Creating Trauma-Informed Long-Term Care Organizations

By Samantha P. Koury, LMSW, and Susan A. Green, LCSW

Trauma-informed long-term care organizations recognize that residents, patients, family members, and staff may have histories of adversity and trauma that impact their experiences within the dailiness of the organization. Similar to how health care professionals put on gloves as a universal precaution when there is a chance that they may be exposed to pathogens, being trauma-informed involves metaphorically putting on gloves by being intentional about how we do our work.

When we recognize that those who have experienced trauma may perceive ill intentions or threatening interactions in practices that may be commonplace in health care, we are able to choose to intentionally respond to everyone with universal precautions by ensuring the five trauma-informed values and principles of safety, trustworthiness, choice, collaboration, and empowerment, while also promoting diversity, equity, inclusion, and accessibility.

Self and World View

Self and world view reflect how we think and feel about ourselves, others, and the world — the lens through which all of us experience the here and now. This lens is shaped early on by our individual and community experiences. It can also continue to shift later in life when impacted by what are called significant emotional events. Such events could be as simple as a meaningful conversation or as complex events. Such events could be as simple as a meaningful conversation or as complex events. Such events could be as simple as a meaningful conversation or as complex as living through the COVID-19 pandemic, civil and social unrest, and economic instability. Significant emotional events in the present often replicate themes that have shaped an individual’s self and world view; this is especially true for individuals who have experienced prior trauma.

When individuals have experienced trauma, especially when it was prolonged, the brain learns that it needs to remain in survival mode — also referred to as the fight, flight, or freeze response. The overactivation of the survival response in the brain combined with a self-view that reflects ideas such as “I’m not good enough,” “People will hurt me,” and “I can’t trust anyone,” causes individuals to be more likely to experience threats in the present, whether they are real or perceived.

We cannot change what has happened to someone in the past, but potential activation of the survival response is something we do have control over in our roles when we respond in ways that “neutralize the environment” or prevent retraumatization (see Figure 1).

Retraumatization: What Hurts

What we continue to see in our work is that the way organizations and systems function can unintentionally hurt people. Retraumatization is when interactions (e.g., tone or language use), procedures (e.g., having a resident in a room by themselves), the physical environment (e.g., poor lighting or close seating), or even current events (e.g., COVID-19 or acts of racism or discrimination) replicate someone’s history of trauma literally or symbolically. Consequently, these may result in the activation of an individual’s survival response.

We may not know the exact details of someone’s history of adversity or trauma. However, there are common themes or dynamics that are generally experienced as retraumatizing, even though they are usually unintentional. Some of these themes are listed in the System/Relationship chart in Figure 2 (you can view the full chart of examples at https://www.pacesconnection.com/blog/new-re-traumatization-chart). For example, consider a resident who has told the same health information to multiple providers before finally receiving care and now has a history of feeling unheard; or staff members who now believe they are failures after their overwhelmed supervisor fixed something for them because there was no time to coach them on how to address it.

We cannot change the fact that trauma has happened, and it is not necessarily our role to treat trauma. However, by intentionally reviewing the way we and our organizations do our work for the potential of these trauma themes/dynamics, we can do our part in engaging in universal precautions for all involved.

Making a Commitment

Long-term care organizations looking to be trauma-informed need to make a commitment to ensuring universal precautions at all levels of the organization to prevent retraumatization of residents, patients, family members, and the workforce. As illustrated in Figure 3, this requires organizations to:

(1) Recognize and reflect on self and world view.

• All workforce members are aware of how their own self and worldview impact the work they do, and that the self and world view of their patients or residents and colleagues is different than their own — acknowledging that past individual, historical, and systemic narratives influence the present moment.

• Individuals and the organization recognize racist beliefs, oppressive thoughts, and discriminatory behaviors that often occur in organizations and systems.

(2) Maintain a basic understanding of trauma and adversity.

• Everyone in the organization has a common language to describe trauma, adversity, and their impacts on others and themselves.

• The organization provides training to workforce at all levels as well as psychoeducation to patients, residents, and families as needed.

(3) Consider the workforce.

• The organization prioritizes workforce wellness and resilience. Like the oxygen mask guidance on airplanes, staff members need to be supported and taken care of so that they can provide trauma-informed care to those they work with.

• The organization intentionally ensures the trauma-informed values and principles of the workforce and provides structures and supports such as supervision, debriefing, and regular check-ins to address the possibility of what we call the negative impacts of the work (e.g., burnout, compassion fatigue, moral distress, vicarious trauma, etc.).

• The organization recognizes and addresses the systemic barriers and processes that perpetuate trauma.

(4) Plan and facilitate organizational strategy.

• A trauma-informed organization is one that uses the filter of the values
results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person’s attitudes, behavior, and other aspects of function” as well as “any serious physical injury” (https://dictionary.apa.org/trauma).

Whatever definition of trauma that a facility uses, it is important that the team has a common understanding. “Educate everyone including outside people coming in to do behavioral health about the definition you’re using,” suggested Barbara Ganzel, PhD, LMSW, of the Clinical Associates of the Southern Tier in New York. This helps ensure that everyone is on the same page from the start.

There are also multiple definitions of TIC. Although the Centers for Medicare & Medicaid Services has yet to provide a formal definition for use in PALTIC, Dr. Ganzel noted that the agency “is pointing us toward the SAMHSA definition,” which says that “a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and systems involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization” (SAMHSA’s Trauma and Justice Strategic Initiative, SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Organization, HHS Publication No. (SMA) 14-4884, July 2014, http://bit.ly/3AqbMKY).

TIC isn’t about pushing or forcing people to confront or address their traumas. Instead, it offers them an opportunity to consider the impact of a trauma, how they’ve coped in the past, and how we can avoid retraumatization and trigger reactions.

Trauma is very personal, and it also is very common. All individuals have experienced negative things in their lives, but they don’t all react the same way. “The data suggest that about 80% of the general population has a trauma in their past, but everyone has developed different ways of coping with things happening around them — such as personal care or being taken out of their home and being put into a new environment,” said Dr. Ganzel. She added, “Trauma accumulates over time. Just because someone has been exposed to a trauma doesn’t mean that they have post-traumatic stress disorder. But as people become older and sicker, their coping mechanisms diminish; and they may react more to triggers.”

“The lens has to shift from diagnosis to a focus on symptoms,” said Dr. Ganzel. TIC also means moving from asking “What’s wrong with you?” to “What’s happened to you?” TIC also demands a different way of working with staff. Dr. Ganzel suggested, “there are people who will insist that treatment is not part of trauma-informed care, but CMS is requiring that treatment be available to reduce symptoms related to trauma, whether or not there is a formal trauma-related diagnosis.”

Sarah Sjostrom, associate chief nursing officer at Hebrew Rehabilitation Center, Suffolks, MA, said, “We need to think beyond regulatory requirements. It’s not enough to ask the questions, check the boxes, and be done with it. There should be more consideration and some assurance that the care being delivered addresses what TIC really means.”

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If you teach staff competent coping mechanisms, Dr. Ganzel observed, these help them, and they can impart these competencies to residents. She stressed, “It’s important to teach them the difference between empathy and compassion. Empathy can lead them to re-experience traumas along with the residents. A compassionate response enables them to be more effective without depleting themselves. They need to be a compassionate, healing presence without costing them personally. This has to come out of trauma symptom management training.”

Helping staff understand what to watch and listen for is at the core of TIC. For instance, Dr. Ganzel said, “One nursing home resident started staying up at night. She didn’t want to go back to bed.” She was becoming incontinent, and she was agitated and irritable. Her care team didn’t understand what was happening with her until she was talking to a staff member one night. She told the story of having a puppy when she was a child. It was having accidents in the house, and her mother told her father to take it out and shoot it. The staff realized that her incontinence was triggering memories of this childhood trauma and causing her behavior. “Just understanding that there is something behind the behavior can make a huge difference,” Dr. Ganzel said.

Each organization will have different approaches to TIC implementation, said Ms. Sjostrom; but if a resident opens up and expresses a sensitive history, they likely have established a sense of safety with that individual. “We see that day in and day out with [certified nursing assistants] who have established a sense of trust and emotional safety with residents who seek to have these conversations. I wouldn’t encourage them to attempt any intervention alone, but they can listen and allow residents to express whatever they feel comfortable discussing,” she said. Then they can share this conversation with a nurse or other clinician and collaborate on interventions with the interdisciplinary care team.

**The Power of Stress First Aid**

“We have been deeply challenged by this pandemic, and this is where something like Stress First Aid [SFA] can help,” said Dr. Ganzel. SFA is a model designed to improve recovery from stress reactions. It supports and validates friendship, mentorship, and leadership actions through efforts to identify and address early signs of stress reactions. The SFA’s goal is to identify stress reactions in oneself and others and reduce the likelihood that outcomes evolve into more serious or long-term problems.

SFA is a peer support model, said Ms. Sjostrom. Its pieces are simple enough that it doesn’t require an advanced degree to use. “It’s about understanding the basic ways in which people may respond to stress and trauma and building awareness to recognize these in yourself and your colleagues,” SFA gives practitioners and staff on the front line a chance to step back and recognize their challenges. It gives them the support and tools to address issues proactively and not wait till they cause problems. “It doesn’t happen overnight, but over time you can build a more resilient team and organization,” suggested Ms. Sjostrom. “If you can truly get behind a program that supports staff and helps them support each other, it tells people that you’re there for them and trying to help healing,” said Dr. Ganzel.

Ms. Sjostrom added, “It may sound like a cliché, but it’s true. If you don’t take care of yourselves, you can’t care for others. The more we can support our teams, the better care we can provide.” She emphasized, “As we’re giving people tools and providing education, we need to be careful not to help people think that if you do this, you’re done. This is ongoing. You don’t do it once and assume everything is okay. The same is true of TIC.” (See Ms. Sjostrom’s article on Stress First Aid in this issue, p.15.)

**Rolling Out TIC**

Whether it’s for residents, which has some regulatory pressure, or which is regulated, TIC is only as good as the organization’s commitment to providing it. “If you don’t have good support to roll out a robust program that provides tools, training, and resources and you don’t have the commitment, it will be tough to get something meaningful off the ground. You have to commit to do more than just check the box. You have to be able to think beyond the regulations,” Ms. Sjostrom said. This calls for engagement and input of key staff, who have been given the training to identify potential concerns and possible symptoms of trauma and understand why this is important to the provision of quality care.

“In many ways, this is part of what they do every day — caring about residents and supporting them holistically,” said Ms. Sjostrom. “We can build this into workflows, but that requires staff to be well versed in what this means. You need to give people the ‘why.’”

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