# Reality vs. Propaganda. PTSD among Civilian Healthcare Staff and Patients and the Rhetorical Invention of the "War on Coronavirus"*

By Patrizia Piredda

**Abstract**: As the coronavirus pandemic broke out in March of 2020, many countries' healthcare systems were overwhelmed by the sudden increase in the number of hospitalised patients and deaths. Not only hospitals but the healthcare staff struggled too, who faced unprecedented stressful work conditions for which they often had no training. Politicians and the media addressed the sanitary crisis using the metaphor of "war on coronavirus", calling the national and international communities to an emotional "call to arms". However, the article argues that the use of war-metaphors was misleading and incorrect because PTSD triggered in civilian healthcare staff by the harsh work conditions during the crisis was not entirely comparable with PTSD in military medical staff deployed in combat zones. The ethical burden and the exposure to risks of physical injury and death made the conditions of these two groups comparable. However, the technical and professional preparation of the military and the civilian healthcare staff diverge and make their operational contexts incomparable. The author thus argues that the "war on coronavirus" was a wrong metaphor used to divert public attention from the actual state of the inefficiency of the national health systems in such countries as Italy and the UK.

**Keywords**: *Coronavirus, PTSD in civilian healthcare staff, metaphor, rhetorical manipulation and propaganda*

## Introduction

Posttraumatic stress disorder (PTSD) is a syndrome that occurs in subjects who have gone through traumatic experiences such as dreadful and dangerous events that have threatened their physical safety. PTSD symptoms can vary from mild to severe and studies have demonstrated that a vast number of people suffer or have suffered from PTSD.[1] PTSD is not only related to war and conflict, although the stressors should be sufficiently intense to trigger it: "some events such as bullying, divorce, death of a pet, and learning about a diagnosis of cancer in a close family member are not deemed extreme enough to precipitate PTSD" (Bisson and others, *Post-Traumatic Stress Disorder*: 1). Therefore, this syndrome does not appear whenever one goes through a traumatic experience but might occur as a consequence of experiences that do not imply extreme violence, injury, or death. PTSD can break out in someone

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who

> directly experiences the traumatic event; witnesses the traumatic event in person; learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related). (Rizzo and others, *Expansion*: 334)

The recent Coronavirus-pandemic offers a remarkable case study of how the application of the notion of PTSD to civilian healthcare staff was framed within a media campaign that described the struggle with the epidemic as a war against the virus. Especially during the worst moment of the crisis in Europe, i.e. between early March and late April 2020, politicians and the media of many European countries used the metaphor of the "war against an invisible enemy" to mean the mobilisation of resources to tackle the spread of the virus. Healthcare staff were depicted like "soldiers" and "heroes" fighting bravely in the trenches on the frontline, and the communities were encouraged to support the effort of these brave professionals who risked their lives to protect the lives of many others. Such rhetorical "call to arms" was basically aimed at triggering an emotional response among the public, based on fear, and at encouraging the "patriotic" formation of a "second line" backing the "frontline", where the healthcare staff were deployed. Despite the emotional mobilisation, neither politicians nor the media said anything about the actual conditions of the national health systems in countries such as Italy, UK, France, or Spain (not to mention the USA), in which years or even decades of cut to expenditure have put the systems to their knees. As a consequence, doctors, paramedics, and nurses were forced to work in conditions of high pressure and stress, not only due to the sanitary emergency and the following impact on hospitals, but above all due to the inefficiency and lack of medical structures and equipment, such as Personal Protection Equipment (PPE), scarcity of beds in Intensive Care Units (ICUs), and inadequate supply of technical equipment (ventilators). Moreover, healthcare staff had not received any specific training to face such an emergency, which is one of the reasons why psychologists state that the stressful experience could spiral out and result in PTSD or burnout.

In this article, I am analysing the reasons why the media in the UK and Italy (which I chose as relevant case-studies) talked about the traumatic experience of healthcare staff involved in the treatment of Covid-19 patients by referring to war-metaphors. As they did so, I claim, they blurred the condition of civilian

healthcare staff with that of military medics who come back from combat zones, thus blurring two different kinds of PTSD. In fact, despite the extensive similarity of symptoms, the causes of PTSD in military medics remain different from that of civilian medics. Therefore, I claim that it is correct to talk about PTSD for healthcare staff involved in the treatment of Covid-19 patients, but I also claim that it is misleading and wrong to compare the epidemic to a war.

## PTSD in civilian healthcare staff deployed against Coronavirus in Italy and the UK

Not one month after the outbreak of the epidemic, and two weeks after its spread across northern Italy, on March 8 the World Health Organisation (WHO) published a document that declared the state of "health emergency". Each paragraph of that document conveyed one precise political message: the first addressed the broader population by inviting all to be empathetic to those who had fallen sick, because "people who are affected by COVID-19 have not done anything wrong, and they deserve our support, compassion and kindness" (WHO, *Mental Health*: 1). The second paragraph was also important because it urged people not to call the infected patients "victims" or "diseased" but rather by using the paraphrase "people who have covid-19" (1). One further message was meant to reach directly the healthcare workers and concerned about the serious stressful and mind-affecting conditions in which they were about to be deployed:

> Feeling under pressure is a likely experience for you and many of your colleagues. It is quite normal to be feeling this way in the current situation. Stress and the feelings associated with it are by no means a reflection that you cannot do your job or that you are weak. Managing your mental health and psychosocial well-being during this time is as important as managing your physical health. (2)

The advice provided in that paragraph would soon reveal itself ineffective for a great number of doctors and nurses: "Try and use helpful coping strategies such as ensuring sufficient rest and respite during work or between shifts, eat sufficient and healthy food, engage in physical activity, and stay in contact with family and friends" (2). Prolonged tiredness without recovery, lack of food and water during the shifts, and the separation from family and friends would eventually result as the major causes of mental breakdown. Insofar as these causes also feature among the stressors that might trigger PTSD in military medics, it is clear that PTSD "is not only associated with exposure to combat

and traumatic events, but also to increased stress in one's home life, such as frequent moves and family separations" (Pitts and others, *Effect of Hardiness*: 279). By acknowledging such risk-factor, the WHO document went on to address the managers of health facilities, no longer by "urging" but rather by "commanding":

> Keeping all staff protected from chronic stress and poor mental health during this response means that they will have a better capacity to fulfil their roles. Be sure to keep in mind that the current situation will not go away overnight and you should focus on longer-term occupational capacity rather than repeated short-term crisis responses. (WHO, *Mental health*: 3)

Little further on, the document went on recommending:

> Ensure that staff are aware of where and how they can access mental health and psychosocial support services and facilitate access to such services. Managers and team leaders are facing similar stresses to their staff and may experience additional pressure relating to the responsibilities of their role. It is important that the above provisions and strategies are in place for both workers and managers, and that managers can be role-models for self-care strategies to mitigate stress. (3)

Since the beginning, it was evident that the emergency would put great pressure on healthcare staff both physically and spiritually. Anyone could develop symptoms of psychophysical stress, anxiety, emotional breakdown, or burnout. The most dangerous moments were those in which doctors and nurses were not in action, because the accumulated emotional stress would then emerge abruptly. Many witnesses admitted that during the breaks, as they remained alone, they released the tension by crying. Once distress, sadness, and frustration were overcome by willpower (Lee, *Coronavirus*), they could resume their job.

The main symptoms that appeared in healthcare staff during the two months of the Corona-crisis in Europe were discouragement, helplessness, weariness, and fear, all symptoms that could lead to the diagnosis of PTSD, whose triggering causes include

> (1) exposure to a traumatic event that involved actual or threatened death or serious injury, (2) reexperiencing that event with distressing recollections, dreams, flashbacks, and/or psychological and physical distress, (3) persistent avoidance of stimuli that might

> invite memories or experiences of the trauma, and (4) increased arousal. (Victor and others, *Posttraumatic Stress Disorder*: 284)

To prevent mass-burnout, which would eventually cause not only healthcare staff but also the whole health system to collapse, by the end of March the Italian authorities began to consider deploying psychologists in the hospitals. On March 24, the action "*iniziativa psicologi online*" started: over 8000 psychologists were deployed to support anyone who was affected by the psychological effects of the epidemic, be they staff, patients, and families who had someone in critical conditions or even deceased (CNOP, *Una banca dati*). On April 6, the national institute for the insurance and safety of workers (INAIL), in cooperation with the national association of psychologists, published the official document "Gestione dello stress e prevenzione del burnout negli operatori sanitari nell'emergenza COVID-19" (Di Tecco and others, *Gestione dello stress*), which pointed out the possible causes and psychological consequences of emotional and physical overload, determining what the health system was supposed to do in order to prevent such events. The document did not mention PTSD but rather replaced this acronym with the word "burnout", or a work-related chronic-stress syndrome characterised by a "feeling of impoverished energies or exhaustion, increased mental detachment and negative or cynical feelings toward work and other people, resulting in reduced professional capacities" (*ibid.*).

In the UK too, the problem of stress in healthcare staff was promptly tackled. On March 28, the WHO and the International Labour Organisation launched the survey "Global Health and Safety of Health Workers in COVID-19" to monitor and prevent the major risks which healthcare staff were exposed to. The NHS established a mental health hotline soon after to provide support to healthcare staff because experts had warned that the risk of developing PTSD was high. However, only on May 12, a team at the University of the Highlands and Islands started to project an app capable of monitoring the mood and the anxiety level of NHS workers (Editorial, *Coronavirus: Mental Health*).

Italy was the first European country where the virus spread fast and aggressively: here doctors and nurses were confronted with a highly stressful experience, especially in the most seriously affected areas in Bergamo, Cremona, and Brescia, where at the end of March ICUs were on the brink of collapse, due to shortage of beds and equipment to treat the increasing number of admitted patients. The staff had to work in hard conditions of stress, fatigue, danger, and frustration due to the fact that a great number of chocking patients

were beyond their ability to help, which forced the medical personnel to sort those who were to be treated from those who could not be saved. David Lazzari, president of the Italian national association of psychologists described the dire conditions of work in an article of March 28, in which he mentioned extenuating shifts of up to twelve hours, during which doctors and nurses remained wrapped in insulated PPE that did not permit transpiration (Mazza, *Coronavirus*).

Many a witness confirmed such description, for example in the letter that one 39-year-old nurse from Senigallia addressed to Italian PM Giuseppe Conte. In her letter, the woman explained why she refused the proposal of the Government to raise the healthcare staff's salary by 100 Euro, a measure which she considered offensive. During the shift, she claimed, she could not drink, nor did she dare use the toilet due to the fear that the least distraction could cause her to contract the virus. And in the evening, when she went back home with her face bruised by the protective mask, she could not even sit and eat with her family (Editorial, *Coronavirus, la lettera di un'infermiera a Conte*). One further testimony of the extent to which healthcare staff were exposed to exhaustion was the picture of Mrs Elena Pagliarini that was taken on March 8 in the hospital of Cremona, in which the nurse was portrayed asleep over her desk after a devastating shift and still wearing her full PPE (Editorial, *Coronavirus, l'infermiera sfinita*).

Healthcare staff in other nations were confronted with the same problems. In the UK, on April 14, Louise Wigginton, a specialist respiratory nurse working in an intensive care Covid-19 Red Zone in central London, told the BBC that she worked in 13 hour-long shift often without breaks: "I was so hot in my PPE – she said – that I thought I was going to faint. My eyes felt funny and my legs felt like jelly" (Lee, *Coronavirus: Covid-19 Nurse*). *The Guardian* reported on March 25 that doctors and nurses were "worr[ied] about carrying the virus into their homes where their children, partners and parents could be exposed" (Frangou, *Coronavirus Heroes*).

Stress was both physical and mental. On the one hand, there was fear of being infected and of spreading the contagion among families, not to mention the preoccupation of committing mistakes at work due to tiredness. On the other hand, the staff had to endure physical strain and fatigue, as the PPE caused skin-rashes, blocked the transpiration, and left bruises on the face. The most serious cause of stress, though, was – according to the President of the national association of psychologists – the lack of "individual and general safety conditions" (Mazza, *Coronavirus*), followed by fatigue and the sense of

helplessness in the face of many a patient who died away alone and without the comfort of their families.

The extreme conditions of medical staff in these two countries were well depicted in two articles, respectively written by a doctor in the hospital "Papa Giovanni XXIII" in Bergamo, and by medical staff in the tertiary care hospital in North Midlands, Royal Stoke University Hospital. The former described the appalling conditions of the hospital during the peak of contagion:

> 300 beds out of 900 are occupied by Covid-19 patients. Fully 70% of ICU beds in our hospital are reserved for critically ill Covid-19 patients with a reasonable chance to survive. The situation here is dismal as we operate well below our normal standard of care. Wait times for an intensive care bed are hours long. Older patients are not being resuscitated and die alone without appropriate palliative care, while the family is notified over the phone, often by a well-intentioned, exhausted, and emotionally depleted physician with no prior contact. (Nacoti, *At the Epicenter*. 2)

The witness went on describing the conditions in other hospitals in Bergamo on the brink of collapse, where "medications, mechanical ventilators, oxygen, and personal protective equipment [were] not available" (2). The hospitals were so overcrowded, that "patients lay on floor mattresses" and basic services, from maternity to oncological treatment, had to be reduced or even suspended.

The English article openly revealed the inadequacies of the NHS that in those chaotic moments released confusing guidelines that caused mayhem, for example, those concerning PPE. Only on April 2, the NHS released one official set of guidelines, albeit

> probably a month too late for the staff that had either died or had contracted coronavirus by that time only to succumb to it later. By the 5th week of this pandemic reaching the UK, although the government only confirmed 49 verified deaths of NHS staff, sources claim the number of health care fatalities to be more than a hundred. (Chaudhry and Raza, *Covid 19*: 2)

Despite that, British healthcare staff had to face the epidemic "wearing thin plastic Aprons and short gloves, leaving the whole of [their] arms exposed, despite studies clearly indicating that corona virus survives on skin and cloth" so that the constant exposure to threat produced "an adverse impact on staff morale". Both articles mentioned the danger of burnout as one of the most feared consequences.

**Sharing and acknowledging traumatic war and/or pandemics experiences: from group frailty to social strength**

Scholars have demonstrated that PTSD can also be triggered by the impossibility of sharing traumatic experiences. In this case, the traumatised person tends to share it only with other colleagues or comrades who have experienced something similar, which causes them to feel isolated and frustrated by the lack of moral and psychological support from their social environment. Concerning this aspect, the experience of healthcare staff involved in tackling Covid-19 resembles that of war-veterans. One of the most acute reasons for suffering for these people consists in being under the impression that their society fails them, refuses to listen to their stories, and is just eager to reintegrate them into civil life as if nothing happened. Even worse suffering is finally caused by the existence of individuals or groups that openly blame veterans for the evil that they have committed in war. Whenever trauma remains unelaborated, it produces suffering. When PTSD derives from untold and repressed suffering, its origin is not only psychophysical but cultural: when society refuses to cope with pain and suffering and rejects or stigmatises traumatic experiences as something merely to hide and forget, people who have endured pain and suffering will eventually risk developing PTSD.

While the epidemic raged in Europe, medics and journalists wondered whether it was acceptable for healthcare staff to show frailty and to cry openly in front of patients, families, and colleagues. This question recalls one diffused problem among veterans affected by PTSD, for military personnel is expected to be brave, resilient, unemotional, and capable of enduring physical strain and psychological stress. When soldiers begin to perceive that they are not so strong as they "should" be, they are afraid of being called "weak", "cowardly", "too soft", and of being discharged. As a consequence, they tend to suppress that feeling, which is likely to trigger PTSD. Where social support is not provided, such a reaction could cause the traumatised person to self-isolate in the so-called "paradox of silence":

> Combat veterans want to be understood, but they do not want to talk about their experiences or how they're feeling, or what they're thinking. Combat veterans want those who have never served in the military to understand what serving in the military means, and what it takes to survive in combat, yet do not want to talk about their combat experiences, or what it is like to kill someone. Most combat veterans become extremely annoyed when someone, especially strangers, ask them if they have killed anyone. In fact, the more one talks about their combat experiences, the less likely they are to be believed

> by other combat veterans. (Castro and others, *The Combat Veteran*: 304)

Such a spiral of reticence can jeopardise the difficult process of acknowledging the traumatic experience, thus pushing the traumatised person more and more into a pathological state of mental distress (Ko and others, *Creating Trauma-Informed Systems*; Kuhn and others, *Multiple Experiences*; Langlois, *Influence*; Litz and others, *Moral Injury*; Lloyd and others, *Comorbidity*).

During the first peak of the epidemic, which also made the moment of most acute fear and collective anxiety, when ICUs were no longer able to admit new patients and graveyards had to pile the coffins due to shortage of land to bury all corpses, a number of solidary demonstrations took place. People saluted healthcare staff from homes and public institutions acknowledged their sacrifice officially. Doctors of the Royal Stoke University Hospital wrote:

> The public response towards NHS staff has been heart-warming. On leaving the hospital, we see numerous messages of support displayed on walls and windows. Every Thursday people open their windows to clap and cheer to express their gratitude for the health workers. People are keen to help and support the NHS and nearly 1 million have signed up as volunteers. (Chaudhry and Raza, *Covid 19*: 4)

**After the crisis**

However, no sooner had been the emergency called off than healthcare staff returned to be the object of intolerant attitude. For example, on April 28, in the city of Anzio in Italy, the family of a 32-year-old patient who died from Coronavirus reached the Covid-area in the hospital and assaulted one doctor, accusing her to have caused their relative to die (Pistilli, *Anzio*). Still, in April, nurse Damiana Barsotti came home after a long shift at the hospital of Lucca only to find a note from her neighbours that read: "Thank you for the Covid that you bring to us every day. Remember that elderly and children live here. Thank you" (Gasperetti, *Coronavirus*). Mrs. Barsotti told the journalist: "It was like being stabbed in the back, I felt betrayed and threatened, like a plague-spreader. I felt so depressed that I could not even get angry."[2]

After the crisis was over, attention was quickly drawn away from the precarious work conditions of many a member of healthcare staff. And no sooner had diminished the fear of malady and death than the general tendency to forget and move on became quite evident. This caused frustration in

healthcare staff in Italy and other European countries, where doctors and nurses organised demonstrations. They asked for respect and acknowledgement of their sacrifice, instead of being called "heroes" and rewarded with ridiculous alms of a few hundred Euros. They felt unjustly mocked at, exploited, and betrayed. This gap that suddenly split the corporation of healthcare operators from their social environment could be one cause of PTSD.

And finally, also patients who had survived developed PTSD. Several cases were acknowledged in the UK and Italy: people who had been treated in ICUs were haunted by nightmares and hallucinations similar to those that commonly affect veterans. These patients were haunted by monstrous visions, anxiety, and hyper reacting response to danger. For example, one of the early Italian Covid-patients, a policeman in Rome who remained in a coma for several weeks, after his awakening remembered recurring dreams of being sitting in a helicopter on its way to the frontline, where he was abandoned in the trenches dug in a desert, perhaps in Iraq or Afghanistan. There he saw his friends and comrades die and for long he continued hearing their voices calling for him (Marani, *Coronavirus*).

Another example is that of nurse Sadie Hallett-Chambers, who "hallucinated she was in a Spanish convent under attack by the IRA", as she recounted after recovery: "I'm getting flashbacks most days, mainly of the delirium, my brain is really trying to figure out what was real and what was not" (Editorial, *Nurse who had coronavirus*). One further example is that of Claudia Brondolo, who said: "Nightmares wake me at night. I jump up and scream. I dream of being choking. Sometimes I lie in a cave, covered under the leaves that press me down. Other times, I lie on a stretch and crave for breathing" (Mondo and Sola, *Dalla rianimazione*).[3]

These examples present many similarities with the symptoms of PTSD that can be observed in military medics and soldiers after their return from combat zones. However, the similarity is mostly formal because the specific contexts in which PTSD occurs in civilians and military personnel are quite different. What I am going to discuss next is how the public debate on Coronavirus, much unfortunately, was linguistically based on the will to comparing the medical emergency with a war, which blurred the two contexts and, as a consequence, the problem of PTSD.

## PTSD in military medical personnel

Before starting to analyse the linguistic and ideological abuse of war-metaphors made during the Coronavirus-pandemic, I would like to consider the specific problem of PTSD in military medical personnel. The majority of studies devoted to this theme concerns American veterans. A great deal of experimental studies demonstrates that many veterans, both soldiers and medics, developed PTSD after their return from overseas. One cause was an exaggerated sense of vulnerability due to the fact that "they are then deprived of a sense of control, a flow of information regarding their surroundings and status, sophisticated equipment to which they are accustomed, and physical comfort" (Baker, *Preventing Post-Traumatic Stress Disorders in Military Medical Personnel*: 262), as well as "witnessing death and serious injury to others" (Carson and others, *Psychophysiologic Assessment*: 890).

Factors that may contribute to triggering PTSD in veterans are numerous and affect them in non-systematic ways. The studies highlight, in fact, that these factors are more or less effective also depending on the individual personality. One notion that is often used is that of "resilience", a faculty that permits the person to absorb the trauma and not to develop PTSD or burnout. The lower the resilience, the likelier that a veteran will be affected by PTSD: this inference does not limit to understand the human response to trauma in the sphere of the military. This phenomenon has been defined through the metaphor of "hardiness", which indicates the individual quality of being "hardy", i.e. "strong and able to cope with difficult conditions".[4] Scholars have argued that the hardier we are, the more resilient to PSTD we are (Bartone and others, *Norwegian Adaptation*). What does that mean in moral and psychological terms? Is it some form of numbness or indifference? Does it imply a lack of empathy? In the works that I have consulted concerning the connection between PTSD, resilience, and hardiness, I could not come across any conclusive definition, and it is probably very hard to precisely tell how these three conditions interact.

Scholars often use the term hardiness by taking for granted that its possession would protect from exposure to traumatic experiences, as though it was some sort of amulet. For example, the authors of the article *Effects of Hardiness and Years of Military Service on Posttraumatic Stress Symptoms in U.S. Army Medics* assume that medics in a combat zone are exposed to trauma like other combatants because they too are involved in dangerous and potentially harmful actions. Medics must not only take care of wounded and ill soldiers but must they ensure their own safety, as far as they are exposed (unlike civilian healthcare staff) to the danger of being harmed, injured, or killed. Thus, the authors state that being trained or having qualities "such as hardiness that protects against posttraumatic stress may be valuable for better supporting this

high-stress military occupation" (Pitts and others, *Effects of Hardiness*: 279). And yet, what the relationship between hardiness and PTSD consists of remains obscure. It is only assumed that "psychological hardiness is a personality factor that describes individual differences in commitment, control, and challenge" and that hardiness improves with job satisfaction, "perceived social support and lower self-reported strain and illness, in high-stress business managers" (279). This seems to suggest that the more someone gains and achieves from their professional activity, the more will their hardiness benefit from such self-confident intoxication. Conversely, the more one experiences suffering, frustration, and discouragement, the less will their hardiness develop as a protective shield.

In the article by George Bonanno *Loss, Trauma, and Human Resilience*, the notion of resilience is used as though it was perfectly clear what we mean by it. From the perspective of language, though, the notion of "resilience" is not different from that of, for example, "taste": everyone knows what it is, but if one tries to describe how it works and how differently it affects the individual perception of the world, it becomes difficult to define such notions clearly and unequivocally. Both resilience and taste are abstract notions that convey some practical meaning as we use them in a specific language-context, which is a practical context. These notions are blurred because the premises on which their meaning rests – and the variables that make that meaning consistent and evident – cannot be established in advance. This causes resilience and taste to be largely dependent on the ineffability of the "individual" personality, which is moreover influenced and shaped by experiences (breeding and education), often those very same experiences in which resilience and taste play a crucial role in determining our responses. For all these reasons, it is almost impossible to determine in advance which people, in given stressful environments, will develop PTSD and why. One can only state, as common sense suggests, that hardier people will resist better to trauma, a conclusion to which also the authors of *Effects of Hardiness and Years of Military Service* arrives by stating that "having a hardy personality may protect those with extensive military service from experiencing posttraumatic stress" (282).

The point is therefore that the most reliable source of protection from PTSD is not so much the mysterious and absolutely subjective quality of hardiness or resilience, but rather prevention. The article *Professional Stress and Burnout in U.S. Military Medical Personnel Deployed to Afghanistan* starts by assuming that a dearth of resilience increases the risk of developing PTSD and burnout, but also argues that there are several ways of reducing the statistical probability of being affected by PTSD through self-care, team-care, and appropriate training that

prepares the medical corps to cope with difficult conditions. The Geneva Convention states that military medics have no combat duties. They must preserve life through their medical expertise. However, in given circumstances, medics are supposed to use weapons and lethal force to defend themselves and their patients: "medics are required to cope not only with the emotional burdens associated with maintaining the health and wellbeing of their fellow soldiers, but also with their own potentially life-threatening situations resulting from combat operations" (Pitts and others, *Killing*: 538).

PTSD in military medical personnel is therefore different from that of civilian healthcare staff. Pharmacological therapies used to deal with PTSD may be similarly effective in both cases, but the approach to their specific context-related origin remains substantially diverse. For example, civilian doctors need no training to deal with the possible event of killing for self-defence (which is by no means traumatic) or to cope with the threat of remaining injured or killed in action. In general, civilian healthcare staff are not exposed to such forms of stress. Nonetheless, medic staff involved in tackling the Coronavirus-epidemic were exposed to a high risk of falling ill and dying. Moreover, they had to apply strict triage to sort the patients to treat, like combat medics who have in combat zones. The moral burden implied in such decisions is therefore common to both categories, and the risk of developing PTSD makes their cases similar but not identical. However, the Coronavirus-epidemic was "narrated" like a war, with doctors in the trenches of an imaginary "frontline", which created a distorted perception of the emergency as a false close encounter with war.

## A "made-up" encounter in war: war-metaphors and the pandemic

On March 8, about ten days after the Coronavirus outbreak in Lombardy, which later became the most disease-stricken region in Europe, *la Repubblica* reported the words of the Italian PM Giuseppe Conte, urging all authorities to tackle the virus' rapid spread. In the first of a long series of releases to the nation, Conte said: "During the last few days, I have thought of old readings on Churchill, it is our darkest hour, but we will make it" (Cappellini, *Coronavirus: Conte*).[5] With this metaphor, Conte compared himself to Churchill and our times to wartime, when the British government and people were called to respond firmly and bravely to the Nazi threat. Conte's appeal actually sounded like a "call to arms". Two days later, the paper *il Mattino* reported the words of virologist Roberto Burioni, who said: "A tyrant has turned our lives upside down, and it's called coronavirus. We shall resist and fight everywhere, in homes, in the workplaces, by helping our most fragile fellow citizens and sacri-

ficing us for a better future. Then we'll be rewarded. Coronavirus, you won't win. We have chased much worse ones" (Ajello, *Coronavirus come la guerra*).[6] In this case, the virus was depicted as a villain and a tyrant, which should force people to welcome any restriction of their freedom to be protected. Thus, the message read that in order to restore a "better" free society tomorrow, people should resist, sacrifice, fight the enemy wherever it is[7] and believe in Burioni's last words, who briefly addressed the tyrant-virus directly and in the form of a slogan, warning it that it would not prevail, because the Italians already demonstrated their ability in chasing worse tyrants/viruses (like Mussolini, polio, and smallpox) in the past. On March 17, France lays in the grip of the epidemic. All French and foreign newspapers reported the war declaration of President Emmanuel Macron, who stated "we are at war" ("*nous sommes en guerre*"), implicitly citing Minister of War Georges Clemenceau's speech of November 20, 1917, before the National Assembly,[8] as several journalists pointed out (Berdah and others, *Confinement*; Chazot, *Macron*; and Fressoz, *Le combat*). The pandemic being in full expansion in all European countries and America, Macron's sentence was borrowed two days later, on March 19, by American President Donald Trump, who by "describing himself as a 'wartime president', has vowed the US will achieve 'total victory' over the coronavirus" (Editorial, *Coronavirus: Trump*). The meaning of this metaphor is clear: the effort made by the health system to cope with the pandemic emergency is a war between humans and the virus, a war that will lead, in line with the propaganda language typical of American conservatives (Steuter and Wills, *At War with Metaphor*), to total victory.[9] As far as the problem of PTSD in medical staff is here in focus, I should like to carry out some analysis of how metaphors were used to describe healthcare staff and their deployment by referring to the semantic domain of war, i.e. as soldiers and heroes:

1) The concept of enemy and "invisible and insidious enemy" (Santarpia, *Coronavirus: Conte alla Camera*)[10] and the metaphor of the virus as a "bullet", which was coined by the lieutenant paramedic and vice president of the Fire Department of New York's Emergency Medical Services officers' union Anthony Almojera, who said: "In wars you see the bullet, you know who your enemy is. This is a war with an invisible bullet – everyone you come into contact with is a bullet who could get you" (Cuddy, *Coronavirus in New York*);
2) The concept of trenches and front line to describe hospitals and ICUs: on April 5, the Italian newspaper *la Repubblica* published the article "Coro-

navirus in Rome, the trench of GPs" (Angeli, *Coronavirus a Roma*); on the same day, one article of *The New York Times* reported: "Nurses and doctors treat patients on the front lines" (Stevis-Gridneff, The Rising Heroes); on April 11, *la Repubblica* published an article titled "Claudia alone in the trench, forced to decide whom to save", describing the solitude of the medic in the "trenches" of the ICUs, where health care staff had to sort out via triage the patients to treat from those who could not be saved. On April 20, *The Guardian* published a photographic reportage, whose title read "On the frontline: meet the NHS workers tackling coronavirus" (Editorial, *On the Frontline*);

3) the "atom bomb": the chair of the Welfare Department in Lombardy County Council, Giulio Gallera, described the epidemic effect in Lombardy by saying: "We cannot compare what happened here with things occurred in Veneto or Emilia: in Lombardy, we have had an atom bomb, the virus has spread unchallenged for at least twenty days before we grew aware of it" (Editorial, *Coronavirus, in Lombardia*);[11]
4) "voluntary army" in the UK, where "more than 750.000 people signed up to join the 'volunteer army' to help relieve pressure on the NHS";[12]
5) "the bunker", used by Gallera to describe Lombardy County Council during the lockdown: "I have been in the bunker of the County Council for a month" (Colaprico, *Gallera*).[13]

These figures are "resemblance metaphors", whose structure "X is Y" ("Achilles is a lion") is the same as in logical propositions (e.g. "the house is white," "London is a city," and so on) that, according to the truth table, might be either true or false. It is quite obvious that the metaphor does not belong in the truth table as far as it does not represent a factual state of affairs. However, because in its structure the verb "to be" is used as a copula (Piredda, *The Deceptiveness of the Verb To Be*), a metaphor can convey metaphorical meaning as well as pragmatic messages that from the point of view of rhetoric can direct or manipulate opinion through persuasion. All metaphors convey pragmatic messages that influence our practical choices (Gibbs and others, *Inferring Pragmatic Messages*) since their meanings derive from the connection between two linguistic domains: this connection transfers one part of the characteristic of the first domain (war) to the second (the cure of Covid-19). Because metaphors influence opinions, judgment, and action,[14] it is important to understand if a metaphor is being used ethically or not and if it leads reasoning toward clarity or not. In other words, it is necessary to understand whether someone is using metaphors to

manipulate emotions and desires (Citron and Goldberg, *Metaphorical Sentences*; and Erva and others, *Metaphors and Emotions*) to divert opinions toward the ends of propaganda.

**The need to differentiate**

The war-metaphors used to describe the sanitary crisis are inappropriate because they build on a few and feeble connections between the domain of war and that of the epidemic. If we consider the definition of "war" as provided by the website *Lexico*, we read that it means "a state of armed conflict between different countries or different groups within a country", or "a state of competition or hostility between different people or groups".[15] War is no natural phenomenon but rather a social one and does not, therefore, belong in the domain of necessity, for it concerns human agency, i.e. the sphere of liberty. In the case of a pandemic, instead, the struggle does not occur between two human entities but between humans and a non-human organism that does not aim to kill other forms of life as enemies but to reproduce and survive by using other living beings as hosts.

As for the metaphor of healthcare staff as "heroes", I would say that it is the only appropriate one that has been invented during the crisis. In fact, the definition of the hero is basically the same in all dictionaries: "A person who is admired for their courage, outstanding achievements, or noble qualities".[16] However, although adequate, it also had controversial collateral effects: on the one hand, it fed feelings of profound admiration and gratitude for medical staff among the population; on the other hand, it contributed to diverting the public from considering the real state of disorganization in which years of expenditure cuts have left the national health systems. This caused many members of health care staff to grow frustrated and to reject the metaphor. Their testimonies speak against the abstract and mythical image of medics that heroically sacrifice themselves for the nation's sake, as it was proposed by politicians and media.

On April 2, *la Repubblica* published the testimony of a freshly graduated doctor who had just started his career as a "Covid-19 medic" and said: "We all agree and have a message: we don't want to be called heroes" (Strippoli, *Il neoassunto*).[17] On April 10, *La Stampa* devoted the article "Coronavirus and the anti-hero doctor" to the testimony of a physician who stated: "I think I'm a good doctor, but without any attitude for heroism" (Ercole, *Coronavirus e il medico antieroe*).[18] On the one hand, therefore, we see the language of politics that through the metaphors of war conveyed public opinion towards the idea of the necessary sacrifice and heroism of the medical soldiers; on the other hand,

we can see that healthcare staff had to deal with real problems that nonetheless remained neglected. To see one's own suffering underestimated and to feel that society fails to support and care for one's own sacrifice is often one triggering cause of PTSD.

Over the whole month of March, several Italian papers denounced that health care staff were not receiving an adequate number of swabs to check if they had contracted the virus (Zanotti, *In Piemonte*; Evangelisti, *Coronavirus: il dramma*). The newspaper *la Repubblica*, on March 27, reported about the work conditions of GPs: "We have been in close contact with infected patients but received no swabs and were ordered to keep on working" (Pucciarelli, *Coronavirus in Lombardia*);[19] and eventually, a number of papers focused on the shocking news from the Milanese retirement house Pio Albergo Trivulzio, where dozens of senior guests died and the healthcare staff were forced "to remove their masks not to frighten the patients" (Editorial, *La denuncia*).[20]

The *BBC* denounced the same situation in the UK on April 14, in connection with the decease of Mrs. Roberts, a nurse in Cardiff, in the video called "Coronavirus: "Nurse's PPE 'like soldier without combat gear'" (Editorial, *Coronavirus: Nurse's PPE*). Again on April 28, the *BBC* published two articles: the former read "The son of an NHS doctor who died with coronavirus has called on Health Secretary Matt Hancock to say sorry for mistakes in the government's response" (Editorial, *Coronavirus: NHS*), and the other was a report called "The government failed to buy crucial protective equipment to cope with a pandemic, a BBC investigation has found" (Editorial, *Coronavirus: UK Failed*).

These are just a few examples that show how the metaphors of war represented a huge emotional capital used by politicians to manage the emergency because they permitted to depict the sanitary emergency as a war, which urged the population to get ready to endure restrictions and unpopular policies in order to manage the crisis. The Coronavirus-pandemic was a "close encounter in war" only rhetorically, as politicians and journalists created the war-scenario with words. In a time in which collective imagination is deeply influenced by the idea that heroes (and superheroes) protect society from threats thanks to powers that make them almost invulnerable, the metaphors of soldiers and heroes provided a distorted perception of the real condition of healthcare staff. To deny their physical vulnerability and psychological frailty was a dangerous path towards misunderstanding and consequent lack of support, both practical and empathetic. As this is often one triggering cause of PTSD in veterans, also civilian healthcare staff could develop PTSD, if their

suffering and sacrifice were mistaken for the "heroic" deeds of soldiers who answered their call of duty.

## Conclusions

The experiences of doctors and nurses engaged in war missions and the experience of civilian healthcare staff engaged in tackling Coronavirus surely share many aspects and the symptoms of PTSD surface similarly in both cases. However, distinctions are due: if preventing and healing PTSD requires the desire to understand the suffering of those who have endured traumatic experiences, and to make sure that they do not feel that their sacrifice was in vain, then it is crucial to acknowledge the specific context where PTSD can develop and what cultural implications are involved.

PTSD is a pathological response to trauma, which also depends on culture, ethics, and morals: one of the gravest dilemmas for doctors in ICUs, in the geographic areas where the epidemic was more severe, consisted in deciding which patients they should save because there was not enough medical equipment for everyone. This dilemma concerns both the moral status of the person and the moral status of society: is it right to decide to save the young man and let the elderly die? What if the young man is a mafioso, while the elder one is a benefactor? Who is wise enough to decide? Similar dilemmas confront combat medics in war zones when they have to sort the treatable wounded from those who are not going to survive. Doctors make their decisions, in both cases, based on clinical evaluation. Nonetheless, they may develop guilt or suffer from the stress of making such a difficult decision constantly. It is of fundamental importance to remember that these traumatic choices were made necessary, in the case of civilian healthcare staff involved in the Coronavirus crisis, by the lack of adequate medical facilities, which was in turn due to austerity policies and cut expenditure in public health.

Combat medics face similar moral dilemmas, however in a very different context. We, as a society, are much more inclined to accept the fact that in war people die and kill, regardless of whether this occurs in a just or wrong war. Such a question, in the case of a pandemic, does not make sense at all. Combat medics are armed and ready to use weapons to defend themselves. They are aware of the conditions of danger in which they work as well as of the fact that they and their colleagues can be injured, captured, or killed. These possibilities are completely alien to the work condition of civilian healthcare staff. This is what made it possible that the Coronavirus-epidemic swiped away their expectations, for the hardness of the crisis stretched beyond their imagination.

Military and civilian medical staff, like veterans and patients who have recovered from Coronavirus, may have developed the same symptoms of PTSD as a consequence of exposure to trauma. However, the stories they tell about their discomfort and their suffering are very different and society must understand their traumas by setting the appropriate cultural framework. Warriors must be healed as such, but an epidemic is no war.

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1 An estimated 3% of the British population, for example, shows PTSD symptoms. See McManus and others, *Adult Psychiatric Morbidity*.

2 "È stato come una pugnalata alla schiena, mi sono sentita tradita, intimidita, trattata come gli untori. Da quanto ero depressa non mi sono neppure arrabbiata."

[3] "Di notte mi svegliano gli incubi. Sobbalzo e urlo. Sogno che sto soffocando. A volte sono in una grotta, coperta di foglie che mi pressano. Altre su una barella e non riesco a respirare."

[4] https://www.collinsdictionary.com/dictionary/english/hardy (accessed June 12, 2020).

[5] "In questi giorni ho ripensato a vecchie letture su Churchill, è la nostra ora più buia, ma ce la faremo."

[6] "Un tiranno ha sconvolto la nostra vita, e si chiama coronavirus. Resisteremo e combatteremo ovunque, nelle case, nei luoghi di lavoro. Aiutando i più deboli e sacrificandoci per un domani migliore. E poi ci rifaremo. Coronavirus, non vincerai. Ne abbiamo cacciati di peggiori."

[7] This is a further reference to Churchill speech of 4 June 1940, which was also quoted in the movie *The Darkest Hour*: "We shall fight in France, we shall fight on the seas and oceans, we shall fight with growing confidence and growing strength in the air, we shall defend our Island, whatever the cost may be, we shall fight on the beaches, we shall fight on the landing grounds, we shall fight in the fields and in the streets, we shall fight in the hills; we shall never surrender." https://winstonchurchill.org/resources/speeches/1940-the-finest-hour/we-shall-fight-on-the-beaches/ (accessed July 12, 2020).

[8] "Dans les circonstances actuelles, c'est que nous sommes en guerre, c'est qu'il faut faire la guerre, ne penser qu'à la guerre, c'est qu'il faut avoir notre pensée tournée vers la guerre et tout sacrifier aux règles qui nous mettraient d'accord dans l'avenir si nous pouvons réussir à assurer le triomphe de la France." http://www2.assemblee-nationale.fr/decouvrir-l-assemblee/histoire/grands-discours-parlementaires/georges-clemenceau-8-mars-1918 (accessed July 12, 2020).

[9] The formula "total victory" gloomily recalls the Nazi slogan of "Endsieg".

[10] "Un nemico invisibile e insidioso."

[11] "Non si può fare alcun paragone tra quello che è successo qui e quello che è successo in Veneto o in Emilia: in Lombardia c'è stata una bomba atomica, il virus ha girato indisturbato per almeno venti giorni prima di essere individuato."

[12] https://www.england.nhs.uk/2020/04/nhs-volunteer-army-now-ready-to-support-even-more-people/ (accessed July 05, 2020).

[13] "Da un mese sto dentro al bunker della Regione Lombardia."

[14] What Aristotle merely conceived as a philosophical thesis was confirmed in 2013 in the field of cognitive science by Thibodeau and Boroditsky (2).

[15] https://www.lexico.com/definition/war (accessed June 12, 2020).

[16] https://www.lexico.com/definition/hero (accessed June 12, 2020).

[17] "Siamo tutti d'accordo e abbiamo un messaggio: non vogliamo essere chiamati eroi."

[18] "Credo di essere un buon medico. Ma senza alcuna attitudine all'eroismo."

[19] "Siamo entrati in contatto con pazienti infetti e non siamo stati sottoposti a tampone con l'ordine di continuare a lavorare."

[20] "Togliere le mascherine per non spaventare i pazienti." An inquiry was opened on the case of Trivulzio retirement home. Although the number of deceases among the guests remains unknown, on April 19 the figures were 199 deaths out of 1200 patients.