

## EDITORIAL

# COVID-19 and experiences of moral injury in front-line key workers

The COVID-19 virus outbreak was declared a pandemic by the WHO on 12 March 2020. Whilst the infection mortality rate is not fully understood, it appears to be considerably higher than that of other recent pandemics (e.g. H1N1 pandemic, mortality rate 0.02%) [1]. Furthermore, several groups of people, such as the elderly and those with some pre-existing medical conditions, appear to be particularly vulnerable to the disease [1,2].

International evidence, and the public health messaging put forward by Public Health England, suggests that COVID-19 may place a substantial demand on an overstretched National Health Service (NHS). A lack of specific resources—such as a lack of beds in Intensive Care Units, essential medicines and ventilators—and increased demand on the NHS may mean that front-line workers, such as clinicians, paramedics and other care staff, may be unable to provide adequate treatment to all patients, as seen in Italy [3]. Additionally, current guidance recommends that anyone who is showing signs of a potential COVID-19 infection (e.g. new persistent cough, fever), or who lives in a house with someone who shows such signs, must self-quarantine at home [2] meaning that some clinicians will be unable to return to their ‘front-line’ responsibilities at a time when their colleagues are working exceptionally hard. As a result of these exceptional challenges, lives will inevitably be lost that could, in other circumstances, have been saved. Non-clinical professionals in other essential roles, such as the justice system, media workers, social workers, etc., may also feel the profound effects of being required to perform already highly challenging duties in a more constrained manner which may lead to risks being more difficult to manage. How such events will impact front-line, key worker teams remains unclear, but it is likely that many will experience a degree of moral distress and some moral injuries [4].

Moral injury is defined as the profound psychological distress which results from actions, or the lack of them, which violate one’s moral or ethical code [5]. Morally injurious events can include acts of perpetration, acts of omission or experiences of betrayal from leaders or trusted others. Unlike post-traumatic stress disorder (PTSD), moral injury is not a mental illness. Although experiences of potentially morally injurious events

(PMIEs) can lead to negative thoughts about oneself or others (e.g. “I am a monster” or “my colleagues don’t care about me”) as well as deep feelings of shame, guilt or disgust. These, in turn, can contribute to the development of mental health problems, including depression, PTSD and anxiety [6].

Moral injury is not limited by context or profession. For example, a recent review found that exposure to moral injury was significantly associated with PTSD, depression and suicidal ideation across a range of professions (e.g. teacher, military personnel, journalists) across a variety of countries (e.g. USA, Australia, Israel) [6].

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 [7]. 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 [8].

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 [9,10] that may be applicable to other professions during the COVID-19 Pandemic (Table 1):

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.

**Table 1.** 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 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.

It is important to note, just as not all individuals who experience trauma necessarily develop PTSD, exposure to PMIEs does not automatically result in moral injury. Nonetheless, the following practical recommendations may be beneficial:

1. Front-line staff should be made aware of the possibility of PMIE exposure in their role, and the emotions, thoughts and behaviours that might be experienced as a result. Discussing this topic in advance of exposure to a PMIE, most probably facilitated by supervisory level leaders, may help develop psychological preparedness and allow staff to understand some inevitable symptoms of distress.
2. Front-line staff should be encouraged to seek informal support, from trained peer supporters, managers, colleagues, chaplains or other welfare provision provided by their employer, early on and take a ‘nip it in the bud’ approach—rather than dwelling on the PMIEs they have been exposed to. There is good evidence that social support is generally protective for mental health.
3. If informal support does not help, professional help should be sought early on. Professional support is likely to be needed when difficulties relating to the PMIE become persistent and impair an individual’s daily functioning. Sources of confidential help, which should be rapidly accessible, should be well advertised within organizations. Those providing such support should be aware of the concept of moral injury and also that those suffering with such difficulties may often fail to talk about them because of intense feelings of shame and guilt.
4. Those in leadership roles should be encouraged to proactively ‘check in’ with their teams, offer empathetic support and encourage help-seeking where necessary. It is vital that managers feel comfortable in having psychologically informed conversations with their staff, or if they do not possess such skills, they should ensure that someone else (e.g. trained peer supporter) checks in with their staff on a regular basis instead.

5. Employers of essential staff should be aware that psychological debriefing techniques and psychological screening approaches are ineffective. Instead, it is imperative that organizations actively monitor staff exposed to PMIEs, facilitate effective team cohesion and make informal, as well as professional, sources of support readily available to their employees. Furthermore, exposure to PMIEs should be frankly discussed and efforts should be made to ensure that staff understand the potential for their work during the COVID-19 outbreak to impact on their mental health, whilst ensuring they are also aware that psychological growth can also be expected if staff ‘do their best’.

Recommendations for clinicians providing psychological support during and after the COVID-19 Pandemic include:

1. Psychological support for those in front-line roles and affected by the COVID-19 should be prioritized and made more readily accessible. Lengthy waiting lists for care are a key reason why many individuals do not seek formal psychological help post-trauma.
2. Clinicians should also be aware that individuals who develop moral injury-related mental health disorders are often reticent to speak about guilt or shame and may instead focus on more classically traumatic elements of their presentation. As such, clinicians should make sufficient sensitive enquiries about PMIEs in anyone who presents with mental health difficulties having been an essential worker during the COVID-19 Pandemic.
3. Clinicians offering psychological treatment to patients should continue to do so, taking precautionary measures where needed—such as offering treatment via Skype, Zoom, telephone or similar. Useful information on this subject can be found at <https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/guidance-for-clinicians/digital-covid-19-guidance-for-clinicians>.
4. Steps should be taken by clinical care teams to ensure that vulnerable groups, such as survivors of domestic violence, and those with serious mental illnesses continue to be able to access treatment and support networks. This is likely to require local mental health services to proactively, most probably remotely, check on vulnerable individuals and remind them of effective psychological coping strategies and possibly ‘top up’ their psychological therapy provision where that would be helpful.
5. Clinicians should encourage patients to take practical steps to manage anxiety during this time, including limiting time spent accessing media and

news outlets, seeking COVID-19-related information from trusted sources (i.e. Public Health England, NHS), and encouraging the use of evidence-based coping resources (i.e. <https://www.nhs.uk/oneyou/every-mind-matters/>).

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### Competing interests

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