When the federal nursing home regulations first called for facilities to provide trauma-informed approaches as part of person-centered care as of November 2019, this complex issue received tremendous attention. Then the pandemic hit, and trauma-informed care (TIC) got pushed to the back burner as all efforts focused on managing the pandemic. Yet as the ravages of the pandemic built, the importance of TIC for staff, residents, and families reemerged. Residents and staff alike struggled with a multitude of losses, including the deaths of family and friends and curtailed connections, routines, predictability, and even sense of purpose.

What Is Trauma?
The Substance Abuse and Mental Health Services Administration (SAMHSA) defines trauma as resulting from “an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being” ("Trauma and Violence, updated Aug. 2, 2019, https://www.samhsa.gov/trauma-violence). However, there are other definitions. For instance, the American Psychological Association (APA) defines it as “any disturbing experience that psychological trauma.

As the ravages of the pandemic built, the importance of trauma-informed care for staff, residents, and families took center stage.

The Impact of Pandemic-Related Stress and Trauma in Post-Acute and Long-Term Care Settings
By Lisa Lind, PhD, ABPP

For those of us working in post-acute and long-term care settings during the COVID-19 pandemic, we vividly recall where we were when we heard that a novel coronavirus was detected in a nursing home in Kirkland, WA. We recall the video footage of the ambulances taking residents to the hospital. We remember when the directive of mandatory visitation restrictions was put in place and watched the impact it had on residents.

We’ve been tested for COVID-19 more times than we can count and have tried to engage in meaningful conversations through masks and face shields. We remember the feeling of walking up to our patient’s room only to find an empty bed — and sometimes an entire wing of empty beds. Some of us have tested positive and hoped we would survive unchanged. We have lost patients, colleagues, family, and friends. We remember the feelings of helplessness, sadness, grief, and anxiety of the past two years.

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Post-Acute and Long-Term Care Setting
Anyone who has worked or lived in long-term care facilities has been exposed to traumatic stress. Whether or not an individual is traumatized by the exposure depends on a variety of factors. By definition, a trauma, which produces traumatic stress, occurs when outside events overwhelm our coping mechanisms and have a negative impact on our well-being ("Trauma-Informed Care in Behavioral Health Services: Quick Guide for Clinicians," Substance Abuse and Mental Health Services Administration [SAMHSA], No. SMA 15-4912, 2015, https://bit.ly/3HiyJ0).

Vicarious trauma refers to the indirect trauma that can occur with repeated exposure to the traumatic stories of others; this type of trauma can also negatively impact our overall mental health. In a survey of mental health professionals working in PALTC settings during the first seven months of the COVID-19 pandemic, 32% believed they had been traumatized as a result of working in this setting during the pandemic, and 33% of providers reported contemplated leaving their jobs or moving to another location due to this trauma (Kirzinger et al., “KFF/The Washington Post Frontline Health Care Workers Survey,” Kaiser Family Foundation, April 6, 2021, https://bit.ly/3I4iyJ0).

When a natural traumatic event occurs such as a pandemic, the responses of survivors can be affected by factors such as the degree of impact or devastation, the extent of losses, disruption in normal activities such as travel, media attention, and the effort needed to re-establish daily routines ("Coping Tips for Around Events and Health Emergencies," SAMHSA, updated Nov. 8, 2021). That we are still dealing with the pandemic — having experienced unprecedented loss with no known end point in sight — can certainly contribute to continued increased stress for all of us.

Although it is normal to experience a wide range of emotions during and after a traumatic event, many will recover naturally. However, some individuals may continue to feel anxious and even experience severe distress that significantly interferes with daily life. In these cases, their symptoms may best be described as an acute stress disorder (as defined by the U.S. Department of Veterans Affairs, https://bit.ly/3BBR5vP). If symptoms — including intrusive memories, avoidance, negative thinking, difficulty maintaining close relationships, and ongoing fear, among many others ("Post-traumatic Stress Disorder [PTSD],” Mayo Clinic, July 6, 2018, https://mayoclinic.org/36Q011) — continue to interfere with daily life and last for more than a month after the trauma, then a diagnosis of posttraumatic stress disorder (PTSD) is considered ("What Is Posttraumatic Stress Disorder?,” American Psychiatric Association, Aug. 2020, https://bit.ly/3x4PHp). PTSD is historically associated with combat exposure because research about veterans returning from combat was often referenced in the creation of the diagnosis. However, PTSD can be associated with any event that is perceived as threatening one’s sense of self and safety. Prevalence studies have found that while almost 90% of Americans have been exposed to a traumatic event, only about 8% meet the criteria for PTSD in our lifetime (J Trauma Stress 2013;26:537–547). A 2021 meta-analysis and review found that “the overall pooled prevalence of post-pandemic PTSD across all populations was 22.6%,” with health care workers having “the highest prevalence of PTSD (26.9%)” (Med Psychiatry 2021;26:4982–4998). Although individual or personal factors can impact the development of PTSD, the study found that “pandemic-related factors were associated with increased risk of developing PTSD,” including social isolation, economic loss, impact on livelihood, perceptions of risk, and negative psychological responses to the infection.

Where Do We Go From Here? Drawing from my clinical experience as a geropsychologist working in PALTC settings and administrative experience working with clinical and facility staff, I offer the following suggestions.

Shift your trauma-informed approach back to the mental health care we are still providing residents in PALTC settings. The focus from identification to taking universal precautions will support efforts to prevent the possibility of retraumatization by changing our interactions and policies, and ensuring we are neutralizing our facility environments.

Be aware that the disruption in visitation with family and friends, fears around exposure to the virus while confined to their rooms, grief, and general loss of normalcy created by the COVID-19 pandemic can contribute to a perceived lack of safety for many PALTC residents. Practice using nonviolent communication while interacting with residents and colleagues (see Erasmus, p.13 this issue; Caring for the Ages 2021;22[3]:16-17). Engaging in dialogue with compassion and empathy upholds the trauma-informed care principles of trust and transparency, collaboration, empowerment, and choice, all of which contribute to a feeling of safety.

Acknowledge that most of us have experienced huge losses during the past two years. Not only is grieving expected, but it is also paramount to healing. However, we can simultaneously focus on cultivating the relationships we currently have with our colleagues, residents, and staff. It has been suggested that for every negative interaction that occurs you may need five positive interactions to balance it. Ways to increase positive interactions include responding to others with constructive feedback, displaying appreciation, being respectful, and showing gratitude. Improving relationships with others can also be a primary mechanism for establishing a culturally responsive environment where individuals feel their needs can be heard and addressed. Ensuring social connectedness can prevent social isolation while promoting resiliency.

Become cognizant of the signs and symptoms of emotional sequelae related to the pandemic and ensure you are providing your residents the opportunity to be treated by a mental health provider (see the handout from Psychologists in Long-Term Care, “Mental Health Recovery During the COVID-19 Pandemic in LTC Settings: A Guide for LTC Staff,” July 12, 2021, https://bit.ly/3pWvYj3). Being proactive and making a referral to a mental health clinician in the early stages can assist with a better prognosis.

Be aware of signs and symptoms of burnout in yourself and practice self-care to prevent the possibility of compassion fatigue.
Turning the Lens of Trauma-Informed Care Toward Staff with Stress First Aid

By Sarah Sjostrom, MSN, RN, ACNP-BC

It seems a sad irony — or perhaps fortuitous — that requirements for the provision of trauma-informed care (TIC) were initiated just as the nation and the world were caught in the throes of the COVID-19 pandemic. Considering the SAMHSA definition of trauma, as resulting from events that are experienced as "physically or emotionally harmful or threatening" and that have lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being, there is no doubt that the pandemic, defined by isolation, loss, uncertainty, and disconnection, has been traumatic for us all.

The implementation of TIC practices, which aim to promote "a culture of safety, empowerment, and healing," is critical to our ability to navigate the continuing insults and aftermath of the pandemic. Yet our current discussions of TIC are often limited to applying this model to our care for patients and residents. The pervasiveness of the impact of the pandemic and the characteristics of health care work require that we turn the lens of TIC toward our staff as well.

The Stress First Aid Model

The health care workforce is generally susceptible to stress illness and the psychological repercussions of trauma. Chronic exposure to death, illness, trauma, and heavy workloads combined with a "service before self" culture produces an environment of enormous risk under normal circumstances (Int J Environ Res Public Health 2020;17:4267). With the additional impact of the pandemic superimposed over already existing risk, health care workers are increasingly likely to experience psychological morbidities.

Prevalence reports indicate that nearly one quarter of healthcare workers have experienced depression, one quarter have experienced anxiety disorder, and nearly half have experienced the form of psychological distress as a result of stress during the pandemic (Psychiatry Res 2020;293:113382). If we hope to sustain our workforce through such dire times, it becomes critical to implement a TIC approach to support our caregivers so that they can continue to support those who rely on their care.

Implementing new programs and changing the organizational culture of course, require time. Long-term strategies for responding to the staff’s psychological safety are vital to overall organizational success. However, to respond to acute needs, short-term strategies need to be assessed and implemented in tandem. The Stress First Aid program, a peer-to-peer psychological support model originally developed for the military, can serve as a useful framework for planning short-term interventions and creating the foundation of a long-term strategy.

The foundational research for the Stress First Aid program identifies five key factors for trauma intervention: promoting a sense of safety, of self-efficacy, of calm, of connectedness, and of hope (Psychiatry 2007;70:283–315). Although there are numerous interventions that can serve to support these elements, this model offers tangible short-term strategies to address the experience of acute stress and to proactively reduce the risk of psychological morbidity.

Creating an Environment of Perceived Safety

It likely comes as no surprise that the experience of psychological stress is directly related to the perception of the safety of the environment and — more specific to the pandemic — the risk of infection and exposure (Front Psychiatry 2020;11:583971). Three interventions have been shown to mitigate the experience of perceived environmental risk by limiting uncertainty and enhancing staff sense of control (Psychiatry Res 2020;292:113312; J Emerg Trauma Shock, 2020;13(2):116–123):

1. Having staff work in organized, structured units where work is as consistent as possible.
2. Providing communication from teams and supervisors that is clear, direct, and frequent.
3. Ensuring personal protective equipment is available when necessary.

Enhancing Staff Competence

Multiple studies have identified the positive impact of providing staff education and training. Providing teams with up-to-date information and proactively preparing them with training enhances the staff’s sense of self- and team-efficacy and was identified as a protective factor with regard to the development of posttraumatic stress syndrome (Int J Environ Res Public Health 2021;18:601). Although this factor pertains to more than one type of education and training amid the COVID-19 pandemic education targeted at understanding the virus and proper infection control protocols was noted to be particularly effective at accomplishing this goal.

Giving Permission to Pause

In health care, it is not uncommon for staff to neglect self-care or fail to take a moment to assess and debrief after an incident or loss. This lack of assessment and reflection results in not only physical exhaustion but also heightened anxiety and a failure to acknowledge or cope with negative emotions. In turn, staff become increasingly susceptible to developing maladaptive coping mechanisms and more vulnerable to the experience of psychological morbidities.

Mitigation strategies for such challenges include:

- Instituting formal, scripted pauses at set times or debriefing after incidents.
- Using moments of pause and hillsides to acknowledge and verbalize difficulties. This normalizes the experience of stress for staff and further promotes the safe discussion of stress responses.
- Giving permission for individual team members to take breaks. Introducing models such as the Stress Continuum Model or the S.T.O.P. (Stop, Think, Observe, Proceed) for use during pauses encourages individuals to build self-awareness of their own stress reactions.

Building Personal Connections

Humans are inherently social beings, so it is understandable that we find significant protection from stress through social supports. Two specific strategies for enhancing this sense of connection have shown benefits in health care settings.

- Having leaders who are physically present, are outwardly supportive of their teams, and engage teams in joint decision-making.
- Encouraging the development of “battle buddy” relationships among team members. Such connections give staff a go-to person to approach for support or encouragement.

Sustaining Hope

The foundational research for the Stress First Aid Program is not the only study to have identified hope as a factor that enables individuals to overcome adversity and protect against reactions to trauma (Psychiatry 2007;70:283–315; J Emerg Trauma Shock, 2020;13(2):116–123). Fortifying such positive sensations can be supported in health care teams through numerous small acts — which may be as simple as acknowledging team members for their work contributions, celebrating patient recoveries, and highlighting recognition from patients and families. Taking the time to infuse each day with doses of hope fortifies staff morale and boosts engagement.

The application of short-term strategies to support the staff’s psychological safety serves as a starting point for larger programs that can shift organizational culture. To achieve long-term success, organizations must commit to investing in supportive programming, such as Stress First Aid, and to creating a culture that eliminates the stigma of acknowledging stress and fosters an environment where it is okay to not be okay and to seek support.

As with any successful venture, it must be remembered that a TIC approach for our staff is not a destination or box to be checked. Rather, it is a long-term commitment and a continuous process that will allow us to sustain, strengthen, and care for those who spend each day caring for others.

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