More Than Burnout:

Addressing Pandemic Related Moral Distress Among Health Care Professionals

Jeff S. Matsler, STM, ThM, MDiv
Director of Ethics
CHRISTUS Healthcare

Decimation

x 3

MORAL SUFFERING

“MORAL SUFFERING is Characterized by the Following Symptoms:

(1) guilt feelings and self-punishment;

(2) perception of oneself as a scapegoat;

(3) rage and other violent impulses directed against indiscriminate targets;

(4) brutalization resulting and its attendant psychic numbing;

(5) alienation from one's own feelings and from other people;

(6) doubt about continued ability to love and trust others.”

William P. Mahedy

“MORAL Suffering” Timeline

- 1969 Post Vietnam Syndrome / ”SOUL SICKNESS”
- 1979 Belmont Report – 4 Ethical Guidelines
- 1980 “Post Traumatic Stress” (DSM 3)
- 1984 “Moral Distress” Defined by Andrew Jameton
- 2009 “Moral Injury” Defined by both Shay and Litz

WHY?

What’s Going On In Medicine that Requires These Categories and Terms?

What is PTSD?

- **Exposure** to actual or threatened death, serious injury, or sexual violence
- **Intrusions/Re-experiencing** of the traumatic event(s)
- **Avoidance** of cues associated with the traumatic event
- Negative **alterations in thoughts and mood**
- **Increased arousal and reactivity** associated with the event(s)

American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders [DSM-5],* 2013

“PTSD - Background”

Willam Mahedy,

Clinician, VA Health System

“SOUL SICKNESS”

Post Traumatic Stress Disorder

DSM-3

1980

Post-Vietnam Syndrome

By CHARS F. STRATAN

Steve stiffened, looked around fearfully, and thought, "These people all look alike. How do I know who's friend and who's enemy?" Then he shook himself, remembering: "They are all your friends. This is Times Square, U.S.A." Eighteen months after a nonpsychiatric discharge following four years Marine combat duty in "the Nam," Steve still suffers unpredictable episodes of terror and disorientation.

Coming around a curve in a Washington park path, Mike kept to the inside so that "hostiles" would not see him. He has observed this precaution automatically for five years since his service as a medic in Vietnam.

Vietnam veterans have recounted these and other experiences to me and my colleagues in "group rap" sessions. These meetings were initiated in 1970 by veterans themselves, either because of their distrust of "establishment" psychiatric services, or because their disturbances manifested themselves too late to prove the "service connection" required for Veterans Administration treatment.

In the group raps certain commonly shared c
Since they do
diagnostic labe
loosely as the p

What are its

(1.) Easiest t
feelings for tho
on both sides a
the fate of frien
veterans ask:
off the guilt?
they provide th
speak of "payi
viving intact v
They invite sa

home, veterans have great difficulty mastering these impulses in the face of the ambivalent civilian reception.

(4.) Combat brutalization. "You get chewed up in the Vietnam war machine, and get spit out unfeeling. Then you are just the fingers that pull the triggers." Basic combat training—"harassing the troops" in Marine jargon—promotes obedience through humiliation and maltreatment. Only one permissible outlet is presented for the soldier's impotent fury: the dehumanized image of the "enemy." Under guerrilla conditions of universal terror, this dehumanization has no clear-cut boundaries. Hatred is then generalized to any Oriental, and eventually to any civilian, the more so when the G. I.'s learn how expendable they are themselves. Many veterans do not doubt the validity of this hate until their discharge.

(5.) Alienation from their feelings and from other human beings: after systematically numbing their humane responses, veterans find it difficult and painful to experience compassion for others.

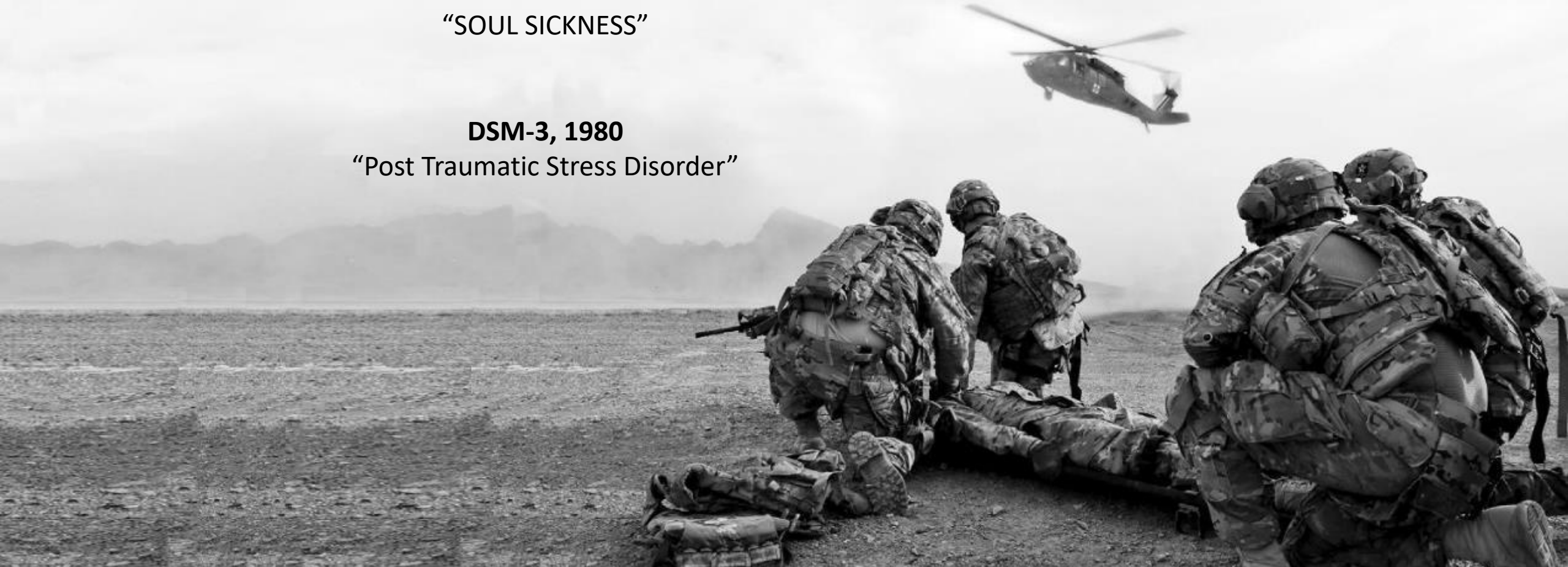
(6.) The most poignant feature is an agonizing doubt about their continued

“PTSD - Background”

Willam Mahedy,
Clinician, VA Health System

“SOUL SICKNESS”

DSM-3, 1980
“Post Traumatic Stress Disorder”



Part of the personality which seeks to transcend self has been dulled but is not yet dead. The person is usually vaguely aware that something is amiss, but apathy is the common response.

A sense of guilt is often present. The feeling of having been victimized or scapegoated by the government extends in a subtle and sometimes almost imperceptible way to moral and spiritual authorities — the churches and the spokespersons of the various movements spawned by the war.

William P. Mahedy

Treating PTSD

- **Pharmacologic** Symptom Reduction
- **Talk Therapy** that allows for **Exposure** to Cues/Memories of Trauma and sometimes **Reframing** of thoughts/beliefs
- Social/Vocational/Spiritual S**upport**

PTSD and “Moral Injury”

- **Moral injury**: “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations” (Litz et al., 2009)
- Focus on **guilt/shame** rather than (only) fear/anxiety
- May or may not describe acts that violate social norms or laws

Post-Vietnam Syndrome

By CHARS F. STRAIN

Steve stiffened, looked around fearfully, and thought, "These people all look alike. How do I know who's friend and who's enemy?" Then he shook himself, remembering: "They are all your friends. This is Times Square, U.S.A." Eighteen months after a nonpsychiatric discharge following four years Marine combat duty in "the Nam," Steve still suffers unpredictable episodes of terror and disorientation.

Coming around a curve in a Washington park path, Mike kept to the inside so that "hostiles" would not see him. He has observed this precaution automatically for five years since his service as a medic in Vietnam.

Vietnam veterans have recounted these and other experiences to me and my colleagues in "group rap" sessions. These meetings were initiated in 1970 by veterans themselves, either because of their distrust of "establishment" psychiatric services, or because their disturbances manifested themselves too late to prove the "service connection" required for Veterans Administration treatment.

In the group raps certain commonly shared c
Since they do
diagnostic labe
loosely as the p

What are its

(1.) Easiest t
feelings for tho
on both sides a
the fate of frien
veterans ask:
off the guilt?
they provide th
speak of "payi
viving intact v
They invite re

home, veterans have great difficulty mastering these impulses in the face of the ambivalent civilian reception.

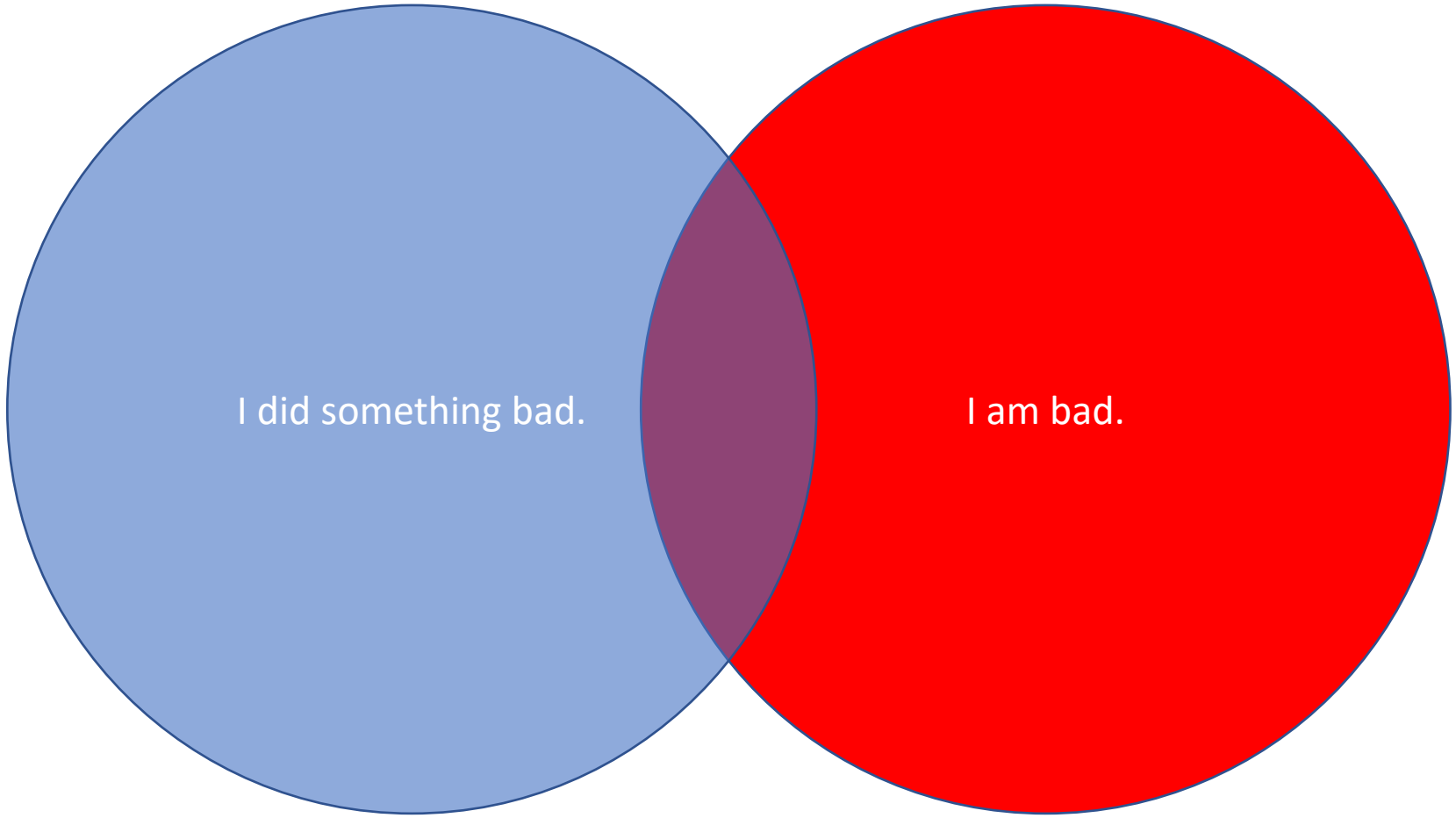
(4.) Combat brutalization. "You get chewed up in the Vietnam war machine, and get spit out unfeeling. Then you are just the fingers that pull the triggers." Basic combat training—"harassing the troops" in Marine jargon—promotes obedience through humiliation and maltreatment. Only one permissible outlet is presented for the soldier's impotent fury: the dehumanized image of the "enemy." Under guerrilla conditions of universal terror, this dehumanization has no clear-cut boundaries. Hatred is then generalized to any Oriental, and eventually to any civilian, the more so when the G. I.'s learn how expendable they are themselves. Many veterans do not doubt the validity of this hate until their discharge.

(5.) Alienation from their feelings and from other human beings: after systematically numbing their humane responses, veterans find it difficult and painful to experience compassion for others.

(6.) The most poignant feature is an agonizing doubt about their continued

PTSD Produces “Guilt”

Moral Injury Produces “Shame”



It's normal in our profession to confront moral challenges.
Especially in times like these.

Pandemics can cause us to:

- Question why we do what we do
- Feely guilty about our actions
- Feel betrayed and/or ashamed
- Distrust the leadership and institutions we serve
- Overwhelmed by the scope of care

"MORAL DISTRESS"

MASS CASUALTY PRESSURES

Record Number of Deaths

Patients Not Responding To Care

Distrust of Leadership

Lack of Trust From Public

Feelings of Professional Isolation

MORAL DISTRESS

"Psychological disequilibrium, painful feelings that result from recognizing an ethically appropriate action but failing to take that action. This inability to act can be the result of either internal (personal) or external (institutional) constraints on taking the "right" action."

Andrew Jameton, 1984

MORAL DISTRESS

Simply Defined

"Moral distress occurs when one knows the ethically correct action to take but feels powerless to take that action."

Jameton, 1978

MORAL DISTRESS

Occurs when a nurse “knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” [1].

Andrew Jameton, 1984

LATER BROADENED:

Morally challenging situations that give rise to distress but which are not necessarily linked to nurses feeling constrained, such as those associated with moral uncertainty. so that it is not confined to the experiences of nurses.

Carina Fourie, 2017

MORAL DISTRESS: 2 TYPES

CONSTRAINT:

the nurse knows the morally correct action to take—and there is something which prevents the nurse from being able to take the morally correct action.

MORAL UNCERTAINTY:

morally challenging situations that give rise to distress but which are not necessarily linked to nurses feeling constrained.

CASE / EXAMPLE

Distress felt by a nurse caring for a terminally ill child in a situation in which the parents insist on the child receiving aggressive life - extending treatment, although it is in the best interest of the patient for health professionals to stop treating her and to arrange for the provision of palliative care to avoid prolonging her suffering .

CASE / EXAMPLE

CONSTRAINT DISTRESS

the distress experienced is a signal that something has definitely gone morally wrong in terms of patient care; the treatment is not to the benefit of the terminally ill child (assuming the nurse is correct in his moral assessment

of the case).

CASE / EXAMPLE

UNCERTAINTY DISTRESS

The nurse experiences moral distress due to moral uncertainty— she might not know what is in the best interest of the patient because she is uncertain of the moral implications of her actions.

MORAL RESIDUE

Lingering feelings after a morally problematic situation has passed; in the face of moral distress, the individual feels as if seriously compromising himself or herself, or allowed others to be compromised, resulting in loss of moral integrity.

Epstein and Hamric (2009)

MORAL SUFFERING

All of these manifestations are debilitating and harmful to those impacted.

There are paths to healing for those experiencing any form of moral suffering.

Acute Stress Reactions

- Develops soon after a traumatic event
  - ~ 1 in 5 will develop

- Symptoms
  - Intrusion (flashbacks, memories, dream)
  - Negative Mood (sadness, negative thoughts)
  - Dissociation (altered sense of reality, lack of situational awareness, memory problems for event)
  - Avoidance (of thoughts, places, people related to event)
  - Increased Arousal (tension, on guard, difficulty sleeping)

PTSD “Moral Distress” and “Moral Iniury”

"Soul Sickness”

William Mahedy

1976

“Post Traumatic Stress Disorder”

DSM-3

1980

“Moral Distress”

Andrew Jameton

1984

Post-Vietnam Syndrome

By CHARS F. STRATAN

Steve stiffened, looked around fearfully, and thought, "These people all look alike. How do I know who's friend and who's enemy?" Then he shook himself, remembering: "They are all your friends. This is Times Square, U.S.A." Eighteen months after a nonpsychiatric discharge following four years Marine combat duty in "the Nam," Steve still suffers unpredictable episodes of terror and disorientation.

Coming around a curve in a Washington park path, Mike kept to the inside so that "hostiles" would not see him. He has observed this precaution automatically for five years since his service as a medic in Vietnam.

Vietnam veterans have recounted these and other experiences to me and my colleagues in "group rap" sessions. These meetings were initiated in 1970 by veterans themselves, either because of their distrust of "establishment" psychiatric services, or because their disturbances manifested themselves too late to prove the "service connection" required for Veterans Administration treatment.

In the group raps certain com-
monly shared c
Since they do
diagnostic labe
loosely as the p

What are its

(1.) Easiest t
feelings for tho
on both sides a
the fate of frien
veterans ask:
off the guilt?
they provide th
speak of "payi
viving intact v
They [illegible] sa

home, veterans have great difficulty mastering these impulses in the face of the ambivalent civilian reception.

(4.) Combat brutalization. "You get chewed up in the Vietnam war machine, and get spit out unfeeling. Then you are just the fingers that pull the triggers." Basic combat training—"harassing the troops" in Marine jargon—promotes obedience through humiliation and maltreatment. Only one permissible outlet is presented for the soldier's impotent fury: the dehumanized image of the "enemy." Under guerrilla conditions of universal terror, this dehumanization has no clear-cut boundaries. Hatred is then generalized to any Oriental, and eventually to any civilian, the more so when the G. I.'s learn how expendable they are themselves. Many veterans do not doubt the validity of this hate until their discharge.

(5.) Alienation from their feelings and from other human beings: after systematically numbing their humane responses, veterans find it difficult and painful to experience compassion for others.

(6.) The most poignant feature is an agonizing doubt about their continued

PTSD and "Moral Injury"

- **Moral injury**: "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" (Litz et al., 2009)

- Focus on **guilt/shame** rather than (only) fear/anxiety

- May or may not describe acts that conflict with Rules of Engagement

Post-Vietnam Syndrome

By CHAIM F. SHATAN

Steve stiffened, looked around fearfully, and thought, "These people all look alike. How do I know who's friend and who's enemy?" Then he shook himself, remembering: "They are all your friends. This is Times Square, U.S.A." Eighteen months after a nonpsychiatric discharge following four years Marine combat duty in "the Nam," Steve still suffers unpredictable episodes of terror and disorientation.

Coming around a curve in a Washington park path, Mike kept to the inside so that "hostiles" would not see him. He has observed this precaution automatically for five years since his service as a medic in Vietnam.

Vietnam veterans have recounted these and other experiences to me and my colleagues in "group rap" sessions. These meetings were initiated in 1970 by veterans themselves, either because of their distrust of "establishment" psychiatric services, or because their disturbances manifested themselves too late to prove the "service connection" required for Veterans Administration treatment.

In the group raps, certain commonly shared concerns have emerged. Since they do not fit any standard diagnostic label, we refer to them loosely as the post-Vietnam syndrome.

What are its basic themes?

(1.) Easiest to talk about are guilt feelings for those killed and maimed on both sides and preoccupation with the fate of friends still overseas. Often veterans ask: "How do we turn off the guilt? Can we atone?" And they provide their own answer: they speak of "paying their dues" for surviving intact when others did not. They invite self-punishment through

home, veterans have great difficulty mastering these impulses in the face of the ambivalent civilian reception.

(4.) Combat brutalization. "You get chewed up in the Vietnam war machine, and get spit out unfeeling. Then you are just the fingers that pull the triggers." Basic combat training—"harassing the troops" in Marine jargon—promotes obedience through humiliation and maltreatment. Only one permissible outlet is presented for the soldier's impotent fury: the dehumanized image of the "enemy." Under guerrilla conditions of universal terror, this dehumanization has no clear-cut boundaries. Hatred is then generalized to any Oriental, and eventually to any civilian, the more so when the G. I.'s learn how expendable they are themselves. Many veterans do not doubt the validity of this hate until their discharge.

(5.) Alienation from their feelings and from other human beings: after systematically numbing their humane responses, veterans find it difficult and painful to experience compassion for others.

(6.) The most poignant feature is an agonizing doubt about their continued ability to love others, and to accept affection. One veteran said: "You paid a high price for trusting other people in the Nam. Everytime you acted human, you got screwed." And another: "I hope I can learn to love as much as I learned to hate—and I sure hated, man. But love's a pretty heavy word."

In extreme situations—death camps, active warfare—grief threatens the morale necessary for survival and combat effectiveness. Both intimacy and grief are actively discouraged in the modern military. Trainees are

Moral Distress

“The feelings of frustration, anger, and anxiety people experience when faced with institutional obstacles and conflict with others about values …

the distress that people feel when they do not act upon their initial distress.”

(Epstein & Hamric, 2009)

LATER BROADENED:

“Morally challenging situations that give rise to distress but which are not necessarily linked to nurses feeling constrained, such as those associated with moral uncertainty… **so that it is not confined to the experiences of nurses.”**

(Carina Fourie, 2017)

Moral Distress vs. Emotional Distress

- Emotional distress which is more generic
- Moral Distress is about a loss of values
  - Implied in this loss of values is a threat to one's integrity
- Moral integrity is the sense of wholeness and self-worth that comes from having clearly defined values that are congruent with one's actions and perceptions

  - Hardingham (2004)

Examples:

- You know that you need to turn all of your patients every two hours (the right thing) but because of the number of patients assigned to you, you are unable to do so.

- Your patient has advanced stage COVID-19. He is placed on mechanical ventilation and numerous pressors. His blood pressure is dropping and will now require a fifth pressor. The family has not made any decision about goals of care.

How Did We Get Here?

- Factors Internal to Caregiver
  - Perceived powerlessness, lack of knowledge about alternatives, fear of reprisals, lack of courage, doubt (futility of past actions), socialization to follow order
- External Factors to Situation
  - Work environment or culture, legal/regulatory issues, co-worker issues

2ND & 3RD ORDER EFFECTS

(Consequences)

Long term

- Moral Residue:
  - The buren that each of us caries from times of moral distress when we felt ourselves to be morally compromised
    - Webster and Bayliss, 2004

- Crescendo Effect:
  - The interaction of moral distress and moral residue over time
    - Epstein and Hamric, 2009

Institutional Impact of Traumatic Distress

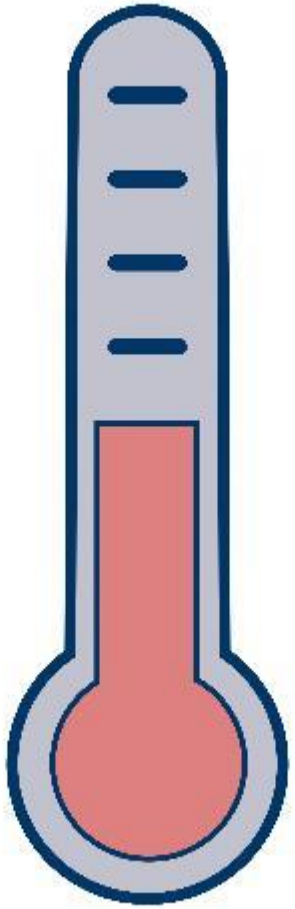
Institutional care costs for patients with traumatic disorders (PTSD, moral distress, etc.,.) are

3.5 times higher

than costs for those without traumatic disorders.

Time to take your temperature

The Moral Distress Thermometer



Worst Possible

Intense

Distressing

Uncomfortable

Mild

None

Select the point on the thermometer that best describes how much moral distress you have been experiencing related to work in the past 2 weeks, including today.

How is this different than six months ago?

Two years ago? (Pre-Pandemic)

How Do You Help Care Teams Perform Their Best in Morally Challenging Times?

DE-ESCALATIONS:

A LONG, SUCCESSFUL HISTORY OF CARING FOR THOSE AFFLICTED

- Beginning in 1978, researchers began investigating moral wounding and recovery methods – specifically by the Department of Defense and the Veterans Administration.

- Primarily among military combatants and military medical personnel experiencing acute levels of trauma as a part of their mission.

- Evidence-Based Methods utilized in MDX-CMP are tried and proven when used in this formulation to reduce moral distress and are attributed to the healing process for moral injury and PTSD.

Purpose of De-Escalations

“Combat Triage”

- **Pandemic environments are different than pre-pandemic**
- **Moral Distress De-Escalation (MDDE) is 1st Line of Assistance to Critical Care & Other Teams**
- **Responding to and De-Escalating provider’s moral distress**

NOT A CURE

MDDE and MDX-CMP are not a cure for moral distress…
Rather it is a “de-escalation” providing helpful, accessible, tested methods and tools so clinicians can better manage and significantly decrease their distress, fears, anxieties, and feelings of being overwhelmed or disconnected.

The model is designed to give confidence to the individuals and to build better empathy across teams;

It provides tools to decrease feelings of helplessness and feeling alone;

It helps clinicians feel heard and understood;

It normalizes being able to talk about moral distress with colleagues and teaches communication skills within the clinical team.

MDDE as a Civilian Technique is a New Field that Requires More than a “Fire and Forget” Mentality

- As pandemic continues, more will be learned of how moral suffering impacts trauma medicine in a civilian setting
- Moral Distress Consult Services continue beyond initial care, training and supervision of on-site MDDE Consultants
- Provides Updates / Continuing Ed / Information for use to improve local MDDE teams
- Provides training for new team members
- Available for emergency assistance

Concept for Moral Distress De-Escalation

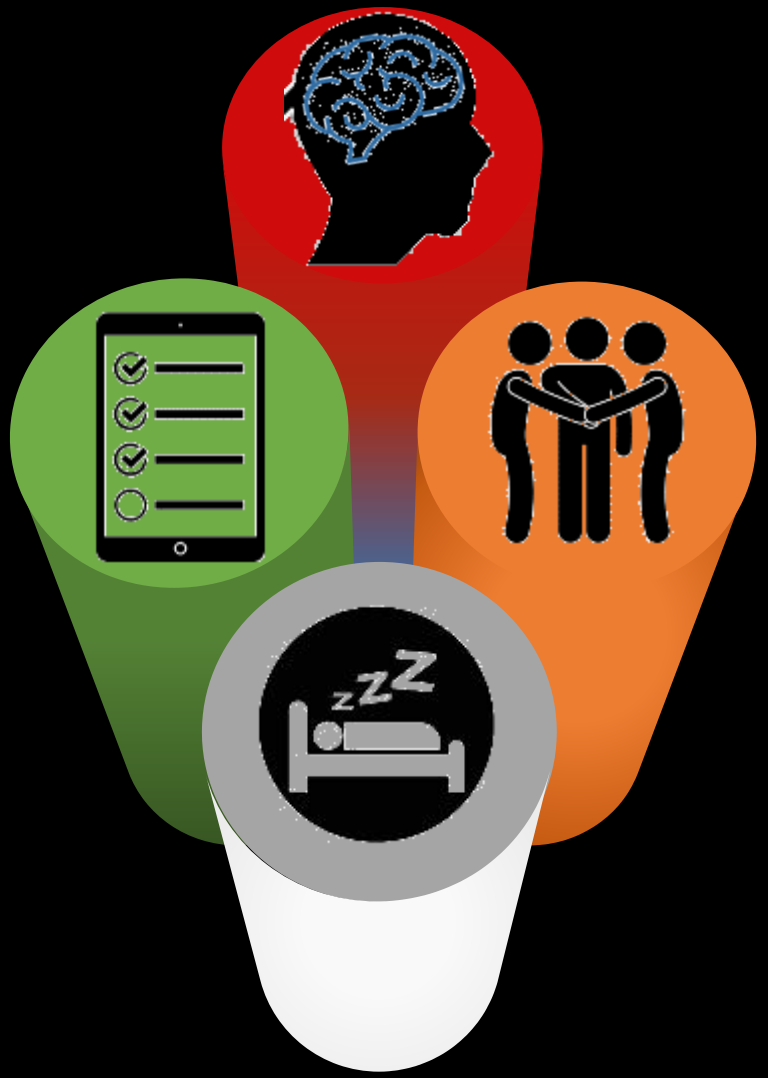
INTERVENTIONS:

1. Briefings (Didactic)	Normalizes
2. De-Escalations (Group)	Stabilizes
3. De-Escalations (Individual)	Decompresses

Dedicated Approaches to Optimal Performance

CHECK-INS

Daily self evaluation and coworker assessments to identify daily distressers



OVERCOMING STRESS

Tactical Breathing
Grounding
Prioritize Thoughts
Build Confidence
Visualization
Relaxation

SLEEP OPTIMIZATION

Strategic Naps
Sleep Banking
Up Your Sleep Area
Unwind Before Bed
Fatigue Scanning
Strategic Caffeine

TEAM COMMUNICATION

Tactical Communication
Conflict Resolution

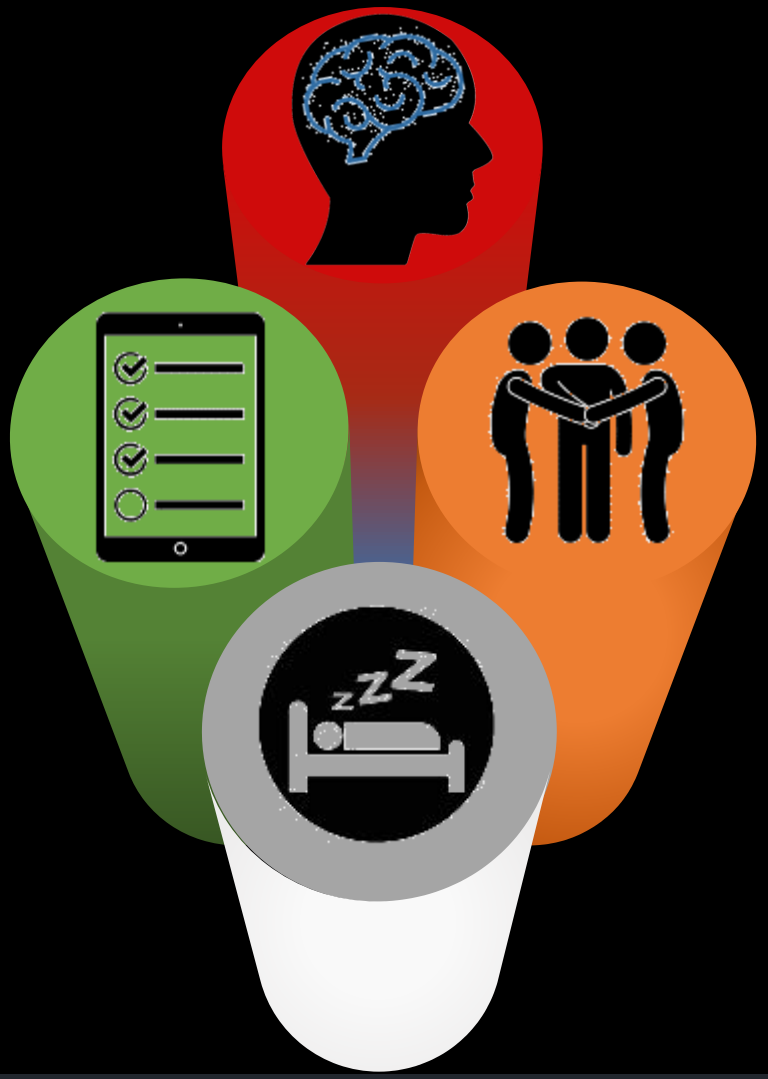
MDDE Approach to Optimal Performance

CHECK-INS

Daily assessments to identify domains of focus.

SLEEP OPTIMIZATION

Strategic Naps
Sleep Banking
Up Your Sleep Area
Unwind Before Bed
Fatigue Scanning
Strategic Caffeine



OVERCOMING STRESS

Tactical Breathing
Grounding
Compartmentalization
Build Confidence
Visualization
Relaxation

TEAM COMMUNICATION

Tactical Communication
Conflict Resolution

Stress Related Problems & Acute Stress Reactions

Stress Related Problems

- Signs
- How to Help

Acute Stress Reactions

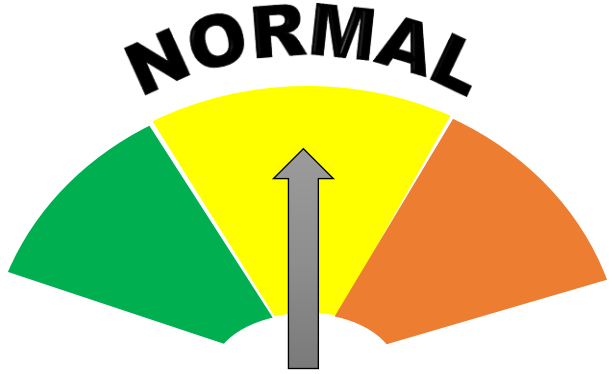
- Description & Signs
- Normalize Response

Acute Stress Reactions – What to Do

- Talk with Individual
- Calm, orient & stabilize them
- Increase feelings of safety
- Discuss concerns
- Educate on stress reactions
- Suggest & practice strategies to reduce distress
- Connect with supportive unit members

Acute Stress Reactions – What to Do (con't)

- **Normalize the Response to Trauma**
  - Anxiety, fear, helplessness, dissociation, increased alertness, re-experiencing, fatigue, difficulties with concentration and avoidance are common responses to trauma
  - They usually go away within hours or a few days
  - Not a sign of mental illness



Prioritize Thoughts
What it is & How to Do It

- "What's Important Now?" (W.I.N.)
  - Identify target
  - Execute task
  - Decide to deal with other concerns later

- When to do it:
  - High stress situation
  - Frequent distracting thought

- Avoid:
  - Past or future
  - Judging or Analyzing

Use Daily!

Don't Wait for the next Crisis

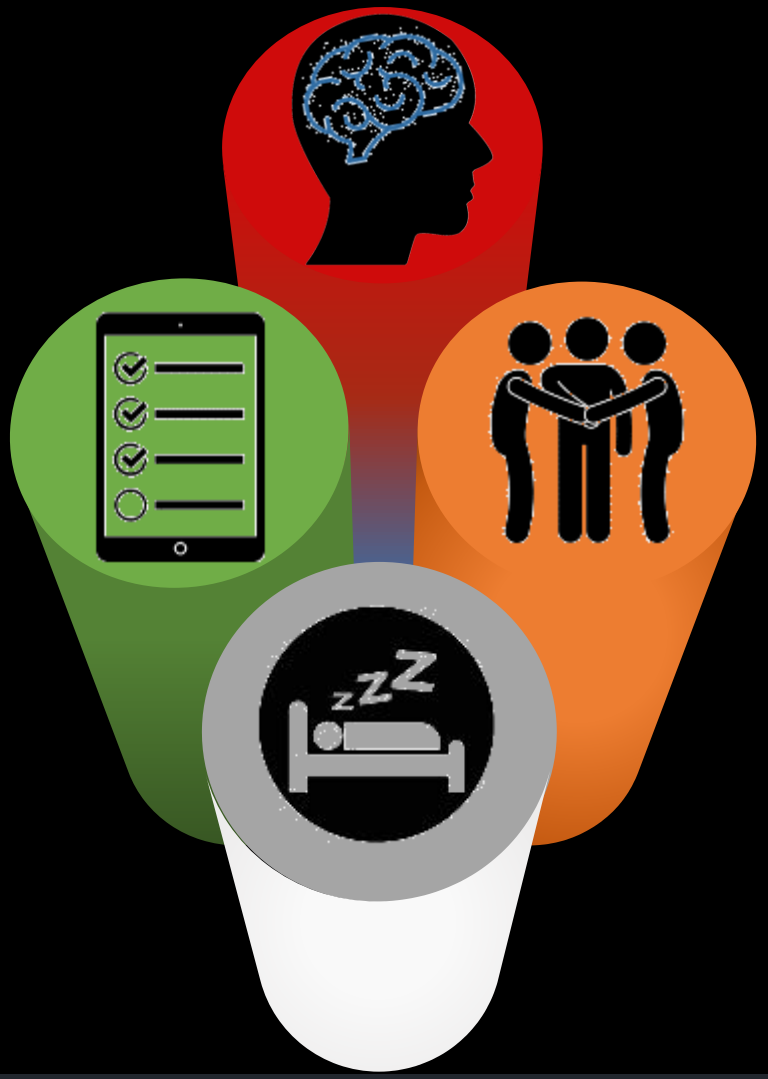
MDDE Approach to Optimal Performance

CHECK-INS

Daily assessments to identify domains of focus.

SLEEP OPTIMIZATION

Strategic Naps
Sleep Banking
Up Your Sleep Area
Unwind Before Bed
Fatigue Scanning
Strategic Caffeine



OVERCOMING STRESS

Tactical Breathing
Grounding
Compartmentalization
Build Confidence
Visualization
Relaxation

TEAM COMMUNICATION

Tactical Communication
Conflict Resolution

CHECK-INS

- “Mini - De Escalations”
- Informal
- Co-worker “Buddy Check”
- Daily
- Reinforces Resilience
- Builds Team Cohesion

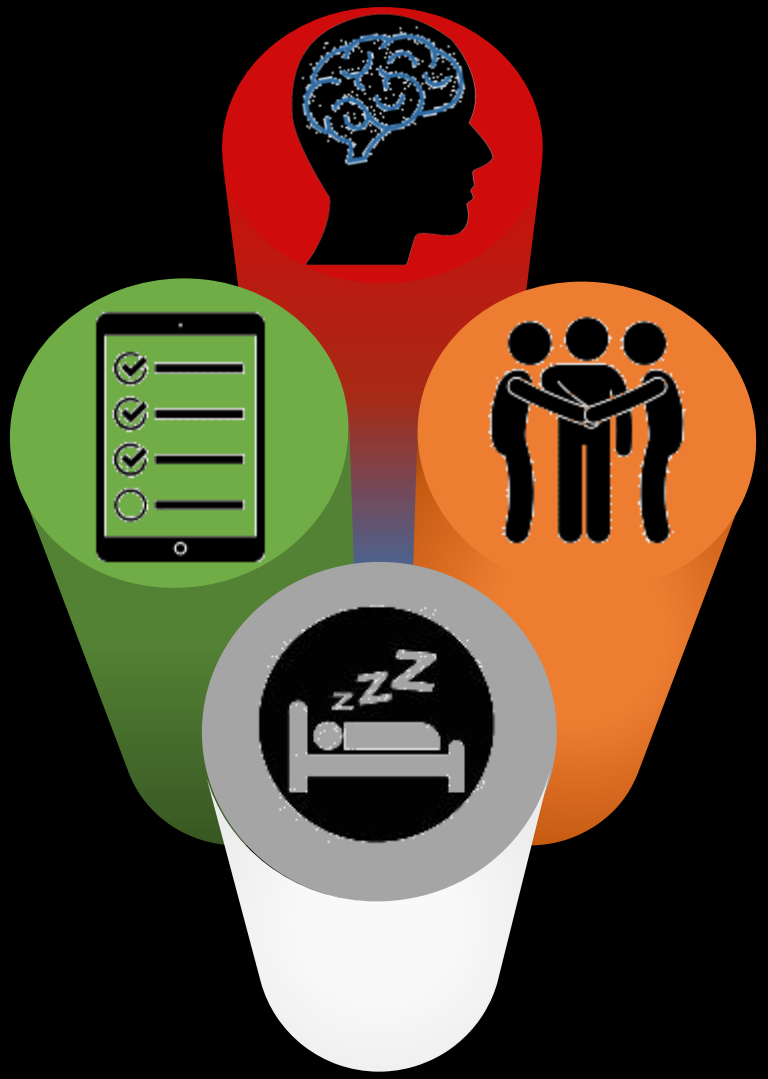
MDDE Approach to Optimal Performance

CHECK-INS

Daily assessments to identify domains of focus.

SLEEP OPTIMIZATION

Strategic Naps
Sleep Banking
Up Your Sleep Area
Unwind Before Bed
Fatigue Scanning
Strategic Caffeine



OVERCOMING STRESS

Tactical Breathing
Grounding
Compartmentalization
Build Confidence
Visualization
Relaxation

TEAM COMMUNICATION

Tactical Communication
Conflict Resolution

Sleep Optimization

PROVIDES TIPS FOR:

- Falling Asleep
- Staying Asleep
- Nap length
- Nap timing
- Sleep Inertia

(post nap grogginess)

Should've

Strategically

Napped!!!

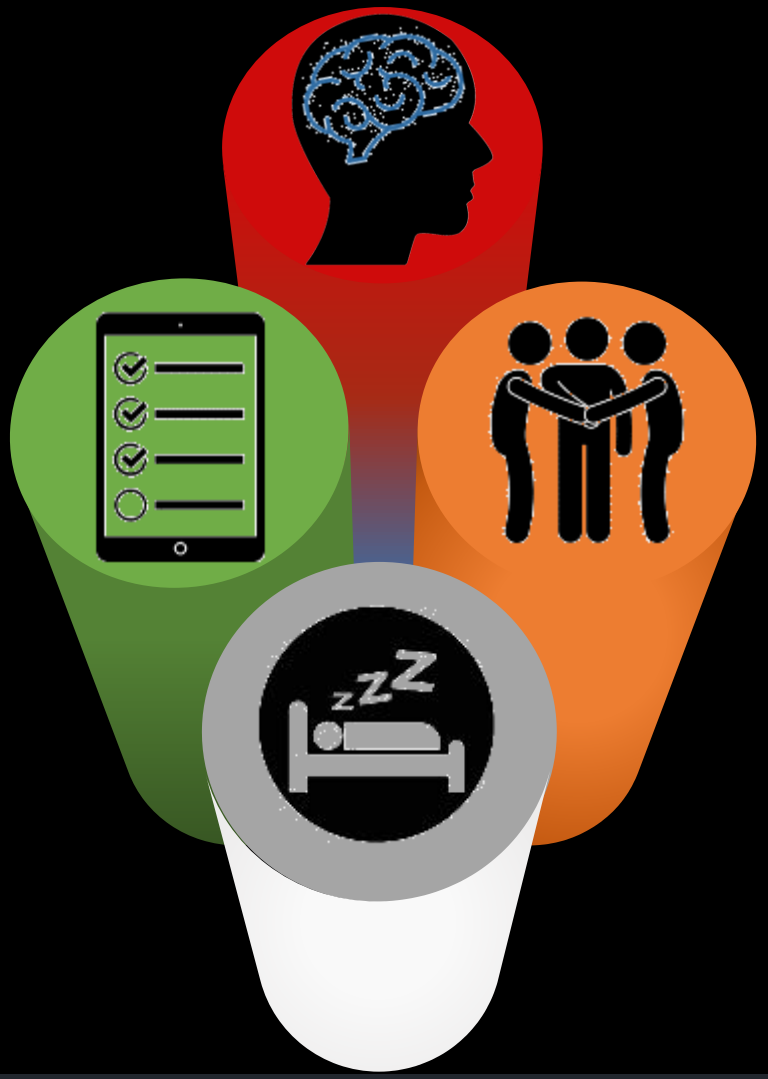
MDDE Approach to Optimal Performance

CHECK-INS

Daily assessments to identify domains of focus.

SLEEP OPTIMIZATION

Strategic Naps
Sleep Banking
Up Your Sleep Area
Unwind Before Bed
Fatigue Scanning
Strategic Caffeine



OVERCOMING STRESS

Tactical Breathing
Grounding
Compartmentalization
Build Confidence
Visualization
Relaxation

TEAM COMMUNICATION

Tactical Communication
Conflict Resolution

Teamwork & Communication

- When stressed, less sensitive to social cues
- Narrowed attention implicated in many team failures
- Effective Teams:
  - Develop systems that facilitate sharing of critical information
  - Effectively resolve conflicts
  - Communicate honestly, assertively and show empathy

Intervention Timeline

Intervention Timeline

Team Leader Brief

ASAP

- Coordinate and Schedule
  - Initial Team Brief,
  - Team Debriefing
  - Individual De-Escalations

Initial Team Brief

Monthly Mtg or TBD by RN Mgr

- Didactic in Nature
- ”Check-In” with Team by Ethicist
- NORMALIZES feelings of distress and isolation

Team De-Escalation

NLT 2 Wks after Brief

- Interactive
- Groups of 4
- Facilitates Expression of Distress
- STABILIZES Team

Individual De-Escalation

NLT 2 Wks after Team Debriefs

- Reflective
- Individual Assistance
- Facilitates Reduction of Distress

Re-Engage Regularly

4-6 Weeks after De-Escalations

- Revisit Issues
- Re-Encourage
- Revive

De-Escalation Team: Skills Needed

- Strategies for Recognizing Problems
  - Identification of signs of moral distress / moral injury problems
  - Advanced Knowledge of Moral Suffering in the Medical Context:
    - Causes
    - Effects
    - Treatments

- ADVANCED Communication Techniques
  - Building rapport & trust
  - Group Facilitation
  - Reflective / Reflexive Communication Skills

- Empathy

- Background in Traumatic Injury and Trauma De-Escalation

SUMMARY

- The Moral Burden of the COVID-19 MASS CASUALTY Pandemic Event =Decimation of Forces (X3) (and People Continue to Leave)
- Remaining Professionals Experience Moral Distress at Unprecedented Levels
- The Military Has Been Successfully Treating MASCAL Moral DX in Health Care Professionals for Decades
- Lesson Learned: <u>NO IMMEDIATE CURE</u>

Regulate Pressure

- While there is NO CURE for Pandemic Related Moral Distress, De-Escalations Can Minimize / Neutralize the Destabilizing Effects of Long-Term Moral Trauma on our Medical Team Personnel.

THANK YOU!

Questions?

Jeff S. Matsler, STM, ThM, MDiv
jeff.matsler@christushealth.org
(806) 681-4663