her PTSD symptoms, and eventually recovering from the illness. In Rolf's case his initial help-seeking led to a PTSD diagnosis, which allowed him to receive medication and psychotherapy services. Over time he has developed an openness to these treatment modalities and has come to realize their benefits for himself and others.

However, in David's case, it took multiple help-seeking attempts before he obtained proper care. His scenario points to individual, social, and organizational factors that functioned as roadblocks or open doors to healthcare services. For example, David sought medical help during the early phase of his (still undiagnosed) illness, but the healthcare provider he met failed to recognize PTSD and even went on to state that it is not applicable to Sweden and its military force. More than a decade later and with the encouragement of his partner, David once more sought medical help with mixed results. On one hand, the healthcare provider was more familiar with PTSD, which unlocked the door to medical services. On the other hand, the treatment led to the worsening of symptoms leading David to drop out completely. Several years later and with the help of a fellow veteran, David was able to receive long-awaited help at a newly opened veteran clinic. In David's scenario it took several of his social networks (domestic partner, fellow veteran) coupled with a military-culturally competent healthcare provider and system before finally receiving the appropriate care.

IP3's case is similar to that of David's, whereby several attempts were needed to finally obtain proper care. His initial help-seeking attempt was successful in that he was able to obtain medication and psychotherapy.

However, in his therapeutic sessions, the full experience of a military deployment, which reflects both exhilarating and debilitating effects, were not discussed because IP3 reported the deployment as a positive experience. He managed and struggled through several years, all the while receiving medication and shock therapy (in the aftermath of the psychotherapy). He subsequently attempted to raise the possibility of a PTSD diagnosis only to be met with a healthcare provider who denied the existence of the illness among Swedish soldiers who have not been to war. The third and final health-seeking attempt resulted in a trauma care specialist recognizing severe and incurable PTSD symptoms. This prognosis allowed IP3 to be medically retired and pivot to a new life in new surroundings. For him this meant living in the countryside where he is able to engage in activities that help him manage his symptoms (e.g., hiking, fishing) without medications.

In all these cases, coming into contact with a clinician familiar with PTSD was critical. However, when dealing with military veterans, clinical competence is not enough: clinicians need to demonstrate an additional type of competency that accounts for military culture.

Simply put, "military cultural competence pertains to a provider's attitudinal competence, cognitive competence, and behavioral competence in working with service members and veterans" (Atuel & Castro, 2018, p. 77). This means that healthcare providers must be aware of their own biases about the military (attitudinal), knowledgeable about military structure, norms, and identities (cognitive), and possess the skillset for assessing and treating service members and veterans (behavioral; see Atuel & Castro, 2018). The relative lack of military-culture competency can be clearly seen in David and IP3's cases, where the clinicians stated that Sweden does not have PTSD cases, particularly among its military force owing to the absence of war experiences.

This line of reasoning begs the question of who qualifies to receive a PTSD diagnosis? Research has already shown that while PTSD can stem from combat experiences, PTSD can also be found among military personnel who have not had combat experiences (Macia et al., 2020; Thomas et al., 2017). Outside of war experiences, deployment-related trauma and PTSD has been argued and found to be a significant and pervasive challenge across various NATO and other European countries with active military engagement (Yehuda et al., 2014). Moreover, deployment can be riddled with veteran paradoxes (Castro et al., 2015), where a single experience can be described simultaneously as being the best (e.g., I am home again with my military buddies) and worst (e.g., I am away from my partner and children) thing that has ever happened to a military veteran. Knowing and addressing the unique challenges of military life—its cycles and rhythms in peacetime and

war, the transition timepoints and associated stressors—is also part of military cultural competency (Atuel & Castro, 2018). Failure to address the nuances of military life in a therapeutic setting is a disservice to military veterans, as shown in David and IP3's cases from the present study, further reinforcing the military-civilian divide. The onus to close this cultural gap is on healthcare professionals who are working with military veterans.

IDENTITIES, MIS, AND SIS

Above and beyond PTSD, all 4 cases reported the persistence of the (past) military identity, and its centrality in defining the self. In addition, some have reported moral and spiritual injuries, which are distinct, but interrelated to each other and the self-concept.

The Veteran Identity

For Rolf he could be wearing civilian clothes, but his military identity is salient across time and in various contexts. It is not “turned off.” In addition, his military veteran network is an important source of identity as well as emotional and social support. Similarly, David's military identity continues to be central to his self-concept. He has maintained strong ties to the veteran community, and considers this collective a safe haven compared to his civilian family and community. For IP3, he described his military identity as marking him for life. A wall inside his house is dedicated to his military memorabilia.

However, Linda's case is similar and different from the other 3 cases: similar because of the shared military identity, different because she is a woman. Like her male veteran counterparts, the military identity continues to be quite salient for Linda. In fact, she has a side of her that is the “military Linda” built around values, norms, and achievements typically prized in the military. On one hand, this mindset has served her well in her military-civilian transition, providing her with a framework to operate and navigate through civilian life. On the other hand, she has come to realize that she is simply a “human being” apart from the “military Linda”—a member of a superordinate category (e.g., human race) that appears to be devoid of uniqueness and belongingness.

As a woman veteran, Linda's military identity intersects with her female identity. While on active duty, this intersectional identity was experienced as having no place in military life because the female identity was devalued, marginalized, or ostracized; only the military identity mattered (e.g., Badaró, 2015; Burkhart & Hogan, 2015). As a woman veteran living in a civilian community and as part of her personal growth, Linda has slowly cultivated her female identity and let it be known in this non-military space.

The military-civilian transition process is more than a physical crossover from the military to the civilian world. It is also a social transition where people learn or relearn

civilian norms and values (see Hollingshead, 1946). And one of the most critical questions that need to be answered is, “who am I now?” *Who is the military veteran?*

For our purposes, we adopt Atuel and Castro's (2016, 2018) definition of veteran identity as past military identity operating in present civilian space and time. This means that when service members transition out of the military, their military identity is brought to bear on their civilian life. Again, borrowing from the typology of veteran identity (Atuel & Castro, 2019), some veterans have been categorized as *dogmatic veterans* or *reluctant civilians*, which occurs when civilian life and identity is perceived or experienced as less meaningful to military life and identity. It is this type of veteran that seems to fit the pattern of results for the four cases. For Linda, however, her female identity is seemingly becoming more salient over time in civilian spaces. Stated differently, the female identity devalued in the military context is possibly experienced as a source of esteem in the civilian context.

Moral and SIs

In Rolf's case, his MI revolved around the guilt of a fallen battle buddy. Through therapy he has come to accept responsibility for the death of another person. Whether he caused it or not is unclear, yet he clings to the perceived guilt associated with another person's death. To let go of the guilt does not make sense because to do so means he is lying to himself. His decision to stay true to himself is at the cost of living with guilt.

For David, his MI centered on acting on information that resulted in the death of a young person. In the aftermath, rumination has led to questions of “what if” as well as having done right or wrong. It becomes more complex, from his own admission, because he has engaged in perspective taking that has led him to see himself as a parent. In addition to MI, David is experiencing SI. He questions the goodness and subsequently rejects an almighty Being based on the perception that negative outcomes could have been prevented with some divine intervention. For IP3, his MI revolves around his failure as a parent. He acknowledges not being there for his son, except for one Christmas. Thoughts of not being a father, let alone a good father, are the basis for his tormented conscience.

In all 3 cases, it becomes apparent that MI pertains to the perception and/or experience of moral failure that reflects combat and/or noncombat events (see Atuel et al., 2021). Moreover, it is relational (e.g., Yandell, 2019) in that there is a subject-object relationship related to the moral failure. Specifically, the MI depicted in these cases describe failure to do the right thing at a particular (or over) time and place(s) towards another person—a battle buddy, a stranger, a family member. Moreover, in David's case, the MI is directly linked to a spiritual injury where there is an outright rejection

of a higher being. Again, a severing of a relationship with an other. From their own admission, it is these MIs that are more painful to bear compared to the PTSD symptoms.

In sum, these cases suggest that MIs and SIs can be related to the participants' time in the military as well as to events outside of that timeframe (i.e., civilian life). Hence, in healthcare settings, we suggest a wider focus that accounts for the continuity of experiences and fluidity of identities across the military and civilian spheres to fully address struggles beyond clinical PTSD symptoms. We also suggest that veterans grappling with moral or spiritual conflicts, which over time can develop into injuries, are perhaps engaged in a longer cognitive and emotional rumination and reflection process. In other words, the meaning making involved in the moral and spiritual issues of life in general, may require addressing specific moral and spiritual failures that occurred in various areas (e.g., military, civilian) over one's lifetime (e.g., past, present). With a growing moral and spiritual awareness there is also a greater sensitivity to such issues. As such, screening for moral and spiritual conflicts and injuries should not only be a golden standard in the health care setting, it should also be conducted among service members after deployment as part of prevention and early intervention efforts (Grimell & Nilsson, 2020; Koenig et al., 2018).

LIMITATIONS AND DIRECTIONS FOR FUTURE RESEARCH

There are several limitations to this study, which should be taken as directives for future research. First, while this multi-case-study approach allowed for a deeper exploration of subjective experiences, the small sample size renders these experiences unique to the participants themselves and not necessarily representative of the military veteran population in Sweden and in other countries. However, given that the life narratives yielded themes that were applicable to all (e.g., saliency of past military identity), most (e.g., MI) or few (e.g., SI) suggest commonalities and differences in experiences across the military veterans in the study. Future research should examine the applicability and utility of these themes in the narratives of other military veterans diagnosed with PTSD. In addition, the qualitative results provide several domains that can inform quantitative measurement development encompassing several subscales that include MI, SI, and identity.

Second, that all 4 military veterans were diagnosed with PTSD yet reported identity and S/R struggles above and beyond PTSD indicates that a particular traumatic event can activate trajectories that are not necessarily clinical in nature. In other words, existential and S/R domains (non-clinical) seemingly coexist with PTSD (clinical). Hence, future research should consider a dual pathway model (Atuel et al., 2021;

Barr et al., 2022) or a bio-psycho-spiritual approach (Grimell, 2016, 2019, 2020b) to understanding PTSD and/or MI.

Finally, because the veterans in our sample had mixed experiences with the healthcare system, future research could use a case-control study design that compares veterans receiving PTSD care versus not receiving PTSD care (control group) within the healthcare system to examine the trajectory and related outcomes of PTSD. Another avenue of research could be a mixed-method case comparison study of veterans with PTSD and receiving care from mental health clinicians, community-based peer supports, or religious/spiritual persons. In this study, quantitative measures that capture MI (e.g., Bryan et al., 2016; Koenig et al., 2018; Litz et al., 2022), SI (e.g., Berg, 2011), and identity should be included to assess the unique and interactive effects of the various treatment modalities. In doing so, we are able to identify programmatic sectors needed for a holistic approach to PTSD.

FINAL REMARKS

Living with PTSD has been a struggle for veterans in the present study, as well as for other military veterans in various parts of the world (Yehuda et al., 2014). Beyond PTSD, results of the current research illustrate veterans' struggle with identity, MI, and SI, which are experienced to be more painful than the PTSD symptoms. The argument can be made that the reported intensity of these nonclinical domains reflect broad existential concerns that are part and parcel of what it means to be a human being (see experimental existential psychology, Pyszczynski et al., 2004; see meaning making, Frankl, 1972; see existential psychotherapy, Yalom, 1980). Questions of identity (e.g., who am I?), morality (e.g., how do I become good?), and spirituality (e.g., does a higher being cause people to suffer?) are not pathological by nature, but have been argued to be fundamental to an individual's *raison d'être* or search for the basic conditions of human existence (Greenberg et al., 2004; Pyszczynski et al., 2015). That they coexist with PTSD should not come as a surprise. However, these existential concerns are perhaps amplified in the co-occurrence of PTSD. In other words the presence of a clinical disorder intensifies an individual's search for identity, morality, and spirituality. The question then becomes who is responsible for helping veterans navigate through their existential struggles?

Earlier we introduced a holistic bio-psycho-social-spiritual approach (Berg, 2011; Grimell, 2016, 2019, 2020a; Smith-MacDonald et al., 2018) to the treatment of PTSD. This could be a multidisciplinary team (e.g., clinician, chaplain, and veteran peer) working together in a formal treatment setting. Or strengthening the various social networks (e.g., family; Atuel et al., 2016), or informal groups military veterans

are already part of or embedded within (e.g., veteran peer groups; Demers, 2011). Rather than seeing these approaches as adjunctive to clinical treatment, perhaps it is time to muster the people and resources needed for military veterans to answer the more pressing existential struggles.

DATA ACCESSIBILITY STATEMENT

The authors will make the data and materials that support the results or analyses presented in the paper freely available upon request.

NOTE


- 1 The prevalence of PTSD and PTSD symptoms among Swedish military veterans is not fully surveyed yet. A large, scaled survey is planned over the year to come. The Swedish Armed Forces Veterans Center has estimated the incidence within the veteran population to 1–5% in recent email communication (Grimell, 2022). The incidence of clinically diagnosed PTSD among Swedish military veterans is about 1% (Grimell, 2023).

COMPETING INTERESTS

The authors have no competing interests to declare.

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TO CITE THIS ARTICLE:

Grimell, J., & Atuel, H. R. (2023). Beyond PTSD: A Multi-Case Study Exploring Identity, Moral Injury, and Spiritual Injury. *Journal of Veterans Studies*, 9(3), pp. 9–22. DOI: <https://doi.org/10.21061/jvs.v9i3.436>

Submitted: 01 March 2023 **Accepted:** 19 June 2023 **Published:** 31 July 2023

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