Caring for those who care for us during the Covid-19 Crisis

Understanding and managing the effects of PTSD and Moral Injury for professionals involved in the Covid-19 crisis (Long version)

by Myrna Jelman – August 2020

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Foreword by the author

Across the world, the Covid-19 crisis has raised to our awareness our dependence on key workers of all types who we now know are the backbone of our society, economy and collective well-being. It is likely that many will suffer long-term emotional after-effects as a direct result of their contribution during the Covid-19 crisis.

When it comes to the likely waves of Post-Traumatic Stress Disorder (PTSD), Moral Injury and other trauma-related conditions that will arise in the months and years after this crisis abates, we will I hope, feel a sense of duty to care for those who cared for us and prepare a thoughtful and coordinated approach to their emotional support, now and following the crisis. It will require foresight, planning, financial investment and a dedication both to evidence-based practice and to a willingness to innovate.

I hope that this document will support those who are in a position to do this work, by accompanying their journey with information that can support their choice of treatments, policies, research programmes and organisational practices.

I also hope that this paper might be helpful to those who suspect they may be suffering from PTSD or have experienced a Moral Injury in offering them useful information to support their choice of treatment or support.

To all the readers of this article, I hope you will share this paper with those in a position to shape policy or practice around these issues in your organisations and your countries.

A shorter version of can be found at: www.springblueconsulting.com/springblue-articles

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About the author

Myrna Jelman specialises in Leadership and Organisation Development and especially in creating transformative learning experiences for both personal and organisational learning. She is also an executive coach and group facilitator. She has worked with numerous organisations in the private, public and humanitarian sectors, often at an international level. She has consulted to various parts of the NHS in the UK and is currently a coach on the Health Foundation's GenQ Leadership and Quality Improvement programme for senior leaders.

This paper started as personal background research following the prospect of volunteering to coach frontline health and social care staff during the spring of 2020. What started as a quick personal briefing to be a responsible coach grew into this report.

The author does not claim to have professional expertise in either PTSD or Moral Injury but hopes that the collated academic sources above will stand up for themselves in terms of usefulness.

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1 Executive Summary

Even during normal times, a certain proportion of professionals will end up suffering from Post-Traumatic Stress Disorder (PTSD) after experiencing a trauma at work. This proportion will increase if the professionals are also involved in the traumatic event(s) as civilians (Luce, et al., 2002). In addition, many may also suffer from a relatively new concept called Moral Injury.

We owe it to those who care for us during the Covid-19 crisis to prepare thoughtful policies, programmes, treatments and research to promote the return of these individuals to a healthy mental and emotional state.

This paper highlights in brief the mainstream treatments recommended for PTSD: Trauma-Focused Cognitive Behavioural Therapy (TFCBT) and Eye Movement Desensitisation and Reprocessing (EMDR) but also Schwartz rounds as well as new treatments based on recent discoveries in the field of neuroscience, such as Somatic Experiencing (SE) and Van Der Kolk's approach. These treatments are focused on appeasing the brain's physiological reaction to stress instead of asking the individual to re-live their emotions and experiences. The unfortunate controversy over team debriefing for professionals is explained, with arguments for and against detailed. Guidelines for professional team debriefing are offered.

Moral injury is introduced. Shay's original definition is offered:
1) a betrayal of what is right
2) by someone who holds legitimate authority
3) in a high-stakes situation (Shay, 1994)
Moral Injury can occur after individuals experience either perpetration or betrayal-based Potentially Morally Injurious Events (PMIEs) which cause them to experience certain moral emotions. Negative moral emotions are: Guilt, Shame, Anger, Disgust. Positive moral emotions are: Compassion, Pride and Elevation ("A feeling of warmth in response to witnessing human goodness or "moral beauty" and motivates better living and the emulation of good deeds (Keltner & Haidt, 2003, p. 305; Tangney et al., 2007 in Farnsworth et al., 2014)".

A related concept from nursing called Moral distress is touched upon and additional characteristics of Moral Injury are explained: Moral Injury across groups and across time, why heroification doesn't help, and finally the wisdom in holding Moral Injury as a lesson at the systemic level for both for organisations and societies. Treatment options are described in the form of programmes for veterans in the US, the main source of knowledge on Moral Injury to this day.

For both PTSD and moral Injury, reviewers of treatment efficacy agree that there is not enough good research to draw sufficiently robust conclusions, something very much needed at this time.

Finally, as the notion of support from trusted people in one's work environment seems to be one recurring element found to help mitigate the risks of PTSD, this paper proposes one simple, pragmatic method of peer support adapted from Co-counselling, called here Co-Listening, and which can very easily be implemented and sustained.

2 Introduction

In 2017, “Data were analysed from 26 population surveys in the World Health Organization World Mental Health Surveys. A total of 71,083 respondents ages 18+ participated. The Composite International Diagnostic Interview assessed exposure to traumatic events as well as 30-day, 12-month, and lifetime PTSD… The cross-national lifetime prevalence of PTSD was 3.9% in the total sample and 5.6% among the trauma exposed. Half of respondents with PTSD reported persistent symptoms” (Koenen et al., 2017). “Social disadvantage, including younger age, female sex, being unmarried, being less educated, having lower household income, and being unemployed, was associated with increased risk of lifetime PTSD among the trauma exposed” (Skogstad et al., 2013).

Under normal circumstances, a small proportion of emergency services professionals experience debilitating, long-term symptoms of Post-Traumatic Stress Disorder (PTSD). Skogstad et al (2013) share incidence for some professional groupings following an experience of trauma:

- 10% for Police officers
- close to 20% for ambulance personnel
- 20% for firefighters
- 30% for war correspondents

Unfortunately, the authors do not provide a figure for healthcare workers or mental health professionals, but nevertheless report the incidence as high.

In addition “Luce, Firth-Cozens, Midgley and Burges (2002) found that individuals who experience a trauma both as a civilian and as a professional have higher levels of symptomatology than do those who experience the traumatic event solely as a civilian or as a professional” (in Leitch, Vanslyke and Allen, 2009). How much worse is the incidence then likely to be following the Covid-19 crisis for all the professionals involved in tackling the crisis?

In their March 2020 article in the British Medical Journal, Greenberg et al (2020) summarised and predicted the mental health strain that is starting to show in our frontline staff. They talk of managing PTSD but also moral injury: “Moral injury, a term that originated in the military, can be defined as the psychological distress that results from actions, or the lack of them, which violate someone’s moral or ethical code. Unlike formal mental health conditions such as depression or post-traumatic stress disorder, moral injury is not a mental illness. But those who develop moral injuries are likely to experience negative thoughts about themselves or others… as well as intense feelings of shame, guilt, or disgust. These symptoms can contribute to the development of mental

health difficulties, including depression, post-traumatic stress disorder, and even suicidal ideation".

Williamson and Greenberg (2020) predict that "Front-line key workers, such as healthcare providers and emergency first responders but also other non- healthcare-related staff (e.g. social workers, prison staff) may be especially vulnerable to experiencing moral injuries during this time. A lack of resources may mean they are unable to adequately care for those they are responsible for which may result in great suffering or a loss of life. A lack of resources, clear guidance or training may also mean staff perceive that their own health is not being properly considered by their employers and feel at increased risk of disease exposure. Similar challenges may also be experienced by other essential workers such as supermarket workers or delivery drivers, who routinely would not have considered themselves as providing critical services to the public..."

"… It is important to note, just as not all individuals who experience trauma necessarily develop PTSD, exposure to Potentially Morally Injurious Events (PMIES) does not automatically result in moral injury" (Williamson and Greenberg, 2020).

Both PTSD and moral injury are important to address. For both, definitions will be shared along with highlights of relevant research and treatment options.

3 PTSD

Skogstad et al (2013) explain that "PTSD 'arises as a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone'".

3.1.1 Incidence data in US, Europe, Developing countries and by gender

Skogstad et al. (2013) also highlight other notable differences: "The prevalence of potentially traumatic events that are reported in the USA is generally higher than in Europe. Lifetime prevalence of PTSD in the USA has been reported to be around 10 % for women, who seem more vulnerable than men where the corresponding figures are 5%. Countries in Europe generally have a lower prevalence of PTSD, whereas data from developing countries suggest higher numbers".

3.2 Symptoms and diagnosis

The National Center for PTSD (US Department for veterans Affairs) describes the revised diagnostic criteria for PTSD in the fifth edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

"All of the criteria are required for the diagnosis of PTSD. The following text summarizes the diagnostic criteria:

Criterion A: stressor (one required)

The person was exposed to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):

- Direct exposure
- Witnessing the trauma
- Learning that a relative or close friend was exposed to a trauma
- Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

Criterion B: intrusion symptoms (one required)

The traumatic event is persistently re-experienced in the following way(s):

- Unwanted upsetting memories
- Nightmares
- Flashbacks
- Emotional distress after exposure to traumatic reminders
- Physical reactivity after exposure to traumatic reminders

Criterion C: avoidance (one required)

Avoidance of trauma-related stimuli after the trauma, in the following way(s):

- Trauma-related thoughts or feelings
- Trauma-related external reminders

Criterion D: negative alterations in cognitions and mood (two required)

Negative thoughts or feelings that began or worsened after the trauma, in the following way(s):

- Inability to recall key features of the trauma
- Overly negative thoughts and assumptions about oneself or the world
- Exaggerated blame of self or others for causing the trauma
- Negative affect
- Decreased interest in activities
- Feeling isolated
- Difficulty experiencing positive affect

Criterion E: alterations in arousal and reactivity

Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s):

- Irritability or aggression
- Risky or destructive behaviour
- Hypervigilance
- Heightened startle reaction
- Difficulty concentrating
- Difficulty sleeping

Criterion F: duration (required)

Symptoms last for more than 1 month.

Criterion G: functional significance (required)

Symptoms create distress or functional impairment (e.g., social, occupational).

Criterion H: exclusion (required)

Symptoms are not due to medication, substance use, or other illness.

Two specifications:

- **Dissociative Specification**: In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:

- **Depersonalisation:** Experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).
- **Derealisation:** Experience of unreality, distance, or distortion (e.g., "things are not real").

- **Delayed Specification:** Full diagnostic criteria are not met until at least six months after the trauma(s), although onset of symptoms may occur immediately.

3.2.1 Physical symptoms

Leitch, Vanslyke and Allen (2009) warn that "there is substantial evidence indicating that in addition to psychological trauma, survivors of trauma also suffer significant and often debilitating physical or somatic symptoms resulting from their experience. Thus, traumatic stress causes both mental health problems and a variety of serious somatic symptoms, including loss of bowel and bladder control, … shaking, trembling, and increased heart rate, … myofascial pain, … diabetes, … heart disease… and a continuum of stress-related diseases".

3.2.2 Timing of symptoms

The Royal College of Psychiatrists state that the symptoms of PTSD can start immediately or after a delay of weeks or months, but usually within 6 months of the traumatic event.

> "I am infected with the same virus that I have written down countless times as the "primary cause of death" on the death certificates of my patients… Did they give it to me? Or did I give it to them? I'll never know, but I stay up at night wondering…
>
> … While I sit at home in isolation, my mind is occupied by fear and guilt. I replay images of breathless patients in my head and recall my telephone conversations with their families. I wonder if I had been just that tiny bit more careful, or washed my hands once more or not scratched my face with my gloves that maybe I could have prevented some of those deaths…
>
> … Beyond all the fear and worry, I miss my friends and my family so much. They ring me daily and ask how I am doing. They probably can't even imagine the things that I have had to do or see. I don't know if I will ever tell them how bad things have got because I can't bear the thought of them being worried".
>
> Rosie Hughes (2020) "On the effect of getting Covid-19 'I feel fear and guilt':

3.3 PTSD Risk factors

"In adults exposed to trauma, risk factors for post-traumatic stress disorder include childhood abuse, family psychiatric history, low intelligence, lack of social support, and life stress… The intensity of the traumatic event and factors that follow exposure ("social support" and "further stressors") are the strongest predictors of PTSD, whereas "previous" (i.e., pre-traumatic) factors have smaller individual effects (combined effects were not computed)… Thus, once a traumatic event has occurred, the major risk factors for PTSD appear to lie ahead, suggesting ample opportunity for secondary prevention of this disorder" (Shalev, 2001).

If at-risk individuals' experiences in the direct aftermath of the crisis are a stronger predictor of their susceptibility to PTSD than previous risk factors, then how do we identify at-risk individuals and protect them during the crucial few months following trauma from any additional stressors that are under our control (e.g. job loss, re-organisation, etc.)?

3.3.1 For police officers

"Among 262 police officers followed after a critical incident, factors associated with post-traumatic stress reported after 3 months included introversion and difficulties expressing feelings, insufficient time given by the employer for individuals to deal with the trauma, dissatisfaction with the support from the organisation and a low degree of job security…"

… It has been found that the organizational and psychosocial work environment of police officers may affect the degree and strength of PTSD symptoms. Malfunction of equipment, a low degree of role clarity, dysfunctional social interaction between colleagues, the experience of being discriminated against and offence against physical integrity may increase the prevalence of PTSD." (Shalev, 2001)

3.3.2 For fire fighters

"Firefighters with high levels of hostility and low self-efficacy developed more post-traumatic symptoms, depression, anxiety and alexithymia (deficiency in understanding, processing or describing emotions)" (Shalev, 2001).

"In a longitudinal study of Australian firefighters engaged in a bushfire disaster, neither the severity of exposure nor losses of property were major determinants of morbidity at the last follow-up. Pre-morbid factors such as neuroticism and a history of psychiatric disorders were better predictors of post-traumatic stress symptoms. Fear of emotions and negative social interactions have also been associated with high levels of post-traumatic stress symptoms. In a cross-sectional study support from the trade union, employers, family and friends were associated with less depression" (Shalev, 2001).

"PTSD symptoms in volunteers exceed those of the professional firefighters, suggesting that training and experience protect against PTSD" (Shalev, 2001).

3.3.3 For ambulance personnel

"Lack of social support, unacceptable organizational conditions at work and individual factors have been associated with more PTSD symptoms among ambulance workers. They may suffer from persistent stress symptoms as a result of frequent exposure" (Shalev, 2001).

3.3.4 For healthcare professionals

"The suffering and death of patients are part of the workday, and physical assaults on health care personnel are a challenge in this occupational setting. Emergency health care workers who had experienced an emotionally distressing work event, which presented *either* a direct threat to themselves *or* a witnessed threat to patients, displayed similar levels of PTSD symptoms..."

"… Mental health professionals may be exposed to violence from patients and report high levels of PTSD symptoms. Senior nurses had fewer post- traumatic stress symptoms and symptoms of burn out syndrome compared with junior nurses. It is possible that nurses with persisting post-traumatic stress reactions leave the profession earlier, while the more resilient remain" (Shalev, 2001).

3.4 Resilience factors

Haglund et al (2007) summarise from academic evidence the existence of 6 psychosocial factors that protect against and aid recovery from Post-Traumatic Stress.

Factor	Definition
Active coping style	Problem-solving and managing emotions that accompany stress; learning to face fears
Physical exercise	Engaging in physical activity to improve mood and health
Positive outlook	Using cognitive-behavioural strategies to enhance optimism and decrease pessimism; embracing humour
Moral compass	Developing and living by meaningful principles; putting them into action through altruism

4 PTSD treatments

4.1 Cochrane review: trauma-focused CBT and EMDR

The Cochrane organisation's 2015 review of the evidence for psychological therapies for chronic PTSD in adults states that "Trauma-Focused Cognitive Behavioural Therapy (TFCBT) and Eye Movement Desensitisation and Reprocessing (EMDR) are currently recommended as the treatments of choice by guidelines such as those published by the United Kingdom's National Institute of Health and Clinical Excellence (NICE)" (Bisson et al., 2015).

"TFCBT is a variant of cognitive behavioural therapy (CBT), which includes a number of techniques to help a person overcome a traumatic event. It is a combination of cognitive therapy aimed at changing the way a person thinks, and behavioural therapy, which aims to change the way a person acts. TFCBT helps an individual come to terms with a trauma through exposure to memories of the event".

"EMDR is a psychological therapy, which aims to help a person reprocess their memories of a traumatic event. The therapy involves bringing distressing trauma-related images, beliefs, and bodily sensations to mind, whilst the therapist guides eye movements from side to side. More positive views of the trauma memories are identified, with the aim of replacing the ones that are causing problems…"

"… Although we included a substantial number of studies in this review, each only included small numbers of people and some were poorly designed. We assessed the overall quality of the studies as very low and so the findings of this review should be interpreted with caution. There is insufficient evidence to show whether or not psychological therapy is harmful" (Bisson et al., 2015).

4.2 Supplementary treatments and supportive alternatives

Keeping in mind the poor quality of evidence as assessed by Cochrane, it seems useful to describe supplementary treatments that may offer alternatives. Team debriefing, Schwartz Centre rounds (Now often referred to as Schwartz rounds) as well as two somatic approaches issued from advances in neuroscience will be described below.

4.2.1 The controversy around group debriefing

After being widely used as a method for stress-management, efficacy research into group debriefing has led to concerns about being used after trauma. However, some argue against the validity of the research quoted. Arguments representing both sides will be presented here.

In a 2003 article targeted at the Emergency Medical Services (EMS), Bryan Bledsoe seeks to expose the myth of the effectiveness of Critical Incident Stress Management (CISM) in managing EMS-related stress. He first starts with a short history. “CISM was introduced to EMS in 1983 through an article by Dr Jeffrey Mitchell published in a trade magazine. The process was called Critical Incident Stress Debriefing (CISD) and was described as "an organized approach to the management of stress responses in emergency services. It entails either an individual or group meeting between the rescuer and a caring individual (facilitator) who is able to help the person talk about his feelings and reactions to the critical incident." Later, the goals of CISD were expanded to include prevention of disorders that may develop as a result of traumatic stress, such as post-traumatic stress disorder (PTSD). It also came to serve as a tool to help identify personnel who should be referred for further treatment; to facilitate verbalisation of experiences; to normalise reactions to stressful events; and to improve peer group support and cohesion. The name of the process was changed to CISM, purportedly to reflect these more global objectives” (Bledsoe, 2003).

4.2.1.1 The case against group debriefing

In a recent document on mental health in emergencies, the World Health Organization (WHO) stated: "Because of the possible negative effects, it is not advised to organize forms of single-session psychological debriefing that pushes persons to share their personal experiences beyond what they would normally share”.

Similarly, in the UK, the latest NICE (National Institute for Health and Care Excellence) guidelines on PTSD explain that “given the considerable evidence for trauma-focused CBT, EMDR, self-help and non- trauma-focused CBT interventions targeted at specific symptoms, the committee considered it appropriate to set a relatively high bar for other interventions. No evidence was identified for psychologically-focused debriefing (for treatment of PTSD symptoms more than 1 month after trauma)” (p.285).

Answering for himself why CISM might not work, Bledsoe concludes “that CISM and other forms of psychological debriefing may actually interfere with the natural recovery process inherent in normal individuals. The alternation of intrusive and avoidant thoughts characterizes normal psychological processing following a traumatic event that may be disrupted by this approach to intervention. CISM may also lead affected personnel to bypass established personal support systems (family, friends, co-workers, clergy) usually used for non-occupational-related crises in the belief that the CISM session should be sufficient to alleviate their distress. Furthermore, a certain amount of time appears necessary for an individual to process the psychological impact of exposure to a traumatic event, and no external stimulus or program may be capable of shortening this interval.” (Bledsoe, 2003).

4.2.1.2 *The case for group debriefing*

By contrast, a British Psychological Society (BPS) Symposium on Early Intervention for Trauma yielded a challenge to the now widespread concern about group debriefing.

Hawker and Hawker (2015) state the case for group debriefing by returning to the original studies forming the basis for the NICE guidelines and highlighting the two poorly constructed randomly conducted trials (RCTs) where trauma victims offered debriefing had poorer outcomes following treatment compared to the control group. The studies were: Mayou et al (2000) and Bisson et al. (1997). Indeed, in those studies, debriefing was offered:

- to non-professional patients who had experienced trauma (e.g. burn victims) instead of trained professional teams
- too early (e.g. as early as within 24 hours of the trauma)
- in the wrong setting (e.g. in a noisy area of the hospital where patients were receiving treatment)
- for too short a time (e.g. 40mns instead of 2-3 hours plus follow-up contact)
- by the wrong people (e.g. insufficiently trained staff, or in one case by the same nurses who also deliver painful medical interventions to these patients)
- one-to-one instead of in groups

The NICE guidelines committee itself recognises that "with the exception of a handful of outcomes of moderate quality, all the evidence reviewed was of low or very low quality, reflecting the high risk of bias associated with the studies".

Hawker and Hawker (2015) continue: "What troubles us is that over-generalisation from the NICE guidelines has meant that some emergency service workers, aid workers and military personnel, who want to talk about their experiences in a debriefing setting, no longer have the opportunity to do so. We do not hold NICE or the researchers responsible for the over-generalisation, which may be an unintended consequence of well-intentioned guidance. Mayou et al. (2000) took particular care in stating: 'The findings are limited to individual trauma and cannot be extended to group debriefing or later intervention' (p.593). Bisson et al. (1997) cautioned that their results may not apply to group debriefing or to trauma other than burns trauma. Yet over-generalisation has occurred..."

"… Personnel in the military, emergency service and humanitarian aid fields often request debriefing, and speak of its benefit for them. Yet many of these self-sacrificial professionals are now being refused a valued form of support on the basis of the studies described. There is no evidence that debriefing is harmful when used with such groups. These groups report finding debriefing beneficial and recent RCTs have supported this.

Therefore, we believe that it is time to stop saying that debriefing is harmful for occupational groups, and to allow those who want to receive debriefing to be offered it, within the context of informed consent" (Hawker and Hawker, 2015).

It should be noted that the NICE guidelines were based on a large number of studies tackling traumas of very different types, including:

- Being an emergency responder in a traumatic event
- Motor Vehicle Collisions
- Witnessing war as a civilian 'Survivors of systematic violence'
- War refugees
- Survivors of genocide
- Terrorist attacks
- Childhood sexual abuse
- Domestic violence
- Exposure to non-sexual violence
- Natural disasters

The committee responsible for drafting the NICE guidelines themselves raised the important point that "there is limited evidence on how certain subpopulations with PTSD have differential response to alternative psychological treatments" (NICE guidelines Evidence D, p.289) and they draw out one significant difference for a professional group in their assessment of EMDR with its efficacy is only proved for non-combat related traumas.

Might each type of trauma engender a different psychological experience, even if the surface symptoms may be very similar? Might the efficacy of treatment not logically also differ if patients have experienced war, sexual violence in the home, a motor vehicle collisions, or on the job trauma? Once again, more research is urgently needed to further evaluate treatments by type of trauma and for professionals versus members of the public.

Hawker and Hawker (2015) bemoan the fact that "because guidelines have advised against the routine use of single-session CISD, some organisations have withdrawn debriefing… Some of our colleagues have admitted being so afraid of being accused of debriefing that they no longer ask about traumatic events when assessing patients who are known to have experienced trauma...

… However, many people still seek debriefing. Having considered the evidence, many organisations in the UK (and abroad) continue to use CISD openly. These include NHS foundation trusts, police services; NGOs and United Nations departments (Regel et al, 2014). Some professionals continue to offer CISD, but now use a different name for it, having been told they can do debriefing as long as they use another name such as Psychological First Aid" (Hawker and Hawker, 2015).

Hawker and Hawker offer guidelines for those wanting to use good practice debriefing. It should:

- Never be compulsory
- Not offered too soon after trauma, but instead when the recipient is receptive, in which case it can act as a reinforcement of the fact that the trauma is now in the past and a new phase of recovery begins
- Not be too short, usually 2-3 hours with some follow-up contact

- The credibility of the debriefer is important and knowledge of the emergency services culture is preferable for that population
- No probing for details, instead asking people to recount what happened from their perspective
- Emphasise the event is in the past, support coping strategies and encourage a return to normal

4.2.2 Schwartz Centre rounds

Greenberg et al. (2020) suggested using Schwartz rounds as early support for staff during the crisis. The Schwartz Centre for Compassionate Healthcare explains that "the Schwartz Rounds program, now taking place in hundreds of organizational members in the U.S., Canada, U.K., Ireland, Australia and New Zealand offers healthcare providers a regularly scheduled time during their fast-paced work lives to openly and honestly discuss the social and emotional issues they face in caring for patients and families. In contrast to traditional medical rounds, the focus is on the human dimension of medicine. Caregivers have an opportunity to share their experiences, thoughts and feelings on thought-provoking topics drawn from actual patient cases. The premise is that caregivers are better able to make personal connections with patients and colleagues when they have greater insight into their own responses and feelings… Panellists from diverse disciplines participate in the sessions, including physicians, nurses, social workers, psychologists, allied health professionals and chaplains. After listening to a panel's brief presentation on an identified case or topic, caregivers in the audience are invited to share their own perspectives on the case and broader related issues" (Schwartz Centre for Compassionate Healthcare website). The Point of care foundation has a license with the Schwartz Center for Compassionate Care in Boston, USA to run the Rounds in the UK.

"The purpose of Rounds is to understand the challenges and rewards that are intrinsic to providing care, not to solve problems or to focus on the clinical aspects of patient care. Rounds can help staff feel more supported in their jobs, allowing them the time and space to reflect on their roles. Evidence shows that staff who attend Rounds feel less stressed and isolated, with increased insight and appreciation for each other's roles. They also help to reduce hierarchies between staff and to focus attention on relational aspects of care. The underlying premise for Rounds is that the compassion shown by staff can make all the difference to a patient's experience of care, but that in order to provide compassionate care staff must, in turn, feel supported in their work" (Point of Care Foundation website).

The National Institute for Health Research (NIHR) reviewed the effectiveness of Schwartz rounds against alternative programmes and found that "there was no change in

engagement, but poor psychological well-being (12-item General Health Questionnaire) reduced significantly ($p < 0.05$) in Rounds attenders (25% to 12%) compared with non-attenders (37% to 34%)… Rounds were described as interesting, engaging and supportive; four contextual layers explained the variation in Rounds implementation. We identified four stages of Rounds, 'core' and 'adaptable' components of Rounds fidelity, and nine context–mechanism–outcome configurations: (i) trust, emotional safety and containment and (ii) group interaction were prerequisites for creating (iii) a countercultural space in Rounds where staff could (iv) tell stories, (v) self-disclose their experiences to peers and (vi) role model vulnerability; (vii) provide important context for staff and patient behaviour; (viii) shining a spotlight on hidden staff and patient stories reduced isolation and enhanced support/teamwork; and (ix) staff learned through reflection resulting in ripple effects and outcomes. Reported outcomes included increased empathy and compassion for colleagues and patients, support for staff and reported changes in practice. The impact of Rounds is cumulative". (Maben et al., 2018)

4.2.3 Physiological and Somatic treatments

Moving away from purely psychological routes, a relatively new school of thought emerges from progress in the field of neuroscience and our increased understanding of the changes to the brain's physiology caused by the experience of trauma.

These in turn have prompted alternative trauma treatments that focus on helping patients' brains and bodies to accept that the trauma is indeed over and to relax the physiological response, whether arousal or immobilization, that keeps them living the trauma in the present long after the reality of the traumatic experience has ended.

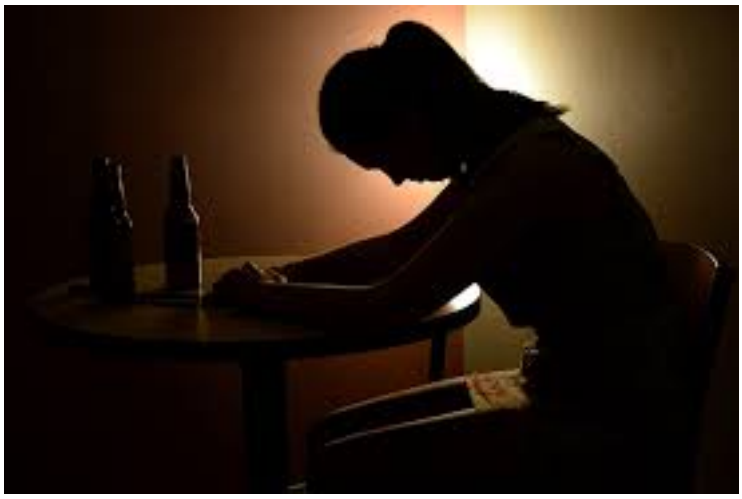
A meta-analysis by Sakellariou and Stefanatou (2017) on the neurobiology of PTSD and implications for treatment concludes that "a combination of medication and psychotherapy is suggested for the treatment of PTSD. Body awareness studies are promising. As scientists and clinicians, we certainly have to develop methods of treating a disease as a personal experience of a global phenomenon...

…The clinical picture PTSD sufferers present is characterized by the disruption of experience, movement and action, the tendency to respond to triggers in the here and now with automatically activated action patterns of the traumatic past, the restricted attention capacity and working memory that causes increased engagement in the present, the difficulty to identify and articulate their sensations, feelings and physical condition in an adequate manner. Taking these facts into consideration the question emerges how can traditional approaches of CBT and psychodynamic therapy that are based on understanding and insight efficiently cope with the challenge of treating PTSD sufferers? Bessel A. Van der Kolk, a pioneer in the field of PTSD treatment concludes that "Neither CBT protocols nor psychodynamic therapeutic techniques pay sufficient attention to the experience and interpretation of disturbed physical sensations and pre-programmed physical action patterns"" (Sakellariou and Stefanatou, 2017).

4.2.3.1 Bessel Van der Kolk, author of 'the body keeps the score'

In a 'Science of Success' podcast (See Resources), Bessel van der Kolk explains his approach.

Trauma is defined and recognised by the level of helplessness attached to the experience. What trauma does to the brain is make it feel as if it is still going on, over and over with the body staying in constant alert for something "The perceptual system is rewired to overreact to current stressors". It also makes it more difficult to learn and grow as a result. New neuroscience technology allowing visualisation of the areas of the brain affected by trauma enabled the discovery that trauma affects the 'housekeeping' part of the brain and barely goes into the rational part of the brain.



The body as a result puts those affected in either arousal (Fight and Flight response) or shutdown (Freeze response) mode. The shutdown response explains people turning to alcohol and drugs as they try to shut down sensations in keeping with the urge brought on by their deregulated brain functions but they also might do so because they are scared of their body's attempt to engage a Fight or Flight response and the strong bodily sensations associated with that unfamiliar physiological response., which in animals discharges fast and leaves little observable trace.

In this school of thought, healing comes from ensuring the brain learns to believe that the trauma is now really over and restores its normal functions. This is done with mind-body awareness and in the absolute safety needed for the brain to exit its stuck pattern.

In his research, Van der Kolk found that yoga was more effective than drugs in helping this dynamic. He shares his assumption that other practices that teach self-regulation of the body would also be effective and names Qi Gong and Tai Chi. He also adds that chanting in groups helps, explaining that the experience of trauma makes sufferers feel isolated within themselves and the experience of chanting with others helps, adding that such practices have of course been used in religions and in armies for centuries.

On exposure therapies (i.e. healing through asking the patients to revisit the memory), Van der Kolk is clear that he believes this is the worst thing you could do. Such techniques may desensitise the trauma but also desensitise the client about other aspects of life too. "It is not the memory that is the issue, it is that your brain relieves it in the present".

Instead, according to him, the most helpful practice is to create an environment of safety where patients can feel safe in their body and find control of their physiology through feeling the intense sensations associated for example with the return of arousal (Fight and flight) without being scared by them.

For this reason, van der Kolk is cautious about the use of pure meditation because by becoming still, thoughts and feelings emerge that may overwhelm the patient. Instead he deems that body-mind practices that keep the mind occupied such as Tai Chi or Yoga are safer.

At his final words, Van der Kolk insists that "none of this has to do with understanding. Understanding why you're messed up does not stop you being messed up. It is not a problem you can rationally solve".

Indeed, it seems perfectly rational that the experience of Trauma may trigger physiological changes that need to be treated in a different manner than our thoughts and feelings about the trauma.

4.2.3.2 Somatic Experiencing (SE) and TRM (Trauma Resiliency Model)

Peter Levine, recipient of the Lifetime Achievement award from the United States Association for Body Psychotherapy (USABP) in 2010 for his work in the field of stress and trauma, is the developer of the Somatic Experiencing (SE), a method concerned with restoring the balance of the nervous system to treat PTSD symptoms.

Leitch, Vanslyke and Allen (2009) explain that Trauma Resiliency Model™ (TRM), developed by Laurie Leitch and Elaine Miller-Karas, is the brief, early intervention form inspired by SE, used for stabilization in disaster and emergency settings. SE/TRM emphasizes that human responses to threat are primarily instinctive and biological and are only secondarily cognitive and psychological" (Leith, Vanslyke and Allen, 2009).

They further explain that "SE/TRM is designed to be used in settings in which brief treatment is appropriate… SE/TRM develops sensory resources (for example, places in the body that do not feel pain, places that feel strong, alive) that help the client feel safe in developing sensory awareness and the corresponding self-regulation. The clinician then works with small increments of traumatic sensation (the SE skill is called *titration*) alternated (the SE skill is called *pendulation*) with work with resource states in the body. It is believed that the alternating awareness between traumatic sensations and resource sensations helps restore the natural, pre-trauma rhythm of the autonomic nervous system. As the work shifts from trauma sensations to resource sensations, blocked traumatic energy that was originally intended for mobilization of the fight or flight response is released (and can be observed as trembling, heat, tingling, stomach gurgling, tears, laughter)" (Leitch, Vanslyke and Allen, 2009).

The authors share a study to assess the efficacy of their brief stabilisation SET method (Somatic Experiencing Treatment) offered directly following hurricane Katrina and hurricane Rita to social service workers. "The results, although tentative because this was not a randomized controlled trial, do suggest that SE/ TRM was effective in attenuating the observed emergence of PTSD symptoms and promoted resiliency... … The promising results of this study raise the interesting question of whether there may be a "window of opportunity" in which an integrative, low-dosage intervention such as SE/TRM can promote stability shortly after a disaster. There is considerable debate about when it is appropriate for mental health interventions to be initiated following catastrophic events. Studies of crisis intervention used immediately following a traumatic event have shown

mixed or, as in the case of Critical Incidents Stress debriefing, negative results. However, traditional models of crisis intervention focus on problem solving and rely on other cognitive skills. Research cited earlier shows that during and immediately after stress, the executive functions of the neocortex are diminished. This may account for the mixed results of traditional early interventions. An early intervention stabilization model such as SE/TRM that focuses primarily on restoring nervous system regulation appears to be effective at relieving distress and PTSD symptoms and increasing resiliency in the early stages of post disaster response when it is often difficult, if not impossible, to provide more than one or two sessions. SE/TRM is also a useful complement to cognitive models" (Leitch, Vanslyke and Allen, 2009).

It seems important to research the potential benefit of somatic-based approaches at the very early stages of a trauma, as a complement to other approaches later on.

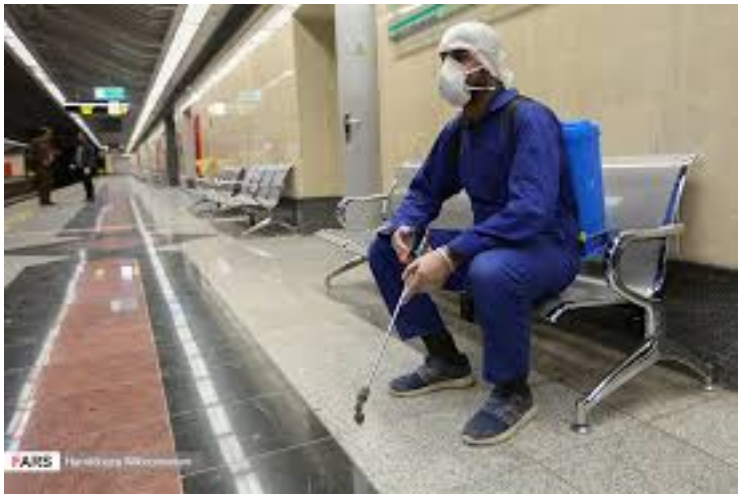
5 Moral Injury

"The nascent concept of moral injury focuses on the emotional damage resulting from perpetrating, witnessing, or falling victim to perceived moral transgressions. That is, while PTSD is about acts that violate one's sense of safety, moral injury concerns acts that violate one's sense of morality and ethics (Molendijk, 2018)".

Anyone who has been involved in the frontline of the Covid-19 crisis but also anyone who has been involved in decision-making that impacted lives directly may experience moral injury. This includes:

- Healthcare, Social care and Mental Health professionals
- Public sector professionals (Police, Immigration, civil servants, etc.)
- The charitable sector
- Journalists and politicians
- Affected medical research and medical testing, government scientific advisors
- Public transport and distribution professionals
- Food production, distribution and retail workers

Rita Brock, director of the US-based Shay Moral Injury Center tells us that "betrayal wrecks trust, profoundly disrupts identity, and destroys relationships" (In Jeffrey, 2020).



"Both Brock and Palmer fear that some healthcare workers will take their own lives because of moral injuries experienced during the pandemic, having been crushed by the decisions they were forced to make, unrelenting grief, and fury and humiliation at the authorities who failed them" (Jeffrey, 2020). It becomes obvious that many of us must learn much more about moral injury in order to adequately support all individuals who may be affected.

5.1 What is moral injury?

Jonathan Shay introduced the concept of Moral Injury in his 1994 book 'Achilles in Vietnam'. He described it as 1) a betrayal of what is right, 2) by someone who holds legitimate authority, 3) in a high-stakes situation. (Shay, 1994)

It is important to remember that moral injury started with betrayal by leadership. Its current conceptualisation has slipped from being about an individual's betrayal by the system and power structures to something more akin a syndrome suffered by the individual. We will return to this most important distinction later.

Since Shay's first definition, the concept has evolved. In 2009, Brett Litz and colleagues defined Potentially Morally Injurious Events (PMIEs) as "perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations may be deleterious in the long term, emotionally, psychologically, behaviourally, spiritually, and socially" (2009, p. 695).

According to Litz et al., the term moral injury had been developed in response to the inadequacy of mental health diagnoses such as PTSD to encapsulate the moral anguish service members were experiencing after returning home from war. Unlike PTSD's focus on fear-related symptoms, moral injury focuses on symptoms related to guilt, shame, anger, and disgust.

5.1.1 Moral distress

Before dwelling further into Moral Injury, it is worth discussing the adjacent concept of Moral Distress, a concept from the nursing world. Moral Distress first coined in 1984 by Andrew Jameton and defined by the American Nurses Association's Code of Ethics for Nurses with Interpretive Statements as "the condition of knowing the morally right thing to do, but institutional, procedural, or social constraints make doing the right thing nearly impossible."

Rushton et al (2017) explain that "the concept has been associated with negative consequences for both people and systems. At the individual level moral distress may cause burnout, lack of empathy, and job dissatisfaction, while at the organizational level it may lead to reduced quality of care, increased staff turnover, and poor patient outcomes… There is a paucity of research into moral distress, including its true cost to both individuals and systems and highlight a very important point for our particular context, that a "well-documented aspect of the experience of moral distress is its nonlinearity… arguing that the accumulation of moral distress has a cumulative effect, also known as a "crescendo effect," that may escalate progressively over time" (Rushton et al., 2017).

Rushton et al (2016) argue that experiences of moral distress may be an opportunity to develop moral resilience, which has been defined as "the capacity of an individual to sustain or restore [her or his] integrity in response to moral complexity, confusion, distress, or setbacks." The authors propose that "moral resilience encompasses several dimensions, including:

- knowing who you are and what you stand for in life

- a commitment to ongoing exploration, refinement, or in some cases revision of one's values, ideals, and point of view (moral conscientiousness)
- cultivating self-regulatory capacities
- being responsive and flexible in complex ethical situations
- [the] capability to discern the boundaries of integrity including the exercise of conscientious objections
- the ability to be resolute and courageous in one's moral action despite resistance or obstacles
- being able to discern when one has exerted sufficient effort to fulfil one's ethical obligations and to be realistic about one's limitations and the constraints and pressures of the situation
- seeking meaning in the midst of situations that threaten integrity or cause dissonance with one's moral sensitivity and reasoning…"

"… Creating morally habitable work environments means encouraging nurses (and other clinicians) to voice their emotional concerns, and this is essential to the provision of nursing care that more closely meets the core values of the profession. New educational interventions should strive to create such environments, using a robust variety of approaches" (Rushton et al, 2016). The authors refer to ethics training as an obvious route to engaging in Moral Resilience training.

Rushton et al (2016) continue: "Suggested interventions for teams include structured interdisciplinary debriefing sessions, interdisciplinary discussions to facilitate explicit discourse about morally distressing cases, and colleague-to-colleague dialogues to foster mutual understanding". Once again, it seems that teams of professionals coming together to reflect on morally distressing experiences would be beneficial. This seems to support the practice of team debriefing and Schwartz rounds but also that of Co-Listening which will be introduced later in this document.

"Several factors make practice environments increasingly likely to engender moral distress; these include nurse staffing shortages, increased patient acuity, lack of intra- and interdisciplinary collaboration, and an unsafe or inadequate moral climate. Mitigating these environmental factors will require significant political as well as organizational change" (Rushton et al, 2016).

> "Psychiatric wards are not designed for physical distancing… We have limited PPE. We get it, we are not priority – but we are scared because we are locked into spaces with people who find it almost impossible to physically distance. We know that if one goes down, we all do…
>
> … Staff anxiety is high. We are absorbing the fear and distress of our patients while trying to contain our own. We all feel vulnerable. It is no longer shocking to see colleagues break down on shift, and the exhaustion of holding everyone's emotions is taking its toll".
>
> Anonymous (2020) "My mental health ward is not equipped for coronavirus. We feel like sitting ducks", The Guardian, 14th April 2020

It is clear that further research into both moral distress and moral injury needs to be carried out. For the purposes of this report, information gleaned from research and practice in the moral injury field will be the focus, despite the research being largely focused on the experience of veterans and army personnel, because of a dearth of research on moral distress and the fact that moral injury seems to have been referred to more often than moral distress in recent publications about the impact of Covid-19 on frontline staff mental health (e.g. Williamson, Murphy and Greenberg, 2020).

5.1.2 Causes and potential risk factors of moral injury

Farnworth et al (2014) explain that "initial exploration of the potential causes and consequences associated with moral injury suggest that the construct is distinct from the classic threat-based conception of trauma. In a qualitative study of 23 clinical professionals with extensive backgrounds working with service members (Drescher et al., 2011), the most commonly identified stressors that might precipitate a moral injury included betrayals (e.g., leadership failures, failure to act in accordance with one's personal values), incidents involving injury or harm to civilians (e.g., killing, unnecessary destruction of property), within-rank violence (e.g., friendly fire incidents, sexual assault), inability to prevent death/ suffering, and ethical dilemmas/moral conflicts…

…Reviewing this list of potential causes reveals that although threat to life and safety may also be present, morally injurious stressors are characterized by additional features, such as the violation of social trust and distress over involvement in inflicting harm on others."

Williamson, Murphy and Greenberg (2020) share their expectation about the likely occurrence of Moral Injury resulting from the Covid-19 crisis.

The Potentially Morally Injurious Events (PMIEs) they refer to are events that are risk factors for moral injury. The authors explain that "much of the research in moral injury at this stage has been carried out in military personnel and veterans. However, several potential risk factors for moral injury have been identified that may be applicable to other professions during the COVID-19 Pandemic:

Potential risk factors for moral injury
1. Increased risk of moral injury if there is loss of life to a vulnerable person (e.g. child, woman, elderly); 2. Increased risk of moral injury if leaders are perceived to not take responsibility for the event(s) and are unsupportive of staff; 3. Increased risk of moral injury if staff feel unaware or unprepared for emotional/psychological consequences of decisions; 4. Increased risk of moral injury if the Potentially Morally Injurious Event (PMIE) occurs concurrently with exposure to other traumatic events (e.g. death of loved one); 5. Increased risk of moral injury if there is a lack of social support following the PMIE".

5.2 Moral emotions

First of all, it is important to distinguish between two types of Potentially Morally Injurious Events (PMIEs) as labelled by Jordan et al (2017): There can be perpetration- or betrayal-based morally injurious events.

As much of the research on moral injury is issued from supporting military personnel in returning to duty, it is likely that perpetration-based moral injuries are significantly more researched than betrayal-based PMIEs. Nevertheless, some psychological dynamics start being better understood. For example, the extent to which someone might experience moral injury as a result of experiencing a PMIEs seems to be regulated by the moral emotions they experience. Moral emotions fall in three categories below. It is useful to delve further into each emotion to understand its meaning in this context.

5.2.1 Painful self-conscious emotions: Guilt and Shame

Farnsworth et al. (2014) describe the emotions:

Guilt: "The emotion of guilt centers on a negative evaluation of a specific behavior and is associated with tension, remorse, and regret over the perceived infraction (Tangney, Stuewig, & Mashek, 2007)… Guilt has historically been considered a prosocial emotion, as the tension created by damage to one's valued relationships will ideally be associated with accepting responsibility and initiating reparative actions in response to transgression (Tangney et al., 2007)"

Shame: "Shame has been consistently associated with a wide variety of psychological symptoms across populations and measurement methods (e.g., Tangney et al., 2007). Whereas guilt focuses outwardly on a specific behaviour, shame involves a negative global evaluation of the core self that is accompanied by feelings of worthlessness, powerlessness, and feeling vulnerable and exposed (Lewis, 1971; Tangney et al., 2007).

Accordingly, whereas guilt can promote greater empathy and socially reparative actions, shame typically activates social hiding behaviours and decreases empathy due to increased preoccupation with one's own distress and emotional discomfort (Joireman, 2004). Furthermore, shame has been robustly associated with substance abuse, anger, and aggression (e.g., Tangney & Dearing, 2002), whereas guilt often discourages these types of problematic behaviours (e.g., Tangney, Miller, Flicker, & Barlow, 1996)" (In Farnsworth et al., 2014).

5.2.2 Other-condemning emotions: anger, disgust and contempt

Anger: "Of these three other-condemning moral emotions, anger is the most widely researched in military populations and involves a tendency to aggressively approach others in order to discourage or end acts that are perceived as immediate threats to the self or desired goals and rewards (Hutcherson & Gross, 2011). In particular, evidence suggests that anger can be provoked by the perceived intentional violation of one's personal rights and freedoms (Rozin, Lowery, Imada, & Haidt, 1999; Russell & Giner-Sorolla, 2011)".

Disgust: "Moral disgust is… evoked by acts that are perceived to contaminate one's sense of moral purity… (Haidt, Rozin, McCauley, & Imada, 1997)… Research has found moral disgust reactions tend to be highly resistant to change (e.g., Hutcherson & Gross, 2011; Haidt et al., 1997)".

Contempt: "Contempt, the third other-condemning moral emotion, is arguably the least understood at present, although evidence has supported it as a distinct moral emotion that pertains to judgments of others as incompetent or morally lax (Hutcherson & Gross, 2011). Prior research with non-military samples has also implicated contempt in response to violations of communal relationships (i.e., respect for hierarchies and social obligations; Rozin et al., 1999; Laham, Chopra, Lalljee, & Parkinson, 2010)" (In Farnsworth et al., 2014).

Similar to the paucity of research on PTSD by type of trauma and by type of population, it seems there is also a need to research the characteristics of Moral Injury by emotion: It is likely for example that Moral Injury centred around guilt might respond to very different treatments to Moral Injury centred around contempt.

5.2.3 Positive moral emotions: compassion, elevation and pride

Three positive moral emotions potentially point to foundations for treatment.

Compassion: "Lazarus (1991a) defines compassion as the emotion that is experienced "when one comprehends and reacts to someone else in trouble by wanting to ameliorate the suffering" (p. 821) and enhances social cohesion by encouraging caregiving between group members. In addition, a growing body of research has documented the beneficial effects of directing compassion toward oneself, a process that Neff (2003) describes as "being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness" (p. 87). Research suggests that self-compassion serves as a buffer to negative emotion while

simultaneously encouraging taking responsibility for personal failures (Leary, Tate, Adams, Batts Allen, & Hancock, 2007)".

Elevation "can be described as a feeling of warmth in response to witnessing human goodness or "moral beauty" and motivates better living and the emulation of good deeds (Keltner & Haidt, 2003, p. 305; Tangney et al., 2007)".

Pride "can be considered a positive moral emotion that provides feedback about the self as being good, competent and virtuous (Lazarus, 1991b; Lewis, 1993)" (In Farnsworth et al., 2014)

5.3 moral emotions and group norms

Social-functional perspectives of moral emotions suggest that moral emotions are attached to different behaviours across different groups. An illustration is that of the soldier who learns a moral code within the army that is different to that their civilian circles, causing some of the disturbances they experience when returning to civilian life, i.e. what causes pride or contempt in an army context is very different to what causes pride or contempt in a civilian context.

Farnworth et al (2014) further explain that "upon entering basic training, recruits are immersed into a new moral system. This assimilation usually involves intensive socialization and indoctrination for the purpose of reorienting a recruit's moral emotions and judgments to the social context of their military branch (Soeters, Winslow, & Weibull, 2006). Training drills, rituals and ideologies (e.g., *semper fi*) form individual and collective military identities, which are calculated to enhance both small and large group cohesion, and ultimately survival in the theatre of combat (Manning, 1994). This training capitalizes on moral emotions such as pride in order to generate an *esprit de corps* that will bind recruits' sense of self and obligation to their respective military branches and comrades in arms. A recruit's successful completion of basic training therefore involves not only competence in fundamental professional skills but a sense of moral identification with the military culture as well..."

"…This selfless commitment to the larger group is critical for survival in the context of a war-zone deployment. Here, where concern for the welfare of one's comrades is the preeminent determiner of morality, sharp distinctions are created between friendly and enemy forces. Moral emotions and judgments become likewise calibrated to the immediate social context of combat, wherein morality is defined as the suppression of (oftentimes lethal) external threats to ensure the success and survival of one's unit members. In such a moral system, the greatest shame for a service member would be to forsake his or her

unit in the face of danger, and the greatest moral anger is typically reserved for those who put group members at risk". (Farnworth et al., 2014)

If moral codes differ across groups and are learnt and reinforced by recruitment, training and work norms, it may be useful to understand what is considered morally 'right' and morally 'wrong' in each professional grouping involved in Covid-19. What is right to a politician may be different to what is right for a civil servant, to what is right for an epidemiologist, a social care senior leader, a vaccine researcher, a clinician, a nurse, a porter, etc. Some of the moral injury may happen at the intersection of such groupings where one's moral rules do not fit another's.

"Cross-cultural research has identified that moral emotions are evoked in relation to a number of core social issues such as caring, fairness, loyalty, authority and sanctity" (Graham, Haidt, & Nosek, 2009). To find out the moral norms of any particular grouping, you might therefore ask the following questions:

- How do you show care in this group? Or recognise that someone is lacking care?
- How is fairness maintained? What constitutes unfairness?
- How does loyalty/disloyalty manifest itself?
- How does authority manifest itself and how do group members respond? What constitutes a betrayal of authority in this group?
- What has sanctity in this group? Why?

5.4 The time factor in moral injury

The Moral Injury Project at Syracuse University highlights that "moral injury almost always pivots with the dimension of time: moral codes evolve alongside identities, and transitions inform perspectives that form new conclusions about old events". With their work centred on helping veterans, it may explain the delay in experiencing moral injury as an individual gradually gravitates from a military moral code to a civilian moral code and looks back on actions carried out and events experienced in service with new eyes, especially as news becomes history and military decisions are eventually classed as either successful or unsuccessful, warranted or unjustified.

What might be the particular dynamic over time for moral injury during the Covid-19 crisis? Will moral injury be more immediate in this case or would some individuals realise the depth of the betrayal they feel after public inquiries are held on, say, in the case of the UK, the date of first lockdown, provision of PPE or social care policy? Will individuals realise the guilt they hold after evaluating their unit's work against other hospitals, mental health wards, elderly care homes, other countries?

> *"It's now clear that so many people have died, and so many more are desperately ill, simply because our politicians refused to listen to and act on advice. Scientists like us said lock down earlier; we said test, trace, isolate. But they decided they knew better... Between 12 and 23 March, tens, if not hundreds of thousands, of people will have been infected". Helen Ward is professor of public health at Imperial College London*
>
> *Helen Ward (2020) "We scientists said lock down. But UK politicians refused to listen", The Guardian, 15 April 2020*

5.5 Moralisation and heroification adds to moral injury

The social-functional perspective might also explain how high moralisation or heroification of key actors might contribute to increasing moral injury as they are judged by 'external' standards which may hold little validity compared to the views of their peers shaped by the same moral code.

Molendijk (2018) explored the ways in which the experience of moral injury is embedded in and shaped by public debates on military intervention. She highlights that "public criticism and admiration may both be experienced as misrecognition, and, in turn, societal misrecognition may directly or indirectly contribute to moral injury".

This dynamic seems particularly important in a context where we are talking of our 'NHS heroes' in the UK and much of the rest of the world is making heroes of their health and social care staff.

This additional social and emotional isolation of frontline teams involved in the crisis behind the current bubble of heroification, or indeed behind gagging orders from their organisation, may create more damage than good, with individuals feeling unable to raise when they don't feel they are up to the task, for fear of not living up to the image of the frontline superhero so reassuring to the rest of the population. They may also fear betraying their unit. In some cases, the team or work unit may have become the oppressive psychological force that makes it impossible to act morally according to the individual's own conscience, thus causing a moral injury.

In terms of intervention strategies, tackling any form of alienation must be part of any treatment for moral injury as individuals are likely to feel that 'no one else understand what we've been through'.

Going back full circle to the original definition of moral injury, by having largely removed the notion that moral injury is an injury between an individual and a system, or between an individual and a leadership or political decision, means that individuals are now left to suffer the symptoms alone but also in silence when, at its source, moral injury might instead be trigger for political change, for societal transformation.

5.6 The missing link: politics and moral injury

Molendijk (2019) states that studies have emerged examining the ways political, economic and cultural forces produce distress, thus locating society firmly back within the many dynamics that might cause or aggrieve individual suffering.

"Having one's dependency and trust betrayed is indeed what many of the interviewed veterans describe. In response, these veterans sought reparation from the political domain at least at one point in their lives… To them, their suffering was not caused by risks that are simply part of the job, but by avoidable political failure… Being confronted with political failure and intentional silence, veterans developed the sense that they were part of a "puppet show… For them, it meant an inability to find meaning and justification beyond the direct experience of injustice and a sense that they were being used and abandoned while all of this was denied. As a result, these veterans developed the sense that they were betrayed by the political and military leadership…"

… "As long as there is war, there will be moral injury. Yet, political decision-making and framing can increase the risk of moral injury and adversely affect its consequences, which, moreover, may not be recognized and acknowledged at the political level. The problem of this silence is twofold. First, it means that insufficient attention is paid to the ways in which political practices can cause or prevent distressing situations. Second, it means that the biggest part of the burden of moral injury is loaded onto the shoulders of individual (ex-)soldiers, which may be felt as (yet another) institutional betrayal and thus perpetuate their distress…"

… "So, a moral conflict may exist both within the veteran and between the veteran and the political domain, which makes it important to include in moral injury theory potential experiences of institutional betrayal and resultant efforts to seek acknowledgment and reparations. More generally, it is important to consider deployment-related suffering as both a mental disorder and a response to political disorder…" (Molendijk, 2019).

6 Moral Injury Treatment

6.1 overview of moral injury treatment efficacy

Williamson and Greenberg (2020) state that "currently, there are no manualized approaches to treat moral injury-related mental health difficulties. In fact, some standardized treatments for PTSD (e.g. prolonged exposure) may potentially be harmful and worsen patient feelings of guilt and shame. Some emerging US evidence suggests that Adaptive Disclosure (where forgiveness is received from a benevolent moral authority) may be helpful. UK clinicians also report using an amalgamation of validated treatments (e.g. compassion-focused therapy, schema therapy, etc.) to treat patients affected by moral injury". A few of those treatments are described below.

6.2 Adaptive disclosure

Both the Atlantic and HuffPost recently published articles on Adaptive Disclosure treatments.

In her 'The Atlantic' article on Moral Injury, Maggie Puniewska explains that "even after diagnosis… therapists may have a hard time figuring out an effective treatment plan for moral injury, which requires a different approach than PTSD. "Current interventions for PTSD do well when trauma is fear- and victim-based, but not all moral injury fits under this umbrella," says Brett Litz, the director of the Massachusetts Veterans Epidemiological Research and Information Center. In 2007, Litz and his colleagues developed a moral injury-specific treatment they call "adaptive disclosure," a multi-session program rooted in cognitive behavioural therapy. The program is designed to help veterans accept their infractions, rather than erase them from memory or explain them away. Veterans also learn how to disclose experiences to others in a safe space without feeling guilt or shame…"

"… Adaptive disclosure is designed as a gradual progression, with each 90-minute session building upon the last. The first meeting is more instructive than participatory, a sort of "Moral Injury 101": Therapists explain the meaning of the term, the different kinds of situations that cause it, and the negative impact it can have on the psyche and relationships. In the sessions that follow, veterans begin to share their stories, receive encouragement from peers, and write letters, either apologizing to the person they

believe they wronged or confiding in a benevolent moral authority figure (like a trusted friend or spiritual leader)" (Puniewska, 2015).

The Huff Post article by Wood (2014) describes in more detail a parallel Adaptive Disclosure programme led by Amy Amidon, a staff psychologist at the San Diego Naval Medical Center. "Everybody has demons, but there are some wild kind of demons when you come back from combat," said a Navy corpsman (the Navy's name for its medics) who served a tour each in Iraq and Afghanistan and asked not to be identified by name… "You come home and ask yourself, what the hell did I do all that for? You gotta live with that shit and there's no program that the military can send you to or any class that's really gonna help".

"Guilt is the root of it," he said. "Asking yourself, why are you such a bad person?" He wasn't that way before his military service. "I have a hard time dealing with the fact that I'm not me anymore".

"People try to make sense of what happened, but it often gets reduced to, 'It was my fault,' 'the world is dangerous,' or, in severe cases, 'I'm a monster,'" explained Peter Yeomans, a staff psychologist at the VA Medical Center in Philadelphia…"

"… People mostly try to push those experiences away and not look at them, and they inevitably end up with an oversimplified conclusion about what it all meant," he said. "We're trying to get them to unearth the beliefs that are causing their distress, and then help them analyze it, consider the evidence for and against the way they see it, and ultimately develop a more nuanced belief about what happened and what their responsibility actually is…"

"… The therapies and drugs developed to treat PTSD don't get at the root of moral injury, experts say, because they focus on extinguishing fear. PTSD therapy often takes the form of asking the patient to re-live the damaging experience over and over, until the fear subsides. But for a medic, say, whose pain comes not from fear but from losing a patient, being forced to repeatedly recall that experience only drives the pain deeper, therapists have found…"

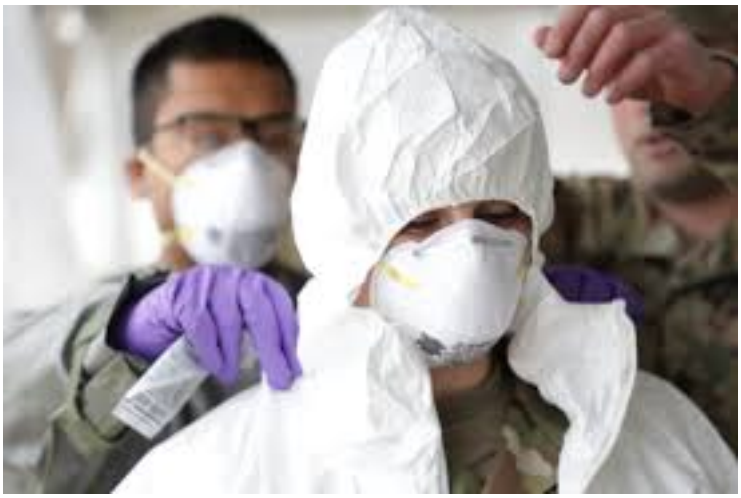
"… On the battlefield, some have devised makeshift rituals of cleansing and forgiveness. At the end of a brutal 12-month combat tour in Iraq, one battalion chaplain gathered the troops and handed out slips of paper. He asked the soldiers to jot down everything they were sorry for, ashamed of, angry about or regretted. The papers went into a makeshift stone baptismal font, and as the soldiers stood silently in a circle, the papers burned to ash... "It was sort of a ritual of forgiveness," said the chaplain, Lt. Col. Doug Etter of the Pennsylvania National Guard. "The idea was to leave all the most troubling things behind in Iraq..."

"… At the San Diego Naval Medical Center, the eight-week moral injury/moral repair program begins with time devoted simply to allowing patients to feel comfortable and safe in a small group. Eventually, each is asked to relate his or her story, often a raw, emotional experience for those reluctant to acknowledge the source of their pain. The idea is to drag it out into the open so that it can be dealt with..."

"… The group is instructed to listen and respond with support but not judgment, neither condemning nor excusing what happened. Whatever caused the moral injury, Amidon

said, “we are not going to brush it aside. It did happen and it wasn’t OK. The point is to help them feel OK sitting in the darkness with the evil they experienced” … Often, patients feel guilty or ashamed, convinced they are unforgiven, worthless and impure...”

“… Further into the sessions, group members are encouraged to do community service, and to practice acts of kindness. “One of the consequences of moral injury is self-isolation,” said Amidon. “The idea here is for them to begin to recognize the goodness in themselves, and to reinforce their sense of being accepted in the community.” Toward the end of the eight weeks, group members are invited to write a letter to themselves from a benevolent figure in their lives – a spouse, or grandfather, or mentor – to explain how they feel and to imagine what this person would say in response. “What is really healing,” Amidon said, “is to hear, whether it’s in this imagined conversation or with the others, someone sharing really shameful experiences and having people accept them…”



“… One participant, now 33, struggles with the guilt of having killed the wrong person. “My big thing was taking another man’s life and finding out later on that wasn’t who you were supposed to shoot,” he told me, asking not to be identified because of his continuing psychological treatment. “The [troops] out there, they don’t talk about it. They act like it never happened. Completely don’t ever bring it up.” But in the San Diego moral injury program, he did summon the courage to stand up and talk about it. “Just saying it was helpful”, he said later. “There were about five people in the room, and they got it. I didn’t need to have anyone say it’s OK, because it’s not OK – that would have just pissed me off”. What was the response of his peers? “It was silence,” he said. “that said, ‘I don’t care what you did, we are still good’…”

“… The adaptive part of the therapy involves helping the patient accept his or her past actions… Patients are asked to make a list of everyone, every person and institution, that bears some responsibility for their moral injury. They then assign each a percentage of blame, to add up to 100 percent…”

“… After having patients describe in painful detail what caused their moral injury, therapists asked them to choose someone they saw as a compassionate moral authority and hold an imaginary conversation with that person, describing what happened and the shame they feel. They were then asked to verbalize the response, using their imagination. Inevitably, patients imagined being told they were a good person at heart, that they were forgiven, and that they could go on to lead a good life. Of course, these conversations rely on imagination. But the technique allows the patient to articulate in his or her own words an alternative narrative about his injury...”

"… Does this method actually work? The results are promising but not conclusive, in part because the studies conducted so far were designed as intense, short-term interventions with troops preparing to go back to war. True healing of a moral injury seems to take time..."

"… That was the conclusion of Gray's clinical research trial in which adaptive disclosure therapy was used with 44 active-duty combat Marines with PTSD and moral injury. In six 90-minute sessions, Gray found that the Marines experienced "substantive" improvement in their symptoms" (Wood, 2014).

6.2.1 Compassion-Focussed Therapy

The web-based www.goodtherapy.com explains that "Compassion-focused therapy (CFT) aims to help promote mental and emotional healing by encouraging people in treatment to be compassionate toward themselves and other people. Compassion, both toward the self and toward others, is an emotional response believed by many to be an essential aspect of well-being. Its development may often have the benefit of improved mental and emotional health".

"Some main components of the approach are aspects of:

- Cognitive behavioural therapy
- Developmental psychology
- Evolutionary psychology
- Social psychology
- Neuroscience
- Buddhist philosophy

CFT is grounded in current understanding of basic emotion regulation systems: the threat and self-protection system, the drive and excitement system, and the contentment and social safeness system. Treatment sessions highlight the association between these systems and human thought and behaviour. The aim of CFT is to bring these three affect systems into balance". (www.goodtherapy.com)

6.2.2 Schema Therapy

In their website, the British Psychological Society describes Schema Therapy (ST) as "an integrative therapeutic model, with a strong relational emphasis, designed to address deeper level maladaptive schematic beliefs and interpersonal patterns that are not responsive to first-line therapeutic approaches..."

"…ST was initially developed as a treatment for 'Personality Disorders' and complex clinical problems. However, over the past 20 years, it has been further applied to an increasing range of clinical problems, and client groups... ST draws on a range of therapeutic modalities, including psychodynamic, object relations, gestalt, person-centred and cognitive-behavioural (CBT), and is steeped in attachment and developmental theory and research…"

"…The practice of ST is process-oriented, and utilises techniques from 4 main domains: experiential, interpersonal, cognitive and behavioural, as well as powerful experiential

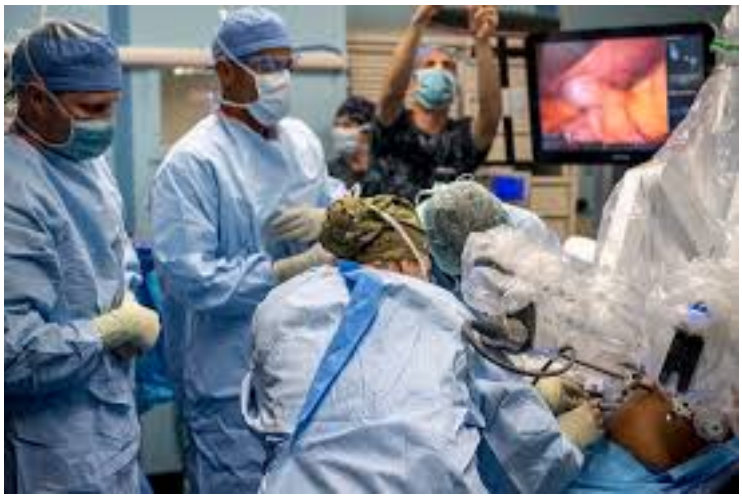
techniques (such as imagery rescripting, chair-work, and historical roleplay) designed to provide corrective emotional experiences that facilitate deeper level 'core' emotional growth and change". (British Psychological Society website)

6.3 The interdisciplinary approach of the Moral Injury project in Syracuse

"The Moral Injury Project at Syracuse University was formed in Summer 2014 after a gathering of academics, administrators, researchers, religious scholars, veterans, professors, chaplains, and mental health providers addressed the question: *What are we doing about moral injury among US military veterans?"*

"We favour the tenet that "treatment" of moral injury must be defined by the individual according to their beliefs and needs. Outlets for acknowledging and confronting moral injury include talk therapy, religious dialogue, art, writing, discussion & talking circles, spiritual gatherings, and more".

"Moral injury can lead to serious distress, depression, and suicidality. Moral injury can take the life of those suffering from it, both metaphorically and literally. Moral injury debilitates people, preventing them from living full and healthy lives... The effects of moral injury go beyond the individual and can destroy one's capacity to trust others, impinging on the family system and the larger community".



"Therapists, counsellors, social workers, and clergy are often at the front lines of addressing moral injury; however, the larger community can also take part. Consider that moral injury affects, and is affected by, the moral codes across a community. In the case of military veterans, moral injury stems in part from feelings of isolation from civilian society. Moral injury, then, is a burden carried by very few, until the "outsiders" become aware of, and interested in sharing it. Listening and witnessing to moral injury outside the confines of a clinical setting can be a way to break the silence that so often surrounds moral injury". (The Moral Injury Project at Syracuse University website)

This project thus acts according to the Social-functional perspective of moral emotions that suggests that moral emotions are attached to different behaviours in different groups. In this programme, a strong focus is clearly placed on helping veterans and community knit together a trusting relationship where stories of moral injury can be shared safely.

6.4 Acceptance and Commitment therapy

Nieuwsma et al (2015) propose that core principles used in Acceptance and Commitment Therapy to reach psychological flexibility might be particularly well matched to treating Moral Injury.

The Association for Contextual Behavioral Science (ACBS) explain that "The core conception of Acceptance and Commitment Therapy (ACT) is that psychological suffering is usually caused by the interface between human language and cognition, and the control of human behaviour by direct experience. Psychological inflexibility is argued to emerge from experiential avoidance, cognitive entanglement, attachment of a conceptualized self, loss of contact with the present, and the resulting failure to take needed behavioural steps in accord with core values…"

"…ACT protocols target the processes of language that are hypothesized to be involved in psychopathology and its amelioration, such as:

- cognitive fusion…
- experiential avoidance…
- the domination of a conceptualized self over the "self as context"…
- lack of values, confusion of goals with values, and other values problems that can underly the failure to build broad and flexible repertoires
- inability to build larger unit of behaviour through commitment to behaviour that moves in the direction of chosen values and other such processes" (ACBS website).

In contrast, psychological flexibility can be defined simply as "the ability to be present, open up, and do what matters... Psychological flexibility, the main goal of ACT, typically comes about through several core processes:

- Developing creative hopelessness involves exploring past attempts at solving or getting away from those difficulties bringing an individual to therapy. Through recognition of the workability or lack of workability of these attempts, ACT creates opportunity for individuals to act in a manner more consistent with what is most important to them.
- Accepting one's emotional experience can be described as the process of learning to experience the range of human emotions with a kind, open, and accepting perspective.
- Choosing valued life directions is the process of defining what is most important in life and clarifying how one wishes to live life.
- Taking action may refer to one's commitment to make changes and engage in behaviours moving one in the direction of what is most valued". (www.Goodtherapy.org)

6.5 Moral Injury and learning at the level of the system

Going back full circle then to the original definition of moral injury, it is likely that moral injuries linked to the Covid-19 crisis will emerge from pressures in the relationship between individuals and the system.

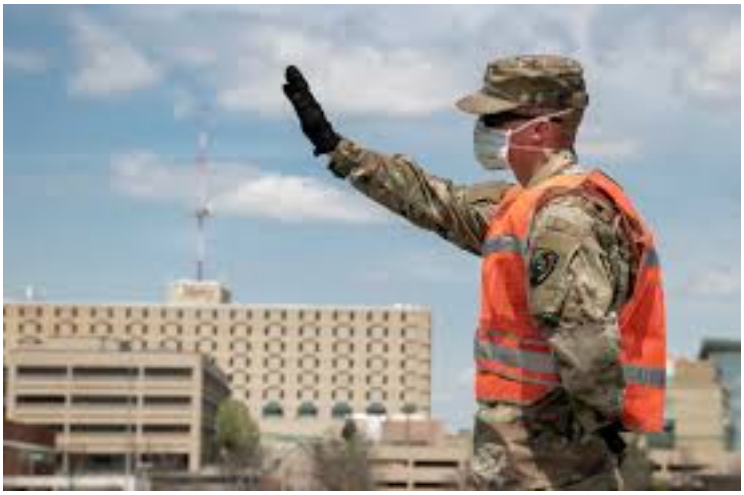
> "We are two infectious disease doctors, currently caring for people with COVID-19 on specialist wards in Liverpool, England... In our personal experience, a stiff upper-lip mentality persists among the medical profession, especially in the UK.
>
> Although not actively discouraged, an environment in which our feelings and fears can be shared is not actively nurtured. Indeed, there have been reports of suicide in healthcare workers in Europe during the COVID-19 pandemic. This is unacceptable. Sometimes the best response is not to keep calm and carry on, but to speak out..."
>
> Wingfield, Tom and Taegtmeyer, Miriam (2020) 'Healthcare workers and coronavirus: behind the stiff upper lip we are highly vulnerable'. https://theconversation.com/uk.

At the local organisational level, it is likely then that tackling any form of alienation or inability to speak out must be part of both the prevention and treatment for moral injury. This is where ensuring healthy organisational cultures and leadership development are actually supportive of maintaining a healthy climate.

At the tactical level, Greenberg et al (2020) recommend that organisations invest in preparation about the moral dilemmas likely to be faced, in making available a place to make sense of emotional and social challenges, in routine monitoring and managing avoidance as well as in education of staff and in supportive behaviour from line managers.

The wider political level is a more delicate matter. However studies are emerging examining the ways political, economic and cultural forces produce distress, thus locating society firmly back within the many dynamics that might cause or aggrieve individual suffering (Molendijk, 2018).

The Covid-19 crisis may indeed become an unprecedented opportunity to research policy and politics and their impact on real lives (and deaths) as each country seeks to combat the crisis in its own inimitable style, relying on different strategies, communication styles, degree of control and openness.



7 Co-counselling – Pragmatic peer support for people at risk of PTSD and Moral Injury

With all of the above in mind, it seems important to encourage all involved, but especially frontline staff, to carve out some time for sharing their experiences amongst themselves, to be able to do this with people they know and trust already, people who understand their day to day experience, their stressors and the rhythm of good, bad and awful days in their team. Of course, professional help also needs to be made available, but peer support could be the most pragmatic access to widespread and meaningful psychological support.

In my work supporting senior NHS staff and civil servants directly involved in tackling the COVID-19 crisis, I have found that already established relationships of trust seemed to come into their own and became the easiest way of accepting and receiving support.

For this reason, a simple approach inspired by the Co-counselling method is shared here under the name 'Co-listening' (to distinguish it from the original Co-counselling method which is more sophisticated and requires around 40 hours of training).

7.1.1 Setting up co-listening pairs

People first need to be paired up. This can be done voluntarily, randomly or matched by someone, but in all cases partners must both believe that they will work well together.

Before they start co-listening the first time, pairs need complete a simple check to ensure that there is no major transference or projection super-imposed on the co-listening partners. They do this by checking in turn if their partner reminds them of anyone. If they do, they answer three further questions:

1. "In what ways am I like that person"?
2. "What is left unsaid between you and that person"?
3. "In what ways am I different from that person?"

If partners find any unusual irritation or other transference feelings with their partner during subsequent sessions, they are advised to return to this de-identification process.

Everything that is said during these sessions is strictly confidential. As with every helping contract however, both partners need to have made an agreement that if a client is deemed a risk to themselves or others, their partner has a right and a duty to raise that concern with the relevant third party.

7.1.2 Co-listening sessions

This simple method totalling 30mns in time can be used once or twice a week as a way to leave difficult experiences and emotions at work, in effect it acts as a 'Now wash your head' process.

The co-listeners need to find a place where they can speak freely. They can sit but they can also walk and talk if they prefer this option. They then start co-listening: One person is the client, the other the listener for a total of 15 minutes and then they switch roles.

For the first 12 minutes, the client has time to express whatever they want or need to express. At 12 minutes, the co-listener makes the client aware of time and asks the client to wrap up their last thought and to conclude their session with the following two steps:

- **Self-validation:** Highlighting something they value about themselves. Often, this will be linked to what they have explored out loud during their session, but sometimes not.
- **Make a decision, commitment or choice:** The client then decides what they want to do as a result of their session. This may be a decision made, a commitment to a new habit or a change of attitude towards someone or themselves. If the client has no resulting action or commitment to make, they just say so and that is absolutely ok.

The session will thus have lasted 15mns. The partners then change role and repeat the process. The listener is now the client and vice versa (It is important to safeguard equality in time at all times as reciprocity helps people open up as they know their partner will have the exact same experience they have).

7.1.3 Role of the co-listener

The co-listener is charged with creating a non-judging environment, where they listen with a calm presence and an intention to allow space for their partner:

- They are not responsible for helping, solving, reassuring, teasing or concluding anything
- They may not even need to speak, respond or ask any questions during that 12 minutes if their partner fills the time with their own reflections
- They do not need to make reassuring faces, soothing sounds or anything else than listening non-judgementally. On the contrary, the emptier of thoughts or emotions they can be and thus being at their most available for their partner, the more useful they are.
- If the client wants to use his or her time in silence, they are also entitled to do so. Silence and space in the company of another can be healing for some more than words are. The time remains theirs till the end.

8 Extra resource - Psychological First Aid: Guide for Field Workers

A guide for field workers created by the WHO, War Trauma Foundation and World Vision International offers good guidelines for dos and don'ts of basic listening as well as rest and relaxation for carers. Even though they are meant for disaster relief staff, the listening guidelines are applicable across many situations (WHO, War Trauma Foundation and World Vision International, 2011).

Dos:

- Try to find a quiet place to talk and minimize outside distractions.
- Respect privacy and keep the person's story confidential, if this is appropriate.
- Stay near the person but keep an appropriate distance depending on their age, gender and culture.
- Let them know you are listening; for example, nod your head or say "hmmmm...."
- Be patient and calm.
- Provide factual information, **if** you have it. Be honest about what you know and don't know. "I don't know, but I will try to find out about that for you."
- Give information in a way the person can understand – keep it simple.
- Acknowledge how they are feeling and any losses or important events they tell you about, such as loss of their home or death of a loved one. "I'm so sorry. I can imagine this is very sad for you."
- Acknowledge the person's strengths and how they have helped themselves.

Don'ts:

- Don't pressure someone to tell their story.
- Don't interrupt or rush someone's story (for example, don't look at your watch or speak too rapidly).
- Don't touch the person if you're not sure it is appropriate to do so [Note from the author: This may not be relevant in a time of Covid but important to keep in mind after physical distancing requirements are lifted in future].
- Don't judge what they have or haven't done, or how they are feeling. Don't say: "You shouldn't feel that way," or "You should feel lucky you survived."
- Don't make up things you don't know.
- Don't use terms that are too technical.
- Don't tell them someone else's story.
- Don't talk about your own troubles.
- Don't give false promises or false reassurances.
- Don't think and act as if you must solve all the person's problems for them.
- Don't take away the person's strength and sense of being able to care for themselves.
- Don't talk about people in negative terms (for example, don't call them "crazy" or "mad").
- Allow for silence.

<u>Rest and Reflection for field workers</u>

"Taking time for rest and reflection is an important part of ending your helping role. The crisis situation and needs of people you have met may have been very challenging, and it can be difficult to bear their pain and suffering. After helping in a crisis situation, take

time to reflect on the experience for yourself and to rest. The following suggestions may be helpful to your own recovery.

- Talk about your experience of helping in the crisis situation with a supervisor, colleague or someone else you trust.
- Acknowledge what you were able to do to help others, even in small ways.
- Learn to reflect on and accept what you did well, what did not go very well, and
- the limits of what you could do in the circumstances.
- Take some time, if possible, to rest and relax before beginning your work and life duties again" (WHO, War Trauma Foundation and World Vision International, 2011).

9 Resources by alphabetical order

The American Nurses Association Code of Ethics for nurses with interpretive statements

Association for Contextual Behavioral Science

Bessel van der Kolk's website and Science of Success podcast

British Psychological Society

Cochrane

Co-counselling

www.goodtherapy.com

The Moral Injury project at Syracuse University

Point of Care Foundation - Schwartz Rounds

Royal College of Psychiatrists

Somatic Experiencing Trauma Institute – Peter Levine

WHO, War Trauma Foundation and World Vision International (2011) Psychological first aid: Guide for field workers.

10 References

Bisson, J.I., Jenkins, P.L., Alexander, J. & Bannister, C. (1997). Randomised controlled trial of psychological debriefing for victims of acute burn trauma. British Journal of Psychiatry, 171, 78–81.

Bisson, J.I., Roberts, N.P., Andrew, M., Cooper, R., Lewis, C. (2015) 'Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults (Review) The Cochrane Collaboration. Issue 8, 2015. Published by John Wiley & Sons, Ltd.

Bledsoe, B. (2003) 'EMS Myth #3: Critical Incident Stress Management (CISM) is effective in managing EMS-related stress' *EMSworld.com*, December 2003

Everly, G. and Mitchell, J. (2000) The debriefing 'controversy' and crisis intervention: A review of lexical and substantive issues, International journal of emergency mental health, 2(4):211-25

Farnsworth, J. K., Nieuwsma, J.A., Drescher, K.D., Walser, R.B., Currier, J.M. 'The Role of Moral Emotions in Military Trauma: Implications for the Study and Treatment of Moral Injury' (2014) *Review of General Psychology In the public domain*, Vol. 18, No. 4, 249–262

Graham, J., Haidt, J., & Nosek, B. A. (2009) 'Liberals and conservatives rely on different sets of moral foundations'. *Journal of Personality and Social Psychology*, 96, 1029–1046

Gray, M.J., Schorr, Y., Nash, W., Lebowitz, L., Amidon, A., Lansing, A., Maglione, M., Lang, A.J., Litz, B.T. (2012) Adaptive disclosure: an open trial of a novel exposure-based intervention for service members with combat-related psychological stress injuries. *Behavior Therapy*, 2012 Jun;43(2):407-15

Greenberg, N., Docherty, M., Gnanapragasam, S., Wessely, S. (2020) 'Managing Mental Health Challenges Faced by Healthcare Workers During covid-19 Pandemic', British Medical Journal, 2020 Mar 26:m1211

Haidt, J., Rozin, P., McCauley, C., & Imada, S. (1997) 'Body, psyche, and culture: The relationship between disgust and morality'. *Psychology and Developing Societies*, 9, 107–131

Haglund, M., Cooper, N., Southwick, S., Charney, D., (2007) '6 keys to resilience for PTSD and everyday stress' *Current Psychiatry* April;6(4):23-30

Hawker, D. and Hawker, D. (2015) 'What can be learnt from the debriefing controversy?' BPS Early interventions for trauma Proceedings from symposia held on 25 November 2014 and 8 January 2015 *June 2015*

Heron, J. (1998) 'Co-Counselling Manual', third and revised edition 1998

Hutcherson, C.A., Gross, J.J. (2011) 'The Moral Emotions: A Social-Functionalist Account of Anger, Disgust, and Contempt'*, Journal of Personality and Social Psychology*, 2011 Apr;100(4):719-37.

Jeffrey, J. (2020) Moral Injury and the Battle against COVID-19*, Quillette.com*, *Published on April 14, 2020*

Joireman, J., (2004) 'Empathy and the self-absorption paradox II: self-rumination and self-reflection as mediators between shame, guilt, and empathy'. *Self and Identity*. 3:225–38

Jordan, A. H., Eisen, E., Bolton, E., Nash, W. P., & Litz, B. T., (2017) 'Distinguishing war-related PTSD resulting from perpetration- and betrayal-based morally injurious events'. *Psychological Trauma: Theory, Research, Practice, and Policy*, 9(6), 627-634.

Keltner, D., & Haidt, J., (2003) 'Approaching awe, a moral, spiritual, and aesthetic emotion'. *Cognition and Emotion*, 17, 297–314

Koenen, K.C., Ratanatharathorn, A., Ng, L., McLaughlin, K.A., Bromet, E.J., Stein, D.J., Karam, E.G., Meron Ruscio, A., Benjet, C., Scott, K., Atwoli, L., Petukhova, M., Lim, C.C.W., Aguilar-Gaxiola, S., Al-Hamzawi, A., Alonso, J., Bunting, B., Ciutan, M., de Girolamo, G., Degenhardt, L., Gureje, O., Haro, J.M., Huang, Y., Kawakami, N., Lee, S., Navarro-Mateu, F., Pennell, B.E., Piazza, M., Sampson, N., Ten Have, M., Torres, Y., Viana, M.C., Williams, D., Xavier, M., Kessler, R.C. (2017) 'Posttraumatic stress disorder in the World Mental Health Surveys', *Psychological Medicine*. 2017 Oct;47(13):2260-2274.

Laham, S. M., Chopra, S., Lalljee, M., & Parkinson, B., (2010). 'Emotional and behavioural reactions to moral transgressions: Cross-cultural and individual variations in India and Britain'. *International Journal of Psychology*, 45, 64–71

Lazarus, R.S., 1991. Emotion and Adaptation. New York: Oxford Univ. Press

Leary, M. R., Tate, E. B., Adams, C. E., Batts Allen, A., & Hancock, J., (2007) 'Self-compassion and reactions to unpleasant self-relevant events: The implications of treating oneself kindly'. *Journal of Personality and Social Psychology*, 92, 887–904.

Leitch, M.L., Vanslyke, J. and Allen, M. (2009) 'Somatic Experiencing Treatment with Social Service Workers Following Hurricanes Katrina and Rita', *Social Work* Volume 54, Number 1 January 2009

Levine, P. (2005). Somatic experiencing: Resilience, regulation, and self. Unpublished paper.

Lewis, H.B., (1971) *Shame and Guilt in Neurosis*. New York: Int. Univ. Press

Lewis, M., (1992) *Shame: The Exposed Self*. New York: Free Press

Litz, B.T., Stein, N., Delaney, E., Lebowitz, L., Nash, W.P., Silva, C., Maguen, S., (2009) 'Moral injury and moral repair in war veterans: A preliminary model and intervention strategy' *Clinical Psychology Review* 29 (2009) 695–706

Luce, A., Firth-Cozens, J., Midgley, S., & Burges, C. (2002). 'After the Omagh bomb: Posttraumatic stress disorder in health service staff'. *Journal of Traumatic Stress*, 15(1), 27–30

Maben, J., Taylor, C., Dawson, J., Leamy, M., McCarthy, I., Reynolds, E., et al., (2018) 'A realist informed mixed methods evaluation of Schwartz Center Rounds® in England'. *Health Services and Delivery Research* 2018;6(37)

Manning, F. J., (1994). Morale and cohesion in military psychiatry. In Jones, F.D., Sparacino, L.R., Wilcox, V.L., Rothberg, J.M., (Eds.), Military psychiatry: Preparing in peace for war (pp. 1–18). Washington, DC: TMM Publications

Mayou, R.A., Ehlers, A. & Hobbs, M. (2000). Psychological debriefing for road traffic accident victims. *British Journal of Psychiatry, 176,* 589–593

Molendijk, T. (2018) The Role of Political Practices in Moral Injury: A Study of Afghanistan Veterans, Political Psychology, Vol.40, issue 2

Molendijk, T. (2018) Moral injury in relation to public debates: The role of societal misrecognition in moral conflict-colored trauma among soldiers. Social Science and Medicins, Vol.211, p.314-320

Molendijk, T. (2019) 'The Role of Political Practices in Moral Injury: A Study of Afghanistan Veterans'. *Political Psychology*. 40 (1): 261–275. doi:10.1111/pops.12503

National Institute for Health and Care Excellence (2018) Post-traumatic stress disorder [D] Evidence reviews for psychological, psychosocial and other non-pharmacological interventions for the treatment of PTSD in adults, *NICE guideline NG116 Evidence reviews December 2018*

Neff, K., (2003) 'Self-compassion: An alternative conceptualization of a healthy attitude toward oneself'. *Self and Identity*, 2, 85–101

Nieuwsma, J.A., Walser, R.D., Farnsworth, J.K., Drescher, K.D., Meador, K.G., Nash, W., (2015) 'Possibilities within Acceptance and Commitment Therapy for Approaching Moral Injury', *Current Psychiatry Reviews (Continued as Current Psychiatry Research and Reviews)* Volume 11, Issue 3 , 2015

Puniewska, M., (2015) 'Healing a Wounded Sense of Morality' The Atlantic, July 3, 2015

Regel, S., Hannigan, D., Lamerton, M., Perone, S.A., McNidder, R., Shaw, M., Morton, K., Scoging, A. & Reid, T. (2014). 'Workplace trauma support: Current practice and challenges', Conference proceedings, 9–10th October, Nottingham, UK. Centre for Trauma, Resilience and Growth, The University of Nottingham, UK

Rozin, P., Lowery, L., Imada, S., Haidt, J., (1999) 'The CAD triad hypothesis: a mapping between three moral emotions (contempt, anger, disgust) and three moral codes (community, autonomy, divinity)'. *Journal of Personality and Social Psychology* 76:574–86

Russell, P. S., & Giner-Sorolla, R., (2011) 'Moral anger, but not moral disgust, responds to intentionality'. *Emotion*, 11, 233–240

Rushton, C.H., (2016) 'Moral resilience: a capacity for navigating moral distress in critical care' *Advanced Critical Care* 2016 27 1 111–9

Rushton, C. H., Caldwell, M., Kurtz, M., (2016) 'Moral Distress: A Catalyst in Building Moral Resilience', *The American Journal of Nursing*: July 2016 - Volume 116 - Issue 7 - p 40-49

Rushton, C. H., Schoonover-Shoffner, K., Kennedy, M. S. MA, (2017) 'Transforming Moral Distress into Moral Resilience in Nursing', *The American Journal of Nursing*: February 2017 - Volume 117 - Issue 2 - p S2-S6

Sakellariou MO, Stefanatou A. (2017) 'Neurobiology of PTSD and implications for treatment: An overview'. *Current Research: Integrative Medicine* 2017;2(1):50-53

Shalev, A. Y. (2001) Review: 14 risk factors for post-traumatic stress disorder include childhood abuse and family psychiatric history, *Evidence-Based Mental Health* 2001;4:61

Shay J. (1994) "Achilles in Vietnam: Combat Trauma and the Undoing of Character". New York, NY: Scribner

Shay, J. (2002). Odysseus in America: Combat Trauma and the Trials of Homecoming. New York, NY: Scribner.

Skogstad, M., Skorstad, M., Lie, A., Conradi, H.S., Heir, T., Weisaeth, L., (2013) 'Work-related post-traumatic stress disorder', Occupational Medicine, Volume 63, Issue 3, April 2013, Pages 175-182

Soeters, J. L., Winslow, D. J., & Weibull, A., (2006) 'Military culture'. In Caforio, G., (Ed.), Handbook of the sociology of the military (pp. 237–254). New York, NY: Springer

Tangney, J.P., Dearing, R., (2002) Shame and Guilt. New York: Guilford

Tangney, J.P., Miller, R.S., Flicker, L., Barlow, D.H., (1996a) 'Are shame, guilt and embarrassment distinct emotions?' *Journal of Personality and Social Psychology*, 70:1256–69

Tangney, J.P. , Stuewig, J., Mashek, D.J. (2007) Moral Emotions and Moral Behavior, *Annual Review of Psychology,* Vol. 58:345-372

WHO, War Trauma Foundation and World Vision International (2011) Psychological first aid: Guide for field workers

Williamson, V., Murphy, D., Greenberg, N., (2020) 'COVID-19 and experiences of moral injury in front- line key workers', *Occupational Medicine,* 02 April 2020

Wingfield, T., and Taegtmeyer, M., (2020) '*Healthcare workers and coronavirus: behind the stiff upper lip we are highly vulnerable*'. https://theconversation.com/uk. https://theconversation.com/healthcare-workers-and-coronavirus-behind-the-stiff-upper-lip-we-are-highly-vulnerable-133864

Wood, D. (2014) 'Healing: Can we treat moral wounds?' *Huffpost*, March 20, 2014