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Trauma and Resilience among Direct Care Workers in Nursing Homes: Coping Through COVID-19

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Trauma and Resilience among Direct Care Workers in Nursing Homes: Coping Through COVID-19

by

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ABSTRACT

Direct care workers (DCWs) face persistent challenges with low pay, few benefits, heavy workloads, and limited access to paid leave. COVID-19 have increased the precarity of the long-term care system and has left many direct care workers more vulnerable. With layered risks of systemic racism, COVID-related risks, and political turmoil on top of socio-economic challenges, direct care workers, older adults, and those with disabilities experience high risks to health and well-being. Using the socio-ecological framework, the aim of this exploratory study was two-fold; (1) examine DCWs understanding of trauma and how it affects their ability to provide care, and (2) understand the strategies and supports DCWs and organizations use to cope with trauma. Using semi-structured interviews with 25 certified nursing assistants, the findings demonstrate the impact of COVID-19, work stress, and systemic inefficiencies that negatively impact care work and examined strategies to support resilience-building and ultimately empowerment practices.

INDEX WORDS: Trauma, Resilience, Direct care workers, Nursing Homes, Long-Term Care

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DEDICATION

I humbly dedicate this work to the Lord Almighty for his Faithfulness and Mercies towards me throughout my life and my studies.

I also dedicate this work to the two most important people in my life, Rev. Kwaku Owusu-Boachie, and Mr. Stephen Boakye for their Immeasurable Love, Support and Encouragement throughout my life and education. I say, May the Good Lord continually bless and keep them.

This work is dedicated to the Gerontology Institute at Georgia State University, residents in Georgia nursing homes, and older adults across the world.

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LIST OF ABBREVIATIONS

DCWs	Direct Care Workers
CNA	Certified Nurse Assistant/Aide
LTC	Long-Term Care
LTSS	Long-Term Care Services and Support
SAMHSA	Substance Abuse and Mental Health Services Administration

1 INTRODUCTION

The U.S. population is aging rapidly, and nearly half of those over 65 will require long-term care to meet their needs (Johnson, 2019). Direct care workers provide daily support to several million older adults and people with disabilities. However, these direct care workers face challenges that force them out of long-term care. Residents also face adverse health, well-being, and overall quality of life outcomes due to unmet needs (Kaye et al., 2010). The COVID-19 pandemic has only increased the precarity of the long-term care system and the direct care workforce. Increased workload, risk of infection, shifting tasks and responsibilities, and few incentives challenge direct care workers providing care. Several reports indicate how direct care workers had to strive to provide care amid inadequate access to relevant training, limited paid sick leave, a lack of Personal Protective Equipment (PPEs), and limited forms of support (Lyons, 2020). This has left many direct care workers more vulnerable. Systemic racism and political turmoil have contributed to fragmenting the healthcare system. Direct care workers experience high rates of burnout, anxiety disorders, depression, reduced quality of life as well as post-traumatic stress disorders (Wu et al., 2009; Koh et al., 2005; Maunder et al., 2003; McAlonan et al., 2007; Son et al., 2019).

Addressing challenges among direct-care workers in LTC settings requires solutions on how employees can stay focused and become psychologically stable in the face of adverse or traumatic events (Shatte, 2012; Kwok et al., 2014). More than ever, employers are seeking information on how to build resilient organizations to achieve competitive advantage (Meadows et al., 2015; Meredith et al., 2016). More scholarship is needed to bridge the paucity of research on trauma and resilience among direct care workers. Building resilience among direct care workers requires understanding their ability to develop protective buffers to manage demanding work

situations in long-term care settings. This information is critical to enable long-term care employers to support resilience-building and ultimately empowerment practices.

2 LITERATURE REVIEW

2.1 Impact of COVID, Political Turmoil, and Systemic Racism

The emergence of COVID-19 sparked intense innovation and strategy by world leaders on how to contain the virus. Despite interventions such as wearing masks, social distancing, sheltering in place, and lockdowns to suppress the spread of COVID-19 (Garcia et al., 2021; Dugarova, 2020), it continues to spread globally. Significant trauma, loss, and hardship has occurred for older adults, typically those in the healthcare system (Liu & Modir, 2020). The multisystemic impact of the pandemic has brought to light the weaknesses in healthcare, political, economic, and social systems, and the critical role of care (Wenham et al., 2020). The United States (U.S.) led the world in the number of confirmed COVID-19 cases making it the epicenter of the novel coronavirus disease (Dong et al., 2020). Reported cases rose exponentially since the first detection in the state of Washington (Holshue et al., 2020). The emergence of COVID-19 impacted older adults and long-term care staff, evidenced by the high rates of hospitalization, morbidity, and mortality (e.g., Bialek et al., 2020; Garg et al., 2020; CDC, 2020a; Millet et al., 2020; Rodriguez-Diaz et al., 2020; Stafford, Hoyer, & Morrison, 2020; Wolf, 2020).

Black and Latinx communities made up about 33% of the total COVID deaths in the United States (U.S.) (Strafford, Hoyer, & Morrison, 2020; Wolf, 2020). Racial health disparities for Black, Indigenous, and People of Color are significant and enduring (BIPOC) (CDC, 2019; Liu & Modir, 2020). Discrimination creates chronic stress among those who experience it. This can lead to mental health problems such as depression, anxiety, substance use, and abuse (Pascoe & Richman, 2009). According to Williams, Lawrence, and Davis (2019), racism operates on three levels: individual, cultural, and structural. Individual racism is when one perceives implicit and explicit beliefs about being inferior to other people from specific racial/ethnic backgrounds (Neblett Jr.,

2019). Cultural racism is when assumptions of inferiority of a particular group are infused into cultural practices such as imagery, symbols, and language (William et al., 2019). Structural racism emanates from the policies, laws, and practices within societies and institutions that either covertly or overtly discriminate, neglect, disadvantage, or oppress a particular race or ethnicity (Williams et al., 2019). An example of structural racism is seen in the healthcare systems where most direct care workers, typically people of color, were unable stay safe through the pandemic (Liu & Modir, 2020). Structural racism contributes to the health disparities of racial/ethnic minorities, and these experiences have traumatic impacts (Williams et al., 2019). Women make up about 96 million or 70.4 percent of the total health workforce, yet they face the highest wage discrimination, persistent hierarchical structures and gender stereotypes (WHO, 2019). Extant studies have indicated that multi-generational households, low socio-economic status, and disproportionate employment with high exposure risks account for the alarming COVID-19 infection rates and death among racial/ethnic minorities (Gross et al., 2020; Razaq et al., 2020).

Brown (2008) makes a profound assertion on how African Americans, over the past decades, have built resilience in the face of many challenges. She indicates that "African Americans, compared to their White counterparts, are more likely to face poverty, live in violent neighborhoods, have fewer financial resources, and have higher mortality rates from the disease." She then adds, "Yet, while African Americans are at risk for poor developmental outcomes, there are many who can overcome the negative consequences of their environments and experience a healthy quality of life" (p. 32 – 33). This emphasizes the importance of protective factors and subsequent resilience and how they intersect with race, ethnicity, and social stratification.

2.2 Trauma

Trauma has been defined in different ways depending on its impact on the individual, family, community, and society (van der Kolk, 2014). According to the American Psychiatric Association (2013), trauma refers to experiencing events that can threaten serious injury or death. The definition of trauma has consistently included the following criteria: (1) an identified event or series of events, (2) experienced by the individual as physically or emotionally harmful, overwhelming, or threatening, which (3) has holistic and lasting effects on the individuals' functioning (Ringel & Bradell, 2012; SAMHSA, 2012; van der Kolk, 2014).

Trauma has become widespread and a public health problem (SAMHSA, 2014). Trauma has no boundaries; it can affect anyone irrespective of gender, age, race, ethnicity, sexual orientation, socio-economic status or even geography while social groups, due to differing life circumstances, have different risks of experiencing trauma (Kilpatrick et al., 2013). The call for addressing the issues surrounding trauma is an important step toward building an effective and efficient behavioral health service delivery system (SAMHSA, 2014). However, there has been efforts at the local, state, and national levels to make systems and processes within the health system more "trauma-informed" (Lang, Campbell, & Vanerploeg, 2015). This is evident in the growing amount of research and knowledge on the prevalence of trauma, its consequences, and associated costs (Maynard et al., 2019).

Traumatic experiences also affect one's performance, satisfaction, health, and wellbeing (Maunder, Peladeau, Savage, & Lancee, 2010; Kusmaul & Waldrop, 2015). Potentially, 70-100% of direct care workers have been exposed to traumatic events and especially those working in the inner-city environments (Kusmaul & Waldrop, 2015). These traumatic experiences are specific to the nature of work in the healthcare setting. Such include but are not limited to self-injury (79%),

constant screaming (86%), smearing feces (79%), physical violence (82%), physically resisting care (79%) and even aggression (Hilton et al., 2021, 2020; Rodrigues et al., 2020).

2.3 Individual to Collective Trauma Framework

Trauma can best be understood when evaluated using a much wider lens. The impact of trauma makes ripples. A traumatic event affects an individual but goes a long way to affecting their immediate environment. Context plays a critical role and expands the focus beyond an individual perspective to a broader system that recognizes interactions between communities, cultures, governments, social interactions, and how these factors influence each other. A broader lens means integrating the biopsychosocial, community, interpersonal and societal variables (SAMHSA, 2014).

Trauma can be devastating for not only individuals but groups of people within the individual's surroundings. Trauma affects the whole society and how they perceive the world around them. It takes meaning-making to be able to reconcile the impact of trauma. When trauma moves from an individual level to a collective one, its negative consequences injure the very fabric of society (Somansundaram, 2014). At this level, trauma is not an individual psychological phenomenon but a collective one (Anderson, 2004). Networks, social processes, institutions, functions, practices, resources, and relationships that make up the entire community are traumatized. Collective trauma is the psychological reaction from a group responding to a traumatic event and can affect the entire society. The pervasiveness of the COVID-19 pandemic has spurred collective trauma both through widespread impact and ripples from vulnerable individuals who experience disproportionate impact which impact their social networks. While individual trauma poses psychological distress to a person, collective trauma incites collective fear,

identity crises, feelings of vulnerability, and heightened levels of new threats on a group of people (Somansundaram, 2014; Saul, 2014; Burkle, 2011, Anderson, 2004).

According to the Centers for Disease Control and Prevention (2009), Bronfenbrenner's (1979) and Bronfenbrenner and Ceci's (1994) socio-ecological framework helps to understand trauma and trauma prevention strategies. The socio-ecological model is appropriate for this study as it directs us to examine the effects of trauma on the interpersonal relationships between individuals and their environments. These environments can be specific – such as a particular nursing home or type of long-term care setting or the larger community within which individuals reside. These relationships between individuals and environments can be places where risks abound or where protective factors buffer the impacts. The socio-ecological model captures the components within the microsystem closest to the individual. It further explains the bi-directional relationship between the other components (Pointer, 2015; Ali et al., 2013). Specific characteristics of the trauma, length of exposure, available resources, and community reactions determine how an individual will respond to trauma across time.

The direct care workers, residents, and residents' families in long-term care are all interconnected within a system. The health of one has a rippling effect and can affect the others. When direct care workers go through traumatic events at work, it has a negative impact on their physical, psychological, and emotional wellbeing. This affects the level of care they provide for residents. These direct care workers also translate whatever effects emanating from the traumatic experiences to their families thereby impacting family relationships. The family belongs to a broader community, and this naturally translates to how they interact with other families and individuals within societies. The socio-ecological model sets the context for explaining how all

the individual systems are connected to much broader systems and how the impact on one affects the other parts of the system.

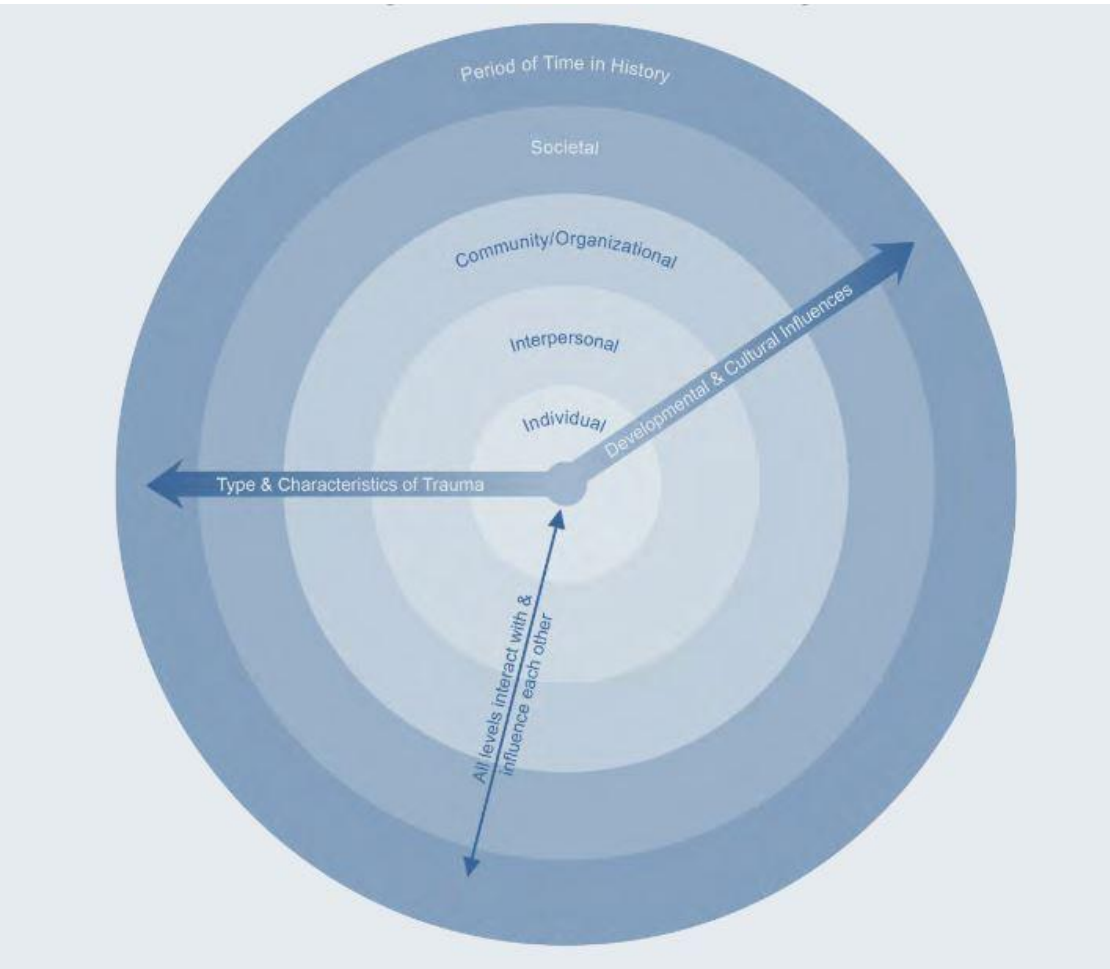

Figure 2.1: A Socio-Ecological Model for Understanding Individual to Collective Trauma

Note. The image was created to better understand individual and collective trauma and how it impacts the various aspects of the socio-ecological framework. From Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). *SAMHSA's Concept of Trauma and*

Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration.

2.4 Trauma and Organizations

Many organizations are composed of several units with different people performing different tasks to ensure overall productivity in terms of delivery of goods or services. Existing research has tried to explore organizational trauma and its influence on the overall performance of employees and organizational productivity (Venugopal, 2016). Many organizations, if not all, are being affected by trauma in one way or the other (Hopper, 2012, p. 35; Valikangas et al., 2009, Hormann, 2007, p. 1; de Klerk, 2007, p. 49; Khan, 2003, p. 364) and this calls for more scholarship on how trauma impacts these organizations (Hales et al., 2019). Organizations act like "living humans where their existence is expressed through the hearts, minds, and hands of its employees, members, and volunteers" (Vivian & Hormann, 2002. p. 37). Whether short or long-term, trauma can be debilitating to an organization, and its impact can affect other aspects of the firm. Organizations are traumatized by how ineffective they respond to their workers emotional and psychological needs (Khan, 2003). Workload or complexity of jobs, downsizing, poor role definition, relationships, poorly structured career development plans, organizational culture, and ethical conflicts can cause organizations to be traumatized (Venugopal, 2016).

Generally, implementing a trauma-informed approach within organizations has shown some benefits, such as increased staff satisfaction (Hales et al., 2019), and helped to reduce turnover. Resilient workers are highly confident, find their jobs more satisfying and rewarding, and believe in their organization’s values (Elliot et al., 2015). Dysfunctional long-term care settings can re-create traumatic experiences among direct care workers due to a lack of structure and the influence of perpetrators (Pross & Schweitzer, 2010). Implementing trauma-informed

approaches is challenging due to the absence of evidence-based studies on how it impacts direct care workers and the organization. Addressing the intrinsic needs of direct care workers through interventions to promote resilience cannot make up for organizational changes; however, it has the potential to go a long way to address workplace issues that other means cannot.

Trauma-informed approaches within organizations and healthcare systems are limited (Reaves, 2015). Trauma-informed approaches creates a need for evidence-based approaches to supporting direct care workers' physical, mental, and psychological needs as more essential (Amateau, Gendron, & Rhodes, 2022). Overall, the goal is to prevent re-traumatization (Institute on Trauma and Trauma-Informed Care, 2015) among direct care workers by developing a framework to respond to trauma through their own experiences. Organizational self-care through the creation of healthy work environments that promote support, communication, and training, for example, could improve individual self-care. An organizational culture that is sensitive to and recognizes the impact of trauma on the health of its workers and consumers can develop a framework that responds to trauma issues through a more person-centered approach. Such organizations can draw knowledge on their strengths, patterns, and resources to assess and strategize how to handle trauma. The result is a safer, normalized experience that gives way to an open system for new energy, optimism, confidence, and, ultimately, to set priorities to move forward at work (Vivian & Hormann, 2013).

2.5 Trauma and Direct Care Workers

With the expected number of older adults turning 65 doubling by 2030, how to create and sustain the direct care workforce has become a central question (Institute of Medicine, 2008). This demographic change forces long-term care consumers to recruit additional workers due to the

increasingly destabilized and continued decline in the real wages of the caregiving workforce (Dawson, 2016). The Direct Care Workforce (DCW), also known as part of the essential workforce, constitutes home health aides, personal care aides, and nursing assistants who, according to the Bureau of Labor Statistics occupational classification system, provide "assistance with activities of daily living and instrumental activities of daily living to older adults and people with disabilities across diverse settings" (Scales, 2020). The direct care workforce includes nearly 4.6 million workers, with about 735,000 direct care workers in residential facilities, 2.4 million home care workers, and 566,000 nursing assistants in nursing homes across the United States (PHI, 2020). Soon, the direct care workforce will have to add 7 million jobs with uncertainties in retention. There has been a severe shortage in long-term care settings due to the high worker demand and turnover. The Wisconsin Center for Assisted Living has estimated a 25% vacancy rate, with 1 in 3 providers limiting their services (Wisconsin Health Care Association/ Wisconsin Center for Assisted Living et al., 2020; Scales, 2020).

The direct care workforce is predominantly female, making up about 87% of the total DCW workforce in the United States. People of color make up about 59%; 53% have a high school education, and 27% are immigrants (PHI, 2021). Several inequalities persist within this essential workforce, with people of color earning lower than their white counterparts, experiencing strain and burnout, and living in poverty and under-resourced settings (Palmer & Eveline, 2012; Osterman, 2017; Scales, 2020; Shippee et al., 2020). According to PHI (2021), the median wage for direct care workers stands at $13.56 per hour, and median earnings at $20,200 per year. This median wage has seen a meager increase adjusted to inflation over the past decade. Moreover, 32% of these direct care workers struggle to maintain affordable housing, with 17% lacking health insurance. The direct care workforce is gendered and racialized; typically, it is staffed with women

of color, and immigrants who live below the poverty line (Duffy, 2007; Ehrenreich & Hochschild, 2002).

Direct care work is one of the most physically demanding jobs leading to high rates of injury (Khatutsky et al., 2012; Quinn et al., 2017; Walton & Rogers, 2017) and requires both emotional and relational skills to thrive (Duffy et al., 2015). Heavy workloads, inadequate supervision, limited training, career advancement opportunities, and scheduling care work are a few of the glaring challenges direct care workers face. Increased turnover rates and employee dissatisfaction has undermined the quality of care (Stone et al., 2017; Franzosa et al., 2019; Castle et al., 2020; Temkin-Greener & Cen, 2020). The direct care role has become somewhat more complex and this increased complexity is attributed to an increase in consumer acuity (Harris-Kojetin et al., 2019; Scales, 2020). Direct care workers have identified the lack of support, feelings of unpreparedness, and little to no support from their emotionally stressed co-workers (Anderson & Gaugler, 2007; Franzosa, Tsui, & Baron, 2019). Direct care workers need to live and maintain their functional abilities while maintaining their health and well-being (Scales, 2021). The persistent challenges facing this workforce systematically make maintaining health and well-being very difficult.

Generally, nursing is a compassionate yet stressful profession where nurses provide physical, mental, emotional, and spiritual support to patients (Zhang et al., 2018; Ariapooran, 2014; Lombardo & Eyre, 2011). Nurses often choose this career path because of their desire to help others (e.g., Wu et al., 2015), which exposes them to different interactions with people they care for (Bilici et al., 2016). According to Liu et al. (2019), one out of four nurses have reported exposure to aggression at work. Certified nursing assistants (CNAs) are critical in healthcare, especially nursing homes. However, they face repeated exposure to traumatic experiences which

are not limited to just suffering, severe illness, and even death of patients whom they have developed a close relationship with over time (Reinhardt et al., 2022; Cagle, Unroe, Bunting, et al., 2017; Barooah et al., 2015). CNAs face poor working conditions, such as physically and emotionally demanding workloads and lack of career development, and this affects their health and well-being (Austin et al., 2009) coupled with less training, under compensation and the undervalued status of their profession in the healthcare setting (Bowers et al., 2003). Due to this, there are continuous challenges with retaining CNAs in long-term care facilities (Dill et al., 2013; Sterns & D'arcy, 2008). Extant literature has established that CNAs, due to their caregiving roles, often have significant health issues. Self-care skills, which can be developed because of the CNA's ability to be resilient, are beneficial (DePasquale et al., 2016; Dreher et al., 2019). Systems can be instituted to support CNAs in handling trauma, grief, loss, and resident deaths in addition to addressing other aspects of job quality.

The glaring social-based discrimination in long-term care facilities has made it difficult for CNAs to recognize who they are and look beyond their profession (Hoeve, Jansen, & Roodbol, 2014). More than 50% of racial/ethnic minorities and foreign-born (about 90% female) are mostly found working in nursing homes or other long-term care facilities (Squillace et al., 2009; Travers et al., 2020). Direct care workers are prone to racial discrimination within the healthcare services sector (Tak et al., 2010; Smith et al., 2007). Similar to other direct care workers in different long-term care settings, CNAs have been victims of racial epithets from residents, residents' families, and even colleagues (Ramirez, Teresi, & Holmes, 2006; Ryosho, 2011; Ejaz, Rentsch, Noelker, & Castor-Binkley, 2011). The 17.4% of CNAs who are immigrants are generally recruited from Africa, Haiti, Latin America, the Philippines, the Caribbean, and Asia to fill the significant gaps in the direct care workforce and are three times more likely to report discrimination (Khatusky et

al., 2010; Shaw, 2017). According to a study by PHI (2017), one in three CNAs is Black/African American, representing 33%, compared to one in four home care workers representing 25%. Language-related communication barriers, job insecurity, and acculturation difficulties are common challenges immigrant CNAs face (Novek, 2013; Ryosho, 2011; Acker et al., 2015). On the contrary belief that direct care workers are unified, CNAs who are racial/ethnic minorities have experienced racial discrimination from their peers and other staff members (Parker & Geron, 2007; Travers et al., 2020) with little or no support to address the occurrences (Dodson & Zincavage, 2007; Holmberg et al., 2013).

2.6 Resilience

According to Cooper et al. (2020), resilience in long-term care is a "dynamic and complex process which, when present and sustained, enables nurses to adapt positively to workplace stressors, avoid psychological harm and continue to provide safe, high-quality patient care" (p. 567). Resilience is a relational process where individual, social, cultural, and environmental factors interplay (Liebenberg et al., 2015). Building a resilient direct care workforce can contribute immensely towards their recovery from events that are traumatic and can protect them from such adverse workplace outcomes (Hollywood & Philips, 2020). In the wake of the pandemic and predicted health worker shortages, healthcare workers, and healthcare systems need to be resilient.

Currently, limited research examines the impact of resilience on direct care workers (Johnson et al., 2020; Moorfield & Cope, 2020; Chmitorz et al., 2018). Interventions developed in intrinsically motivated long-term care facilities need to receive some attention. Supervisors at the organizational level who exhibit positive attitudes also help reduce employee stress (Cai et al., 2020; Khalid et al., 2016), increase self-efficacy, and improve overall well-being (Flesia et al.,

2020; Proches, 2020), and makes employees more resilient. According to Robertson et al. (2016), resilient employees have meaningful life perceptions and strong beliefs and are more flexible to adapt to change.

Over half a decade of research on resilience shows the critical role of protective factors to mitigate the impact of trauma (Amateau, Gendron, & Rhodes, 2022) despite poor health outcomes associated with high exposure to traumatic events. Protective factors such as care and support, tangible aid, advice, emotional support, information; racial socialization; religiosity, and spirituality are potent predictors of resilience, especially among the African American community. The protective factors buffer against the risk factors that impose on the health and well-being of direct care workers. According to Brown (2008), the most potent protective factors to bolster people's resilience are showing care and support to facilitate positive outcomes.

More evidence-based research continues to emerge to draw a strong relationship between resilience and problem-solving skills as a strategy against traumatic events and experiences (Rushton et al., 2015; Zhang et al., 2018). High resilience has been associated with reduced mortality risks and depression (Smith & Hollinger-Smith, 2015; Jeste et al., 2013; Bowling & Iliffe, 2011; Gooding, Hurst, Johnson, & Tarrier, 2012; Hildon et al., 2010; Martin, Distelberg, Palmer, & Jeste, 2015), better self-perceptions about life (Martin, Distelberg, Palmer, & Jeste, 2015; Jeste et al., 2013), improved lifestyle behaviors and increased quality of life (Smith & Hollinger-Smith, 2015; Jeste et al., 2013)

One critical intervention that can fuel resilience among direct care workers in long-term care facilities is the application of a trauma-informed approach developed by the Substance Abuse & Mental Health Services Administration (SAMHSA) in 2014. A trauma-informed approach, according to SAMHSA (2014), is one that "realizes the widespread impact of trauma and

understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; seeks to actively resist re-traumatization of both persons served and staff" (p.9).

The approach follows the principles of safety; trustworthiness and transparency, peer support; collaboration and mutuality; empowerment, voice, and choice, and cultural, historical, and gender issues (Fallot & Harris, 2009; SAMHSA, 2014). Prioritizing the principles of trauma-informed care in long-term care facilities has lagged considerably (Kussmaul & Anderson, 2018), especially among direct care workers. Utilizing trauma-informed approaches with a specific focus on building resilience is foundational to building a support system for direct care workers.

There is a paucity of research on resilience, with no investigation on resilience and how it plays out in long-term care settings (Lin et al., 2021). There is also a gap in the literature on the relationship between trauma and resilience among direct care workers. More complex care, relationships, and increasing demand to provide care in long-term care settings call for and make a case for resilience research.

2.7 Resilience and Coping

Most people experience traumatic events at some point in their lives (Ozer, Best, Lipsey, & Weiss, 2008). Some will be able to avoid the consequences of the traumatic events, while others will remain challenged by it. Responses to a traumatic situations or events are not the same across individuals. Resilience is one's ability to have a stable balance and not the absence of psychopathology. On the other hand, coping is one's ability to combine cognitive and behavioral efforts to manage stress or stress-related events. Resilience and coping are related but cannot be

used interchangeably (Glennie, 2010). To Glennie (2010), coping requires a skillset and purposeful responses to stressful events, while resilience results from successfully applying those skills. Despite the controversies on what precisely resilience is, researchers have tried to present resilience in different dimensions. Resilience is an interactive phenomenon that enables individuals to thrive despite severe adversity or trauma by maintaining high levels of stable physical and psychological functioning. Coping is a process, given the context or situation, and can change from time to time. Strategies for coping are neither good nor bad. One strategy can be ineffective in one situation but does not mean it will be in another situation and vice versa.

How and why resilience is developed is unknown (Trompetter, de Kleine, & Bohlmeijer, 2016). Yet, some researchers (e.g., Bernard, 1991) have concluded that protective factors such as individual personality dispositions and attributes, environmental support, family characteristics, and an optimal environment can fuel resilience in people. In essence, coping is the means to becoming resilient. To become resilient, the individual needs to build purposeful responses to build their skillset to manage traumatic events or experiences. Both resilience and coping are essential for overall well-being and quality of life among direct care workers and individuals who have faced or face traumatic situations or events. The environment contributes greatly to the ability to become resilient through multi-level attachments, either at the proximal or distal which includes family, organizations, community, society, and the nation. Within the organization, structural factors such as paid leave, training and development opportunities, and support from supervisors and co-workers can foster resilience among staff.

2.8 Purpose of the Study

This current study aims to fill the gaps in the existing literature on trauma and resilience among direct care workers in long-term care facilities. There is a paucity of knowledge on managing trauma among CNAs in healthcare settings. The study seeks to:

1. Understand and describe the CNAs' experiences of trauma during COVID-19.
2. Examine how traumatic experiences affect their ability to provide care.
3. Understand the strategies direct care workers use to cope with trauma.
4. Explore strategies organizations use to cope with trauma among direct care workers.

3 METHODS

3.1 Method Rationale and Research Strategy

The aim of the study was to understand trauma in nursing homes and how direct care workers can use coping to build resilience within the nursing home environment. The study adopted a qualitative exploratory research design underpinned by an interpretivist epistemology as a strategy to recount the lived experiences of direct care workers in long-term care facilities (Blanche, Durheim, & Painter, 2006; Moser & Korstjens, 2017; Rahman, 2017). Essentially, phenomenological approaches were adopted. According to Miles and Huberman (2013), adopting a qualitative research design provides detailed descriptions and explanations about the inner experiences of a population under study and how culture shapes this trajectory (Corbin & Strauss, 2008). This design is again ideal for this study because it uses an open-ended, descriptive, and non-directional approach through data-gathering techniques such as interviews, official documents, and observations (Creswell, 2003). In addition, qualitative researchers agree that this design inspires insights that can inform policy and practice on improving long-term care settings (Yau et al., 2021). Narrative approaches report individuals' experiences and describe the meanings they attach to those experiences through storytelling. It is most effective when the researcher focuses on studying an individual rather than a group or community. It also provides a broader and more profound reflection of trauma and resilience and how it plays out in long-term care facilities, builds knowledge in the resilience and trauma framework, and creates channels that empower caregivers to talk freely about their experiences (Frank, 2010; Smith, 2016; Whitley et al., 2022). A phenomenological approach to inquiry further strengthens the search for knowledge by studying and analyzing the lived experiences of direct-care workers in long-term care facilities. This powerful approach enables researchers to "live in the world" of participants and to draw

meaningful relationships between phenomena. Despite difficulties in data gathering, analysis and interpretations, this approach can contribute to theory development because data is collected over time in a more naturally occurring way.

In-depth semi-structured interviews were conducted to gather data on the experiences of direct care workers within the long-term care context (Mkum et al., 2021). According to Magaldi and Berler (2020), semi-structured interviews are exploratory. In essence, it enables researchers to dig deep into discovery despite its topical trajectories (Ruslin et al., 2022). Semi-structured interviews usually contain the main questions, follow-ups, and probes (Rubin & Rubin, 2005), following a framework of themes to be explored by the researcher (Ruslin et al., 2022). Through this technique, researchers can "enter into the other person's perspective" (Patton, 2002, p. 341) to develop "thick descriptions of a given social world, analyzed for cultural patterns and themes" (Warren, 2002, p. 85). In-depth semi-structured interviews go beyond retrieving information from participants (Mahat-Shamir, Neimeyer, & Pitch-Prelorentzos, 2019) but are seen as conversational practices to understand the meanings interviewees associate with their experiences (Mahama & Khalifa, 2017). Researchers describe this data collection approach as the primary method used in qualitative research (Doody & Noonan, 2013; Oltmann, 2016). Its flexible nature to include topics outside the interview guide makes it ideal for a qualitative study (Yau et al., 2021; Power, Campbell, Kilcoyne, Kitchener, & Waterman, 2010). In addressing sensitive topics such as trauma, in-depth semi-structured interviews are preferable to other interviews, including for instance, focus group interviews or survey methods (Ashton, 2014; Dempsey, Dowling, Larkin, & Murphy, 2016).

3.2 Participants and Recruitment

This study adopts a purposive and convenience sampling method to recruit participants. Sampling can either be probability or non-probability. Probability sampling is quantitative (Alvi, 2016; Etikan & Bala, 2017; Rahi, 2017) in nature, whereas non-probability is qualitative (Taherdoost, 2016). Non-probability sampling, aside from being less complicated, easier to apply, and cost-effective, is essential in gaining insight into a particular phenomenon by examining real-life occurrences (Yin, 2003; Alvi, 2016; Showkat, 2017). Convenience sampling, also known as accidental sampling, will be used to recruit participants who are easy to approach and readily available to be part of the research. Purposive sampling is also adopted when there is a primary purpose in mind (Alvi, 2016) to document and analyze the experiences of Certified Nurse Assistants and the role trauma and resilience play in the services they render in long-term care facilities. Again, the researcher can judge or determine who can best provide the needed information (Etikan & Bala, 2017), making this approach suitable for the study. The goal was to interview 25 (twenty-five) respondents from two different long-term care facilities for the study. Since sampling is a continuous process to recruit participants, data saturation was used to determine the number of interviews to be conducted (Henderson, Gore, Davis, & Condon, 2003). This was achieved when the same information is repeated and confirmed by participants within the target group (Streubert & Carpenter,1999).

As a recruitment strategy, the research investigators through official letters, reached out to the leadership of the identified long-term care institutions. Detailed discussions and explanations of the study were conducted with the leadership for consideration and approval. Designed posters were shared with CNAs who work with any of the two identified skilled nursing homes sites. This was done through staff emails, and information boards accessible to staff detailing who and what

it takes to be part of the study and how to sign up to be a participant. CNAs who belonged to any of the minority groups were included in the study. To further qualify, participants must be at least 18 years or older and must be able to communicate fluently in English.

3.3 A Trauma-Informed Approach to Improving Dementia Care in Georgia Nursing Homes Funded Grant

This project is informed and partially supported by the grant-funded study "A Trauma-Informed Approach to Improving Dementia Care in Georgia Nursing Homes" awarded to Morgan (Principal investigator) and Burgess (Co-investigator). The study which has been approved by the Georgia State University (GSU) Institutional Review Board (IRB – TIADC H22423) seeks to train nursing home staff across the state to improve care for residents with dementia by emphasizing new trauma-informed approaches and reducing the use of antipsychotic drugs to manage residents' symptoms. This project is an add-on to the wider project which focuses on direct care workers in nursing homes in Georgia to examine the traumatic experiences of Certified Nurse Aids (CNAs) especially during and post COVID-19 pandemic and how those experiences has shaped their care work.

3.4 Data Collection

Data collection lasted for two months (February & March 2023) from two study sites. The embedded project with CNAs explore their experiences with trauma and how they have built or can build resilience as a coping mechanism. Interested CNAs were scheduled for a 30–45-minute interviews. The ethical considerations from the main project were extended to this study and adhered to strictly.

The in-person interviews were conducted in a private room or office designated by the institution. As a measure to ensure confidentiality and to give participants the opportunity to speak freely, all doors were secured firmly with no interruption from other employees. The private room was made as comfortable as possible with proper ventilation. No participant requested an online interview.

The research team also kept a notepad to record impressions and descriptive insights as they shared their experiences during the interviews. The notes gave a deeper understanding and corroborated the data or information shared by CNAs. Demographic data were gathered after the interview as a rapport-building strategy or a cooling-off strategy after a somewhat emotional interview. This has been reported in the data analysis section of this paper. The research team made provisions for additional resources during the interview to make room or cater for emotional moments and to provide extra support to CNAs.

Each interview lasted approximately 45 minutes with a couple running into one hour. This helped the data collection team to dig extensively into the subject area and to better understand the experiences of the CNAs interviewed. Prompts were provided in cases where caregivers were unsure what the questions or terms meant. This was carefully and tactfully done to avoid deep explanations which may result in leading questions from the researchers. Thus, CNAs may use the research team's explanation or meaning as an answer to the team. Each CNA was compensated for their time with a $25 cash for all the 25 in-person interviews. Once all data were collected, they were analyzed using NVivo version 12, discussed, and recommendations proffered for future research, policy, and practice.

3.5 Benefits & Risks

There were no direct benefit to the participants. The overall aim was to support long-term care facilities to build the direct-care workforce. This study presented no more risks than the participant will have in a normal day of life.

3.5 Data Analysis

In exploring the relationship between trauma and resilience among direct care workers in long-term care facilities, the current study analyzed data from CNAs' experiences with trauma, its impact on their service delivery and themselves as individuals, and proffered lasting recommendations for research, policy, and practice. All data were audio-recorded with the respondents' permission and transcribed in English. All transcriptions were verbatim and repeatedly checked for accuracy. The author and four other research team members conducted the interviews. This was to give room for varied interview skills and to check for areas other researchers may have overlooked or skipped. The research team later coded the transcripts to center on trauma and resilience among CNAs, referred to as direct care workers. The lead researchers read the transcripts thoroughly to familiarize themself with the data.

Data were analyzed with NVivo version 12. An initial list of subject codes were developed from the interview guide and shared with the research team. Other research team members were tasked to review the coded themes and the findings for accuracy and made revisions where necessary. This was to improve the validity of the data (Maxwell, 2013) and to ascertain whether the data links directly to the themes and research questions. The socio-demographic characteristics of the respondents were computed, and quotes from the interviews were highlighted to support the

identified themes from the data. The table below explains in detail the research process, team formation, ad data analysis structure.

Table 3.1: Select Information on the Research Processes, Team, and Methods by Area

Research area	Description
Approvals and consent procedures	
Institutional Review Board Approval	Approval comes from Georgia State University (TIADC H22423).
Study site consent	Written permission was obtained from the study sites prior to data collection and access to the study sites. The Principal Investigator (JCM) together with the Student Investigator (AB) were given authorization by the representatives of the selected sites. A tour of the study sites occurred prior data collection.
Participant written consent	A written consent was developed and administered throughout the interviews. Each participant read, understood, and signed the informed consent with any questions answered by the research team. The detailed and clearly written consent included sections such as purpose of the study, procedures, implications for future research, associated benefits and risks, alternatives, compensation, voluntary participation and withdrawal, confidentiality, contact information for post data collection questions and clarifications, and final consent which requires a printed name and signature, date, and printed name of principal investigator or researcher getting consent.
Assent procedures	Permission were sought throughout the study period. For each interview, we sought permission from the participants and the representatives from each of the study sites. This was done before, during, and after each interview session.
Research team and reflexivity	
Size and composition	Our research team, which was diverse, involved 8 individuals with backgrounds in gerontology, sociology, psychology, nursing, and social work. The team also included faculty researchers, staff, and graduate students. The research team and staff were trained in qualitative methods, trauma and resilience, and nursing home care. Of the authors, [JCM, AB, AS, LO, LS], collected data during one or both data collection sessions.
Participant-Researcher relationships	The research team were divided into groups of 2 individuals per team and assigned to either one of the sites. Authors [JCM & AB] conducted interviews on both sites within the data

	collection period. Rapport building was instrumental as team members were able to constantly touch base with the research participants throughout the data collection process.
Study design	
Interviewing	Researchers conducted in-depth semi-structured interviews face-to-face. Lasting an average of 45 minutes, most interviews were completed in one session. All interviews were digitally recorded using audio recorders and transcribed verbatim.
Interview guides	
Participant observation	The interviewees were observed in the work setting and so the research team were careful to pay attention to their participants expressions (verbal & non-verbal). Interview memos were written and used in the analysis.
Recruitment, refusals, and participant retention	Recruitment was mainly done in-person. Representatives from both study sites were given recruitment fliers to post on various announcement boards and to register interested participants willing and available to partake in the study. All 25 registered participants were available on the set day and time to be interviewed. No refusals were reported.
Verification and member checking	The research team used member checking to ensure the interview questions were gathering the appropriate data needed for the study. The team met a couple of times in the early stages of data collection to discuss the data. Member checking helped to gain analytic insights because of the continuous interaction with the participants. Through the member checking process, the interview protocol was revised twice to incorporate new questions to elicit more information from participants.
Analysis	
Coding within team	The initial coding was reviewed and conducted by three team members from the already developed codebook which was done collaboratively and iteratively by the entire research team. AB led the targeted analysis presented in this thesis project.
Coding development, codebook, and analytic procedures	The research questions/aims interwoven with extant literature and analysis; new concepts were modified. This was captured in the project code book which presents broad themes relating to COVID-19 related traumas and major coping strategies. This was helpful in building higher codes to fit the focus of the study. We examined codes that were relevant to the study focus and labelled them as “COVID-19 related traumas”, “Nature of direct care work”, and “Trauma-coping strategies”. The research team documented the similarities and differences in the data responses and presented them with quotes directly from the interview responses.

4 RESULTS

Results presented in this section include descriptive statistics compiled from demographic data collected from a structured survey given to each interviewee and thematic analysis related to the study aims.

4.1 Direct Care Worker Demographics

Twenty-five Certified Nursing Assistants (CNAs) were selected through purposive and convenience sampling techniques. Almost all participants (23; 92.0%) were female. The average age was 41 – 50 years (n=12; 48.0%) and most identified as African American or Black (n=23; 92.0%). Twenty-one respondents (84.0%) were U.S. born. Ten interviewees were single (40.0%); 12 were married (48.0%), and three were divorced (12.0%). Twelve participants (48.0%) had received at least college education, and Nine (36.0%) had some high school education. Comparing the work experiences of the participants, 10 had worked between 11 – 20 years in the healthcare field, seven had worked between 21 – 30 years, and 15 worked ten or fewer years in the study site. Twenty-four interviewees were CNAs while 1, a Temporary Nursing Assistant, was in the final stages of being Certified. Most of the interviewees worked full-time hours (31 – 40 hours) with most of them working from 7am – 3pm (n=21; First shift). In terms of average household income, about a third earned between $30,001 – $40, 000 annually (n=7; 28.0%). Eight interviewees, representing 32% of the total sample, earned more than $50,001 US-per year. Seventeen (68%) interviewees maintained only one paid job. Three participants did not disclose their average household income. Twenty-two participants (88.0%) maintained some form of health insurance while three (12.0%) had no health insurance.

Table 4.1: Socio-Demographic Characteristics of Direct-Care Workers

Characteristics	**Frequency (n)**	**Percentage (%)**
Gender		
Male	2	8.0
Female	23	92.0
Age		
20 – 30 years	3	12.0
31 – 40 years	2	8.0
41 – 50 years	12	48.0
51 – 60 years	7	28.0
61 – 70 years	1	4.0
Ethnicity		
(Spanish/Hispanic/Latino)	1	4.0
Yes	24	96.0
No		
Race		
White or Caucasian	1	4.0
African American or Black	23	92.0
Other	1	4.0
Citizenship status (U.S. Born)		
Yes	21	84.0
No	4	16.0
Marital Status		
Single	10	40.0
Married	12	48.0
Divorced	3	12.0
Educational qualification		
High School	9	36.0
Some College	12	48.0
College Degree	3	12.0
Graduate Degree	1	4.0
Tenure (Healthcare Organization)		
0 – 10 years	7	28.0
11 – 20 years	10	40.0
21 – 30 years	7	28.0
31 – 40 years	1	4.0
Tenure (Current Nursing home)		
0 – 10 years	15	60.0
11 – 20 years	6	24.0
21 – 30 years	3	12.0
31 – 40 years	1	4.0

Job Title		
Certified Nursing Assistant	24	96.0
Temporary Nursing Assistant	1	4.0
Work Hours		
21 – 30 hours	1	4.0
31 – 40 hours	22	88.0
≥ 40 hours	2	8.0
Work Shift		
First shift	21	96.0
Second shift	1	4.0
Average Household Income (Annual)		
10,001 – 20,000 dollars	1	4.0
20,001 – 30,000 dollars	4	16.0
30,001 – 40,000 dollars	7	28.0
40,001 – 50,000 dollars	4	16.0
≥ 50,001 dollars	6	24.0
Not disclosed	3	12.0
Second paid job		
Yes	8	32.0
No	17	68.0
Health insurance		
Yes	22	88.0
No	3	12.0

4.2 Nature of Direct Care Work

Direct care work is physically demanding and can pose high rates of injury to CNAs. Care typically includes Activities of Daily Living (ADLs) such as transferring residents, bathing, grooming, dressing, feeding, preparing them for the day's activities, and delivering trays when its breakfast, lunch, or dinner. High physical demands often mean burnout among CNAs and takes a toll on their bodies especially in a time where they are short-staffed. Some CNAs have also reported abuse from residents during the process of giving care. Despite the nature of direct care work, CNAs reported they are poorly compensated and not appreciated. Three CNAs had this to share about their daily routine and the wear and tear they experience due to the multiple physically challenging tasks they complete with multiple residents every shift.

> *What I do here, basically I come here and help the residents with they ADLs—their daily living, whatever they need help with—washing their face, brushing their teeth, dressing, eating, anything. I'm also a wound tech, so on some days I do come and do the check-ins with my wound nurse, I do wrap things and I do a lot of things affiliated with wounds. That's about it,* yeah **(Certified Nursing Assistant 02, Site 1).**

One interviewee described the physical and mental weariness that comes from doing the challenging job of being a CNA:

> *This is what I would say, the most tiresome, hardest job on this planet, apart from being a mother. Yes, it is. I kid you not because pulling on resident, pulling them up—when you come in this building, you wear another hat or any facility, as you're a nurse assistant, you wear so many hats. That eight-hour period you wear a hat for—you gotta be a psychiatrist 'cause the patients talk to you about their families. Then you're a caregiver, you have to assist who needs assistance with feeding, there again. There's a lot of hats that nurse assistants, they have to wear and they're not getting paid enough to do all this* **(Certified Nursing Assistant 21, Site 2)**

One of the interviewees describes the wear and tear on their bodies from physical abuse from residents:

> *A combative patient who kicks and punches, and scratches and pinches, and we've requested him to be moved, but they just "Suck it up. You guys can do it," but they're not the one dealing with it. Yeah, they don't get hit. They don't get punched. They say, "Leave them to let them calm down, and come back and try it again," but he's just the same way. There's nothing we can do, and then we get screamed at if we leave them* **(Certified Nursing Assistant 25, Site 2)**

Some of the CNAs interviewed shared opinions on how the workload coupled with abuse and combative nature of some residents, insufficient support and appreciation affect the quality of care they administer to residents. One CNA shared this:

> *Yeah, that can definitely affect it [the quality of care] because you have residents who fight physically—they don't just scream, they won't let you touch them—and they can be drenching and need to be cleaned, and they're refusing to let you clean them. They're fighting you, they're scratching*

> *you, they're kicking at you, so that definitely affects the quality of care that they would receive because you don't wanna really get down and really scrub them down the way you want to, but realistically you can't clean them as good as you would like to. Yeah, that does affect the quality of the care that they would get* **(Certified Nursing Assistant 09, Site 1)**

One interviewee shared her experiences about how layered vulnerabilities related to race, gender, and sexuality affected the quality-of-care residents received:

> *When I first started working here, we had plenty of Caucasian residents. Now we're probably majority black. At that time, they didn't mind spitting on you, scratching you, calling you the N-word, and you had to tolerate that. There's nothing you could say. There was no grievances. You couldn't do any of that. You just had to deal with it. That was probably one of my most traumatic moments. You get used to the spitting, the scratching, the cussing. You get used to it, and you push on to hoping days will get better* **(Certified Nursing Assistant 14, Site 1)**

4.3 COVID-19-Related Trauma

The emergence of the COVID-19 pandemic has had serious negative impacts on individuals, families, and communities. The healthcare industry, especially direct care workers and residents in long-term care institutions, have endured the burden of the COVID-19 pandemic. Prior to COVID-19, direct care workers faced multiple traumas including abuse, racism in different forms, and financial insecurity, among others. The pandemic led to additional exposures to trauma, and this is evident in the analysis conducted. Several changes within the healthcare system contributed to direct care workers' experiences as they had to adjust and make new changes to the way they worked. DCWs had to wear personal protective equipment (PPE) that included masks, shields, gloves, gowns, shoe covers, head covers, respirators and eye protectors. Required PPE has changed over the course of the pandemic but at the height it included several barriers between residents and direct care workers. More recently, surgical masks are used regularly but when there is an outbreak

additional PPE is re-added to support infection control. The fear of the spread of the virus created anxiety, panic, stress, and even post-traumatic stress disorders. The study describes interviewees' experiences during COVID-19 outbreaks and how it impacted their mental health, their relationships with family and friends and their ability to provide quality care to residents. For example, one DCW shared this about the collective experience of COVID-19 across the nursing home staff:

> *I feel like it really does impact our—not only mine, but in general, the staff's mental health just 'cause—like I said, I've been here a while, and just seeing this every day, not even with her. It's just different residents. The trauma level is sometimes high with us and then with the residents. 'Cause COVID hit everybody. It changed the way we do things and think. It's just over the top right there. Yeah. We did things that was strange, like playing bingo in the hallway, social distance. We couldn't all be together. Yeah. No group activities. I don't know. That was a frustrating time for us* **(Certified Nursing Assistant 14, Site 1)**

Another described the uncertainty and burden related to personal protective equipment and how the DCWs had to navigate protecting themselves and their residents.

> *Oh, yeah. I hate to keep saying it, but back to COVID. I didn't feel safe at a point that—because I guess it was new to everybody, and—we were trying to get a whole understanding, trying to see what could make us stay safe. We was going through a lot, masks, gowns, gloves, shields, glasses. You gotta wear this, you gotta wear this. No, not your glasses, you gotta put on shield. You have to take your glasses off. I can't see without them. You just doing everything to try to protect yourself and protect the patient as well* **(Certified Nursing Assistant 01, Site 1)**

A third interviewee described how being traumatized by COVID has personal and professional impact.

> *I feel like if somebody is traumatized, it definitely affects your mental—because it affects how you think daily. You know what I mean? It affects how you handle situations. It affects how you react to another person. You know what I mean? I could have a combative Elder and, if I'm traumatized, I'm not gonna handle that Elder as well as I would if I was not traumatized.*

> *You understand? Because I would have a different reaction to them. Yeah*
> **(Certified Nursing Assistant 24, Site 2)**

The COVID-19 pandemic impacted the way interviewees interacted with residents and spurred a roller coaster of emotions that both residents and staff had to manage. About 80% of the participants shared that trauma from caring for residents during this time and especially trauma from COVID-19 interfered with the care they provided to residents due to the negative impact it had on their own mental health. One DCW had this to say:

> *Just, I guess, I really—haven't really experienced a whole lot of trauma at work, but I can say, I guess, if you want to relate it to fear, it was during the COVID period. That was very traumatic especially caring for the residents, building relationships, and people that were well, up, talking, walking, doing everything to, all of a sudden, they've got COVID, they're not coming out of their rooms, they're not eating, and, the next thing you know, they have passed. You know what I'm sayin'? That was really traumatic*
> **(Certified Nursing Assistant 07, Site 1)**

Another DCW reflected on how taking care of herself and being in "good spirits" relates to her ability to take care of the residents under her care:

> *It affects it a lot. Because, like I said, if I'm calm and if I'm in good spirits, then it allows me to take care of my elders better, if I'm not in good spirit. I can't really take care of somebody when I'm not takin' care of myself. You know what I mean? To me, mental health for healthcare workers is very important, because it allows you to give better care, in my opinion*
> **(Certified Nursing Assistant 24, Site 2).**

Some of the interviewees also had to deal with personal traumas in their lives coupled with the traumas COVID-19 brought. One emotional participant shared this:

> *A bad breakup, bills and then I had COVID. I couldn't go out of the room, and that was very, very depressing. The breakup part, I just had to pray myself out of it and didn't think that—I never want nobody else to take control of my life like that. I was in a dark place crying all the time. I didn't eat. It was like I was a walking zombie, and then I still had to come to work. There*

> *was times where I was at work, I would go to my car and cry and then I'd come back to work like nothing ever happened* **(Certified Nursing Assistant 20, Site 2)**

Another impact from the COVID-19 pandemic was the consistent decline in the number of direct care workers and the need to "work short." Staff shortage was a problem prior to COVID, and the pandemic only increased this. This staff shortage forced two people to do the work of five DCWs which was stressful and posed risks to workers and residents.

> *When there was no staff during COVID. Nobody wanted to work. Everybody quit. When COVID hit, everybody was scared. You know what I'm sayin'? Everybody was scared to work in healthcare. We were down. We went from having 10 CNAs in the daytime to having like 5. Staff was basically cut in half. We have some people in offices that are CNAs, that are nurses, some people that work in the kitchen. Wherever you work, everybody was called to give care. Then we had to use agency, which we have never—I have been here 26 years and we never use agency until COVID* **(Certified Nursing Assistant 24, Site 2)**

Short staffing, experienced frequently over time, leads to burnout. One interviewee describes:

> *It's, pretty much, the burnout, the burnout. A lotta people have left because of the burnout. Short staff; staffin' is a major issue and stuff like that. The burnout. Then it's, just dependin' on the facility, nursin' isn't the same anymore, pre-COVID* **(Certified Nursing Assistant 13, Site 1)**

Short staffing, burnout and turnover make it difficult for interviewees to keep going or recruit others. As one interviewee explains, the organization is trying to use creative problem-solving to combat the issue.

> *We lost a lot of staff, and I don't think—I think it's put a damper on this field 'cause people are still kind of hesitant to come into the healthcare field. Right now we try to use med techs. We didn't use them before. Just trying to use different sign-on bonuses. We're thinking about doing other shifts, like 12-hour shifts. We're looking at other ways to help the normal nursing routine, like even orderlies, things like that, volunteers, looking for more volunteers* **(Certified Nursing Assistant 05, Site 1)**

4.4 Trauma – Coping Strategies

Interviewees shared trauma-coping strategies direct care workers can adopt to manage their trauma experiences. These strategies helped maintain mental health and increase the ability to withstand difficult experiences that interfere with normal functioning. The best care can only come from DCWs who understand their experiences and are able to develop protective factors and receive support from their employing organizations. The following strategies were identified after analyzing the data collected from CNAs. Individual, organizational, team functioning, and community strategies were the major domains of coping strategies that were pulled from the interviews.

4.4.1 Individual Strategies

4.4.1.1 Religion, Faith, and Prayer

The key individual coping strategy with the highest prevalence in the data was the use of religion/faith (16 out of 25 interviews). Many CNAs relied heavily on a "supreme being" and in this case, God, who would see them through all the challenges they face in life. For most of them, they preferred to engage in various religious activities such as prayer anytime they go through a traumatic experience. Anytime they (CNAs) faced any challenge in life, either personal, or at work, their consolation often come from God through prayer. Often interviewees described using prayer when they take a breather. They also described using prayer to stabilize their emotions and to forge ahead. One DCW, who used prayer as an individual strategy, shared this:

> *I just prayed my way out of it, to be honest. I just took it day by day. It was hard, and I think I stayed like that for a year and a half maybe. It was kind of hard, I'm not gonna lie. I can't even tell you what state of mind I was in, what personality I had. I can't even tell you that. I mainly just prayed a lot, but not to say that it was easy because it wasn't* **(Certified Nursing Assistant 20, Site 2)**

Another interviewee also commented that they also used prayer to cope. They stayed “prayed up” so they would have the resources to move forward in their work and lives:

> *All I can say is faith and prayer. Yes, you have to stay prayed up. You have to. You have to. I don’t let nothin’ bother me from this job, hm-mmm ’cause that’ll drive you crazy. That's all I can say about that. Got to keep consistent with prayer* **(Certified Nursing Assistant 14, Site 1)**

Prayer as a strategy was common among interviews. Another interviewee related:

> *I ain't gonna lie. I don't know, man. My thing is prayer, man. I pray a lot. I talk to God a lot. I believe in him a lot. I dedicated my life to him. I did. I had to. I don't know. It's sad to see all this—everything that's goin' on, though, but I don't know. I just pray. That's all I can do* **(Certified Nursing Assistant 08, Site 1)**

Prayer combined with faith and spirituality were also cited as resources for coping as described by this interviewee:

> *Or maybe it's because I believe in God? I don't know. Spiritually, I don't know, maybe that helps me cope with a lot of things? I'm not no perfect Christian or anything, but I do believe in God so maybe that does help me cope with a lot of things?* **(Certified Nursing Assistant 09, Site 1)**

This strategy was seeded in family, habit and helped individuals make tough choices to support their own well-being:

> *I was raised on prayer. A challenging situation, I was young in a horrible relationship. I told myself I had to get out of this 'cause this is not how I was raised and did not see this kind of relationship. I had to pray. One day, he just whispered in my ears and said, "This is the time, get up and go." I got up and left and I never ever turned back. I was raised on prayer* **(Certified Nursing Assistant 23, Site 2)**

4.4.1.2 Personality/Learned Behaviors

At the individual level, personality and learned behaviors seemed to play a major role in how interviewees manage traumatic situations. People dealt with challenges differently and this is

attributed to the personality type they have and certain behaviors they have built through experiential learning. Some are more patient than others. Others are more optimistic, strong, loving, and passionate than others. CNAs used their personality strengths and learned behaviors to better understand their experiences and to make sure they are focused on what is supposed to be done and to continue to do their jobs to the best of their ability.

One interviewee who uses learned experiences as a coping strategy to manage trauma at home and work said:

> *Well, as a CNA you gotta learn how to balance stuff. If you are having a bad day, or having something that going on at home, you can't bring it to work with you. You have to learn how to balance it, check that at the door once you get here, get into your workplace, because you know what you got to do. You got to be focused with your patients. You can't be focused and providing care, and then worry about what's going on outside of those doors* **(Certified Nursing Assistant 10, Site 1)**

Another interviewee who has used learned behaviors to manage personal and organizational trauma said:

> *I think I surround myself with people who are likeminded. Even if let's say—I know I try to be as positive as possible, but we all have our moments where we're a little down, we're worn on. I surround myself with people who are also positive. If they see me down or what have you, they will lift me up, not only in the workplace, but friends, they can tell. My husband, my kids, they can tell* **(Certified Nursing Assistant 07, Site 1)**

This CNA attributes her strategies to her "personality" which is also informed by her view of herself as a patient person and her belief in the golden rule as the rationale for continued patience and kindness toward others:

> *Just because I've always been told that I'm patient—I didn't really think that was a thing—throughout the years people complimented me on my patience like, "How do you do it? How are you so patient?" so I realized that's just me, that's my personality. People just like, "How are you in a good mood?" or "What you been through or whatever not let it affect you?" 'cause I highly believe in treating others the way that you would wanna be treated. I feel*

> *like my personality takes a toll on my work because I just feel like, I don't know, it just makes my job—I don't know, I can't explain it, it's just I don't know?* **(Certified Nursing Assistant 09, Site 1)**

Yet, another interviewee uses non-emotionality or toughness as a coping skill to manage personal and workplace trauma:

> *I guess not wearing your feelings on your sleeves. I guess I would say take it with grain of salt. Basically, we do that a whole lot, just brush it off or whatever and keep going because I feel like they don't know. Some of 'em living with dementia or whatever the case might be, they don't understand what they're going through. I know it hurts us, but I look at it this way. They really don't. I don't think they know what they're doing due to some of their health problems or whatever the case might be* **(Certified Nursing Assistant 14, Site 1)**

4.4.1.3 Self-Care

There are several recreational activities the participants engaged in as a cooling off strategy anytime they experience a traumatic situation either in their family, home, or work. Traumatic situations can be overwhelming for any individual who experiences it. Through recreational activities like going to the movies, going to the spa, shopping, hangouts, vacations, listening to music, and spending quality time with families and loved ones, which was reported by most of the participants, is used to put soul, mind, and body together. It is also an avenue to balance one's mental health, stay rejuvenated, and focused on care. Self-care is essential for CNAs as they expressed it helps reduce depression, stress, anxiety, increase their happiness levels and to help them build sustainable relationships with their families, co-workers and to recover from any setbacks from trauma.

One CNA who uses music as therapy and self-care strategy had this to say:

> *I like music, some music sometimes. Good gospel music is relaxing to me, and just get your—it just gets me in a good mindset* **(Certified Nursing Assistant 22, Site 2)**

Another one preferred to engage in spa activities to relax and to destress:

> *Not really. Just nails, toes done and probably a hot bath, long hot bath with the music just going down, that would just be about it* **(Certified Nursing Assistant 20, Site 2)**

One of the CNAs who believed meditation was beneficial to her emotional wellbeing and overall mental health shared:

> *I meditate a lot. I read a lot. It clears my mind, though. When I sit in my little corner, I don't have the lights on. I have my lights turned off. Sometimes I have a little candle burning. You know how you have little candles burnin' around. I sit. Then I just meditate. I don't know. I just feel like just a door open up, and everything just go. You know what I'm sayin'? It just feel like—and it feels so good. Meditating helps me cope with this in my life. It does with this job, yeah* **(Certified Nursing Assistant 08, Site 1)**

One of the CNAs who combines several self-care activities to manage her experiences opined:

> *Besides working out, I try to meditate a lot. I try to travel a lot, just find whatever type of peace, whatever my peace is. For me, it's traveling and working out and it makes a difference not just in my personal life at home but everywhere I go. It plays a huge part* **(Certified Nursing Assistant 06, Site 1)**

Taking time off work for travel and relaxation had reported positive impacts on one's health. One CNA explained:

> *Vacation is good. We go for vacation. The good thing is if you feel like even your body is not functioning anymore, you don't take a break, the management encourage you to take days off. Don't even kill yourself, 'cause you have Paid Time Offs, take a few days off. What I normally do, I take like a week. Like last week I took a whole week, and I make sure I'm not even in my house, away. Every year I have to take a longer one to go home to Africa and see my folks there.* **(Certified Nursing Assistant 16, Site 2)**

4.4.1.4 Calling/Informal Caregiving Experiences

Some have used family history and how their families have travailed through traumatic events as a source of personal motivation to continue to face their own traumas. For them, it is an opportunity to give back to others who share similar experiences as their family but not support for them to push through. Most of the CNAs interviewed believe that their love for the care work could be attributed to their family history and support, and this is what keeps them going and still want to provide quality care to residents, especially, those diagnosed with Alzheimer's and other Dementias.

A CNA who had a personal experience with a family member with Alzheimer's said:

> *I enjoy being a CNA because of my grandmother. My grandma had Alzheimer's, so we used to have to help with her, and I just decided that once I was old enough that I was going to become a CNA* **(Certified Nursing Assistant 10, Site 1)**

Another CNA whose motivation for the care work rose through experiences said with her dad who had multiple strokes and needed a more person-centered care said:

> *I've always loved caring for people, caring for anyone for that matter, even older people. When I was nine years old, my grandfather got sick. He had a stroke and he had 10 strokes. It was just my grandmother, and we took care of him. We cleaned him, we did the daily things as a caregiver need to do. That just stuck with me for years, and I was like, "Okay. I'm gonna grow up when I come here," 'cause I'm from Antigua. I was like, "When I come here, I'm gonna go to school and then I'm gonna become a nurse." That didn't fall through, so I was like, "Okay, let me start with the CNA portion," and from that, it just stuck with me. I just continued caring for people. I just have that nature to care for someone* **(Certified Nursing Assistant 23, Site 2)**

One CNA whose family caregiving experiences drove her into the care work without any prior experience reported:

> *I been takin' care of my mom for 24 years, and I, also, was takin' care of my father before he pass. That's what drew me into the nursin' home. As far as me, this is my first time into a facility. This is a total different environment for me. I came from the airport. I was a manager at a airport for 12 years, so you can imagine that was a whole switcheroo. It's different, but I love the people* **(Certified Nursing Assistant 11, Site 1)**

The positive family caregiving experiences of this interviewee encouraged her into the nursing field after the loss of her care recipient:

> *I actually like taking care of the Elders. When I was younger, I said if I didn't work with the kids, I'd work with the Elders. I started out working with the kids and then I ended up working with the Elders. I started with my mom and once she left it was like, "I might as well just keep going." I like it, the interaction with them, the stories while I'm doing the care with them, all that. I love that* **(Certified Nursing Assistant 17, Site 2)**

4.4.2 Ideal Organizational Strategies

4.4.2.1 Better Pay

Trauma that occurs within the organization has an influence on the overall performance of employees and their productivity. Throughout the interview data, one of the major themes in interviewee responses about what organizations could do for CNAs is to provide better compensation (n=10). However, most interviewees (n=17 out of 25) shared that the organization was considering their pay rates to make them more competitive. This motivated workers who would typically “call off” work to come to work more often than usual. Whiles some CNAs felt the nursing home was doing their best to keep up with compensation, others felt a little more could be done to save more staff from attrition.

A passionate CNA who believed pay was the best motivator for retaining talents in nursing homes shared:

> *That's the thing. That's why we don't have no CNAs because it's the money. It's like they really don't wanna pay you no money. We work a lot. We work. We work a lot that we do. We do a lot. It's just the number one thing. It's the pay. That's the pay. That's the only thing I can just say. It's the pay. That's the number one thing is the pay. If they pay us some more money, the pay you know. They'll stay. Some of 'em then they should get more when they first start. We'll keep 'em for a little bit, and they be gone. That's somethin' I have to say is the money* **(Certified Nursing Assistant 12, Site 1)**

Another interviewee who also believes pay helps provide support to meet their needs and the needs of their families said:

> *The pay is one. What we have to pay for healthcare is two. It's too expensive. Some people can't even afford to have health insurance because it takes too much out of their check. You know what I mean? They don't make enough to take care of they families and have healthcare* **(Certified Nursing Assistant 24, Site 2)**

Increasing pay according to one interviewee can serve as a compensation for the stressful and demanding nature of care work:

> *The pay. I'm not gonna say too much say on that, but the pay will help if it could go up a little bit more too. Because I think we have a harder job than a judge or a lawyer, I feel like it. Maybe the judge and the lawyer feel like their job is harder than—but I feel like we have a harder job because these people fight and we can't fight them back. As a judge and a lawyer, if they attack you you can attack them back* **(Certified Nursing Assistant 17, Site 2)**

Although the current hourly rate is manageable, better is always better:

> *It's good. It's good, but better is better. Better is always better. More is always better I think. It could be a little better, but it's good. It pays the bills. I get fed. I pay for my car. I pay my insurance, phone bill. I pay my life insurance, pay my dental insurance. Yeah, it's okay. It'll never be enough. You know what I'm sayin'?* **(Certified Nursing Assistant 08, Site 1)**

4.4.2.2 Increased staffing due to workload & burnout

Aside from pay, about 90% (n=20) of participants reported that increasing the number of CNAs was another reliable strategy nursing homes can adopt if they want to maintain their staff to continue to provide quality care to residents. Workload is a serious problem in nursing homes and bringing more staff on board, according to the majority of interviewees, can help reduce the physical burden on them. Short staffing was persistent during the COVID-19 period. Many CNAs, due to fear of the virus and how it was contained, left the workforce either to take care of their families or to find jobs elsewhere.

One interviewee attributes most nursing home being short-staffed to burnout from the workload:

> *It's, pretty much, the burnout, the burnout. A lotta people have left because of the burnout. Short staff; staffin' is a major issue and stuff like that. The burnout. Then it's, just dependin' on the facility, nursin' isn't the same anymore, before and during COVID* **(Certified Nursing Assistant 13, Site 1)**

Aside being short-staffed, practices espoused as best practices within the nursing homes contributed to workload and burnout among DCWs:

> *It's a lot like they wanna say, like they want us to provide care every two hours, but if we short staffed, how could we provide care two hours? I'll say three, or sometimes they give us these impossible—they give us just as possible stuff to do, that doing it can't be done. Like I'd say, how are we gonna provide care every two hours, when one CNA got 11 residents, you still gotta do two meals, then you have residents that they feel if they urinate one time, they gotta be changed right then. They saying that they are VIP, when I feel everybody should be VIP, but first thing they say, well, you can't tell them to wait, or you gotta go on and do it. Stuff like that* **(Certified Nursing Assistant 10, Site 1)**

Another interviewee who was concerned about the workload as the antecedent for burnout among CNAs noted:.

> *It was very difficult, very difficult, especially at the time when COVID hit. That was the worst. I have done this for a while, but that was the worst. That*

> *made me feel as if this ain't for me. Just like any nurse, they feel like, "Oh no, I'm burned out." I was working at another nursing home where they were on the staff and I had to pull—I had to do 26 patients by myself. That day I had not even got a glass of water. Then she pulled me from that floor to go to another floor and I had to do 10 more. I did it, but the next day I end up in the hospital* **(Certified Nursing Assistant 23, Site 2)**

4.4.2.3 Developmental/educational opportunities

Most participants also shared their opinion on how nursing homes can reduce attrition among CNAs by providing developmental training and educational opportunities. To them, this is another great way of supporting CNAs who have no idea of how to manage their emotions and to seek mental health counselling when they are overwhelmed. For the nursing home selected for the study, CNAs mentioned that the management had several training courses and provided mental health counselling to any staff who needed it. The trainings extended how to provide person-centered care to residents. These in-service training courses equip workers with information on the special needs of residents diagnosed with dementia and other chronic diseases and how to manage their own emotions as healthcare practitioners.

For example, The EDEN Alternative trainings and customer service trainings were mentioned as programs that can provide up-to-date information on how to manage one's emotions and to provide more person-centered care to residents:

> *We just did an in-service on customer service and residents' rights. I think sometimes we all need that refresher. Yeah, but definitely the customer service piece because we get stuck in our every-day routine, and sometimes you don't realize people may take things a certain way even though you didn't mean it. Like you said, "How did you feel when you walked in today?" You know what I'm sayin'? Just little things like that where you just didn't feel yourself or you're tryin' to—even though you don't mean any harm, but, by not being as social as you normally are, some people might take offense to that, especially the residents. We do a lot of in-services on all types of—with the pandemic, the safety, the masks. They also have this thing called Eden Alternative. Especially with the pandemic, we were doing so many in-services, like just enough to protect yourself, what you can use, and what*

> *you need. All the types of in-services here. We do all types of in-services all the time on just everything. Yeah. We do a lot of in-services here* (Certified **Nursing Assistant 07, Site 1)**

One interviewee benefitting from her employer's educational scholarship programs to become a CNA said:

> *I'm a temporary CNA, but I'm working towards getting my CNA currently. They're doing the classes for me. They're paying it for— They're paying me for me and everything, so I'm just waiting to take the test* **(Certified Nursing Assistant 15, Site 2)**

4.4.2.4 Extracurricular activities

Aside from the training and developmental opportunities, the interviewees expressed that managers promote extracurricular activities among staff. Some typical activities organized by management include group vacations, celebrating staff through events such as recognition weeks (CNA Week), birthdays, and group exercise programs. Also, according to the interviewees, the organization encourages staff to participate in the available wellness programs within the nursing home and provides ways for CNAs to speak up, share their grievances and creates a safe space to learn, unlearn, and relearn new coping strategies.

Organizing activities such as Christmas parties and appreciation weeks boost CNA morale and keep them engaged:

> *So before COVID, we still have days to do a Christmas party every year, and they often do stuff like—at Christmastime, they give away gifts. They have little employee appreciation stuff, where they're bringing food and different people does different things. Yeah, they try. They do as much as they can possibly do. I feel like they try. You know what I mean?* **(Certified Nursing Assistant 24, Site 2)**

Another interviewee stressed the importance of increasing staff engagement through the various wellness programs organized in nursing homes.

> *There's some places you work, they say your paycheck is—that's your reward. That's all you get. That's all we care about. That's your paycheck. You do the job, we pay you, that's it. But they try. They do. They try to show us that they appreciate us. We have fresh fruit Friday, I think, once or twice a month, where Activities go about and buy fruit and they give each employee a bag of fruit. Fresh fruit Friday. They do stuff like that. They have a wellness program where you can accumulate so many points and you get gift cards. Like if you get your mammogram and stuff like that, you can report it in, and you get points, get gift cards. Yeah. They do stuff* **(Certified Nursing Assistant 24, Site 2)**

Another interviewee who believes organizing appreciation events such as CNA week can make DCWs feel they are appreciated and seen:

> *Like CNA, we have a good CNA week. They do. They do. They cater. They give us cater. We had a little convo there a couple months ago. Yeah. They do some. Yeah, they do stuff for us* **(Certified Nursing Assistant 12, Site 1)**

4.4.3 Team Functioning

4.4.3.1 Recognize and encourage teamwork

Twenty-three interviewees expressed the need for teamwork, especially in the nursing home setting, the impact it brings to the work and would always encourage that. To them, teamwork reduces the workload, burnout, and associated stress with care work.

Working with other co-workers who understand and appreciate teamwork is an instrumental part of the care work:

> *Oh, you gotta have teamwork. You can't do this job by yourself. You can't. The job is very hard. If you don't have somebody helping you with that, like a coworker helping you with that, you can't do it by yourself. You just can't. It takes a team of people to make things like this work. From the top, we have a good administrator, a good DON. You know what I mean? A good*

> *coworker, a good nurse, then it works. But if you don't have those things, it don't work. You gotta have teamwork. You have to.* **(Certified Nursing Assistant 24, Site 2)**

While some DCWs are strong on teamwork, others are not. One interviewee had this to share:

> *Teamwork is actually pretty good. You have some that are not really big team players, but, for the most part, a lot of us are really big team players. Teamwork, I think, it plays a big part in your success especially when you're workin' on the floor. It really helps a lot if we can—a lot of times, you can get more done if we work together versus tryin' to do everything on your own* **(Certified Nursing Assistant 07, Site 1)**

When there is teamwork, DCWs become more engaged and ready to support each other when the need arises. This increases productivity as well as strengthen interpersonal relationships and that's what this interviewee shared:

> *I love teamwork. That like literally, this place or any other place, would not survive if it wasn't for teamwork. As for teamwork I don't think I've ever had a problem with that because I think I pretty much get along with a lot of people* **(Certified Nursing Assistant 15, Site 2)**

Another DCW who was strong on teamwork and how it promotes success within the organization intimated:

> *The good here would be that there's more worker help, there's more teamwork. We actually work together here. From where I was you couldn't get anybody to just stop for a second just to help you with a resident. You were just stuck. You do care on them, if they wanted to get up right they will have to wait. As compared to over here if they wanna get up now and you see somebody walking like they're walking to get a brief to help somebody else, they'll stop or come help you real quick and then they'll—I like that* **(Certified Nursing Assistant 17, Site 2)**

When teamwork is recognized and encouraged, it promotes a strong bond and connection among DCWs. Another interviewee had to emphasize this assertion:

> *You have to have teamwork. That's the number one thing. If you don't have teamwork, a lot of times it just don't work. It helps when you have team players. If you don't have that, a lot of things don't work out. Well, like I said, we already had a great team. My team that I was actually working with, I think we was already strong I think it made us a little more stronger. It's because we put our heads together to try to figure out things that we could do to make things better when we were working through COVID* **(Certified Nursing Assistant 18, Site 2)**

Teamwork reduces workload, burnout, anxiety, and physical injury among CNAs. Care work can be demanding and overwhelming at times. It takes teamwork to ensure that residents receive the person-centered care for which they were admitted in the nursing home.

Through teamwork, DCWs are able to assess each other's challenges and find best ways they can support themselves:

> *Well, I think everybody get overwhelmed sometime. Like I said, someone else steps in, When they see that person is getting overwhelmed, it doesn't escalate into something that it shouldn't have. We've learned to do that. If this person is having a hard time and we see they're having a hard time, somebody will come in and say, "Hey, let me do this right here for you, and you need to move out of the situation," and they'll handle that for you* **(Certified Nursing Assistant 03, Site 1)**

4.4.3.2 Dismantling "Cliques"

Other CNAs who were interviewed felt that teamwork was not so much encouraged because management or supervisors and work colleagues had created cliques. Out of a particular clique, one did not get the support needed. Most often, according to some of the interviewees, supervisors did more for one person than they would do for another person. Also, they picked and chose who would do certain things at a certain time instead of encouraging everyone to do everything. The interviewees felt that when DCWs feel there is favoritism, it breeds resentment, and animosity, weakens loyalty and trust, and reduces morale. When there is fairness, people feel equitable, engaged, and reduces turnover among staff.

Building cliques does not encourage engagement among staff but rather mistrust and one interviewee who experienced this said:

> *Yeah. I feel like sometimes in places like this, to me, I feel like they have cliques. They do more for one person than they'll do for you. I don't know if it all workplaces, but they pick and choose who they gonna let do this and do that. Half of the time, sometime, this person might not even be qualified for it, but you got a person that really qualify for the position. They give it to the person what they choose, not the person that is qualified* **(Certified Nursing Assistant 01, Site 1)**

Yet, another DCW who believes open communication is the best way to maintain teamwork rather than forming cliques shared:

> *There's no teamwork here. I think that there should be—instead of gettin' in a pack or group of other workers and discussing what's goin' on with somebody or what someone's doin', I feel that it should be more of a communication. It's more of a team-up thing type here. If you're not with this team, you're not gonna feed into this. It do too much of that. Hm-mmm. That's what I'm just told—I'm serious. If you don't run with this pack of nurses over here and this pack—it's like pull them, pull them* **(Certified Nursing Assistant 11, Site 1)**

4.4.3.3 Encourage better communication

Better communication has also been seen to improve collaboration among team members. When staff understand each other and the role they all play in the care work, they will be able to work together. Knowing each other's communication styles makes them work more effectively and efficiently without misunderstanding or conflicts while being able to maintain relationships. Communication can be one-on-one conversations, phone calls, check-ins, emails, and in-person group meetings. The goal is to encourage teambuilding among care staff or partners. The more staff communicate better, the more they trust each other, stay engaged, and their morale is boosted.

One CNA shares the importance of communication and how it fosters unity and openness among staff and residents:

> *Communication. Communication. Communication is key, you have to have everybody on the same page 'cause if not, something is not going to work with them. I think communication is the key thing to anything, you have to communicate with your staff, and communicate with your residents. If everybody isn't on the same page then it's not gonna work. I don't know, like I said, you got get out, you got to speak, you got to communicate, you got to get the word out, you have to love one another, you care—that's it, you have to care* **(Certified Nursing Assistant 02, Site 1)**

4.4.3.4 Introduce & encourage check-in options

Encouraging check-in options such as emails, phone calls, and daily meetings helps DCWs to stay informed. This reduces any form of fear, or anxiety:

> *We have daily meetings, emails, phone calls. We're very united. We're like family, so nothing is gonna get past us. Every morning we go to each other's office to talk about what's going on, what has happened, what needs to happen. There's an email. Communication is huge. Once we lose that, then it may be a problem but I think as long as we can continue to communicate and listen and address what's going on, I think that's what's gonna carry us* **(Certified Nursing Assistant 06, Site 1)**

4.4.4 Community Strategies

4.4.4.1 Family/non-kin family-like groups

Sixteen out of the twenty-five interviewees reported that families and non-kin family-like groups are a major support to CNAs. Interviewees relied on families to heal through traumatic situations. Some CNAs shared their experiences on how their families have supported them:

> *Yeah, like the losing of my grandchild. My daughter is home with me, and when she lost a baby, we had all stuff set up like a support group for moms and grandmoms who went through losing a child. We had people to talk to and express our feelings, we talked to each other, we prayed together, that's how we got through a lot of stuff. We talk about it—and we*

> *may be mad once, but we gonna talk about it—we're gonna get through* **(Certified Nursing Assistant 02, Site 1)**

4.4.4.2 Finding a good support system

Building a good support system provide safe spaces for DCWs to share and to navigate their traumatic experiences:

> *Just being a good support system. You can be a support system by--it doesn't have to be monetary. It can be just talking to me, just someone I could call and lean on no matter what I'm going through. A good support system is good. That's all you need, a support system* **(Certified Nursing Assistant 21, Site 2)**

One interviewee shared how her family is ready to support her financially and emotionally to stay focused:

> *Well, I have a supportive family so usually if it's anything that's going on, the family's there to support, even if it is financially, or if it's just something emotionally going on. I mean, I have family support. Even working here, you have people that are supportive and that are caring that will try to be there for you emotionally, whichever way you need. Some people here—it's not a bad place to work. I think it's a good place to work. I think when it really boils down to it, everybody will pull together like a family here* **(Certified Nursing Assistant 22, Site 2)**

Another interviewee expressed some family activities that provide safe spaces to share and to build their mental health:

> *As far as with my family, we all sit down, and we talk. We do have our family—we have our family every Sunday—our family dinners. Yeah. We go out to dinner and stuff. We try to stick it out. We're still together through a lot of stuff, through a lot of stuff. They don't make the problems go away, but it's helpful* **(Certified Nursing Assistant 08, Site 1)**

4.4.4.3 Finding alternative support groups

However, about half of the participants had little or no knowledge of whether community support, beyond their families, existed. Religious organizations such as the church, was not identified by

the participants (n=3) as a safe space or avenue to seek support when faced with a traumatic situation.

This is because they were skeptical about the support they would receive and the form in which they would come.

Instead of family support, one interviewee would prefer to speak to her healthcare provider instead:

> *I do not know of any, but my doctor is there. She and I, we have conversations. If I'm feeling any type of, not depression 'cause—I'm not saying I don't get depressed, but she's there. I used to go to church often, but how I see our own kind treating each other in church, I try not to go there. I feel like there is community resources, but I don't really* **(Certified Nursing Assistant 23, Site 2)**

4.5 Conclusion

The analysis presents several themes which emanated from the data collection at the two study sites. Individual (faith/religion, personality traits/learned behaviors, recreational/self-care activities, family history/experiences), organizational strategies (better compensation, developmental trainings & opportunities, extracurricular activities), family/community strategies (support groups i.e., family & non-kin family), and team functioning were the major themes identified from the study. Table 3 below represents the major domains of coping strategies adopted and maintained by DCWs in responding to trauma either at home, in the family or at work and the frequency these themes are presented in the data that were collected and analyzed.

Table 4.2: Major Domains of Coping Strategies by Direct Care Workers

Major domains of coping strategies	**Frequency from the qualitative data (out of 25 interviews)**
Individual strategies	
Faith/Religion	16
Personality traits/Learned Behaviors	22
Recreational/ Self-care Activities	20
Family history/Experiences	5
Organizational strategies	
Better Compensation (Pay)	10
Developmental trainings & Opportunities	20
Extracurricular/Self-care activities	15
Team functioning	
Effective Communication	11
Buffer to Workload & associated Mental health Implications	20
Family/Community strategies	
Support Groups (family & Non-kin family)	16

5 DISCUSSION AND IMPLICATIONS

Employing trauma-informed approaches with direct care workers and the organizations that employ them is foundational towards building support for and ensuring that staff can understand and manage their own traumas and support coworkers. Direct care workers should be able to realize and understand the impact of trauma and the possible pathways through which they can occur. Using a trauma-informed approach at the organizational level means that direct care worker experiences, knowledge and needs can be reflected in policies, practices, and procedures to avoid re-traumatization of both the persons served and staff (SAMHSA, 2014). This study examined the various traumas DCWs experienced in their everyday lives (with a focus on work lives) and how this impacts their care work. It goes further to explore some coping strategies essential to responding to traumatic situations and ultimately supporting both staff and organizations to become more resilient.

Adopting trauma-informed approaches to care is important if an organization wants to create an environment that supports the mental health of workers (ASPPH, 2022). Building a culture of safety, choice, collaboration, trustworthiness, and empowerment, cultural, and gender issues (SAMHSA, 2014) improves engagement across the organization. The principle of safety

accounts for concerns for both the physical and psychological safety of staff. Thus, reducing risks factors and building a sense of control among employees (Parker & Johnson-Lawrence, 2022; Edelman, 2023). When DCWs feel safe, they can engage with supervisors, co-workers, and residents. This promotes peer support and healthy relationships across the organization (Parker & Johnson-Lawrence, 2022). The principle of empowerment and choice allows employees to decide from multiple options and the freedom to re-evaluate those options based on their individual strengths as well as experiences. Providing workforce development opportunities and services for DCWs fosters inspiration. Since there is shared decision-making especially in stronger teams, setting clear goals coupled with organizational support motivates staff to work effectively and efficiently (SAMHSA, 2014; Parker & Johnson-Lawrence, 2022). The trustworthiness principle ensures that decisions and operations from management are carefully tailored or consistent with the needs of staff so they can build trust with residents, among staff, and other care partners directly or indirectly involved in the organization. In simple terms, DCWs can build trust when they are understood and respected by their employers. According to SAMHSA (2014), the principle of collaboration emphasizes the need to level power differences among staff, residents, and other non-nursing staff. This seeks to encourage meaningful decision-making with others. Thus, the organization recognizes the role of DCWs in maintaining their own mental health and that of others. Collaboration is partnership where each other's expertise is acknowledged and respected. The final principle recognizes culture, gender, and historical trauma issues related to individuals at home and work. Organizations need to move past biases and stereotypes (SAMHSA, 2014; Parker & Johnson-Lawrence, 2022). Employers need to leverage on healing strategies by offering services that responds to gender and cultural issues deeply incorporated in policies and processes. These services can equip DCWs to heal through any historical trauma. DCWs can grow through

their obstacles and become more engaged when they realize they are included irrespective of their race, ethnicity, sexual orientation, age, religion, gender-identity, geography among others (SAMHSA, 2014; Parker & Johnson-Lawrence, 2022; Edelman, 2023).

COVID-19 is still lingering; cases remain recorded in several states and across the globe. The COVID-19 pandemic not only increased the trauma DCWs experienced in Long-Term Care (LTC) institutions, but it also increased the workload, burnout, stress, rates of infections, anxiety, and fear among DCWs. Residents needed more person-centered care while staff were leaving the workforce in large numbers. Nursing home staff experienced loss and associated grief at unheard rates (634,179 COVID-19-related deaths with about 21 percent of these deaths reported in nursing homes in the U.S. as of 2021 with decreasing numbers over time) (Agarwal, et al., 2021). We collectively experienced many changes to our lifestyles and habits (Garcia et al., 2021; Dugarova, 2020). These changes impacted relationships for residents as they were kept indoors for long periods of time and families were intermittently able to visit them. Group activities changed, making it harder to keep both residents and staff engaged. Staff were equally restricted in how and when they interacted with residents, depending on infection control procedures, rates of infection in the building and staffing. This hampered relationship-building, engagement, and limited the intrinsic meaning-making part of the DCW job. The study further indicated staff trauma experiences very likely affected the quality-of-care residents received. Several DCWs felt unsafe, and the impact of the virus affected their mental health.

DCWs expressed the nature of their work as tiresome, and the analysis corroborate this assertion. DCWs had to struggle through their work by taking up additional responsibilities to already full job descriptions. This overload is related to both staffing and COVID-related trauma, increased burnout, and mental health challenges. DCWs who are not able to cope with the stress,

burnout, fatigue, and anxiety had to leave the workforce. From the analysis, it was obvious that workloads increased through COVID mainly related to short staffing experienced industry wide. Taking on additional patients and having great difficulty caring for sometimes double the usual number of residents led to overwork and often to burnout for these workers (Scales, 2020; Wisconsin Health Care Association/Wisconsin Center for Assisted Living et al., 2020). When CNAs were asked about how they were able to handle the workload, they responded that their co-workers were there to support them despite being understaffed. Organizations that had strong teams in place likely weathered the storm of COVID more easily. Issues that have plagued DCWs seemed even more difficult when seen through the COVID lens. Pay, benefits, workload, physical or verbal abuse, sexual and race-based harassment, lack of appreciation and lack of supervisor support all were mentioned as persistent problems by direct care staff (Dill, Morgan & Marshall 2013; Morgan, Dill & Kalleberg 2013; Burgess et al. 2018).

Developing and maintaining protective factors help staff to cope with the impact of trauma either individually or collectively. Problem solving skills, support to facilitate positive outcomes, religiosity and spirituality, emotional support, effective socialization, and tangible aid can serve as a buffer and facilitate positive outcomes (Zhang et al., 2018; Rushton et al., 2015). When DCWs can cope with trauma, they become more resilient which reduces mental health risks (Martin, Distelberg, Palmer, & Jeste, 2015, Smith & Hollinger-Smith, 2015; Jeste et al., 2013), it improves their lifestyle behaviors, and ultimately their quality of life (Smith & Hollinger-Smith, 2015; Jeste et al., 2013). The study revealed that DCWs used individual strategies such as religion/faith, identity and values, self-care, and informal caregiving experiences which is sometimes seen as a calling to cope with traumas. Most of the DCWs would prefer to “stay prayed up” anytime they experienced any form of trauma. Engaging in activities such as meditation (Bonamer & Aquino-

Russell, 2019), prayer (Lin, Chan, Hendrickson, & Zuniga, 2020), going on vacations, spending quality time with friends and family, music (Steinberg et al., 2017) and taking care of oneself (Hewson, 2014; Alexander, Rollins, Walker, Wong, & Pennings, 2015; Salmon, 2001) were strategies used to reduce depression, stress, anxiety and improve happiness, physical health, self-esteem, relationships, and mental health (Barratt, 2018).

Long-term care organizations have an important role to play when it comes to trauma and direct care work. Designing and implementing intrinsic interventions for DCWs can boost their confidence and approach to care (Pross & Schweitzer, 2010). Although LTC institutions are doing their best to keep DCWs engaged (this was mostly the case for the respondents from the study sites), better can be better. Compensation needs to be considered by employers if they want to keep the best talent in their organization. Most DCWs are not paid their worth (Bowers et al., 2003), and this was reinforced through the voice of interviewees in the study. DCWs who were employed directly by LTC institutions compared to agency staff received lower compensation. Interviewees perceived that agency staff do not know the history of residents and the care they need as compared to staff who have worked with the residents over months and years. Better compensation means DCWs will be able to pay for their housing, health, and car insurance, and provide for their families. When these needs are met, DCWs will be able to focus on providing quality care to residents.

Aside from the pay, LTC employers need to encourage extracurricular activities among staff and extend to residents. This creates team cohesion and an environment for staff to destress from stressful situations which may have taken over their mental health. It also enhances and fosters networking skills, teamwork, and leadership opportunities for staff (Southwell-Sander, 2021). The overall mood of DCWs is improved where they no longer feel stressed as well as feeling

a sense of fulfilment, character enhancement, confidence, and self-esteem. DCWs can learn new approaches to overcome their own traumatic experiences through learning from others. This can be difficult because direct care workers have full lives and often have second jobs to make ends meet. A combination of strategies can be tailored to the needs of the workers in each organization.

Training and development of staff should be a priority for LTC employers. These in-service trainings can include stress management, coping with trauma, how to become an effective communicator, customer service, and person-centered care training. It helps to bolster their skills and knowledge about trauma, how to build strong interpersonal relationships, and this can build their confidence and value (Elliot et al., 2015). They become more effective and efficient, increasing their morale and productivity (Wagner, 2000; Rosenwald, 2000). When employees feel safe in their workplaces, attrition rates decline, and the organization becomes more competitive (Fateminejhad & Kolahjoei, 2013; Khan, Khan, & Khan, 2011). Creating transparent career maps and adhering to it helps employees to plan a clear career path with the organization where they feel there is more room for them to improve on their current work conditions (Remsburg, Richards, Myers, Shoemaker, Radu, Doane, & Green, 2001). There can also be employer-subsidized educational opportunities (e.g., Tuition reimbursement or Tuition remission) where staff can go for further studies to obtain higher degrees or learn new skills directly related to their job. In the long run, the organization that invests in staff in these ways increases employee engagement, reduces recruitment costs, lowers turnover rates, and experiences a return on investments making such organizations more valuable (Khan, Khan, & Khan, 2012; Jehanzeb & Bashir, 2013; Chaghari, Saffari, Ebadi, & Ameryoun, 2017).

Education and practices that supports teamwork, through the strengthening of relationships, communication and team cohesion is another important area to emphasis. This can

only be achieved when people come together knowing their strengths and weaknesses and collaborate with one another to achieve a common goal (World Health Organization, 2014). It helps to reduce burnout, physical injury, and anxiety that results from work overload (Schaufeli, Bakker, & Van Rhene, 2009). Building and encouraging team cohesion has proven to make workplaces more functional with increased productivity and high job satisfaction (Kalisch et al., 2010; Welp & Manser, 2016) has increased over time. Dysfunctional organizations and teams can lead to low motivation and low productivity, loss of communication, trust issues, and lack of culture sensitivity (Institute of Medicine, 2001; Kim, Bochatay, Relyea-Chew, 2017). Due to the nature of direct care work, team building, or team functioning helps reduce burnout among CNAs and this was widely reported by the participants interviewed for the study. When DCWs build purpose, they also become better problem solvers, increases collaboration and support to get work done effectively and on time, measurable job outcomes and satisfaction (Wheelan, 2013), increases innovation, personal growth, and a congenial environment for staff to work without fear, anxiety, and stress. Again, DCWs become fully aware of what is expected of them and can carry out their duties and responsibilities. When the mental health of DCWs is improved, the organization only creates high-performing teams who will drive the organizational goals and successes and make the organization more competitive (Manzoor, Ullah, Hussain, & Ahmad, 2011).

Through a much broader lens, trauma can move from an individual to a collective one which affects an individual's immediate environment (SAMHSA, 2014). That means integrating the individual's bio-psychosocial, community, interpersonal as well as their societal variables to better understand trauma and its impact is essential. Collective trauma only breeds collective fear, vulnerability, and new threats to a group of people. (Somasundaram, 2014; Anderson, 2004). Using the socio-ecological model (Bronfenbrenner, 1979; Bronfenbrenner & Ceci's, 1994) in

understanding individual to collective trauma, participants were asked how their personal traumatic experiences affected their families and communities and how their communities have supported them through those experiences. A way communities can help people and, in this context, CNAs, is to encourage support groups that helps to speak to their emotional, psychological, physical, informational and appraisal needs. Support groups can serve as a channel to destress, reduce anxiety, and depression and to improve one's mental health (McFarlane, 2001; Worrall, Schweizer, Marks, Yuan, & Lloyd, 2018). Social support helps individuals and families to cope with any traumatic experiences, improves their sense of belonging, self-esteem and encourages autonomy. Support groups are a source of strength and most effective when they are bi-directional in nature. People rely on support groups to thrive.

5.1 Conclusions

This study sought to understand the traumatic experiences of direct-care workers, the impact before and during the COVID-19 pandemic and direct care workers perceive the impact of COVID-19 and their experience of it on the quality-of-care residents received. The study further investigated some coping strategies that direct care workers are currently utilizing to cope with trauma and if their organization has a role to play in its management. The study outcomes clearly indicate that direct-care workers have been heavily impacted by the COVID-19 pandemic thereby creating another level of trauma in addition to the existing traumas often experienced. Increased workload resulting in burnout, stress, anxiety, fear of virus contamination and several changes within the healthcare system was reported. Unfortunately, staff shortage, lower compensation, and little to know support from supervisors account partly to this menace. All these factors have

influenced the quality level of care residents receive as well as productivity in various nursing home settings.

Direct care workers have developed some coping strategies to help manage trauma at home and at work. These strategies such as religion/faith, recreational activities, and counselling helps them to de-stress, stay focused and continue to give care. It is important for the study organization to consider improvement in compensation packages to complement the already existing training and development programs available to staff. Building the spirit of teamwork among staff is critical towards ensuring residents receive person-centered care. Teamwork makes staff engaged, increases their morale, and feel supported and generally promotes collaboration and healthy interpersonal relationships among staff, and between staff and supervisors. Teamwork can only make the dream work when it's more of a partnership.

Support groups such as family, friends, and community members can help direct-care workers to manage their trauma. Promoting community education about support groups available and how people can assess them will go a long way to encourage involvement. Due to the perceptions about assessing support groups such as mental health support groups, most people do not want to be judged by others and would prefer to keep their traumatic experiences to themselves. Faith-based organizations can through religious teachings encourage members of which DCWs are a part to seek help anytime they feel threatened or experience any form of trauma.

5.2 Strengths, Limitations, and Future Directions

Just like any research, the current study was not without limitations. One limitation is the limited diversity of the organizations from which we sampled interviewees. The two buildings we recruited from shared leadership and non-profit management. We believe that these organizations

represent some of the most supportive organizations for nursing home staff. Given this, our findings of persistent challenges to DCWs needs to be contextualized to high-performing and supportive organizations. This is an exploratory study and so this sets the stage for further deep research into the area of trauma and resilience among DCWs in nursing home settings. Their responses and experiences, however, shaped the researcher's knowledge and understanding of the topic.

From the responses of the participants, the researchers realized that LTC institutions were hiring "agency staff" to complement the care work especially during COVID. However, this study did not interview any of these agency staff and to learn about their own experiences and how this impacts quality care for residents. Future studies can consider interviewing agency staff to measure their own experiences, how it has shaped the care work, and what strategies they have developed to manage their own experiences. Certified nursing assistants working in nursing home are only one group of direct care workers. Further research should consider other workers working in a variety of long-term care settings.

5.3 Recommendations for Practice, Policy, and Research

From the study findings, the researcher makes the following practice, policy, and research recommendations:

Given the many lessons learned from the COVID-19 pandemic and the long-standing discussions on the nature of care work, it is imperative that LTC organizations support DCWs to understand their traumas and identify protective factors to manage those traumas. Formally creating, managing, and sustaining team buddies within the organization can help DCWs to form meaningful inter-personal relationships with colleagues and supervisors that will serve as a channel to react deeply to traumatic situations. They can meet at agreed times in the form of

"check-ins" to evaluate how they are being supportive and ways to improve. From the findings of the study, many of the DCWs in our study sites run to their cars as a safe space to de-stress before going back to work. LTC employers should provide resources such as private spaces to truly get a break from work. These could be small rooms or pods within the nursing home building designed to support psychological safety and comfort (e.g., Code Lavender programs). Aside from raising the hourly rates for DCWs, which is crucial, LTC employers need to identify and implement other sustainable compensation packages that would improve the job quality of DCWs (e.g., Employee Assistance Programs, better paid leave).

For policy, administrators of Long-Term Care Services and Support (LTSS) should collaborate effectively with nursing home employers to develop a clear state plan that considers equitable approaches to support DCWs. Such approaches can include setting a minimum wage for DCWs across the state and country. Again, national training should be enforced to ensure universality in nursing home healthcare and to erase any form of role superiority such as "agency staff" receiving better employment benefits compared to traditional CNAs attached to nursing homes. The EDEN Alternative Training, Customer service, and mental health training among others should become a national requirement to become a CNA and effectively regulated by various stakeholders.

For future studies, more investigations need to be done around trauma and resilience among DCWs in various nursing homes. More empirical tools need to be developed to measure the impact of trauma on DCWs, their families, as well as their work. Future studies can explore different geographical and experiential constructs and how these can affect how DCWs provide care to residents in nursing homes. That notwithstanding, the outcomes of this study provide great insights towards establishing a strong foundation in research development and practice in Georgia and the

United States of America. Researchers should also collaborate with state agencies (for funding support) to conduct studies on trauma and resilience on a large scale such as the current study. The current study is associated with a broader grant-funded project awarded to the Gerontology Institute at Georgia State University to improve the nursing home workforce as well as residents. Other educational institutions, researchers, and consultants can establish such collaborations in the future to expand and fill the knowledge gap on the direct care workforce.

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APPENDICES

Appendix A: Informed Consent

Georgia State University

Informed Consent – Direct Care Workers Interviews

Title

A Trauma Informed Approach to Dementia Care in Georgia Nursing Homes

Principal Investigator: Jennifer Craft Morgan, PhD

Student Investigator: Alfred Boakye

Sponsor: Gerontology Institute, Georgia State University

Purpose

The purpose of this study is to describe the impact of trauma and resilience on direct care workers' daily lives and stress levels and how this translates into the care offered to residents in nursing centers. This will help to better understand the extent to which resilience is developed among direct care workers to develop a trauma-resilience inventory to support the direct care workforce and organizations.

You are invited to take part in this research study because you are a direct care worker, working as a nursing assistant, who have constant interactions – any form – with residents in a nursing center. A total of up to 25 direct care workers will be invited to be part of the interviews.

Your role as a direct care worker qualifies you to be recruited into the study. Your participation will go a long way to help the research team to achieve their research goals.

Procedures

After your decision to be part of this research, you will be interviewed. Through your responses, the researchers will be able to more fully understand your experiences as a direct care worker

and how trauma and resilience impacts your care work. You can choose to be interviewed in-person or we can use a virtual video chat platform. The interview will be audio-recorded for transcription purposes and responses will be transcribed verbatim. The interview is set to last for approximately 30 – 45 minutes. At the end of the interview, you will be asked to fill a short demographic survey, so we are able to describe the characteristics of the interviewees. Please feel free to ask any questions you may have. Once you start the interview, you not under any obligation to finish and your responses will still be used for the purposes of analysis.

Future Research

Your responses are for the sole purpose of this research and so your data will not be given out for any future research outside this one.

Risks

There are not any more risks than you would have in everyday normal life. However, you are cautioned that, some emotions may surface due to the sensitive nature of the research. Either way, resource will be shared that may help you manage those emotions.

Benefits

This study will not benefit you personally. We hope to gain information about how to resource nursing homes to use a trauma-informed approach to supporting staff. We hope that this will help support person-centered care of all residents. This will be done by building systems to resource Georgia's nursing homes. We will do this by using a variety of in-person and online communication and training strategies.

Alternatives

The alternative to taking part in this research is not to take part in the research.

Compensation

For taking part in the study, you will receive a $25 as thank you for your voluntary participation.

Voluntary Participation and Withdrawal

You are not in any way obligated to participate in this study. You have the right to withdraw from this study at any time. You can skip questions that you are not comfortable with. You have every right to seek clarification if the question does not seem clear to you. Do not hesitate to inform the researcher if you want to stop the interview any time.

Confidentiality

Every effort will be taken to protect your identity as a participant in this study. Your data will be kept confidential to the extent of the law, and you will continue to remain to protect your identity. The following people, the study team, will have access to the information you provide:

Principal Investigator: Jennifer Craft Morgan, Co-Investigator: Elisabeth O. Burgess, Project Manager: Crystal Warren Williams; Research Staff: Celeste Greene, Alfred Boakye, Lynette Okwaro, Waqar Ahmad and Yun-zih Chen

- GSU Institutional Review Board
- Office for Human Research Protection (OHRP)

All files will be stored on password protected servers provided by GSU. All of your information will be coded and remain private. The codes linking your information to your study ID are private and secret. The information you provide will be stored in a locked cabinet and on password- and firewall-protected computers and/or servers. After the interview has been copied word for word, the audio will be destroyed. The copy of interviews will not be given to the Department of Community Health or your organization. When we present or publish the results of this study, we will not use your name or other information that may identify you.

Contact Information

Contact Dr. Jennifer Craft Morgan at jmorgan39@gsu.edu and aboakye4@student.gsu.edu

- If you have questions about the study
- If you have questions, concerns, or complaints about the study

  Contact the GSU Office of Human Research Protections at 404-413-3500 or irb@gsu.edu

- If you have questions about your rights as a research participant
- If you have questions, concerns, or complaints about the research

Consent

We will give you a copy of this consent form to keep.

If you are willing to volunteer for this research, please sign below.

Print Name Here

Signature Here

Principal Investigator or Researcher Getting Consent

Date

Appendix B: Staff Demographic Profile (CNAs)

Staff Demographic Profile (CNAs)

Date: ____/____/____

_____

1. How old are you? **years.**

2. Sex: **(Select One)**

- Male
- Female
- Other? _____
- Prefer not to answer

3. Are you Spanish/Hispanic/Latino **(of any race/Choose One)**?

- Yes
- No

4. Choose one or more races to indicate what you consider yourself to be: **(Select all that apply)**

- White or Caucasian
- African American or Black
- American Indian or Alaska Native
- Native Hawaiian
- Korean
- Filipino
- Vietnamese
- Samoan
- Asian or Pacific Islander
- Native American
- **Other race: please specify**?_____

5. Were you born in the U.S. or were you a U.S. citizen at birth?

- Yes
- No

IF NO, in which country were you born? _____

6. What is your marital status (**Select One**)?

- Single
- Married or in a Committed Relationship
- Divorced
- Widowed

7. What is the highest credential or degree you have earned?

- Less than High School
- High School
- Some College
- College degree
- Graduate degree
- **Other: please specify**?_____

8. How long have you been employed in any healthcare organization?

_____ **years.** _____ **mos.**

9. How long have you worked at this nursing home?

_____ **years.** _____ **mos.**

10. What is the title of your job at this nursing home? _____

11. How many hours do you work in a typical week in this position? _____ **hrs/week**

12. What shift do you currently work? (Circle all that apply)

- First
- Second
- Third
- **Other: please specify?**_____

13. What is your average Household income? (***per year/month***) _____

14. Do you have a second *paid* job? _____

15. Do you have health insurance from any source? _____

Thank you for your time and Responses. We really appreciate it.

Appendix C: Interview Protocol

Interview Guide for Trauma and Resilience among Direct Care workers in Long Term Institutions

Target Group: Direct Care Workers Estimated Time: Approx. 45 minutes.

This study seeks to understand the relationship between trauma and resilience among direct care workers, particularly, those in long term care facilities. How direct care workers can build resilience in their line of work to manage traumatic situations or events typically guides this conversation. In as much as there are some questions posed, kindly know that other questions may come up. Please feel free to share your thoughts, experiences and recommendations in detail and anything you feel will contribute to understanding these constructs better.

1. How are you feeling today?
    - Did you say anything to yourself before leaving the house, and if so, what did you say?
    - Did you encounter anything on your way to work?
    - How would you describe the work environment when you first arrived to work today?
    - Can you walk me through what you have done today or intends to do before close of day?
    - What makes you enjoy working as a caregiver in this facility?
2. Understanding trauma and how it impacts us is necessary towards developing protective factors?

    Please explain what “trauma” means to you and your work as a direct care worker.

    - Can you tell me about a time when you experienced something that was threatening to you?
    - Can you share your thoughts on how trauma impacts your mental health and approach to work?
    - How has your past experiences influenced your current situation?
    - How does the trauma you experience affect the quality of care you provide to your residents? Can you share an experience?
3. Do you feel physically, psychologically, and emotionally safe in this working environment?
    - Can you tell me about a time where you were faced with the most difficult work problem? How were you able to resolve it?
    - Have you ever thought of or suspected that employees in your organization are not treated equally?
    - What is the worst thing that could happen to you as a direct care worker?
    - How do you intend to manage that situation should you be faced with it in future?

4. In your own words, how would you define resilience and what does it mean to you?
    - What makes you come back or bounce back to work after you have gone through a traumatic event?
    - Can you describe a situation where somebody you know exhibited or demonstrated resilience?
    - Can you share a time where you thought someone could have demonstrated resilience in a particular situation?
    - How can one's personality contribute to becoming resilient?
5. Considering your identity or who you are, what are some of the factors that affects how you cope with trauma at work?
    - How do you respond to trauma at home or in your community?
    - What support does your family or community provide to someone who experiences trauma?
    - Can you describe a time where you or someone in your family experienced a traumatic situation and how it was managed?
    - How do you think your gender might play a role in how you respond to traumatic situations at work?
6. How do you think collaboration and working with others play out in your organization?
    - How does teamwork play out in this organization?
    - How do you ensure your team do not get overwhelmed?
    - What is the organizational structure like, and does it allow for independence?
    - Generally, do you think your supervisors and co-workers understand you and the work you do?
    - If you were the team lead, how would you ensure your team is improved?
7. There is continuous change in the healthcare landscape since the emergence of COVID-19. What one change do you think has impacted your work?
    - How often have you experienced burnout and exhaustion while providing care?
    - Do you think this has impacted your decision to stay or leave?
    - Comparing your current experiences to pre-COVID, what would you say the experience has been for those who have left and what do you feel about this?
    - Can you share your thoughts on how COVID-19, political turmoil and systemic racism has affected your work and organization as a direct care worker?
    - Can you think of some innovative ways to improve the current work situation?
    - Can you share a time when you had to do something different to save a situation and what was the outcome?
    - How would you say your organization responds to and implement new changes?
    - Can you tell me about a time where you or a staff disagreed with a change idea from management? How did they respond to your resistance? Do you think that change would have improved the work of direct care workers in this organization?

- Aside from COVID-19, political turmoil and systemic racism in the healthcare sector, do you think there are other factors that impact your work as a direct care worker? *(eg. Socio-economic factors such as wages or salaries etc?*

8. What have you done to maintain a healthy work-life balance?

    - Can you share with me some of the activities you engage in to ensure you are rested, healthy and high performing?
    - Does your organization encourage self-care and taking time off work to put soul, mind and body together?
    - If yes, what are some of the activities or events that keeps employees engaged? *(eg. Site seeing, vacation together as staff etc.)*
    - If no, what could be reason? Are there policies (ones that you know of) that prevent them from implementing those strategies?
9. What has your organization done or is currently doing to make sure you are successful?

    - Are there trainings or developmental activities geared towards managing trauma among direct care workers? Can your organization do more?
    - Can you tell me about a time where you applied a training to your work?
    - Can you recommend trainings for your organization that will promote your health and wellbeing?

10. What comes to mind when you reflect on the deaths of any of these people?
    - George Floyd
    - Breonna Taylor
    - Keshia Chanel Geter

11. How do you think you can become more resilient at work, home and in your community?

    - What steps can you take to become more resilient?
    - What can your family do to help you become more resilient?
    - What can the community do to help you become more resilient?

12. Is there anything that I haven't asked about that you think is important for me to know about your experiences as a direct care worker in this long-term care institutions including other institutions where you have worked?