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Application of trauma-informed care principles in academic nursing settings during the COVID-19 pandemic

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Abstract

The persistence of the COVID-19 pandemic has led to a multitude of changes in the ways nursing education, research, and practice are carried out. In addition to the demands of shifting to remote education as well as finding alternatives to direct patient care learning, nursing faculty and students are directly confronting morbidity and mortality among classmates, colleagues, friends, and family members. These experiences unquestionably meet criteria for traumatic experience, and this must be accounted for in nursing education as they can have detrimental effects on learning, teaching, and well-being. The current generation of nursing students and faculty will necessarily carry the traumatic experiences of this chaotic time into workplace, classroom, and community settings. Understanding how to manage this trauma appropriately not only supports individuals through this experience but provides increased opportunity and capacity for the provision of trauma-informed care (TIC) to patients and colleagues going forward. This paper describes some of the ways COVID-19-related trauma may affect nursing faculty and students; and proposes application of TIC principles to research, education, and practice environments to enhance well-being and overall functioning in the profession.

KEYWORDS
administration, education, safety, workforce

The COVID-19 pandemic has led to myriad changes in the way health care is accessed, provided, and even conceptualized. In addition to the demands of shifting practices, providers are faced with patient morbidity and mortality—and with their own risk for contracting the disease. As of January 2022, the United States reported more than 820,000 deaths related to COVID-19; more than 3600 of those were health care providers, with roughly 30% of them nurses.[1,2] These alarming figures speak to the strain that nurses and other healthcare providers continue to experience on a daily basis, and argue strongly for consideration of the COVID-19 pandemic as a source of trauma. A trauma-informed approach, which provides a model for understanding, recognizing, and responding to the effects of trauma and is based on principles that acknowledge the pervasive

impact of trauma on individuals, is therefore, warranted in all nursing settings.[3] This paper describes some of the ways COVID-19-related trauma may affect nursing faculty and students. We offer examples of how trauma-informed care (TIC) principles can be applied to nursing research, education, and practice environments.

1 | TIC ASSUMPTIONS AND GUIDING PRINCIPLES

The Substance Abuse and Mental Health Services Administration (SAMHSA) has established a framework for TIC that includes four keData sharing not applicable to this article as no datasets were

generated or analysed for this manuscript.y assumptions and six guiding principles (see Tables 1 and 2).[3] These assumptions can be summed up as taking "a universal precautions approach to trauma." The key assumptions are that a TIC approach (1) *realizes* the prevalence and impact of trauma as well as potential paths to recovery; (2) *recognizes* signs and symptoms of trauma; (3) *responds* by ensuring trauma awareness is integrated into the environment; and (4) actively *resists* retraumatization. The six guiding principles then identify the elements necessary to put such an approach into practice: (1) *Safety*; (2) *Trustworthiness and transparency*; (3) *Peer support*; (4); *Collaboration and mutuality*; (5) *Empowerment, voice and choice*; and (6) *Cultural, historical, and gender issues*. In the remainder of this paper we summarize each principle and provide examples of academic responses at institutional and individual levels. These examples are not exhaustive but cover a range of common violations of the principles and positive exemplars for implementing them in nursing education. Table 3 provides examples of common violations of TIC principles and exemplars for applying TIC principles during the COVID-19 pandemic to help illustrate how a TIC approach may be used to address pandemic related trauma in academic settings.

1.1 | Cultural, historical, and gender issues

Although listed by SAMHSA as the sixth principle, we begin this discussion with cultural, historical, and gender issues since the current global and political climate provide the context for application of the other guiding principles. Nursing research and education were already unfortunately common sites for the enactment and replication of racist, classist, and sexist attitudes, with the result that students and faculty feel traumatized and devalued.[4–7] For example, students report experiencing racial microaggressions in both clinical and educational settings[4,8]; faculty struggle with gender normative expectations[9,10]; and the nursing profession itself frequently wrestles with other types of structural traumas.[11] Trauma thus clearly intersects in numerous ways with culture, history, and gender. Stereotypes and biases based on race, ethnicity, gender, sexual orientation,[12] and other cultural identities are pervasive sources of trauma at individual, structural, and historical levels.[13] A trauma-informed approach acknowledges the contributions of cultural, historical, and gender issues to trauma and seeks to move past stereotypes and biases to provide policies, protocols, and processes responsive to the cultural needs of individuals. Cultural awareness, responsiveness, and understanding are critical to increasing the effectiveness of trauma-informed services.[14] These factors impacting the nursing workforce are not unique to COVID-19, yet each impacts a student, staff, or faculty member's experience during the COVID-19 pandemic. The COVID-19 pandemic has brought many of these issues to the forefront, highlighting social,[15] health,[16] and economic disparities[17] that were often already present within the nursing workforce.

TABLE 1 Substance Abuse and Mental Health Services Administration's key assumptions of a trauma-informed approach ("The Four Rs")[3]

Assumption	Definition
Realizes	*Realizes* the widespread impact of trauma and understands potential paths for recovery
Recognizes	*Recognizes* signs and symptoms of trauma in clients, families, staff, and others involved with the system
Responds	*Responds* by fully integrating knowledge about trauma into policies, procedures, and practices
Resists	Seeks to actively *Resist* re-traumatization

TABLE 2 Substance Abuse and Mental Health Services Administration's guiding principles for a trauma-informed approach[3]

Principle	Definition
Safety	Throughout the organization, staff and the people they serve feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety.
Trustworthiness and Transparency	Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among clients, family members, staff and others involved with the organization.
Peer Support	Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, serving as models of recovery and healing, and maximizing a sense of empowerment.
Collaboration and Mutuality	Partnering and leveling of power differences between staff and clients and among organizational staff from direct care to administrators, demonstrates that healing happens in relationships, and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach.
Empowerment, Voice, and Choice	Individuals' strengths and experiences are recognized and built upon; the experience of having a voice and choice is validated and new skills developed. The organization fosters a belief in resilience and clients and staff are supported in developing self-advocacy skills and self-empowerment.
Cultural, Historical, and Gender Issues	The organization actively moves past cultural stereotypes and biases, offers gender-responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.

TABLE 3 Application of trauma-informed care principles in academic nursing settings during the COVID-19 pandemic

Trauma-informed care principles	Common violations during the COVID-19 pandemic	Exemplars for applying trauma-informed care principles during the COVID-19 pandemic
Cultural, Historical, and Gender Issues	• Culture of maintaining or exceeding level of productivity • Inadequate representation in COVID response planning	• Recognizing the disproportional impact of COVID on marginalized communities • Realistic goal setting • Ensuring diverse representation in decision-making
Safety	• Fear of job loss due to budget cuts or reduced productivity • Highly punitive or inflexible culture on campuses around COVID • Risk of contracting COVID due to in person nursing workplace environments (e.g., clinical or laboratory settings)	• Provide appropriate, evidence-based PPE to all individuals to mitigate COVID risk in situations where in-person classes and clinical are occurring • Flexibility in allowing individuals to decide what level of in person contact is safe for their own circumstances • Clear communication about safety procedures and budget impacts
Trustworthiness and Transparency	• Unilateral decision-making and lack of transparency around COVID-related policies on campuses and clinical settings • Invasive monitoring of at-home work	• Clear communication and frequent updates regarding COVID-related policies • Implementing practices that increase autonomy, flexibility, and trust of students, faculty, and staff around workload and assignment completion
Peer Support	• Judgment from peers/administration • Mandating attendance at peer support groups in addition to usual work activities	• Providing nonrequired opportunities for students, staff, and faculty to share concerns in safe and nonjudgmental spaces • Increasing linkages to noncampus related resources that do not report through University chain of command • Listen to students, staff, and faculty regarding the things that would be most helpful to them in your environment.
Collaboration and Mutuality	• Decisions made behind "closed doors" • Applying a "one size fits all" approach to meetings, activities, etc.	• Incorporate multiple voices and a diverse group in decision making • Making space for everyone's experience
Empowerment and Choice	• Paternalistic policies and practices • Requiring cameras on during meetings	• Choosing how and when to engage with educational/work tasks • Allowing flexibility for care-taking and other responsibilities

To effectively apply trauma-informed principles in responding to the COVID-19 pandemic, it is critical that the nursing profession recognize whose voices are least often heard and thus less likely to be incorporated into response strategies. Health disparities are fueled by structural inequities related to multigenerational discrimination and barriers related to gender identity, race/ethnicity, geographic location, and socioeconomic factors.[13] The disproportionate impact of COVID-19 on marginalized groups underscores the critical role that structural inequities play in health care access and outcomes.[18] This necessitates an urgent need for structural, multilevel changes to improve health care access and health outcomes.

While progress has been made to increase diversity and representation, the nursing workforce remains predominantly female and white, non-Hispanic—90.9% and 80.8% of registered nurses in the U.S., respectively.[19] This is further reflected in academia where nursing faculty are 93.0% female, 82.0% white, non-Hispanic, and 70% are over 45 years old.[20] This represents a largely privileged demographic, and one that has come to dominate much of scholarly nursing discourse. Dominant voices in academia can easily marginalize underrepresented groups, particularly when there are large differences in circumstances and perspectives between groups. The

COVID-19 pandemic illustrates the need for application of TIC principles when approaching workload and productivity. During the pandemic, many nurse faculty have felt pressure to maintain and even increase workloads and productivity–references to which can be found in several published articles and editorials.[21–23] These provide direction, encouragement, and recommendations to nurse scientists and academicians for maintaining scholarly momentum during the pandemic.[22] The suggestions provided are indeed timely and useful for those who match the perspective from which these articles were written: that is, nurse scientists whose work and life remained largely unchanged as a result of the pandemic. They however, failed to recognize the voice of those often underrepresented in nursing academia—faculty caring for children at home or those from racial/ethnic groups suffering both pandemic-related as well as standing impacts of structural racism. For those whose lives changed drastically during the pandemic, the goal of "staying productive and on track" in the suggested manner is unrealistic and may only increase feelings of failure and inadequacy.[24] Rather than setting goals unattainable for some faculty, nursing academia should provide the flexibility and options to match differing circumstances of *all* faculty. Doing so requires the input of a diverse

range of faculty in terms of demographics as well as rank, experience, and scholarly focus.

1.2 | Safety

SAMHSA defines this key principle as the sense among everyone in an organization that they are both physically and psychologically safe.[3] In nursing, this often means having confidence in routines, protocols, and procedures. This is nigh impossible under the current circumstances as information about SARS-CoV-2, the healthcare response to the pandemic, and even procedures and precautions are in constant flux. Regardless of institution, local, state, and/or national guidelines, each individual (person, classroom, school, etc.) will need different approaches to creating a sense of safety. For nursing students, constantly shifting plans for clinical instruction have created uncertainty, and promulgated fears of contagion and about being unable to complete courses. Early in the pandemic many clinical sites were closed to students in an effort to preserve PPE supplies, and limit student exposure to the virus and patients' exposures to students. Many nursing schools had to limit class sizes, or suspend admissions altogether, in a time when frontline health workers are desperately needed. Conversely, in schools of nursing that were able to maintain clinical placements, students felt they were not adequately protected, and criticized administrators for compromising their safety.[18,25]

As the pandemic continues, nursing education has adapted and returned students to clinical environments while employing harm reduction strategies to minimize potential for COVID-19 spread. This process has, however, often been inconsistent and highlights how *Safety* is both an internal and external construct. Faculty, staff, and students all have unique risk profiles—be they preexisting health conditions, home environments with young children or aging parents, or other essential jobs that require interaction with the public. Recognizing and accounting for these variables, and providing clear information about institutional strategies to protect these individuals can aid in fostering an environment where individuals feel safe. At the same time, these strategies must avoid singling out those affected, such as by requiring formal exemption procedures or other "proof" of need. At an institutional level, variables such as access to PPE, availability of no-cost testing, and local and state policies also factor into what activities may be deemed safe at any particular time. A school in a community with limited testing, increasing positivity rates, and where clinical sites must provide PPE for students may have a lower threshold for keeping students in virtual and simulated environments than one where the university has universal testing; provides vaccination, testing, and contact tracing services; and provides PPE to students.

To address the need for *Safety*, some campuses have taken an all hands on deck approach to addressing many of the basic needs of students that are going desperately unmet during the pandemic. These campuses are introducing or updating food pantries and the federal government has temporarily loosed the criteria for SNAP to allow approximately 3 million additional college students to qualify,[26,27] providing access to health care services[28]; and ensuring that students do not have to go without housing.[29,30] Each of these programs addresses a need that impacts students safety, health, and learning.

Safety has been severely disrupted for many other groups within nursing education. Graduate students who relied on assistantships, international students mandated to appear on campus to meet visa requirements, and staff members who have lost income related to transition to remote work or needing to take time off to care for family are just some of the individuals whose *Safety* requirements may not be met on any given day. Promoting a trauma-informed response to these situations also requires clear communication regarding policies, budgets, and institutional responses to those who may be in these situations. For example, while notifying students that assistantships will not be available virtually may seem unkind, sharing this information clearly as it becomes available is more helpful than allowing ongoing uncertainty. Promoting *Safety* thus involves supporting all members of the academic nursing community through sharing of information and encouraging individual choices about what is in fact "safe." This is closely related to principle 5: *Empowerment and Choice*.

1.3 | Trust and transparency

Trust and Transparency are defined by SAMHSA as situations in which "Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust with [all those] involved in the organization."[3] Both play an important role in developing functional and flourishing educational systems, which can only occur when institutions are nimble and able to adapt to the changing needs of their communities. When organizations make unilateral decisions that impact student, staff, and faculty lives without transparency regarding process or consequences, trust is compromised.

For example, at one author's university, COVID-19 policies for nursing students during their residential clinical experience stated: "Students must socially distance at all times, even with roommates, outside of their living quarters to avoid the *appearance* of violations" (emphasis added) and "In order to be in the [medical center] students must commit to no travel outside the [local] area (~30 miles) and no visitors for the remainder of the semester." These requirements, at face value, have no basis in evidence—the appearance of a policy violation by being in the same dining table or vehicle as a roommate cannot increase infection risk, but does impact students' ability to participate in activities both in and outside of the classroom. It requires each individual student to have a vehicle to travel to clinical sites—carpooling was prohibited by the policy—and to remain isolated except inside the confines of their home. These requirements create both a ranked system of privilege and a significantly isolating situation for students. That these strict policies focused on both controlling many aspects of students' actual behavior and inclusion of

policing the "appearance of violations" demonstrates an important lack of trust in students' ability to make reasonable choices.[31]

A second clear example of lack of trust and transparency within nursing education during the pandemic is the use of surveillance technologies. Students and faculty are increasingly being asked to be on camera and to download software programs that track their computer histories and record their personal environments in the interest of limiting academic misconduct. Robust discussion in higher education literature has demonstrated that such technologies invade privacy and as such are a form of violence.[31–34] These technologies have also been demonstrated to lack impact on learning, as the multiple choice exams they often accompany are a poor marker of understanding.[35,36] As a profession, embracing this opportunity to step away from standardized testing models to those that allow students to demonstrate understanding in other ways would be an excellent step forward.[37,38]

For example, during the transition from in-person to online courses in Spring of 2020, one syllabus transitioned from assessment based on four high stakes multiple choice examinations to assessment based on 25% each: low stakes weekly quizzing, a group presentation, a clinical toolkit written and online discussion relating didactic content to clinical experiences, and one summative multiple choice examination.[39] This diversified syllabus allowed students to demonstrate their mastery of content in multiple formats rather than relying primarily on one method. There have also been examples of faculty embracing the unknowable nature of a pandemic and the need to trust students including alternate methods for course completion.[40] One of these was the enactment of an alternative assignment option, or a "Plan B" policy, within courses.[41] The "Plan B" policy was written into the syllabus and designed for students to have a clearly identifiable way to contact the instructor when the original assignment was not feasible—and to propose a workable and appropriate "Plan B." No further explanation was required. This allowed students the autonomy to miss classes, modify deadlines, or ask for help without judgment. Establishing trust and fostering students' effort to take ownership and responsibility for their education has been found to be more effective in promoting academic integrity than surveillance and punitive approaches.[34,42,43]

Transparency in communication is also critical for fostering trust during traumatic events and involves consideration of the content, method, people, and partners.[44] Effective such communication involves listening to others to identify needs and concerns; providing accurate and honest information, even when negative; delivering information that is clear, simple, and consistent; offering rationale for decisions; setting reasonable expectations; and providing credible updates to promote certainty and reassurance.[45] The *method* of communication is also critical to promoting trust and transparency. During the pandemic, email became the primary way of sharing information within academic settings. A proliferation of confusing or conflicting emails can lead people to ignore and/or overlook relevant information. Consolidating and distributing email on a routine basis can help alleviate email burnout. Providing opportunities to communicate interactively outside of email such as virtual town halls, peer

support groups, and online chat functions can also help promote a culture of trust.[46] As an example of transparent communication, one school of nursing instituted multiple changes to ensure students, faculty and staff had up-to-date information regarding the evolving pandemic. These included: (1) weekly safety briefs, (2) just-in-time information communicated directly to affected students, (3) all COVID related resources posted publicly on an intranet site for ease of access by students and clinical faculty and updated or replaced when needed.

1.4 | Peer support

Perhaps the most significant impact on nursing education during the COVID-19 pandemic has been the necessary shift to remote learning. Although many programs provided significant logistical support for this transition, students and faculty may be largely isolated in the remote environment, especially where stay-at-home mandates were also in place. According to SAMHSA, "Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration."[3] Under remote learning protocols, students and faculty may only interact with each other and their peers via technology, and only in structured settings such as class or organizational meetings. In-person education, by contrast, offers less formalized opportunities for interaction and connection within the educational milieu. The lack of an accustomed scholarly community reduces potential for serendipitous "hallway" meetings, as well as increasing effort required to contact instructors, classmates, or colleagues.

For faculty not readily facile with remote technology, and for both faculty and students struggling with issues of internet access,[47] family needs, mental health concerns, or other logistical factors, making additional effort may be neither possible nor a priority.[48] In addition, struggling with such issues may be perceived as weakness, embarrassment, or otherwise worthy of censure. It may thus be especially helpful to promote and foster access to resources not affiliated with the academic institution (e.g., community resources providing aid for internet access, local mental health resources, programs to promote technology literacy) such that privacy and confidentiality can be better assured. This will allow students and faculty more freedom to choose resources that fit their needs, rather than being restricted to only certain avenues. As an example, one author of this paper created a learning management system-based "hub" including trauma-informed educational and resource materials for both faculty and students.[49] Along the same lines, maintaining open channels of communication among faculty, students, and administration with regard to needs and supports is critical to peer support. Ensuring that the diverse needs of faculty and students are taken into account, and that there is flexibility as well as equity across environments, further promotes engagement with the academic environment, and reduces both isolation and potential for over-extension of individual coping. These and other considerations are further addressed in principle 4: *Collaboration and Mutuality*.

1.5 | Collaboration and mutuality

In addition to the loss of peer interactions, students and faculty have had to learn new ways of collaborating and sharing knowledge in the remote learning environment. The fourth key principle of a trauma-informed environment states that, "Importance is placed on partnering and the leveling of power differences...demonstrating that healing happens in relationships and in the meaningful sharing of power and decision-making."[50] The circumstances of the pandemic require both collaborative interaction and acknowledgment of collective and individual needs among students and faculty. One example of a novel, successful collaboration is that of a university where PhD students were offered summer stipend funding to help faculty transition courses to online learning. In this instance, the collaboration allowed students to gain critical pedagogical training—often lacking in nursing doctoral education—and faculty to have assistance from a group of students who had received training in remote course development.[51,52] Elsewhere, many institutions have established mental health and wellbeing services for students and faculty, and encouraged both groups to be as flexible as possible while navigating changed learning structures.[53] While some faculty may be unaccustomed to allowing greater leeway in coursework and participation, absolutist approaches are not only unfeasible but potentially detrimental in the current circumstances.

1.6 | Empowerment and choice

Effectively trauma-informed organizations build upon strengths and recognize how power imbalances have traditionally silenced and limited options for those with less power.[50] Educators, particularly in the demanding discipline of nursing, have tremendous power over the students in our programs and may be feared as much as respected. Faculty must therefore be mindful of how interactions are perceived. For example, there has been much faculty discussion about the difficulty of teaching online when students do not have their cameras on. Some faculty even expressed desire to tie attendance or participation points to whether or not a student enabled video during class times, but this approach exacerbates an extant power imbalance. While teaching online presents different challenges than teaching in person, a student may have their video off for a multitude of reasons. Among these are the fact that greater internet bandwidth is required for video connections than for audio only—a problem if more than one person needs to be online in a home.[47] There is also the issue of being "camera ready." For some students this may require a significant outlay of time or energy, due to mental health concerns, stress, or simple lack of confidence in their appearance. It is unreasonable to demand such efforts at a time when many already feel overwhelmed and indeed exhausted from the burden of coping with the pandemic and all it entails.

At the same time as the emergent shift to online teaching, many if not all primary schools and daycares were closed. For students and faculty with small children or other competing priorities, the pressure to keep working at a prepandemic pace was dismissive of these concerns. In one school, an email was sent by senior administration stating that faculty with school aged children must let administration know if their ability to work in Fall 2020 would be reduced—so that they could be replaced.[19] This statement was later walked back, but the push to continue teaching as planned denied faculty appropriate flexibility in fraught circumstances. Such issues were compounded for many when best practices in online learning were ignored—many faculty were urged to keep the same class time and to require students to be logged into video conferences for the same amount of time they normally would have been "in class." This placed an undue burden on those with multiple caregiver priorities—many were forced to compromise safety by violating social distancing protocols to obtain child care, and some students forced to forgo participation points if they were unable to attend class as normal. Similarly, in a well-publicized case of a professor who collapsed while teaching online and later died of COVID, the deceased was characterized as "dedicated."[54] Though there is no evidence this individual was coerced into continuing to teach while ill, the culture of overwork in academia is a pre-pandemic norm which undoubtedly influenced the situation.

Empowering faculty and students to engage when and how they are best able is an appropriately trauma-informed approach to continuing education and online degree progress.[37] Empowering students to attend without requiring video can be as simple as recording synchronous sessions and giving students permission to watch or attend whenever able. This was demonstrated in one nursing faculty syllabus through statements such as:

- *I do not require you to have your video "on" in Zoom sessions as a form of gauging participation. Bandwidth and life variations may preclude you from having your video on, this is fine. I do request that you actively participate if you are online, for example contributing to breakout discussions or other synchronous activities.*
- *I do not take attendance for in-class sessions. All synchronous sessions will be recorded. Recordings will be posted to [learning management software] typically before the close of business on Friday of each given week. You are responsible for the material and activities performed in class. I do not create alternative makeup assignments for a missed synchronous session.*
- *Additional accommodations may be requested and considered on a case-by-case basis, all requests must be received in writing before the due date.*[55]

Similarly, empowering faculty to use asynchronous teaching modalities may be what works best during this time period.[38,56] All options should be explicitly stated or posted prominently so students and faculty understand their options and can make cogent decisions about day-to-day participation in the educational process.

2 | CONCLUSIONS

The pandemic has highlighted the trauma routinely inflicted on faculty and staff, as well as on students. We should and indeed must do better, for ourselves, our colleagues, and our students. As the

current generation of nursing students and faculty will necessarily carry the traumatic experiences of the COVID-19 pandemic into workplaces, classrooms, and community settings, we offer the foregoing examples as opportunities for discussion of how institutional policies can influence trauma and healing. Understanding how to manage this trauma appropriately not only supports individuals through this experience, but also increases opportunity and capacity for provision of TIC to patients and colleagues going forward. It is therefore vital that faculty, staff, and administrators model the highest standards of trauma-informed approaches to interactions with students as well as with each other. These approaches foreground attention to individual histories, sociocultural contexts, social and institutional interactions, and personal agency to assure that all those engaged in the educational, practice, and scientific aspects of nursing can achieve their greatest potential.

DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed for this manuscript.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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