Nurse Self Care through a Trauma-Informed Lens

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Overview

Applying Trauma-Informed Care (TIC) to ourselves and our patients

ACEs and/or trauma ≠ Destiny: Resilience

The intersection of ACE scores and trauma

What are ACEs and what do they have to do with me?

"The Tyranny of Personal Responsibility": Self Care in Pandemic Times

Applying Trauma-Informed Care (TIC) to ourselves and our patients
The ABCDEs of Self Care* in Pandemic Times (and Beyond); AJN 4/2020

• 2017: 3,957,661 RNs, of those leaving job, >31% burnout as a reason (Shah, et al., 2021)
• 2018-19: ANA’s Healthy Nurse, Healthy Nation report >117,000 nurses: “70% of nurses surveyed report putting the health, safety, and wellness of their patients before their own”
• Jan/Feb 2020: Wuhan, 1257 HC workers: women, nurses esp. implicated in increased dep/anx/insom/distress (Lai, et al., 2020)
• Mar/Apr 2020: 33,062 HCW; anx 23.2 prevalence, dep 22.8, insom 38.9; w/ “female HCPs and nurses exhibiting higher rates of affective sx (anxiety/depression/incoming) compared to male and medical staff,” (Pappa, et al., 2020)
• 2020: Independent Panel on Pandemic Preparedness and Response reports 70% of national nsg associations reporting MH distress among nurses
In the past 14 days, have you experienced any of the following feelings?

- Exhausted: 51%
- Overwhelmed: 43%
- Irritable: 37%
- Anxious or unable to relax: 36%
- My work has meaning: 32%
- Sad: 30%
- Desire to quit: 28%
- Confidence in my ability to handle things: 28%
- Depressed: 23%
- Determined: 23%
- Isolated and lonely: 22%
- Angry: 22%
- Optimistic about the future: 21%
- Pessimistic about the future: 21%
- Resilient: 20%
- Motivated: 16%
- Numb: 15%
- Focused: 14%
- Betrayed: 12%
- Guilty: 11%
- Like a failure: 10%
- Suicidal: 1%

ANF/ANA Year One COVID-19 Impact Assessment Survey: Mental Health and Wellness; >22K nurses
### A: About

- Stay informed as you need to, then pull away and unplug
- Sensory diet: limit anxiety-provoking exposure to TV/radio/social media
- Fearful news is addictive—don’t let the powers that be make you an addict

### B: Body

- Of course: PPE, handwashing, masks, social distancing, vaccines
- ALSO: Care for yourself exactly as you would advise a patient; sleep, physical activity, nutrition, healthy relationships
C: Connect

• Yes, socially—schedule proactive time to connect safely in person
• Also connect *internally*:
  • Meditation, mindfulness, and breath (Insight Timer, Calm, Ten Percent Happier, Breathwrks)
  • Note negative, anxiety-based thoughts and redirect into positive
  • Play: TV/movies, games, pets, gardening, laughter

D: Develop

• Think #COVIDSilverLinings: telehealth, less MH stigma; innovation and creativity:
  • New hobbies
  • Creativity: Journaling, writing, painting, dance
  • Creating scheduling templates with breaks for you: reading, walks, one yoga pose, “five minute vacations”
  • Focus on “post-traumatic growth” (for the long-term) in wake of traumas (vs. PTSD)
• The pandemic created unprecedented fear and uncertainty
• More emotion can mean irritability, insomnia, depression, anxiety for everyone
• Women, nurses, and healthcare providers are especially vulnerable
• We all deserve to reach for support—a cardinal sign of strength, not weakness
  • Behavioral health: psychotherapy and medication
  • Lines for Life Helpers Wellness Rooms or other support groups (e.g. NurseGroups.org)
  • emotionalppe.org
• Soon: Oregon Wellness Program (oregonwellnessprogram.org)
• A trusted friend/partner*
• Avoid “The tyranny of personal responsibility”—it’s not all on you and your self care; we can rise up together and change unhealthy healthcare cultures—nurses can transform healthcare!
Lived Experience: “Nurse-specific traumas”

Voices from the COVID-19 frontline: Nurses’ trauma and coping

Karen J. Foli¹ | Anna Forster¹ | Chang Cheng² | Lingsong Zhang²,³ | Yu-Chin Chiu⁴
Abstract

Aim: To describe the experiences of frontline nurses who are working in critical care areas during the COVID-19 pandemic with a focus on trauma and the use of substances as a coping mechanism.

Design: A qualitative study based on content analysis.

Methods: Data were collected from mid-June 2020 to early September 2020 via an online survey. Nurses were recruited through the research webpage of the American Association of Critical Care Nurses as well as an alumni list from a large, public Midwest university. Responses to two open-ended items were analysed: (1) personal or professional trauma the nurse had experienced; and (2) substance or alcohol use, or other mental health issues the nurse had experienced or witnessed in other nurses.

Results: For the item related to psychological trauma five themes were identified from 70 nurses’ comments: (1) Psychological distress in multiple forms; (2) Tsunami of death; (3) Torn between two masters; (4) Betrayal; and (5) Resiliency/posttraumatic growth through self and others. Sixty-five nurses responded to the second item related to substance use and other mental health issues. Data supported three themes: (1) Mental health crisis NOW!!: ‘more stressed than ever and stretched thinner than ever’; (2) Nurses are turning to a variety of substances to cope; and (3) Weakened supports for coping and increased maladaptive coping due to ongoing pandemic.

Conclusions: This study brings novel findings to understand the experiences of nurses who care for patients with COVID-19, including trauma experienced during disasters, the use of substances to cope and the weakening of existing support systems. Findings also reveal nurses in crisis who are in need of mental health services.

Impact: Support for nurses’ well-being and mental health should include current and ongoing services offered by the organization and include screening for substance use issues.
| Theme #1: Psychological distress in multiple forms: Including anxiety, depression, guilt and symptoms of PTSD | Subtheme: New and increasing mental health issues
Subtheme: Exacerbation of existing mental health issues |
| Theme #2: Tsunami of Death: Overwhelming grief and loss | Subtheme: These deaths are different: dying alone |
| Theme #3: Torn between two masters: Personal/family safety and professional duties | Subtheme: Nurses as victims: Exposed to and sick with COVID–19
Subtheme: Living vector/endangering family |
| Theme #4: Betrayal: Professional disillusionment, job dissatisfaction and intention to leave job/profession | Subtheme: Organizational betrayal
Subtheme: Constant changing guidance
Subtheme: Public ignorance |
| Theme #5: Resiliency/posttraumatic growth through self and others: Professional experiences and other sources | Subtheme: Sources of resiliency: experience and exposure to positive significant others (e.g., parents, peers and friends) |
pandemic brought this experience to the foreground. Nurses were also dealing with grief and loss in their personal lives due to loss of family and friends, and such bereavement may have been exacerbated by their experiences at work. A subtheme also emerged that conveys how these deaths were distinct from the pre-pandemic world of nursing care: ‘these deaths are different: dying alone’. The patients are isolated, without family, and the nurses describe the burden of how the patient deaths are unique in their aloneness:

...I have seen so much suffering and death, I have had to face some families on a small pad to let them tell their loved one goodbye before compassionately extubating patients. I have been the only one in the room when a person has passed away... (Participant 88).

The third theme, ‘torment between two masters: personal/family safety and their professional duties’, also reflected psychological distress and trauma. The nurses working during COVID-19 felt the strain of wanting to provide quality care but having to consider the impact their professional positions place on their home/family life. This placed them in a difficult situation because they wanted to provide care, but they also want to keep their families safe. This led to role and identity tension for the nurse as well. They were striving to offer care and comfort while faced with unprecedented circumstances:

The deaths were so sad the worst was not letting families come see them before they die. Nurses feel they need to be the person to be by their side all the time if the pt is going to deo: we don’t let people die alone ever! (Note: unedited text!) (Participant 154).

Several nurses described contracting the virus and becoming ill, reflected in the subtheme: ‘nurses as victims: exposed to and sick with COVID-19’:

We experienced PPE shortages in March, and by the 2nd week of March I showed symptoms of COVID and tested positive. I was out of work for 32 days recovering. I experienced quite a bit of loneliness, isolation, fear, and anxiety while I was sick (Participant 63).

Becoming a ‘living vector/endoangering family’ was another subtheme. They faced the burden of putting themselves and their families at significant risk by being the point of contact with patients diagnosed with COVID-19.

...being thrown into a pandemic patient room with little or not enough PPE, and advised that this is all we have. being concerned about taking the virus home to my family and having no support from administration and no communication from them (Participant 114).

Nurses also forwarded decreased support from family and friends who were fearful of contracting the COVID virus from the nurse, thereby increasing the psychological distress of the nurse.

The fourth theme was based on the repeated narratives that described ‘betrayal: professional disillusionment, job dissatisfaction, and intention to leave their job/profession’. Feelings of being betrayed stemmed from organizational use of nurses, constant changing guidance related to caregiving practices, and public ignorance. In the following text, one nurse equated the nurse to an anonymized
<table>
<thead>
<tr>
<th>Theme #1:</th>
<th>Subtheme:</th>
</tr>
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<tbody>
<tr>
<td>Mental health crisis NOW!!: 'more stressed than ever, and stretched thinner than ever'</td>
<td>Unusual times: 'forever changed' due to pandemic</td>
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<table>
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<tr>
<th>Theme #2:</th>
<th>Subtheme:</th>
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<tbody>
<tr>
<td>Turning to substances to cope: Alcohol, food, tobacco/smoking, recreational drugs/marijuana</td>
<td>Normalizing use of substances through check-ins and talking about increased use</td>
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<td></td>
<td>Coping with alcohol: Backing away versus questioning dependency</td>
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<th>Theme #3:</th>
<th>Subtheme:</th>
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<tr>
<td>Where is the support?</td>
<td>Less peer and family support/isolation</td>
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We are all on edge, and do not have the social support from each other that we used to have. Remaining isolated from each other and not having the opportunity to “vent” or commiserate, or even give and get a hug is traumatic. We spend more awake time together than with our families and we have lost the ability to give and get the support we are used to on the floor (Participant 18).
Take a breath
What is Your ACE Score?

- **While you were growing up, during your first 18 years of life:**
  1. Did a parent or other adult in the household often ...
     - Swear at you, insult you, put you down, or humiliate you?
     - or Act in a way that made you afraid that you might be physically hurt?
     - If yes enter 1 ______
  2. Did a parent or other adult in the household often ...
     - Push, grab, slap, or throw something at you?
     - or Ever hit you so hard that you had marks or were injured?
     - If yes enter 1 ______
3. Did an adult or person at least 5 years older than you ever...
   - Touch or fondle you or have you touch their body in a sexual way?
   - or Try to or actually have oral, anal, or vaginal sex with you?
   - If yes enter 1 ________

4. Did you often feel that ...
   - No one in your family loved you or thought you were important or special?
   - or Your family didn’t look out for each other, feel close to each other, or support each other?
   - If yes enter 1 ________
What is Your ACE Score?

5. Did you often feel that ...
   - You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you?
   - or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   - If yes enter 1 _______

6. Were your parents ever separated or divorced?
   - If yes enter 1 _______
7. Was your mother or stepmother:
   - Often pushed, grabbed, slapped, or had something thrown at her?
   - or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   - or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   - If yes enter 1 ______

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   - If yes enter 1 ______
9. Was a household member:
   - Depressed or mentally ill or did a household member attempt suicide?
   - If yes enter 1 ______

10. Did a household member go to prison?
    - If yes enter 1 ______

Now add up your “Yes” answers: ______ This is your ACE Score
What Does Your ACE Score Mean?

Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan
How Common Are They?

How Common are ACES?

ACE Study

- Zero: 36%
- One: 26%
- Two: 16%
- Three: 9.5%
- Four or More: 12.5%
Experiencing 4 or more ACEs is associated with dose dependent increased risk for 7 out of 10 leading adult causes of death, including heart disease, stroke, cancer, COPD, diabetes, Alzheimer’s dz, and suicide.

Higher ACE scores increase rates of smoking, depression, anxiety, diabetes, disability, unemployment, substance/etoh abuse, lower educational attainment, work impairment, financial stress, early sexual activity, STIs, adolescent pregnancy, sexual abuse risk, fibromyalgia....
How This Works (Neurobiology)

ACES create:

- Elevated glucocorticoids, CRH, ACTH, hypothalamic and pituitary hormones
- Hyperactivity of the SNS
- Chronically activated stress response, slower return to baseline
- Longterm blunted neural reining in of glucocorticoid production
- Impaired cognition, impulse control, emotional regulation, learning, and memory
- Decreased hippocampal volume and increased amygdaloid volume/hyperreactivity
- Chronic inflammation
- Chronic inflammation
History of the Adverse Childhood Experience Score


1995-1997 study of over 17,000 middle class, educated adults of all demographics in San Diego through Kaiser and CDC

More than 70 follow up studies done to date, including in Oregon (2011-2015), where ACE Scores are higher than average:

- 62.2% had at least one ACE
- 26.4% had ≥ three ACEs
- 9.2% had ≥ five ACEs
Where ACEs and Trauma Intersect

- **Trauma** is an experience, or multiple experiences, of fear, anxiety, or helplessness that overwhelm a person’s coping capacities.
- **Development trauma** results from unmet developmental needs for safety and secure attachment in childhood.
- **Historical trauma** denotes the cumulative trauma wounding throughout a person’s lifespan, from fetal life to death, as well as intergenerational transmission of trauma.
- **Vicarious trauma** is the “emotional residue” from exposure to hearing another person’s trauma story.
- **Interpersonal retriggering** is an experience that activates memories, sensations, or emotions connected with past trauma that can “flood” a person with anger, anxiety, or other stress response.
- **Allostatic load** refers to a composite measure of chronic activation and stress on the body, including BMI, cytokine and catecholamine levels (e.g., “cortisol soup”).
A Few Notes about PTSD (Gender)

- Men: more likely to display irritability and aggression with PTSD
- Men: more likely to have difficulty understanding dysfunctional behaviors (being female is a resiliency factor!)
- Women: more likely to have depressive/anxiety symptoms, including self blame and negative affect
- Women: twice as likely than men to develop PTSD
- One year PTSD prevalence higher among victims of “intentionally inflicted trauma” (pt aggression); e.g.: women
A Few Notes About PTSD (Liebschutz, 2007)

- Urban academic primary care center
- N = 509
- 23% screened positive for PTSD
  - Only 11% of these 23% had dx noted in EHR
- Of those with depression noted in EHR,
  - 51% screened positive for PTSD
  - PTSD prevalence also higher if anxiety, IBS, chronic pain
- Grossly underdiagnosed, undertreated
A Few Notes About PTSD (Goldstein, 2017)

- 152 largely Latino primary care patients
- 37% had positive PTSD screen
- 89% said they felt comfortable being asked about PTSD by their provider
- 76% believed their provider felt comfortable discussing PTSD (not!)
- 78% believed their provider could help them with PTSD
Never Fear—Good News for You & Your Patients: You’re Healing Them (and Yourselves) by Sitting Here!

- Learning about ACEs and assessing your own ACE score gives you significantly more understanding of the science and clinical utility of ACEs, and makes your practice more trauma-informed.
- ACEs ≠ destiny. It’s a tool for understanding population, not individual, risks.
- Knowledge = power; working with ACEs and TIC can change outcomes.

But, how do you apply this to you (and your patients)?

First do, then teach.
How do many individuals with high ACEs turn into seemingly functional adults?

- Resilience Theory, Emmy Werner, Developmental Psychologist, born 1929

- 1 out of 3 children she studied with severe trauma grew into “competent and caring adults”

- Resilience theory is strength-based
  - Focuses on “positive contextual, social, and individual variables that interfere or disrupt developmental trajectories from risk to problem behaviors, mental distress, and poor health outcomes.”
Promotive Factors: Assets and Resources

Internal Assets:
  - Self-efficacy and self esteem
  - Affection
  - Intelligence
  - Achievement orientation
  - Ability to construct meaning out of events, increasing your own understanding
  - Internal locus of control
  - Problem-solving, help-seeking skills
  - Emotional regulation
Resilience Theory

- External Resources (for children and adults)
  - Parental support, positive parent-child relationships
  - Adult mentors (e.g., that special teacher, grandparent)
  - Youth programs that facilitate coping skills practice
  - Community (e.g. spiritual or religious community, neighborhood watch)
- Supportive relationships
- Intimate partner support
How do we apply this knowledge to ourselves and our patients?
Trauma-Informed Care (TIC)

Asking:
- Avoid the term “abuse” as some may have a stigmatizing definition or association
- “What traumatic events or unhealthy things happened to you as a child?”
- Read the patient, especially if they do not want to disclose
- “That’s totally okay; how do you think you might feel if you were to talk about it?” (Reduce shame)
Educating ourselves and our patients:
- Let patients know research shows childhood events directly impact health later in life
- Self compassion
- Normalize ACEs/trauma
- Decrease shame
- Educate regarding resilience, neuroplasticity
- Avoid re-traumatization in relationships
- Village Effect
- Mindfulness
- Skills: adaptive coping, problem-solving, emotional regulation
Trauma-Informed Care (TIC)

- Treating ourselves and our patients:
  - Trauma-focused (or other supportive) psychotherapy
  - EMDR
  - SSRIs or SNRIs (high doses)
  - Prazosin (nightmares, hyperarousal, overall symptoms) BID to TID
  - Benzodiazepines prn (with caution)
Seeing: Ourselves and Each Other Through a Trauma-Informed Lens

“What has happened to you?” vs. “What is wrong with you?”

TIC asks us to wonder how a patient became disrespectful, entitled, nonadherent, substance abusing, self-destructive, etc.

Respect their dignity AND your own boundaries; don’t accept unacceptable behavior

SAMHSA’s TIC:
- Safety
- Trustworthiness and transparency
- Peer support
- Collaboration and mutuality
- Empowerment, voice, and choice
- Cultural, historical, and gender issues
Take a breath
Lived Experience Peer Support

- Reflect on a mild-moderately triggering episode
- Ask, "What happened to you?"
- Supportee:
  - Give details of the difficult event
  - Concretely “paint a picture” so your partner can see it clearly
  - Use feeling words to describe how it made you feel
- Supporter:
  - Nod, make eye contact, ask “Is there more?" “How did that feel?”
- Switch, then reflect
Instructions on Not Giving Up

More than the fuchsia funnels breaking out of the crabapple tree, more than the neighbor’s almost obscene display of cherry limbs shoving their cotton candy-colored blossoms to the slate sky of spring rains, it’s the greening of the trees that really gets to me. When all the shock of white and taffy, the world’s baubles and trinkets, leave the pavement strewn with the confetti of aftermath, the leaves come. Patient, plodding, a green skin growing over whatever winter did to us, a return to the strange idea of continuous living despite the mess of us, the hurt, the empty. Fine then, I’ll take it, the tree seems to say, a new slick leaf unfurling like a fist, I’ll take it all.

~Ada Limón
References

- Iconique Psychology (2018.) How to build resilience and become mentally strong. [https://www.youtube.com/watch?v=Lf1ngfqjvwU](https://www.youtube.com/watch?v=Lf1ngfqjvwU)
- Schiolla, AF. (2018.) Trauma-Informed Care in the Management of PTSD: From the 5th Annual Update and Advances in Psychiatry, presented by University of Wisconsin SOM and PH, Department of Psychiatry, 2018.
- Understanding the Health and Social Effects of Adverse Childhood Experiences (ACEs): Anastasia Rose, Med, MSN/MHA, RN and Sherrill Hooke, Med, RN, 2018.
Thank you!

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