Caring for the Caregivers During COVID-19: Trauma-Informed Education Practices and Graduate Nursing Students

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The evolution of trauma-informed education practices (TIEP) began in the K-12 grades about 20 years ago, in part because of educators' realization of how adverse childhood experiences (ACEs; Felitti et al. 1998) could translate into youths' psychological traumas and behaviors. An awareness of how past trauma affected children and adolescents naturally extended to how the brain, and ergo, learning was impacted. Attempting to mitigate the use of punitive approaches, a trauma-informed platform was adopted by many in K-12 educational settings, although practices and policies have varied (e.g., Berger and Martin 2021). In higher education, trauma-informed educational practices (TIEP) seeped into our consciousnesses a few years later, as college students' exposure to psychological trauma was realized: up to 84% of students report one or more traumatic events (Smyth et al. 2008).

Renewed interest arose as the COVID-19 pandemic created new platforms and challenges to the adult learner, with plenty of trauma to go around. In this paper, I describe how I employed TIEP in a graduate nursing course during Fall 2020 semester when the COVID-19 pandemic continued to surge. The duality of student roles – nurse as caregiver and as adult learner – shaped the TIEP, as did my roles as theorist, researcher, and expert in nurse-specific psychological traumas. Last, I present informal results of the TIEP and my recommendations for the future.

To fully grasp how TIEP can be implemented, the course itself and the fluid intersections of the lives of the adult students needs to be considered. In this specific instance, I was assigned a graduate nursing course that covered content related to nursing theory. Nursing theory is widely regarded as the basis of scientific knowledge within the discipline with synergistic ties to both research and practice. But make no mistake, nursing is a practice-oriented discipline. Therefore, in fall 2020, my 21 advanced practice students, sturdy bedside providers, were not particularly thrilled to be enrolled in this required course that covered what they considered to be esoteric and impractical information.

Second, the pandemic continued to provide a "marathon of crisis" (Foli et al. 2021), exhausting nurses who continued to see patients' suffering and, in many cases, their deaths. As an active researcher in this area, I simultaneously taught this course while in the throes of analyzing

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Recommended Citation: Foli, Karen J. 2021. "Caring for the Caregivers During COVID-19: Trauma-Informed Education Practices and Graduate Nursing Students." *Susan Bulkeley Butler Center for Leadership Excellence and ADVANCE Purdue Center for Faculty Success Working Paper Series* 4(2): 23-30.
Acknowledgements: The author would like to thank Mangala Subramaniam, Professor and Butler Chair and Director, and Laura Zanotti, Professor and Co-Chair, Support Circle Faculty Allies, for their encouragement and support of this discussion.

qualitative data from a sample of nurses working in critical care areas during the pandemic. Therefore, the contexts were twofold: a fairly unpopular course required in the nursing graduate curriculum, and student enrollment of healthcare providers, many of whom were rendering care during the COVID-19 pandemic. Realization of both factors – potential resistance to learning and students extremely vulnerable to multiple ongoing traumas – enabled me to successfully implement trauma-informed actions that not only supported but facilitated learning.

My own background is also of note. I approached the class, which I have taught for seven years, from that of instructor, theorist, researcher, and expert in nurse-specific psychological trauma. Nurses are the largest workforce in the United States at approximately 3.8 million; women account for about 91% of this group (Smiley et al. 2018). I am a registered nurse, although not actively practicing. My practicing colleagues and most of my students are with patients 24 hours a day, seven days a week when hospitalized. Based upon my research, personal experiences, and ontological presence, that is, my sense of knowing and knowledge of psychological traumas, I have developed a theory that describes the unique types of nurse-specific trauma (Foli and Thompson 2019; Foli et al. 2020). In my work and as a foundation to understanding trauma, I use the Substance Abuse and Mental Health Services Administration (2014;7) description, which contains the three Es of trauma: Event, Experience, and Effect:

> Individual trauma results 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.

Some event or series of events takes place, and these are perceived or experienced by the individual in different ways. What may be traumatic for me may be experienced very differently by someone else. And how we are positioned in society also affects how we perceive traumatic events. In a similar fashion, the lingering effects of the event may be individualized and shaped by prior trauma. That is, what becomes posttraumatic stress disorder symptomology (e.g., intrusive thoughts, avoidance, etc.) for some individuals, may be processed without leaving lingering effects for others. To approach individuals in a trauma-informed way, Substance Abuse and Mental Health Services Administration (SAMHSA 2014) forwards six principles of trauma-informed care (see Table 1). During the COVID-19 fall 2020 semester, I extrapolated trauma-informed educational practices (TIEP) into each of these principles. This semester was surely distinct because of the pandemic, but there was more. Students seemed to be dealing with significant stressors in addition to caring for patients with active COVID-19 infections. During virtual office hours or one-on-one meetings, one student described an extended family member whose substance use had reached a crisis state; another student described being assaulted while a bedside nurse; and a third student disclosed that a close family member had been recently diagnosed with cancer. All traumatic events that are layered within layers of societal roles: gender, age, nurse, family member, and student. To achieve learning, I couldn't ignore these perspectives, these layers of real and potential psychological trauma.

First, and to me, the critical piece to authentically providing TIEP is the provision of psychological safety, the first trauma-informed principle (SAMHSA 2014; see Table 1). I tried to

convey a sense of safety by engaging with students in low-risk participation. Despite students' hesitation, I enjoyed teaching the theory class for the advanced practice nursing students, which

Table 1
Trauma-Informed Care/Educational Practices

Trauma-Informed Care Principles[1]	**Trauma-Informed Educational Practices**
Safety	Low risk participation Clear about time to learn/time to evaluate Minimize risk of re-traumatization Approach students in non-hurried, calm, centered way Be aware of own ontological presence Know boundaries and resources Ensure cultural safety
Trustworthiness and Transparency	Be organized and available Prompt and accurate feedback Make syllabus a contract with students Clear expectations Set positive tone; communicate, communicate and then, communicate more
Peer Support	Online/on-site discourses and discussions: reward community civility Overtly encourage connections with peers Make classroom interactions meaningful and purposeful
Collaboration and Mutuality	Design projects that provide opportunities to complement strengths Provide clear expectations for group work Role model respect towards groups User-friendly technology for adult learners Flatten hierarchy when appropriate
Empowerment, Voice and Choice	Say "yes" whenever possible Acknowledge students' stress/symptoms when appropriate Be honest with student and allow them to orient themselves to the learning environment/be aware of adult learner roles Allow for student feedback in a non-defensive way
Cultural, Historical and Gender Issues	Honor differences and acceptance Promote DEI values Become knowledgeable about differences; ensure instructor cultural competency Foster student feelings of competency Use discourse that is culturally informed and promotes a sense of safety

[1] (SAMHSA 2014)

stimulates creative and wonderfully "gray" answers versus right/wrong responses driven by a logical empiricism approach. I was clear about providing a time to learn and a time to evaluate learning. As these were actively practicing nurses, I purposefully minimized the risk of re-traumatization by approaching the course with organization and adhering to the syllabus as a contract between me and students. No surprises. No hidden agendas.

To foster a sense of safety, I also created spaces to interact with them in a non-hurried, calm manner. Since the pandemic was affecting me, my research, and those around me in an intimate way, I had to use mindfulness to heighten my sense of awareness of my own behaviors and stress levels. For example, I had to stop at times to read my own levels of anxiety and purposefully invite awareness of my thoughts and actions. Last, to ensure safety for my students, I schooled myself on the available resources within my organization so that I could refer students to additional help. I had to know my limits and boundaries.

The second principle of trauma-informed care is trustworthiness and transparency (SAMHSA 2014). In the context of TIEP, on the first day of class, I set the tone for the semester, implementing several trauma-informed care principles from the start. I provided prompt feedback based on clear expectations. I was available, holding virtual office hours in the mornings and evenings to accommodate the students' shift schedules, which typically ran from 7 am to 7 pm (days) or 7 pm to 7 am (nights). I again, adhered to the syllabus; however, if quizzes were postponed or other adjustments were made, communications to those changes were sent timely. One of the most impactful TIEPs that I implemented was weekly email messages that served several purposes: reminders for upcoming assignments and quizzes, bringing attention to textbook readings, and other classwork tasks.

More importantly, I offered support in the email messages, cheering the students on to keep working, acknowledging that they were facing their professional roles in the midst of a disaster, with difficult choices and conditions. In parallel to the course, I was also analyzing data related to frontline nurses' trauma and substance use as the pandemic surged (Foli et al. 2021). Narratives of nurses' experiences were raw, unfiltered, and reflected horrific conditions. I felt secondary trauma from reading about the pain and suffering the nurses experienced. But the research findings gave me a better understanding of what some of my nurse-students were also experiencing. So, in reaction to those data, my weekly messages served as a proxy of what I wanted to say to the nurses in my study. I imagined what those nurses needed to hear: the pandemic would end one day. We would have normalcy again in our world, and yes, what they faced was more death and isolation than anyone should ever have to face. Several students contacted me after I sent those messages to tell me how much they meant to them and their mental well-being. They told me they looked forward to them and would keep them to re-read later.

Yet, the chronicity of the pandemic was evident. My study reflected how exhausted the nurses were and the waning of peer support due to fatigue and being emotionally spent. This is also reflected in the third trauma-informed care principle: Peer support (SAMHSA 2014). In educational practices, I transformed this to safe discussion boards, which were civil, and served to authentically communicate support for peers' thoughts and academic deliverables. Authenticity was derived from familiarity – that is, reading, processing, and reacting with knowledge and understanding of students' thoughts and emotions. When grading, I purposefully pointed out when a student had cheered a peer on or offered how their post had impacted their practice or generated new ideas. One assignment was to record a presentation focused on a nurse theorist. When the recorded student presentations were evaluated, I included peer reflections to create a sense of community. As an instructional designer, I tried to make the virtual classroom

interactions meaningful and with purpose. I also realized the students were tired and exercises without purpose would dilute their motivation.

The fourth trauma-informed principle is collaboration and mutuality (SAMHSA 2014). One of the ugliest characteristics of the pandemic was its forced isolation in many aspects of life, which negated or transformed what collaboration and mutuality looked like. For those in the healthcare system, either as a giver or receiver of care, solitude induced suffering, which was especially pronounced at the end of life when people passed away alone or with only the nurse at the bedside. Students flipped roles in a matter of minutes, from end-of-life provider to adult learner. They didn't need some instructor who wasn't there with them on the frontlines telling them what to do. Transforming from a hierarchical structure to a flatter distribution of power, lessening the power gradient, enforced this principle. In fact, what I tried to do was infuse a sense of empowerment to the students as they crafted presentations and wrote papers, which also implemented the fifth trauma-informed principle, empowerment, voice, and choice (SAMHSA 2014). The forced virtual course design did not lend readily to opportunities for student collaborations and several of the adult learners had grown tired of group work, openly expressing as much. Therefore, I assumed the role of advisor, mentor, one who was invested in their success. I received feedback in a non-defensive way; I voiced how difficult changing roles so dramatically must be, from student to end of life care provider; and I said, "yes" whenever I could. I owned my own guilt as a registered nurse in not being there with them, allowed to stay safely at home (Foli 2020).

Nurses, perhaps because we are an historically female-dominated profession, or perhaps because our genesis is rooted in uneducated, home care providers, our voices are often not heard. I offered choices whenever I could in response to student voices: some needed extensions on assignments, some were missing in action for quizzes, and some were struggling with the conceptual material. For the first time, I contacted students who had missed quizzes, genuinely worried about them. I allowed for make-up quizzes, following the syllabus for minor point penalty. I weighed fairness with compassion.

The sixth principle surrounds cultural, historical, and gender issues (SAMHSA 2014). I argue that nursing is a culture in itself. It's certainly more than a professional role as it seeps into your identity. You *are* a nurse. I know this culture well and could relate to this group of people in ways that extend beyond the classroom. Historically, we are female dominated, but men are slowly joining the discipline, and several males were enrolled in the class. I saw their suffering in my computer screen; in this instance, the pandemic was an equal-opportunity player. I was aware of minority students in the class and in important ways, the virtual environment supported inclusivity. Overall, however, I was sensitive to the fact that ethnic and racial minority students, sexual minority and LGBTQ+ students, veterans, and students with disabilities bring added layers of past trauma, microaggressions, and other violence that places them at risk for re-traumatization.

So how did all this turn out? The answer depends on what "all" means. If it means how satisfied I was as a teacher, then I think the answer is highly satisfied. I concentrated on learning, not the noise around me as a teacher, which can clutter our focus: to teach, to guide, to mentor, to role model ethical values. If it means how much learning occurred, the answer would be more than in

a typical semester. I found my students striving to do their best work. The concept analysis final papers, which requires advanced interpretive skills based on a review of literature, were strong. And if it means learner-consumer feedback, my evaluations were affirming with comments that reflected TIEP. One student example of the feedback I received was:

> Dr. Foli truly cares about all of us. I had a very emotionally difficult semester with things that were out of my control. Dr. Foli made me feel loved and cared for, she also supported me academically when I needed additional insight and guidance. She made herself available according to my schedule, which speaks volumes. This is a very tough course, but I feel like I learned so much and grew as a person and nurse because of the assignments in this course.

My TIEPs were intentional, purposeful, effective, and exhausting. By the end of the semester, I was experiencing several conflicting thoughts. The semester ranked highly in terms of job satisfaction; those activities related to teaching/learning. I also felt that my TIEP implementation had offered me the results I'd been hoping for: a rigorous course with authentic instructor compassion that positively impacted students as individuals and learners. My values as a person were also supported by the TIEPs, which align with my identity as a person and nurse. At the end of the semester, however, the isolation of the virtual world, necessitated by a pandemic with what seemed like no end in sight, left me feeling fatigued and experiencing the effects of secondary traumatic stress. I was relieved to have the winter break and news of a vaccine being developed.

Clarifications should be added. Teaching about trauma needs to be distinguished from TIEP, although some would include it as a trauma-informed approach to education, especially for the "helping professions" (Sanders 2021). In this instance, I did not incorporate overt discussions of trauma into the course, other than reviewing my theory (Foli 2021). I did not present potentially traumatizing content as such materials need to be treated very judiciously to avoid new traumatic experiences or re-traumatizing an individual (Carello and Butler 2014; Harrison et al. 2020). Best TIEPs are being discussed and differ based on subject areas, from literature to theology to service professionals (Carello and Butler 2015; Sanders 2021). Pedagogical practices need to be tested to determine evidence-based approaches for implementing TIEPs and should consider how adult learners' brains are affected by trauma (Perry 2006). There is much work to be done to add to our certainty of best practices, but rich conversations have begun (e.g., Davidson 2021; Sherwood et al. 2021).

A final note is that the TIEP that I implemented should be viewed as a beginning rather than an inclusive list. Further, these practices are not solely for the "helping disciplines," nor only during a pandemic. Rather, given the widespread nature of psychological trauma in our world, TIEP should be considered across the spectrum of professions and disciplines in higher education. Minorities, such as LGBTQ+, veterans, women, and racial/ethnic groups, who are located across major plans of study, may especially be vulnerable to trauma, and therefore, influenced by teachers who implement TIEPs. Despite the energies it entails, the results for both student and teacher are evident. As I begin to populate my online learning portal with materials, I thought this fall might be different. But with the ongoing threat of virus mutations, I believe TIEP are again needed. Then I stop and realize that for *every semester I teach*, TIEP are needed. Moving

forward, I will gladly take the TIEP approach in my courses and in my graduate student mentoring.

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