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MACDONALD FRANKLIN OSI RESEARCH CENTRE
LAWSON HEALTH RESEARCH INSTITUTE

Disclosure of Moral Injury

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EHN Webinar - September 2, 2021

St JOSEPH's HEALTH CARE LONDON

Western UNIVERSITY · CANADA

Conflict of Interest Statement

No conflict of interest.

Perceived conflict of interest:

- Co-founder of 

(www.participaid.co), platform used to recruit participants for some of the studies mentioned in the presentation. No person, nor organization received any financial remuneration for the use of this platform for these studies.

Outline

1. Military mental health
2. What is moral injury?
3. Why is it important?
4. What are the gaps?
5. Treatment-seeking barriers
6. Confidentiality and moral injury
7. Our findings
8. Future directions

The pendulum of the mind oscillates between sense and nonsense, not between right and wrong.

— Carl Gustav Jung

Canadian Armed Forces

67,492 active RegF personnel
36,381 active Primary ResF personnel

629,300 veterans (1.7% of population)

deployments include[1]:

- Iraq
- Haiti
- Congo
- Egypt
- South Sudan

NOW: 2000 deployed on approximately 20 missions

OSI in the CAF

Canadian Forces Mental Health Survey[2,3]

	2002	2013
Any selected mental or alcohol disorder	15.1%	16.5%
MDD	7.6%	8.0%
PTSD	2.8%	5.3%
Generalized Anxiety Dis.	1.8%	4.7%
Social Phobia	3.6%	N/A
Panic	1.6%	3.4%

OSI in the CAF

Canadian Forces Mental Health Survey[2,3]

	2002	2013
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Social Phobia	3.6%	N/A
Panic	1.6%	3.4%

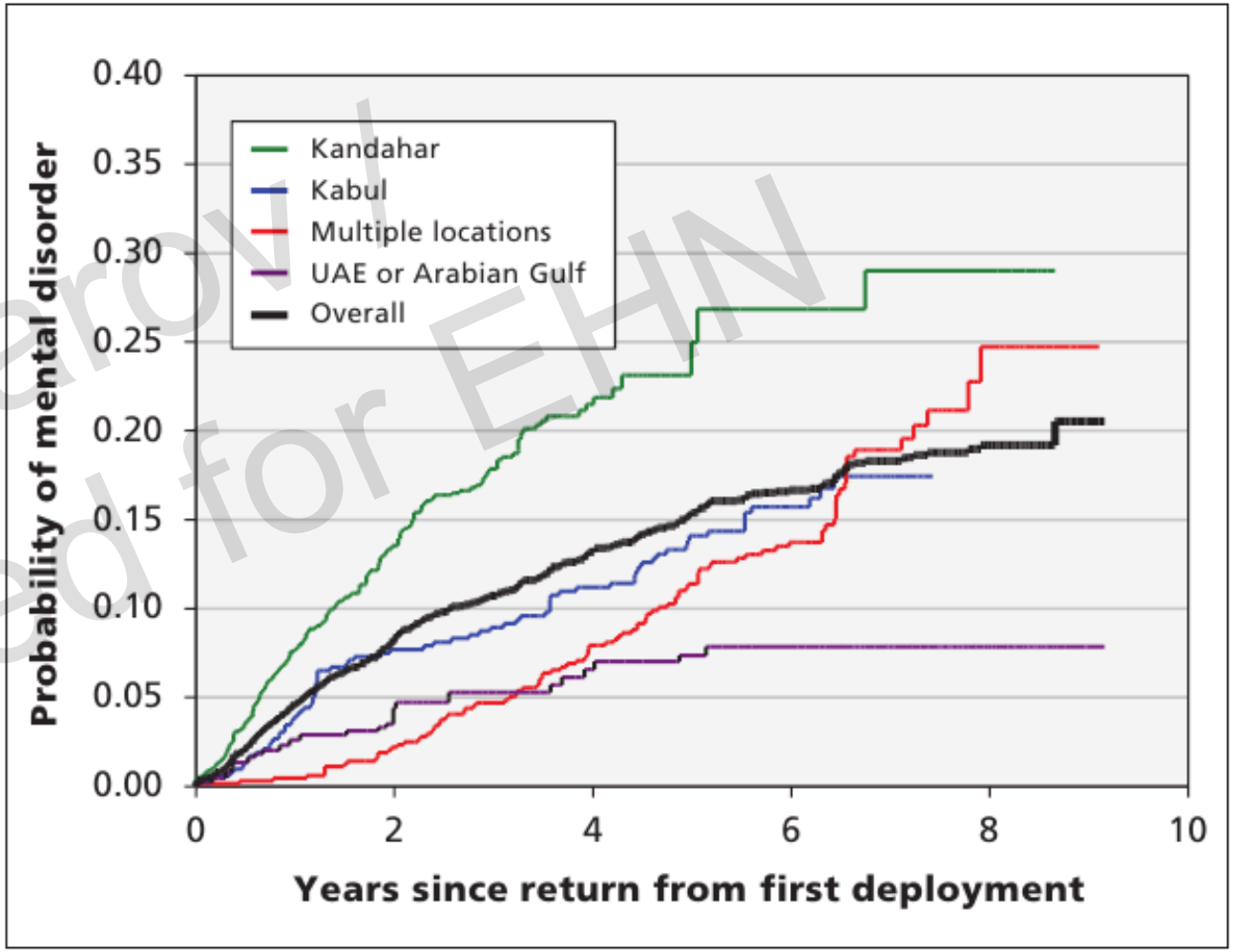
- **41%** of medically released suffered from OSI[4]
- **30%** seek mental health services after deployment[5]
- **2x** rate of suicides in released CAF personnel *vs.* civilian (25 y.o. & under)[6]
- **70%** of active personnel suicides are 29 years old or younger[32]

OSI in the CAF

- 13% received OSI during Afghanistan service[5]
  - 8% PTSD
  - 25% PTSD (combat heavy-zones)
  - 6% MDD (60% co-morbid)

- Compared to civilian population:
  - 10% lifetime prevalence of PTSD[21]
  - 2.5% point prevalence of PTSD[21]

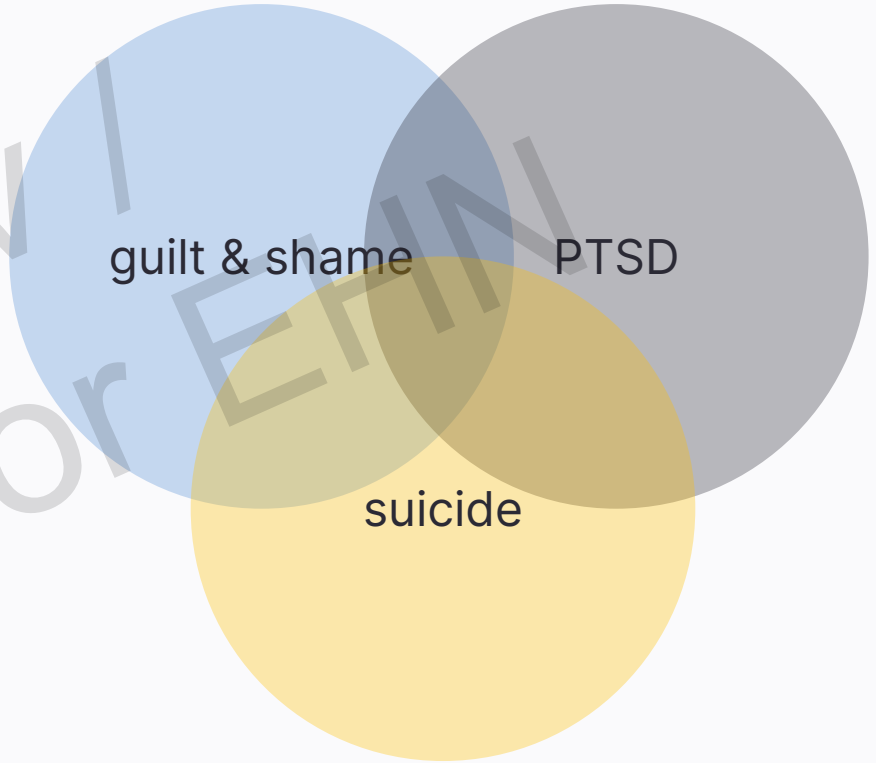
- 20-30% lifetime prevalence of PTSD of CAF combat personnel[21,22]



Guilt / Shame / PTSD overlap

guilt and shame are widely reported in PTSD[23–25]

both linked to suicide and suicidal ideation in military samples[10-12]

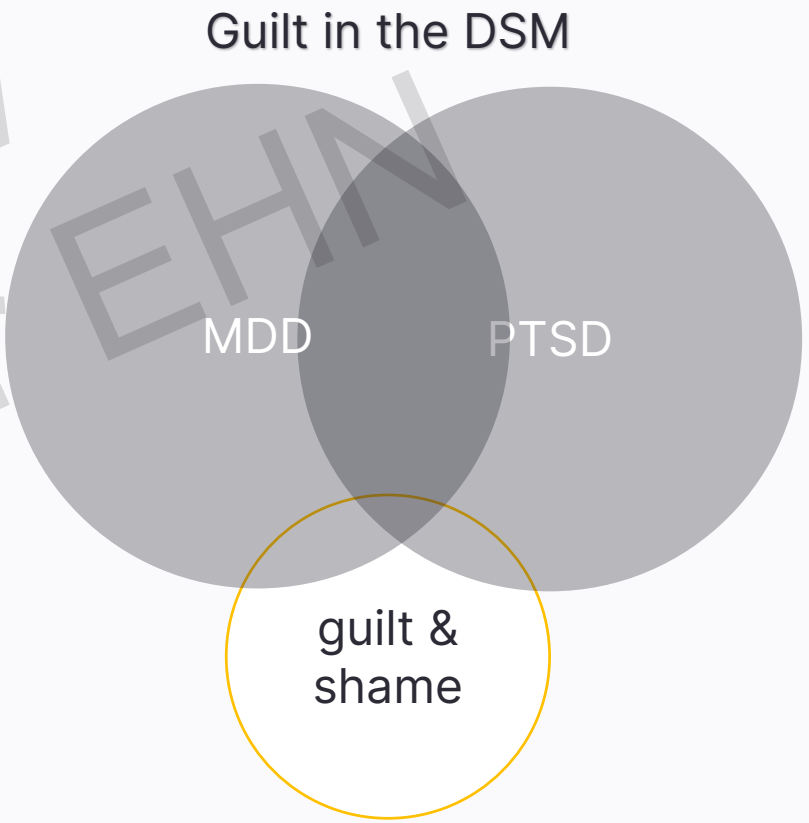


Guilt & Shame

common

complex cognitive and emotional experiences[37]

arise when one perceives their behaviour to transgress an **internal moral standard**[38]



Guilt / Shame / PTSD overlap

guilt better predictor of PTSD Sx than degree of combat exposure[24]

lower guilt cognitions associated with PTSD resilience[59]

shame symptoms temporally tied to PTSD onset[25]

combat-related guilt better predictor of suicide than PTSD or MDD severity [27,61,62]

Biomarker overlap[63,64]

Guilt / Shame / PTSD overlap

For some, guilt & shame could be at the core of their distress.

Broken heart vs. racing heart

shame and guilt [45-52]

evaluation of:	self	behaviour
due to:	personal inadequacies	context
rigidity:	stable over time	dynamic
future:	cannot be changed	reparation is possible
affect:	worthlessness powerlessness inferiority	tension regret remorse
psychological distress:	inward	outward
behaviour:	avoidance withdrawal	approach-and-amend
	self-condemnation	self-forgiveness

↑ empathy[51]
↑ ToM[50]

shame and guilt [45-52]

MH outcomes:

MDD[54]
PTSD[55]
GAD[56]
suicidal ideation[57]

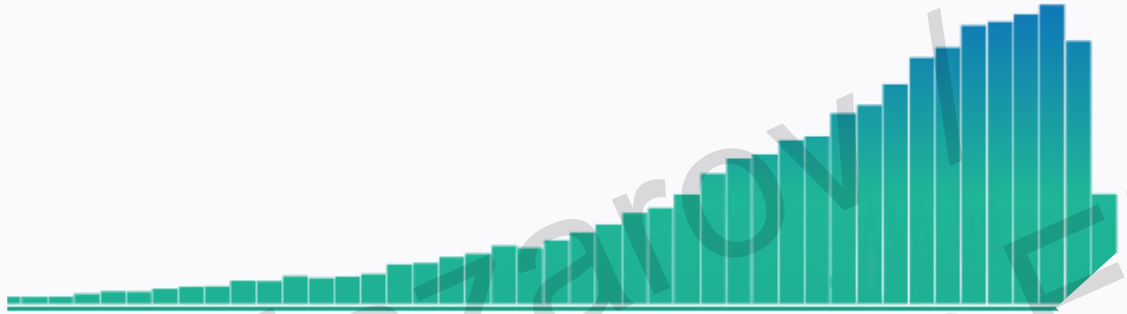
*only when paired with shame[49,58]

maladaptive guilt

adaptive guilt

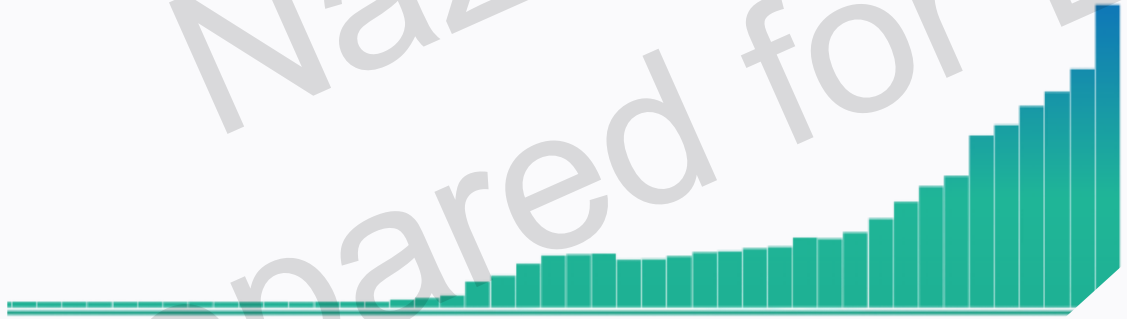
MEDLINE search hits

36,357 results



Moral Injury

39,177 results



Telehealth

1970

2020

Definition is unclear

Psychology Philosophy Social Work Spirituality

Richardson, N., Lamson, A., et al.
Defining Moral Injury Among Military Populations: A Systematic Review. (2020).
Journal of Traumatic Stress.

Psychological distress
character wound
spiritual wound
“undoing of character”
Intrapersonal crisis

– Shay, 1994, Nash and Litz, 2013

in response to the

perpetration of
bearing witness to
failure to prevent
learning about

– Drescher et al., 1994

…

… any event that transgresses

Deeply held personal beliefs
subjective moral standards
one’s belief about “what’s right”

– Litz et al., 2013

Betrayal:

“betrayal of justice by a person of authority in a high-stakes situation”

– Shay 2014

Moral Injury

Psychological manifestations include, but not limited to:

- Alterations in self-perception
- Alterations in moral thinking
- Relational impacts
- Emotional aftermath
- Self-harm
- Spirituality

But also... symptoms of PTSD

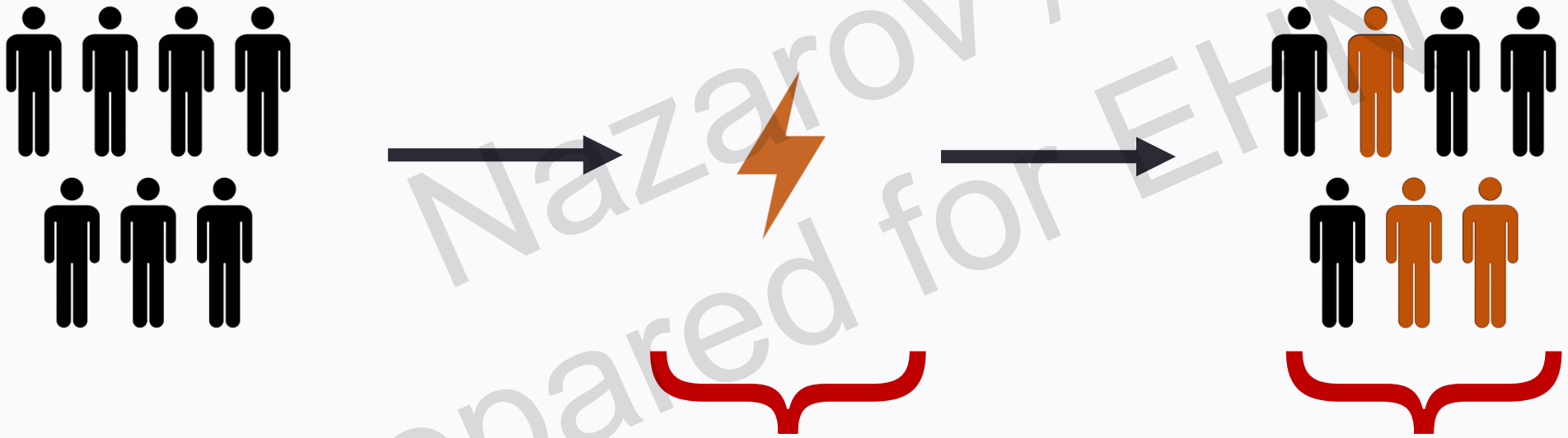
Psychological Trauma
(PTSD Criterion A)

PMIE

Potentially morally injurious experience

PMIE

Potentially morally injurious experience



Moral Injury

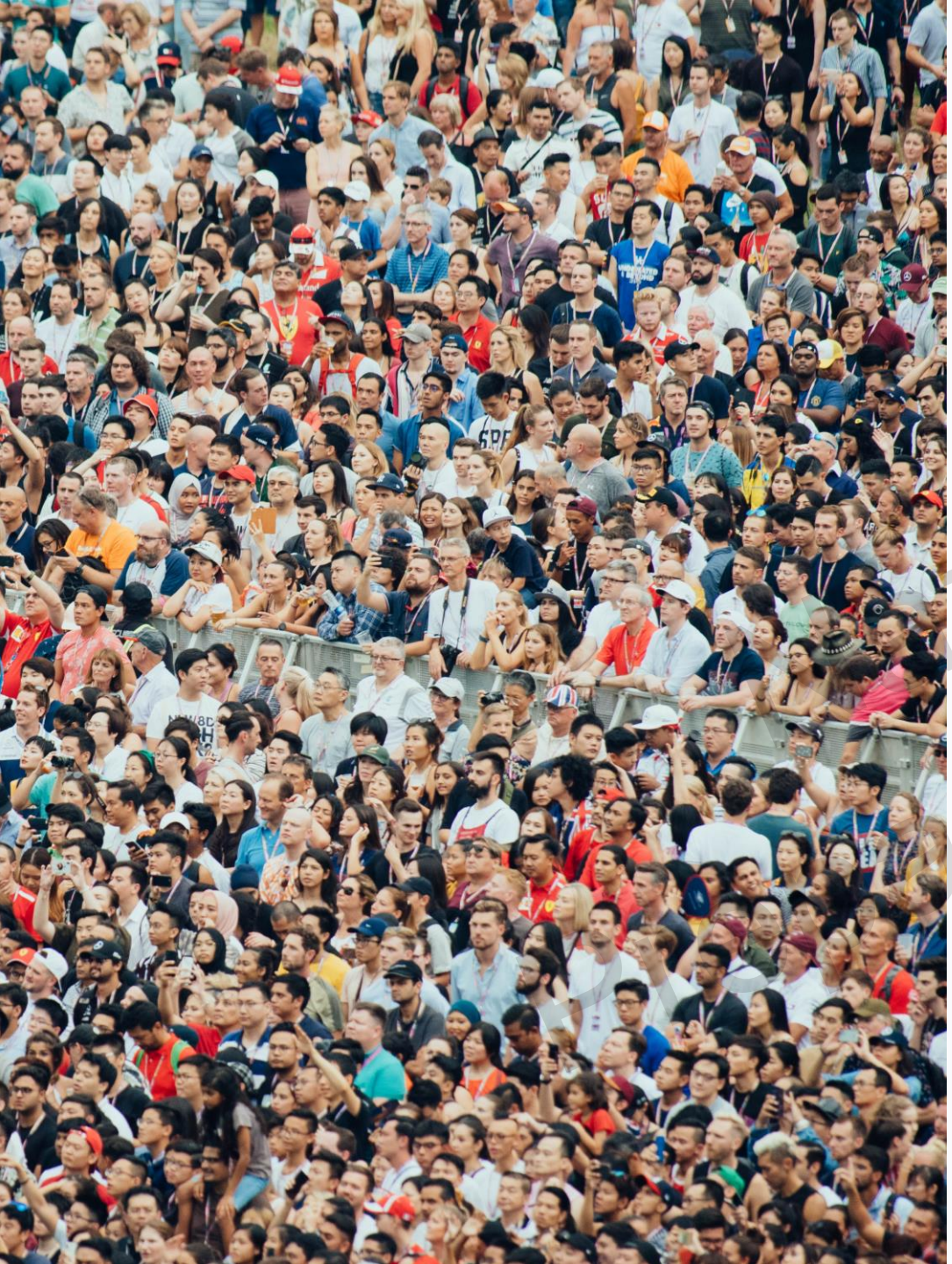
Evolving construct

Currently, not a mental health diagnosis

- Classic PTSD symptoms and outcome measures do not capture all symptoms commonly associated with moral injury
- PMIE may not always meet PTSD Criterion A / psychological trauma

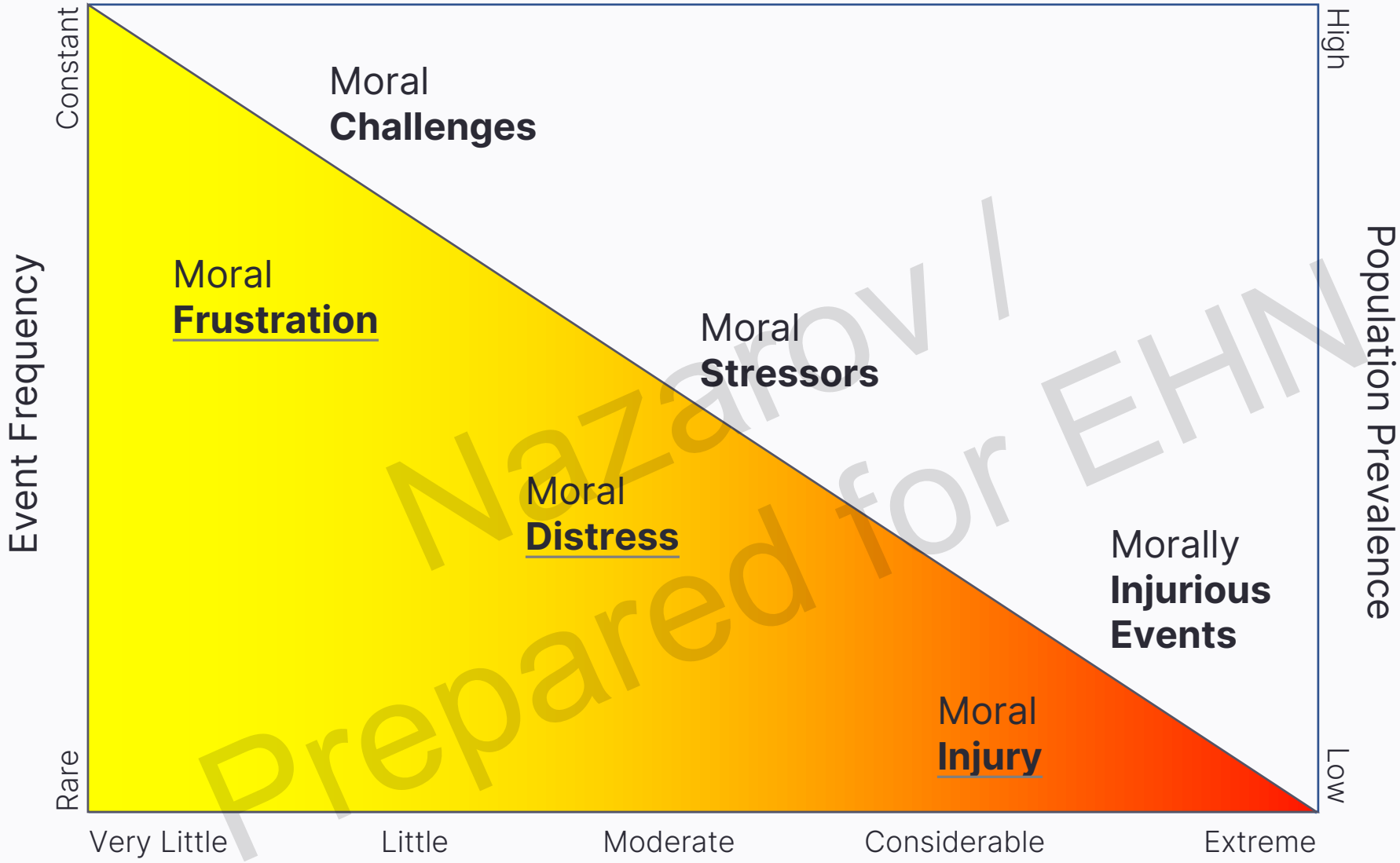
Dichotomy in the debate

- For some, it's a term that "finally describes the essence of their struggle"
- From other perspectives, it may be a subtype of PTSD
- Whether moral injury is a construct independent of PTSD is still under debate (many signs point to yes…)

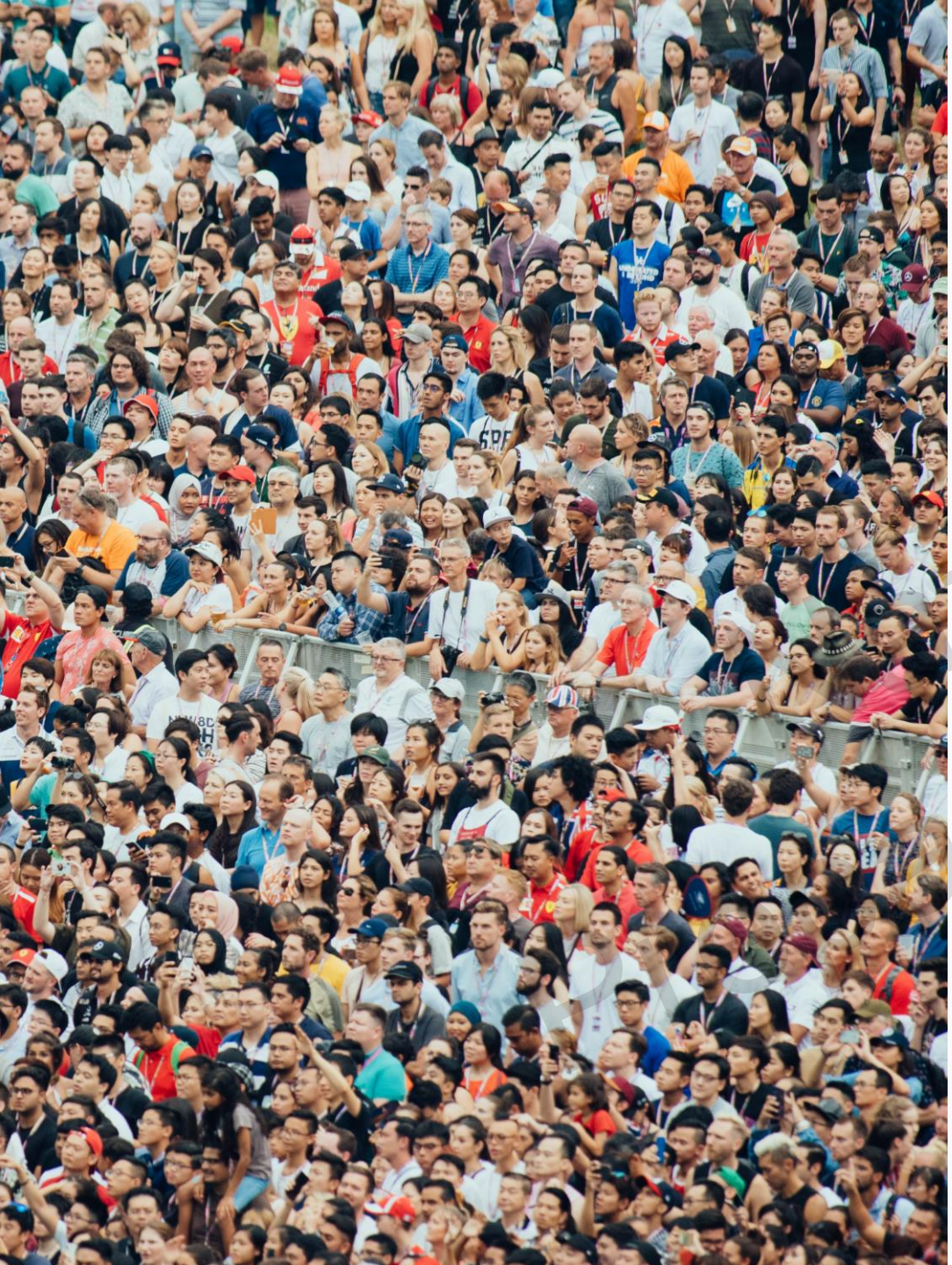


Who can be impacted?

Everyone.



- Litz & Kerig, 2019



Who can be impacted?

Individuals who need to make difficult, moral-ethical decisions in high-stakes environments.

Military personnel
Health care workers
First responders
Legal

But no one is off limits...

Why is it important?

Common

Linked to poor outcomes

Difficult to treat

It’s common

- Guilt and shame are widely reported in PTSD
- PMIEs are common
  - Over 50% of CAF personnel deployed to the mission in Afghanistan endorsed a PMIE – Nazarov, et al., 2018

Exposure to events that may trigger MI are common in military environments

- Today's operations **go against schematic beliefs about warfare**:
  - Urban warfare
  - Unmarked enemy
  - Enemy deliberately plays against ethical standards
  - Combat, humanitarian aid, stabilization – all in one

"One of the consistent facts of wars is that they place people in terrible, often life-threatening situations that are shaped by conditions beyond their control. These situations can force people to make difficult choices between undesirable alternatives." (Schulzke, 2013)

Nazarov, Fikretoglu, Liu, Thompson, Zamorski (2018)

POTENTIALLY MORALLY INJURIOUS EVENTS (PMIEs) IN DEPLOYED CAF	% of pop	95%CI
Seen ill or injured women or children who you were unable to help	42.6	(41.1–44.2)
Ever felt responsible for the death of Canadian or ally personnel	7.4	(6.6–8.2)
Had difficulty distinguishing between combatants and noncombatants	38.4	(36.8–40.0)
Any PMIE	57.7	(56.1–59.2)

OP LASER…

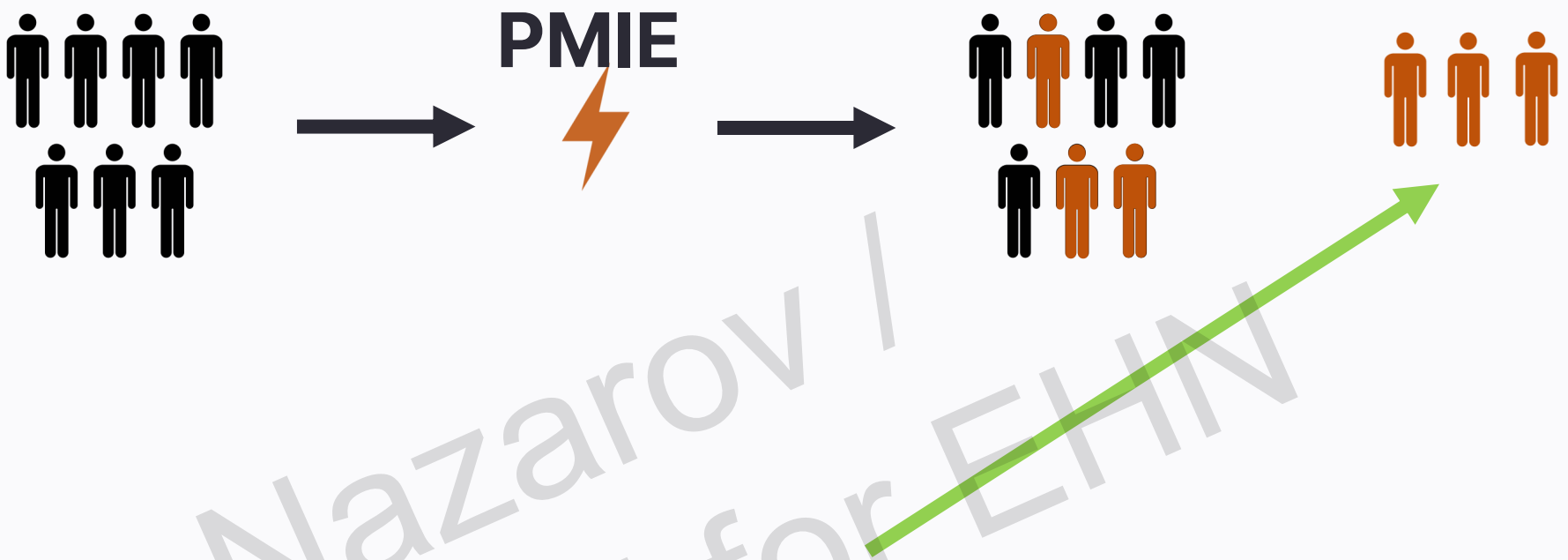
Linked to adverse mental health outcomes

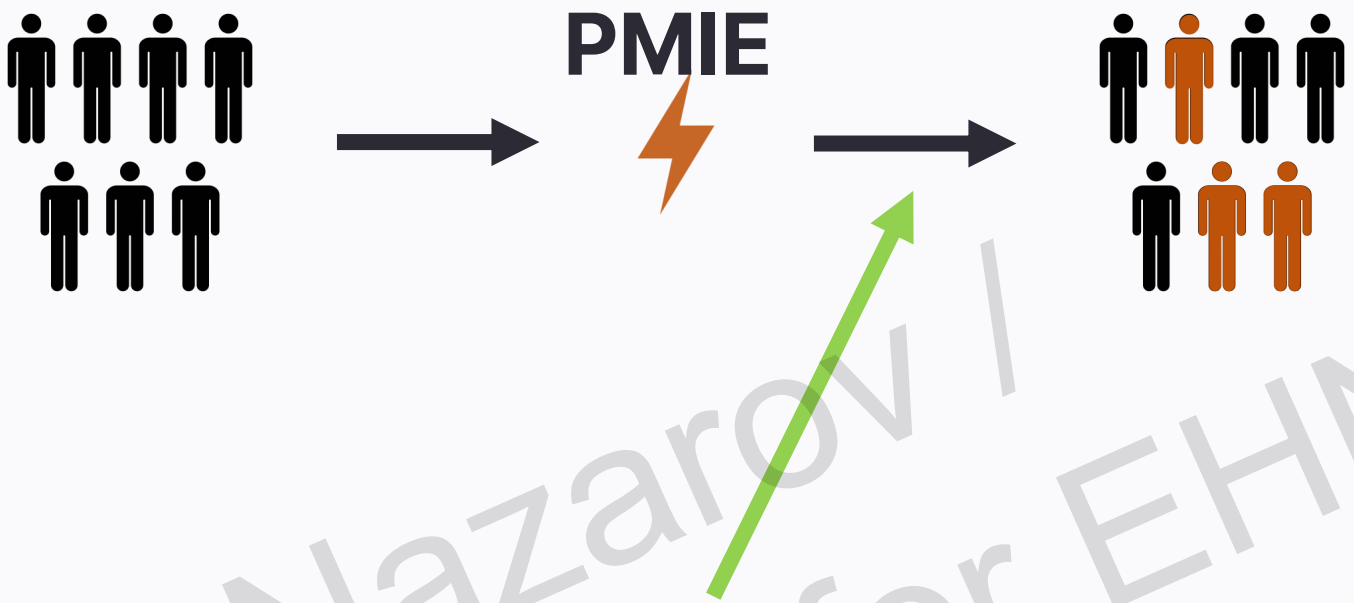
- Guilt better predictor of PTSD symptoms than degree of combat exposure
- Shame symptoms temporally tied to PTSD onset
- Canadian military context:
  - Those endorsing PMIE were 1.5-2.9x more likely to have 12-M PTSD – Nazarov, et al., 2018

Challenging to treat

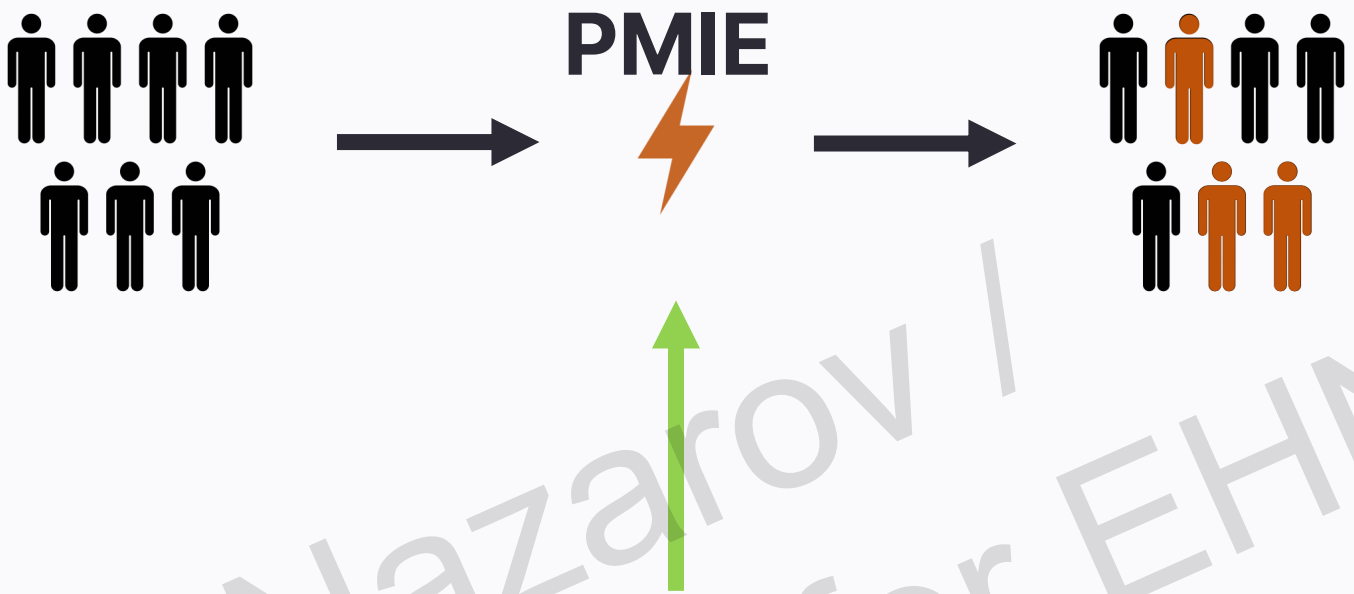
- Current/typical/common PTSD treatments may not be appropriate or effective
- Barriers to care
  - CAF pers with PMIEs are 2x more likely to seek help from civilian healthcare providers. – Nazarov, et al., 2020

What can we do about it?
Where do we go from here?

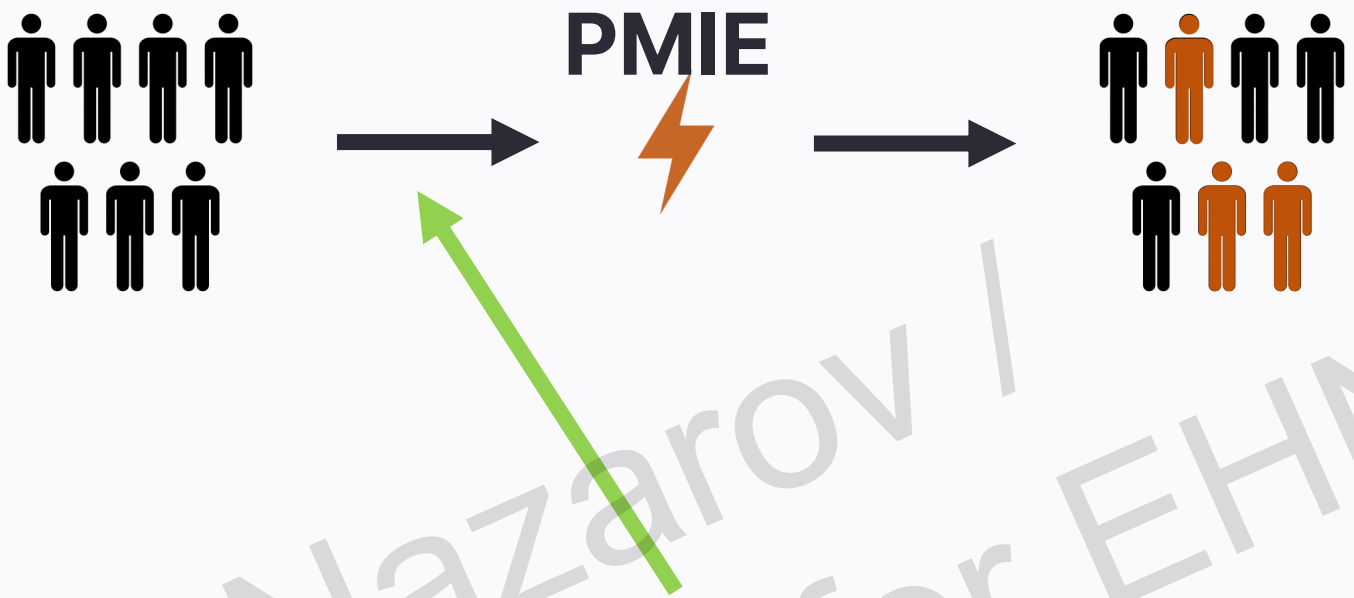




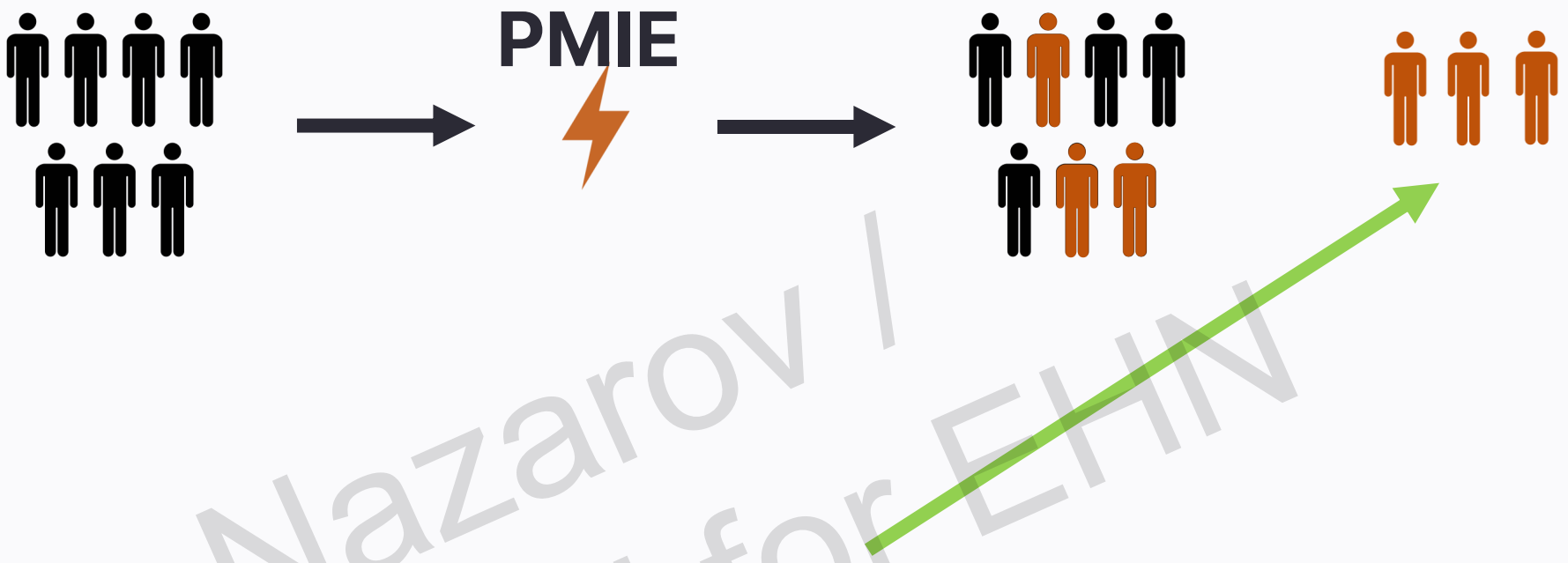
Prevention: Early Intervention



Prevention: Avoid Exposure



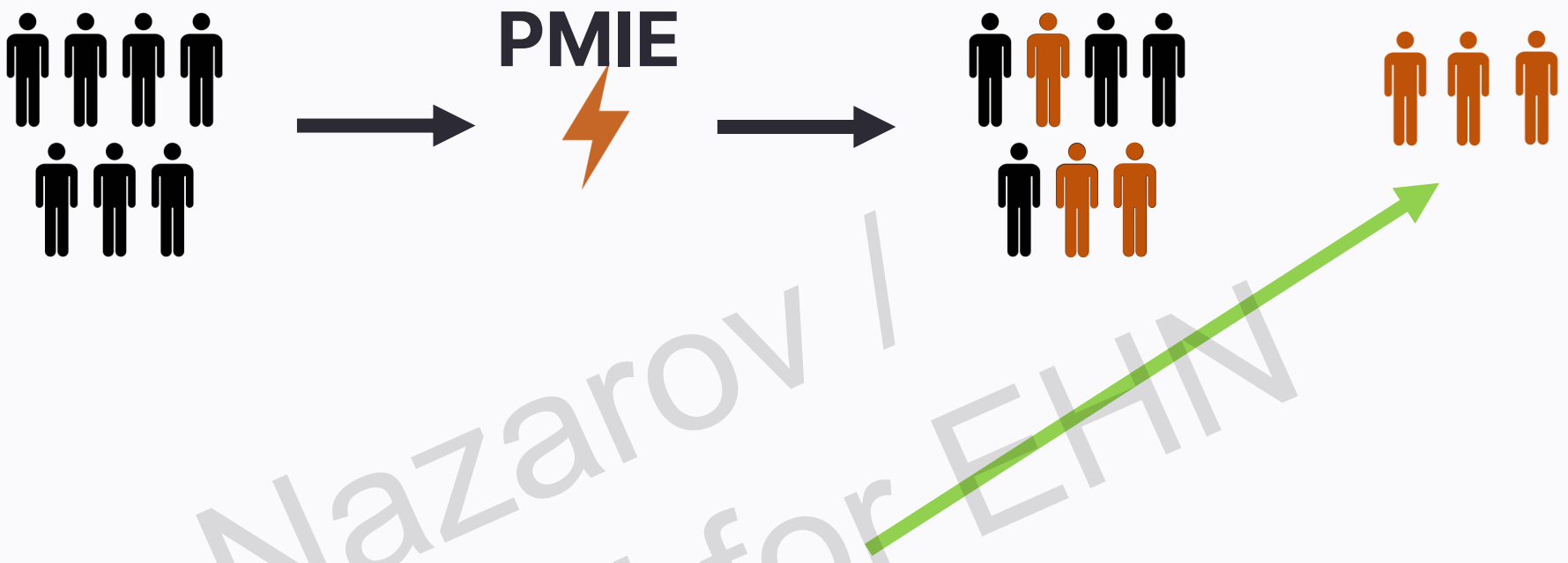
Prevention: Prepare



Challenges and gaps

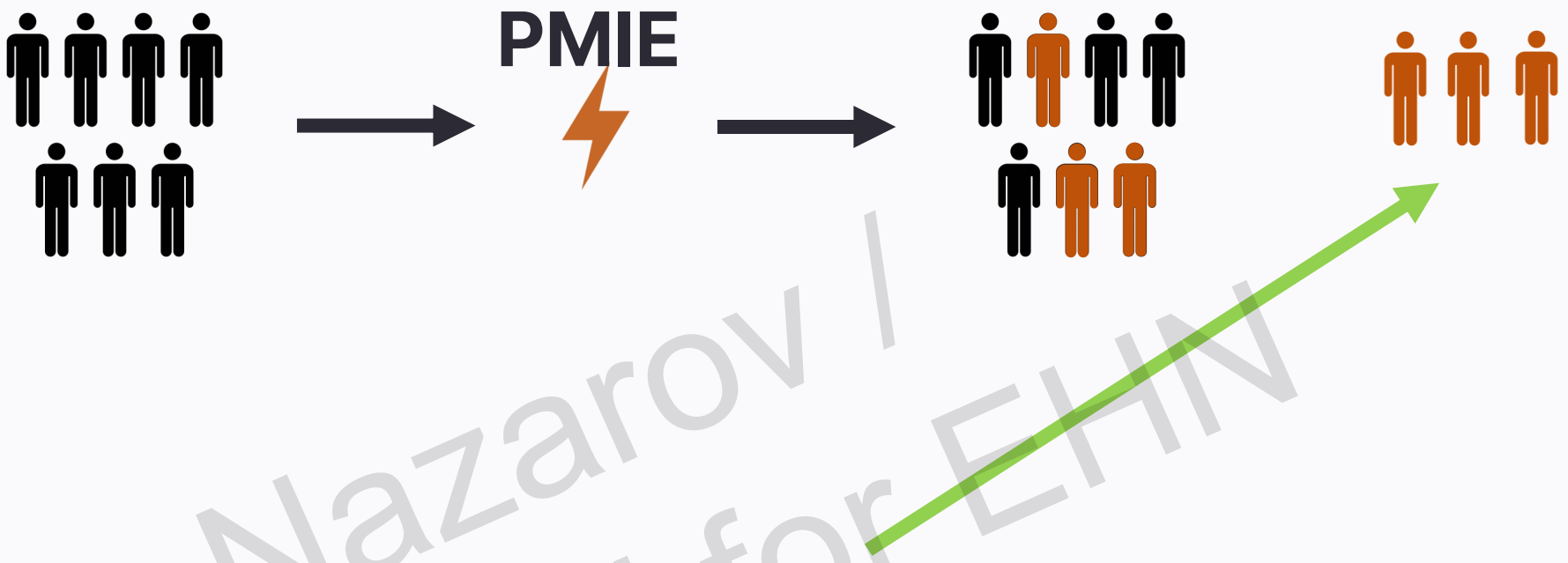
1. No valid method to **capture/assess** moral injury. **We need to know who to treat, and whether the treatment is effective.**

Moral Injury Outcome Scale
(Litz, Plouffe, Nazarov, et al., submitted)



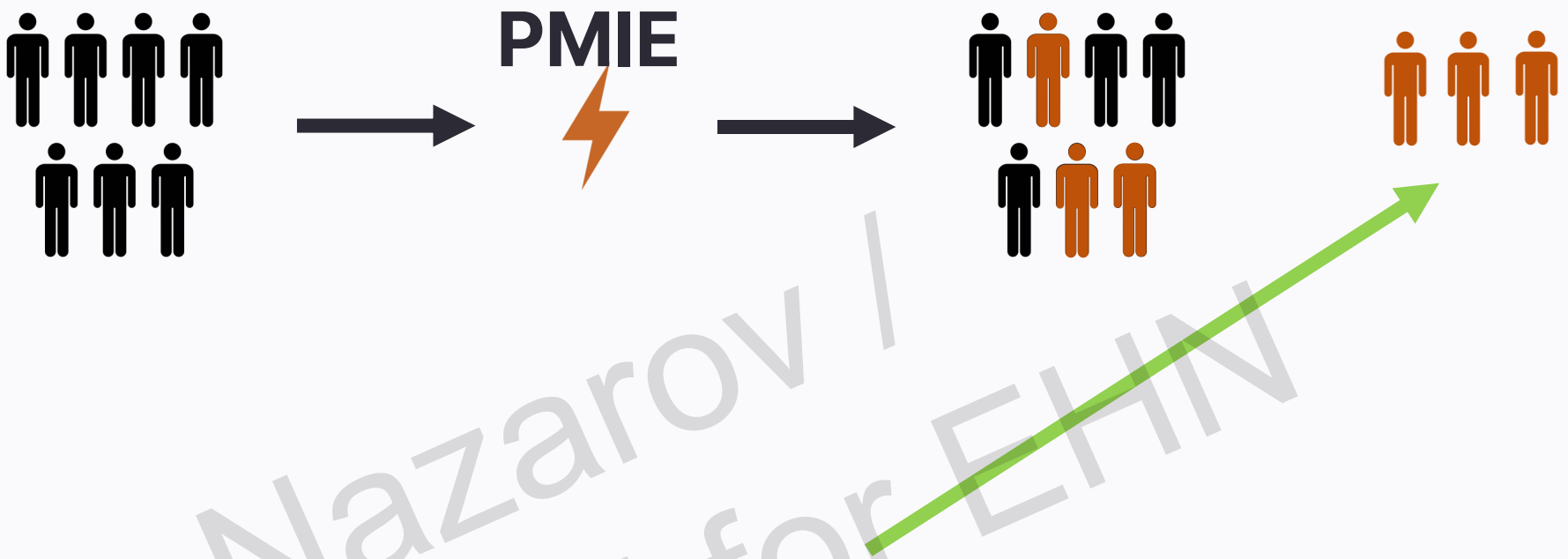
Challenges and gaps

2. Ambiguous treatment targets and outcomes.
Identify targets and measure outcomes.
Promising interventions are already being evaluated (meaning-making, adaptive disclosure).



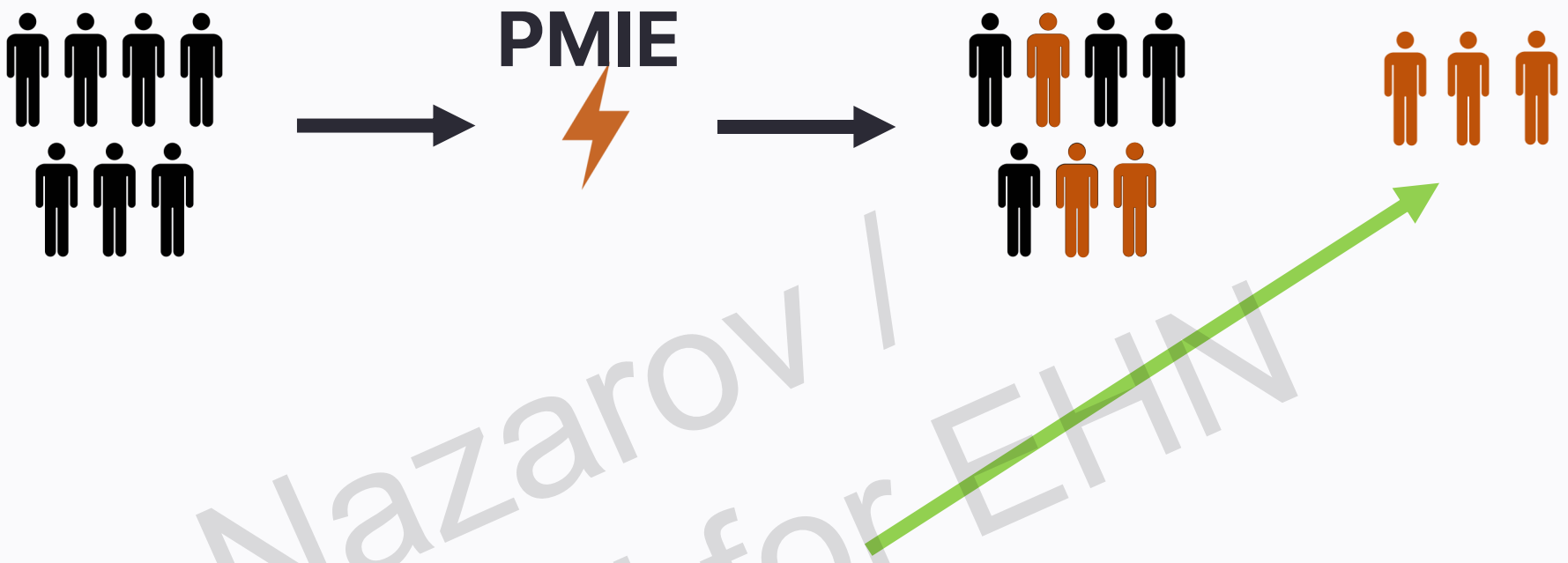
Challenges and gaps

3. **Treatment coverage**
   Requires a diagnosis.
   How to provide help to those who need it **now**?



Challenges and gaps

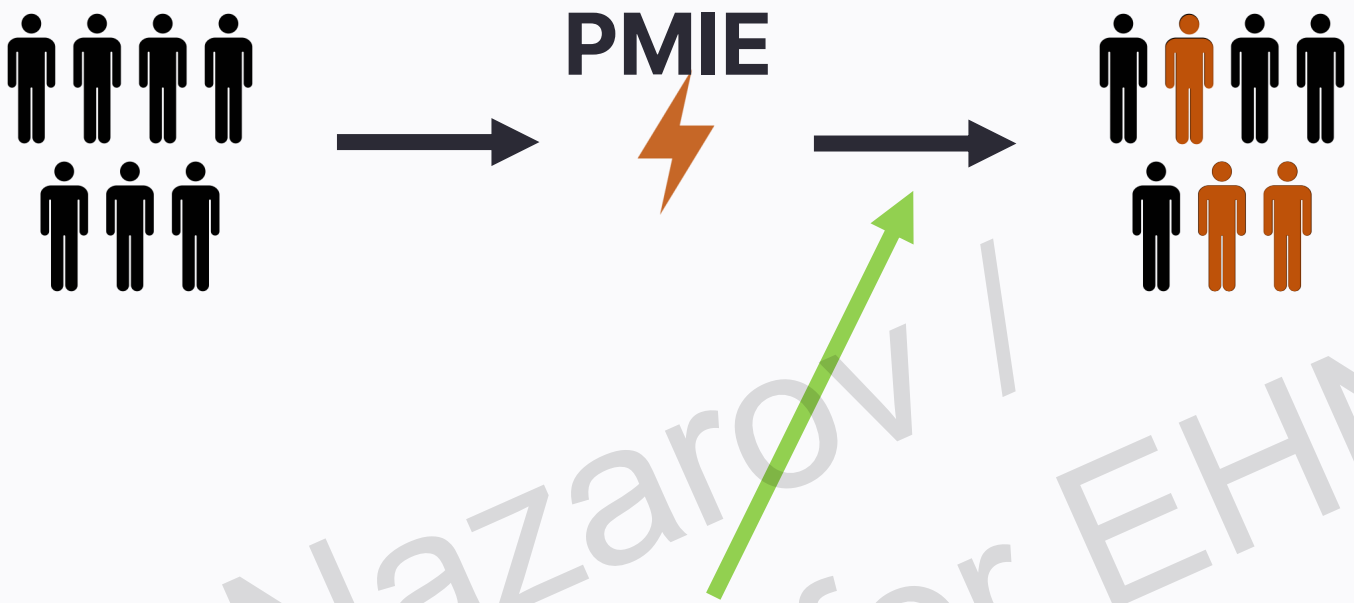
4. Unlike for PTSD, no animal models for moral injury



Challenges and gaps

5. **Help-seeking avoidance**
   - confidentiality
   - shame and guilt are socially withdrawing

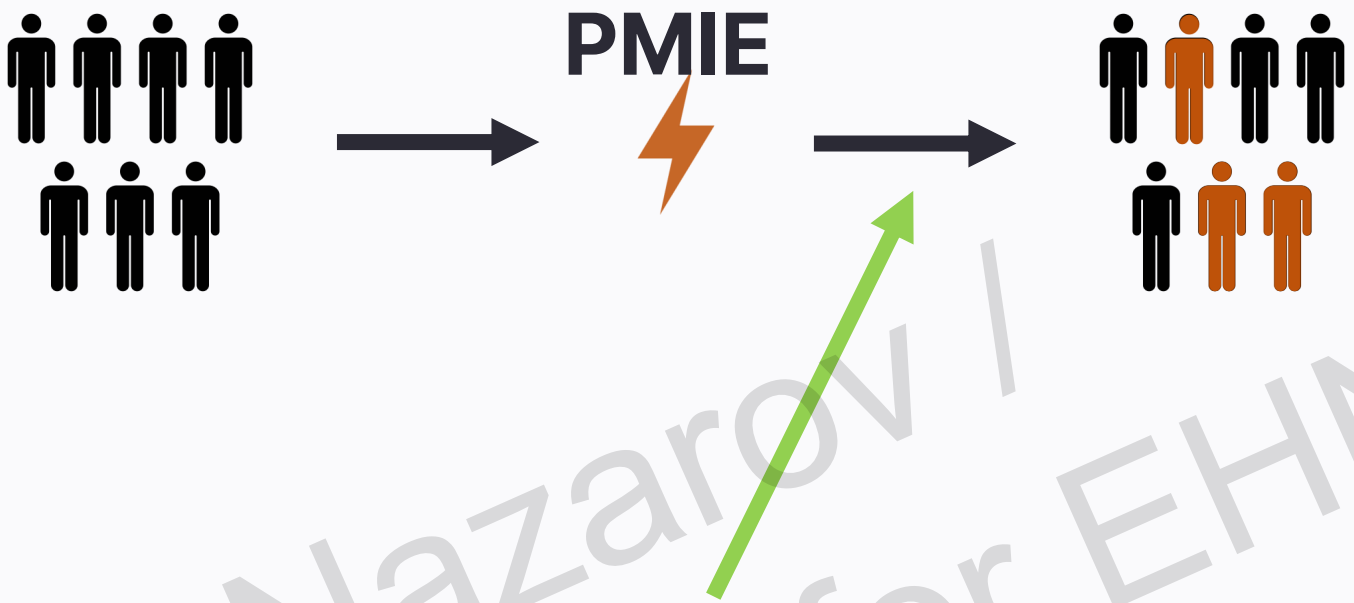
Need to better understand barriers to care for moral injury



Prevention: Early Intervention

Challenges and gaps

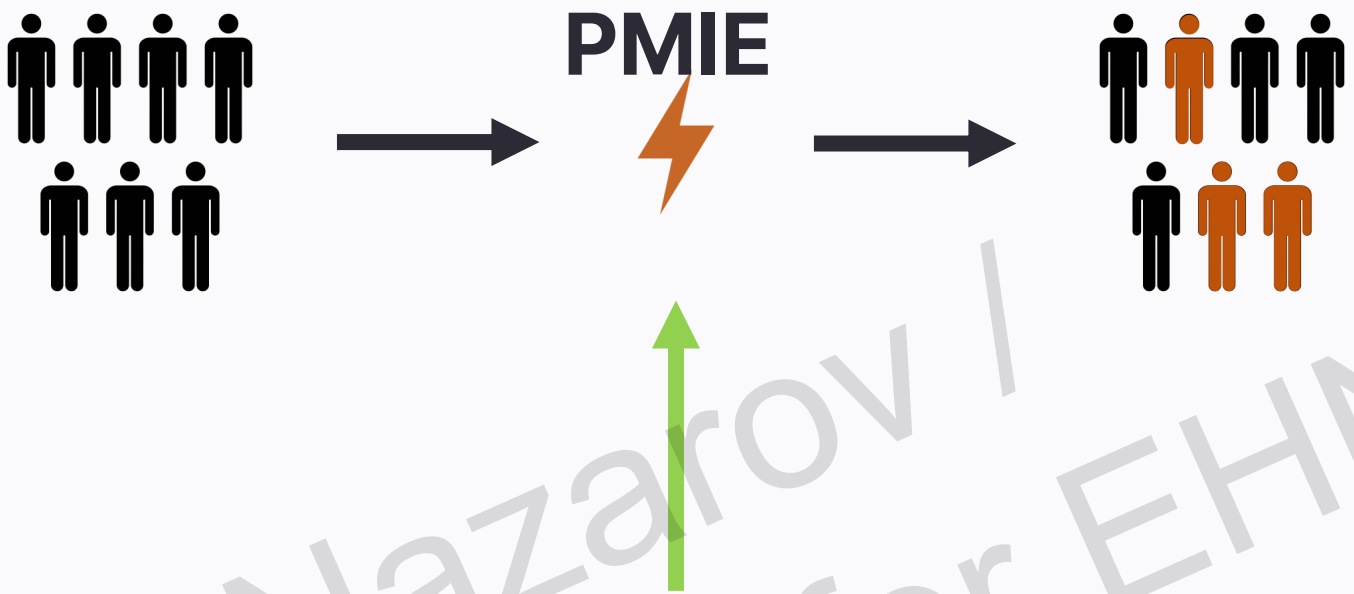
1. Link between exposure (PMIE) and outcome (MI) is ambiguous; not all PMIEs are the same.
2. What supports are required? Can we make things worse? Need data on outcome monitoring.
3. Interval between PMIE and adverse MH outcomes can be lengthy. Can we identify prodromal symptoms?



Prevention: Early Intervention

Challenges and gaps

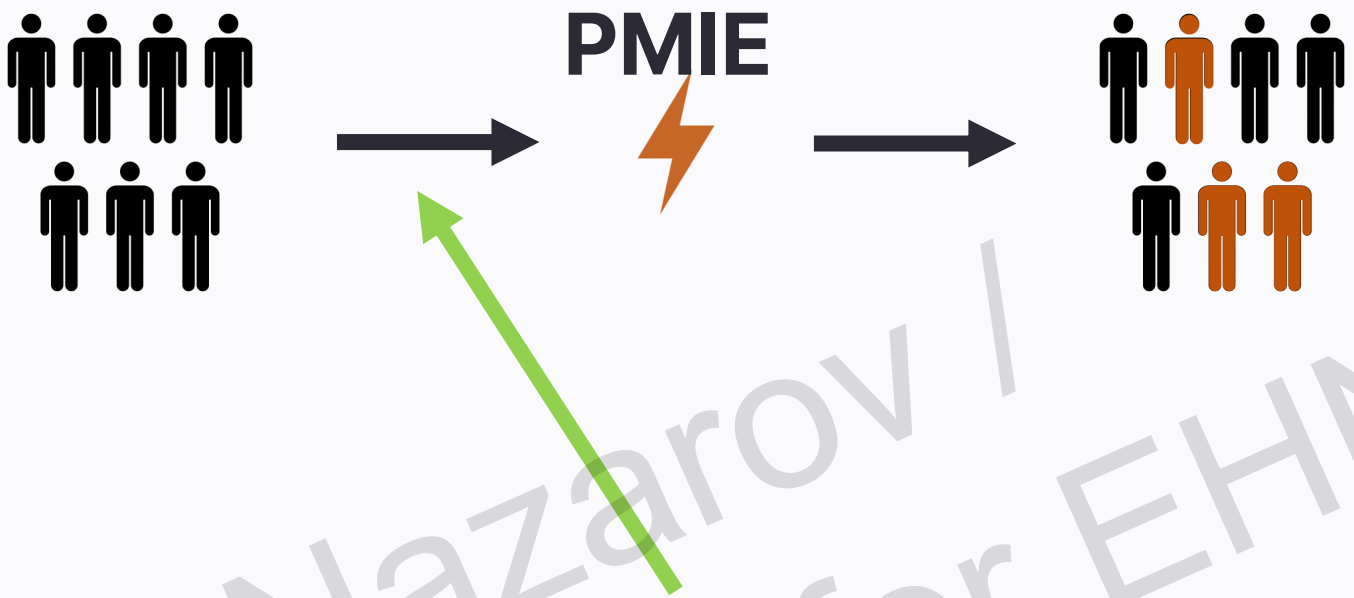
4. Guilt and shame are necessary human emotions; natural response. What magnitude and impact is reasonable? For how long?



Prevention: Avoid Exposure

Challenges and gaps

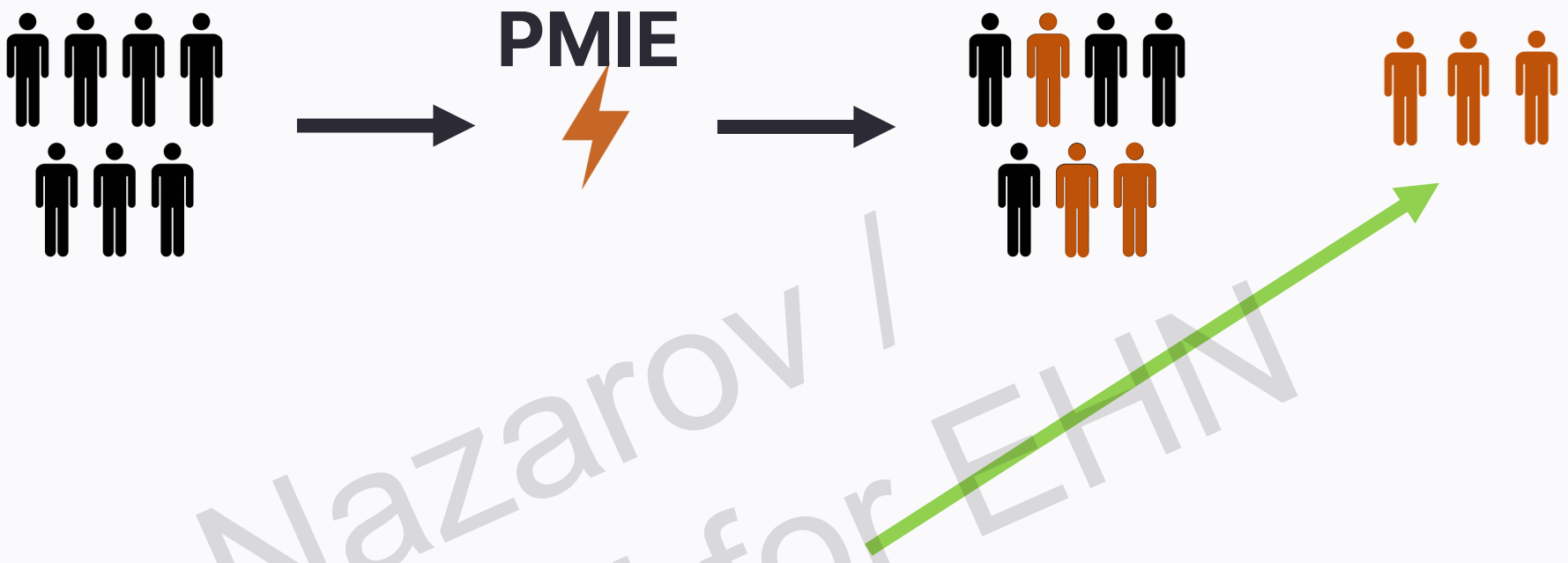
1. For some population segments (e.g., occupations), this is not an option.
2. What isn't perceived to be a PMIE now, could be reframed as a PMIE later; Need to understand impact of culture.



Prevention: Prepare

Challenges and gaps

1. Long gap between training, exposure, and expression
2. What are the goals of preparation? How do we measure outcomes? How do we deliver the intervention effectively?



Challenges and gaps

5. **Help-seeking avoidance**
   - confidentiality
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Need to better understand barriers to care for moral injury

Mental Health Service Use (MHSU)

MHSU by military personnel is largely underutilized

29% of service members with a past-year MH problem reported seeking or utilizing MH services in the same time period (across 11 studies; N=189,021 individuals) (USA, Canada, UK, Netherlands, China) (Hom et al., 2017)

Increasing over time (i.e., 20% to 36% increase between 2003 and 2011 in US Army soldiers) (Quartana et al, 2014). Despite the increase, still a signal of underutilization.

Service members often do not seek care until they have **reached a point of crisis** or until the concern is **life-threatening** (Zinzow et al., 2013). And most do seek treatment, but it takes years… (Fikretoglu, et al., 2010).

Barriers to Care

There are many…

As of 2017, there were **57** studies examining barriers to help-seeking and MHSU in military personnel.

Barriers to Care

Large literature on this topic (see Hom et al., 2017 for review, but also Adler et al., 2015; Britt et al., 2008; Hoge et al., 2004; Kim et al.,2011, Zinzow, et al., 2013, Britt, et al., 2008, 2016, 2019).

Impact on military career (or "Career Stigma" – Britt et al., 2019)
- blame or differential treatment by others
- less confidence in ability from peers/leaders
- general career harm
- did not want information presented in military records (21-43%)
- concerned it will not remain confidential (23-37%)

Stigma (self- and perceived public stigma)
- embarrassment/seen as week
  - however… mixed findings and a complicated concept to measure

Operational/Structural barriers
- difficulties scheduling appointments, getting time off work

Barriers to Care

Provider-related concerns

not trusting mental health professionals (38%) (Hoge et al., 2004)
did not have confidence in MH, administrative, or social services (Sareen, et al., 2007)
will not be treated for their presenting problem
will be prescribed unwanted medications
it will be difficult to relate and open up to a provider

(Fikretoglu et al., 2008; Pury et al., 2013; Stecker et al., 2013; Zinzow et al., 2013)

Preference for self-management, lack of perceived need, negative treatment beliefs

beliefs that treatment is ineffective (4–17%)
that it is more advantageous to handle the problem on their own/that they do not need care (52–64%)

(Hoge et al., 2004; Stecker et al., 2013; Valenstein et al., 2014; Zinzow et al., 2015)

Barriers to Care

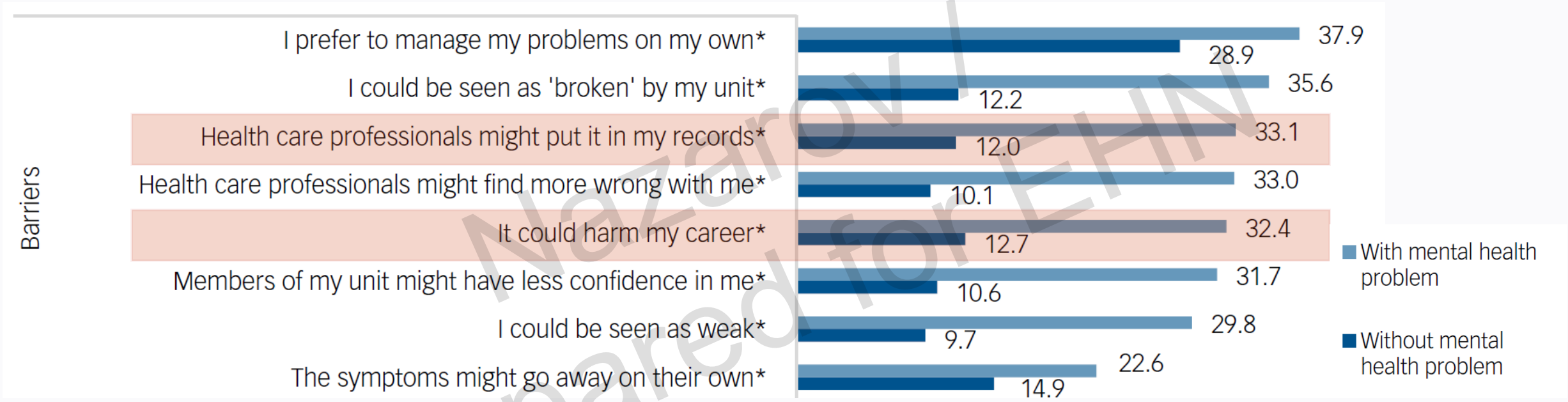
(Britt et al., 2019)

Barriers to Care

	Mental health symptoms		
	Junior enlisted	NCOs	Officers
Barriers			
I could be seen as weak	12.7	11.2	16.7
Members of unit less confidence	**12.7[a]**	**12.8[a]**	**22.4[b]**
It could harm my career	**13.4[a]**	**16.6[a]**	**26.3[b]**
Symptoms might go away [on own]	**14.8[a]**	**15.9[a]**	**25.2[b]**
I prefer to manage problems myself	**27.1[a]**	**33.5[b]**	**42.9[c]**
I could be seen as 'broken' by unit	**13.9[a]**	**16.4[a]**	**23.2[b]**
Might find something else wrong	**11.5[a]**	**16.4[b]**	**14.3[b]**
Might be put in my records	**13.0[a]**	**17.3[b]**	**20.8[b]**

(Britt et al., 2019)

Barriers to Care



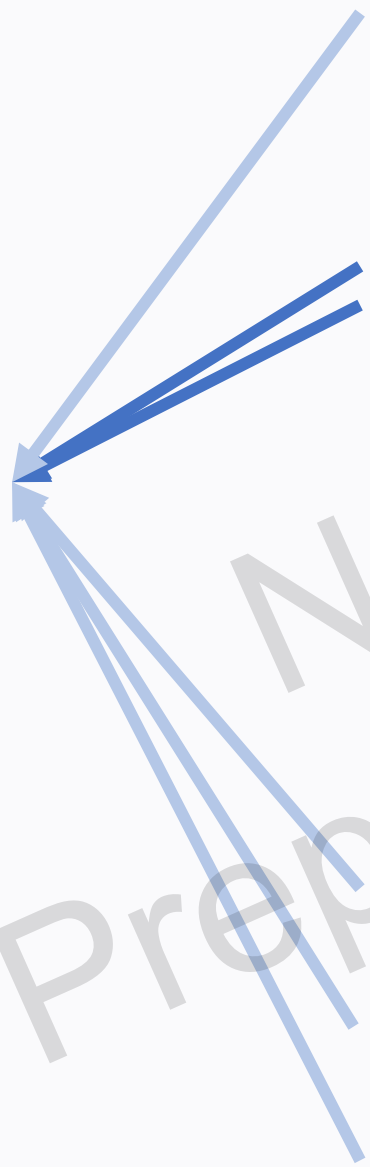
(Britt et al., 2019)

Confidentiality

Known Barriers to MHSU

Getting mental health treatment would harm military career
Blame from unit leaders
Differential treatment from leaders
Less confidence in ability of competence from leaders/peers
Leader discourages treatment
Don't want on military record
Concern it won't remain confidential
Embarrassment
Being seen as weak
I would feel weak/inferior
Others in my unit would treat me differently
I would be concerned about the operational readiness of a unit member who was getting treatment
Difficulties Scheduling appoitnment
Difficulties getting time off work
Transportation issues
Cost concerns
Not knowing where to go
Mistrust of providers
Will not be treated for their presenting problem
Will be prescribed unwanted meds
Will be difficult to relate or open up
Belief treatment is ineffective
Self-management is better
Not comfortable talking about emotional problems

Confidentiality



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Barriers to Care

Relative importance, causal path unclear

(Britt et al., 2019)

Barriers to Care

Relative importance, causal path unclear

(Britt et al., 2019)

Confidentiality

General **mistrust** of mental health practitioners (MHP) by mil pers (Hoge et al. 2004; French et al., 2004)

- Barriers to related to mistrust (Hom, Stanley, Schneider, & Joiner, 2017; Rüsch et al., 2017; Gould et al., 2010; Bonar, Bohnert, Walters, Ganoczy, & Valenstein, 2015)
  - e.g., general career harm, don't want info in military records, concerned will not remain confidential

- Mil pers likely to underreport mental health (MH) issues on screeners (Warner et al., 2011; French, Rona, Jones, & Wessely, 2004)

Table 5. Perceived Barriers to Seeking Mental Health Services among All Study Participants (Soldiers and Marines).*

Perceived Barrier	Respondents Who Met Screening Criteria for a Mental Disorder (N=731)	Respondents Who Did Not Meet Screening Criteria for a Mental Disorder (N=5422)
	no./total no. (%)	
I don't trust mental health professionals.	241/641 (38)	813/4820 (17)
I don't know where to get help.	143/639 (22)	303/4780 (6)
I don't have adequate transportation.	117/638 (18)	279/4770 (6)
It is difficult to schedule an appointment.	288/638 (45)	789/4748 (17)
There would be difficulty getting time off work for treatment.	354/643 (55)	1061/4743 (22)
Mental health care costs too much money.	159/638 (25)	456/4736 (10)
It would be too embarrassing.	260/641 (41)	852/4752 (18)
It would harm my career.	319/640 (50)	1134/4738 (24)
Members of my unit might have less confidence in me.	377/642 (59)	1472/4763 (31)
My unit leadership might treat me differently.	403/637 (63)	1562/4744 (33)
My leaders would blame me for the problem.	328/642 (51)	928/4769 (20)
I would be seen as weak.	413/640 (65)	1486/4732 (31)
Mental health care doesn't work.	158/638 (25)	444/4748 (9)

(Hoge et al., 2004)

Confidentiality

Ambiguity relating to limits to confidentiality in military setting

- **Dual role** of military practitioner (responsibility to organization and patient) – may conflict
  - Additional limits to confidentiality in military treatment settings (Hoyt, 2013)
- Ambiguity across different MHPs
  - Unlike the strictly protected communication with chaplaincy, no patient-physician privilege exists in military setting

Confidentiality and trust integral to therapeutic process

- Lack of perceived confidentiality may hinder honest responding and undermine treatment
- Increased perceptions of confidentiality related to more honest reporting, in both civ (Haut & Muehleman, 1986; Woods & McNamara, 1980; Lothen-Kline, Howard, Hamburger, Worrell, & Boekeloo, 2003) and mil samples (Anestis & Green, 2015; Warner et al., 2011)
- In civ samples, tendency to believe that absolute confidentiality should exist (Ambrose, 1999)

Confidentiality

Fear of confidentiality breach during MHSU may be exacerbated when experiencing moral injury

- Perceptions of illegality/fear of legal repercussions

Confidentiality

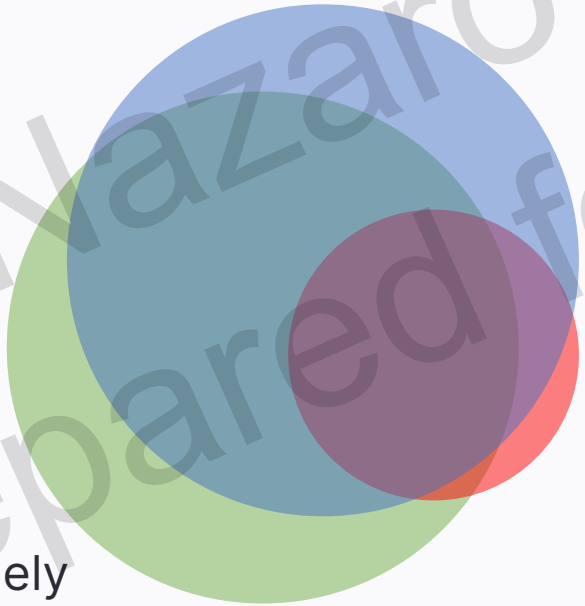
Confidentiality

Ethics

Philosophical study of morality...

Prescribes standards of conduct for individuals and groups, so as to prevent and resolve moral problems

Professional/corporate ethics/morals (e.g., research ethics, military ethics, clinical ethics)



Morals

Individual's own sense of what's good, right, and meaningful (largely based on widely held societal values)

Law

basic, enforceable standards of behaviour necessary for a community to succeed and in which all people are treated equally

-Defined by government, based on concepts of justice and equality; --
-Coercive, rules of law, uniform

Confidentiality

Ethics

SHOULD

Philosophical study of morality...

Prescribes standards of conduct for individuals and groups, so as to prevent and resolve moral problems

Professional/corporate ethics/morals (e.g., research ethics, military ethics, clinical ethics)

Morals

Individual's own sense of what's good, right, and meaningful (largely based on widely held societal values)

Law

MUST

basic, enforceable standards of behaviour necessary for a community to succeed and in which all people are treated equally

-Defined by government, based on concepts of justice and equality; --
-Coercive, rules of law, uniform

Confidentiality

In what situations and contexts does mandatory disclosure to authority (e.g., military institution, professional body, law enforcement) apply?

What impact does it have on the help-seeker?

Confidentiality

Some evidence suggesting:

- Lack of knowledge/ignorance of confidentiality laws by MHPs (Jagim et al., 1978; Mengeling, Booth, Torner, & Sadler, 2014; Faustman, 1982)
- Potential misperceptions of confidentiality laws by mil pers (Dao & Frosch, 2009)

Increased focus on moral injury (MI) in research and treatment settings

Three issues:

- Patients may be particularly **reluctant to disclose MI**
- Disclosure of MI by patient may lead to **unnecessarily breaches of confidentiality** by MHPs
- Individuals may hesitate to disclose moral injury even in research settings
  - Throws into question much of the literature on prevalence

⚠ Patients with moral injuries may be avoiding mental health services

1. Mil pers' beliefs about confidentiality and attitudes toward disclosure of MI are unknown
2. MHP's beliefs about confidentiality and attitudes toward breaching confidentiality surrounding MI are unknown

⚠ Patients with moral injuries may be avoiding mental health services

Early evidence suggests this:

CAF pers with PMIEs are 2x more likely to seek help from civilian healthcare providers. (Nazarov, et al., 2020)

> “Confidentiality and psychological treatment of moral injury:
> **the elephant in the room**” - Williamson et al., 2020

Exploring the issues of confidentiality as it relates to moral injury in CAF Veterans

Funded by

Anciens Combattants Canada

Veterans Affairs Canada

Acknowledgments

Cassidy Trahair, MSc Student
Callista Forchuk, MSc
Rachel Plouffe, PhD
Michelle Marlborough, MD, FRCPC
Don Saklofske, PhD
Paul Tremblay, PhD
Lucy Brown, MBA
J Don Richardson, MD, FRCPC

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Veteran and Family Well-being Fund,
Veteran Affairs Canada

Study 1 - Objectives

Are individuals with moral injuries more likely to suffer in silence...?

Determine whether Canadian Armed Forces Veterans are reluctant to disclose MI to MHP

- Potential hesitation/bias to disclose personal encounters/experiences
- Individual experiences may be very nuanced

Used an experimental paradigm with hypothetical vignettes

-control for trauma details
-manipulate variables of interest
-specifically, compare with non-MI trauma

Study 1 - Objectives

Determine whether Canadian Armed Forces Veterans are reluctant to disclose MI to MHP

Primary manipulations:

Role of **trauma type** (MI *vs.* control (PTSD Criterion A type trauma))

CAF Status at the time of help-seeking (active *vs.* released)

Secondary manipulation:

Degree of stated **confidentiality protection**

Study 1 - Methods

Sample:	CAF Veterans
Medium:	Online Survey
Recruitment:	ParticipAid and Social Media
Year Collected:	2020

Process:

1. Read vignette
2. Answer questions related to vignette
3. Repeat 3x with different vignettes
4. Answer sociodemographic, MH tx-seeking history, and related self-reports (e.g., scale on social stigma, distress disclosure index)

Study 1 – Methods – Experimental Design

Conditions:

Trauma Type (within)	**Military Status** (within)	**Confidentiality** (between)
PMIE	Active	Fully Assured
PTSD	Released	Ambiguous

Outcomes:

- Seeking help
- Disclosing trauma details
- Perceived legal harm
- Perceived career harm (only for active condition)

Vignette Development

Developed specifically for this study

4 Moral Injury Vignettes
1 PTSD Vignette

Consultation with:

- military psychiatrists
- senior ranks, junior ranks
- individuals with deployment experiences
- individuals familiar with moral injury (those who have been exposed to PMIE)
- professional fiction and war authors

Controlled for:

- word count
- vocabulary level
- perceived emotional salience (via micropilot with clinicians, researchers, and military personnel)

Vignette Development

PTSD Vignette:

1. injury to self

MI Vignettes:

1. Woman and child injured but unable to help
2. Witnessing intentional harm to innocent civilian by peer
3. Children sexually abused by a local community leader
4. Unable to save refugees due to RoE as a peacekeeper
5. Intentional harm to community informant/asset by insurgents

Instructions: A series of hypothetical scenarios are presented below. Each scenario describes a particular traumatic event that may occur during a deployment, as well as experiences that may follow such an event. As you read each scenario, please try your best to imagine yourself as the character being described, and continue imagining yourself as this character as you respond to the questions following the scenario.

A year ago, you returned from an overseas deployment where…

insurgents committed atrocities against their own civilians. You frequently drove through villages where you witnessed injured women and children by the side of the road. On one particular day, you noticed a mother with an infant and a small child who were all injured and desperately in need of medical attention. You could see the mother was attempting to care for her children but was too critically wounded to sustain care. There were no other civilians around to provide care, and it appeared safe to approach the family. You requested permission from your chain of command to help them but received orders to not intervene. You followed these orders, though you realized that the family may not make it without intervention.

Since returning from this deployment…

you feel guilt for not helping the villagers and keep on thinking of what you could have done differently.

You have also experienced unwanted memories and disturbing dreams. You find yourself upset and physically reactive (e.g., heart racing) when reminded of the experience. You have not told others about the details of your experiences. You have been distant with friends and family, irritable and quick to anger, and unable to feel happiness or affection. You cannot focus on work and you are accomplishing less than you'd like. You haven't been participating in normal social or household activities. Your family members mention that you have changed and recommend that you seek help from a mental health professional.

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After each scenario

[ACTIVE condition] Imagine you are still serving in the Canadian Armed Forces.
[RELEASED condition] Imagine you have been released from the Canadian Armed Forces.

1. Given all of the information provided, and assuming there are no structural (e.g., financial, transportation) barriers to treatment, how likely would you be to seek help from a mental health care provider? (SEEK)

2. In this case, how likely would you be to disclose details of your traumatic experience with a mental health care provider? (DISCLOSE)

3. In this case, how severe do you perceive the risk in terms of legal repercussions if the details of this event were disclosed to a mental health provider? (LEGAL HARM)

4. In this case, how severe do you perceive the risk in terms of career repercussions if the details of this event were disclosed to a mental health provider? (CAREER HARM)

1 - very unlikely
2 - unlikely
3 - neutral
4 - likely
5 - very likely

Extra - Confidentiality Manipulation

[ASSURED condition]	You have been made aware that if you choose to seek help from a mental health professional, your personal information and details of your experiences will be kept absolutely confidential, and will not be shared outside of the sessions with the mental health care provider. In other words, personal and medical information given to a health care provider will not be disclosed to others unless you have given specific permission for such release.
[AMBIGUOUS condition]	You have not been made aware of whether your information and details of your experiences will be kept confidential if you choose to seek help from a mental health care professional. You are unsure whether your personal details and information will be shared outside of the sessions with the mental health care provider.

Study 1 – Methods – Experimental Design

Conditions:

Trauma Type (within)	**Military Status** (within)	**Confidentiality** (between)
PMIE	Active	Fully Assured
PTSD	Released	Ambiguous

Covariates:

Distress Disclosure Index (Kahn & Hessling, 2001)
Social stigma for seeking professional help (Komiya, Good, & Sherrod, 2000)
Professional experience with MH
Past history of seeking help for MH issues
Age, ethnicity, marital status, education, years in CAF, rank at release

2x2x2 design; linear mixed models utilized for main outcomes

Final sample size: 335 participants

Study 1 – Results

Active Military Status:

Trauma type (moral injury vs. PTSD) had a significant main effect on likelihood of help-seeking, $F(1, 163) = 14.73$, $p = <.001$, $\eta_p^2 = .08$. **Moral injury associated lower likelihood of help-seeking.**

Confidentiality condition (uncertain vs. assured) had a significant main effect on likelihood of help-seeking, $F(1, 163) = 4.22$, $p = .04$, $\eta_p^2 = .03$. **Uncertain confidentiality associated with lower likelihood of help-seeking.**

Study 1 – Results

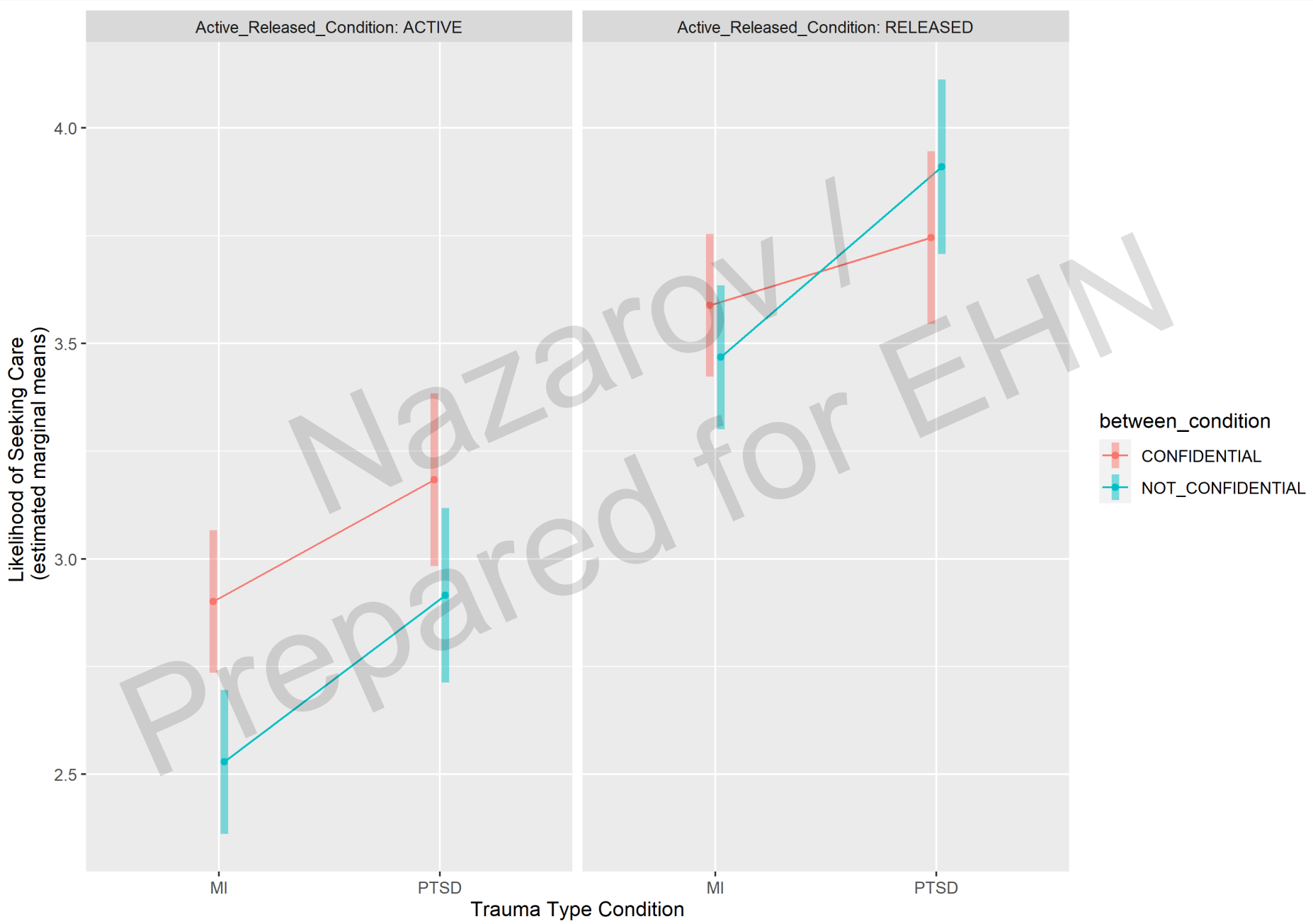
Released Military Status:

Trauma type (moral injury vs. PTSD) had a significant main effect on likelihood of help-seeking, $F(1, 163) = 26.51$, $p = <.001$, $\eta_p^2 = .14$. **Moral injury associated with lower likelihood of help-seeking.**

Trauma type * Confidentiality interaction was significant, $F(1, 163) = 4.37$, $p = .04$, $\eta_p^2 = .03$. **Confidentiality condition had a greater effect for moral injury than PTSD.**

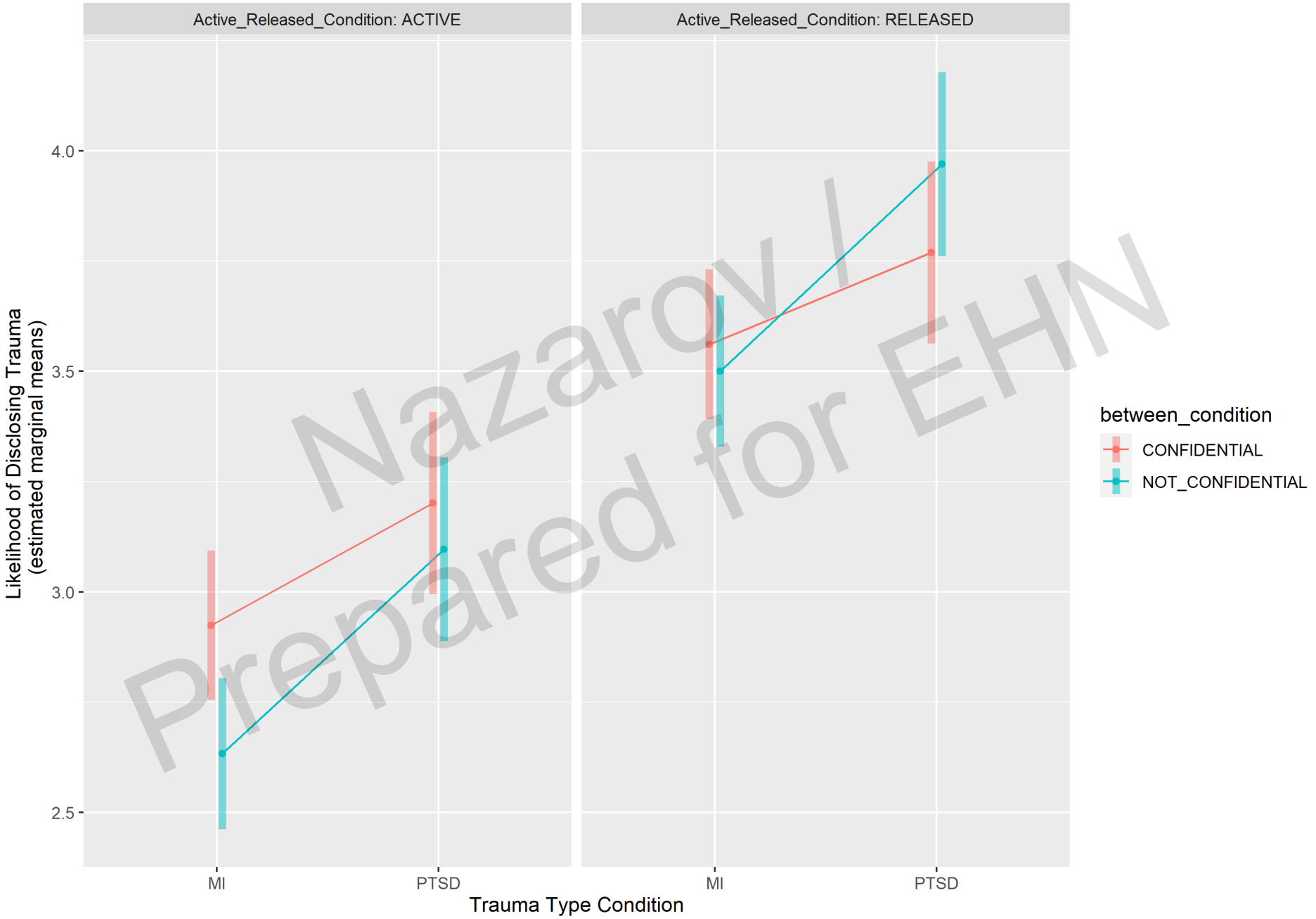
Likelihood of **Seeking Help**

5 - very likely
4 - likely
3 - neutral
2 - unlikely
1 - very unlikely

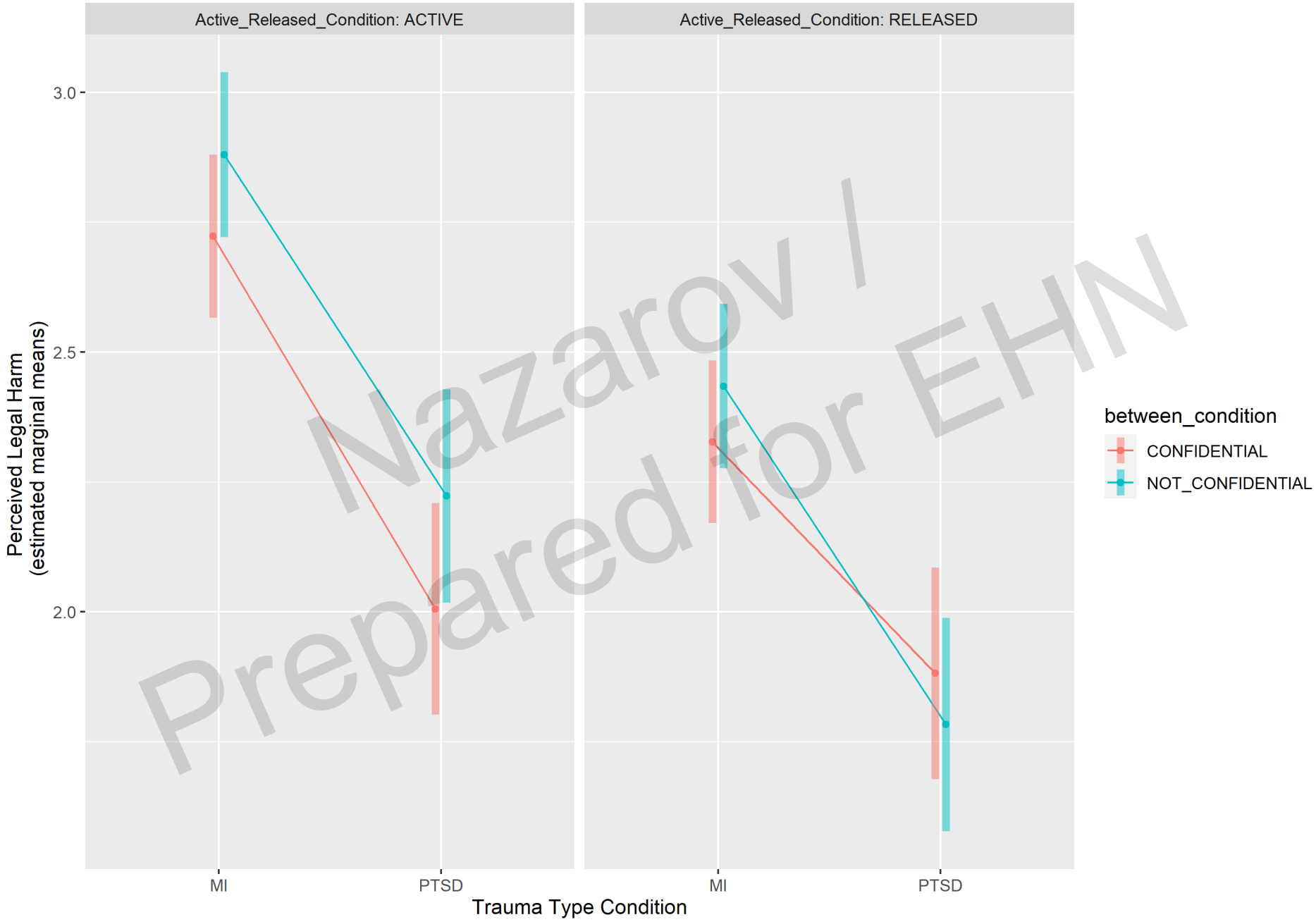


Likelihood of **Trauma Disclosure**

5 - very likely
4 - likely
3 - neutral
2 - unlikely
1 - very unlikely



Perceptions of **Legal Harm**



Perceptions of **Career Harm**

Take away points

- First study to provide evidence behind patterns of intentions to seek treatment for moral injury
- Well-powered experiment – able to test intended hypotheses, explore role of covariates
- Successful remote administration of experiment - conducted during COVID-19 pandemic

Highlights that:

- **Trauma that has elements of moral transgressions/PMIE are associated with decreased likelihood in the intention to seek treatment.** PMIEs are perceived to be associated with **greater career and legal harm.**

- There is a clear difference in intention to seek treatment depending on whether member is active or released. Regardless of whether it's for PTSD or MI, **seeking treatment as an active member is associated with hesitation in the intention to seek treatment.**

- Explicit assurances of confidentiality during treatment **is associated with increased intention to seek treatment for MI, particularly for active personnel.**

Next Steps

- Tendency to seek treatment may be mediated by perceptions of legal and career harm – analysis in progress

- Understand the role of covariates on outcomes

- **Conduct in-depth interviews with military personnel**
  (currently, must be a CAF Veteran to participate)

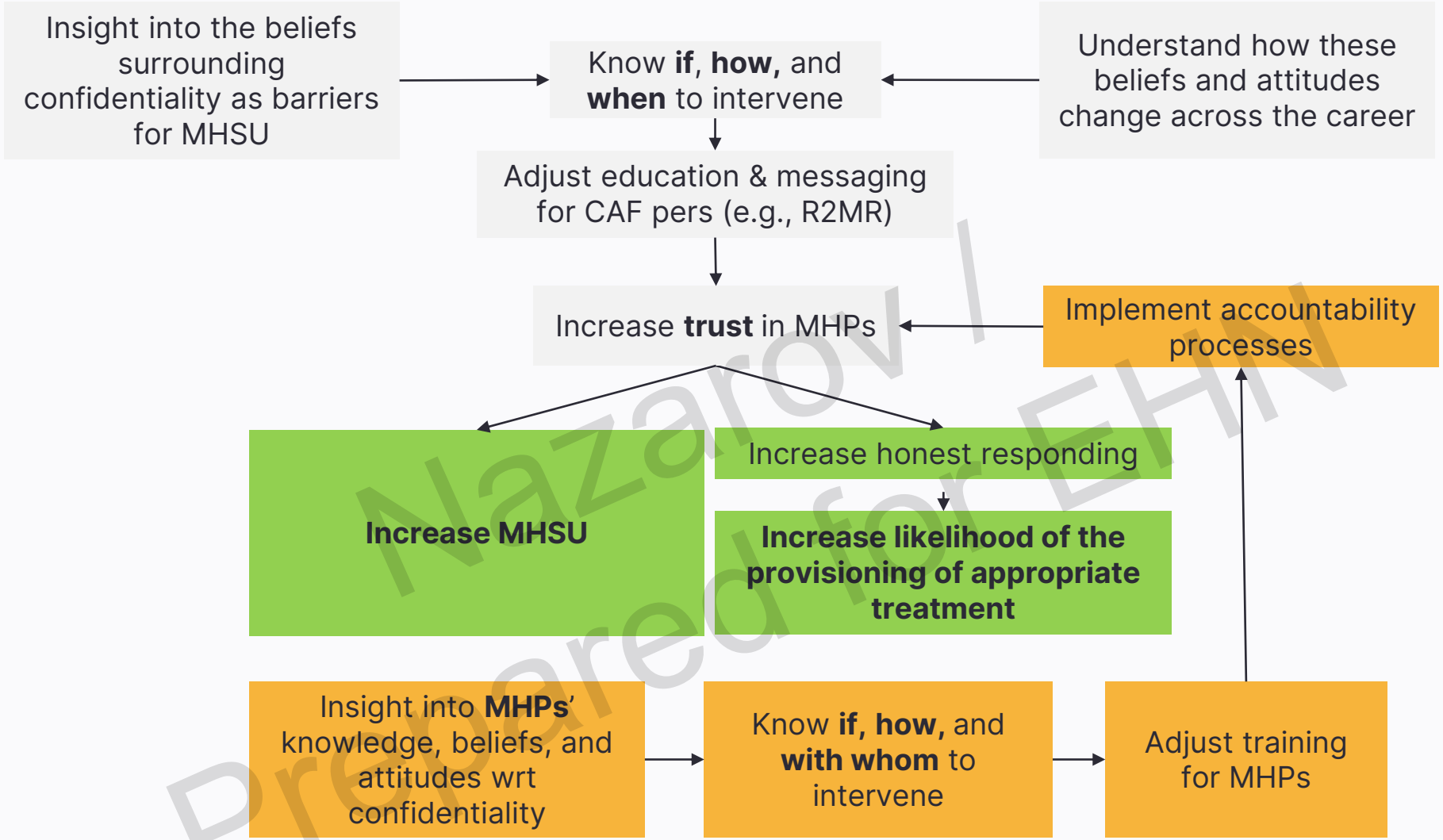
  - Nuanced understanding of beliefs and attitudes, both from a hypothetical perspective and those with lived experiences
  - Understand how barriers interact

  - For this follow up study, we've had significant consultation from military psychiatrists, chaplains, qualitative experts

- **Conduct in-depth interviews with MHPs**
  - Soon to be open for recruitment

Questions remain unanswered

- How do MHPs approach confidentiality issues now?
- Is there a mismatch between mandatory disclosure laws and MHP practice (study upcoming)?
- What are the mandatory disclosure laws/regulations across different MHPs, researchers (paper in progress)?
- What is the independent contribution of confidentiality in the entire landscape of MHSU barriers?
- Are system process changes necessary to further assure confidentiality protections? Can/should we do better? What contexts? By what roles?
- Is this a Pandora's Box? Will it cause more issues trying to improve the process?



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Questions?

Thank you

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