Trauma-informed leadership and posttraumatic growth

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T rauma-informed care as a framework used to care for patients through the lens of their exposure/experience of trauma is a familiar concept in healthcare settings. Trauma-informed concepts can also be applied to leading and supporting healthcare teams through and beyond the COVID-19 pandemic. Trauma-informed leaders understand that the pandemic has resulted in collective and individual trauma experiences. The traumatic loss of control over so many aspects of what was "normal" in life has been particularly difficult to integrate. Mark Goulston and Diana Hendel describe the impact clearly: "Besides having to process the speed and intensity with which 'normal' life has been altered—and in many cases dealing with grief and worry over loved ones who've been infected with this novel coronavirus—healthcare professionals have faced incredible hardship in their work. They've seen and done things that have scarred them for life. In many ways their working environment became a war zone almost overnight."[1] Trauma-informed leadership was called for at the height of the crisis and will be even more essential as the acute crisis subsides and healthcare workers cope with the long-term effects of their traumatic experiences.

Trauma-informed leaders recognize that people, including themselves, will struggle due to current

and past traumatic experiences and they respond with compassion and empathy. They understand the importance of presence for themselves and their teams to facilitate coping and growth, and they recognize the need for their teams to feel heard, protected, prepared, and seen by organizational leaders. The process of posttraumatic growth is facilitated by leaders who are present, understand trauma and trauma responses, and can listen to and support individuals and teams by meeting them exactly where they are. Four relational practices—attuning, wondering, following,

begin with the simple question, "What's on your mind about nursing?" based on Marie Manthey's Nursing Salon.[2] In this article, we share what we've learned from listening to the experiences of more than 100 healthcare leaders from the beginning months of the pandemic to our current state.

Four needs
During our discussions, four needs emerged: the need to strengthen leaders' ability to consistently support their teams, the need to focus on self-care as fundamental to leading and support-

and risk to themselves and their families. Some described exhaustion and loss of passion for their work. Experiences ranged from teams feeling more connected and collaborative due to their work together through the pandemic to others feeling detachment, irritability, and tension within team relationships. Finally, some described ongoing grief and loss, both personal and professional.

The polarization associated with political differences, resistance to public measures, and even debate in communities over whether COVID-19 is "real" has exacerbated feelings of emotional
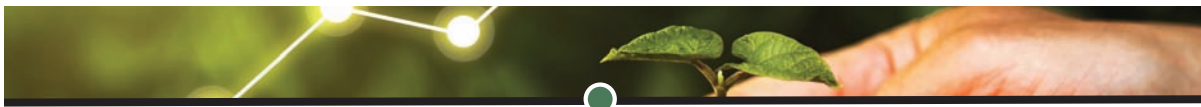
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and holding—provide a mental model for intentional and consistent presence. These skills can be learned and serve as a primary means of interaction and support. Trauma-informed leaders also understand that to support others, they must prioritize their own self-care, which requires commitment and practice.

We've listened to leaders at the department and executive levels though a virtual program we offer called "Trauma-Informed Leadership." We've also listened in virtual calls and roundtable discussions, as well as complimentary nursing salons with leaders from a variety of settings, including academic and service settings. These conversations are open-ended and often

ing others, the need to cultivate peer support for leaders, and the need to identify and leverage strengths to lead forward and support growth and healing.

Leaders identified their most important priority as supporting their teams so frontline staff members can manage and heal from the trauma of the pandemic and reconnect with the joy and meaning of their work. The leaders described a spectrum of individual responses from their teams. Some staff members expressed pride in getting through such a difficult time. Others expressed disappointment and mistrust, especially related to the early months in which personal protective equipment (PPE) was scarce and they felt the fear of exposure

overwhelm, uncertainty, exhaustion, and grief. Symptoms of burnout and moral distress were a concern before the pandemic; however, leaders described symptoms as being more acute and troubling now. They noted a high potential for widespread depression, substance abuse, burnout, and/or posttraumatic stress disorder (PTSD), and reported that their leadership time has been consumed with problem solving and operational issues while also striving to be present and supportive of their teams. They indicated a great need for ongoing emotional support and organizational actions to facilitate healing and growth.

Practicing self-care is one of the most challenging areas for

leaders who've experienced prolonged periods of hyperresponsibility and described feeling guilty if they take time for their own health and needs because, as one leader put it, "everyone is working so hard and stretching themselves constantly." The uncertainty and overwhelming nature of the pandemic and the complex needs of their teams and patients/families mean that there's never enough time, energy, staff, resources, and so on, and prioritizing and addressing their own needs can seem unrealistic. Some leaders expressed worry about the residual effect of this time of chronic uncertainty and emotional overwhelm. Some reported feeling a loss of passion for their work, others noted ongoing concerns for the impact on their families, and many admitted to struggling with times of physical and emotional exhaustion.

Although peer support programs for staff were put into place in some organizations before and during COVID-19, such formalized support for leaders is uncommon. Some leaders reported they never even questioned that they, and their colleagues, would simply "soldier on." Peer support programs for leaders are a highly effective way to promote and enculturate self-care and provide support essential for leaders to be present and compassionate with themselves and their teams. Leaders who participated in virtual facilitated conversational sessions with their peers about the challenges of the pandemic and their struggles and successes reported that this time together was supportive, informative, and helped them cope and lead with greater ease through the difficult times. One leader remarked, "As we were preparing for and going through the surges, we were so busy we didn't identify that we as leaders were also going through traumatic events. We knew staff were, and we were focused on supporting them, but we didn't really think about ourselves. I and many of my colleagues feel depleted and we've found strength in supporting each other in these sessions."

A significant concern for leaders was that they and their teams were unprepared for this extreme and overwhelming situation and needed to learn on the fly. As they reflected on where they are today as compared with the early stages of the pandemic, they expressed pride in their accomplishments. Their extraordinary ability to adapt and lead through this collective trauma is a source of strength they'll carry forward. They identified professional growth and flexibility during the biggest professional challenge of their collective careers, and they would like a systematic way to leverage this growth and use these strengths for moving into the future.

Why trauma-informed approaches?
Defining a traumatic event varies based on individual factors. Ten people can each experience the same event and each of them will have a different response. Our responses to difficult or challenging events are influenced by multiple factors, including genetics, historical factors, and internal and external resources. For this reason, one person's trauma is another's "bump in the road" and depending on the response, this event may change a person's life trajectory—or not. An individual's response to trauma should be considered normative. Trauma responses occur on a continuum. First on this continuum is a natural recovery process. Humans are wired for recovery from traumatic experiences both physically and emotionally.

A reaction to a traumatic event often begins with an acute stress reaction, which may look like PTSD. Symptoms include hyperarousal; avoidance of reminders of the event; and reexperiencing the event through thoughts, emotions, and images. These reactions are the way our nervous system responds to a "shock to the system." For many individuals, this response lasts for a month or so, depending on the factors mentioned earlier, and then the system returns to baseline and symptoms resolve.

When the natural recovery process is interrupted and symptoms last for longer than 30 days, an individual is considered to meet criteria for PTSD. There are times when PTSD becomes chronic and requires professional help to continue through the recovery process. Complex PTSD (C-PTSD) falls on the more severe end of the continuum. This is a newer category of trauma reactions, not yet considered an official DSM-V diagnosis; however, emergent research suggests that C-PTSD will likely become part of the trauma disorders in the next DSM.

As the name suggests, C-PTSD is a more complex trauma response, and the complexity of this response is likely accounted for by previous exposure to

trauma earlier in life. Early exposure to trauma, neglect, or abuse creates conditions for increased vulnerability to subsequent trauma and more complex traumatic responses. There's considerable symptom overlap between PTSD and C-PTSD, namely the symptom clusters of hyperarousal, avoidance, and reexperiencing. Those with C-PTSD also experience pervasive, less acute symptom clusters that include a negative sense of self/identity, interpersonal difficulties, and difficulty regulating emotions. These symptom clusters are associated with the neurologic and

responding with compassion and support.

Identifying and responding to sources of anxiety
In the early months of COVID-19 and its surge in New York City, a research team from Stanford University School of Medicine and Mount Sinai's Icahn School of Medicine held informal meetings with 69 clinicians (physicians, nurses, advanced practice clinicians, residents, and fellows). The team wanted to understand how COVID-19 was being experienced by clinicians and what key considerations should be in place to

The authors offer this additional important observation regarding the requests or needs expressed: "A final overarching request of healthcare workers—even if only implicitly recognized—is 'honor me.' The genuine expression of gratitude is powerful. It honors and thereby could serve to reinforce the compassion of healthcare workers who risk their lives to help patients infected with this deadly disease."[3] This research serves as a call for leaders to understand that leading through a traumatic event requires them to be emotionally present and accessible to
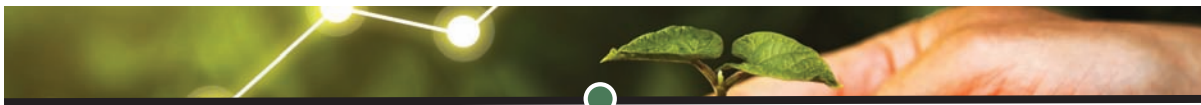
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behavioral adaptations made by the individual to survive an unsafe environment. Although useful during times of trauma, these adaptations are no longer useful in a safe environment.

We mention these responses to trauma because they're important and relevant for healthcare workers and first responders who are exposed to trauma through the course of their professions. Additionally, childhood abuse, neglect, or other trauma experienced before the pandemic may significantly affect an individual's ability to manage the ongoing trauma of COVID-19. Healthcare leaders can support frontline workers and each other by recognizing signs of a trauma response in team members and

support them through this traumatic event and beyond.[3] After holding listening sessions, they identified eight sources of anxiety, such as inadequate access to PPE, uncertainty that the organization will support personal/family needs, being deployed to new areas, and lack of access to information/transparency. In addition to tangible actions to address specific concerns, the participants in the listening sessions emphasized their desire for visible and present leadership.

Five requests or needs were identified:
• hear me
• protect me
• prepare me
• support me
• care for me.

hear, prepare, support, and care for their teams as they navigate and heal.

As we listened to leaders, their anxieties relative to the pandemic were similar to clinicians, and also unique. Their priority request to their organizations can be expressed as follows: Support me and hear me as I tell you about the needs, challenges, and readiness (or lack thereof) of my team to recover and adapt to the "new normal" as the pandemic subsides. I worry as much, if not more, for their well-being as the crisis subsides and they have more space to remember and deal with all they've given and witnessed over this time of emotional overwhelm, fear, loss, and uncertainty. Be with me in under-

standing the toll this has taken on our team and lead the way in conveying honor and gratitude for their extraordinary dedication and work. Be with me in supporting their healing and growth.

Relational framework for self-care and team support

Supporting their teams requires trauma-informed leaders to prioritize their own self-care, making regular time for reflection and slowing down. This is the practice of getting to know yourself and your own needs, which may take the form of engaging in regular meditation, practicing self-compassion, journaling, attending an ongoing peer support group, or participating in individual therapy. The goal is to connect with yourself to connect with others more fully. Connection requires awareness, focused attention, genuine interest, and moments of stillness.

The four practices of attuning, wondering, following, and holding can support instant connection, compassionate presence, active listening, and creative actions.[4] The purpose of deconstructing these practices and giving them language and definitions is to take the mystery out of what constitutes supportive presence and caring interactions. (See *Four relational practices.*)

Attuning—the action of being present in the moment—is the doorway to human connection, shutting out distractions and giving your focused attention to yourself and the person in front of you. When we tune in, we notice things about ourselves and about the other person.

Wondering is a practice of curiosity and genuine interest in

Four relational practices[4]

Practice	Meaning	Language
Attuning	• Practice of human connection • Shutting out distractions, focusing attention, and listening • Being present • Noticing	• Thank you for coming to me… • I feel honored that you would share… • It makes sense you would feel….
Wondering	• Practice of curiosity and genuine interest • Suspending judgment and assumptions • Noticing • Listening	• How are you…really? • What worries you? • What's most important to you? • What do you need?
Following	• Practice of quiet listening • Staying with what we hear and notice • Being in the moment • Allowing expression of emotions	• Tell me more about… • Do I have this right? • What's most important to you right now?
Holding	• Practice of creating a safe space • Doing what we said we would do • Remembering what we've been told • Taking the right action • Listening without defense • Honoring boundaries	• I remember when you told me… • I'll follow through and make sure… • Thank you for being open and vulnerable with me… • I'm here.

what's happening in yourself and others. Wondering is asking: "How are you…really? What do you need?" Wondering prevents us from reaching premature conclusions, assumptions, or judgments.

Following is the practice of quiet listening and staying with what we hear or notice. It's being led in the moment, allowing others or yourself to have emotions, and respecting and acknowledging them.

Holding is creating a safe space in which a person experiences feeling heard and seen. We hold when we do what we said we would do. We hold when we help resolve an issue or concern. We hold when we listen without defense or retort. We hold when we honor boundaries—our own and others.

When we teach these practices, the feedback we receive is that "they put the 'how' in empathy" and when put into action, they result in people feeling heard, seen, supported, and valued. "Being there" is a small action with huge significance. The act of being there supports the leader's well-being and is fundamental to supporting the well-being of their team. The leaders who've spoken with us noted a significant shift in mindset from problem solving, explaining, filling in the blanks, and moving on to the next item on the checklist.

These relational skills require a different way of relating. They involve slowing down, avoiding jumping in with answers or solutions, and putting aside the hamster wheel of tasks. Listen, be

curious, and be willing to look underneath the content of the conversation to discover what the underlying need is of the person in front of you.

The posttraumatic growth process
It's said that every cloud has a silver lining. We can all look back at some of the most difficult times in our lives and, with the perspective of time, identify how those difficult times produced some positive outcomes for us. This isn't to say that difficult times aren't difficult, they are. But with adversity, there's an opportunity for growth.

Resilience is important and quite useful in the throes, and aftermath, of adversity. However, posttraumatic growth isn't discussed as often as resilience. Although the two share characteristics, they're also different. The biggest difference has to do with outcome. Resilience allows us to weather the storm well and return to our baseline functioning. If we're resilient, we can adapt to changing conditions and face our difficult challenge successfully. Posttraumatic growth is a process, and the outcome of this process is positive change in five different domains of life: opportunity, relationships with others, personal strength, greater appreciate of life, and change in belief system of life.

When we experience posttraumatic growth, we're irrevocably changed. The traumatic experience is no less traumatic, and we may still experience distress or pain from what happened. At the same time, we can experience greater meaning and purpose in our lives not in spite of but because of the traumatic event.[5]

Talking about what happened may facilitate cognitive processing, which can lead to shifts in our belief system and life narrative by integrating and interpreting the meaning of the traumatic event and our reaction/response to the event and its aftermath. When cognitive processing is accompanied by self-disclosure (with another person, group, or in written form) in the presence of social support, pretrauma beliefs can be challenged, and cognitive processing can then facilitate posttraumatic growth.[6]

Trauma-informed leaders cultivate the conditions for posttraumatic growth through their compassionate presence, understanding of trauma responses, and ability to attune to and hold themselves and team members who are experiencing emotional struggles or distress. They're also able to guide their teams forward using the following questions to promote open conversations:[5]
• What seemed difficult before the trauma that now seems relatively easy for you, given what you've gone through?
• What advice might you have for others who think that a situation similar to yours is too difficult to manage?
• What have you noticed that you're grateful for or appreciate about yourself and your life since this traumatic experience?
• What positive changes have you noticed in your organization that you want to build on?

Be present
Trauma-informed leaders appreciate that emotional responses are triggered in the workplace and individuals respond based on the emotional scars and

trauma in their history. Strive to respond with compassion and empathy, creating an environment of safety and acknowledging and respecting the human capacity to cope, heal, find meaning, and grow. Advocate to diminish any stigma associated with expressing emotional distress and the need for support, including mental health support. Show up as present and emotionally accessible. Lastly, model and inspire self-care as foundational for caring for others. **NM**

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