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MORAL INJURY *EXPERIENCES* IN *PEER SUPPORT* OF ODHA SURVIVORS: BETWEEN CONCERN AND MORAL CONFLICT

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ABSTRACT
People living with HIV/AIDS (PLWHA) face not only medical challenges but also complex psychosocial stressors arising from stigma, discrimination, and moral value conflicts. One psychological phenomenon that remains underexplored in the context of HIV/AIDS is moral injury, particularly among individuals who occupy dual roles as survivors and peer support workers. This study aims to explore experiences of moral injury among peer support PLWHA in Indonesia. A qualitative approach with an interpretative phenomenological design using Interpretative Phenomenological Analysis (IPA) was employed. Six PLWHA serving as peer support workers and residing in Banyumas Regency participated in this study. Data were collected through semi-structured interviews and participatory observation, then analyzed thematically. The findings identified two primary forms of moral injury: perpetration-based moral injury, characterized by guilt, self-disgust, beliefs in divine punishment, and shame toward family; and betrayal-based moral injury, arising from value conflicts in caregiving roles, institutional stigma and discrimination, betrayal in intimate relationships, and family rejection. In addition, processes of moral repair were identified, including spirituality, meaning making, social support, self-acceptance, and the reconstruction of moral identity. These findings extend the conceptualization of moral injury within the psychosocial context of HIV/AIDS and underscore the importance of structural and systemic support to safeguard the psychological well-being of peer support workers.

INTRODUCTION

HIV is a virus that weakens the immune system and if not treated promptly can develop into AIDS. HIV is transmitted through exposure to infected blood or body fluids, especially through unprotected sexual intercourse, the

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use of contaminated syringes or invasive devices, mother-to-child transmission, and transfusions of infected blood (Ministry of Health, 2024). The prevalence of HIV/AIDS in Indonesia shows an increasing trend, with an escalation of cases that stands out in the productive age group. Although the number of active cases is relatively high, the level of involvement in treatment services remains low, confirming HIV/AIDS as an ongoing public health issue. Demographically, the majority of individuals with HIV/AIDS are men of productive age, secondary education, working in the private sector, married, with the dominant route of transmission through heterosexual relationships (Adi, 2024);(Pramatasari et al., 2025);(S&P 2020).

HIV management emphasizes the importance of continuous antiretroviral (ARV) treatment from the early phase of diagnosis to suppress disease progression and improve quality of life. Therefore, early acceptance of treatment after diagnosis is an important factor in maintaining health and preventing further transmission (Nathanael et al., 2022). Individuals living with HIV/AIDS not only face medical challenges, but also experience profound psychosocial distress (Rosmalina & Kurnaedi, 2020). Psychological reactions such as anxiety, depression, guilt, and difficulty establishing social relationships often appear, especially in the early stages of receiving an HIV diagnosis (Purwadi, 2020). People with HIV/AIDS often receive stigma and discrimination as social punishment in the form of rejection, isolation, and avoidance, which systematically undermines an individual's self-esteem, social identity, and sense of moral worthiness. In this context, stigma goes beyond its role as a psychological stressor, so the condition encourages concealment of HIV status, avoidance of testing and health services, and social withdrawal, which ultimately increases psychological and health vulnerability (Violla & Ritonga, 2025);(Triana & Suriadi, 2020).

This pressure reflects not only emotional distress, but also intrapersonal value conflicts when individuals internalize guilt, unworthiness, or perceptions of violation of social norms. This condition indicates a deeper psychological wound, related to the violation of moral values and the meaning of individual life. In these situations, experiential social support, such as *peer support*, has the potential to play an important role in helping ODHA recover their self-meaning, rebuild their sense of connectedness, and renegotiate their identity and personal values in dealing with their illness (Violla & Ritonga, 2025);(Tursilarini et al., 2019);(Thompson et al., 2022). According to Richard et al., (2022), *Peer support* It is interpreted as a form of social and emotional support provided by individuals who have similar life experiences. Based on research conducted by Øgård-Repål et al., (2022) *Peer support* plays an important role in strengthening the emotional well-being of people with disabilities through empathic and stigma-free reciprocal relationships.

Existence *peer support* proven to be effective in reducing stigma levels, strengthening coping mechanisms, increasing motivation to undergo treatment, and encouraging the creation of a more inclusive environment for people with disabilities (Pramatasari et al., 2025). *Peer support* plays a crucial role in supporting the adaptation process of individuals who have just received an HIV diagnosis. Through similar experience-based interactions, *peer support* provide a safe space for people with disabilities to express their experiences, reduce feelings of isolation, and strengthen the meaning of life after diagnosis (Nathanael et al., 2022). In general, the role *peer support* focus on providing support However, the burden of the role becomes more complex when *peer support* is also ODHA. Individuals face the dual burden of health management and personal stigma, as well as fulfilling professional responsibilities that are fraught with ethical dilemmas. This condition has the potential to trigger *moral injury*, namely psychological wounds that arise due to conflict or violations of moral and ethical values adhered to. (Litz et al., 2009).

At the beginning *moral injury* It is only examined in the military context as psychological, social, and spiritual wounds that arise as a result of behavior or experiences that violate one's moral and ethical beliefs, especially in the context of combat or high-risk situations (Magen & Litz, 2012). According to Nash & Litz (2013), *moral injury* as a psychological wound that arises when an individual engages in, witnesses, or fails to prevent an event that fundamentally violates the moral beliefs he or she holds. According to Wingerter (2023), explaining that *moral injury* is a trauma syndrome that arises from exposure to actions that violate or contradict the moral values that a person

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believes in. In this case, moral wounds do not only relate to physically or emotionally traumatic experiences, but mainly concern the ethical and existential dimensions of human experience.

As research progresses, *moral injury* understood as a phenomenon across professions and contexts, not limited to military experience (Koenig & Al Zaben, 2021). Moral injury is reported in educators who face systemic injustices in educational policies and structures, which hinder the fulfillment of professional moral and ethical responsibilities (Levinson, 2015). A similar phenomenon is found in health workers who work in bureaucratic and regulatory systems that are contrary to the moral values of the profession, so that the suffering experienced goes beyond burnout and reflects moral wounds due to structural stress (Ford, 2019). Research by Greene et al., (2020) shows that *moral injury* experienced by religious leaders during the COVID-19 pandemic. They face psychological distress due to policies that restrict religious activities, resulting in a sense of failure to fulfill their moral and spiritual responsibilities. In addition, they experience double trauma because they have to endure personal pressure while accompanying the grieving congregation. This experience arises from actions that are forced to be ignored, moral violations by others, and crises of faith and the meaning of life. Other research conducted by Halimatusa'diyah (2019), showing that women with HIV/AIDS in Indonesia experience *moral injury* due to social stigma, discrimination, and religious moral interpretations that view HIV as a moral issue. This leads to guilt, shame, and loss of self-esteem, which is exacerbated by discrimination in healthcare. However, family support, peer groups, and involvement in HIV/AIDS organizations play an important role in recovery, and can even turn moral wounds into a collective force to fight for recognition and self-dignity. Based on these cross-contextual findings, *moral injury* It can be understood as a psychological condition characterized by intrapersonal conflict and deep distress due to the experience of violating, failing to prevent, or witnessing violations of the fundamental moral and ethical values of individuals, whether stemming from the actions of oneself, others, or systemic pressure. This condition manifests in feelings of guilt, shame, moral anger, loss of meaning, and disturbances in moral identity and the meaning of life.

A preliminary study on October 10, 2025 of participant Y showed that experience *moral injury* It started from emotional and spiritual conflicts after HIV diagnosis, which was characterized by feelings of hopelessness and loss of meaning in life. These experiences shaped professional empathy in peer support roles, but were also reinforced by experiences of discrimination and moral betrayal from health workers, which were consistent with findings of high discriminatory intentions against people with disabilities (Nilsson Schönnesson et al., 2022) (Idris et al., 2025). Over time, community and peer support play an important role in moral recovery, the discovery of new meanings, and the improvement of work well-being, in line with the literature on the role of peer support in psychological resilience (Agarwal et al., 2019).

Although many studies have been conducted on stigma, mental health, and peer support in ODHA, research that specifically examines *moral injury* in the context of HIV/AIDS, especially in individuals who act as *peer support*, is still very limited, especially in Indonesia. Most moral injury research focuses on the context of the military, health workers, or public service-based professions, while the experience of moral injury in HIV/AIDS survivors who simultaneously perform the role of peer mentor has not been widely explored. In fact, the position of peer support for ODHA survivors puts individuals in a unique role tension, namely as a recipient of stigma as well as a supporter, as an individual who is still struggling with personal inner wounds but is required to provide professional empathy for others.

Based on these gaps, this study aims to explore in depth the experience of *moral injury* in peer support of ODHA survivors, especially in the dynamics between empathy, moral responsibility, and the inner wounds they experience. This study is expected to make a theoretical contribution in expanding the concept *of moral injury* into the psychosocial context of HIV/AIDS, as well as a practical contribution to the development of a support, supervision, and psychological welfare protection system for peer support in HIV/AIDS services in Indonesia.

Sosioedukasi
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METHOD

This study uses a qualitative approach with an interpretive phenomenological design through *Interpretative Phenomenological Analysis* (IPA). This approach was chosen because the purpose of the research focuses on an in-depth understanding of how ODHA peer support workers interpret the experience of moral injury that arises in the context of mentoring fellow ODHA (La Kahija, 2017). Participants in this study amounted to 6 participants, 4 male, 1 female and 1 transgender, with ODHA status, willing to become participants by signing *informed consent* and domiciled in the Banyumas Regency area.

In this study, the researcher used semi-structured interview data collection techniques and field observation. This technique was chosen because it is in accordance with the objectives of phenomenological research that seeks to understand the meaning of participants' life experiences in depth (Creswell, 2013). This study uses semi-structured interviews to explore experiences *moral injury* on ODHA peer support in the context of mentoring fellow survivors. This approach allows for a systematic and flexible exploration of the participants' experiences. In addition, participatory observations were carried out to understand the social and situational context surrounding the experience. Data collection is supported by voice recorders and visual documentation to ensure the accuracy and completeness of the data, while adhering to the principles of research ethics, including *informed consent* and participant confidentiality. Interview data was analyzed using *Interpretative Phenomenological Analysis* (IPA) through the process of verbatim transcription, exploratory comment marking, development of emergent themes, and identification and synthesis of intra- and inter-participant superordinate themes (La Kahija, 2017).

Data analysis was carried out through the organization of verbatim interviews, *coding* systematically, and theme development, with the validity of the data strengthened through triangulation of methods and sources to improve the validity of the findings (Nurfajriani et al., 2024). In this study, source triangulation was used. Source triangulation is a data validation procedure that is carried out by comparing information obtained from various sources or research informants (Mekarisce, 2020). This research has obtained *ethical clearance* from the Research Ethics Commission of the Faculty of Health, University of Muhammadiyah Purwokerto and carried out according to the ethical principles of psychological research, namely *respect for persons*, *beneficence*, and *justice* (Creswell, 2013).

RESULT AND DISCUSSION

RESULT

This study aims to explore the experience of *moral injury* in peer support of ODHA survivors. Data collection began with a preliminary study (October 10, 2025), followed by in-depth interviews with six participants who had given written consent, and was held on November 10–13, 2025. Interviews were conducted using interview guidelines with the support of voice recorders and documentation, and were strengthened through a literature review to support the depth of analysis.

Initials	**P1**	**P2**	**P3**	**P4**	**P5**	**P6**
	YD	RS	IS	CC	RK	BB
Gender	Male	Male	Women	Transgender	Male	Male
Age	49	19	25	29	24	27
Sexual orientation	LSL	LSL	Normal	LSL	LSL	LSL
Education	SMA	SMK	SMK	SMK	SMK	S1
Domicile	São Paulo	São Paulo	São Paulo	São Paulo	São Paulo	São Paulo
Length of peer support	2th	1bln	6bln	1,5th	1,5th	2th
Religion	Islam	Islam	Islam	Islam	Islam	Islam

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Data analysis began with a verbatim transcription of the entire interview, followed by the selection of statements relevant to the research objectives. The statement is then described and supported by participant citations, before being reflected to develop meanings that represent psychological dynamics according to the focus of the research. The results of the analysis are then presented systematically in a table.

Tema moral injury

Theme	Emerging subthemes
Perpetration-based moral injury	Guilt about the status of the disease
	Self disgust
	Conviction of God's Punishment
	Feelings of shame towards the family
Betrayal-based moral injury	Conflict of values in providing education
	Institutional and environmental stigma and discrimination
	Betrayal in intimate relationships
	Family rejection

Another finding in this study is the process of moral *injury* experienced by each participant which is described in the following table:

Moral Repair

Moral repair	**Getting closer to God**
	Self improvement
	Meaning making
	Helping others
	Social support
	Restoration of moral identity
	Self acceptance
	Self awareness

In the process of analysis, the researcher compiles a structured description of the participants' experiences and groups them into main themes. A detailed overview is presented in the following sections.

1. *Moral Injury*
   a. *Perpetration-based moral Injury*

      Moral wounds that arise due to the perception of personal involvement or responsibility for violations of moral values held by individuals.

      1). Guilt over the status of the disease

      All participants experienced self-guilt, both stemming from the perception of deviant behavior as the cause of HIV infection and from the experience of transmission by their partners.

      > *"Honestly, yes, because of my deviant sexual orientation, I'm of the same sex, yes, it's true that we have to be in accordance with the rules of the road or according to religious orders..."* ***(P1-YD10112025)***
      >
      > *"Maybe with myself ee because I'm a man who likes fellow men, it's said it's wrong, but one of us regrets it and tries to stop many times, but yes, it can't be like that now"* ***(P2-RS11102025)***
      >
      > *"I'm naughty but open up who has sex like that, not who has sex like that, then I'm rich from whom, and then the doctor also asked if I was playing here and there, at that time my husband's position*

Sosioedukasi
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wasn't dead, but I flashed back from what the dictator said, asked if I was inherited" ***(P3-IS13112025)***

"Guilt must be there, yes, but it is richer, so it is for correction in the future, for example, if you take an attitude that should be like" ***(P4-CC13112025)***

"If you feel guilty, yes, maybe you should be like this, not like this, yes, I'm only two years old, it's still a while, yes, sometimes it's as if there is something wrong, it should be like this, it's not like this ever" ***(P5-B13112025)***

"The feeling of guilt that there was a sense of guilt Only came back again we realized that we were doing something that was risky and it has passed" ***(P6-RK10112025)***

YD participants interpreted HIV transmission as a consequence of same-sex sexual orientation that they perceived to be contrary to moral values and religious teachings, resulting in remorse and an urge to ask for forgiveness. Hospital participants internalized their sexual orientation as a moral fallacy, accompanied by repeated regrets and attempts to stop the behavior, even though they still experience internal conflicts. IS participants described initial reactions of shock, fear of the future, and a collapse of meaning in life, accompanied by attribution of guilt mixed with confusion about possible transmission from a partner. CC participants acknowledged the emergence of guilt related to sexual orientation, but interpreted it reflectively as an encouragement to improve behavior and decision-making going forward. Meanwhile, RK participants reported guilt for risky behaviors in the past, but chose to accept the event and focus on health care and a more adaptive life orientation.

2). *Self-disgust*

Feelings of self-loathing appeared in participants in response to perceptions of violations of social and moral norms, particularly related to same-sex sexual orientation associated with HIV positive status.

"I feel disgusted with myself, with myself I feel like I'm rich, how can I also do that, I'm going to do it as an ODHIV like that" ***(YD10112025)***

YD participants expressed deep feelings of disgust for themselves as an initial response to their status as ODHA. These feelings reflect the process of internalizing negative moral judgments of life experiences.

3). Belief in God's punishment

A belief in God's punishment arises in the participant as a consequence of a conscious violation of moral values, which reinforces the experience of moral wounds and emotional conflicts.

"There must be I'm sure everyone who is diagnosed like that will definitely have flashbacks about events in the past, right, this is God's punishment, right" **(YD10112025)**

YD participants revealed that after receiving an HIV diagnosis and often experiencing flashbacks to past behaviors and interpreting the condition as a punishment from God for their actions.

4). Feelings of shame towards the family

Feelings of shame towards the family arise as a consequence of the participant's actions that are considered to violate applicable values and norms.

"Honestly, if my mother was still there, they were very, very disappointed, my sister was a girl, at that time I was from Baturaden, I continued to drink, yes, the road continued, it was the flow to drink immediately, they were sorry for crying, they thought they were people affected by HIV, I'm sorry, yes, those who were excluded in a hut with wounds, wounds that were there, if that's the case" **(YD10112025)**

Participants felt embarrassed and afraid of disappointing their families if their HIV status was known. Families are perceived to still have a negative stigma towards ODHA, who are seen as individuals who are excluded and live in deplorable physical conditions.

Sosioedukasi
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b. Betrayal-based moral injury

Moral wounds arise as a result of the betrayal of moral values committed by the other party, where the participant is not the main perpetrator, but still bears the psychological impact of the violation.

1). Conflict of values in providing education

This type of moral wound is triggered by a conflict of values when providing education, especially when participants encounter clients who refuse a medical examination during the mentoring process.

> *"Sometimes the regrettable that we come is that usually I am with a service or with a village midwife to remind or advise that the disease does have a cure, don't feel desperate"* ***(YD10112025)***
>
> *"Because I'm a girl, I'm for pregnant women and children like that, if it's not more about children, it's quite difficult to handle"* ***(IS13112025)***
>
> *"The hardest thing is that for example, patients who really have to fight with their mouths, even it's my own friend, it's a problem for him to obey to take medicine"* ***(CC13112025)***
>
> *"I was threatened that I wanted to report it to the police because it was considered to interfere with his privacy, which means that we have gone back and forth to remind him of that, yes, I have been angry with him" (**RK13112025)***
>
> *"It's about being hit with a glass or throwing it, fortunately it's not the most stressful, the other is the most ignored" (**RK13112025)***
>
> *"Eee like I've been here before, I've been maki maki on the street too"* ***(BB13112025)***

Participants described serious conflicts in the assistance of HIV clients, especially in clients who refused a diagnosis, delayed or stopped ARV treatment, as well as exhibited aggressive emotional responses such as scolding, threatening, or refusing the presence of a companion. The toughest challenges arise in clients lost to follow-up, pregnant women, and children with HIV, because they pose a direct risk to safety and health. Client rejection often triggers interpersonal conflicts, emotional pressure, and legal threats against the companion, even though the intervention is carried out for the client's medical interests. This situation raises a moral dilemma because the intention to help is actually retaliated with extreme rejection.

2). Stigma and discrimination from institutions and the environment

Stigma and discrimination originating from institutions and social environments are perceived by participants as a form of betrayal of their roles and dignity.

> *"The doctor at that time came into the room and didn't even enter the curtain or approach me from afar, just said bring me my mas, I referred to Margono like that, right, honestly, I felt really offended, especially since we were encouraged that we are HIV, it's not as easy as what those people say is that the transmission is like that, right" (**YD10112025**)*
>
> *"I was hurt because the teacher said that if you never succeed, people like you will not get a happy life" (**RS11112025)***

YD participants experienced discrimination from medical personnel who kept their distance and did not provide direct services when making referrals, causing offense because of the stigma of HIV transmission. Hospital participants suffered psychological injuries due to the teacher's demeaning statements and stated that they would not be successful or happy, which is still imprinted even though they have tried to accept.

3). Betrayal in Intimate Relationships

Moral wounds also arise from betrayal in an intimate relationship, when an individual is hurt by a partner or close person who has a strong emotional bond.

> *"I am indeed from my partner from my husband" (**IS13112025)***

Sosioedukasi
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Volume 15 No. 1. March 2026 https://ejournal.unibabwi.ac.id/index.php/sosioedukasi/index

"I myself as an EEE is classified as LGBT where the category of men likes men or LSL there I became a victim in approximately 2023, my EE became HIV AIDS on July 4 in 2024, so the time limit is one year like that" ***(RS11112025)***

"Maybe in terms of harassment because maybe the victim was forced to do it first, like that, there are still some threats, there are some actions that we may have to take in the end, we should not be here from earlier, we shouldn't know this person" ***(RS11112025)***

The IS participant stated that the HIV transmission she experienced came from her husband in a marital relationship. Meanwhile, the hospital participant explained that she contracted HIV in the context of same-sex relationships, where she also experienced violence and harassment, including coercion and threats. The experience causes deep regret and feelings of betrayal, because intimate relationships that are supposed to be a safe space are actually a source of moral wounds and trauma.

4). Rejection from the immediate family

Rejection from the nuclear family is the most severe form of moral wound, because betrayal comes from the party that is supposed to provide a sense of security and emotional support.

"Because I don't have any parents, no one makes a story... I have a place to complain and now I don't have any" ***(IS13112025)***

"On the other hand, my family only expects me when I have the money, so when I don't fall, what do they care about, even my own mother" ***(CC13112025)***

"The family environment is not able to accept such riches, but the plan is to be open about such a plan in the near future" ***(BB13112025)***

The IS participant described losing a source of emotional support after both parents died, leaving her with no place to share and complain. CC participants felt emotional rejection from their families, who according to them were only present when they needed financial support, including from their biological mother who rarely communicated except to ask for money. Meanwhile, the BB participant stated that his family has not been able to fully accept his condition, although he has plans to open up to his family in the near future.

2. *Moral repair*

Moral repair is the process of self-recovery after a person has experienced moral wounds, with the aim of helping individuals feel valued again, reconcile with their moral values, and rebuild trust in themselves and life.

a. Getting closer to God

Spirituality plays an important role in healing moral wounds by helping individuals find calm, accept themselves, and reinterpret suffering, so that life still feels meaningful despite experiencing a traumatic experience.

"Of course, the first thing is to get closer to God, for sure, how can we be sure" ***(BB10112025)***

The BB participant stated that the first step in the recovery process that he carried out was to get closer to God, which he saw as the main way to gain strength and calm in facing the conditions he was experiencing.

b. Self improvement

Self-improvement efforts are a form of active recovery, when individuals consciously try to rebuild life values, self-abilities, and sense of worth that have been shaken.

"For future corrections, for example, if we take an attitude what should be like, even though for example as human beings, if we feel that it is right, it is not good, yes, I have learned a lot from the incident" ***(CC13112025)***

"It's impossible that with the situation that we continued to change yesterday, there must be a change in the MBA how to do good and do good like that, the MBA" ***(YD10112025)***

Sosioedukasi
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*"If it is possible, if I myself make amends, maybe by doing the best we can, I mean not doing such a thing again" (**RS11112025)***

Participants interpreted moral recovery as an effort to improve themselves through reflection on difficult experiences. Guilt-inducing experiences encourage them to change, not repeat mistakes, do better, and live a more responsible life as a form of self-development after a difficult experience.

c. *Meaning making*

Through *the process of meaning making*, individuals reinterpret the experience as part of the journey of life, so that moral wounds are no longer interpreted as the end, but as experiences that form a new meaning and identity.

"With KDS and other friends, yes, it provides support, can provide inputs that you are not alone, there are still many people out there who are affected" **(YD10112025)**

*"A person who has HIV AIDS is not the end of everything but it is an encouragement for them to be able to carry out normal activities as usual and even be able to work in college and even get married like that" (**RS11112025)***

*"I have to make peace because maybe the main spirit is from my son, I don't want it to drag on to be rich and sad" (**IS13112025)***

*"I want to encourage others as well from the process of their first diagnosis, they must be very mentally down, I want to encourage them" (**CC13112025)***

Participants reinterpreted their experiences of living with HIV through involvement in Peer Support Groups (KDS). Exposure to the stories of other ODHA with diverse backgrounds helps to reduce internal stigma and moral guilt. HIV is understood not as the end of life, but as a condition that still allows individuals to carry out meaningful social roles. This process encourages the restoration of moral integrity, strengthening self-identity, and transforming moral wounds into motivation to provide support to others.

d. Helping others

When individuals who have suffered moral wounds are able to help others, their sense of worth and moral integrity are restored, along with the belief that they remain valuable and are able to have a positive impact on others.

*"I am also with this, I am also happy when the clients we provide educational motivation understand oh it turns out that all this time I have been on the wrong path oh all this time I have lost to follow up leaving ARV tuh it is indeed something wrong and being able to return them is something to be proud of, right, that this life can be more meaningful and can be more useful for people and that's why the mba anggi" (**YD10112023)***

*"One as a peer support role plays an important role, not only as a companion, we are also involved in a service where when someone to access availability we continue to visit, we do counseling until we accompany" (**RS11112025)***

*"I position myself as a companion so that I can accompany friends who need it like me" (**RK13112025)***

Participants interpreted mentoring as a source of moral recovery. Success in educating clients to return to compliance with treatment fosters a sense of pride, meaning, and value. An active role in education, counseling, and service assistance strengthens one's identity as an individual who is beneficial to fellow ODHA.

e. Social support

Social support reduces feelings of loneliness and moral isolation, and is the basis for restoring an individual's trust in others and the social environment.

Sosioedukasi
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Volume 15 No. 1. March 2026 https://ejournal.unibabwi.ac.id/index.php/sosioedukasi/index

"KDS friends are also very supportive, especially if KDS friends are the same as us, right, very supportive of BGT" ***(YD10112025)***

"If we don't know what to do with our lives, then we will learn to live together, and if we don't know what to do, we will learn from each other." ***(RS10112025)***

*"My family supports the one who is hospitalized, that's really my family all who are waiting" (****IS13112025)***

*"When I first confided in my aunt, my aunt was already rich, just keep being rich, how else can this person risk your actions continue from my mom, he is not even surprised that he is already normal" (****CC13112025)***

"Eee from me I have to reach my family, especially the mother takes one year and yes, the response is shocked at first, yes it's just because she knows I'm healthy, maybe so it's like that, yes I don't feel any difference like that, as long as it's still healthy, I just accept it, it's even supported" ***(RK13112025)***

Social support from the KDS community and families helped participants feel not alone and accepted. The similarity of experiences at KDS strengthens mutual understanding, emotional support, and cooperation in sharing knowledge and mentoring. Family support through acceptance, maintaining status secrecy, and assistance when sick is a source of security that reduces isolation and strengthens participants' psychological resilience.

f. Self Acceptance

Self-acceptance is a process of coming to terms with the experience of self-pain and limitations, in which the individual stops the blame self-judgment and begins to view himself in a more human, realistic, and compassionate way.

"It's reconciled but it still takes time, so when someone is diagnosed, let them cry first" ***(YD10112015)***

"Okay, maybe it can be said to be peaceful, maybe there are still a little bit of regret, but one thing, we can't regret what has happened so we go through the process that we still have to live our lives for the future" ***(RS11112025)***

*"Now I realize that because of my own mistake like it or not, I also have to be married like the west, I don't want to live it, it's just like the rich already lived" (****BB13112025)***

"We can make peace with the person to receive the motivation so that we can keep calm and make ourselves more peaceful, that's the motivation" ***(RK13112025)***

*"I want to be rich and useful for people even though I am affected by this, but I can't still do my usual activities and I don't want to be rich with people who are sick like that" (****IS13112025)***

*"Self-reflection to myself is like this, it's already a risk that I have taken because of my own actions, and then I think like everyone else if I take the wrong path, I must be ready to take the risk, yes, I realize that" (****CC13112025)***

Participants interpreted self-acceptance as a gradual process that began with sadness, rejection, and regret, before finally reconciling with the status of ODHA. This process is characterized by the awareness that the past cannot be changed, so the focus is shifted to medication adherence, maintaining health, and moving on with life responsibly. Self-acceptance also encourages participants to continue to function socially, have a more positive meaning of life, and strive to be a useful person despite living with HIV.

g. Self awareness

Sosioedukasi
JURNAL ILMIAH ILMU PENDIDIKAN DAN SOSIAL
ISSN: 2086-6135 E-ISSN: 2541-612x
Volume 15 No. 1. March 2026 https://ejournal.unibabwi.ac.id/index.php/sosioedukasi/index

With *self-awareness*, individuals are able to recognize the source of negative emotions such as guilt, anger, and disappointment, so that they can respond to experiences more adaptively and support the psychological recovery process.

> *"Self-motivation is self-motivation if we are aware of ourselves and we feel that we need it, and we will be aware of ourselves" (**RK13112025)***
> *"A person has his own life and must be responsible for his own life, so he must strengthen himself and himself must be fully responsible" **(CC13112025)***

Participants emphasized that self-awareness and motivation are the main factors in the recovery process. When individuals are aware of their own needs, there is an attitude of responsibility and the ability to take care of themselves independently without having to be constantly reminded by others. *This self-awareness* is seen as a form of internal reinforcement, in which the individual realizes that each person is fully responsible for his or her own life and should be the main source of strength in the face of the conditions experienced.

DISCUSSION

This research aims to explore the experience of*Moral Injury*on *peer support* survivors of ODHA, a phenomenon that has been rarely studied in psychosocial studies in Indonesia, especially in groups that carry out the dual role of *survivor* as well as a companion. Moral Injury can occur in non-military populations, including civilians who have experienced interpersonal trauma or vulnerable groups with experiences of stigma and social trauma (Fani et al., 2021). The findings in this study show that *moral injury* In ODHA is not only internal (involving personal value conflicts), but is also triggered by the experience of moral betrayal by the social, institutional, and intimate environment, a finding that enriches the description of moral injury in the social psychology literature. Moral injury involves the psychological, social, spiritual, and behavioral impacts of actions that violate moral beliefs such as committing the act of violating oneself, failing to prevent and witnessing actions that violate morals (Litz et al., 2009).

Findings *perpetration-based moral injury* in the form of guilt, self-disgust, belief in God's punishment, and shame for the family are consistent with the findings of previous studies showing that internalized HIV stigma often develops into complex moral and psychological conflicts. Previous research has revealed that internalized stigma encourages individuals to blame themselves, experience deep shame, and view HIV as a moral consequence of past behaviors (Geibel et al., 2020). This is in line with the concept of Moral Injury defined by (Litz et al., 2009), where violations of upheld values can lead to deep guilt, shame, and remorse. Based on research conducted by (Rakasiwi & Nurchayati, 2020) HIV-positive individuals experience negative stigmatization and discrimination, as a result, they feel anxious, guilty and worthless.

Based on research conducted by (Ramadhan et al., 2024) Stigma against people with HIV/AIDS is still a major obstacle because it creates fear and makes people reluctant to get tested for HIV/AIDS, embarrassment to start treatment, and reluctant to receive education about HIV/AIDS. Stigma arises due to the public's ignorance of correct and complete HIV information, especially in the mechanism of HIV transmission, groups of people at risk of contracting HIV and ways of preventing it including the use of condoms. This stigma is the biggest barrier to HIV transmission prevention and treatment. In social life, stigma also hinders ODHA from carrying out social activities. They will shut themselves off and are not willing to socialize with family, friends, and neighbors (Mendrofa et al., 2021). In carrying out its duties, KDS often faces big challenges, especially in dealing with ODHA who are not willing to open up to their status. Strong stigma from the environment as well as self-stigma are the main obstacles. Based on research conducted by (Amal et al., 2024) noted that ODHA with high self-stigma tends to close themselves off, withdraw from treatment, and lose their zest for life. In this case, the task of KDS becomes very heavy, but also very important.

Sosioedukasi
JURNAL ILMIAH ILMU PENDIDIKAN DAN SOSIAL
ISSN: 2086-6135 E-ISSN: 2541-612x
Volume 15 No. 1. March 2026 https://ejournal.unibabwi.ac.id/index.php/sosioedukasi/index

The finding that religious beliefs about HIV as God's punishment deepen inner conflict and experience moral injury in *peer support* survivors of HIV are in line with previous research in Indonesia, which showed that the perception of HIV as divine punishment is related to shame, guilt, and delays in health decision-making (Hutahaean et al., 2025). Other findings also show that internal stigma against HIV significantly affects the self-esteem and psychological well-being of people with HIV (Sutanto et al., 2023). Research conducted by (Shaluhiyah et al., 2015), some people think that people with HIV/AIDS are people who have behaviors that are contrary to existing norms in society such as women sex workers, drug users, and homosexuals. This group is considered to be influencing as one of the factors in the spread of HIV/AIDS and makes people reject and hate the group.

This feeling is exacerbated by the emergence of self-disgust, this narrative shows a deep internalization of stigma, in which the individual not only feels hurt, but also dirty and cursed. Facing the reality of being an HIV-positive person presents significant psychological and social complexity. Individuals who are members of the population of People With HIVAIDS often have difficulty adapting, not only due to various external challenges, but also due to internal burdens. Some ODHA have difficulty receiving a diagnosis, which leads to prolonged negative mindsets such as feeling like they are just 'waiting for death', as well as an internal stigma that their condition is 'disgraceful', 'disgusting', 'despicable', and will be rejected by society. On a more severe level, the deep emotional distress of disappointment, sadness, and anger can prompt the emergence of ideas to end life (Muda et al., 2021). These findings reinforce previous research (Griffin et al., 2019) that *Moral Injury* It often involves the feeling of failing to meet the expectations of loved ones, including family as the closest people.

On *betrayal-based moral injury*, value conflicts in providing education and stigma experiences from institutions and social environments show that structural support for ODHA is still not optimal. These findings are in line with previous research showing that social stigma inhibits people with HIV from seeking appropriate care, delays diagnosis and treatment, and worsens their psychological condition, reflecting a lack of structural support from health systems and the social environment (Asyari et al., 2024). As a Peer Companion, often experience the form of *Moral Injury* What is unique is the conflict of values in providing education. This conflict causes moral distress because on the one hand they have a commitment to help, but on the other hand they are faced with rejection and risks that threaten themselves. In carrying out their duties, peer support often faces big challenges, especially in dealing with ODHIV who are not willing to open up about their status. Strong stigma from the environment as well as self-stigma are the main obstacles (Utami & Haryanti, 2025).

The findings of discrimination by health workers due to the status of ODHA are often found, in line with the findings of other studies that state that betrayal by the health system, which is supposed to be a refuge, actually hurts and reinforces the stigma that they do not deserve to be treated humanely. These findings are consistent with research (Idris et al., 2025) which reveals the high discriminatory intention of health workers against ODHA. Other research findings state that discrimination against health workers against people with HIV is a major barrier to HIV prevention and treatment, reflecting the need for improved policies and training to address stigma in health facilities (Zhang et al., 2025).

The experience of betrayal in intimate relationships, such as the transmission of HIV by a partner, emphasizes the importance of understanding interpersonal relationships in the study of moral injury. Recent studies show that intimate partner violence negatively impacts engagement in HIV care and can result in emotional stress and decreased openness to partners (Schrubbe et al., 2025). In addition, research on *betrayal trauma* indicates that emotional injury from betrayal by a partner creates profound psychological effects, including feelings of fear, vulnerability, and loss of trust (Barboza-salerno et al., 2025). It also shows that moral trauma does not only occur in individuals who commit actions that are considered wrong, but also in individuals who are victims of the actions of trusted parties. These findings expand the study of psychosocial trauma in ODHA by including intimate relationship experiences as a determinant factor of moral injury.

Sosioedukasi
JURNAL ILMIAH ILMU PENDIDIKAN DAN SOSIAL
ISSN: 2086-6135 E-ISSN: 2541-612x
Volume 15 No. 1. March 2026 https://ejournal.unibabwi.ac.id/index.php/sosioedukasi/index

Betrayal is not only experienced from the outside, but also comes from the sphere of the immediate family, where the individual feels treated solely as a financial resource. In addition, the absence of parents makes her without a figure to share stories, complain, or obtain emotional support. This situation shows the loss of *safety net* the most basic social aspects. In line with other research that states that financial exploitation carried out by family members against individuals who are in a position of dependence is a form of violation of trust in significant interpersonal relationships. Such practices not only injure the family's protective function as the main support system, but also have the potential to increase psychological vulnerability and worsen the mental health conditions of individuals who are targeted for exploitation (Hall et al., 2024).

Despite facing severe moral wounds, participants demonstrated a variety of resilient Moral Repair strategies. This recovery process is a transformative journey from passive victim to active agent in their own lives. Social support emerged as a crucial factor. ODHA follows a community such as a peer support group consisting of individuals of the same degree (Yunita & Lestari, 2017). Meeting people with similar conditions helped her reinterpret her experiences and change *self-disgust* became a motivation to rise up and make friends aware. This reinforces the findings (Øgård-Repål et al., 2022) that *peer support* creating an empathetic space that is free of stigma for people with disabilities. By seeing other individuals as equals, motivating ODHA to return to health (Windiramadhan, 2021). Peer support groups are a safe space for ODHA to share their experiences and feelings without fear of being judged. This task is essential in the process of emotional healing and helps individuals get out of the slump after knowing their HIV status (Anggraini & Sokhivah, 2024).

From this social support, self-acceptance grows (*self-acceptance*) and self-awareness (*self-awareness*). The results of the study state that the greatest power must come from within. This process of reconciliation involves the recognition that "life cannot end in mourning" and full responsibility for one's own life. Self-acceptance is a person's ability to accept themselves, which is related to a psychologically healthy condition, having awareness, and full acceptance of who and what is ODHA. Positive self-acceptance is important for everyone, including ODHA. An individual who is able to accept himself means that he or she is also able to understand himself, adjust to his or her environment, and not be afraid to look at himself honestly (Audina & Tobing, 2023).

This self-acceptance is often triggered by strong external motivations, such as parental responsibility that doesn't want their child to see them down. ODHA self-change causes various problems besides physical and psychological. Problems such as childcare, the burden on the economy and the role of single parents (Mendrofa et al., 2021). ODHA has a dual role both as parents and breadwinners for the economic needs of the family, especially children after the husband is gone. Children indirectly have a positive impact on the view of ODHA on reality, so that it becomes the main goal of continuing life. Children give a sense of optimism to ODHA (Syafitasari et al., 2012).

From self-acceptance, self-improvement efforts are born (*self-improvement*), helping others (*helping others*). By being a peer support, they turn their bitter experiences into a source of meaning and strength. They are no longer just passive victims, but active agents of change. The act of helping others who have gone through a similar path is a form of *meaning-making* which is very effective, because it restores their sense of self-worth and competence (Worthington Jr, 2013). Finally, the process *meaning-making* and getting closer to God helps participants integrate traumatic experiences into larger life narratives. For some, God is no longer perceived as a punisher, but as a source of peace and strength to live a new life.

CONCLUSION

This study provides an in-depth overview of the experience of moral injury in peer support of ODHA survivors, a phenomenon that is still rarely studied in the psychosocial context in Indonesia. The findings show that moral injury in this group is not only intrapsychic, in the form of personal value conflicts, guilt, shame, and self-disgust, but is also triggered by external experiences of moral betrayal, including social stigma, institutional discrimination, intimate

Sosioedukasi
JURNAL ILMIAH ILMU PENDIDIKAN DAN SOSIAL
ISSN: 2086-6135 E-ISSN: 2541-612x
Volume 15 No. 1. March 2026 https://ejournal.unibabwi.ac.id/index.php/sosioedukasi/index

relationships, and family relationships. The position of the participants as survivors as well as companions places them on a double moral burden, which reinforces moral distress and value conflicts in carrying out their social roles.

Theoretically, this study extends the concept of moral injury to non-military civilian populations, particularly ODHA, by asserting that moral wounds can develop in the context of stigma, structural injustice, and interpersonal relationships that violate trust. This finding also enriches the literature by positioning the peer support of ODHA not only as a supporting actor in health services, but as a subject of moral injury as well as an agent of moral repair. Moral injury in this study appears to be a relational and structural phenomenon, so its recovery cannot be understood solely as an individual process, but as an intersubjective process involving social relations, communities, and broader systems.

Despite facing severe moral wounds, participants demonstrated a resilient and transformative process of moral repair. Social support through peer community is a key factor that allows the emergence of self-acceptance, self-awareness, and the formation of new meaning in life. Through involvement as peer support, traumatic experiences are no longer interpreted solely as suffering, but are transformed into a source of meaning, strength, and social contribution. This process marks the shift of identity from passive victim to empowered active agent, and shows that helping others is an effective form of meaning making in the healing of moral wounds.

The findings of this study have important practical implications for the development of HIV services. Health services need to integrate trauma-informed care and moral injury-informed care approaches, which focus not only on medical aspects and medication adherence, but also on the recovery of moral wounds, internal stigma, and self-identity reconstruction of ODHA. In addition, peer support requires structured psychological supervision, value conflict management training, and protection from emotional exhaustion and moral distress. At the policy level, the results of this study affirm the urgency of strengthening anti-stigma policies, improving the empathy and professional ethics of health workers, as well as formal recognition of the role of peer support as a strategic component in the HIV service system.

However, this study has some limitations. A qualitative approach with a limited number of participants limits the generalization of findings to the broader population of ODHA. The focus on peer support causes the experience of non-companion ODHA to not be comprehensively accommodated. In addition, this study has not explored differences in moral injury experiences based on gender, age, cultural background, and religiosity, and has not captured the dynamics of moral injury and moral repair longitudinally. Therefore, further research is recommended to use a longitudinal design and involve a more diverse population to enrich the understanding of moral injury and its recovery process in ODHA.

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Volume 15 No. 1. March 2026 https://ejournal.unibabwi.ac.id/index.php/sosioedukasi/index

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ISSN: 2086-6135 E-ISSN: 2541-612x
Volume 15 No. 1. March 2026 https://ejournal.unibabwi.ac.id/index.php/sosioedukasi/index

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