



The Influence of Psychological Trauma in Nursing

Karen J. Foli & John R. Thompson

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PRAISE FOR *THE INFLUENCE OF PSYCHOLOGICAL TRAUMA IN NURSING*

“From beginning to end, The Influence of Psychological Trauma in Nursing is a remarkable contribution to the discipline and practice of nursing. The text brings together insights gained from research, theory, and practice to explain how psychological trauma—both the nurse’s and the patient’s—is experienced and outlines the paths to recovery and healing. Throughout the book there are real-life stories to illustrate the major concepts and invitations to reflect on one’s own experiences and practices. Most notably, this book is true to the fundamental values and purposes of nursing, explaining how nursing theory and nursing’s patterns of knowing provide ways to organize competent, trauma-informed nursing care. This book should be required for every nursing student at every educational level (including continuing education). It will revolutionize how nurses think, how they engage with their own experience and with one another, and ultimately, how nursing is practiced.”

—Peggy L. Chinn, PhD, RN, FAAN
Professor Emerita, University of Connecticut
Editor, *Advances in Nursing Science*

“Finally! A book that explains psychological trauma in an understandable fashion, based on science. The most pressing public health problems in the US today, addictions and suicide, usually have trauma precursors. Yet nursing education has not provided a coherent path to understanding trauma’s basic concepts. Authors Foli and Thompson have written a book that each nursing school should integrate into its curricula, both undergraduate and graduate. By doing so, RNs will understand that the phenomena they encounter in everyday practice are rooted in psychological trauma and will be equipped to implement evidence-based treatments for remediation.”

—Teena M. McGuinness, PhD, CRNP, FAANP, FAAN
Professor, University of Alabama at Birmingham School of Nursing

“Trauma is all around us. This text is essential reading for our times, preparing nurses to address ancestral and patient trauma, as well as their own trauma. Through stories, reflections, conceptual models, nursing theories, and research, this book provides the latest evidence on how to unveil and heal from trauma during the formative years of nursing education to engage in professional nursing praxis from a place of self-awareness with wisdom, courage, and compassion.”

—Sara Horton-Deutsch, PhD, RN, PMHCNS, FAAN, ANEF, Caritas Coach
Professor, University of San Francisco School of Nursing and Health Professions

“This text is a much-needed compilation of the literature on trauma and nursing. The authors have thoughtfully organized each chapter with trauma-informed reflections and excellent case examples. All nurses and nursing students should read this book to understand the pervasive effect of trauma on health and learning and the impact of trauma on nurses as caregivers. As an academic, I especially appreciated the application of trauma-informed content to the AACN Essentials of Baccalaureate Education for Professional Nursing Practice. The quality of this book is outstanding, with the latest research on trauma rendered in reader-friendly prose.”

–Kathleen Wheeler, PhD, PMHNP-BC, APRN, FAAN
Professor, Fairfield University Egan School of Nursing and Health Studies

“Trauma, whether the big T (loss of a family member) or the little t (a friend moves away), affects the body’s systems and the brain’s architecture. This book provides the knowledge and skills to address self and patient symptoms precipitated by trauma. The authors engagingly describe the causes of trauma and the constructive ways that nurses can respond, based on research evidence, solid experience, and insightful wisdom. A true companion to promote a rewarding practice.”

–Genevieve E. Chandler, PhD, RN, Resilience Expert
Associate Professor, University of Massachusetts Amherst





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TABLE OF CONTENTS

ABOUT THE AUTHORSVIII

FOREWORDXVII

INTRODUCTIONXXI

1 UNDERSTANDING PSYCHOLOGICAL TRAUMA 1

LEARNING OBJECTIVESXXX

TRAUMA IN SOCIETY2

TRAUMA NURSING3

TRAUMA: THE BASICS5

POSTTRAUMATIC STRESS DISORDER AND POSTTRAUMATIC STRESS SYMPTOMS6

THE NEUROBIOLOGY OF TRAUMA: KEY CHANGES IN PHYSIOLOGY AND BEHAVIORS8

TOXIC STRESS9

TRAUMA AND THE EFFECTS ON THE BODY12

TRAUMA AND LEARNING13

TRAUMA AND PTSD: VULNERABLE GROUPS.....18

TYPES OF TRAUMA.....19

CONCLUSIONS25

HIGHLIGHTS OF CHAPTER CONTENT26

REFERENCES.....27

2 TRAUMA AND BECOMING A NURSE 31

LEARNING OBJECTIVES30

TRAUMA UNIQUE TO NURSES AND CAREGIVERS32

TRAUMA EXPERIENCED BY NURSES AS CAREGIVERS.....32

NURSES AS AN OPPRESSED GROUP38

TREATMENT TRAUMA39

TRAUMA WITHIN THE ORGANIZATION AND THE PROFESSIONAL ROLE OF BEING A NURSE43

CONCLUSIONS	52
HIGHLIGHTS OF CHAPTER CONTENT	52
REFERENCES	53

3 ASSESSING FOR PSYCHOLOGICAL TRAUMA 57

LEARNING OBJECTIVES	56
INDIVIDUALIZED ASSESSMENT	58
ASSESSING FOR PAST TRAUMA	62
SECONDARY TRAUMATIC STRESS.....	72
ANOTHER SIDE TO THE COIN: US AS TRAUMA PERPETRATORS	75
CONCLUSIONS	77
HIGHLIGHTS OF CHAPTER CONTENT	77
REFERENCES	78

4 HEALING FROM PSYCHOLOGICAL TRAUMA: AN OVERVIEW 81

LEARNING OBJECTIVES	80
RECOVERING FROM THINGS AND PEOPLE THAT HURT US	82
HEALED FROM TRAUMA: THE LIVED EXPERIENCE.....	93
AVOIDING HARMFUL SELF-MEDICATING.....	100
HEALING ADULTS, YOUTH, AND CHILDREN WHO HAVE BEEN AFFECTED BY TRAUMA.....	105
CONCLUSIONS	106
HIGHLIGHTS OF CHAPTER CONTENT	107
REFERENCES	107

5 TRAUMA-INFORMED PRACTICES IN EDUCATIONAL AND HEALTHCARE ORGANIZATIONS 113

LEARNING OBJECTIVES	112
EDUCATIONAL COMPETENCIES IN TRAUMA-INFORMED CARE	114
PRINCIPLES OF TRAUMA-INFORMED CARE FOR NURSES IN ORGANIZATIONS	118
PSYCHOLOGICAL SAFETY WITHIN ORGANIZATIONS	124
CONCLUSIONS	131
HIGHLIGHTS OF CHAPTER CONTENT	132
REFERENCES	133

6 APPLYING TRAUMA-INFORMED CARE AS A NEW NURSE 137

LEARNING OBJECTIVES	136
TRAUMA-INFORMED CARE IN NURSING: EVIDENCE FOR CHANGE	138
WAYS OF KNOWING THROUGH A TRAUMA-INFORMED LENS	144
THEORY TO THE RESCUE	155
PROGRAMS FOR SUPPORTING MENTAL HEALTH POST TRAUMA	161
CONCLUSIONS	167
HIGHLIGHTS OF CHAPTER CONTENT	168
REFERENCES	168

7 TRAUMA AND GEOPOLITICAL SPACES 173

LEARNING OBJECTIVES	172
ETHICS AND TRAUMA-INFORMED NURSING CARE	174
TRAUMA AND SEXUAL VIOLENCE: NOTALONE	177
EDUCATION, HEALTH, TRAUMA, AND LEGAL GUIDANCE	179
TRAUMA-INFORMED SCHOOLS: K–12	182

SEXUAL ORIENTATION AND GENDER IDENTITY.....	183
RESOURCES AND ORGANIZATIONS FOR TRAUMA HELP.....	185
CONCLUSIONS	189
HIGHLIGHTS OF CHAPTER CONTENT	190
REFERENCES.....	191

8 CONCLUSIONS AND FUTURE DIRECTIONS 195

LEARNING OBJECTIVES	194
LESSONS FROM FLORENCE NIGHTINGALE AND THE INTERPROFESSIONAL TEAM	196
TRENDS IN TRAUMA-INFORMED (NURSING) CARE.....	198
MOVING FORWARD AS A SOCIETY TO PROTECT FUTURE GENERATIONS.....	201
CLOSING THOUGHTS	206
HIGHLIGHTS OF CHAPTER CONTENT	207
REFERENCES.....	208

GLOSSARY 211

INDEX 219



FOREWORD

The Influence of Psychological Trauma in Nursing, by Karen J. Folli and John R. Thompson, is an outstanding book and an essential read for all nurses, regardless of specialty, practice site, or education level. While the book is particularly applicable to psychiatric nurses, it is useful to all nurses regardless of setting. Though not all nurses come to the profession with past trauma, few nurses practice without experiencing some trauma or stress as they provide care. As Folli and Thompson so eloquently note, these experiences are part of the caring role of nursing, with its emphasis on humanistic, attentive, and intentional practice. Trauma is a hazard of providing good nursing care.

As I read the introduction to this book, I was transported back to my years as a nursing student who was drawn early on to psychiatric nursing, curious about what had created the human struggles I already saw across the life span. In 1972 there was little mention of trauma as the root cause of so many physical and mental health problems I saw in my patients. These included the elder veteran on the medical-surgical unit at a Veteran's Administration hospital, with pancreatitis and alcoholism and numerous medals for heroism; the drama of my first obstetrical patient, barely 12 years old and pregnant from sexual abuse; and the 7-year-old boy in a state-run group home for foster children. I volunteered in that group home as a sophomore in nursing school at the recommendation of my faculty advisor, who saw my leanings toward child psychiatric nursing. It was a pivotal career moment, as I got to observe and work with a houseful of children who had experienced so much stress in their young lives. The child assigned to me for play was a boy who quickly latched on to me with an intensity and neediness that baffled and frightened me. As I concluded that placement, I remember him tearfully begging me to take him to my house so I could be his mother. I was 19 years old.

My point in this self-revelation is to emphasize that 40 years ago in nursing, there was little discussion of trauma as the root of so many healthcare issues encountered by nurses. As I went to graduate school and on to a job in a federally funded community clinic, I saw many foster children who were dealing with the loss of family, the trauma of placement, and the early experiences that had initially put them into foster care.

I didn't have an anchor to understand what they were presenting to me or the skills to effectively intervene. This continued into a faculty position, followed by a clinical nurse specialist role in a state psychiatric hospital for children. The trauma was described but not named as a specific event with an outcome. The staff watched it, lived it, and tried to intervene. I often wondered what effect this environment had on the people around me, the nurses and childcare workers. Most of their energy went toward managing these incredibly damaged children and their symptoms. I saw a lot of compassion fatigue during that time.

After I got my PhD in nursing, I took a faculty position in a medical school where my office was next to a trauma researcher. He focused almost entirely on intervention models with clients and built a successful academic career around this. As the only nurse in the department, I often wondered how nurses, who I realized by then were different in the ways they approached and understood the people they worked with, dealt personally with these issues. So many of the nurses I knew (including me) had their own trauma history that they worked on and had to partially resolve to do the work. While I realized that all clinicians had to know the transference and countertransference issues influencing their work, I thought nurses were specifically vulnerable to the stress of working with traumatized individuals. And honestly, weren't all the people we saw directly or indirectly suffering from the effects of some sort of trauma?

This book is a beautifully nuanced, thorough description of the definitions of trauma, the theoretical underpinnings, and the nursing theory that defines assessment and interventions. It is liberally sprinkled with carefully crafted case studies and examples. It speaks volumes to nurses who are practicing in many settings with patients, other nurses, and students.

I am happy to say that there is currently a different level of attention to the issues of trauma that influence our practice and care as psychiatric nurses. I now do a thorough trauma assessment on every child and adolescent presenting for outpatient care in my practice. I have trauma treatment resources readily available, and I can now put a name to the reactions I repeatedly see in parents and children that have roots in trauma.

FOREWORD

In an ideal world, trauma would not occur, but this, of course, is unrealistic. We are fortunate to have books like this one that provide the specific support nurses need beyond the usual descriptors of trauma and trauma treatment. Kudos to these authors for this important work!

– Geraldine S. Pearson, PhD, PMH-CNS, APRN, FAAN
Editor-in-Chief, *Journal of the American Psychiatric Nurses Association*
Associate Professor–retired, UConn School of Medicine
Co-Chairperson, Committee on Publication Ethics (COPE)

INTRODUCTION

“You must not lose faith in humanity. Humanity is an ocean; if a few drops of the ocean are dirty, the ocean does not become dirty.”

—Mahatma Gandhi

Welcome! In this book, you’ll find a confluence of words surrounding the concept of “psychological trauma.” Some of these words will apply directly to you and your image of who and what you are. Some of these words will apply to you in the context of nursing and the act of rendering care to others. The beginning quote by Mahatma Gandhi reflects that trauma is a two-party system: Someone is the receiver of trauma, and another is the giver of trauma—intentional or unintentional. Gandhi’s words remind us, however, to take a broader view in that the world is bigger than those who are responsible for trauma in others.

We begin with a story told by Karen:

She stumbled into my office, a petite young woman with thick, dark, long hair. I looked up, distracted by a manuscript I was drafting. In the middle of earning tenure at a university, I was a “poster child” for today’s nursing faculty: middle-aged (and then some), yet driven to produce in the “three-legged stool” of academia: discovery, teaching, and engagement. She sat across from my desk in a lopsided way and calmly told me that because she was in one of my courses, I ought to know: “I was raped over the weekend.”

As a nurse, I’ve seen babies born and individuals take their last breaths, but for a few seconds, I could only stare at this young woman. People who go to school to become nurses change. It is not just a major in school; the “nurse” is swallowed inside us and becomes part of who we become as people. I paused, blinked, and the nurse stepped up. The questions spilled into one another: “Are you all right?” “Have you reported this?” “Whom did you report this to?” Then I stopped and looked into her face. Her features became paralyzed as she stared at me.

Those weren’t the questions she needed right now. She needed me to reach out to her and with her, to acknowledge the hurt and pain, and to offer acceptance and support. After this pause, we actually communicated.

I listened, and I saw and felt her tears. She led and I followed. But I also knew that I wasn't going to let her out of my office without connecting her to services. Looking back, her case was straightforward: The appropriate people (legal, medical for her physical injuries, and academic) had been notified. She thought she was done, but I knew her survivorship and healing would be molded in the next few days, and then the next few months, and onward after that.

She told me she was fine. It was over. She wanted to go on with her life. I wanted that too but knew that work—very hard work—needed to be done. Together, we walked a few blocks to the on-campus crisis center located in the Psychological Sciences department. I waited in the room with her and helped her fill out the intake form. After what seemed like hours but was only a few minutes, she was called back to see the on-call therapist. After she had left, I stared at the pictures on the wall, the posters that advertised various student services, and the outdated magazines on the side table beside me. I thought of her parents. I had two boys and a little girl. I wondered what I would feel if it were my child. I thought of the young man who had hurt her. I wondered about his parents and whether they knew. I wondered about loss and sadness at such a young age. I thought about the media and how people were objectified. I thought about all this as the hard wood of the chair pressed up against my back. I thought about psychological trauma.

Before leaving my office, I had galvanized my backup and resources: the director of the student's program. After receiving my message that I needed to speak with her, she stepped out of a meeting and arrived at the counseling office as soon as she could. Slightly out of breath, she sat down next to me. About the same age as I am, Julia¹ was one of those nurses you couldn't help but admire. She was the whole "package" as a nurse: decades of clinical experience, pragmatic, honestly straightforward with feedback, and brilliant. We sat there in the Psychological Services clinic, and I communicated to her what had happened. There was something about the two of us sitting there in those hard wooden chairs. We were two nurses, two women, who had experienced life in good and bad ways, and we shared our sadness in silence. And we waited for this student, whom we cared very much about, to emerge from her first session.

¹My colleague's name has been changed to further protect the student's identity.

Over the ensuing weeks, Julia and I put together a plan to support our student. One day during our regular meetings, I watched as Julia pulled some papers out of the copy machine. She reached for a marker and began writing on the top sheet.

“What are you doing?” I asked.

She smiled, and I watched as Julia flipped the page to show me. It was a calendar that extended to the end of the school year, with X’s showing the days that had passed.

“This way, she’ll know there’s an end in sight.” Julia turned back to the sheet, and her smile was replaced by a look of sorrow.

Julia and I became closer as we supported the student, who felt so unsafe and unsure. Her go-to support system of peers had abandoned her, taking sides over the assault, trying to make sense of it by assigning blame. We knew her class schedule and ensured she walked with someone to and from each class. Julia took the majority of the escorted trips, and gradually, the student felt more at ease. Many times, I saw Julia walking across campus so that at the end of her class, the student had someone present with her to provide that feeling of safety as she went to the next classroom. We became new social connections for her, and she forged ahead with the goal of finishing the program. Finally, after a few weeks, graduation arrived.

After the school’s recognition ceremony, which included a pinning ceremony and the Nightingale Pledge being recited, parents and students approached faculty and asked for photos and received handshakes of congratulations. Emerging from the crowd, I saw her approaching me with her mom—the same dark hair—and her father. Their faces, their smiles, their steps toward me, each a showcase of joy and hurt, as if a wound in each of them had yet to heal and the presence on campus had carved a fresh layer of pain. They greeted me. I saw each of their features in their daughter and then, a gift bag and a card were offered to me. Words of gratitude were spoken, “We can’t thank you enough for what you did for our daughter.” I murmured how brave she was and how I knew the future would be bright and fresh. She had secured a wonderful professional opportunity out of state.

I will always remember this student—her experiences, her courage, and my friend Julia’s kindness and trauma-informed support. The student

taught me about resiliency, healing, compassion, and the power of being connected to other human beings. These are important in the transition from victim to survivor. She taught me about educating students whose lives had been affected by trauma. The purpose of this book is for individuals who are becoming nurses to begin to recognize past traumas in their lives—how these experiences may affect behaviors and perceptions of others, as well as the trauma experienced by those they render care to.

YOUR TRAUMA “SCRIPT”

Perhaps you recognize yourself or someone you know in the story Karen just shared. If not the specific injury, the student’s experiences after a traumatic event may have reminded you, become a trigger, of an event in your life. This event might have occurred in your past, in childhood for example, or more recently. Diagnoses such as attention deficit disorder and learning disabilities can carry with them labels such as “lazy,” “stupid,” and “broken.” Overcoming an initial traumatic event, such as physical and emotional injuries in a car accident, can precipitate another trauma, such as the loss of function. Sometimes, we may not consciously recognize when trauma has occurred until later when we’ve had time to reflect and process it—or be reminded of it through a real-time event.

Now you’re in nursing school and may be faced with additional forms of trauma related to offering comfort to others in times of crisis and extreme vulnerability. In life, we experience many universal emotions, including love, joy, and hope. We are compelled to add that, for many of us, experiencing trauma is also a common thread. Nurses are unique creatures who listen to, empathize with, and at times, grieve with individuals they render care to. It is important to understand your “trauma script” as you read these pages because you take on many roles in society, and trauma touches each of us in different ways.

You have a cultural and historical context that brings with it experiences, both good and bad, that have shaped who you are. You or a family member/friend may have experienced significant trauma. Nursing as a profession has yet to achieve gender balance, and therefore, as women, we have experienced our own trauma or been caregivers to those who have.

Yet, as men increasingly join the nursing workforce, they also bring with them stories of trauma, such as sexual harassment, from both patients and managers. Sons and daughters, partners, mothers, and fathers—we care for them, literally and figuratively. Trauma affects not only the person who has experienced it but also those who are indirectly involved. You may be part of this second layer of trauma. In other words, no one is without some exposure to psychological trauma. The overall goal of this book is twofold: to help you recognize trauma (in yourself and others) and to learn ways of recovering from trauma so that you can heal and bring holistic healing to others.

AIMS OF THIS BOOK

We take this opportunity to clarify that this is not a “self-help” book. It is also not a substitute for a therapeutic relationship with a mental health provider or a proxy for support from family and friends. However, this text is an important first step in becoming aware of how trauma may have influenced you as an individual and/or those around you, including peers and family. We discuss a viewpoint that includes the psychological implications of trauma’s effects, why people who have been traumatized act in the ways they do, and how to intervene in smart, informed ways as you render care as a nurse. Specifically, our goals are:

To expand your understanding of what psychological trauma is and what types of trauma exist in society today. Although nurses are caring professionals with unique knowledge and skills, we also recognize that trauma invades internal and external environments. This book offers a primer on conceptualizing psychological trauma and understanding the common forms of trauma in society. It is meant to provide a foundation of knowledge in this area so that you can move forward as a caregiver in a “trauma-informed” way. Being trauma-informed means that you see individuals’ behaviors through the lens of how trauma impacts an individual. Their behaviors may appear to be odd, difficult, hostile, or even aggressive. Internally, they may be struggling with a need to feel safe, low self-esteem, anxiety, sadness, loneliness, or depression. This book describes the “why” behind how people who have experienced trauma may feel and act.

To increase your personal insight into your past, present, and potential future experiences that may be traumatic. Our trauma scripts are with us, similar to a physical feature that may change with time but is in some form a part of us. It is not that we want to be reminded of past trauma; instead, often we suppress, ignore, minimize, or intellectualize our past hurts and harms. By reading this book, you may begin to appreciate what has happened in your life and brought you to this point of becoming a nurse, and you may make sense of the whispers of past traumas. We describe some of the particular ways that nurses are vulnerable to both physical and psychological trauma. We know that trauma can instill a fear of the future, one's prediction that outcomes will always be negative. Thus, stress increases. But the right amount of stress can serve to motivate us, provide a sharper focus. It is finding that balance between motivating stress and toxic stress that we want to achieve. Despite the fact that we are a caring and trustworthy group of professionals, nurses continue to be targets of peer and supervisor bullying and targets of violence in the workplace. This brings us to another theme that we want to weave into our book.

To build a resilient workforce who is prepared to process and heal from trauma and help others heal. The duality of personal and patient-focused trauma is real, and as nurses, the more centered we feel, the more we can offer to our patients. It is important to understand how certain populations may be more vulnerable to psychological trauma: those involved with natural disasters or war-time activities, minority groups (racial/ethnic and sexual minorities), and those who have experienced stressful childhood and lifetime events. These patients will become part of your lens as you instinctively offer care in a trauma-informed manner, with ease, competence, and tools to lessen pain.

ORGANIZATION OF THE BOOK

What you'll discover in this discussion is both basic and advanced information about trauma and how we as nurses have much to offer in overcoming trauma's legacy. Nurses are consistently rated as the highest trusted professionals for ethics and honesty (Brenan, 2018), and our hope is that this book will support continuation of this trust. We have organized this book's initial

content in Chapter 1 to provide a foundation of what psychological trauma is and its physical, developmental, and emotional manifestations. The reactions of our brains to such fear-inducing situations and events explain much in future behaviors. Next, we move on to how trauma impacts the ability to learn and function, and we further emphasize how an individual successfully navigates herself in society. Behaviors that are born from trauma can be easily misinterpreted. Once those narratives are in place, they are difficult to amend. The heart of this book, however, revolves around specific strategies to increase your awareness of life experiences that include trauma and traumatic events, as an individual and as a nurse.

In Chapter 2, we examine trauma as you become a nurse and the unique aspects of the nursing profession that interface with psychological trauma. We provide information so that you can recognize signs and symptoms of trauma to support your journey in becoming a nurse. Myriad types of trauma, unfortunately, invade nursing today. From historical trauma, passed down from generation to generation, to workplace violence, nurses need to be ready and prepared to face these phenomena.

In Chapters 3 and 4, we discuss ways to assess for psychological injuries and specific strategies to heal from trauma. We discuss how adverse experiences in childhood impact individuals' health and mortality. As well, we provide an overview of the experience, event, and effects of trauma, important considerations for individuals as they interpret the meaning of the trauma in their lives. In these chapters, principles of trauma-informed care and how nurses' different forms of knowledge can address trauma are emphasized. Lastly, we offer advice on how nurses can use information from trauma-informed approaches to provide effective interventions to those who have experienced trauma.

This brings us to Chapter 5, in which education and healthcare organizations can integrate trauma awareness and practices. Existing guidelines are mapped to trauma-informed principles for educators and supervisors. Moving from systems to individual practices in Chapter 6, we present ways the new nurse can promote healing in patients through the use of theory and the ways of knowing in nursing. In Chapter 7, we describe how trauma may be situated in the legal and ethical environments, carved by federal laws and an awareness of violence against women and men, particularly in academic

settings. We examine the vulnerabilities of those whose sexual and gender identifications lay outside of mainstream ideologies.

We summarize our discussion in the final chapter, and with your new self-awareness, leave you with thoughts to consider as you move closer to becoming a professional nurse. Through a delineation of the trends reflected in this body of work, we discuss what we see for the future shaped by a trauma-informed view. Our hope is for you to become more resilient and more compassionate and to deliver higher quality care with the knowledge provided in this book.

A word about the evidence we cite in this text. Many individuals believe that literature published longer than five years ago is outdated. While we agree with this rule the majority of the time, we take a slightly different view in this book for a number of reasons. First, the discovery of new knowledge is cumulative. At times, there may not be more recent literature to cite; therefore, an older publication still offers new, relevant information. This may be a seminal paper, influencing later work, or simply knowledge that no other piece of published work can replace. Second, we take an interdisciplinary approach to the literature cited in this book. As trauma is continually and increasingly studied in various disciplines, including nursing, we needed to ensure that the best information was included, regardless of the discipline of origin. Third, while our goal has been to present an overview of trauma, the literature far surpasses what our space in this book allows. Given this, we have attempted to include systematic review articles, meta-synthesis and meta-analysis, and other “state of the science” reviews. In other words, these articles provide rigorous summaries of the published literature on the topic. The student nurse and new nurse are encouraged to pursue additional study as needs and interests direct.

We also interject “Trauma-Informed Reflections.” These questions may be the basis for individual, paired, or group reflections and discussions. They coincide with the subject being discussed and provide opportunities for you to expand on the topic. The questions are meant to bring a deeper understanding of the content, more than the consumption of knowledge brings us.

INTRODUCTION

One last thought to share with you. Companion books accompany this text: an instructor's guide and student workbook. These supplementary texts offer activities and simulations that allow application of the content of this "parent" book. As with the narratives presented in this book, each simulation is based on composite cases, representing no one individual, but a conglomeration of vignettes to facilitate application of trauma-informed care. You may recognize yourself, a family member, a peer, or a friend in the accompanying student workbook's simulation case studies. These cases reside in our academic and practice environments, in individuals and patients whose paths cross ours, bound together by trauma.

As we close this introduction, we'd like to leave you with another quote from Gandhi—one that speaks to what we believe to be a critical part of person-centered care. As data science and technology construct important paradigms in healthcare today, we want to remind you that it is the humanness we bring to those under our care and to ourselves that brings us healing. We discuss compassion at length in this book, but for now, it is an important reminder.

“Compassion is a muscle that gets stronger with use.”

– Mahatma Gandhi

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LEARNING OBJECTIVES

At the end of this chapter, you will be able to:

- Articulate the types of trauma that often are unique to nurses and experienced in the workplace.
- Examine the phenomenon of compassion fatigue and its effects on personal and professional functioning.
- Consider nursing clinical settings and exposure to trauma.
- Offer a rationale for why certain groups in society, including nurses, may experience historical trauma.
- List ways to modify patient environments to minimize treatment trauma.
- Analyze the distinct traumas in the workplace for nurses, from patient assault and second-victim trauma to incivility (horizontal violence).
- Deconstruct the ethical, legal, and safety factors related to secondary trauma in disaster management activities performed by nurses.



TRAUMA AND BECOMING A NURSE

2

PURPOSE OF THE CHAPTER

Now that we've described the various types of trauma that can affect individuals and have a grasp of what each of these means, we turn our attention to trauma that is unique to nurses and other healthcare workers. In this chapter, we discuss types of traumatic experiences within the healthcare context and as we render care to patients. Although nurses are one of the highest-regarded professions, our business is a risky one, leaving us vulnerable to trauma in myriad ways. From the long-term erosion of our spirits due to vicarious experiences with patients' traumatic events to being treated by peers in mean-spirited/hostile ways, nurses are surrounded by trauma.

TRAUMA UNIQUE TO NURSES AND CAREGIVERS

We want to start this chapter with a story about a nurse. This nurse was a role model for new nurses on the inpatient psychiatric unit. Although fairly young with two small children, she was articulate, solid as a leader, and had a calming influence over the other staff members. Yet, when it came time to pass medications, she needed a supervisor to watch her administer certain drugs. Later, she confided to Karen that her license was on probationary status for opioid diversion, in part due to “alarm fatigue” (Sendelbach & Funk, 2013). Her story is one of secondary trauma. After working for years on a pediatric intensive care unit, she began to experience insomnia, anorexia, and hyperarousal due to a trauma trigger. Whenever an alarm or beeping noise would sound, she would be triggered into reliving a past trauma. “You see,” she said, “the sound reminds me of a ventilator alarm, of something gone wrong and a young life in my care.” When she was discovered for drug diversion (taking medication that was meant for patients), she knew it was time to reclaim her life. Months of therapy ensued, and she agreed to a recovery monitoring agreement with the state board of nursing to save her nursing license. Karen will always remember this nurse, one she looked to for guidance as a new nurse. She was someone whom Karen never would have guessed would be diverting substances. Yet the secondary trauma was too overwhelming for her, and her coping mechanisms were insufficient at the time. Fortunately, her story ends with peace after the crisis and reclaiming her career and personal life. Let’s discuss forms of trauma that are specific and relevant to nurses and other healthcare providers.

TRAUMA EXPERIENCED BY NURSES AS CAREGIVERS

Because of the seemingly unending barrage of needs presented by patients, nurses are particularly susceptible to a unique form of psychological fatigue that impacts the ability to provide emotional availability to their

patients. This is called *compassion fatigue*. A similar but distinct form of trauma is secondary trauma or vicarious trauma—what the nurse who diverted substances experienced. The nurse, through witnessing or living through others' trauma, may begin to experience secondary posttraumatic stress symptoms (PTSS). In these instances, nurses are not experiencing firsthand trauma but experiencing the symptoms related to having gone through such stress. We believe nurses, and the nursing care that is rendered, create a unique context and even a vulnerability to experiencing compassion fatigue and secondary trauma.

COMPASSION FATIGUE AND SECONDARY TRAUMA

As a nurse, you hear individuals speak in times of crisis about physical and emotional periods of vulnerability, which, over time, with repeated intensity, can leave a caregiver emotionally spent and unable to give to others. We discuss ways to assess for and combat compassion fatigue in Chapters 3 and 4, where we describe paths to restoration and healing. For now, it is important to understand the characteristics of compassion fatigue and the recurrent themes that appear through a description of the literature. A concept analysis serves to help us understand what the term means and what its attributes or characteristics are. In a concept analysis, Coetzee and Kloppe (2010) defined compassion fatigue in nursing as:

a state where the compassionate energy that is expended by nurses has surpassed their restorative processes, with recovery power being lost. All these states manifest with marked physical, social, emotional, spiritual, and intellectual changes that increase in intensity with each progressive state. (p. 237)

The authors describe compassion fatigue as a cumulative process that may eventually exceed the nurse's endurance and restorative abilities (Coetzee & Kloppe, 2010). There is a multidimensional quality; compassion fatigue affects many areas of an individual's functioning. We believe compassion fatigue is a possible outcome of secondary trauma, also referred to as vicarious trauma. Secondary traumas are "stress reactions and symptoms resulting from exposure to another individual's traumatic

experiences, rather than from exposure to a traumatic event” (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014, para. 2). Secondary trauma isn’t unique to nursing; rather, this exposure can be experienced by many in the health professions, as well as first responders and clergy (SAMHSA, 2014).

Compassion, according to Georges (2011), is a complex phenomenon that occurs within a biopower context. It is the “power over life” in healthcare (p. 131). Nondiscursive forms (values we may believe but not vocalize or express), carrying powerful influences, create the unspeakable in nursing: “the creation/maintenance of biopolitical spaces in which compassion—for oneself or one’s patients—is rendered severely diminished or impossible” (p. 131). Frequent, unrelenting elements such as social and market forces, conscious withholding of emotion toward patients and students, valuing evidence and empiricism over theoretical understanding, and other factors in today’s nursing care and academic environments result in an inability or unwillingness to show compassion to ourselves and others (Georges, 2011). The unspeakable is often assumed, ingrained into our way of thinking so that we forget to question the very foundations of our thoughts and beliefs.

In your career, you will see, smell, and touch reactions to those who have experienced trauma. The hand you are holding may squeeze yours so tightly you are not sure how much longer you can bear it. An utterance from a patient may catch you off guard, so unexpected that you are not sure you heard correctly. You may be in the ED or on a medical/surgical unit or in a long-term care facility. The patient may be in a life-threatening state from an automobile accident, or hemorrhaging post-surgery, or have been placed in a skilled nursing unit after having lived in the same home for 30 years. The individual may be cognitively aware, or part of the trauma may be intensified by confusion, delirium, or pain (see Table 2.1). In nursing, we are taught that caring and empathy are valued in our patient interactions. But if we don’t strategize to sustain and restore our psyches and souls, we are just as vulnerable as our patients.

TABLE 2.1 NURSING CLINICAL SETTINGS AND EXAMPLES OF EXPOSURE TO TRAUMA

NURSING SETTING	NURSING EXPOSURE TO PATIENT TRAUMAS
Acute care	Emergency and urgent situations where patients feel vulnerable and in crises. Unexpected diagnostic information. Visual, auditory, tactile, and olfactory scenes of intense physical and emotional distress.
Home care	Witnessing adults and children in unsafe environments. Exposure to poverty and food insecurity.
Long-term care	Grief processes that are complicated by cognitive and other impairments. Seeing staff objectify older adults.
Community/Public health	Group events that appear unsafe or in geographic locations that have high crime rates. Post-disaster efforts with multiple traumas impacting individuals on a large scale.
Primary care	Agitated patients or those seeking substances that are contra-indicated. Patients lacking the resources necessary to carry out treatment plan (for example, lack of or insufficient insurance).
Education: School nursing	Seeing others being bullied by peers or faculty. Witnessing patients' pain and suffering for the first time in different clinical areas.

As Table 2.1 illustrates, several areas of clinical practice bring us into the worlds of patients who carry with them the pain of trauma.

TRAUMA-INFORMED REFLECTION

Experiencing trauma through listening and offering comfort can be exhausting. Yet, that comfort, when offered at the appropriate time, can support patients and their families in healing. How will you ensure a balance of empathetic listening and caring efforts, while protecting your own sense of well-being to avoid compassion fatigue?

HISTORICAL TRAUMA

The concept of historical trauma began in 2001 with Kellermann's seminal work that examined Holocaust survivors' traumatic experiences and the transmission of the effects of those experiences to their children and grandchildren. In this paper as well as previous work, Kellermann (2001) attempts to address the question of how trauma is transmitted from one generation to the subsequent generation.

Intergenerational trauma, then, is the nexus of historical trauma in many respects. The lack of resolution, healing, and processing of traumatic events leaves subsequent generations vulnerable to the effects of the original traumatic stress. This became apparent when Karen was performing a pilot intervention study with rural-dwelling kinship parents (Foli, Kersey, Zhang, Woodcox, & Wilkinson, 2018; Foli, Woodcox, Kersey, & Zhang, 2018). These kinship parents, often grandparents, had assumed the care of their grandchildren, who had been removed from their birthparents' care. Mental health services were scarce, and there had been a significant upsurge in the number of children locally and nationally who had been placed in either foster or relative care due to the opioid crisis. Many of the parents had become dependent upon and misused substances and unable to care for their children and provide a safe environment for them.

With extension educators (field-based lay educators), Karen's team implemented a trauma-informed parenting class in rural counties in Indiana. The curriculum, designed by the National Child Traumatic Stress Network (NCTSN; Grillo, Lott, & Foster Care Subcommittee of the Child Welfare Committee, National Child Traumatic Stress Network, 2010), was specific for resource parents, which includes adoptive, foster, and kinship parents. The lessons offered expertly crafted information, ranging from the biological changes a child's brain undergoes when faced with trauma to the often-challenging behaviors that were born from such events. The last module describes secondary trauma that kinship parents can experience when learning of the child's past trauma and pain.

The team and families would meet in safe places, such as the YMCA and county libraries. The children were engaged in play activities with nursing students, so the kinship parents could be attentive to the trauma-informed information. The grandparents would often sit down and freely

express what they were experiencing, eager to share with others. Some described their grandchildren's behaviors they simply weren't prepared to address: sexual acting out, aggression, nightmares, and hoarding of food. Some shared guilt over their parenting skills and blamed themselves for their sons' and daughters' faults, which they attributed to the child being removed from the home. Still others confessed to their own traumatic events.

Karen had arrived early to the last class to assist with the setup, and just prior to beginning, one older grandmother sat down next to her. Karen turned to her and offered a smile of welcome. She met Karen's eyes and said in a whispered voice, "I was abused when I was a child. I never told anyone that." Karen saw such a mixture of emotions in her eyes and body language. First there was relief at speaking her secret, the unspeakable, to another human being. Karen met her eyes and nodded slightly, trying to convey acceptance and comfort. The woman then paused, hesitant. Karen interpreted this to signify the fear of risking such a disclosure. The older woman also seemed surprised—but pleased—that she had shared such an intimate experience. About that time, more people situated themselves close by, and the conversation ended. Karen tried to meet her eyes again, and fleetingly did so. Due to the activity for the rest of the day, Karen was unable to follow up with her. But the interaction reminded Karen of intergenerational trauma, the secrets kept for decades, and the invisible yet real posttraumatic influences that may be passed down from generation to generation, often without the person being aware of these effects.

Historical trauma is also an influence for many African Americans. In a position statement by the NCTSN (2016), the following was asserted:

In spite of progress, the legacy of slavery has been carried forward in many areas of American society, including the racially related injustices that persist, such as mass incarceration, and the lethal violence directed disproportionately toward African Americans. As such, the impact of the unresolved historical trauma of slavery on intergenerational trauma and community trauma should be addressed within a child trauma services framework. Embedded institutional racism associated with these traumas is not yet adequately addressed in child trauma care and continues to shape current policies and attitudes. (para. 2)

Our politics shape our view of trauma. With insight into psychological trauma, we can increase our understanding of views of self, others, and society in a way that can increase our own competencies as caregiver. For example, we have a child of color whom we adopted as an infant. Looking back, our naivete regarding race relations in the US is a compelling case study. As her parents, our daughter's skin color was inconsequential to us. But what we didn't realize is that our perspective was only one piece of her experiences. Through interactions with the adoption community, we realized she wouldn't have the luxury of being colorblind and would need to be able to face the realities of a different world.

TRAUMA-INFORMED REFLECTION

Think about your parents and grandparents. What traumatic events have they faced in their lives? Perhaps they lived through World War II, the Vietnam War, or the Great Depression. If part of your heritage, how has slavery impacted your view of life and society? Does your family discuss related experiences with you as they share their narratives? How have their lives/your life been affected by such intergenerational events?

NURSES AS AN OPPRESSED GROUP

Some might argue that nurses have historically been an oppressed group. Perhaps our oppression has been a function of gender, perhaps our humble roots as unpaid caregivers in the home, and perhaps because nurses are viewed as a significant (group/de-personified) expense on the balance sheets of healthcare organizations. Our expense or budget liability stands in contrast to the medical-industrial complex that profited from individual medical providers. Our voices have been, on certain occasions, muffled, silenced, and censored. In a concept analysis of oppression and its relationship to nursing, Dong and Temple (2011) cited three attributes: 1) unjust treatment; 2) the denial of rights; and 3) the dehumanizing of individuals (p. 172). The authors conclude that nurses are both an oppressed group and, in turn, work with oppressed groups (Dong & Temple, 2011).

With a focus on trauma, horizontal violence or incivility in the workplace—and the psychological injuries that result—may be explained by nurses as an oppressed group. In *Pedagogy of the Oppressed* (1971), Paulo Freire forwards a theory of how oppressed individuals are silenced when confronted with those in authority. Fear, low self-esteem, and marginalization result. Then these emotions give way to anger and aggression toward their own group members. In this case, it is violence from one nurse to another. These behaviors, if Freire is correct, set us up within the profession to propagate our own historical trauma.

Roberts, DeMarco, and Griffin (2009) were one of the first groups of scholars to link such oppressed behaviors to the culture of nursing. More recently, Croft and Cash (2012) situate oppression within the organization (a hegemonic/dominant force) that significantly impacts nurses' lived experiences within institutions. Specifically, four prisms of understanding horizontal/lateral violence through discourse are named: economy and workload (causative factor due to economics of nurses' work); lack of interpersonal skills (blaming the nurse and keeping them marginalized); lack of management skills (managers based on seniority who themselves are isolated); and hierarchical and generational factors (organizational structures and practices; Croft & Cash, 2012). The questions become: Do we continually treat our new nurses as objects, and therefore, treat them in ways that ignore their rights as human beings and colleagues? And if we do, do these abhorrent behaviors stem from being oppressed?

TREATMENT TRAUMA

Nurses frequently see a full spectrum of individuals in need of care, from health promotion and prevention practices to those who are critically ill and injured. Recently, the healthcare context has been viewed as a source of trauma to those who have faced critical illnesses and cancer treatment. We believe this to be especially true with two patient groups who have undergone invasive, pain-inducing, and complex treatment: those who have been patients in the intensive care unit and those who are cancer survivors.

The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5; American Psychiatric Association [APA], 2013), describes a diagnosis of cancer as a traumatic event only when it is sudden and seen as catastrophic. However, based on the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-4; APA, 1994), a diagnosis of cancer was included with other serious illnesses and viewed as a potentially traumatic stressor. Using the DSM-4 (APA, 1994) description, researchers who conducted a meta-analysis reported that cancer survivors are 1.66 times more likely to experience PTSD than individuals who had not been diagnosed with cancer (Swartzman, Booth, Munro, & Sani, 2017). In a slightly earlier study, risk factors for cancer-related PTSD were those who were younger in age, had been diagnosed with more advanced stages of cancer, and had completed treatment recently (Abbey, Thompson, Hickish, & Heathcote, 2015). Further evidence of the presence and impact of PTSS, however, was found by James, Harris, Kronish, Wisnivesky, and Lin (2018). These researchers describe early cancer survivors' adherence to self-management of diabetes mellitus being negatively impacted by the presence of PTSS.

Increasingly, cancer is being viewed as a chronic illness. This chronicity brings the potential for recurrence and cycles of treatment. For the cancer survivor, these memories may bring trauma triggers of past psychological and physical pain. In a concept analysis of survivor in the cancer context (Hebdon, Foli, & McComb, 2015), the authors describe how individuals who have survived cancer have been impacted in positive and negative ways. Follow-up screenings, long-term side effects from treatment, and the memories from receiving painful treatments are cited in this concept analysis and set cancer apart from other illnesses for survivors of the disease. In the "Cancer Survivor's Treatment Trauma" sidebar, we present a narrative about the family impact of a cancer diagnosis.

CANCER SURVIVOR'S TREATMENT TRAUMA

Paul was an active pricing analyst in his late fifties. Married later in life, he and his wife, Beth, had two children in elementary and middle schools. As the sole source of income, he knew his family depended upon him. Despite increasing pain in his left side, he continued to work full time until the pain prevented him from eating. Paul surmised that the discomfort was probably due to a problem with his gall bladder—his mother had hers removed at about the same age. However, over the past two days, his pain tolerance was exceeded, and he decided that Beth should drive him to the ED.

Upon arrival, his blood pressure was noted to be 180/92 with a heart rate of 110 beats per minute. Oxygen saturation was 95%. After a detailed history and presenting problem assessment were done, the physician ordered a CT scan of the abdomen as well as other baseline laboratory tests to rule out myocardial infarction, among other emergent issues.

The test results stunned Paul and his wife. A large mass was found, extending from his spleen to his pancreas. Pancreatic cancer was a strong possibility; however, without a tissue biopsy, the diagnosis could not be confirmed. Both he and Beth knew what such a diagnosis would mean.

Within an hour, Paul was in an ambulance, on intravenous morphine sulfate, headed to a large urban medical center an hour and a half from home. His life changed within the span of three hours, from thinking that he needed a cholecystectomy to wondering whether his life would continue and, if it did, what that would look like for him and his family.

The next two weeks were filled with uncertainty and painful procedures for Paul and bureaucracy, worry, and psychological pain for Beth. The good news was that the biopsy had confirmed a treatable cancer: stage III diffuse large B-cell (DLBC), non-Hodgkin lymphoma. The treatment, R-CHOP (rituximab, cyclophosphamide, doxorubicin hydrochloride, vincristine sulfate, and prednisone), carried multiple side effects, including thrombocytopenia, fatigue, fever, anorexia, and immunosuppression. During a short surgical procedure, a port was placed under Paul's skin in his right shoulder area to prevent tissue damage from chemotherapy that may occur in a peripheral IV. Insurance forms, short-term disability, and communications with Paul's company filled Beth's days as she tried to determine how they would financially survive.

Over the next 18 months, the family supported Paul during his treatment: six cycles of R-CHOP. Paul's personality changed every time he took the prednisone to prepare for the chemotherapy agents. Irritability, hyperactivity, and lack of sleep were uncharacteristic of him and created tension at home. When off the prednisone, he was lethargic, sitting in a chair for hours at a time and tasting metal from the chemotherapy agents. He lost his hair, and Beth had to shave the wisps that remained from his head.

Beth took a part-time job to fill in financially where the short-term disability payments fell short. The children pitched in more at home and made sure Paul was taken care of when Beth was working. Slowly, Paul improved, and although still receiving chemotherapy, follow-up tests at seven months post diagnosis confirmed that his cancer was in remission.

However, the good news, while joyously received by Paul, Beth, and their children, wasn't the end of their journey. Paul, in particular, feared a recurrence, unsure whether he could endure additional cycles of R-CHOP. Every six months, he dreaded the repeat scan and follow-up visit with his oncologist to determine whether the cancer was back in his body. He became hypervigilant about his health, experienced recurrent nightmares of painful procedures, and visited his primary care physician for minor concerns. Though he returned to work, he had difficulty concentrating, and his hearing had been affected due to the cancer treatment.

Beth, sensing Paul's increasing stress and what appeared to be reactions to past traumatic experiences, arranged for him to become involved in a cancer survivor support group offered through their local hospital. Paul resisted the support group initially, believing it was a private experience and not one he wanted to relive with strangers. However, at Beth's insistence, he began attending. After several months, Paul began to be more relaxed and optimistic about the future, planning realistic physical activity and consuming an improved diet. His quality of sleep improved, and he became more engaged with the children and Beth. With time, Paul also began to feel a sense of safety and spiritual growth, knowing that whatever may happen in the future, he had supportive people in his life. He felt empowered with knowledge from past experiences and confident that he and his family had survived and could do so again.

Paul's story ended well with physical remission from cancer and psychological growth post trauma. Feeling less isolated as he connected to others who shared a similar narrative and coming to the realization that he could define safety in a new way were components of his psychological recovery.

Treatment trauma is not a new phenomenon. One of the most profound works of literature is the semi-autobiographical novel *Cancer Ward*, by Aleksandr Solzhenitsyn (1969). In this work, Solzhenitsyn details life in a cancer ward in the Soviet Union in 1955, two years following Stalin's death. The physicians, nurses, and patients experience life and healthcare under brutal and stark conditions. The central question Solzhenitsyn poses is: What is the price of being cured? The protagonist, a 34-year-old former army sergeant, Kostoglotov, pleads with the physician whom he begged for treatment:

And therefore you make the logical deduction that I am to you to be saved at any price! But I don't want to be saved at any price! There isn't anything in the world for which I'd agree to pay any price! (p. 75)

Has our approach changed so much since the time of *Cancer Ward*? What is the price each of us is willing to figuratively pay to be treated, to be saved from illness? Do we ask our patients what the price is for them? These are ethical questions with economic ramifications that our health-care system leaders cannot seem to completely answer. Kostoglotov continues to discuss suffering and alleviation of suffering. And with the pain and suffering relieved, he begs to "Only now, let me go" (p. 75). One thinks of palliative care and our system of prolonging life based on odds ratios and available treatment. We have spoken to healthcare providers who experience secondary trauma because of what they perceive to be prolonged suffering and the "price of being cured."

TRAUMA WITHIN THE ORGANIZATION AND THE PROFESSIONAL ROLE OF BEING A NURSE

In our professional capacities and roles, we are actors in traumatic events. In this section, we describe how, through our interactions with patients in different ways and contexts, we are exposed to, directly experience, and even create traumatic events. Due to human error, we may be culpable

of injuries caused by nursing errors, leaving us and our patients with traumatic stress. Conversely, our lives can change as quickly as a flash of lightning: As caregivers, we may be suddenly assaulted by patients, or as humanitarians and first responders, we experience and witness human suffering in the aftermath of disasters. Remembering the intricacies of our roles allows us to act in safe ways to protect ourselves and our patients.

PATIENT SAFETY AND SECOND-VICTIM TRAUMA

Imagine you're in a clinical experience with your nursing instructor, and it is the first day to "pass meds" in a long-term care facility that still uses paper records. The instructor is distracted and called out of the room. But first, she tells you to get everything ready for her inspection. In the interim, a staff nurse comes into the crowded "med room," and your process is disrupted when she needs to check the med sheets to administer a pain medication. When you return to the records, you are careful to resume the retrieval of meds from the drawer and compare them to the order sheet. The instructor arrives, verifies the meds, and instructs you to go ahead and administer them to the patient, which you do. You return to document your actions and realize you have given a diuretic at the wrong time, doubling the prescribed dose. Your heart pounds as you look for your instructor to tell her. You wonder whether the patient will be harmed by what you did. You also wonder what will happen to your grade.

Approximately 20 years ago, the Institute of Medicine (2000) published a report that changed the way medical errors in US healthcare were perceived. The report described the startling prevalence of patient deaths per year due to medical errors. More than that, the report led the way to make safety a priority in discussions surrounding healthcare. Additional disciplines, such as engineering, were brought into conversations to broaden the perspective from individual culpability to system failures. Organizations brought forth concerted industry efforts to provide safer care. Two examples are the Institute for Healthcare Improvement, which was founded in 1991, and the Agency for Healthcare Research and Quality (2018), which is the lead federal agency charged with improving patient safety.

As increasing attention has been paid to patient safety and quality improvement efforts, so, too has our focus changed to how system defects, provider workarounds (improvisations in care delivery that often deviate from accepted procedures; Debono et al., 2013), and other organizational factors can negatively impact safety. Think of the crowded med room and the interruptions that may have led to the error described at the beginning of this section.

But as our ability to see, and often address, such factors has improved the patient experience, we now realize there is a second victim: the provider who made the error (Wu, 2000). Since that time, several approaches to supporting the second victim have been implemented in various healthcare organizations. How does trauma factor into this second-victim phenomenon? Scott and colleagues (2010) defined the second victim as a:

Health care provider involved in an unanticipated adverse patient event, medical error and/or a patient-related injury who becomes victimized in the sense that the provider is traumatized by the event. (p. 233)

Second-victim trauma is real and can seriously affect the individual who has made the error. In the helping professions, such as nursing, our motivation often comes from the idea of supporting people and improving their lives and health. To “do harm” via errors is difficult to process. Such errors can lead to serious outcomes, including long-term disability and even death.

Most of the work that has examined second-victim trauma has been located in the acute care setting with bedside clinicians. We review the ways that organizations are stepping up to support nurses who have made errors in the delivery of care in Chapter 5. For now, you should be aware that advanced practice nurses also experience trauma when medical errors are made. Delacroix (2017) describes the impact of medical errors with nurse practitioners through a phenomenological (qualitative) study. The author describes how the nurses experience a “yearning for forgiveness and a supportive other” (p. 403).

WORKPLACE VIOLENCE

In much of the literature, incivility, bullying, lateral, and horizontal violence are subsumed in the category of workplace violence. We discussed this phenomenon in the earlier “Nurses as an Oppressed Group” section. For our purposes here, we examine verbal and physical abuse from patients and visitors directed toward nurses. With the ability to use phones to capture real-time events, almost everyone is a cameraperson. These images have found their ways into social media, journalists’ accounts, and in society. For nurses, videos document the extent of workplace violence that healthcare providers encounter. According to the American Nurses Association (ANA; 2018), one in four nurses has been assaulted in the workplace. This troubling statistic raises concerns at both an individual and an organizational level and on a global scale (Wei, Chiou, Chien, & Huang, 2016; Zhang et al., 2017). In the US, a movement is underway to “end nurse abuse” (ANA, 2018). These incidents counter our notions of patient behaviors, as patients are often assumed to be grateful and passive recipients of our benevolent care. The US Department of Labor (n.d.) defines workplace violence as:

An action (verbal, written, or physical aggression) which is intended to control or cause, or is capable of causing, death or serious bodily injury to oneself or others, or damage to property. Workplace violence includes abusive behavior toward authority, intimidating or harassing behavior, and threats. (n.p.)

In terms of trauma, both physical and psychological damage may result. Our feelings of safety have been shattered because we wonder whom we can trust as we render care. Certain physical spaces carry more risk, such as EDs. In one study, Speroni, Fitch, Dawson, Dugan, and Atherton (2014) reported that out of 762 nurses, 76% experienced workplace violence (physical or verbal abuse by patients or visitors). White male patients ages 26 to 35 years were the most cited group to inflict harm and were often under the influence of alcohol or other substances, or confused (Speroni et al., 2014).

In April 2018, the Joint Commission issued Sentinel Event 59: Physical and Verbal Violence Against Healthcare Workers. In 1996, the Joint

Commission released a sentinel event policy, which defined these serious events as not necessarily related to the patient's condition and those needing immediate attention and response. In Sentinel Event 59, the Joint Commission (2018) described what constitutes workplace violence: the everyday occurrences directed toward those who work in healthcare, from name calling to choking, spitting, and punching. As a way of providing guidance to healthcare organizations, the Joint Commission recommended seven actions. (See the sidebar "The Joint Commission: Sentinel Event on Workplace Violence.") In addition to those listed, nurses need to report the incidents in question to their supervisors, security staff, and even law enforcement. Unfortunately, nurses often do not report incidents of violence. Nurses often excuse such behaviors and rationalize them in various ways:

- The patient didn't know what he was doing (for example, due to dementia, mental illness, extreme emotional state, etc.).
- There was no permanent injury sustained.
- Everyone is bullied. Name calling and so on are inherent in nursing.
- I've seen my coworkers endure this type of behavior.
- I'm careful, but this was probably my fault. I was in a hurry and didn't assess the situation well enough. I put myself in harm's way.
- What are they (such as nurse managers, risk managers, chief nursing officers) going to do about it? There's nothing they can do.
- It was a unique situation. There's no need to make a big deal out of it.
- I don't want anyone to be punished or investigated.
- I don't have time to report it, and I surely don't have enough time to be part of an investigation.
- What if I'm blamed or something goes in my file? I don't want to be labeled as a troublemaker or weak.

- I just want to put it behind me and forget it.
- I'm leaving the organization anyway, so it doesn't make any difference whether I report it.

By labeling workplace violence as a sentinel event, we can understand the importance of these occurrences. Nurses should remind themselves that by reporting situations, they may be helping to identify system issues that can be addressed, moving beyond the individual level to an organization and policy level. Think about those nurses whom you work with. By reporting workplace violence, we support defining and describing the extent and frequency of such violence. Additionally, by reporting incidents, we contribute to the solutions that can be found and, thereby, contribute to supporting a safer environment for both patients and our peers.

As importantly, we've discussed healing from trauma. Workplace violence has both a physical and a psychological component. We believe the psychological trauma occurs most frequently, if not in all cases. By not reporting or sharing the incident with those who can effect change at the system level, paradoxically, nurses deny themselves an opportunity to heal at an individual level. It may become something unspeakable and lay buried within the nurse, shut off from the opportunity to heal the wound that has been inflicted. By remaining silent, we do a disservice to ourselves, our peers, and our organization and create limitations for providing safety in our environments.

TRAUMA-INFORMED REFLECTION

Suppose your co-student and friend has been grabbed in a sexually inappropriate manner by a patient during a medical/surgical clinical experience. (Her breast was squeezed while checking an IV line.) Your friend was assertive and instructed the patient to stop touching her. The patient immediately apologized, stating it must have been the medications he's taking that contributed to his inappropriate behavior. Your friend is adamant about not reporting the event but is shaken and confused. What would you say to her? What is the priority for your friend? For the student's faculty instructor and the school? For the healthcare organization?

THE JOINT COMMISSION: SENTINEL EVENT ON WORKPLACE VIOLENCE

The Joint Commission's suggested seven actions:

- Clearly define workplace violence and put systems in place across the organization that enable staff to report workplace violence instances, including verbal abuse.
- Recognizing that data come from several sources, capture, track and trend all reports of workplace violence—including verbal abuse and attempted assaults when no harm occurred.
- Provide appropriate follow-up and support to victims, witnesses, and others affected by workplace violence, including psychological counseling and trauma-informed care if necessary.
- Review each case of workplace violence to determine contributing factors. Analyze data related to workplace violence, and worksite conditions, to determine priority situations for interventions.
- Develop quality improvement initiatives to reduce incidents of workplace violence.
- Train all staff, including security, in de-escalation, self-defense, and response to emergency codes.
- Evaluate workplace violence reduction initiatives.

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NURSING AND SUICIDE

Knowing someone who has attempted or committed suicide increases most nurses' psychological discomfort. What is perhaps more disconcerting is when a nurse chooses to end her life. Increasing attention has been focused on nurse suicide with a noted lack of available data (Davidson, Mendis, Stuck, DeMichele, & Zisook, 2018). In the US, we are still searching for definitive trends and answers to why nurses choose to end their lives. However, in England, recent statistics point to a troubling finding: Between 2011 and 2015, nurse suicides were 23% above the national

average (Windsor-Shellard, 2017). Zeng, Zhou, Yan, Yang, and Jin (2018) studied suicide rates of nurses in China by reviewing public reports. Findings include 46 nurse deaths by suicide; 98% were female, and the most common way was by jumping off a building. They reported data were scarce, but that, “Overall, Chinese nurses work under too much pressure, overwork, depression, suicide and other things together broke their white angel wings” (“Introduction,” para. 4). Suppositions related to nurse suicides are exposure to medications and knowledge of methods of ending one’s life; occupational stress; giving to others without giving to self; high-stress environments, from acute care to home health; and incivility-embedded organizations.

We believe concentrating on the traumatic aspects of these factors may lead to opening the conversations around the sad journeys of nurses electing to end their lives. Evidence supports the relationship between trauma and suicide. Could such an approach allow us to ask the right questions at the right time to intervene and avoid such loss? The dichotomy of “white angel wings” and the brutality of what nurses are often exposed to leads us to wonder whether being mindful of the effects of trauma could be a place to begin.

TRAUMA SURROUNDING DISASTERS

As with other first responders and subsequent caregivers, nurses face traumatic stress during disasters, from ministering to others to experiencing firsthand the effects of disasters. Since 9/11, with the four coordinated terrorist attacks against the US, we have been on alert for man-made disasters. Yet the term “disaster” is complex, with several descriptions possible (for example, natural versus man-made and acute versus long-term impact). The United Nations Office for Disaster Risk Reduction (2017) defines disaster as:

A serious disruption of the functioning of a community or a society at any scale due to hazardous events interacting with conditions of exposure, vulnerability and capacity, leading to one or more of the following: human, material, economic and environmental losses and impacts. Annotations: The effect of

the disaster can be immediate and localized, but is often widespread and could last for a long period of time. The effect may test or exceed the capacity of a community or society to cope using its own resources, and therefore may require assistance from external sources, which could include neighbouring jurisdictions, or those at the national or international levels. (“Disaster,” para. 1–2)

From this description, we understand the fluidity of the scope and scales of disasters and, therefore, the impact on resources. Disasters may be created by large masses, such as shifts in tectonic plates, or microorganisms, such as those causing infectious diseases. Disaster relief efforts may be made within a structure, such as a hospital, or in the open environment/community, at temporary shelters. As the largest workforce of healthcare professionals, nurses have been, are, and will be drawn into disaster relief efforts. Although their work was preliminary in nature, Baack and Alfred (2013) found that most of their sample of 620 rural-based nurses did not feel confident in responding to disasters; those with previous experiences with disasters felt the most confident. The ANA (2017) challenges nurses to become prepared. For a historical perspective on nurses and their role in disasters, both natural and man-made, see Wall and Keeling (2010).

The ANA (2017) has issued a policy statement on nurses’ role in disasters. The ANA, while acknowledging the ethical imperative of the nurse’s response, also describes legal and regulatory issues as well as safety, including ongoing violence. In the 2017 document, the ANA also describes secondary trauma by citing possible situations in which the nurse would have to “walk past a mortally wounded person to treat someone else, or to take a terminally ill patient off a ventilator to allocate it to a patient with a better chance of survival” (p. 3). Such dilemmas have the potential to become traumatic events that create lasting psychological harm for the nurse.

CONCLUSIONS

Chapter 2 describes those unique traumas and traumatic events that nurses experience. We included secondary trauma, compassion fatigue, historical trauma, nurses as an oppressed group, trauma experienced because of the treatment offered in the healthcare system, second-victim trauma/trauma resulting from errors, workplace violence, nurse suicide, and trauma surrounding disasters. For students and new nurses, it is important to understand the ways in which trauma may be experienced because of their professional responsibilities.



HIGHLIGHTS OF CHAPTER CONTENT

- Nurses are particularly susceptible to secondary trauma and compassion fatigue due to the nature of their work. Examples are offered based on the setting where care is offered.
- Historical and intergenerational trauma may be difficult to assess; however, the nurse should be aware of its impact on patients.
- When viewed as an oppressed group, the actions of the nurse may explain the horizontal violence seen in the workplace and academia.
- Nurses should be aware of the potential of causing trauma to patients while administering treatment plans.
- Medical errors not only cause patient safety issues but also have the potential of causing second-victim trauma for the nurse.
- Workplace violence is increasing and creates significant physical and psychological trauma; the Joint Commission (2018) has classified workplace violence as a sentinel event.
- Disasters may be sources of professionally related traumas, including secondary trauma, fears related to physical safety, and a lack of preparedness.

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INDEX



A

- AACN (American Association of Colleges of Nursing), 116–118
- AAN (American Academy of Nursing), 200
- AAP (American Academy of Pediatrics), 22–23
- AAT (animal-assisted therapy), 101
- abuse. *See also* neglect; SAMHSA; sexual abuse/violence; substance abuse
 - ACEs, 65–66
 - CDC/Kaiser Permanente ACE tool assessment, 63, 65–66
 - “Four Common Types of Abuse,” 23
 - global crisis, 23
 - poly-victimization, 22, 214
 - SANE-certified nurses, 179
 - Sentinel Event 59: Physical and Verbal Violence Against Healthcare Workers, 46–47, 49
 - sexual orientation, 183–184
 - types of, 23, 65
- ACEs (adverse childhood experiences)
 - adult morbidity and mortality, 13–15
 - CDC/Kaiser Permanente ACE tool assessment
 - abuse, 63, 65–66
 - household dysfunctions, 64–66
 - neglect, 64–66
 - definition of, 212
 - PTSD and ACE behaviors, 66–67
 - with adults/older adults, 69–72
 - with children/adolescents, 67–68
 - society, effects on, 14–15
 - survival after, 203–206
 - trauma prevention emphasis, 201–203
- acute stress disorder, 8
- acute trauma. *See also* chronic trauma; complex trauma; developmental trauma; historical trauma; secondary trauma; second-victim trauma; treatment trauma
 - definition of, 20, 212
 - healing from, 60–62
 - individual-focused, 20
 - relationship with other traumas, 4
- adherence to treatments, 140–141, 212
- adjustment disorders, 8
- adverse childhood experiences. *See* ACEs
- Agency for Healthcare Research and Quality (AHRQ), 44
- alarm fatigue, 32
- American Academy of Nursing (AAN), 200
- American Academy of Pediatrics (AAP), 22–23
- American Association of Colleges of Nursing (AACN), 116–118
- American Association of Critical-Care Nurses, 130
- American Nurses Association. *See* ANA
- American Psychiatric Association. *See* APA
- American Psychiatric Nurses Association (APNA)
 - resources, 185–186
 - standards of practice, 115–116
- ANA (American Nurses Association)
 - Code of Ethics for Nurses, 150, 174
 - nurses
 - disasters, role in, 51
 - flexible staffing, 120
 - as trauma victims/survivors, 200
 - psychiatric-mental health nursing, 115
 - workplace violence, 46
- animal-assisted activities/therapy, 101–103

animal-assisted therapy (AAT), 101
 anxiety. *See* stress
 APA (American Psychiatric Association)
 child neglect results, 24
 Diagnostic and Statistical Manual of Mental Disorders
 cancer diagnosis as traumatic event, 40
 Event, three E's, 58
 PTSD criteria, 7, 214
 neglect, psychological harm of, 24
 nurses, core competencies, 114
 APNA (American Psychiatric Nurses Association)
 resources, 185–186
 standards of practice, 115–116
 assessment of trauma
 from ACEs, 63–66
 CDC/Kaiser Permanente ACE tool, 63–66
 with CFST, 75
 Compassion Fatigue Scale–Revised, 75
 nurses/healthcare providers as perpetrators, 75–76
 from PTSD events, 66–67
 adults/older adults, 69–72
 children/adolescents, 67–68
 with STSS, 72–74
 three E's and healing
 from acute trauma, 60–62
 complex trauma, 59–60
 definitions of, 58, 216
 attachment disorders, 8, 11, 129–130

B

Bloom, Sandra, 175–176
 Bride, Brian, 72
 bullying/cyber-bullying. *See also* workplace violence
 chronic trauma, 21
 excuses for, 47
 horizontal/lateral violence, 213
 intrusion symptoms, 70

nurses as victims, 35
 poly-victimization, 22
 SAMHSA's zero tolerance, 122
 TICs, 182

C

Campus Climate Survey Validation Study, 178
 cancer and PTSD, 40–43
 “Cancer Survivor's Treatment Trauma,” 40–42
 Cancer Ward, 43
 caregivers. *See* nurses/healthcare providers and trauma
 Caring Science, 216
 Caring Science Institute, 160
 caritas process, 161, 216
 CDC/Kaiser Permanente ACE tool and ACEs
 from abuse, 63, 65–66
 from household dysfunctions, 64–66
 from neglect, 64–66
 Centers for Disease Control and Prevention. *See* CDC
 CFST (Compassion Fatigue Self Test for Helpers), 75
 Children's Health Act, 187
 chronic trauma. *See also* acute trauma; complex trauma; developmental trauma; historical trauma; secondary trauma; second-victim trauma; treatment trauma
 definition of, 21, 212
 relationship with other traumas, 4
 type of trauma, 20
 circadian rhythm, 100
 Code of Ethics for Nurses, ANA, 150, 174
 compassion. *See also* compassion fatigue
 definition of, 212
 with LGBTQ individuals, 184
 medication adherence, 140
 patients' perspectives, 143–144

- secondary trauma, 33–35
 - types of, 141–143
 - compassion fatigue. *See also*
 - compassion
 - assessment of
 - with Compassion Fatigue Scale–Revised, 75
 - with Compassion Fatigue Self Test for Helpers, 75
 - with Secondary Trauma Stress Scale, 72–74
 - definition of, 212
 - S.E.L.F., 176
 - Compassion Fatigue Scale–Revised, 75
 - Compassion Fatigue Self Test for Helpers (CFST), 75
 - competencies for nurses
 - AACN, 116–118
 - APA, 114
 - APNA, 115–116
 - ISPN, 115–116
 - NCLEX, 116
 - NLN, 116
 - for STS supervisors, 127–129
 - complex trauma. *See also* acute trauma; chronic trauma; developmental trauma; historical trauma; secondary trauma; second-victim trauma; treatment trauma
 - definition of, 21, 212
 - healing from, 59–60
 - relationship with other traumas, 4
 - type of trauma, 20
 - culture care diversity/universality theory, 158–159, 215
- D**
- Department of Defense, National Trauma Research Repository, 188
 - Department of Education, FERPA, 180–181, 213
 - Department of HHS (Health and Human Services), SAMHSA
 - Evidence-Based Practices Re-
 - source Center, 106
 - National Child Traumatic Stress Network, 187
 - trauma
 - assessment of, 58
 - definition of, 5
 - resources, 106, 186–187
 - Department of Justice, Office on Violence Against Women guidelines, 178
 - Department of Labor, workplace violence, 46
 - Department of Veterans Affairs, National Center for PTSD, 187–188
 - Department of Veterans Affairs, PTSDpubs Database, 188
 - developmental trauma. *See also* acute trauma; chronic trauma; complex trauma; historical trauma; secondary trauma; second-victim trauma; treatment trauma
 - definition of, 21–22, 212
 - relationship with other traumas, 4
 - type of trauma, 20
 - Diagnostic and Statistical Manual of Mental Disorders
 - attachment disorders, 11
 - cancer diagnosis as traumatic event, 40
 - PTSD criteria, 7, 214
 - secondary stress, 72
 - three E's of trauma, 58
 - disasters and trauma
 - Children's Health Act, 187
 - definition of, 216
 - National Child Traumatic Stress Network, 187
 - nurses/healthcare providers, aftermath of, 50–51
 - Psychological First Aid, 163–164, 214
 - Society for the Advancement of Disaster Nursing, 186
 - traumas
 - relationship with other, 4

types of, 20
 United Nations Office for Disaster
 Risk Reduction: International
 Strategy for Disaster Reduc-
 tion, 50–51
 disinhibited social engagement disor-
 der, 8, 11
 DSM-4 or DSM-5. *See* Diagnostic
 and Statistical Manual of Mental
 Disorders
 Duck Syndrome, 68–69, 213

E

eating disorders
 apps, use of, 105
 trauma-specific intervention
 programs, 140
 educational competencies for nurses
 AACN, 116–118
 APA, 114
 APNA, 115–116
 ISPN, 115–116
 NCLEX, 116
 NLN, 116
 for STS supervisors, 127–129
 Effects of trauma. *See* three E's (Event,
 Experience, and Effects) of trauma
 emancipatory knowing, 151–152, 154
 Emergency Nursing, Board of Certifi-
 cation, TCRN, 3
 emic/etic knowledge, 158
 emotional trauma. *See* neglect
 empirical knowing, 147, 153
 esthetics/art of nursing, 148–149, 153
 ethical knowing, 150–151, 153
 ethical/legal issues
 ANA, Code of Ethics for Nurses,
 150, 174
 emotion management, 176–177
 ethical ways of knowing, 150–151,
 153
 FERPA, 180–181
 HIPPA, 179–181
 PHI, 179–180

Sanctuary Model, 175–176, 215
 S.E.L.F., 176
 standards, 174–175
 Title IX, 181
 etic/emic knowledge, 158
 eustress response, 6
 Events of trauma. *See* three E's (Event,
 Experience, and Effects) of trauma
 Evidence-Based Practices Resource
 Center, 106
 Exceptional Nurse organization, 125
 Experience of trauma. *See* three E's
 (Event, Experience, and Effects) of
 trauma

F

fatigue. *See* compassion fatigue
 fears/phobias
 apps, use of, 105
 fear extinction, 9
 FERPA (Family Educational Rights
 and Privacy Act), 180–181, 213
 “Four Common Types of Abuse,” 23
 “Framework for Safe, Reliable, and
 Effective Care,” 124
 Freire, Paulo, 39

G

GAS (General Adaptation Syndrome),
 6
 Gay, Lesbian & Straight Education
 Network (GLSEN), 182
 gender identity/issues
 basics, 183–184
 definition of, 215
 Project Implicit, 76
 SAMHSA principles of TIC, 123
 Title IX of the Education Amend-
 ments of 1972, 181
 trauma-informed schools, 182
 White House Task Force report,
 178
 GLSEN (Gay, Lesbian & Straight Edu-

cation Network), 182

H

Health Belief Model, 141

healthcare providers. *See* nurses/
healthcare providers and trauma

Health Education Center, LGBT, 183

Herman, Judith, 2

HIPAA (Health Insurance Portability
and Accountability Act), 179–181,
213

historical trauma, 36–38. *See also* acute
trauma; chronic trauma; complex
trauma; developmental trauma;
secondary trauma; second-victim
trauma; treatment trauma

African Americans, 37

definition of, 213

intergenerational trauma, 36–37
nurse/other-focused, 20

politics, 38

relationship with other traumas, 4

home care settings. *See* nurses/health-
care providers and trauma

horizontal violence. *See* workplace
violence

household dysfunctions, ACEs, 64–66

I

IHI (Institute for Healthcare Im-
provement), 44, 124

implicit biases, 75–76, 123

incarceration of parents, ACEs, 64–65

incivility in nursing. *See* workplace
violence

indirect trauma. *See* secondary trauma

Institute for Healthcare Improvement
(IHI), 44, 124

Institute of Medicine (IOM) report.
See National Academy of Medicine
report

intergenerational trauma. *See* complex
trauma

International Association of Forensic
Nursing, SANE certification, 179

International Society for Traumatic
Stress Studies (ISTSS), 188

International Society of Psychiatric-
Mental Health Nurses

resources, 186

standards of practice, 115–116

International Strategy for Disaster
Reduction, United Nations, 50–51

Interpersonal Relations in Nursing: A
Conceptual Frame of Reference for
Psychodynamic Nursing, 156

interpersonal relations theory, 156–157,
216

interpersonal trauma. *See* complex
trauma

intrusion symptoms, 70, 213

IOM (Institute of Medicine) report.
See National Academy of Medicine
report

ISTSS (International Society for Trau-
matic Stress Studies), 188

J

JAPNA (Journal of the American
Psychiatric Nurses Association), 114

Johns Hopkins Hospital's RISE (Re-
silience in Stressful Events) model,
125

Joint Commission

seclusion and/or restraint use, 139

Sentinel Event 59: Physical
and Verbal Violence Against
Healthcare Workers, 46–47, 49

journaling, 96–97, 213

Journal of the American Psychiatric
Nurses Association (JAPNA), 114

Journal of Trauma Nursing, 3

K

Kabat-Zinn, Jon, 97

Kovner, Christine, 129

Kuhn, Thomas, 198

L

lateral violence. *See* workplace violence

legal/ethical issues

ANA, Code of Ethics for Nurses, 150, 174

emotion management, 176–177

ethical ways of knowing, 150–151, 153

FERPA, 180–181

HIPPA, 179–181

PHI, 179–180

Sanctuary Model, 175–176, 215

S.E.L.F., 176

standards, 174–175

Title IX, 181

Leininger, Madeleine M., theory of culture care diversity and universality, 158–159, 215

LGBT (lesbian, gay, bisexual, and transgender), 183. *See also* gender identity/issues

LGBTQ (lesbian, gay, bisexual, transgender, queer, and questioning), 182, 184. *See also* gender identity/issues

M

mantram meditation, 98–99, 213

medical errors

Institute of Medicine report, 44

RISE model, 125

second-victim trauma, 45, 215

meditation

apps, use of, 105

mantram meditation, 98–99, 213

Mental Health First Aid, 162, 200, 213. *See also* Psychological First Aid

Miller, Alice, 25

mindfulness

circadian rhythm, 100

daily structure, 99–100

definition of, 97, 214

meditation/quiet spaces, 98–99, 105

trauma, recovery from, 97–98

Missouri Department of Mental Health, 162

mood disorders, 105

mourning stage of recovery, 82–85

N

narrative discourse. *See* journaling

National Academy of Medicine report

LGBT traumas, 183

medical errors, 44

National Center for PTSD, 187–188

National Child Traumatic Stress Network (NCTSN)

African Americans, trauma position statement, 37

Children's Health Act, 187

intergenerational trauma resources, 36

nursing supervisors, core competencies, 127–129

vulnerable groups, 199

National Conference of State Legislatures report, 201

National Council Licensure Examination (NCLEX), 116

National Council of Behavioral Health (NCBH), 162

National Council of State Boards of Nursing (NCSBN), 127–128

National Institute for Occupational Safety and Health (NIOSH), 126

National League for Nursing, 116

National Organization of Nurses with Disabilities, 125

National Survey of Child and Adolescent Well-Being, 95

National Trauma Institute (NTI), 188

National Trauma Research Repository, 188

Nature (journal), 6

- NCBH (National Council of Behavioral Health), 162
- NCLEX (National Council Licensure Examination), 116
- NCSBN (National Council of State Boards of Nursing), 127–128
- NCTSN (National Child Traumatic Stress Network)
 - African Americans, trauma position statement, 37
 - Children's Health Act, 187
 - intergenerational trauma resources, 36
 - nursing supervisors, core competencies, 127–129
 - vulnerable groups, 199
- neglect
 - abuse types, 23
 - ACEs, 64–66
 - CDC/Kaiser Permanente ACE tool assessment, 64
 - definition of, 214
 - future outlook, 201–202
 - harm from, 24–25
 - relationship with other traumas, 4
 - Sentinel Event 59: Physical and Verbal Violence Against Healthcare Workers, 46–47, 49
 - types of, 20, 23
- neurobiology of trauma
 - definition of, 214
 - physiology and behavior changes, 8–9
 - relationship with other traumas, 4
- Nietzsche, Friedrich, 92
- Nightingale, Florence, 101, 196
- NIOSH (National Institute for Occupational Safety and Health), 126
- NotAlone, 177–178, 214
- Notes on Nursing, 196
- NTI (National Trauma Institute), 188
- nurses/healthcare providers and trauma, 32
 - clinical settings/examples, 35
 - compassion fatigue, 33–35
 - disabled nurses, 125
 - disasters, aftermath of, 50–51
 - educational competencies
 - AACN, 116–118
 - APA, 114
 - APNA, 115–116
 - ISPN, 115–116
 - NCLEX, 116
 - NLN, 116
 - for STS supervisors, 127–129
 - historical trauma, 36–38
 - incivility, 213
 - as oppressed groups, 38–39, 200
 - psychological safety, 124–125
 - PTSS, 33
 - relationship with other traumas, 4
 - retention of nurses, 129–130
 - SAMHSA TIC principles, 118–123
 - secondary trauma, 33–34
 - second-victim trauma, 44–45, 123–124
 - Sentinel Event 59: Physical and Verbal Violence Against Healthcare Workers, 46–47, 49
 - substance use by, 126–127
 - suicides, 49–50
 - supervisors, STS competencies, 127–129
 - TCRN, 3
 - as trauma perpetrators, 75–76
 - treatment trauma, 39–42
 - workplace safety, 130
 - workplace violence, 46–49, 126, 213
- Nurses on Board Coalition, 146

O

- obsessive compulsive disorders, 105
- Office on Violence Against Women guidelines, 178

P

parental incarceration, 64–65
 patients and trauma. *See also* TIC
 compassion perspectives, 143–144
 exposure in clinical settings, 35
 individualized assessment, 58–61
 safety issues, 44–45, 120–121
 treatment trauma, 39–43
 workplace violence roles, 45–48
 Pedagogy of the Oppressed, 39
 Peplau, Hildegard E., 156–157, 216
 personal knowing, 149–150, 153
 PHI (protected health information),
 179–180
 phobias and apps, 105
 physical abuse. *See* neglect
 Physical and Verbal Violence Against
 Healthcare Workers (Sentinel
 Event 59), 46–47, 49
 poly-victimization of children, 22, 214
 Posttraumatic Growth Inventory
 (PTGI), 93
 posttraumatic stress disorder. *See*
 PTSD
 posttraumatic stress symptoms. *See*
 PTSS
 Project Implicit, 76
 protected health information (PHI),
 179–180
 psychiatric-mental health nursing
 American Psychiatric Nurses As-
 sociation standards, 115
 International Society of Psychiat-
 ric-Mental Health Nurses
 resources, 186
 standards of practice, 115
 Psychological First Aid, 162–165, 200,
 214. *See also* Mental Health First
 Aid
 psychological neglect/trauma. *See*
 neglect
 PTGI (Posttraumatic Growth Inven-
 tory), 93

PTSD (posttraumatic stress disorder)
 from ACEs, 66–67
 with adults/older adults, 69–72
 with children/adolescents,
 67–68
 apps, use of, 105
 and cancer, 40–43
 criteria, APA, 7–8
 definition of, 7, 214
 growth after trauma, 214
 intrusion symptoms, 70, 213
 intrusion systems, 213
 National Center for PTSD,
 187–188
 PTSDpubs Database, 188
 recovery from, 92–93, 105
 vulnerable groups, 18–19
 PTSDpubs Database, 188
 PTSS (posttraumatic stress symptoms)
 and cancer, 40
 definition of, 214
 diagnosis components, 8
 Effects, three E's, 58
 recovery with social support, 95
 secondary trauma, 33

R

reactive attachment disorder, 8, 11
 Reasoned Action, Theory of, 141
 recovery from trauma
 animal-assisted activities/therapy,
 101–103
 apps, use of, 104–105
 lived experience, 93–94
 mindfulness, 97–98
 circadian rhythm, 100
 daily structure, 99–100
 definition of, 97, 214
 meditation/quiet spaces,
 98–99
 resiliency
 concept analyses of, 89–91
 definition of, 89–90, 214
 examples of, 87–89
 RISE model, 125

- self-medicating pitfall, 100
 - stages
 - ordinary life, returning to, 82, 85–86
 - remembrance/mourning, 82–85
 - safety, establishment of, 82–83
 - strategies
 - after PTSD, 92–93
 - journaling/narration, 96–97
 - living purposeful/meaningful life, 103
 - positive relationships, 94–95
 - social support, 95–96
 - therapeutic modalities, 105–106
 - Resilience in Stressful Events (RISE) model, 125
 - resiliency
 - concept analyses of, 89–91
 - definition of, 89–90, 214
 - examples of, 87–89
 - RISE model, 125
 - retraumatization, 150–151, 215
 - RISE (Resilience in Stressful Events) model, 125
 - Robert Wood Johnson Foundation (RWJF), 129
- S**
- Safety, Emotions, Loss, and Future (S.E.L.F.), 176
 - SAMHSA (Substance Abuse and Mental Health Services Administration)
 - Evidence-Based Practices Resource Center, 106
 - NCTSN, 187
 - three E's of trauma
 - assessment of trauma, 58
 - definitions of, 58, 216
 - healing with three E's, 59–62
 - neurobiology of trauma, 4
 - TIC principles, 118–123
 - trauma
 - assessment of, 58
 - definition of, 5
 - resources, 106, 186–187
 - Sanctuary Model, 175–176, 215
 - SANE (Sexual Assault Nurse Examiner) certification, 179, 215
 - seclusion and/or restraint use, 139
 - secondary trauma. *See also* acute trauma; chronic trauma; complex trauma; developmental trauma; historical trauma; second-victim trauma; STS; STSS; treatment trauma
 - compassion, 33–35
 - definition of, 215
 - nurse/other-focused, 20
 - relationship with other trauma, 4
 - Secondary Trauma Stress Scale (STSS), 72–74. *See also* secondary trauma; STS
 - second-victim trauma, 44–45. *See also* acute trauma; chronic trauma; complex trauma; developmental trauma; historical trauma; secondary trauma; treatment trauma
 - definition of, 215
 - medical errors, 45
 - nurse/other-focused, 20
 - psychological safety, 124–125
 - relationship with other traumas, 4
 - RISE model, 125
 - S.E.L.F. (Safety, Emotions, Loss, and Future), 176
 - Selye, Hans, 6–7
 - Sentinel Event 59: Physical and Verbal Violence Against Healthcare Workers, 46–47, 49
 - sexual abuse/violence
 - ACEs, 65
 - Campus Climate Survey Validation Study, 178
 - CDC/Kaiser Permanente ACE tool assessment, 63
 - global crisis, 23

SANE certification, 179, 215
 White House Task Force to
 Protect Students from Sexual
 Assault, NotAlone, 177–178, 214
 Sexual Assault Nurse Examiner
 (SANE) certification, 179, 215
 sexual orientation. *See* gender iden-
 tity/issues
 Society for the Advancement of Disas-
 ter Nursing, 186
 Society of Trauma Nurses, 3
 Solzhenitsyn, Aleksandr, 43
 stress. *See also* PTSD
 ISTSS, 188
 responses to, 6–7
 Stress in Health and Disease, 6
 The Structure of Scientific Revolu-
 tions, 198
 STS (secondary traumatic stress). *See*
 also secondary trauma; STSS
 definition of, 215
 nursing competencies, 127–129
 STSS, use of, 72–74
 STSS (Secondary Trauma Stress
 Scale), 72–74. *See also* secondary
 trauma; STS
 substance abuse
 ACEs, 64–65
 CDC/Kaiser Permanente ACE
 tool assessment, 64
 harmful self-medicating after
 trauma, 100
 by nurses, 126–127
 SAMHSA, 58
 resources, 186–187
 SUDs, 126–127
 Substance Abuse and Mental Health
 Services Administration. *See* SAM-
 HSA
 suicides
 ACEs, 64–65
 of nurses, 49–50
 PTSD, 18
 Sunrise Enabler, 159
 system-induced trauma. *See* treatment
 trauma

T

Task Force to Protect Students from
 Sexual Assault, 177–178, 214
 TCRN (Trauma Certified Registered
 Nurse), 3
 Ten Caritas Processes, 161
 theory of interpersonal relations,
 156–157, 216
 Theory of Reasoned Action, 141
 theory of transpersonal caring,
 160–161, 216
 three E's (Event, Experience, and Ef-
 fects) of trauma
 assessment of trauma, 58
 definitions of, 58, 216
 healing with three E's
 from acute trauma, 60–62
 from complex trauma, 59–60
 neurobiology of trauma, 4
 TIC (trauma-informed care)
 adherence issues, 140–141
 compassion/compassionate care,
 141–144
 in daily nursing care, 138–140
 definition of, 216
 Interpersonal Relations in Nurs-
 ing: A Conceptual Frame of
 Reference for Psychodynamic
 Nursing, 156
 interprofessional teams, 196–198
 interventions, trauma-specific,
 140
 Mental Health First Aid, 162, 213
 Psychological First Aid, 162–165,
 214
 Sunrise Enabler, 159
 theories
 of culture care diversity and
 universality, 158–159, 215
 of interpersonal relations,
 156–157, 216
 of transpersonal caring,
 160–161, 216

- Transcultural Nursing Society, 159
- versus trauma/trauma theories, 198
- trends, 198–200
- Times Up movement, 145
- Title IX of the Education Amendments of 1972, 177, 181, 216. *See also* White House Task Force to Protect Students from Sexual Assault NotAlone, 177–178, 214
- purpose of, 181
- toxic stress
 - definition of, 9–10, 216
 - public health crisis cause, 10–11
 - self-regulation of, 10–11
- Transcultural Nursing Society, 159
- transpersonal caring theory, 160–161, 216
- Trauma and Recovery, 2
- Trauma Certified Registered Nurse (TCRN), 3
- trauma effects
 - basics, 5–6
 - on body, 12–13
 - and learning, 13
 - on physical health, 13–14
 - potential sources of, 2–3
 - relationships with other traumas, 4
 - in today's society, 2–3, 201–203
 - types, 4, 20
- trauma-informed care. *See* TIC
- trauma-informed schools, 216
 - GLSEN, 182
 - LGBTQ, 182
- “Trauma in the Shadows,” 14–17
- trauma triggers
 - definition of, 216
 - intrusion symptoms, 70
- treatment trauma
 - for critical illnesses, cancer, 39–42 (*See also* acute trauma; chronic trauma; complex trauma; developmental trauma; historical trauma; secondary trauma; second-victim trauma)
 - definition of, 217
 - nurse/other-focused, 20

U

- United Nations Office for Disaster Risk Reduction: International Strategy for Disaster Reduction, 50–51
- US Department of Defense, National Trauma Research Repository, 188
- US Department of Education, FERPA, 180–181, 213
- US Department of HHS (Health and Human Services), SAMHSA Evidence-Based Practices Resource Center, 106
- National Child Traumatic Stress Network, 187
- resources, 106, 186–187
- trauma
 - assessment of, 58
 - definition of, 5
- US Department of Justice, Office on Violence Against Women guidelines, 178
- US Department of Labor, workplace violence, 46
- US Department of Veterans Affairs, National Center for PTSD, 187–188
- US Department of Veterans Affairs, PTSDpubs Database, 188

V

- vicarious trauma. *See* secondary trauma
- violence. *See also* workplace violence
 - ACEs, 64–65
 - assessment with CDC/Kaiser Permanente ACE tool, 64
 - domestic, 64–65
 - horizontal and lateral, definition of, 213
 - Sentinel Event 59: Physical and Verbal Violence Against Healthcare Workers, 46–47, 49

W

- Watson, Jean, theory of transpersonal caring, 160–161, 216
- Watson Caring Science Institute, 160
- ways of knowing, 154–155
 - case study, 146–152
 - definition of, 217, 245
 - emancipatory knowing, 151–152, 154
 - empirical knowing, 147, 153
 - esthetics/art of nursing, 148–149, 153
 - ethical knowing, 150–151, 153
 - Nurses on Board Coalition, 146
 - personal knowing, 149–150, 153
 - Times Up movement, 145
- Wheeler, Kathleen, 114
- “When a Patient Dies,” 165–167
- White House Task Force to Protect Students from Sexual Assault. *See also* Title IX of Education Amendments of 1972
 - NotAlone, 177–178, 214
 - sexuality and gender vulnerability, 183
- WHO (World Health Organization)
 - abuse, global crisis, 23
 - workplace safety, 130

- Wolters Kluwer information services, 3
- workplace violence. *See also* violence
 - definition of, 46, 217
 - NIOSH, prevention, 126
 - nurses as victims, 200
 - rationalizations for, 47–48
 - Sentinel Event 59: Physical and Verbal Violence Against Healthcare Workers, 46–47, 49
 - traumas
 - relationship to, 4
 - types of, 20