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# Humanity in Trauma

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by

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**Abstract**

The main objective of the literature review is to use the trauma-informed care paradigm to argue that the current implementation of trauma-informed care reinforces hierarchies of harm, leading to feelings of moral obligation and moral injury while perpetuating othering. This literature review criticizes trauma-informed care, emphasizing lived experiences against the characteristics trauma-informed care aspires to reflect. The review centers on the broad themes of understanding, universality, and acceptance of the present trauma-informed care paradigm. The critique comes from the silently excluded group of healthcare workers, with a personal perspective from a professional who worked in an urban hospital emergency department during the novel coronavirus (COVID-19) pandemic. Given the prevalence of trauma, a body of empirical research links trauma to various adverse social and health outcomes, driving many to assert a trauma-informed approach to health, education, social services, and public health is critical. The literature given is intended to elicit thought on the topic, 'Can framing the lived traumatic experiences of healthcare workers during COVID-19 bring innovation to a public health initiative?'

*Keywords:* Trauma-Informed Care, healthcare workers, emergency department, COVID-19, secondary-traumatic stress

**Humanity in Trauma**

On March 23rd, 2020, Oregon Governor Kate Brown's statewide stay-at-home mandate went into effect (Brown, 2020). I had spent the previous weekend in Seattle, seeing Pike Place, Kerry Park (with a quick walk to Meredith Grey's home from Grey's Anatomy), and various Capitol Hill bars and restaurants. That weekend, when I was utterly happy with my current circumstances and future, would serve as a reminder of what used to be, of whom I used to be, as I was soon confronted with the decision to work in healthcare. I had always wanted to be a nurse and was accepted into a program directly after high school, but the cost of attendance was exorbitant for a newly eighteen-year-old. Instead, I went to community college, and after dropping out and returning, I graduated with my emergency medical technician license in the summer of 2014. I worked in emergency medicine from age eighteen to thirty, giving me a sagacious perspective on people's darkest days. Years and states later, I found myself working in an urban Oregon emergency room. I saw this employment as laying the framework for what I desired, and I expected to be financially compensated for nursing school. The pandemic drastically altered my intention to pursue higher education to become a nurse. One could argue that my naivety about what a pandemic could do to an individual caused the shift, but I argue that it was what a pandemic could do to a system that caused the change in attitude. Novel coronavirus 19 (COVID-19) was deviant. There was a quiet seriousness when discussing the virus at work and the events in our neighboring state of Washington. The tension became palpable when the first fatality in Seattle occurred on February 29th, 2020 (Centers for Disease Control, 2020). My simple career choice caused my life to go into a tailspin. No one understood; not even the Centers for Disease Control and Prevention (CDC) had an indication of how widespread the virus was, how quickly it spread, how long it might survive in the absence of a

host, or how many and how quickly people would perish. My personal life and links evaporated, and I had become almost entirely alone, except for infrequent phone calls; social media was too much to handle, with conspiracies and a lack of human accountability depicted with recklessness. Society was reeling around us with skepticism and enmity. But this, this was the moment to focus and buckle down as I continued with what could be described as a calling, or, given the gravity of the work, a moral obligation, to aid and heal the sick. Almost hourly policy and guideline changes were taking place, ranging from operational matters such as housekeeping no longer entering the department and family members not allowed access or entry to the hospital to ensure their safety from exposure, what was deemed appropriate personal protective equipment (PPE), and what constituted occupational exposure. The tension warped into bewilderment as everything I thought about and understood about working in medicine became aberrant. There was much austerity in our body movement with every exchange with a patient with a cough, fever, sore throat, and no sense of taste or smell. We would step out of the room, drenched in perspiration, into a small duct-taped yellow or red box outside the patient's room to remove all of the PPE we were wearing. Doffing quickly became an intonation. Following leaving the patient's room and closing the door, sanitize hands, wipe off with cleanser the powered air-purifying respirator/controlled air-purifying respirator (PAPR/CAPR) or a face shield with N-95 mask, then remove away from my body and place it on a clean tray. Internally monologuing, carefully remove gown from body and deposit in biohazard bin, then sanitize again. Moving on, remove one bootie at a time, step out of the duck-taped zone to the designated 'clean space,' and place booties in the biohazard bin, sanitize again, remove gloves, and discard them in the biohazard bin. I'm almost there; I sanitize again, allowing me to leave the duck-tape square outside my patient's room for the last rinse of soap and water making sure to lather the

bare skin from my elbows down to my hands. I felt the weight of the pandemic on my shoulders, the shoulders of my coworkers, and the shoulders of my failing relationship. Unsure about what the future held, I phoned my brother, emphasizing what extraordinary steps I would take if I were ill and unable to make my own decisions. I wrote a living will and gave him power of attorney. I had only turned twenty-eight in January and had not anticipated how swiftly every bit of happiness I had felt during my weekend in Seattle would vanish.

## Introduction

The literature review in this paper provides a critique of trauma-informed care, emphasizing lived experiences against the characteristics that trauma-informed care aspires to reflect. The review centers on the broad themes of comprehension, universality, and acceptance of the present trauma-informed care paradigm. The critique comes from the silently excluded group of healthcare workers, with a personal perspective from a professional who worked in an urban hospital emergency department during the novel coronavirus (COVID-19) pandemic. The critique's correlation of literature employs the trauma-informed care paradigm to argue that the current initiative reaffirms hierarchies of harm, resulting in feelings of moral obligation and moral injury while sustaining othering, treating healthcare workers as intrinsically different from the larger community.

## Methodology

This literature review emerged from personal experience working in the emergency room. The thoughts I had, and the emotions I experienced at the time about policies and initiatives, propelled me to a new academic study and career pursuit. The original research contemplated as a meta-ethnography began in 2021. A meta-ethnography, often utilized in healthcare research, is "a systematic approach which synthesizes data from multiple studies to

enable new insights into patients' and healthcare professionals' experiences and perspectives. Meta-ethnographies can provide theoretical and conceptual contributions and generate evidence for healthcare practice and policy" (Sattar et al., 2021). Meta-ethnographies' limitation requires more clarity and structure around the synthesis stage and process. COVID-19 was ongoing at the time of the original synthesis, with the United States experiencing a second infection rate spike with the Omicrom variant. I decided to postpone the continuation of the meta-ethnography until later in my academic degree so that I could make use of additional resources, if they were accessible, and reevaluate the approach to the objective of the paper.

The previous meta-ethnography approach hypothesized that resilience interventions containing the underlying promotion of mindfulness are not appropriate for traumatic psychological stress dealt with during the pandemic. Furthermore, the occupational ecosystem of the hospital system contributed to the mass exodus of US healthcare workers. The perspective aimed to contribute an essential reflection to administrative hospital personnel and governing bodies when looking towards the future on properly implementing programs that will support and address the mental health needs of healthcare workers post-pandemic. The qualitative data analysis program Atlas.ti was used the research synthesis. The compilation of research covered data in the form of trials, surveys, interviews, questionnaires that refer back to a number of psychological frameworks including: emotional intelligence, Trauma Screening Questionnaire, Maslach Burnout Inventory, Post-traumatic Growth Inventory short form, Perceived Stress Scale, Depression, and Anxiety Stress Scale, Effort Reward Imbalance, Lazarus' Transactional Model of Stress and Coping, and Compassion Fatigue Model. Atlas.ti analyzed the qualitative data to identify themes, support or criticism of interventions, and statistical data of value from the research. Interviews, testimonies, and trials were included to translate lived experiences into

theoretical and conceptual themes. The analysis identified four key concepts and theoretical themes of focus: (1) first person code group: a call to duty, first-person needs, hero complex, and shouldering the burden, (2) the mental health code group: awareness and stigma (3) occupational burnout group: depression, job stress, traumatic stress, lateral violence, stress management, burnout, bullying, and isolation (4) training code group: leadership, resilience training programs, mindfulness, intervention, and support. Correlation synthesis of the material from twenty-five articles from the theoretical and conceptual themes comprises the 'psychological consequences of the pandemic,' 'occupational factors and interventions,' and the 'theory of implementing resilience programs and training.' The conclusion of the synthesis of the research found the commonality of (1) lack of psychological resources and accessibility to healthcare workers, (2) societal views that perpetuate stigma regarding mental health, and (3) the concept of "shouldering the burden."

**Materials and Methods**

The paper's literature review was performed to find articles assessing trauma-informed care implementation and approach, resilience strategies, and COVID-19-related psychological outcomes for healthcare workers. Due to the extensive nature of this topic, with a wide range of outcomes and strategies, a systematic review was not performed. However, the literature review was extensively analyzed to provide an overview of the following themes around the trauma-informed approach: 'acceptance leads to moral obligation,' 'universality leads to benevolent othering,' and 'understanding reaffirms hierarchies of harm.' The literature review integrated the previous research to focus on articles and research utilizing the terms scoping review, systematic review, and synthesis published between 2020 and 2023. The review of the literature was retrieved from Google Scholar, the Portland State University Library databases,

PubMed, and published books. The keywords/phrases used for the source were trauma-informed care implementation and interventions, healthcare workers, emergency department, COVID-19, mental health, trauma, resilience strategies, and secondary-traumatic stress. The screening for relevance was based on the publications' abstracts. Each was independently read with available abstracts applying the inclusion criteria to make an initial judgment. A total of 34 articles were reviewed in this work including first-person narratives from healthcare workers. Differences concerning inclusion/exclusion criteria were resolved by reading the full texts. The exclusion criteria were if the material presented was not focused on healthcare workers with direct and continuous contact with persons infected with COVID-19, trauma-informed care implementation and interventions, and the psychological state of healthcare workers pre and post-COVID-19. If the full text was not retrievable, then the article was excluded.

**Limitations**

Other scholars have described the limitations of the literature review. Manchia et al. (2022) describes clear conclusions which cannot be reached because the majority of the present studies have significant methodological shortcomings. Manchia et al. (2022) conclude that most studies on stress resilience and mental health outcomes during the pandemic are observational and cross-sectional and use convenience samples with often small sample sizes and limited assessment of contextual and personal characteristics critical to understanding stress vulnerability and resilience. Also, the interpretation of observational studies using non-representative samples is likely to be biased, especially regarding collider bias. Collider bias is "when an exposure and an outcome independently cause a third variable, that variable is termed a 'collider.' Inappropriately controlling for a collider variable by study design or statistical analysis results in collider bias. Controlling for a collider can induce a distorted association

between the exposure and outcome when none exists (Lee et al., 2019). The literature review seeks to mitigate collider bias through the extensive use of resources from which an equitable association of lived experiences may be built. Furthermore, the question ‘can framing the lived traumatic experiences of healthcare workers during COVID-19 bring innovation to a public health initiative?' is central to the paper's methodology.

> Since pathologizing is frightening, we are obliged to follow fear, not with courage, but as a path that leads deeper into awe for what is at work in the depths of the soul. Here we must keep from seizing up in panic and coagulating the frightening peculiarities with a literal interpretation of them, giving them a diagnosis that demands treatment.
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> — James Hillman, *Re-Visioning Psychology*, pp. 74-75

## Background

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the leading authority on Trauma-Informed Care (TIC), frequently also referred as 'trauma-informed approach.' This literature review will use trauma-informed care as the clarifier. TIC is theoretically seen as:

> A new organizational model for public mental health and human services that begins with the idea that every person seeking assistance is a trauma survivor who creates his or her route to healing, aided by the service provider's support and guidance. Survivors are empowered in a trauma-informed atmosphere to create objectives and track progress toward those goals (Salasin, 2011).

There is no universal description of TIC, nor is it an evidence-based intervention with consistent measurements and well-defined strategies. SAMHSA's goal for a shared understanding of trauma resulted in the formation of an 'expert panel' that defined trauma as “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” (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014, p.7). Anyone who has utilized organizational

planning tools in the past, such as the well-known Plan-Do-Study-Act (PDSA) model of iterative change, will be familiar with the overarching process for TIC implementation (Yatchmenoff et al., 2017). The PDSA cycle involves introducing the concept of change, forming a team, identifying goals, developing metrics, selecting, testing, implementing, and then propagating changes (Yatchmenoff et al., 2017). Trauma awareness, understanding of the impact on service consumption and involvement, and dedication to putting those understandings into policy, procedure, and practice are all critical components of TIC mirroring the PDSA model.

SAMHSA's (2014) key TIC assumptions are:

> 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 others involved with the system; and *responds* by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively *resist re-traumatization* (p. 9).

SAMHSA (2014) explains further that the *realization* that,

> people's experiences and behaviors are to be understood in the context of coping strategies designed to survive adversity and overwhelming circumstances, whether these occurred in the past (i.e., dealing with prior child abuse), are currently manifesting (i.e., a staff member living with domestic violence in the home), or are related to the emotional distress that results from hearing about another's firsthand experiences (i.e., secondary traumatic stress experienced by a direct care professional) (p. 9).

The *recognition* of the signs of trauma that may be gender, age, or setting-specific and may be manifest by individuals seeking or providing services in these settings. Trauma screening and assessment assist in the recognition of trauma, as do workforce development, employee assistance, and supervision practices" (SAMHSA, 2014, p. 9). The *response* is to apply the concept of a trauma-informed approach to all aspects of functioning as a universal precaution, where everyone is treated as though there was trauma in every individual's life and that the contact does not reproduce it. The notion of *resisting re-traumatization* reflects that a program,

organization, or system can unknowingly produce stressful and toxic situations for individuals, and trauma-informed people can identify this.

Lewis-O'Connor et al. (2019) literature review found that current trauma screening approaches have inherent limitations. Patients may not feel comfortable or safe enough to give their experiences if standard screening techniques rely on checklists. If providers bear witness to their patients' distress without receiving enough assistance, they may experience vicarious trauma (also known as secondary-traumatic stress). Secondary-traumatic stress "refers to significant, indirect experiences of distress resulting from empathic engagement with clients who experienced trauma" (Kim et al., 2022). Lewis-O'Connor et al. (2019) also found that most current screening methods do not provide providers with recommendations for interventions and actions following trauma disclosure, which counteract the benefits and may produce re-traumatization. Although SAMHSA's six basic principles underpin the assumptions: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, voice and choice, and cultural, historical, and gender concerns. Many of the principles are based on the SAMSHA (2014) notion that:

> The organization fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. The organization understands that the experience of trauma may be a unifying aspect in the lives of those who run the organization, who provide the services, and or who come to the organization for assistance and support. As such, operations, workforce development and services are organized to foster empowerment for staff and clients alike (p. 11).

Brown et al. 's (2022) evaluation noted many shortcomings in current initiatives, including a lack of universal precautions teaching, outcomes data, staff-focused interventions, and cost-effectiveness analyses. There was minimal to no adoption of TIC as a universal precaution for all patients across all therapies, including education- and protocol-driven. All treatments included in our review take a population-specific approach (i.e., survivors of human trafficking,

sexual assault, or community violence). While this strategy may raise healthcare workers' awareness of trauma in specific populations, it does not address the needs of patients who do not have "red flags" or trauma-related problems. Precisely for this literature review, SAMHSA highlights the importance that “staff are empowered to do their work as well as possible by adequate organizational support. This is a parallel process as staff need to feel safe, as much as people receiving services” (Substance Abuse and Mental Health Services Administration, 2014).

## The ‘Trauma’ of Trauma-Informed Care

The COVID-19 pandemic can be perceived as traumatic not only because of the threat of contracting a potentially lethal viral disease but also because of the associated loss of income, restriction of social contacts, and initial uncertainty about the efficacy of infection control measures. Additionally, it increases exposure to stressful events for healthcare workers, such as maltreatment and family violence, lack of predictability and control, and income loss, which can be exacerbated by limited access to social networks and professional support. Chen et al. (2021) argued that COVID‐19 could be categorized as a new type of mass trauma. This pandemic's unique characteristics call for a new perspective on 'what is trauma' and its implications. Trauma has multiple meanings in different settings, and there is no commonly accepted definition. In this literature review, trauma is "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" (SAMHSA, 2014). Trauma can then be identified as a social construct rather than a sequential concept or experience; since it does not refer to a specific concept or experience but rather to a wide range of events and their diverse impacts on individuals in various circumstances. "The American Psychiatric Association (APA) played an important role

in defining trauma. Diagnostic criteria for traumatic stress disorders have been debated through several iterations of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with a new category of trauma-and Stressor-Related Disorders across the lifespan included in the recently released DSM-V" (SAMHSA, 2014). The TIC paradigm is based on accepted trauma classifications as cited in the DSM-V. TIC implores that most current organizations or programs must shift away from a typical "top-down" hierarchical therapeutic approach and toward a psychosocial empowerment partnership that welcomes all available tools and routes to treatment. This is regarded as a "sine qua non," or "without which not," for humane, dignified, cost-effective, genuinely person-centered support and aid in achieving a diverse public health system with multiple levels and types of services and treatment (Salasin, 2011).

Isobel (2021) criticizes TIC's shared understanding of the term 'trauma,' citing the problematic nature of its varying meanings across circumstances. This transforms the meaning of trauma into the context, oftening labeling experiences, effects, and people rather than a factual state or process.

> Trauma is frequently hierarchically categorized (as per screening tools), simplified to diagnostic criteria, or presented as inclusive enough to include all vaguely distressing experiences. Each of these approaches is uniquely problematic. Potentially traumatic circumstances can become genericised, hierarchies of harm reinforced, or individuals who have experienced trauma can be individually pathologized, rather than the environments that induce trauma. When the word is used flippantly to describe any distressing event, its capacity to capture the impact of horrifying or cumulatively harmful events is also diminished (Isobel, 2021).

Since TIC aspires to be universal, its reliance on 'trauma' may result in 'othering,' distinguishing people who have experienced trauma from those who have not, within care. Othering trauma from mental illness minimizes the delivery of inadequate care. However, there is the potential that persons seeking treatment will not obtain the required attention, invalidating the suffering they experience. Trauma is essentially political, and acceptance of broader definitions within the

healthcare profession necessitates changes to power structures and medical hegemony to empower disadvantaged individuals. “To be truly trauma-informed requires consideration of the social and political contexts in which trauma occurs and recognition of social and health policy inequities that sustain its effects. Whose responsibility this is not clear” (Isobel, 2021). Despite increased awareness and rhetoric, there is still uncertainty regarding how healthcare evolves if trauma informs it, leading to ethical uncertainty over its recognition. Vulnerability from exposure to trauma has been recognized as an occupational risk among healthcare workers. COVID-19, on the other hand, socially questioned the moral obligation. The belief that healthcare workers have a moral obligation to their patients is critical to the functioning of healthcare systems. Although the level of dedication varies depending on the circumstances, it is universally accepted and acknowledged that healthcare workers are required to periodically endure more danger, stress, or discomfort in order to provide patients with the care they demand. As described by Macedo et al. (2022), when serving the community versus individual and family safety, healthcare workers were confronted with moral distress:

> It was very anxiety-provoking for workers to know that their work was necessary, and people needed them, but they were also very concerned about their own safety. As the pandemic unfolded, workers reported having noticed colleagues who lost loved ones as a result of the virus trying to manage their distress. This further brought up the realization that the risk was real and near. This perception of risk was likewise amplified by lack of PPE at the early stages of the pandemic and uncertainty around its efficacy in preventing infections. Health workers were experiencing limited sense of control over care delivery procedures and outcomes, increasing their vulnerability to trauma-driven responses (Macedo et al., 2022).

Moral injury can be characterized as psychological distress caused by actions or the absence of actions that violate someone's moral or ethical code. Moral injury refers to the ambivalence and guilt experienced when one's decisions or acts do not align with one's moral beliefs. Moral injury, according to Svold et al. (2021), frames an invisible epidemic among healthcare workers. Inadequate availability of PPE for healthcare workers poses fundamental ethical problems

regarding staff safety at the health system level. What are governments' responsibilities in terms of providing PPE? Under what social structural circumstances would healthcare workers be required to treat COVID-19 patients? How should limited PPE be divided among healthcare providers and organizations? Nguyen et al. (2021) *COVID-19 Impact on the Nursing Workforce Study* recounts the distress felt by one nurse:

> We all just [had] to reuse masks. We were given one N95—which we were told to put in a paper bag and pin to the paper wall of the conference room with your name on it. I think we all know how germs work—this paper is not going to disinfect my mask. So literally between April and September, we were supposed to be re-using that mask for months. I think the hospital was forthright with it—now you can use one N95 per shift. It just makes you feel---I don't know; I feel gaslighted this entire time (Nguyen et al., 2021).

Billings et al. (2021) qualitative study found many healthcare workers felt heroic narratives were harmful because they contradicted the professionalism of health and social care positions, detracted from arguments about compensation and protection, and, at worst, provided a barrier to personnel seeking assistance. After all, they concluded that heroes do not struggle and angels do not have PTSD.

Existing evidence implies that burnout precedes the development of PTSD, according to the DeLucia et al. (2019) study; thus, interventions to increase resilience and reduce burnout should reduce the prevalence of PTSD among healthcare workers. Søvold et al. (2021) indicates burnout is a three-dimensional occupational phenomenon characterized by (1) emotions of energy depletion or tiredness; (2) increasing mental distance from one's employment, or thoughts of negativism or cynicism relating to one's job; and (3) lower professional efficacy. Burnout is a phenomenon that occurs specifically in the workplace and should not be used to explain experiences in other areas of life (Søvold et al., 2021). Most healthcare worker resilience therapies are based on mindfulness training or cognitive behavioral therapy. Studies on resilience training in emergency medicine have yielded conflicting results. Mindfulness-based stress

reduction (MBSR) is "paying attention on purpose, in the present moment, and nonjudgmentally, to the unfolding of experience moment to moment" (Kabat-Zinn, 2003, p.145 as cited in Botha et al., 2015). MBSR programs are designed to be educationally based programs that combines mindfulness meditation, body awareness, and yoga to assist individuals in developing their mindfulness. The practice intends to promote physical relaxation and mental peace by focusing on present-moment awareness and responding consciously rather than automatically (Botha et al., 2015).

> We appreciate the basic things done well… making sure that we get our breaks, that we have access to hot food in our department. Simple things like that are actually really important… I don't think that putting on meditation or resilience training are necessarily the best way to help and support staff. I think that making them feel like their basic needs are helped and they are valued, are probably the most important things (Anna, a Counsultant as cited in Billings et al., 2021).

Resilience is often a component of MSBR. Resilience is "the ability to thrive despite negative life experiences and heal from traumatic events—is related to the internal strengths and environmental supports of an individual" (Bonanno & Mancini, 2011). Center for Substance Abuse Treatment cites in their book Trauma-Informed Care in Behavioral Health Services, "There are not only one or two primary factors that make an individual resilient; many factors contribute to the development of resilience. There is little research to indicate that there are specific traits predictive of resilience; instead, it appears that more general characteristics influence resilience, including neurobiology, flexibility in adapting to change, beliefs prior to trauma, sense of self-efficacy, and ability to experience positive emotions" (Center for Substance Abuse Treatment (US), 2014).

> "Pathologizing the myth onward" means staying in the mess while at the same time regarding what is going on from a mythical perspective. We try to follow the soul wherever it leads, trying to learn the morbid, the fantastic, we do not abandon method itself, only its medical model. Instead we adopt the method of the imagination. By following pathologizing onward we are attempting to discover precisely the methods

> and laws of the imaginal in distinction to the rational and the physical. Madness teaches the method.
>
> — James Hillman, *Re-Visioning Psychology*, pp. 74-75

**Acceptance Leads to Moral Obligation**

Florence Nightingale was born in 1820 in Florence, Italy. Florence received a "divine calling," which sparked her advocacy of social and healthcare causes and eventually led her to establish nursing as a distinct profession, labeling her as the founder of modern nursing (Selanders, 2023). Nightingale's compassion set her apart from others, and she earned her renowned title for visiting her patients by lamplight and frequently sending letters to loved ones at home on their behalf. The army did not always notify families when troops were killed at the time, but Nightingale felt the duty to do so. Haynes (2020), writing for *TIME,* correlated:

> That sense of duty to patient and family has been on full display during the COVID-19 crisis, as nurses champion the need to be with patients until the very end, and have campaigned for iPads so relatives can communicate with loved ones. With nurses around the world on the front lines of a global pandemic, it's a poignant time to reflect on how Nightingale's legacy laid the groundwork for their heroic work in hospitals today (David Green, director of the Florence Nightingale Museum in London).

McDougall et al. (2020) call to distinguishing the duty *of* care and duty *to* care. Distinguishing between the duty of care and duty to care as two distinct but connected ideas is helpful to understand healthcare workers' sense of moral obligation. The legal requirement of health practitioners to adhere to a reasonable standard of care is referred to as the duty of care. Duty to care, on the other hand, is a uniquely ethical term that relates to clinicians' role-based responsibility to provide treatment to patients even when doing so imposes some burden or risk on the clinician. In most cases, the duty to care is fulfilled by providing care despite tiredness or frustration or even considering the patient dislikeable or offensive. In the case of infectious disease, this entails caring for patients despite healthcare workers being in danger. The duty to care for patients is not absolute. It must be evaluated against other ethical concerns, just like all

other ethical obligations or ideals (McDougall et al., 2020). The constraints imposed by COVID-19 safety measures hindered empathy and understanding communication and provided new problems for developing trust between healthcare workers and patients. Empathy for patients in a healthcare setting is frequently exhibited through nonverbal communication, proximity, and prompt reaction. Healthcare workers' routines were disrupted as they were forced to care for patients who had been separated from their families, resulting in significant mental strain and a sense of inadequacy. This condition unavoidably increases moral distress. Nurses, when dealing with end-of-life decisions, tend to regard themselves as simply executing agents to disassociate themselves from decisions in which they did not participate. Patients become just objects of care in this environment, and nurses are unable to respond appropriately to patients' needs. Trauma-related responses (i.e., increased sense of alarm, anxiety, worry, rumination) were shown to increase in healthcare workers, highlighting the necessity for proper care delivery (Macedo et al., 2022). Healthcare workers have conveyed that they felt betrayed by their colleagues, organizations, and society because they could not offer the quality of care they felt professionally and morally obligated to provide. Billings et al. (2021) emphasized the narrative of a nurse whose concept of heroism in healthcare maintained the view of a willing sacrifice, similar to military personnel:

> The Thursday night clap was always very, really like, angering and made us just so frustrated… made us feel like ‘ok, so you think that will be enough for us? Don’t give us safe working conditions and hazard pay,’ but instead, they brought in this idea of heroes, like militarizing the whole response, like our death would be seen as a sacrifice rather than absolutely due to inadequate response from the employer, from the government. That made us so angry. (Alex, Nurse as cited in Billings et al., 2021).

People who have suffered moral injury are more likely to view themselves adversely, question their choices, and feel guilty and embarrassed. These negative ideas may contribute to developing mental health concerns such as depression, suicidal ideation, and post-traumatic

stress disorder (PTSD), as well as thoughts of quitting one's job (burnout). Burnout occurred at alarming rates of 35 percent to 54 percent among nurses and physicians before the COVID-19 pandemic (Baskin & Bartlett, 2021 cited in National Academies of Sciences, Engineering, and Medicine, 2019). Hines et al. (2021) explain that recent views claim that healthcare worker burnout is a sign of moral injury, and historically, moral injury has been assessed in the context of military service members who have post-traumatic stress disorder (PTSD) due to occupational obligations. This can be correlated with the moral injury healthcare workers may suffer, particularly when providing essential care services during highly stressful times such as the pandemic. In the piece, *I Was An ER Nurse For 10 Years. These Are The Nightmare Conditions that Made Me Quit* for HuffPost, nurse Sally Ersun describes the conditions that could lead to moral injury in the emergency room during COVID-19:

> Shortly afterward, I see a young couple standing outside the code room. They are the distressed family members of the deceased patient. I ask the couple if anyone has spoken with them yet. They tell me they were led by hospital security to the body of the patient without anyone speaking with them. I ask the doctor who coded the patient if he will speak with the family to explain that we tried to save his life and hopefully ease their pain. He tells me no. I ask the on-duty social worker if he will speak with the family. He refuses.
>
> Suddenly, I hear a wailing sound from Bed 6 — the patient who fell. I am unable to provide a moment of comfort to the family of the deceased man in Room 9. I run to the bedside of the woman in Bed 6. She needs medicine for pain ― immediately. I obtain a STAT morphine and Zofran order from the doctor. I enter the orders in the computer because the doctor, with so many ER patients solely under his care, is too busy to do so.
>
> Soon after, the woman's discharge paperwork comes in, but she is still crying from intractable pain. She is a multiple myeloma patient and the medications she is taking at home are not helping with her pain today. Are we allowed to admit her because she is unsteady and her pain is severe? The answer is no. We can't allow her to occupy the bed ― there's simply no room for her. I provide her with a walker and wheel her out in a wheelchair to a taxi as tears roll down her cheeks. 'I'm sorry,' I say and then instruct her to call 911 if anything becomes 'worse.'
>
> Earlier, I was forced to discharge a young homeless man with no shoes and no pants who was disabled from previous multiple strokes and who today was unable to even use the toilet by himself. I had already 'gone up the chain of command' with my concern about what I felt was his dangerous discharge, but I was brushed off. I am worried he will not live the next few days (Ersun, 2022).

**Universality Leads to Benevolent Othering**

Recovery cannot occur in isolation. It can only happen in the context of relationships defined by belief in persuasion rather than coercion, ideas rather than force, and mutuality rather than authoritarian control, which are precisely the beliefs damaged by the first emotional bonds. Grey (2016) proposed the idea of benevolent othering. He explains, “like hostile forms of othering, involves simplistic and self-serving representations that gloss over the complexity and diversity of people’s lives, constructing a self-affirming image of ‘benevolent subjects’ as superior and masterful” (Grey, 2016). Benevolent, referring to “being organized for the purpose of doing good” and othering as “being the one or ones distinct from that or those first mentioned or implied” (Merriam-Webster, 2023). According to studies, healthcare practitioners are more prone to suffer in silence due to the perceived stigma associated with "stress" and "mental illness," as well as the worry of revoking their medical license (Søvold et al., 2021). The stigma associated with mental health issues has inward-facing consequences for health professionals' willingness to seek help or disclose a mental health problem, which can lead to an over-reliance on self-treatment, low peer support (including ostracization and judgment from coworkers if disclosure occurs), and an increased risk of suicide.

> One day as I worked in the makeshift ICU, one of the hospital’s leaders went floor to floor making an important delivery. She approached our nursing station in her crisp professional attire and fresh disposition, and proudly delivered a supply of makeup-removing wipes. She told us to use the wipes to clean our faces before putting on our N95 masks so we could reuse the masks later, then moved on to the next nurses’ station without asking how our staff was doing or if we needed anything. I wonder if she had noticed the nurse crying in the supply closet (Skerrett, 2020).

In an August 2020 poll of 2,334 physicians in the United States, 58 percent reported having frequent experiences of burnout, up from 40 percent in 2018. Furthermore, nearly one-quarter of all physicians (22%) reported knowing a physician who had committed suicide, and 26 percent knew a physician who had considered suicide. Furthermore, 18 percent of physicians reported

increasing their usage of medications, alcohol, or illicit drugs as a result of the effects of COVID-19 on their practice or employment position (The Physicians Foundation, 2020).

> I think firstly, there needs to be a way of recognising it because everyone has been so involved that it has been hard to recognise that people are falling apart, one of the people went off with an acute psychotic episode and actually in retrospect we should have picked that up earlier and one of my other colleagues has gone off with very bad depression in the last week and the signs were there but it's a matter of how you try and spot that (Michael, Consultant as cited in Billings et al., 2021).

**Understanding Affirms of Hierarchies of Harm**

Scholars feel that understanding the impact of trauma on service consumption and engagement and a commitment to integrate those understandings into policy, procedure, and practice are key components of TIC. Isobel (2021) found that psychiatrists appreciated TIC's well-intended aspirational potential but dismissed it as a "buzzword" or "lip service" and some argued that TIC is a temporary phase unlikely to achieve significant change. TIC was viewed by the majority as a reframing of existing notions rather than a new theory. "Historically, nurses are always looked upon as the healers and the helpers. They feel they need to be strong for other people. What do you do when the hero needs help?" (Le Beau Lucchesi, 2021). It is critical to address stigmatization as a systemic issue within healthcare systems and to keep those who fear or are burdened by stigma at the heart of any response to stigma. This includes working to empower people or groups experiencing stigma. Focused social and organizational support, as well as an understanding of the distress experienced by healthcare workers during times of crisis and in general, can help reduce stigma and improve social connections, while also lowering barriers to using mental health interventions aimed at supporting healthcare workers. "The problem with healthcare is that mental health is slightly stigmatized in healthcare workers and people don't want to admit that there is a problem… they stress a culture of resilience and I don't think anyone wants to be seen as being unable to cope with anything" (Little, 2021).

> Most insidious of these abuses of psychopathology is the cover it now gives to a moral philosophy. Ideas of mental health and mental illness are ideas about the psyche, about the soul. When we are told what is healthy we are being told what is right to think and feel. When we are told what is mentally ill we are being told what ideas, behavior, and fantasies are wrong.
>
> — James Hillman, *Re-Visioning Psychology*, pg. 77

## Discussion

The main objective of the literature review was to use the trauma-informed care paradigm to argue that the current implementation of trauma-informed care reinforces hierarchies of harm, leading to feelings of moral obligation and moral injury while perpetuating othering. It also aimed to explore how framing the lived experiences of healthcare workers during the COVID-19 pandemic could bring innovation to public health initiatives. The responsibility for recognizing and managing their own stress, burnout, or depression has traditionally fallen on individual healthcare workers, which is unsustainable. In the existing literature, Bargeman et al. (2022), remarks that the notion of trauma-informed care (TIC) still needs to be better defined, with multiple competing definitions on the interpretation and use of TIC in various circumstances. In review there is some literature on the use of TIC in human service delivery systems, but agreement on both the concept and implementation of TIC within and across these systems is limited. Notwithstanding, published TIC literature is very theoretical (Bargeman et al., 2022).

The COVID-19 pandemic has highlighted the importance of investing in the mental health of healthcare workers. The narratives presented in the review emphasize the need for better support and resources, such as identifying indicators of moral injury and providing accessible and confidential mental health treatments. For instance, a study showed that 15 percent of nurses had resigned from their positions due to moral injury, which occurs when they know what is ethically right but are unable to act due to system constraints (Hines et al., 2021).

This example is significant because it demonstrates that the costs of moral injury are incurred by healthcare workers and their employers in the form of decreased employee productivity and greater turnover rates (Hines et al., 2021). Unfortunately, no preventive measures for burnout or other mental health issues will be effective unless attention is paid to improving a positive work environment, which is defined as one "that attracts individuals into the health profession, encourages them to remain in the health workforce, and enables them to perform effectively to facilitate better adaptation" (Finstad et al., 2021). Healthcare leaders and decision-makers should strive to set a good example by working to reduce the stigma associated with mental health disorders among healthcare workers, as well as build a work culture of transparency, trust, respect, openness, equality, empathy, and support, according to Finstad et al., 2021 call to action. While there is limited experimental data on interventions to enhance healthcare worker resilience (Baskin & Bartlett, 2021), normalizing discussions about mental health among physicians and other healthcare workers can help reduce some of this stigma. The severity of moral injury is particularly pronounced during public health emergencies when healthcare workers face high workloads, stressful situations, inadequate equipment, and difficult choices. "I refuse to watch my patients die because of absolute chaos that could otherwise be avoided, while, sadly, we are told to keep quiet as the ship we're on sinks" (Ersun, 2022). Consequently, health and medical leadership need to devote more attention to this issue to acquire solutions.

The narratives draw attention to various obstacles that healthcare workers faced during the COVID-19 pandemic, including limited access to mental health resources, a sense of disregard and insufficient support by their employers and the government, and the stigmatization of mental health in the healthcare system. The significance of basic needs, such as rest intervals, food access, and addressing signs of mental distress, was emphasized. "I work 12-hour shifts in

emergency, rarely got a break, we were not permitted to have fluids at the desk. None. None in the care area. So we were going for five or six hours with nothing to drink. We were so exhausted. So at the end of your 12 hour shift by 6 or 7 hours you're so exhausted that you're crazy. That is now leading to sloppy practice." (Chen et al., 2021). The experiences also, underline the significance of recognizing signs of moral distress and providing accessible and discrete mental health treatments. According to the National Academies of Sciences, Engineering, and Medicine Initiative for Clinician Wellbeing and Resilience, initiatives to improve wellbeing and reduce burnout should target not only people but also organizations as a whole. The National Academies of Sciences, Engineering, and Medicine underlined in their Future of Nursing 2020-2030 study that nurse leaders must be alert and develop a long term strategy to address nurse wellbeing in the aftermath of the COVID-19 pandemic's stress and trauma. "Nurse leaders must create an inclusive, safe work environment and put policies in place to protect nurses" (Chen et al., 2021).

Undiagnosed or untreated post-traumatic stress disorder (PTSD) can have significant consequences and may lead healthcare workers to leave the profession. The concept of vicarious traumatization, where healthcare providers experience distress from caring for patients who have experienced primary trauma, is also significant and has gathered recognition in recent decades. Søvold et al., (2021) details the disorder is related to a variety of psychiatric abnormalities resulting from healthcare providers' concern for patients who have experienced primary trauma. Loss of appetite, weariness, irritability, inattention, numbness, sleep difficulties, dread, and despair are common symptoms of vicarious traumatization. These symptoms are frequently accompanied by trauma responses and interpersonal difficulties. Søvold et al. (2021) cites a recent systematic review and meta-analysis conducted by Li et al. across 65 studies, involving

97,333 health care workers in 21 countries, has identified a high prevalence of moderate depression (21.7%), anxiety (22.1%), and PTSD (21.5%) among healthcare workers during the COVID-19 pandemic. Further, a review evaluated seven studies on COVID-19 related traumatic stress, where five assessed traumatic stress response, one assessed acute stress symptoms and one focused on vicarious traumatization. The findings in all the included studies highlighted the presence of trauma-related stress, with a prevalence ranging from 7.4 to 54 percent, particularly among women, nurses, frontline workers and in workers who experienced physical symptoms. Søvold et al. (2021) as cited in Lotta et al. (2020), who found that this rate can partly be explained by the absence of necessary resources provided to these healthcare workers: women, and black women in particular, have less access to personal protective equipment and training. They argue that female healthcare workers worldwide are also facing the downstream effects of their work, including mental health issues, increased physical violence, alternative arrangements for their families so as to not expose them to risk, and physical exhaustion.

Brown et al. (2022) concluded emergency medicine healthcare workers, in particular, are exposed to direct and secondary trauma, which can contribute to high rates of PTSD and STS. Secondary-traumatic stress is a major issue in the sometimes stressful field of healthcare, notably in Emergency Medicine (EM). EM healthcare workers are regularly forced to work against their natural circadian rhythms, care for a high number of patients with limited resources, and make critical decisions with little time and knowledge. These and other factors are most likely contributing to EM healthcare personnel having one of the highest rates of STS and professional burnout in the healthcare industry. Based on the current situation and working conditions for healthcare workers, as well as previous research findings on the negative mental health impacts of emergencies, and difficult and stressful working conditions in general, preventing a parallel

pandemic of mental health issues among the healthcare workforce should be a top priority in the coming years (Søvold et al., 2021).

> How can we take back therapy from the killing asymmetry of professionalism and the political abuses of wrong pathologizing, from a system which must find illness in order to promote health and which, in order to increase the range of its helping, is obliged to extend the area of sickness.
>
> — James Hillman, *Re-Visioning Psychology*, pg. 77

## Conclusion

A large body of research is noting a higher rate of psychological issues within the healthcare profession, and few conceptual frameworks address this. The intervention framework of Trauma-Informed Care has not been proven to work in the current setting of traumatic stress. Healthcare workers acknowledged that they seemed to be "running on adrenaline" and centered on the task at the pandemic's peak. They recognized that they had more time to reflect mentally after the pandemic's peak, and for many, this was when they realized how much the pandemic impacted their mental health. “Now is the time that people are developing some of the problems. At the time when everybody was immersed and working, there were a few people developing problems, but actually I think that the PTSD and the after effects are coming now” (Michael, Consultant as cited in Billings et al., 2021). The review intended to elicit a dialog of thought on the queston, 'Can framing the lived traumatic experiences of healthcare workers during COVID-19 bring innovation to a public health initiative?' Considering the question and restating TIC's definition would entail, as a community, *realizing* the widespread impact of trauma on healthcare workers. Healthcare workers should be *recognized* for their perceived and societal notion of moral obligation to keep people healthy. In turn, we are responsible for *responding* to their psychological needs and increasing their welfare. Repeatedly referring to healthcare workers as "heroes" may function as a disincentive to them recognizing their trauma. Countering

the hero narrative will propel us as a community to actively *resist re-traumatization* and will redefine healthcare workers as fellow human beings with resiliency limits that are not indestructible. Rather than focusing on external or short-term evaluation and reward, we must invest in and accelerate protective and preventative measures to lessen the long-term burden on healthcare workers. Likewise, *established* evidence-based, proven methods for reducing psychological distress in public health emergencies should be used. Lack of social support, communication, maladaptive coping, and a lack of training are documented risk factors for poor psychological outcomes in various disasters.

Simultaneously, studies on emergency and disaster situations show that long shifts over a more extended period, as well as the risk of personal injury or contamination, are associated with an increased risk of sleep disturbances, harmful alcohol use, anxiety, depression, and PTSD among first responders (Søvold et al., 2021). These situations may be generally similar to those seen by frontline personnel while working with COVID-19 patients while wearing limited personal protection equipment. For lengthy periods of time, healthcare workers have put their health and safety at risk in order to aid as many people as possible while working long hours in stressful circumstances. Moral obligation has been dubbed an "epidemic of empathy," and it has the potential to bring science and humanity together in ways that may be useful even after the pandemic has ended. Healthcare workers who have suffered moral injury are more likely to view themselves adversely, question their choices, and feel guilty and embarrassed.

Unquestionably, issues with mental health, stress, compassion fatigue, and professional burnout are common reasons for healthcare workers worldwide to consider leaving their jobs. While severe for an individual healthcare worker, job abandonment has a wide-ranging impact on the healthcare system. A 2004 study found that the costs associated with physician and

registered nurse turnover were $66,137 and $23,487 per worker, respectively (Hines et al., 2021). Organizations must prevent moral injury, if not for ethical reasons, then for financial ones. If moral injury and moral distress are the same constructions, there is a need to lessen their impact to preserve both the individual and the healthcare system. When healthcare workers leave their employment or commit suicide, they take with them years of valuable knowledge and training. Beyond the individual health workers and their immediate families, this has far-reaching consequences for their coworkers and entire health systems, hampering efforts to meet the needs of various patient populations. Unfortunately, the COVID-19 pandemic is expected to worsen the mental health and suicide rates of healthcare personnel (Søvold et al., 2021). “I’ve just lost my way. When I got back, the problems were still there… Reforming a new life has been tough. I guess you could call it PTSD. I’m proud of what I did… but in my personal life, I’ve paid a heavy price.” (Billings et al., 2021). When the "fight or flight" phase of the pandemic is through, we will be able to see the different mental health consequences much more clearly in the following months and years. If history repeats itself, the harmful health effects of COVID-19 on frontline healthcare workers and all types of healthcare professionals will most certainly last for years, if not decades.

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