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 (Short version)

by Myrna Jelman – August 2020

myrna@springblueconsulting.com
www.springblueconsulting.com

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 report, 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.

The longer version of the report providing more detail on the symptoms of PTSD and all the treatment option along with some first-person accounts can be found at:
www.springblueconsulting.com/springblue-articles

Myrna Jelman, August 2020
Myrna@springblueconsulting.com

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.

TABLE OF CONTENTS

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 Post-Traumatic Stress Disorder (PTSD)

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).

Even 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?

The symptoms of PTSD can start immediately or after a delay of weeks or months, but usually within six months of the traumatic event (Royal College of Psychiatrists) and research suggests that the few weeks and months post-trauma are crucial in protecting potential sufferers from additional stressors that might tip short-term traumatic stress into longer-term PTSD symptoms (Shalev, 2001). Those additional stressors might include bereavement, job changes including job losses, organisational restructures, etc.

In their March 2020 article in the British Medical Journal, Greenberg et al (2020) recommend managing not only 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… Symptoms can contribute to the development of mental health difficulties, including depression, post-traumatic stress disorder, and even suicidal ideation…"

With this in mind, this paper seeks to collate information about both PTSD and moral injury in order to enable the reader to make their own choices, whether it is for their own personal treatment, an organisational strategy they are responsible for, a research budget allocation or a government's policy, depending on the profession of the reader. A longer version of this paper is available with more detail on insights from research and treatment options as well as a few first-person accounts.

3 Psychological treatments for PTSD

Cochrane'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). Both rely on exposure to memories of the traumatic event. However, the Cochrane review authors caution against the poor quality of evidence forming the basis of their assessment. This paper therefore describes further treatments that may offer useful alternatives.

3.1 Group debriefing

Group debriefing helps teams of professionals involved in traumatic events to come together and talk about their experiences in order to digest them. After being widely used as a method for stress-management, efficacy research into one particular type of debriefing unfortunately led to widespread concerns and controversy about all other types of group debriefing, despite the original authors' warning not to extrapolate efficacy from their study (Mayou et al., 2000 and Bisson et al., 1997).

Authors of a key paper at a British Psychological Society (BPS) Symposium on Early intervention for Trauma in 2015 tried to challenge the validity of the research initially quoted, arguing that the two studies pointing to negative effects from debriefing researched two very different forms of debriefing: On the one hand debriefing offered to individual patients following a trauma such as major burns, often by untrained staff within hospital settings and as early as 24 hours after the trauma; and on the other hand

team debriefing offered to professionals as a team following a suitable delay after a traumatic experience and delivered by trained professionals in a congenial setting (Hawker and Hawker, 2015).

Unfortunately, the controversy over team debriefing seems to have stuck despite this attempt to set the record right on team debriefing.

3.2 Schwartz rounds

Greenberg et al. (2020) suggest using Schwartz rounds as early support for staff during the crisis. Initially introduced by the Schwartz Centre for Compassionate Healthcare in the US, these rounds offer 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" (Greenberg et al., 2020).

3.3 Neuroscience-led alternative treatments for PTSD

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

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

Two leading figures in this field, Peter Levine and Bessel van der Kolk, both believe that the basic premise of exposure therapy, which seeks to heal the patient through asking them to revisit the memory of the traumatic experience, is flawed. In a podcast on his work, Van der Kolk points to simple body-mind practices such as Tai Chi, Qi Gong or chanting as available means to alleviate PTSD by building a healthy connection between brain, body and attention.

A number of options are therefore available to both individuals and organisations for tackling PTSD. However, it is not solely PTSD that will affect our essential workers' mental health after this crisis but also Moral Injury, a concept more likely to be unfamiliar.

4 Moral Injury

Jonathan Shay introduced the concept of Moral Injury in his 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)

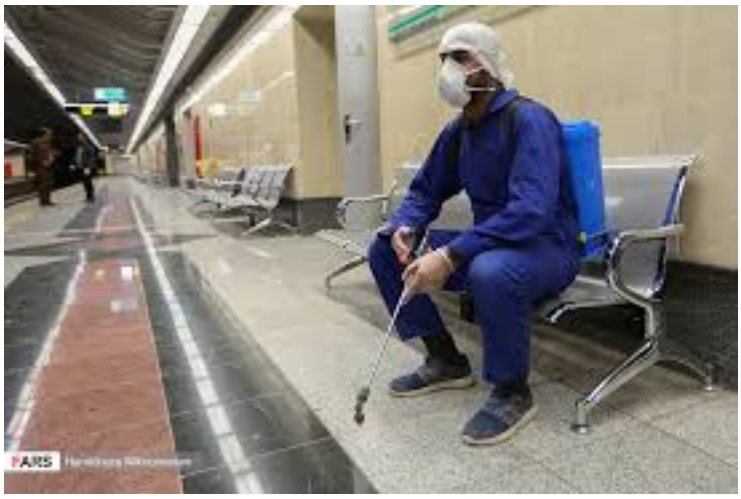
It is important to note that moral injury started with a betrayal by leadership and that, "while PTSD is about acts that violate one's sense of safety, moral injury concerns acts that violate one's sense of morality and ethics (Molendijk, 2018)".

"Moral injury can lead to serious distress, depression, and suicidality… It can destroy one's capacity to trust others, impinging on the family system and the larger community". (The Moral Injury Project at Syracuse University website)

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
- government scientific advisors and researchers involved in the crisis
- public transport, distribution professionals and other essential workers

"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 seems all the more important to learn more about this relatively new concept.



Moral Injury develops after experiencing Potentially Morally Injurious Events (PMIEs). These can be perpetration-based or betrayal-based (Jordan et al., 2017) and cause moral emotions that eventually lead to a more serious experience of Moral Injury. Unfortunately, perpetration based PMIEs have been more widely researched than betrayal based PMIEs because moral injury has more often been researched for the purpose of veteran recovery.

Potentially Morally Injurious Events (PMIEs) are defined 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" (Litz et al., 2009).

The moral emotions they engender are:

- Guilt
- Shame (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)
- Anger
- Disgust
- Contempt (in Farnsworth et al., 2014)

There are also three positive moral emotions that potentially point to foundations for treatment:

- Compassion
- Pride
- 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)

4.1 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 was 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."

"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…" (Rushton et al., 2017)

Once again, there is not enough research into Moral Distress to draw from but 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, 2016). This is a crucial

phenomenon to remember if the crisis lasts into the long-term, as seems might be the case. It means that individuals will be less and less resilient as the crises continues.

In terms of organisational interventions, Rushton et al (2016) suggest" 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 is beneficial. This seems to support the practice of both team debriefing and Schwartz rounds but also the practice of co-Listening that will be introduced later in this paper.

4.2 Moral Injury and groups

Social functional perspectives of moral emotions suggest that different emotions are attached to different behaviours in different groups (e.g. what constitutes pride or betrayal in the army is different to what constitutes pride or betrayal in a civilian setting, a family unit, a faith-based setting…). Moral codes differ across groups. As adults, they are learnt and reinforced by recruitment, training and work norms. It may therefore be useful to understand what is considered morally 'right' or 'wrong' in each of the main professional groupings involved in tackling the Covid-19 crisis. 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 GP, a nurse, a porter, etc. and some of the moral injury may happen at the intersection of such groupings.

"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 and disloyalty manifest themselves?
- 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?

4.3 Moral Injury and time

In addition to social groupings, 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.

What might be the particular dynamic over time for moral injury in this Covid-19 crisis? Will moral injury be more immediate in this case or will 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, or the provision of PPE, or the social care policy?

4.4 Why heroification doesn’t help

In addition, the social-functional perspective might explain why high moralisation or heroification of key actors might actually contribute to moral injury as “public criticism and admiration may both be experienced as misrecognition, and, in turn, societal misrecognition may directly or indirectly contribute to moral injury”. (Molendijk, 2018)

This additional social and emotional isolation caused by the current bubble of heroification 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 hero so reassuring to the rest of the population.

5 Moral Injury treatments

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 may be helpful. Both the Atlantic and HuffPost recently published articles on Adaptive Disclosure treatments which

seeks to help veterans digest their infractions. The treatment seeks to create a safe group environment where veterans can slowly share their story, nuance their responsibility in the event and receive compassion, sometimes from supportive family members, sometimes from members of the community. They sometimes also commit acts of kindness within the community themselves, in order to experience themselves once again as a 'good' person.

In the 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" (Williamson & Greenberg, 2020). It is however important to note that such treatments are focused on *perpetration* based Moral Injury and not *betrayal* based Moral Injury.

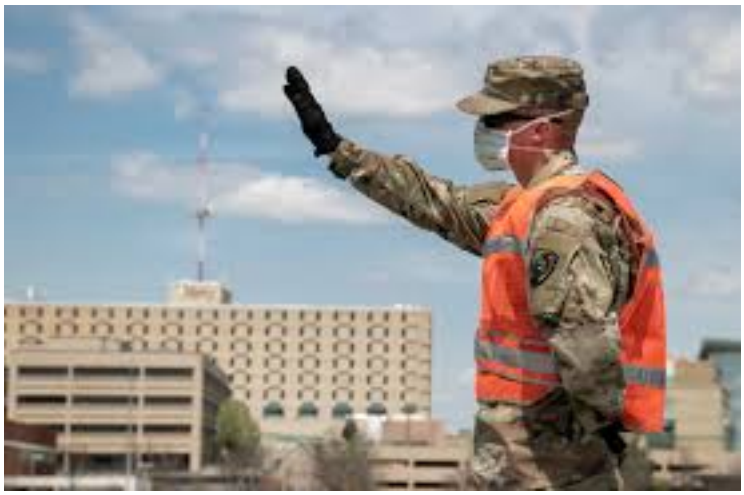
5.1 Moral Injury and learning at the level of the system

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.

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 a 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 supportive behaviour from line managers.

The wider political level is a more delicate matter, however studies in Political psychology 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. 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.



6 Co-Listening - A pragmatic approach to mitigate the risks 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 support also needs to be made available, but peer support could be the most pragmatic access to widespread and meaningful psychological 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 some 40 hours of training).

The process is simple:

- Professionals are matched in pairs, check that they are happy to work together and ensure there is no transference from the past that might impact their ability to talk and to listen freely
- 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.
- They find a suitable place to hold a 30mns conversation and split the time in two equal sessions of 15mns each
- During each session, one co-listener has their partners' undivided, non-judgemental attention for the first 12mns where they can download their experiences, feelings, issues, etc.
- After 12mns, a simple process helps that person wrap up their session. They conclude with:
    1. what they think they did well and
    2. what they now decide to do as a result (if anything)
- At 15mns exactly, they switch roles and repeat the process.

This simple method 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.

As with most methods or treatments, the true efficacy of this method will only be known after it is implemented and after well conducted research trials are carried out.

7 Conclusion

Our world is experiencing the biggest health crisis of a generation. It is likely to cause a proportional mental health crisis that may last well into the future in both the general population and the professionals charged with tackling the crisis. Whatever approaches chosen by individual, by organisation and by government, they need to be based on valid and useful information. This report seeks to collate such information in the hope that it yields beneficial outcomes for many. Please share it widely if you think it has been helpful.

The full report can be found at www.springblueconsulting.com/springblue-articles

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