Building the Airplane in the Air: Trauma-Informed Clinical Pastoral Education during a COVID-19 Summer

Beth Naditch

Like many geriatric organizations across the country, we at Hebrew SeniorLife in Boston watched with dread as the novel coronavirus made its way across the world. It was already clear that elders were at a much higher risk of dying from this new disease, though little else was clear. Hebrew SeniorLife (HSL) quickly began activating our infection control plans to prevent and mitigate the virus in our six Greater Boston-located health care and senior housing communities. In moves that are now familiar across health care, visits, including those from volunteers and family members were stopped. Special, separate COVID-19 units were set up for those who might contract the virus within our system. Anyone coming into the building was screened for symptoms. Our model of communal dining was changed; patients and residents now had food delivered to their rooms or apartments. Many frontline staff members moved into hotel rooms provided by HSL so as not to potentially infect their own family members.

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Despite our best efforts, and perhaps inevitably, HSL experienced multiple COVID-19 cases and deaths once the virus arrived. Each death and loss in long-term care or in housing was felt deeply. These were not anonymous patients known for perhaps a few days or even weeks in the hospital. Each confirmed case and each loss was the loss of a person whom staff, students, other patients, and other residents knew well and lived with on a day-to-day basis. In most cases, staff had worked with these patients and their families for months and even years. Staff was stretched and grieving, patients in long-term care and residents in housing communities were scared and lonely, and our clinical pastoral education (CPE) students and educators, also caught in the maelstrom, tried to adjust as nimbly and flexibly as we could.

Like many other centers, our CPE units in progress were modified to meet the unfolding situation, adjusting to Zoom classes and creative uses of telechaplaincy. As we brought those storm-tossed units to a close, questions of the summer loomed. After much deliberation, Reverend Mary Martha Thiel, ACPE Certified Cducator and director of CPE, and I (Rabbi Beth Naditch) proposed cancelling the level I units scheduled for the summer. A number of factors went into the decision, including the uncertainty about whether students would even be allowed on campus. Another factor was the availability of adequate testing and PPE—these problems were on the way to being solved in May but were not yet there. Critical to our decision-making process was our consideration of the bandwidth of current staff, including staff chaplains, to acculturate students and offer guidance in clinical settings. As the surge of March, April, and May began to wane, it became clear that many staff were suffering from all four of the categories of stress injury as defined by Drs. Patricia Watson and Richard Westphal in their stress first aid model: loss, traumatic injury, moral injury, and fatigue injury.[1] We felt that it would be too much to ask of staff, who were working mightily to keep themselves above water, to add the task of helping to mold and mentor first-unit CPE students. Usually, staff embrace our students with open arms, and usually our students come to appreciate the complexity of people and positions that make a health care organization run successfully. Thrusting beginning students into a situation where they were working with traumatized patients and staff, especially when most of our incoming students had not worked full-time in a professional setting before, seemed to be a poor choice for all involved.

As responsible and rational as the decision felt to cancel our level I program, it left us at a crossroads. As ACPE Educators, we knew that there was a possibility of being furloughed, as many "nonessential" workers who were not able to be "redeployed" into other roles had been. We knew that there was much essential spiritual care to be done with patients, residents, and staff. We knew that fresh, experienced energy would be eagerly and gratefully accepted by our chaplains, who had not had time to so much as breathe since the beginning of the pandemic. We were both impacted by feelings of powerlessness and diminished agency, key components of moral stress.[2]

Thus, in mid-May, we formulated an idea to offer an advanced unit of CPE with a specialty focus on the pandemic and telechaplaincy. Essential to the proposal was the makeup of the potential CPE group, which would be open only to alumni/ae of our program who were already familiar with both the institution and the educators. Critically, alums could "hit the ground running." We began to recruit in earnest for a program that would begin in early June. To our surprise, those whom we contacted responded with alacrity. Many had summer plans that had been cancelled, including, sadly, rescheduled vacations and even a wedding. All were inspired by the possibility of giving back at a time when they felt so powerless.

Decisions in Crafting a COVID-19-oriented CPE Unit

In 2018, our program had received an Innovative Projects Grant from the ACPE Foundation to develop a specialty CPE unit on trauma-informed care. For much of the previous three years (pre-grant, during, and after), I had been immersed in theoretical and practical applications of trauma-informed care *and* the teaching of trauma-informed care in a CPE context. As we crafted the curriculum, we took into account the lessons from that immersion. Zurbriggen (2011) suggests that in clinical education that involves teaching about trauma, it is important to vary the intensity of the material, limit exposure levels, and help students to reflect on and connect with opportunities for self-care.[3] To this end, we recommended that our students read Laura Van Dernoot Lipsky and Connie Burk's excellent *Trauma Stewardship: An Everyday Guide to Caring for Self while Caring for Others* (see resource list at the end of this article). One student, moved by the relevance

of the content, organized a lunchtime discussion group about the material with her peers.

Inspired by a viral social media post on self-care,[4] we added versions of the following questions to our process note template, which was due weekly.

- What am I grateful for today?
- Who am I checking in on or connecting with today?
- What expectations of "normal" am I letting go of today?
- How am I getting outside today?
- How am I moving my body today?
- What beauty am I either creating, cultivating, or inviting in today?

We added: How am I connecting with the sacred or with God today? Students reported that these questions helped them stay grounded when things got overwhelming. Sometimes, their answers provided some much-needed lightness during the mood of the summer. One of my students was fish-sitting for a friend's beloved and expensive fish, and each week one of her answers to the gratitude question was "The fish is still alive!" Reflecting on how even small added stresses—like fish-sitting—or small gratitudes—like fish survival—can impact a period of time became a fruitful thread throughout our supervision.

Given the context in which we were living and working this summer, it was not always possible to limit exposure to intensity. During a summer that contained a global pandemic, the murder of George Floyd and the aftermath of the murder of Breonna Taylor and the subsequent mourning and protests, political unrest, a spiraling economy, and a world that at times was literally on fire, intensity ran high. What we could do as educators, however, was to remind students that our bodies, our hearts, and our souls were having normal and expected responses to an abnormal situation. Helping the students to contextualize gave them language that they could then use with staff and patients.

In their helpful and aptly titled 2014 article "Potentially Perilous Pedagogies: Teaching Trauma Is Not the Same as Trauma-Informed Teaching," Janice Carello and Lisa Butler lay out principles through which to make one's educational practice more trauma-informed. Their fourth principle, "appreciate how a trauma history may impact your students' academic performance, even without trauma being a topic in the classroom,"[5] was also

key in our organization of our virtual CPE classroom. Though we had a clear schedule of what was due when, we recognized that trauma can impact cognitive sharpness. Four, five, and six months into the pandemic, no one was at their organizational best. To respond, we intentionally reviewed coming assignments at the end of each week and held a forgiving stance when students were not at their best. One student expressed her appreciation in her program evaluation, writing, "The educators made space for grief and some of the inevitable lapses in my usual functioning due to trauma's effects, and this was very helpful."[6] When we as educators had lapses, we allowed the modeling of our messy humanity for students as well.

Another example of this principle was baked into the structure of the unit. Trying to be realistic about the capacity of students to learn while coping with their own stress, we offered students the opportunity to choose to do a half unit or a full unit. (Because this was our first serious foray into telechaplaincy, we also wanted to make sure that we created a realistic path for students to complete their clinical hours.) The flexibility proved key for the seven students who registered for the unit. Five out of the seven students chose the half unit, and two, who were interested in completing a fourth unit for certification and were employees of HSL, chose to complete a full unit. In a program evaluation, one student noted, "The 1/2 unit was definitely the right choice for me this summer given all of what was on my plate, so I'm grateful that was an option and a common one. Being able to choose between a 1/2 & full unit made it possible for me to participate." A second noted her gratitude about being able to complete a full unit in the same group with colleagues and peers who needed a half-unit option. Interestingly, in exit interviews, several students advocated having this option open in the future as a possibility for congregational clergy even outside of a pandemic situation.

In many ways, CPE is a natural match for the six key principles of a trauma-informed approach. Ideally, a trauma-informed care environment will create safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, and voice and choice and will acknowledge or transcend cultural, historical, and gender issues.[7] We aspire to these principles in every unit of CPE, though for this summer unit we were also intentional about naming them as critical elements of trauma-informed care.

Demographics

Of the seven students who decided to join us, six identified as female and one identified as nonbinary. Students ranged in age from late twenties to late fifties. All were White. Four students were ordained clergy: an Israeli Reform rabbi, one Lutheran and one United Church of Christ pastor, and one rabbi who affiliated as multidenominational. One student was in rabbinical school, and two students were in discernment in their denominations (Episcopal and Unitarian Universalist). Most students, though familiar to us, had not been in a CPE group together. There was great delight on the part of all seven as they experienced a CPE group in which each and every member had the demonstrated capacity to offer solid spiritual care and each of their peers was committed fully to CPE and personal growth. For some, this felt familiar, and for others, it was a new and eye-opening experience. One student commented on how much her engaging in CPE provided her with structure: "Doing a unit during this COVID summer was helpful to keep me focused and on track with my growth. I appreciated a place to process what was going on in the world in a spiritual sense, particularly alongside others who were dedicated to their own growth and reflection."

Learning from the Spring: Possibilities and Limitations of Virtual Work

As we mapped the potential unit, we integrated lessons learned from our spring experience of moving the units into virtual space. We had discovered in March and April that a seven-hour day on Zoom, even with breaks for lunch or recharging, felt exhausting to students and educators alike. For the summer unit, we scheduled two half days of group/class instead of one long day to mitigate "Zoom fatigue." Students met for educational time via Zoom two mornings a week from 9–12:30 and completed additional "flex" educational time through assigned webinars and discussions.

The group of seven students was split into two smaller groups for verbatim processing, each one led by an educator, and the students met as a full group for all other work. There was some nervousness on the part of the students after orientation, which had been done as a large group, that it would feel like something was missing when we divided into small verbatim processing groups. To the surprise of those who were skeptical, they found that

they appreciated the double-group experience. Several noted, throughout the unit, that by participating in the large group of seven and a smaller verbatim processing group, they gained a deeper appreciation of group dynamics and systems than is often possible in a more traditional CPE unit.

The students met with the leader of their smaller group for individual supervision approximately once per week. One benefit that emerged from co-supervision was the students' opportunity to work with two educators who had similar theory bases but vastly different styles. The students reflected often on our different styles, both during individual supervision and during group. Students felt that we educators worked as an effective team with a united front, which reflected our experience as well.

Another lesson learned from the spring was that telechaplaincy is not tenable with most patients in our long-term care settings, where our students are usually placed for their clinical assignments. The same physical frailty that necessitates that our patients live in a long-term chronic care hospital can make it impossible for them to hold a phone to an ear or hold an iPad for a virtual visit. Dementia also complicates Zoom visits. If you can imagine the issues for a person with memory loss whose "television" screen starts speaking to them directly, this will be clear. With staff stretched thin, all hands were required to facilitate visits with families, so asking staff to hold an iPad for visits with students was not a possibility. As an aside, virtual backgrounds are highly confusing to those who are not very computer literate. Even those patients or residents who are largely cognitively intact can become confused by seeing waving palms trees or the northern lights behind a Zoom visitor who is not physically in those locations.

For these reasons, we placed students virtually in our housing sites and assisted living for their clinical assignments. Half-unit students were responsible for offering spiritual care in their clinical assignments for fourteen hours during the week and full-unit students for twenty-four. In addition to the regular schedule, each student provided leadership of several worship services, groups, and/or Torah study classes for residents and/or staff. Placing students (even virtually) in housing communities was a new endeavor for our program. Liaisons in our housing sites reported excitement about the students themselves and about establishing strong relationships with our CPE program. One executive director reflected that the CPE students became an integral part of helping our housing sites cope with a COVID-19 summer. Students appreciated the opportunity to apply their

skills in a housing environment, the opportunity to learn more about the scope of HSL as an organization, the ability to note differences in culture in each housing community, and the opportunity to join with chaplains in the creative ways they were addressing the pandemic with residents. One student remarked, "I actually found a lot of freedom and grace to be present experiencing a unit of CPE during COVID. Since everyone was learning how to adapt to new realities, I felt like I had room to experiment and be creative on virtual chaplaincy in ways I hadn't before." Three examples of creativity come to mind. We recommended that students write a letter to their residents with their picture and a brief biography so that residents could picture "their" summer chaplain, and we discovered that some residents had pinned this up in their apartments in order to feel close to the person with whom they were engaged. To better understand the environment that her residents, whom she would never meet in person, called home, one student drove to the campus on a Sunday to take a look around and used her observations to create relationships with residents early on. Another student joined the staff chaplain of her housing site outside the building for a summer concert and dance party, waving to residents who watched from their balconies.

What would become a pivotal group learning started out as a casual insight by a student during the "Introduction to Telechaplaincy" didactic session.[8] This student, who was in her twenties, noted that making a phone call without texting first felt like a significant invasion of privacy. Most group members under the age of thirty-five agreed, connecting to the unwritten etiquette of their generation. Those who had come of age during a time when connection was largely by telephone shared that (our) generational etiquette was likely more similar to the older residents' experience. For many residents, a phone call was welcome, perhaps even refreshing, and felt like a familiar, older way of connecting. Students and educators of all generations came away from the discussion with a deeper understanding of how telechaplaincy might be experienced very differently generationally and how our communication patterns and methods have changed dramatically over the course of several decades.

Curricular Content

Because this was intentionally designed as an advanced unit, we were confident in the basic spiritual care skills of the students. We were able to tailor the didactics to focus on issues of the pandemic and telechaplaincy, which helped students integrate their learning into their work in an immediate way. In their exit interview, conducted and summarized by members of our Professional Advisory Committee, students reported that

> the most profound and prominent learning was about the COVID global pandemic, the use of telechaplaincy and the experience of a shared challenge/compromise. Students remarked often about offering chaplaincy when they had some of the same challenges as patients/residents—using the telephone for human connection, using technology, living in a global pandemic and the associated emotional experiences.

One common takeaway was that students learned to work with use of self more concretely because of the shared experience of a communal disaster.

Many didactics were brand new and were created specifically for this unit. Content that we had not previously taught in depth included:

- Emotional Life Cycle of a Communal Disaster
- Introduction to Telechaplaincy
- Ambiguous Loss in the Face of Crisis
- Presence in the Absence of Physical Presence
- Caregiver Distress during COVID-19
- Scarcity Ethics
- Using Dr. Patricia Watson and Richard Westphal's Stress First Aid Model with Staff

We were delighted to bring in teachers who were top names in their field to teach our students for several of these sessions. Because the unit was virtual, we were able to reach out to people beyond our geographic area, several of whom were generous with their time *because of* the pandemic.

In addition to didactic learning and the usual elements of CPE, we felt it was critical to give students opportunities to reflect on these COVID-19 times and their impact on both personal life and spiritual care. One core lesson about being a helping professional during a communal disaster is that

there is no "us and them." In addition to our roles and identities as caregivers, we are also concerned for our own selves, families, and life situations. Rachel Naomi Remen explains this more poetically in her classic book *Kitchen Table Wisdom*. She writes, "The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet."[9]

To underline this point, Mary Martha and I took part in some of the expressive experiences we created for the unit. During orientation, each student was asked to create and present a visual "story map" of their COVID-19 story. Both Mary Martha and I shared our COVID-19 stories as well, sharing our background reasoning for doing so with the students. Near the end of the unit, students and educators together composed and shared a lament in what emerged as one of the most powerful sessions of the summer.[10] Other moments of grieving together came when we observed eight minutes and forty-six seconds of silence together in memory of George Floyd, and when we grieved at a memorial service organized by the Boston Jewish community for victims of COVID-19.[11] A moment of joy came when the students worked together to create a colorful service for the celebration of "Pride Shabbat" in June.

Technology Strategies

We experienced both successes and challenges in this entirely virtual unit. The first challenge was perhaps an obvious one: the Internet can be fickle. We grew used to people fading out or getting choppy, and we called out "You're on mute," or "I think you froze!" more times than I care to count.

One success was the shared online folder that we established to create a centralized location for information, including handbooks, schedule, and resources, This offered a clear and organized way for students to submit their written work when physical proximity was not possible. Students loved having this clearinghouse,also sharing their own resources and interesting findings in the group folder.

One potential drawback of the platform we used was cybersecurity. We did restrict access to only students in the group, and no confidential patient information of any kind was shared in the folders. We would have felt more comfortable, however, if process notes and even handbooks were on a secure server rather than Google Drive.[12] I will note that the workarounds

we developed to address the virtual challenges of the unit were largely successful *because* the students had a high degree of computer literacy and the appropriate computer equipment. As we have learned this fall, the lack of either of these two elements can dramatically diminish the smooth functioning of an online unit.

One challenge related to group formation was the question of how to create community virtually with people who had never seen each other in person. One successful orientation activity was participating in a "virtual escape room,"[13] which gave students a concrete way to work together on a project early on despite not being in the same room. Students keenly missed the "in-between" times of group life—running into a peer in a hallway or in the chaplaincy room or sharing lunch together. At times, they would schedule time after group to "meet" for lunch on Zoom and talk while eating lunch in their separate homes. They did appreciate the creativity possible with Zoom, even as they recognized the losses. In the end, each of the students reported that they were grateful for the virtual nature of the unit, and two students, who themselves were in high-risk categories for COVID-19, noted that it would not have been possible for them to participate otherwise. One student wrote,

> It was very helpful to have a structure of classes two days a week. This helped create structure in my own life which was something that I was craving during this pandemic. Being in my apartment most of the time, this unit allowed me to do something safely from my home which was enriching and rewarding. I was able to process my own emotions during this COVID time with my supervisor and peers, which was invaluable.

In closing, one sweet advantage to the virtual unit was that family members and friends from far away could "attend" graduation. For our final "siyyum"[14] ceremony, people appeared onscreen from six states, four time zones, and two countries to celebrate the graduates. Though at times during this pandemic it indeed felt like we were building the airplane while already flying, I am grateful that we came to a safe landing, which was clear as the summer unfolded. I am reminded of a guiding principle in my faith from Pirke Avot, or Ethics of Our Ancestors: It is not your responsibility to complete the work, but neither are you free to desist from it. In order to share the opportunities of this learning, I leave you with a resource list of books and popular and academic articles to add to your own trauma-informed library.

NOTES

1 Patricia Watson and Richard Westphal, *Stress First Aid for Health Care Workers*, National Center for PTSD, 2020, https://www.researchgate.net/publication/344450660_Stress_First_Aid_for_HEALTH_CARE_WORKERS_NCPTD_2020.

2 Connie M. Ulrich and Christine Grady, eds., *Moral Distress in the Health Professions* (Cham, Switzerland: Springer, 2018), 160.

3 Eileen Zurbriggen, "Preventing Secondary Traumatization in the Undergraduate Classroom: Lessons from Theory and Clinical Practice," *Psychological Trauma: Theory, Research, Practice, and Policy 3*, no. 3 (2011): 223–28.

4 Brooke Anderson, "Six Daily Questions to Ask Yourself in Quarantine," *Greater Good Magazine*, March 24, 2020. https://greatergood.berkeley.edu/article/item/six_daily_questions_to_ask_yourself_in_quarantine.

5 Janice Carello and Lisa Butler, "Potentially Perilous Pedagogies: Teaching Trauma Is Not the Same as Trauma-Informed Teaching," *Journal of Trauma and Dissociation 15*, no. 2 (2014), 164. doi:10.1080/15299732.2014.867571.

6 All quotes from program evaluations are used with permission of the students. These are not from student final evaluations but from a separate document in which we ask students to evaluate each element of the curriculum.

7 Substance Abuse and Mental Health Services Administration, 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, 2014), 9.

8 One helpful resource is Chaplaincy Innovation Lab, "Tips on Offering Telechaplaincy," https://chaplaincyinnovation.org/wp-content/uploads/2020/03/Tips-on-Telechaplaincy.pdf.

9 Rachel Naomi Remen, *Kitchen Table Wisdom: Stories That Heal* (New York: Penguin, 1996) p. 52.

10 In preparation for this experience, Rabbi Shai Held joined us to teach about Psalm 88. A recording of Rabbi Held teaching about this psalm can be found here: "When Everything Goes Dark: Exploring Psalm 88," Hadar, 2019, https://www.hadar.org/torah-resource/when-everything-goes-dark-exploring-psalm-88.

11 "A Time to Mourn: Grieving Together in the Time of COVID," YouTube, https://www.youtube.com/watch?v=Zns_UKfQglY&feature=youtu.be.

12 For fall 2020, we have created a system within HSL's shared drive system. While more cybersecure, it has also been harder for students to access and is a less streamlined solution.

13 "Escape the Room," *Puzzle Break*, https://www.puzzlebreakma.com/.

14 *Siyyum* is a Hebrew word that means "completion." Traditionally, one holds a siyyum upon the completion of a major piece of learning, such as completing a tractate of Talmud. In our program, which utilizes a Jewish lens, we refer to many of the elements of our curriculum by their Hebrew name equivalent, and this is our name for graduation.