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Trauma Bonding in Nursing: A Reflection

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Abstract

Trauma bonding has been addressed in the literature, yet little is offered regarding trauma bonding in nursing. This article addresses trauma bonding as it relates to nursing, compares it to others stressors, and offers insights into interventions from both the organizational and individual nurse's perspective.

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Introduction

There is a hidden crisis in healthcare. The current climate of healthcare environments has a clear impact on an individual's mental health. According to federal data, healthcare workers experienced more significant mental health declines as compared to any other sector between 2018-2022 [1]. Declining professional-wide mental health concerns represent broad consequences for individual nurses, hospital organizations, patient care, and nursing.

Prior to the pandemic crisis, issues including suicide, burnout, and workplace violence were looming areas of concern. Compounded by the Coronavirus Disease (COVID-19) pandemic, these issues have been magnified. This intermittent victimization can cause trauma to the professional nurse. Although several potential stressors affect nurses' well-being, current universal hardships are reviewed. This article explores the mental health consequences of the victimization of nurses and the power bonds within maladaptive environments in which they practice.

One of the most recent unpredictable stressors for nurses working in healthcare has been the COVID-19 pandemic. These job-related stressors included the risk of being infected with COVID-19 or bringing it home to loved ones due to a lack of protective equipment, increasingly verbal and anxious consumers with inadequate information, decreased staffing, and excessive hours [2](Micali et al., 2024). Multiple studies have highlighted the psychological impact on nurses made up of depression, anxiety, insomnia, and stress with mental health deterioration [2].

Work-related stress can affect work performance in professions that demonstrate excessive workloads and lack of social support [2] (Micali et al., 2024). During the COVID-19 pandemic, 36% of nurses experienced exhaustion and burnout [3]. Research demonstrated that when virtual support was presented to assist with the psychological effects of COVID-19, nearly half of the healthcare workers surveyed met the criteria for suicide risk [4].

Prior to the pandemic, alarms sounded over the suicide risk of nurses. Data from 2018 noted that nurses were 18% more likely to die by suicide than the general population prior to the pandemic, which takes approximately two years to collect data [5]. It has been concluded that adverse work environments, knowledge of lethality, and individual factors place nurses at higher risk for suicide[6]. Although suicide risk is multifactorial, nurses are less likely to seek support, including misrepresentation of role stress and exposure to trauma as part of their job, and they should be able to manage it [7]. Nurses, as a profession, are at risk for maladaptive mental health in the context of the job.

Job stress in the nursing profession is evident today. Patterns have emerged of negative job characteristics. Research has found consistent job elements within the profession, including high workloads, low staffing levels, long shifts, time pressures, high psychological demands, negative relationships, and poor leadership and support [8]. The unrealistic expectations of the job, in conjunction with a maladaptive environment, create a non-tenable atmosphere for nursing practice. Among challenging work conditions, emotional distress, disappointment and a culture of hierarchy, nurses intend to leave the profession [9]. However, many choose to stay.

In a maladaptive environment, nurses may feel a sense of loyalty to their workplace even when subjected to challenging work conditions and harmful job elements. This loyalty can lead to a sense of obligation to tolerate abusive behavior and accept unacceptable working conditions. In addition, many healthcare organizations have complicated hierarchical structures that can reinforce trauma bonding by disregarding nurses' needs and concerns through complicated engagement channels. Understanding the trauma bonding process is necessary to identify ways to disrupt the patterns and support healthy collaboration and support within nursing.

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Trauma Bonding Defined and Correlation to Nursing

Trauma bonding is well evidenced in the literature when looking at unhealthy relationships. Described as "the glue that holds abusive relationships together" [10], the term refers to a strong attachment that connects an individual to their abuser and reflects the desire for power rather than love or respect for another [11,12]. The connection is based solely on abuse and mirrors a form of codependency. Like a codependent relationship, the individual may feel safe and integral to the abuser, and the attachment is strongest when in the honeymoon or reconciliation phase.

Trauma bonding reflects an imbalance of power, with the upper hand being noted as the abuser. Positive and negative interactions are planned and are linked to the desired outcome that the abuser determines. Those who have less power in this relationship often blame themselves for the negative and express gratitude for the positive interactions with their abuser, and the connection is often established within a relationship of betrayal and fear. The relationship often serves as a paradox, as those with less power often are perplexed as to their caring and attachment to the abuser. The answer may be associated with the correlation of empathy to the relationship and the trauma bond, as empathy may serve as a catalyst to increase the likelihood for trauma bonding [11,13-15].

In nursing, the trauma-bonding process is reflected in the ideology that "the patient is the highest priority" based on the nature of this empathetic profession [16,17]. Noted by many as "angels of mercy", nurses are cited for dedication to others even at an expense to themselves [18,19]. This mindset reflects empathy and dedication to caring for others. These same dynamics also are connected to relationships where the individual is in a "one down" or less powerful position [20]. This process illuminates an image of nursing which promulgates a lack respect and power dynamic for nurses.

Phases in trauma bonding mirror those of other abusive relationships. Here, there is a period where a deep connection is established, and a sense of euphoria is often felt. This allows an individual to feel "hooked" into the relationship. The "hook" for employment could be salary or benefits based, location of employment or hours that might be conducive to one's lifestyle, at this point, an individual might be rushed into a relationship and trust is built. Tension builds, and stress is noted in the relationship. For the abuser, the stress may be attributed to something that may be projected or attributed to the individual connected to them via a trauma bond, such as patient outcomes or staffing needs. Once the pressure builds to a breaking point, a form of violence occurs.

During this stage, traumatic and even violent acts can occur. These acts can be verbal, lateral, emotional and even physical. The act devalues the nurse. This violent act(s) can release the tension that the abuser is feeling. Either or both partners may indicate that they have had enough and plan to separate from the relationship. Within these abusive environments individuals may ignore stressful issues such as inadequate staffing, limited supplies, or repeated acts that are perceived as traumatic.

However, once the tension is deescalated, both parties return to the relationship as if nothing happened. Excuses are made, and many assume that the situation will not reoccur. There may be statements or remorse by the abuser, and the abused may make excuses and justify the incident by believing they are somehow responsible and tolerable. This often comes across as placated, inspirational messages from those in leadership positions. Offerings of positive experiences are often noted. Within the hospital workplace, a "pizza party" has demonstrated an act of redemption.

The relationship then turns into a normalized situation. This dynamic has been attributed to difficulty with attachment, mirroring of actual relationships or those they witnessed within the family. This phase is mirrored in nursing after staff remove themselves from the relationship, more staff are brought in, or interventions are added to temporarily relieve the stress. This is the stage where the cycle starts anew leading to building tension and stress eventually resulting in another event [21-24].

Trauma bonding can occur in any relationship where the power base is out of balance. It is not unusual to see in work relationships, especially when workers classify themselves as a caregiver and put other's needs above their own. This mental dynamic, self-belief, and moral obligation increases the likelihood of nurses experiencing trauma bonding in their profession.

Differences between Trauma Bonding, Compassion Fatigue, and Moral Distress

In trauma bonding, a cyclical dynamic occurs where an individual connects with others due to the noted trauma. For nurses, this is often their peers. They make significant efforts to correct the situation and continue to stay connected due to the trauma at hand. When we look at other states of imbalance in nursing, such as compassion fatigue, moral distress, or burnout, we note a more linear progression.

Compassion fatigue is when an individual is overwhelmed by the trauma experienced by others. The individual experiences other's trauma vicariously, and the other individual does not necessarily initiate the trauma. This secondary stress disorder has a permanent impact on the individual's life if not correctly addressed, and the dynamics linked to compassion fatigue can compound. Once compassion fatigue results, the individual emotionally separates from the organization and others with whom they interact [25].

Burnout, a portion of compassion fatigue, often results when the individual believes their worth is not appreciated, or their skills are not used to their optimal potential. Here, the individual's emotion "dries up," and the result again is distancing. The dynamic is linear, resulting in a disconnection from others and the organization for which they work [25-27].

Moral distress is noted when an individual believes an intervention is not the best for the patient and their care. Others with more power make decisions that do not coincide with what the individual considers in the best interest of another, and stress results. Left untreated, increased stress develops [25].

Nursing is a profession that is fraught with many challenges and stressors that can lead to significant mental health concerns for individuals which translate throughout the workplace and into the professional culture. Moral distress, compassion fatigue, and trauma bonding are three interrelated concepts that are prevalent in the nursing profession. These concepts share some commonalities, including the potential for negative impacts on the mental health of nurses.

Impact on Nursing

While it is quickly noted that trauma bonding is indicative of unhealthy relationships, information on the trauma bonding impact on nursing is nearly nonexistent. Being a helping profession, nursing is indicative of caring for others before oneself. This dynamic was noted repeatedly during the recent pandemics. Nurses experienced a collective trauma experience where most nurses were on the frontlines, working extended hours with infected patients, often with shortages of protective equipment [28].

These high-pressure circumstances can create an imbalance where the care of others, and the support of an organization can supersede self-care and individual support. Nurses are considered human capital [29,30]. Some may equate nurses with things that can be manipulated to meet organizational needs. When the emotionality is removed, it is easier to exhibit a relationship that reflects a lack of balance.An environment that uses rather than supports those that work within the system can be the result. This further reflects the position of powerlessness that many equate with their profession of nursing [31-33]. Hence, nurses leave the profession.

Explicit violence does not have to be the total result of experience. Lack of respect and care for workers can also reflect this dynamic and are linked to the trauma bond. These dynamics reflect the rigid roles noted within trauma bonding. Powerbrokers abuse and those being abused complain yet do nothing to rectify the situation. If for some reason they separate from their organization, they will often find a work environment that is like the one which they complain about. This triangulated dynamic leads to both mental and physical illness and does nothing to support the health and well-being of anyone within the system [25,33-36]. It is important to consider a clear strategy based on evidence and brainstorm new ideas in applying current information to the specific need noted

Generating Change through Informed Care Approaches

Trauma-informed care is a comprehensive approach that recognizes the prevalence of trauma and its potential impact on individuals seeking healthcare. Trauma bonding are concepts well known within disciplines of psychology and counseling with evidence-based theories and processes to manage trauma bond formation in settings such as residential treatment centers and inpatient mental health care. Within the nursing context, adopting a trauma-informed care approach involves creating a safe and supportive environment for patients while providing education and resources for nurses. By incorporating trauma-informed practices in nursing care, such as using trauma-sensitive language, promoting autonomy, and fostering trust through clear communication, nurses can help mitigate the risk of trauma bonding and promote healing.

Nurse managers can implement a trauma-informed care culture in their units to establish psychological safety for floor nurses by following these steps:

1. Education and Training: Provide comprehensive education and training to all staff members on trauma-informed care principles, including understanding the impact of trauma on individuals and the importance of creating a safe environment.

2. Assessing Trauma History: Encourage nurse managers to assess the trauma history of their staff members sensitively and confidentially. This information can help identify potential triggers and develop personalized strategies for support.

3. Communication and Collaboration: Foster open and transparent communication channels between nurse managers and floor nurses. Encourage regular check-ins, team meetings, and forums for sharing concerns, ideas, and feedback.

4. Supportive Policies and Procedures: Develop and implement policies and procedures thatprioritize trauma-informed care, such as flexible scheduling, self-care opportunities, and access to mental health resources. Ensure that these policies are consistently enforced. Creation of organizational processes to increase real-time access to emotional crisis management for staff.

5. Empowerment and Autonomy: Encourage nurse managers to empower floor nurses by involving them in decision-making processes and providing opportunities for professional growth, fostering a sense of ownership and control over their work environment.

6. Peer Support and Mentoring: Establish peer support programs or mentorship initiatives where experienced nurses can guide and support their colleagues, creating a sense of community and promoting a supportive culture. Implementing behavioral resource nurse into crisis response teams to lead de-briefing about the event and emotional processing in real-time.

7. Ongoing Evaluation and Improvement: Continuously evaluate the effectiveness of the trauma-informed care culture in the unit. Seek feedback from floor nurses and make necessary adjustments to improve psychological safety and overall well-being.

By implementing these strategies, nurse managers can create a trauma-informed care culture that prioritizes psychological safety for floor nurses, ultimately enhancing their overall job satisfaction and well-being. Expanding upon the strategies that nurse management and leadership can utilize, another modality that could be incorporated into the culture of nursing would be Cognitive-Behavioral Therapy (CBT). CBT is a widely utilized therapeutic approach that can be adapted to address trauma bonding in nursing. CBT identifies and challenges maladaptive thoughts and behaviors, helping individuals develop healthier coping mechanisms.

In trauma bonding, CBT can assist nurses in recognizing the underlying dynamics of their attachment to patients, peers, and institutions with the focus on guiding them in reframing their thoughts and emotions. By encouraging self-reflection and providing tools to manage distressing emotions, CBT equips nurses with skills to break the cycle of trauma bonding and establish healthier boundaries in their patient relationships.

To implement the use of CBT within the nursing profession, creating practices for the framework from the orientation of staff and thread interventions within unit culture and structure can shift the emotional reactivity and processing on an institutional level. Self- reflection is a fundamental aspect of professional growth and development for nurses. It involves consciously examining one's thoughts, emotions, and behaviors to gain insight and make positive changes. By integrating cognitive-behavioral therapy (CBT) techniques into self-reflective practice, nurses can enhance their self-awareness, challenge negative beliefs, and develop healthier coping strategies.

The first step in implementing CBT into self-reflective practice is to cultivate mindfulness. Mindfulness involves focusing on the present moment without judgment. Nurses can benefit from incorporating

mindfulness techniques, such as deep breathing exercises or guided meditation, into their self-reflection routine. Nurses can better understand their cognitive and behavioral patterns by cultivating a non-reactive and non-judgmental attitude toward their thoughts and emotions.

By establishing mindfulness, nurses can begin the process of identifying and challenging negative thoughts and beliefs that may contribute to trauma bonding. Nurses can explore their automatic thoughts and question their accuracy and validity. They can ask themselves, "What evidence supports or refutes this thought?" or "What alternative, more balanced perspective can I adopt?" By challenging negative thoughts and replacing them with more positive and realistic ones, nurses can reframe their experiences and reduce the risk of trauma bonding. Another critical aspect of implementing CBT into self-reflective practice is exploring underlying emotions and triggers. Nurses can benefit from examining the emotions they experience in their patient interactions and identifying patterns or recurring themes. This self- reflection can help nurses uncover unresolved personal issues or past traumas that may influence their attachment dynamics. By acknowledging and addressing these emotions, nurses can better understand themselves and their reactions, leading to more effective patient care and healthier professional boundaries.

Incorporating behavioral strategies into self-reflective practice is also crucial. Nurses can set specific goals related to breaking the cycle of trauma bonding and work towards implementing new behaviors. For example, a nurse may establish boundaries in patient relationships by clearly communicating expectations or seeking colleague support when facing challenging situations. By intentionally changing their behaviors, nurses can reinforce positive change and promote healthier interpersonal dynamics.

It is important to note that implementing CBT into self-reflective practice requires ongoing commitment and support. Nurses can seek guidance from mental health professionals, attend CBT workshops or trainings or engage in supervision or peer support groups. These resources provide a valuable space for nurses to discuss their experiences, gain insights, and receive feedback on their self-reflective practice.

In conclusion, integrating CBT techniques into self-reflective practice offers nurses a powerful tool for personal growth and professional development. By fostering mindfulness, challenging negative thoughts, exploring underlying emotions, and implementing behavioral strategies, nurses can enhance their self-awareness, break free from the cycle of trauma bonding, and establish healthier relationships with their patients. Incorporating CBT into self- reflective practice contributes to nurses' overall well-being and effectiveness in providing compassionate and patient-centered care.

On a larger scale, the implementation of group therapy offers a valuable platform for nurses to process and address trauma bonding in a supportive environment. Participating in group therapy sessions allow nurses to share their experiences, gain insights from peers, and receive guidance from trained therapists. This approach fosters a sense of belonging and validation, reducing feelings of isolation and shame that often accompany trauma bonding. Through group therapy, nurses can gain a deeper understanding of the complex dynamics at play in their relationships with patients and develop strategies to break free from the cycle of trauma bonding while providing adequate care. Group therapy can be led by nurses with additional training and is a great opportunity for nurses to expand their skillset while benefiting personally from the knowledge gained. Management and leadership can support this initiative through unit council, champion roles, training interested staff, and prioritizing timing within busy workday schedules for group therapy to occur. Incorporating group therapy practice into the daily routine of nursing can be beneficial in reducing symptoms of trauma. Here are some steps to consider:

1. Assessing the Need: Begin by assessing the needs of the nursing staff and identifying individuals who may benefit from group therapy through confidential screenings or staff self-reporting.

2. Collaboration with Mental Health Professionals: Collaborate with mental health professionals, such as psychologists or counselors, to develop group therapy programs tailored to the specific needs of the nursing staff. These professionals can guide effective therapeutic techniques and interventions.

3. Establishing a Safe Environment: Create a safe and confidential space where nurses can openly discuss their experiences and emotions related to trauma. Emphasize the importance of confidentiality and respect within the group.

4. Structured Sessions: Plan structured group therapy sessions that focus on various aspects of trauma recovery, such as psychoeducation, coping skills, and emotional regulation. Incorporate evidence-based practices into the sessions, such as cognitive-behavioral therapy or mindfulness techniques.

5. Facilitation by Trained Professionals: Ensure trained mental health professionals with trauma- informed care experience facilitate group therapy sessions. These facilitators can guide discussions, provide support, and address any challenges that may arise during the sessions.

6. Regular Schedule: Incorporate group therapy sessions into the daily or weekly nursing routine, allowing nurses to participate without disrupting their responsibilities. Consider flexible scheduling options to accommodate different shifts and availability.

7. Evaluation and Feedback: Continuously evaluate the effectiveness of the group therapy practice by seeking feedback from participating nurses. Monitor trauma symptoms and overall well-being changes to assess the sessions' impact.

By incorporating group therapy practice into the culture of the workspace, nursing can provide a supportive and therapeutic environment for nurses to address trauma-related symptoms. This approach can contribute to their overall healing and well-being.

There are multiple effective treatment frameworks utilized to address trauma and trauma bonding. Shifting culture to allow for healing space in the nursing profession is necessary to promote the emotional well-being of nurses. The intervention ideas mentioned above are evidence-based practices utilized in other venues and can be formatted to fit the workspace of nursing. The benefit of supporting nurses emotional coping through increased distress tolerance benefits not only the workforce of nurses but the patients they serve.

Conclusion

As caregivers, nurses often put their patients first, neglecting their own needs. This can lead to a phenomenon known as silent trauma, which can cause burnout, stress, and impact the quality of care being provided. The workplace environment for nurses is inherently traumatic leading to the formation of trauma bonds between nurses and their workplaces. The experience of trauma and continued abuse cycle in healthcare does not have to continue. Implementation of trauma-informed care within nursing's culture can lead to healing, emotional support and growth for nurses. Nursing has always been a profession focused on compassion, advocacy, and improvement in the lives of others, now is the time that nursing applies our own interventions to our profession.

Competing Interests

The authors declare that they have no competing interests.

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