Confidentiality and psychological treatment of moral injury: the elephant in the room

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ABSTRACT

Morally injurious incidents may present ethical or legal quandaries, yet how military or civilian clinicians should manage such disclosures is poorly understood. Individuals who experience moral injury may be reluctant to seek help due to concerns about the legal ramifications of disclosure. Guidance on breaching patient confidentiality differs by regulatory body but also by profession, geography and context. As moral injury continues to become recognised in clinical practice, in the military and elsewhere, clarity is needed regarding best practice in managing moral injury cases and the dilemmas they present.

Moral injury has been defined as the profound psychological distress that results following one's actions, or the lack of them, which violate deeply held moral or ethical beliefs.[1] Potentially morally injurious events can include harming others, witnessing or failing to prevent harm, or betrayal by trusted others. Specific examples include a soldier being unable to adequately protect civilians due to limitations imposed by rules of engagement. While moral injuries are not currently classified as mental illnesses, they can lead to negative appraisals about oneself or others (eg, *'I am a terrible person'*) and feelings of intense shame and guilt. These experiences can, in turn, contribute to the development of mental disorders, with a recent meta-analysis finding moral injury to be significantly associated with post-traumatic stress disorder (PTSD), depression and suicidal ideation.[2]

Although there has been an abundance of research into the impact of traumatic events, and the onset of mental disorders, studies examining feelings of shame and guilt resulting from morally injurious events have been scant until recently.[3] There is increasing recognition of moral injury as a concept possibly because it offers an explanation for the intense distress caused by events that may not be personally threatening or *'classically'* frightening.[4] This is as true for military personnel as it is for civilians. Moral injury may also offer an explanation for poor treatment response for veterans who suffer with PTSD as fear-based treatment approaches may be ineffective in dealing with the mental health impact of potentially morally injurious events.[5] Furthermore, morally injurious events by their very nature present ethical, and at times legal, dilemmas, and yet how clinicians manage the ramifications of such disclosures is not well understood. Given the ambiguity, this article discusses several key issues relating to confidentiality and managing patient disclosures which should be considered when clinicians provide treatment to patients who have experienced moral injury.

CLINICAL IMPLICATIONS

Clinician–patient confidentiality is a cornerstone of good practice. However, in the UK, the General Medical Council is clear that the disclosure of personal information to relevant authorities may be warranted, even without patient consent, in certain circumstances such as when required by law or if disclosure is justified in the public interest.[6] Additionally, the NHS Code of Practice advises disclosure to *'prevent and support the detection, investigation and punishment of serious crime and/or prevent abuse/serious harm to others'*,[7] where a serious crime can include current or past acts of terrorism, rape, child abuse, murder or manslaughter. However, professional codes of practice vary by role, geographically and by context. For example, UK guidance for clinical psychologists and social workers requires them to uphold a client's rights to confidentiality, with exceptions justified on the basis of a greater ethical requirement. Professionals must therefore report *'allegations of harm and challenge and report exploitation and any dangerous, abusive or discriminatory behaviour or practice'*.[8] In some countries, such as the USA, the reporting mandate often only relates to suspected abuse or neglect of children, elders or vulnerable adults. In environments in which the clinician identifies that there is no current risk, they are not obligated to report historical behaviours of patients, even if a patient discloses that a serious crime took place.[9]

Such caveats to confidentiality have implications for the provision of care for individuals affected by moral injury. Concerns about confidentiality may be a key reason why some individuals do not seek formal help for psychological difficulties; this may be particularly so for military personnel who may fear having their duties restricted and promotion opportunities quashed. However, personnel experiencing moral injury-related distress may be especially reluctant to seek help due to their concerns about the potential legal ramifications of disclosure. Further, if an individual affected by moral injury seeks support, feelings of shame and fear of retribution may inhibit full disclosure and consequently impede treatment effectiveness. Interventions for moral injury, such as adaptive disclosure where patients engage in experiential exercises involving imaginal conversations with a forgiving moral authority,[10] may also be unfeasible in contexts where disclosure of a crime may oblige a clinician to breach confidentiality. As a result, those with moral injury may never access psychological care and, if they do, treatment may be ineffective.

Although clinicians may consider only breaching confidentiality in the most serious of cases, it may be unclear whether someone who recounts apparently perpetrating serious crimes might be suffering with a moral injury-related mental disorder which has distorted their perceptions of what actually happened or not. Studies have shown several mental disorders, including PTSD, are associated with a distortion of perceptions.[11] For example, a patient may present to a medical officer/clinician and disclose being responsible for the deaths of civilian women and children during a military deployment. After further enquiry, the reality of the situation may be more complex than it initially seems. For instance, the patient may believe they were following lawful orders, that an accident

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had occurred, or the clinician may doubt that the patient had acted as they claimed at all. A possible solution is to provide clearer guidance about the limits of confidentiality to patients which could be beneficial for all those who are considering engagement with mental health services, especially those with a moral injury. Such guidance could be routinely provided on engagement with the healthcare facility and provide specific examples about the types of events that may lead to a breach. This guidance could serve to reassure the majority of patients, whose confidentiality would not be breached by a treating clinician, that seeking help was a *'safe'* action for them. However, it would of course not be possible to provide blanket reassurance to all, given the statutory requirements of UK clinicians to breach confidentiality in some circumstances.

ETHICAL IMPLICATIONS

Deciding when to breach confidentiality to disclose ethically challenging behaviours revealed during a clinical consultation can be extremely difficult. Patients may well present many years post-trauma and clinicians are unlikely to have ready access to data/records to clarify whether or not a specific incident took place as described. Moreover, differences in rules of engagement and international agreements between nations can impact whether an event (eg, potential war crimes, genocide) is seen as a crime or not, which adds a further layer of complexity. Fundamentally, it is not a clinician's job to determine whether or not a crime took place—their role is to decide whether what they have been told during the course of treatment constitutes a reason to breach confidentiality in order for authorities to investigate whether a judicial process is warranted. A balance must be struck, between the duty of care to the patient and the clinician's responsibility to defend the public interest. Breaching confidentiality and reporting a patient to the authorities may irreparably damage the reputation of a therapeutic organisation if it became public knowledge, with other patients refusing to use the service. However, if it came to light that a clinician knew of information about a serious crime and failed to take appropriate steps, they may risk sanctions from regulatory bodies, or indeed the police, which could impact on their licence to practise. Where disclosure is being considered, we suggest that good practice should be to first seek advice from senior colleagues and/or organisational lawyers to help guide such decision making. It is also essential to ensure a good standard of documentation so as to show the rationale behind all clinical decisions made.

We further suggest that it may be therapeutically worthwhile to sensitively challenge a patient's appraisals and perceptions of the morally injurious event as doing so could help a clinician form a view about the true nature of the incident. However, such an approach should be intended to be relevant to the well-being of the patient rather than attempting to establish whether or not a crime occurred. If, after due consideration, it becomes very clear that a crime has been committed, then disclosure of the event must follow. This is best done, to relevant authorities, by the patient themselves, and indeed doing so could be a goal of treatment, especially when no current risk is identified. This may be a process which is therapeutically beneficial while also recognising a patient's autonomy. Nonetheless, we urge caution, and appropriate consultation and reflection, before recommending such disclosures.

Research with UK mental health clinicians has found little consensus in terms of when breaches of confidentiality were considered necessary when working with morally injured patients, including patients who are service personnel and military veterans.[12] Disclosure of potentially morally injurious events to relevant authorities is likely to have substantial consequences for a patient's well-being, as well as career and family life. Yet little guidance is available to support how clinicians should reach a decision to break confidentiality and how to manage the subsequent social/legal consequences. Given the increasing recognition of moral injury across clinical settings, we recommend that the NHS and clinical staff who work with patients at high risk of exposure to morally injurious events (eg, military personnel, first responders, medics and so on) generate accessible guidelines about how to navigate this issue.

We also acknowledge that a patient who discloses a potentially morally injurious event may present a personal challenge for clinicians, especially less experienced ones, who might find it difficult to remain neutral when discussing ethically or morally challenging events. We suggest in such situations that good clinical supervision, with a trusted colleague or senior, should focus on helping clinicians maintain their neutrality in relation to the case. Finally, while evidence exists that some clinicians find their experience of working with morally injured patients to be distressing given the nature of the trauma and the patient's symptomology,[12 13] it is unclear whether clinicians may also experience vicarious moral injury in cases where they chose to (or chose not to) breach patient confidentiality. This is an avenue that warrants further investigation to ensure clinicians are adequately supported in their role.

POLICY IMPLICATIONS

The disclosure of an important minority of morally injurious events has the potential to lead to criminal prosecution. For example, media articles suggest that criminal court proceedings against military veterans for events that occurred decades ago are becoming increasingly common,[14] although recent government-proposed policies may challenge such approaches.[15] We suggest that where a patient poses no current threat to themselves/others, and when the incident occurred several years ago, clinicians should pause for reflection before reporting such *'admissions'*, and discussions with senior colleagues are advised. Indeed, this stance is consistent with the Serious Crimes Bill (2015), which originally proposed that the disclosure of all instances of child abuse to authorities should be mandatory, irrespective of victim consent; however, this was successfully lobbied and revised to limit disclosure to cases where the perpetrators still posed a threat to the victim or others.[16] This stance not only safeguards a patient's right to self-determination, but also upholds the requirement for clinician non-maleficence, inflicting the least harm possible to reach a beneficial outcome.

We further suggest that the courtroom is not often the best place to distinguish perception from fact for patients who are suffering from significant mental disorders. In our view, as the experience and potential impact of moral injury becomes more widely recognised, the need for an open discussion regarding the feasibility of an amnesty becomes more pressing. Our view is that a parliamentary debate or deliberation by the Law Commission which considers the balance between a duty of care towards a patient's mental health and the need for criminal investigations may help to shed light on the path forward. Whether the UK should adopt a US approach to this issue, which only requires clinicians to report events which are relevant to current risk-related behaviour, should continue to be a topic of debate.

Box 1 Suggestions for ethically sound clinical practice in cases of moral injury

- Non-disclosure is advocated wherever possible, especially in cases where a patient poses no current threat to themselves/others and when the incident occurred several years ago.
- Patients should be routinely provided with clear guidance about the limits of confidentiality on engagement with mental health services, with specific examples about the types of events that may lead to a breach of confidentiality.
- Where disclosure is being considered, good practice is to seek advice from senior colleagues and/or organisational lawyers to help guide such decision making.
- Clear guidance for clinicians who work with patients at high risk of exposure to morally injurious events is needed that clarifies how clinicians should reach a decision to break confidentiality and how to manage the subsequent social/legal consequences.
- If disclosure to relevant authorities is required, this is best done by the patient themselves which, if no current risk is identified, may be therapeutically beneficial and affirms the patient's autonomy.

SUGGESTIONS FOR BEST PRACTICE IN MANAGING ETHICAL DILEMMAS IN CASES OF MORAL INJURY

The issues we highlight in treating patients with moral injury are by no means an exhaustive list. Nonetheless, the suggestions in Box 1 may help to ensure ethically sound best practice.

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