

Exploring the Lived Experience of Trauma among Obstetric Nurses

BY

JENNIFER M. SCOTese BAXTER
A.B., Princeton University, 2001
B. S. N. New York University, 2005

THESIS

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Defense Committee:

Susan Vonderheid, Co-Chair and Advisor
Karen Kavanaugh, Co-Chair
Carrie Klima
Barbara Dancy, Health Systems Science
Barbara Preib-Lannon, Health Systems Science

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SUMMARY

A study of the lived experiences of obstetric registered nurses was carried out using a hermeneutic, phenomenological approach. Interviews were conducted with 10 obstetric registered nurses who had experienced trauma while providing direct care. Information on demographics and characteristics were collected from the participants.

Seven themes emerged from the data: (a) An internal process; (b) Being faced with the unexpected; (c) Going through the motions; (d) Inability to take action; (e) Engaging others; (f) A visceral imprint, and (g) A changed person. Based on the findings, trauma was an unforgettable, deeply personal, and complex experience for these nurses. It is important that obstetric registered nurses themselves, as well as outsiders, recognize that trauma is ever present and real in obstetrics even if it is a specialty that is more commonly associated with the beginning of life and joyful memories. In addition, and perhaps more importantly, it is important to be aware that trauma is consequential for obstetric registered nurses on a personal and professional level.

I. SPECIFIC AIMS

The long-term goal of this research program is to develop interventions for obstetric registered nurses to address the negative impact of experiencing trauma. For the purposes of this study, trauma for an obstetric registered nurse is defined as the emotional or psychological state of discomfort or stress resulting from an overwhelming event or series of events while providing direct care. When trauma is related to the death and dying or serious injury of an infant, child, or adult, the handling of aggressive patients or patient visitors, or the handling of a dead body or body parts while providing direct care, a startling 81.8% of registered nurses report having experienced trauma (Lam, Ross, Cass, Quine, & Lazarus, 1999). Although these examples of trauma are not comprehensive, or necessarily from the perspective of nurses themselves, nurses experiencing these specific examples of trauma are still at risk for grave mental, physical, and/or emotional health issues (Bimenyimana, Poggenpoel, Myburgh, & van Niekerk, 2009; Chan & Huak, 2004; Jackson, Clare, & Mannix, 2002; Lam et al.; Martin-McDonald, McIntyre, & Hegney, 2005; Peebles-Kleiger, 2000; Regehr, Kjerulf, Popova, & Baker, 2004). These problems can include post-traumatic stress disorder (PTSD) (Carson et al., 2007; Carson et al., 2000; Chan & Huak; Kerasiotis & Motta, 2004; Lauvrud, Nonstad, & Palmstierna, 2009; Lavoie, Talbot, & Mathieu, 2011; Mealer, Burnham, Goode, Rothbaum, & Moss, 2009; Mealer, Shelton, Berg, Rothbaum, & Moss M, 2007), moral distress (Hanna, 2005), substance abuse problems (Bimenyimana et al.; Lillibridge, Cox, & Cross, 2002), and burnout (Bimenyimana et al.; Mealer et al., 2009). Diminished mental health status of nurses is also predictive of job turnover (Andrews & Wan, 2009), which results in not only a significant cost to hospitals (Deane Waldman, Kelly, Arora, & Smith, 2010), but also in understaffing on hospital nursing units thus jeopardizing the quality of nursing care (Penoyer, 2010). Care quality is threatened because nurses who experience trauma not only leave their jobs, but also sometimes resort to inappropriate and non-caring behavior toward their patients in order to cope

with their trauma (Acker, 1993; Froggatt, 1998; Shorter & Stayt, 2010; Yam, Rossiter, & Cheung, 2001). As a result, patient safety may also be at risk (Berland, Natvig, & Gundersen, 2008). Nurse experiences of trauma while providing direct care for patients have been studied in military (Carson et al., 2007; Carson et al., 2000), oncology/palliative care (Froggatt), psychiatric (Abderhalden, Needham, Friedli, Poelmans, & Dassen, 2002; Bimenyimana et al.; Lauvrud et al.), surgical care (Bianchi, 2008; Martin-McDonald et al.; Regehr et al.), critical or intensive care (Acker; Cronqvist, Lütze, & Nyström, 2006; Mealer et al., 2007; Peebles-Kleiger; Shorter & Stayt; Yam et al.), and emergency care (Laposa, Alden, & Fullerton, 2003; Lavoie et al., 2011; Riba & Reches, 2002) nursing. However, very few studies have explored trauma in obstetric nursing (Gardner, 1999; Hanna, 2005; Huntington, 1999; McCreight, 2005; Nicholson, Slade, & Fletcher, 2010), either as researchers have defined it or as it is perceived by nurses themselves.

Obstetric registered nurses repeatedly experience events that may be *perceived as trauma* for them. For example, obstetric registered nurses encounter birth trauma, any physical injury sustained by an infant in the process of birth (Merriam-Webster, 2011), in their practice. From 2.6% to 7% of all hospital births in the United States births are complicated with some type of birth trauma (Moczygemba et al., 2010; Parker, 2005; Sauber-Schatz et al., 2010). Obstetric registered nurses are also exposed to maternal mortality (Lang & King, 2008) and morbidity (Agency for Healthcare Research and Quality, n.d.; Bruce et al., 2008; Kuklina et al., 2009). The United States ranks fiftieth in the world in maternal mortality, which is worse than almost all European countries as well as many countries in Asia and the Middle East (Berg, Callaghan, Syverson, & Henderson, 2010; Kuklina et al., 2009). Obstetric registered nurses also provide direct care surrounding stillbirths and spontaneous and induced abortions. Trauma for obstetric registered nurses may not stop here. Other common birth-related, as well as workplace-related experiences while providing direct care in obstetric health care, include the

hastening, controlling, or mechanizing of birth (Sleutel, Schultz, & Wyble, 2007), and low-resourced environments (Kornelsen & Grzybowski, 2008; Sleutel et al.). Disruptive behavior by colleagues (Felblinger, 2008; Sleutel et al.; Veltman, 2007) may also be considered trauma for obstetric registered nurses but has not been studied in that context.

There are five known research studies (three qualitative, two mixed methods) on the experience of trauma among obstetric registered nurses. All of the studies explored nurses caring for women who experience either perinatal death (Gardner, 1999; McCreight, 2005) or elective abortion (Hanna, 2005; Huntington, 1999; Nicholson et al., 2010). All of the studies concluded that nurses experiencing perinatal death or elective abortions often care for their patients at a high personal cost. Because these few studies only focused on two examples of trauma experiences for obstetric registered nurses, in spite of the broad range of potential trauma events, there remains a wide gap in knowledge concerning the lived experience of trauma among obstetric registered nurses and the possible effect of those experiences on nurses and nursing care.

Phenomenology allows a richer understanding of the details and meaning of everyday experiences, or in this study what it is like for obstetric registered nurses to experience trauma (van Manen, 1990). This critical insight will provide valuable information for the development of educational and administrative interventions geared toward enhancing support for obstetric registered nurses who face trauma, which will ultimately improve their ability to provide quality care for patients. Therefore, **the specific aim of this hermeneutic phenomenological study is to describe and analyze the lived experience of trauma among obstetric registered nurses.**

II. SIGNIFICANCE AND INNOVATION

A. Significance

1. Defining trauma among nurses

In the context of nursing, Lam et al. (1999) defined work-related trauma as the exposure to the death and dying or serious injury of an infant, child, or adult, the handling of aggressive patients or patient visitors, or the handling of a dead body or body parts. Over 80% of nurses from various specialties have experienced at least one of these forms of trauma in the workplace with 48.2% of them experiencing trauma at least once a week (Lam et al.). The incidence of trauma differs depending on variables such as the kind of trauma, measurement criteria, nursing specialty, and institution. For example, up to 70% of psychiatric nurses have been physically attacked by aggressive patients while at work at some point in their career (Abderhalden et al., 2002), while 82% of emergency department nurses experience physical assault over the course of one year (May & Grubbs, 2002).

Trauma has also been more broadly defined as the psychological damage resulting from exposure to overwhelming and uncontrollable events or life experiences (van der Kolk, 1987). Given this wider definition, many more events beyond the definition provided by Lam et al. (1999) may also be considered as trauma from the perspective of nurses. In other words, it is likely that the incidence of trauma experiences among nurses is much higher than research has suggested to this point.

However, this second definition (by van der Kolk) is so general that it is not specific to obstetric nurse experiences. In order to come up with an appropriate definition for trauma for the context of this study and the population being studied, I reviewed trauma definitions from various sources (American Psychiatric Association, 2000; Figley, 1985; Lazarus, 1999; McCann & Pearlman, 1990; trauma, 2004; trauma, 2007). Based on this review, the operational definition of trauma for obstetric registered nurses in this study is the emotional or psychological state of

discomfort or stress resulting from an overwhelming event or series of events while providing direct care. Despite an extensive literature review, I did not identify any published incidence rates of trauma experiences among obstetric registered nurses in particular. However, before research of that nature can be conducted, it is essential to determine what experiences constitute trauma for obstetric registered nurses and to collect and analyze detailed information about those experiences.

2. **Trauma exposure negatively affects nurses: psychological, physical, and professional problems**

Exposure to trauma can lead to post-traumatic stress disorder (PTSD) or its symptoms (Carson et al., 2007; Carson et al., 2000; Chan & Huak, 2004; Gates, Gillespie, & Succop, 2011; Kerasiotis & Motta, 2004; Lauvrud et al., 2009; Lavoie et al., 2011; Mealer et al., 2009; Mealer et al., 2007), moral distress (Hanna, 2005), substance abuse problems (Bimenyimana et al., 2009; Lillibridge et al., 2002), and burnout (Bimenyimana et al.; Mealer et al., 2009). Psychologically, trauma experiences often induce fear (Alden, Regambal, & Laposa, 2008; Bimenyimana et al.; Chan & Huak), anxiety (Kerasiotis & Motta; Mealer et al., 2007), anger (Bimenyimana et al.; Yam et al., 2001), frustration (Bimenyimana et al., 2009; Riba & Reches, 2002; Yam et al.), grief (Shorter & Stayt, 2010; Yam et al.), resentment (Yam et al.), uncertainty (Riba & Reches), helplessness (Bimenyimana et al.; Chan & Huak; Riba & Reches; Yam et al.), hopelessness (Bimenyimana et al.; Riba & Reches), guilt (Riba & Reches), psychological distress (Lam et al., 1999; Regehr et al., 2004), depression (Lam et al.), and cynicism (Bimenyimana et al.). Physically, nurse experiences with trauma can lead to flashbacks and nightmares (Mealer et al., 2009; Mealer et al., 2007), distorted eating behavior (King, Vidourek, & Schwiebert, 2009), and substance abuse problems (Bimenyimana et al.; Cross & Ashley, 2007). Professionally, trauma exposure can lead to job burnout and job dissatisfaction (Alden et al., 2008; Laposa et al., 2003) in nurses.

3. **Trauma exposure contributes to an increase in the nursing shortage, an increase in health care costs, and a decline in quality of care**

About one third of nurses who intend to quit their jobs cite psychologically strenuous and stressful work as their primary reason to do so (Gardulf et al., 2005). As many as 33% of emergency nurses have considered quitting their jobs due to physical or verbal violence from patients and visitors (Gacki-Smith et al., 2009), and 37% of emergency nurses demonstrate decreased performance in the workplace after a violent event (Gates et al., 2011). Nurses exposed to trauma events in the workplace who have a combination of PTSD and burnout syndrome (BOS) have spent 11.6 fewer years working as a nurse compared to nurses who did not have either PTSD or BOS suggesting that their stress symptoms may have contributed to their decision to leave nursing (Mealer et al., 2009). Both a negative assessment of nurses' professional practice environment and low self-assessed health as a measure of job strain correlated with a higher propensity to leave their job (Andrews & Wan, 2009). The loss of these experienced and expert nurses is significant given that a shortage of nurses directly and negatively impacts the quality of care provided (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). The loss of nurses in the obstetrics field in particular is concerning. Expert obstetric nurses are critical in the developing, supporting, and mentoring of novice nurses in areas beyond tasks, such as the holistic understanding of a woman-centered approach, the intimacy of the nurse-patient relationship, and the importance of conversations and touch with the birthing woman (Ryan, Goldberg, & Evans, 2010).

The consequences of trauma exposure may also have a major impact on the cost and quality of healthcare. Turnover accounts for up to 5.8% of a hospital's annual operating budget, the largest cost driver being the loss and the necessary replacement of nurses (Deane Waldman et al., 2010). Turnover and the resulting decreased nursing staff levels negatively affects patient outcomes (Bae, Mark, & Fried, 2010; Penoyer, 2010). For nurses who stay in

their jobs, exposure to trauma can reduce their ability to provide quality care because they may become mentally disengaged and disassociated emotionally from their patients (Shorter & Stayt, 2010; Yam et al., 2001) and may distance themselves from a patient's pain (Froggatt, 1998; Nagy, 1999).

4. **Nurses do not receive sufficient support after trauma exposure: formal interventions are not adequate**

Evidence-based strategies supporting the mental health of nurses may aid nurses who experience trauma in the workplace (Andrews & Wan, 2009; Mealer et al., 2009). However, organized or formal interventions, such as debriefing or counseling, are not always available or are ineffective (Battles, 2007; Cronin, 2001; Cronqvist et al., 2006; Laposa et al., 2003; Martin-McDonald et al., 2005; Wallbank & Robertson, 2008). Even when services are available, they are only voluntarily attended or are underused (Cronqvist et al.; Laposa et al.; Shorter & Stayt, 2010). As a result, nurses resort to negative coping mechanisms (Acker, 1993; Nagy, 1999; Regehr et al., 2004; Shorter & Stayt; Yam et al., 2001). Because so few studies have been conducted about trauma exposure in obstetric nursing and the specific needs in this specialty, known interventions such as debriefing or counseling may not even be the best option for this population.

5. **Obstetric registered nurses repeatedly experience trauma**

Birth trauma is a common occurrence in obstetric settings. Obstetric registered nurses often encounter fetal death (deaths at 20 weeks gestation or more) as about 26,000 occur every year in the United States (MacDorman & Kirmeyer, 2009). Physical trauma to the neonate, such as injuries to the scalp, skeleton and fractures to the clavicle, occur in 29 of 1000 births (Sauber-Schatz et al., 2010). Maternal mortality and morbidity may also be considered trauma for nurses. Seven percent of women who have live births obtain a pelvic or perineal trauma (Bruce et al., 2008) while the rate of third or fourth degree lacerations during instrument-

assisted vaginal deliveries is as much as 16% (Agency for Healthcare Research and Quality, n.d.). Rates of severe obstetric complications have risen recently due to the increasing rate of Cesarean sections (Kuklina et al., 2009). Obstetric registered nurses may encounter “never events”, or adverse health-care events that are serious and largely preventable, such as prolonged periods of untreated, non-reassuring fetal heart rate patterns during labor (National Quality Forum, 2002).

Obstetric registered nurses are also exposed to events other than birth trauma that are potentially considered to be traumas to them, but are unstudied. For example, we know poor staffing levels and the use of unnecessary medical interventions (Sleutel et al., 2007) affect them. More than 33% of obstetric registered nurses face a lack of interdisciplinary collaboration while trying to provide care (American College of Obstetricians and Gynecologists, 2007, 2009; Gilder, Mayberry, Gennaro, & Clemmens, 2002; The Joint Commission, 2008;). Disruptive behavior such as angry outbursts, rudeness, physical threats, noncompliance with existing policies, sexual harassment, and idiosyncratic, inconsistent, or passive aggressive orders occurs in 60.7% of obstetric units (Veltman, 2007). Such workplace encounters have the potential to be overwhelming, uncontrollable, and thus sources of trauma for obstetric registered nurses, but they have not been studied in this context.

6. **Research on the experience of trauma among obstetric registered nurses is limited**

Some research on trauma experiences among midwives (Begley, 2003; Foster, 1996; Leinweber & Rowe, 2010; Lindström, Wulff, Dahlgren, & Lalos, 2011; Nallen, 2006, 2007; Weston, 2011, 2012) and gynecologists (Lindström et al.) exists but because their scope of practice and role in the obstetric setting is different than that of obstetric staff nurses, conclusions from that research are not completely transferable to obstetric registered nurses. Other, non-scientific investigations suggest that doulas can be emotionally devastated by what

they see during hospital births (Block, 2007), but again their role in the obstetric setting is quite different than that of the obstetric registered nurse. Based on the few studies of obstetric registered nurses experiencing trauma, we know that exposure to perinatal death leads to anxiety and their feeling unprepared to handle trauma or to cope with their own grief (Gardner, 1999). While caring for women experiencing pregnancy loss, obstetric registered nurses are “psychologically drained,” and the emotional aspects of their care are marginalized due to their lack of time with patients (McCreight, 2005). During elective abortions, some nurses experience moral distress because they are being forced to provide care against their own will during procedures that are overwhelming for them (Hanna, 2005), while others feel unprepared for the emotional nature of their work and incapable of distancing themselves from reality like other members of society can (Huntington, 1999). Nurses experiencing terminations also felt unsupported, unrecognized, and forced to cope on their own with their distress (Huntington; Nicholson et al., 2010). In a recent review of the literature from 1971-2011 on nurses and care of women seeking abortions, themes included the roles, responsibilities, attitudes, and perceptions of nurses surrounding abortion care, but there were no findings regarding the nurse’s detailed lived experience of providing abortion care (McLemore & Levi, 2011).

7. **Findings from this study will be used to develop interventions**

Obstetric registered nurses play a pivotal role in patients’ birth experiences (Carlton, Callister, & Stoneman, 2005; Goldberg, 2008). From patients’ perspectives, poor nurse-patient interactions, including lack of communication, lack of compassion, and lack of caring and support during birth (Beck, 2004a; Carlton et al.; Elmir, Schmied, Wilkes, & Jackson, 2010; Goldbort, 2009; Salter, 2009; Thomson & Downe, 2008) are risk factors for birth trauma experiences for themselves and their families, also known as traumatic birth (Beck & Watson, 2010). Some patients believe that obstetric registered nurses perceive their trauma experiences during labor or birth as routine (Beck, 2004a). Although there is a growing body of literature

suggesting how obstetric health care providers should improve their care of patients who have experienced trauma during labor or birth (Beck, 2004a; Beck, 2004b; Beck, 2006; Beck & Watson, 2008; Bryanton, Gagnon, Johnston, & Hatem, 2008; Creedy, Spochet, & Horsfall, 2000; Slade, 2006; Soet, Brack, & Dilorio, 2003), the obstetric registered nurse's experience with trauma has been ignored as a factor motivating these improvements. Without proper research on the obstetric registered nurse's experience of trauma, these suggested care improvements might not address the actual source of poor interactions. The findings of this obstetric registered nurse-centered study provides powerful and valid evidence on which to build specific interventions for obstetric registered nurses. It is possible that a consequence of repeated exposure to birth trauma and other trauma events in the obstetric setting cause nurses to appear uncaring and may compromise their ability to provide good care. Therefore, research is needed to determine what constitutes trauma for obstetric registered nurses and how they experience trauma. Based on this fundamental knowledge, I and other investigators can develop evidence-based interventions for use in nursing education, practice, and administration. These interventions will have a tangible impact by exposing obstetric registered nurses to this phenomenon, reducing the negative consequences of trauma exposure, and implementing positive coping strategies so nurses are better prepared for the realities of the obstetric environment.

B. Innovation

There are two novel aspects to this research. First, in contrast to previous studies, this research did not limit nurses to describing a singular, designated example of trauma. This is important because it is possible that events previously labeled as trauma may not be perceived as such by nurses themselves. Instead, the examples of trauma analyzed in this study were anything perceived as trauma to the participants. In other words, participants were allowed to decide which experience(s) to describe. This important change resulted in a more

comprehensive description of trauma examples from the perspective of obstetric registered nurses. By not limiting the definition of trauma, this study uncovered a wide variety of trauma sources, which may have otherwise continued to go unnoticed.

Second, this study explored the lived experience of obstetric registered nurses using a pure hermeneutic phenomenological approach (van Manen, 1990; M. van Manen, personal communication, June 25, 2010), which aims to construct an animating, evocative description of human experience (van Manen, 1990). Multiple reflective stages during the analysis assisted in gaining insight to the essence of what it is like for obstetric registered nurses to experience trauma.

III. METHODS

A. Preliminary studies

I conducted a pilot study looking at the experiences of obstetric registered nurses exposed to birth trauma while providing care. My primary goal for the pilot was to test the interview probes and a demographic form for a larger study. I used a hermeneutic phenomenological approach to data collection (van Manen, 1990) to create the original interview guide, and I based the demographic form on personal data used in similar studies (Lam et al., 1999; Kerasiotis & Motta, 2004) as well as on data needed for reporting purposes. I interviewed four obstetric registered nurses and transcribed two of the interviews. I read and discussed the transcripts with my faculty advisor, Dr. Karen Kavanaugh, PhD, R.N. I adapted the study based on the following learned lessons:

- **Definition of trauma:** Exposure to birth trauma, as it was defined, seemed to limit the nurses' stories to events that, in addition to being perceived as trauma to them, were also considered traumas for patients. This may have missed experiences of trauma that were only perceived as such to the nurse such as events to which the patients or others were oblivious. Therefore, I redefined the required exposure as any experience of trauma while providing direct care. In addition, during the interviews, it became apparent that some participants were confused about the concept of trauma and on whose perspective of trauma the research was focused. I determined that the confusion stemmed from the fact that the definition of trauma provided to participants was based on research from the patient perspective. I conducted a review of the literature on trauma and developed a new and more conceptually appropriate operational definition for trauma in order to ensure conceptual clarity for the participants: the emotional or

psychological state of discomfort or stress resulting from an overwhelming event or series of events while providing direct care.

- **Interview probes:** Based on the pilot interviews, I revised the interview probes. First, I reduced the number of introductory questions, which were originally intended to help develop a rapport with the participants (van Manen, 1990). It became clear that rapport was established quickly. Extraneous questions (e.g., “How long have you been a nurse?”; “What made you become a nurse?”) were eliminated from the list of probes. I maintained one question (e.g., “Why did you choose to work in obstetric nursing?”) as a way to develop a relationship of personal sharing, closeness, and friendliness with participants. Also, after reading through the transcripts of the pilot interviews, it became clear that there were some questions that were not in the probe list that might be useful in future interviews (e.g., “Were there any legal issues that came up related to the event?”; “What documentation/charting occurred surrounding the event?”; “How/what did you document what occurred?”; “How did you feel about your documentation?”; “Others’ documentation?”)
- **Demographic Form:** Due to some confusion over some of the questions in the demographic form, I changed the wording of some questions. For example, I changed the question “What is the total of number of years of education that you have completed?” to “What is the total of number of years of education that you have completed after receiving your nursing license?”
- **Interview schedule:** For the pilot, I interviewed four nurses in three days. I decided that this many interviews, especially given their length and nature, was too many for me to conduct both physically and mentally. For this reason during the dissertation study, I interviewed no more than one participant per day and did

not interview more than three participants per week to ensure that I was able to perform to my best ability for each interview. I also added an option for debriefing meeting for myself during the interviews. I arranged to privately speak with a psychiatric nurse practitioner and with members of my committee (Dr. Barbara Dancy and/or Dr. Barbara Preib Lannon) weekly, if needed, about my personal reactions to the interviews.

Based on their success during the pilot, I maintained the following elements for the current study:

- **Sampling method:** Contacting participants via e-mail was very successful. I heard from seven interested participants within one week of the e-mail being sent.
- **Interview techniques:** As the main instrument for data collection, I was effective at establishing rapport and obtaining the lived experiences of participants, which was illustrated by their eagerness to disclose personal and sensitive stories. I was also flexible with questions in order to elicit the information necessary for the study.
- **Member check:** At the end of their interviews, each of the four participants were very eager to see my results and looked forward to provide their feedback about the results in the future.
- **Analysis:** I used the analysis process recommended by van Manen (1990) with two of the pilot interviews. This approach proved to be possible and successful. For example, I was able to identify several similar themes as well as van Manen's four existential themes across both interviews. At the suggestion of my committee, I created an additional table (see TABLE I) to further explain and clarify the analytical approach.

Table I

VAN MANEN PHENOMENOLOGICAL ANALYSIS: STEP-BY-STEP PROCESS

van Manen term	Detailed steps
Thematic reflection	1. Read each transcript several times.
<i>Wholistic approach</i>	2. For each transcript/experience, determine a phrase that captures the fundamental meaning of the text as a whole.
<i>Selective approach</i>	3. For each transcript, highlight the statements or phrases stand out or are particularly revealing about the experience.
<i>Detailed approach</i>	4. For each transcript, carefully read each sentence or sentence cluster and conclude what it reveals about the phenomenon.
<i>Thematic descriptions</i>	5. Define and elaborate on each theme uncovered through these three approaches paying special attention to the themes that reoccur over interviews.
<i>Essential themes</i>	6. Identify the essential themes of the phenomenon.
Collaborative reflection	7. Discuss thematic descriptions with colleagues through formal and informal conversations to develop deeper insights and understandings. 8. Revise thematic descriptions as needed.
Existential reflection	9. Organize all themes into four fundamental lifeworld themes or existentials: lived space, lived body, lived time, and lived human relation.
Linguistic reflection	10. Research the etymological history of words important to the phenomenon in question. 11. Research phrases mentioned in the transcripts related to the phenomenon. 12. Conduct concept analyses of pertinent concepts that come up during the interviews.
Exegetical reflection	13. Read the results of the search for experiential descriptions (your own documented experience, stories in literature, biographies, diaries, art, or phenomenological literature) to reflect on the phenomenon and develop further ideas or thematic insights.
Hermeneutic interview reflection	14. Discuss initial analysis and preliminary themes with willing and eligible participants. 15. Ask each other: "Is this really what the experience is like?" 16. Reflect on the participants' experiences together and revise analysis as needed to hone in on as much interpretive insight as possible
Phenomenological writing	17. Write anecdotes based on the final essential themes of the phenomenon.

Note. Adapted from *Researching Lived Experiences: Human Science for an Action Sensitive Pedagogy*, by M. van Manen, 1990. Albany, NY: State University of NY Press.

B. Design

This research is a qualitative, hermeneutical phenomenological study (van Manen, 1990). Qualitative research comes out of the naturalistic or interpretive paradigm, also known as interpretivism (Denzin & Lincoln, 2005). The main ontological assumption of this paradigm is that reality has no singular truth. Instead, truth is subjective and meaning is grounded in individual experience (Beck, 2009; Cody, 2006). Thus, epistemologically, interpretivism holds that knowledge is derived from experiences and shared meaning. Since the belief is that no single reality can be generalized or ultimately determined, the goal of research driven by the interpretive paradigm is to increase understanding and knowledge of lived reality (Cody).

As shown in TABLE II, there are many qualitative designs that may be used to explore human experience. Phenomenology is the best design for the proposed research because, unlike other qualitative designs, its intent is to explore human experience by prioritizing *how* a person lives through an experience (Adams & van Manen, 2008). In particular, hermeneutic phenomenology is a combination of descriptive and interpretive phenomenological approaches (van Manen, 1990). Descriptive phenomenology is a process, grounded in the work of philosopher Edmund Husserl, which seeks to purely describe phenomena from the perspective of those who have experienced them (Smith, 2008). Interpretive phenomenology, as first described by Martin Heidegger, is a process in which the researcher seeks to interpret and analyze the participants' experiences and to identify themes of the phenomenon (Cerbone, 2008; McConnell-Henry, Chapman, & Francis, 2009). Hermeneutic phenomenology (van Manen) acknowledges that in the process of describing a certain phenomenon, we are actually already interpreting to some degree.

One of the key elements of a phenomenological approach is reduction. Also known as bracketing, reduction brings a certain attitude of attentiveness to the investigator and helps to bring the phenomenon being studied into a greater focus by setting aside assumptions and

TABLE II
QUALITATIVE RESEARCH DESIGNS

Design	Question	Sampling	Data collection/analysis
Phenomenology	<ul style="list-style-type: none"> ○ What is the lived experience of...? ○ <i>How</i> does a person experience the world? 	<ul style="list-style-type: none"> ○ Purposive (each participant is purposely selected because they have had the experience in question and can articulate it well) ○ 10 or less participants 	<ul style="list-style-type: none"> ○ Primarily in-depth interviews ○ Can also include: literature, biographies, poetry, & art ○ Methods of analysis: Van Manen, Colaizzi, Giorgi, Van Kaam, Benner ○ Result: patterns or themes about the meaning of the phenomenon
Grounded theory	<ul style="list-style-type: none"> ○ What is the central concern in a certain area? 	<ul style="list-style-type: none"> ○ Theoretical- each subsequent is based on theory developing from data 	<ul style="list-style-type: none"> ○ In-depth interviews; participant observation; document review ○ Data collection and analysis are simultaneous; interviews change based on previous interviews ○ Result: conceptual categories and a theory
Ethnography	<ul style="list-style-type: none"> ○ What are the patterns of people? 	<ul style="list-style-type: none"> ○ Key informants knowledgeable about topic 	<ul style="list-style-type: none"> ○ Field work; participant observation; field notes
Narrative Analysis	<ul style="list-style-type: none"> ○ What story does a person have to tell? 	<ul style="list-style-type: none"> ○ At least one participant 	<ul style="list-style-type: none"> ○ Interviews; document review
Qualitative descriptive	<ul style="list-style-type: none"> ○ The who, what, and where of an event or experience. 	<ul style="list-style-type: none"> ○ Purposeful; maximum variation 	<ul style="list-style-type: none"> ○ Including but not limited to interviews, focus groups, observation, document review ○ Qualitative content analysis to summarize the information content of the data ○ Codes are data-derived

Note: Adapted from "Viewing the Rich, Diverse Landscape of Qualitative Research," by C. T. Beck, 2009, *Perioperative Nursing Clinics*, 4(3), p.217-229; "Whatever Happened to Qualitative Description," by M. Sandelowski, 2000, *Research in Nursing and Health*, 23(4), p. 334; "What's in a Name? Qualitative Description Revisited," by M. Sandelowski, *Research in Nursing and Health*,

prejudgments (van Manen, 2002b). In the history of phenomenology, there has been much discussion about the levels of reduction required or even possible in studying human phenomena. Throughout this study, I approached reduction iteratively in five different but complementing ways: heuristic reduction, hermeneutic reduction, descriptive reduction, eidetic reduction, and methodological reduction (van Manen, 2011a). The process of reduction is described in more detail in the “Measures” section.

C. **Setting and sample**

Investigating a lived experience requires gathering data and reflecting on it (van Manen, 1990). Various potential sources of data exist: the researcher’s personal experience with the phenomenon in question, the etymological history of the words related to the phenomenon, idiomatic phrases related to the phenomenon, experiential descriptions from others in written form or through interviews, observation, and experiential descriptions in literature, biographies, diaries, art, and phenomenological literature (Polit & Beck, 2008; van Manen). In this study, the data consists of interviews with nurses who have experienced trauma.

The goal of sampling for phenomenological interviews is to find participants with rich experiences in the matter being studied and who are willing to share those experiences (van Manen, 1990). Therefore convenient, purposive, and snowballing sampling techniques are appropriate. Convenient, or volunteer sampling is used when participants need to self-identify (Polit & Beck, 2008) themselves. This is the best way to identify people who have experienced trauma since it is such a personal experience. Purposive sampling is when the researcher selects cases that will most benefit the study (Polit & Beck). This is important for phenomenological studies because while having the experience in question is technically enough, selecting participants who can remember and articulate their story well will provide richer data to analyze (Morse, 1991; M. van Manen, personal communication, June 25, 2010). Therefore, I asked interested and eligible participants, “Can you remember the details of at least

one experience with trauma?” prior to setting up a time and place for the interview. Once some participants were recruited, snowball sampling—a cost-efficient, practical, and time saving technique that allows early informants to make referrals to other potential participants (Polit & Beck)—was used.

1. **Setting**

The sample was recruited from New York City. I currently live in New York City and have access to an established network of obstetric registered nurses from my past clinical work. About 60,000 registered nurses live and work in New York City (New York State Education Department, 2011). Given that there are at least 40 hospitals offering maternity services within the five boroughs of the city (Manhattan, Bronx, Brooklyn, Queens, and Staten Island) (New York State Department of Health, 2009) and that approximately 7% of registered nurses cite the labor and delivery room as their primary practice setting (American Association of Critical Care Nurses, 1998), there was an ample population in New York City from which to sample participants for this study.

I also had a plan to recruit part of the sample from Chicago if the New York recruitment had not been successful. However, because an ample sample was recruited in New York, a Chicago sample was not necessary.

2. **Eligibility criteria**

The following eligibility criteria were required for recruitment: (a) participant is a registered nurse; (b) participant has worked full-time in obstetric health care; (c) participant has experienced trauma as an obstetric registered nurse; (d) participant can speak, read, and write in English; (e) participant is able to participate in a face-to-face interview in the New York City (or Chicago) area.

3. **Exclusion criteria**

Midwives and nurse practitioners working in an obstetric setting may be considered obstetric registered nurses. However, for the purposes of this study, they were excluded. Their scope of practice and role in the obstetric setting is different than BSN, associate degree, and diploma prepared obstetric registered nurses. Pregnant nurses were also excluded from this study. Although nurses who are pregnant may have experienced trauma as an obstetric registered nurse, if they were pregnant at the time of the interview they were excluded from this study for ethical reasons. The nature of this research is sensitive, deeply personal, and requires the description of personally sacred experiences (Lee & Renzetti, 1990). Because some of the experiences may involve birth trauma or maternal mortality, I decided that this would be unnecessarily *distressing* for women who are about to give birth themselves.

4. **Sample size**

The interest of a phenomenological study is to discover the common, or essential features of an experience (van Manen, 1990). This can be done with ten people or less (Hupcey, 2005; M. van Manen, personal communication, June 25, 2010; Starks & Brown Trinidad, 2007). Therefore, ten participants were recruited and interviewed for this study.

D. **Measures**

The key instrument in qualitative research is the researcher (Creswell, 2009; Hupcey, 2005; Rew, Betchel & Sapp, 1993). Accordingly, during the analysis stage of the research I used my notes taken during the interviews (if applicable), my digitally recorded observations after the interviews, and my personal journal used throughout the research (Creswell; van Manen, 1990). In phenomenological studies, it is also important for the researcher to engage in a process of bracketing, or reduction, in order to set aside his or her own assumptions or prejudgments about the phenomenon in question (van Manen, 2002b). There are five kinds of

reduction that must happen iteratively and throughout the entire research process (van Manen, 2011a).

1. **Heuristic reduction**

Heuristic reduction is the act of setting aside the natural attitude (all of the beliefs, biases, and assumptions that we take for granted) in order to allow wonder, open-mindedness, willingness, and receptiveness into the research (van Manen, 2011a). Wonder allows the researcher, and later the reader, to think more creatively and question the meaning of a particular lived experience (van Manen). When I was reading through the data, if I began to wonder about something, such as why a participant may have said something in particular, I was attentive to that question rather than glossing over it and made note of it in a journal or in a memo to myself. The goal of this process is to stimulate my questioning the meaning of some aspect of the lived experience (van Manen, 2002d).

2. **Hermeneutic reduction**

Hermeneutic reduction requires the researcher to bracket their assumptions and reflect on them in an open and honest way (van Manen, 2011a). While completely forgetting one's assumptions is not humanly possible, it is essential that the researcher explain them honestly to him or herself and to the reader. For example, it was important to note that I have had practical experience in an obstetrical setting of a hospital as a registered nurse and have had my own experiences with trauma in that setting. I wrote out two detailed trauma experiences of my own as an obstetric registered nurse and set them aside. I also listed my assumptions and hypotheses related to this phenomenon.

3. **Descriptive reduction**

Descriptive reduction requires the researcher to avoid abstraction, theorizing, and generalization regarding the phenomenon being studied. Since van Manen (2011) accepts that we need to be familiar with theory related to our topic of research, he proposes that we

seek to understand how certain theories inform or frame a certain phenomenon and thus “prevent one from seeing the phenomenon in a non-abstracting manner” (p. 142) and “gloss or hide the experiential reality” (p. 142). For this study, my appreciation and understanding of feminist theory, caring theory, and stress and coping theory have indirectly informed the phenomenon being studied. Feminist theory and its goal to develop knowledge based on the social realities of women’s lives (Polit & Beck, 2008) naturally frames this type of research since obstetric nursing is a female-dominated field focused on the care of women within the patriarchal environment. Caring theory, a central concept in nursing (McEwen & Wills, 2007), suggests that even one instance of caring becomes part of the life history of both the patient and the nurse (Watson Caring Science Institute, 2010). Stress and coping theory (Lazarus & Folkman, 1984) has informed my thinking about the stress of trauma and its place within a complex social context. Despite my familiarity with these theories, I made an effort to avoid allowing them to conceal the full reality of the phenomenon I was studying. I wrote out my understanding of these theories and how I thought they influenced my understanding of the phenomenon being studied, and set these writings aside.

4. **Eidetic reduction**

Eidetic reduction requires the researcher to compare, contrast, and test the meaning of a phenomenon to find the unique things that make an experience what it is, and without which the experience would not exist. This is done by exploring the experience of trauma in obstetric registered nurses based on data other than the interviews collected. Literature and art that may exist are examples of data that will be used for comparison. When comparing the phenomenon, I asked myself questions such as, “What is the unique nature of the lived experience” and “What makes an experience uniquely different from other related experiences”, for example “What makes a fetal demise a trauma for a nurse one week, but not

the next?” Using this process, I was able to eliminate evolving themes that were not actually essential to the phenomenon being studied.

5. **Methodological reduction**

Finally, methodological reduction requires that the researcher be methodologically informed while also being creative and flexible. For example, while I only planned to interview ten participants based on the design of this study, I was open to the possibility of having to recruit more participants if there were problems with one or more of the first ten interviews (e.g., technical problems, dropout prior to completion, inability of participant to articulate experience).

In addition to the researcher as an instrument, the only other measure in a phenomenological study is the question about the participants’ lived experience with the phenomenon in question. In this case, the question is “Can you tell me about a time when you experienced the worst trauma in your role as an obstetric registered nurse providing direct care?” Probing questions to help the participant stay on topic and be as descriptive as possible can be helpful during a phenomenological interview (Creswell, 2009; van Manen, 1990). Therefore, I developed, piloted, and revised a list of potential probes (see Appendix A), which was used for every interview. A more detailed description of the probe development is described in the “Preliminary Studies” section. After being interviewed, participants received a piloted and revised self-administered demographic form (see Appendix B) to gather information for clarifying and reporting purposes only.

E. **Procedure**

The approval, recruitment, and interview procedures are included in this section.

1. **Approval**

I obtained approval from the University of Illinois at Chicago (UIC) Institutional Review Board for the current study. I also applied for a certificate of confidentiality (CoC) from

the National Institute of Nursing Research (NINR) in order to offer further protection for participants given the nature of the research.

2. **Recruitment**

I planned for two phases of recruitment in the case that the first phase was not sufficient. Phase 1 was planned for New York City and Phase 2 was planned for Chicago. During Phase 1, I sent an e-mail (see Appendix C) to point people in the obstetric registered nurse community of New York City with whom I already had established relationships and rapport. These point people were current or former obstetric registered nurses who have access to many other obstetric registered nurses in the New York City area. I asked the point people to forward an e-mail and flyer about the study to potential participants (see Appendix D and E). Interested nurses could contact me directly by phone or e-mail. After recruiting initial participants, I planned on using a snowballing technique to recruit more participants. I planned to ask participants if they were willing to give out the recruitment flyers (Appendix E) to their colleagues.

After one month of recruitment in Phase 1, I had not completed any interviews and only had a few potential participants. One potential reason for the lack of response was that potential participants were not reading the e-mails being sent to them by the point people. Another possibility is that recruitment began just before the busy holiday season, and potential participants did not have adequate time to respond and/or participate. Because the response to recruitment was not as robust as intended, I added some additional recruitment strategies including asking point people to distribute hard copies of the recruitment fliers to potential participants using a script, approaching professional contacts myself, and distributing flyers to professional contacts myself. When distributing flyers by hand, the point people and I had an approved script to use to ensure that we were not coercive in any way (Appendix F).

With the new strategies in place, the recruitment of ten participants was achieved in the amended Phase 1.

If it had been necessary, Phase 2 would have taken place in Chicago, IL. The plan was to recruit obstetric registered using three techniques: (1) a solicitation e-mail sent to the UIC College of Nursing graduate student listserv (Appendix D); (2) the e-mail text posted to the bulletin board of a Blackboard site used specifically by Women's Health Practitioner and Midwifery students at UIC College of Nursing; (3) a recruitment flyer (Appendix E) posted in appropriate places in UIC College of Nursing and made available to appropriate classes. A script was created for faculty to read, which specified the students' status would not be affected by participation or non-participation in the study so as not to be coercive (Appendix G). Interested participants would have contacted me by phone or e-mail and a snowballing technique would have been used as explained above.

If I was contacted by interested nurses by phone, I used a script to guide what I said (see Appendix H). Due to the busy schedules of nurses, it was assumed that some interested potential participants would prefer to communicate by e-mail. This did turn out to be the case for several of the participants. These participants received a series of form e-mails (see Appendix I) in place of the phone call. During the phone call (or in the e-mail communication, if applicable), I assessed their eligibility for the study, documented their eligibility on a form (see Appendix J), and gave them a more detailed explanation of the study. All of the potential participants who contacted me were eligible and interested in participating in the study. In each case, we agreed on a comfortable, appropriate setting and a time for the interview. The inclusion criteria allowed the best chance for the collection of the rich experiences consistent with the approach (M. van Manen, personal communication, June 25, 2010).

3. **Interviews**

In hermeneutic phenomenology, interviews help to explore and gather experiential narrative material as well as to develop a conversational relation with the participant about the meaning of the experience of interest (van Manen, 1990). Interview settings were convenient, comfortable, private, and as free from distraction as possible (Polit & Beck, 2008; van Manen, 1990). Examples of locations where participants were interviewed included private rooms in public libraries and private rented rooms in rehearsal spaces. I obtained prospective, written informed consent from each participant prior to his or her interview and ensured the participants understood the informed consent and Certificate of Confidentiality by allowing time for questions. Prior to starting each interview, I also ensured the participant still did not meet the exclusion criteria of being pregnant (see Appendix K).

Each face-to-face interview was digitally recorded with two recorders to avoid the loss of data due to technical failure of one recorder. A clock was available to allow me and the participant to keep track of the interview time (no longer than two hours).

I asked participants to identify a pseudonym for the interview, and each participant was also assigned an identification number for the purposes of confidentiality. The interviews were open-ended and unstructured. Consistent with the phenomenological data collection technique (van Manen, 1990), each participant was asked to answer the same main question: Can you tell me about a time when you experienced the worst trauma in your role as an obstetric registered nurse providing direct care? However, to ensure that the interviews remained focused on the aims of the study, I had a list of interview probes available (see Appendix A).

After the interview, each participant completed a short demographic form (see Appendix B) and a contact form (see Appendix L). These forms did not contain the participant's name. They were only identified with the participant's corresponding identification number. Participants were asked if they wanted to see the summarized analysis when it was ready. Their responses

were recorded (Appendix M). All of the participants chose to see the analysis. Finally, each participant received a list of mental health providers in case they needed or wanted to talk more extensively about their experiences with a trained professional after the research interview (see Appendix N). All participants received compensation (\$50 Visa cash card) for their time at the end of their interview. After the participants left the location, I privately audio recorded a post-interview summary to keep track of insights gained, to detect patterns of the work in progress, and to help to reflect on previous reflections (van Manen, 1990). A guide with questions was used for the post-interview summary (see Appendix O).

Immediately after each interview, I downloaded audio recordings of the interviews to the secured UIC WebDisk for temporary storage. According to the UIC Academic Computing and Communications Center, files and folders on the WebDisk are by default not visible to anyone. Only Users/Groups for which the owner sets the permissions can access the content within a WebDisk. Those who are not given permission cannot view the content. Authorized Users sign in to "<http://webdisks.uic.edu>" and provide their NetID and password to view this content. Audio recordings were also downloaded to the secured UIC network server (<sftp.uic.edu>) for safe and confidential transmission to the professional transcriber. This secure network server was approved as a mechanism for safe data storage by the Information Systems Manager of the Research Information Systems and Technology department of the Office of the Vice Chancellor for Research at UIC.

The audio recordings were then erased from the audio recorder. The professional transcriber downloaded the interviews as they were conducted from the secured UIC server. She de-identified and transcribed verbatim the interviews and uploaded the transcriptions back onto the secured UIC server for my retrieval. After checking the transcriptions for accuracy, I erased the audio recordings from the secured UIC WebDisk and the secured UIC network server. Transcriptions were stored on the UIC WebDisk.

I transcribed all of my own post-interview summaries, stored them on the UIC WebDisk, and then erased the audio. I hand-wrote a thank you note to each participant following the interview. This letter was intended to impress upon the participants that their participation was appreciated and very useful in forwarding knowledge in this area (see Appendix P for the text of the thank you letters).

Data from paper forms containing participants' identification numbers (Initial eligibility, Interview eligibility, Demographic, Contact, and Feedback Request) were transferred to electronic copies and stored on the UIC WebDisk. Paper forms were then shredded.

Since all of the participants indicated that they wanted to see the summarized analysis at the time of their interview (as recorded in Appendix M), I mailed it to them with a letter explaining the analysis (see Appendix Q). Included with the analysis was the list of mental health providers they could contact if the analysis brought up feelings that they wanted to discuss further with a mental health professional (see Appendix N). Participants had the option to provide feedback on the summarized findings. The directions for providing feedback were included in the summarized analysis package (see Appendix R). All participants were instructed to contact me by phone prior to submitting the feedback so that I could verbally review the informed consent with them (see Appendix S for script). Participants had the option to respond to the questions by phone or in writing (e-mail or handwritten). Participants received stamped envelopes to return their feedback (if applicable) by mail.

A prepared script (Appendix S) was available to remind participants responding to results about their informed consent. Compensation (\$25 Visa cash card) was available for those who chose to respond.

F. **Analysis**

Approaches to phenomenological analysis come out of various schools of thought such as the Utrecht school (van Manen), the Duquesne school (Colaizzi, Giorgi, and van Kaam), and

Heideggerian hermeneutics (Diekelmann et al., Benner, and Gadamer) (Polit & Beck, 2008). Some approaches are compared in TABLE III. Overall, van Manen's approach requires the most comprehensive and in-depth analytical process. I began analyzing the data after all 10 interviews were completed. This stage of the research requires seven levels of reflection and writing (see Table III) in order to arrive at the essential meaning of the phenomenon in question: thematic, collaborative, existential, linguistic, exegetical, and hermeneutic interview reflections, and phenomenological writing (van Manen, 1990). These seven processes were used iteratively throughout the analysis, but for clarity are referred to here in sequential steps.

1. **Thematic reflection**

I conducted a thematic analysis of the interview transcripts to understand the main structures that make up an experience. This was done using three different approaches (wholistic, selective and detailed) to ensure that all of the themes were identified (van Manen, 1990). The *wholistic approach* requires looking at each transcript and determining what phrase will capture the fundamental meaning of each text as a whole. The *selective approach* requires multiple readings of each transcript and deciding what statements or phrases stand out or are particularly revealing about the experience. The *detailed approach* requires the investigator to carefully read each sentence or sentence cluster and conclude what it reveals about the phenomenon. Using a qualitative software (Atlas.ti, version 6.2), I highlighted these statements and phrases and collected them in a separate document. I then reorganized the statements and phrases into themes. I did this for each interview separately, but did pay special attention to themes that were reoccurring over interviews (van Manen). After completing this process for all of the interviews, I identified the essential themes (themes that were repeated in all of the interviews) of the phenomenon. Essential themes are those that make a phenomenon what it is and without which the phenomenon could not be what it is (van Manen).

TABLE III

METHODS OF ANALYSIS FOR PHENOMENOLOGICAL STUDIES

van Manen	Colaizzi	Diekelman et al.
Thematic Reflection	(1) Read all protocols; (2) Review each protocol and extract significant statements; (3) Formulate meaning for each significant statement; (4) Organize formulated meanings into clusters of themes; (5) Integrate results into an exhaustive description of the phenomenon under study; (6) Formulate an exhaustive description of the phenomenon under study in as unequivocal a statement of identification as possible	(1) Reading interviews to gain a holistic impression; (2) writing interpretive summaries for potential themes; (5) Comparing texts to identify common meaning and shared practice; (6) Identify patterns linking themes
Collaborative reflection ^a		(3) Analyzing transcripts as a group task for an interpretive team ^a (7) Asking the interpretive group and other peers for suggestions on the final draft
Existential reflection		
Linguistic reflection		
Exegetical reflection		
Hermeneutic interview reflection	(7) Ask participants about findings.	(4) Returning to the texts or participants to clarify certain issues
Phenomenological writing		

Note. Adapted from *Researching Lived Experiences: Human Science for an Action Sensitive Pedagogy*, by M. van Manen, 1990. Albany, NY: State University of NY Press; *Nursing Research: Generating and Assessing Evidence for Nursing Practice*, by D. F. Polit and C. T. Beck, 2008. Philadelphia: Lippincott Williams & Wilkins; *Qualitative Research in Nursing*, by I. Holloway and S. Wheeler, 2002. Oxford: Wiley-Blackwell.

^a van Manen encourages collaboration with others over the initial themes while Diekelman et al encourage collaboration over the transcripts

2. **Collaborative reflection**

I discussed identified themes with colleagues through formal and informal conversations. I made formal presentations of the themes to my dissertation committee and to a graduate research seminar composed of PhD nursing students and faculty at UIC. Through collaborative discussion about the themes and thematic descriptions, deeper insights and understandings were generated (van Manen, 1990).

3. **Existential reflection**

According to van Manen (2002c), at least four existentials “probably pervade the lifeworlds of all human beings, regardless of their historical, cultural or social situatedness” and therefore act as good guides and categories with which to organize phenomenological writing. The four existentials are lived space (spatial), lived body (corporeal), lived time (temporal), and lived human relation (relational) (van Manen). These four fundamental lifeworld themes or existentials assisted the reflection process and helped to frame themes of the lived experience of trauma. The use of existential reflection is very unique to van Manen’s phenomenological analysis and acknowledges the experience of a phenomenon within a person’s everyday life (Dowling, 2007; van Manen, 1990).

4. **Linguistic reflection**

I explored the etymological history of the words and idiomatic phrases related to the phenomenon to determine if they offered any insight into the original experiential word meanings. Ordinary language contains within it the richness of the human experience and can have important interpretive significance to the phenomenon being studied (van Manen, 1990).

5. **Exegetical reflection**

I researched literature, poetry, and other story forms (including my own stories and notes, biographies, diaries, art, or phenomenological literature) that have already

addressed phenomenon being studied to expand my insights and develop my ideas on the phenomenon (van Manen, 1990).

6. **Hermeneutic interview reflection**

The interview participants should play a part in the analysis process through hermeneutic conversations, which are collaborative discussions between the researcher and participant that seek to arrive at phenomenological meaning together. All of the participants requested to see the resulting themes of my analysis. Participants who wished to continue their participation in the study with a collaborative discussion with me were encouraged to do so via phone or a written response. This process allowed me and the participants to reflect on their experiences in order to hone in on as much interpretive insight as possible. The main goal of these conversations is for the researcher and participant to ask each other “Is this really what the experience is like?” (van Manen, 2002a).

7. **Phenomenological writing**

Writing is an essential part of the phenomenological process (van Manen, 1990; van Manen, 2006). One writing technique is to write anecdotes based on the final essential themes of the phenomenon. Anecdotes compel and involve the readers, invite reflection, and transform the readers so they are better able to make interpretive sense of the phenomenon (van Manen, 1990). After the final themes in this study were determined, I created an anecdote to help make the themes more comprehensible, transparent, and evocative.

G. **Rigor/trustworthiness**

Qualitative researchers strive for “precision and exactness by aiming for interpretive descriptions that exact fullness and completeness of detail, and that explore to a degree of perfection the fundamental nature of the notion being addressed in the text” (van Manen, 1990, p. 17). This can be achieved through credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985; Tobin & Begley, 2004).

1. **Credibility**

The goal of credibility is to ensure the findings of a study make sense (Miles & Huberman, 1994) and reflect the experience of the participants in a believable way (Whittemore, Chase, & Mandle, 2001). Credibility can be gained during the study with prolonged engagement, peer debriefing, and triangulation, and after the study by establishing referential adequacy and conducting member checks (Lincoln & Guba, 1985). In this study, I spent one to two hours with each participant. Due to the length of the interview, the participant had the opportunity to adjust to me and not feel threatened. Several of the participants indicated their comfort with me without my having to ask. I also had formal and informal collaborative meetings with two groups regarding the final themes. I used multiple data sources (interviews, literature, my own stories, etc.) to help cross verify sources. In order to establish referential adequacy, I checked transcriptions against audio files to ensure their accuracy. The results of the study were sent to participants who agreed to this additional step to allow a deeper interpretation to develop out of the discussions (van Manen).

2. **Transferability**

Transferability enables the reader interested in making a comparison to reach a conclusion about whether a comparison can even be contemplated as a possibility (Lincoln & Guba, 1985). It is the responsibility of the investigator to provide a data base that makes transferability judgments possible on the part of the reader. This was achieved by collecting thick descriptive data and developing thick descriptions (Lincoln & Guba).

3. **Dependability**

Dependability involves making certain the research process is consistent and stable over time (Miles & Huberman, 1994). Dependability is attained by establishing an audit trail to ensure the data collection and analysis processes are free from error, accurate, and acceptable

overall (Lincoln & Guba, 1985). I made notes of the steps I took, and any insights or patterns I observed throughout the study (van Manen, 1990).

4. **Confirmability**

A study is confirmable if the findings are clearly derived from the data (Tobin & Begley, 2004). This requires an audit trail, triangulation, and reflexivity on the part of the researcher (Lincoln & Guba, 1985). In this research, I used multiple data sources, as mentioned above, and kept an audit trail to guarantee that the findings, conclusions, and recommendations were supported by the data. In addition, for the sake of reflexivity I made my understandings, beliefs, biases, assumptions, presuppositions, and theories explicit to myself and others throughout the research process. While I could not completely bracket out or ignore everything I have already experienced, I did my best to hold what I know “at bay” while not allowing presuppositions to “creep back into” my reflections (van Manen, 1990, p. 47).

H. **Ethical considerations**

I took several things into consideration to ensure that this study was of minimal risk to those involved.

1. **Certificate of confidentiality**

A certificate of confidentiality (CoC) is an important tool to protect the privacy of research study participants because it protects identifiable research information from being forcibly disclosed (Office of Extramural Research, National Institutes of Health, 2009). With a CoC, the principle investigator of a study and others with access to the data may “refuse to disclose identifying information on research participants in any civil, criminal, administrative, legislative, or other proceeding, whether at the federal, state, or local level” (Office of Extramural Research, National Institutes of Health). Because it was anticipated that I would be collecting information that, if disclosed, could have negative consequences for participants, especially due to the litigious nature of the possible content, obtaining a CoC ensured confidentiality and

privacy to participants and possibly promoted participation by doing so (Office of Extramural Research, National Institutes of Health).

2. **Researcher self-care**

Due to the nature of the subject matter and the emotional work throughout the data collection and analysis (Dickson-Swift, James, Kippen, & Liamputtong, 2007), I attended weekly sessions with a mental health nurse practitioner to assist me through the processing of emotional material. I also used informal networks of peers, friends, and family members for support throughout the research (Dickson-Swift et al.).

3. **Recruitment and retention with sensitive research**

Recruitment and retention was conducted in a way to ensure that a Theory of Caring was upheld due to the sensitive nature of the research (Kavanaugh, Morro, Savage, & Mehendale, 2006). I used respectful language in all contact with participants; I acknowledged participants during the interview and in written communication for their time a willingness to participate while emphasizing that their stories would be used to help improve the nursing profession; I gave participants tools they could use to help themselves such as a list of mental health resources; I avoided coercion; I maintained confidentiality (Kavanaugh et al.).

4. **Safety monitoring and assessment**

This study was determined by the UIC Institutional Review Board to be of minimal risk because the “probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life” (The Board of Trustees of the University of Illinois, 2010). However, because there was a small possibility that the interview or the optional reflection during the feedback conversation could cause the participants to recall painful memories and cause sadness or stress, I was sensitive to cues from the participants. I slowed down and offered to stop interviews when participants became tearful during interviews. Though it did not come up, I was sensitive to possible acute emotional

distress (participants' statements or behaviors suggesting that the interview was too stressful, a participant considering hurting himself or herself, a participant considering hurting someone else, or a participant being in potential danger if another person found out about the interview (Draucker, Martsof, & Poole, 2009). I limited the interviews to a maximum of two hours and stopped participants after they had recounted a maximum of three trauma experiences. In some cases, when the first or second story shared seemed particularly upsetting or difficult, I stopped the interview before the maximum number of stories was reached. In two cases, I purposely ended the interviews earlier than the allotted two hours out of concern for the participants' physical discomfort (post-operative and chronic back pain).

5. **Data management**

All data were transferred from paper to electronic forms and stored on the secure UIC WebDisk throughout the research. Paper forms were shredded. I mailed the hard copies of the informed consent forms to UIC College of Nursing via the U.S. Postal Service, collected them when I arrived at UIC, and transferred them to a locked cabinet in a locked room where they will remain for six years after the study's completion. At that time, they will be destroyed.

Each participant has an identification number (ID) and pseudonym so actual names are not attached to any of the data except the contact forms and the informed consent forms. Audio recordings from the interviews were only available to the transcriber and me. The transcriber transcribed verbatim all audio recordings after they were safely transferred to her via a secure UIC server (sftp.uic.edu). After checking the interview transcripts for accuracy, I erased all audio recordings. All transcripts were de-identified. All transcripts were stored on the secure UIC WebDisk. Transcripts were uploaded onto my laptop only when I was actively analyzing them after which time they were destroyed. I will erase all electronic files when publications are completed, which at this time is anticipated by July 2013.

Three research advisors (Dr. Karen Kavanaugh, Dr. Carrie Klima, and Dr. Susan Vonderheid) had access to the interview transcripts, but only after they had been de-identified by removing names and any other identifiable information. When the results of the research are published or discussed in conferences, I will not include any information that will reveal the participants' identity.

IV. RESULTS

Ten obstetric registered nurses were interviewed for this study (see TABLE IV). All of the nurses were female. The sample consisted of seven non-Hispanic White nurses and three non-Hispanic Black nurses whose ages ranged from 28-58 years. Their experience in obstetric nursing ranged from 2-37 years with four of the nurses having over 20 years of obstetric nurse experience. The nurses were allowed to share anywhere from one to three stories of trauma experiences with the interviewer. These experiences varied widely, but the most common experiences were with maternal deaths, intrauterine fetal demises (IUFDs), and emergency Cesarean sections (see TABLE V).

A. Thematic reflection

Based on the recorded discussions of what the lived experience of trauma was like for ten obstetric nurses, seven essential themes were uncovered: (a) **An internal process**; (b) **Being faced with the unexpected**; (c) **Going through the motions**; (d) **Feeling helpless**; (e) **Engaging others**; (f) **A visceral imprint**, and (g) **A damaged person**. The following results section will describe each theme along with their individual sub themes in detail. These overall themes were present for all of the nurses. The sub themes are used to illustrate various, more descriptive ways in which the themes were experienced. Therefore, the sub themes may or may not have been present for every nurse.

The themes are not intended to imply that the lived experience of trauma is a strictly linear process. In other words, each of these themes do not necessarily occur at one time in a step-by-step process from the beginning of the trauma to the end of it. Instead, it is important to imagine the themes happening often and simultaneously. Because of this, the themes and/or quotes supporting the themes may overlap at times. Pseudonyms chosen by each participant have been used to keep their identities confidential. The names of people and places have also been changed.

TABLE IV
PARTICIPANT DEMOGRAPHIC AND TRAUMA CHARACTERISTICS

Characteristic	n	Range
Gender		
Female	10	
Race		
Non-Hispanic White	7	
Non-Hispanic Black	3	
Age		28-58 years
Under 50 years	5	
Over 50 years	5	
Years as an obstetric nurse		2-37 years
Under 10 years	1	
10-20 years	5	
More than 20 years	4	
Highest education level		
Diploma	5	
ASN	1	
BSN	4	
Frequency of trauma experiences	5	
Once per month	1	
Once per 2-3 months	3	
Once per year	1	
Once per 5 years		

TABLE V

LIST OF PARTICIPANT EXPERIENCES FROM INTERVIEWS

Participant's pseudonym	Experience (Approximate time since experience, if known)
Maya	<ol style="list-style-type: none"> 1. maternal hemorrhage (~11 years ago) 2. IUFD (~9-10 years ago) 3. prolapsed cord → emergency C-section ("a couple of years ago)
Pamela	<ol style="list-style-type: none"> 1. maternal death (within last year) 2. maternal death→IUFD (~3 years ago)
Bunny	<ol style="list-style-type: none"> 1. failed vacuum/negative nurse-doctor interaction→ emergency C-section→injured neonate (~2 years ago)
Lily	<ol style="list-style-type: none"> 1. fear of doctor (~2 years ago) 2. fear of doctor (bullying) 3. security threat on unit
Maude	<ol style="list-style-type: none"> 1. IUFD (20 years ago) 2. emergency C-section→ hemorrhage & hysterectomy (3 years ago) 3. failed home birth IUFD (11 years ago)
Baby Baby	<ol style="list-style-type: none"> 1. shoulder dystocia (~1.5 years ago) 2. emergency C-section 3. left alone for a high risk birth
Barbara	<ol style="list-style-type: none"> 1. Patient with dissociative identity disorder (~11 years ago) 2. abused patient with child (~8 years ago)
Vanessa	<ol style="list-style-type: none"> 1. Emergency C-section → maternal death (~2-3 years ago)
Jackie	<ol style="list-style-type: none"> 1. IUFD (~10 years ago) 2. premature neonate death
Carol	<ol style="list-style-type: none"> 1. back injury sustained during shift (~6 years ago) 2. elective termination

1. **An internal process**

When we think of nurses, it is natural to think of the caring that they provide to their patients, however, we do not often think about what is internally occurring for them as they provide this care. Most of their internal processing of their work is never revealed to outsiders, but remains private to the nurse. In this study, each nurse internally experienced trauma by (a) **instinctively sensing a problem**, (b) **engaging in internal dialog**, and (c) **asking why**.

These nurses **instinctively sensed a problem** or that something distressing was going to happen right before it occurred. This was a foreboding feeling that something would happen out of the ordinary. This is not to be confused with an intuitive knowing because these nurses are physically feeling a problem before knowledge of any details. Upon walking into a labor room to meet a patient, Pamela knew something was wrong. The patient later died.

Because I felt like this woman is already halfway gone. It was like something inside of me said this woman has to deliver like now. Something is not right here...It was a physical, like, oh my God, this woman has to be delivered because something is not right here and when I went out back out to the desk the doctor was out there and we spoke to each other and I said - we collectively decided that she has to be delivered right now. There's no way.

-Pamela

Another nurse described the feeling of knowing something was wrong on the obstetric floor before even witnessing anything. She was on rounds in the hallway with a group of people and as she neared a patient room, she could hear a slowed fetal heart rate but thought to herself that there was no other associated sounds or sights of something being done about it.

We're making rounds and one nurse was in doing a delivery and it was the resident, the nurse in the room at the time, of course the patient and her husband and as we were making rounds you could feel. It wasn't like if it was sad or whatever but the tone and you could feel like something wasn't going right.

-Baby Baby

When speaking about an obstetrician with whom she had negative trauma-inducing interactions, Lily said she could feel his impending outbursts before they occurred.

Anyway, he was a very busy practice and he had temper outbursts all the time. All the time. You always had to worry about he was going to explode and you can see it coming and then he'd start screaming and yelling...I did not argue. I tried to defend myself but you could feel it. You could see he was going to escalate. His back would get stiff and he would go, ahhhh, right in your face and start yelling at you. He did this all the time...

-Lily

While the traumas were unfolding, these nurses **engaged in internal dialog** regarding what was happening. This internal dialog was often characterized by conflict and confusion but typically had the purpose of redirecting the nurse from being emotionally distracted to taking an active role in the trauma. In the following quote, Maya explains how she began to speak emotionally to a baby who had died in utero and was partially decomposed, but quickly changed to talking to herself instead.

Oh, poor baby, you know, I'm so sorry, you know, talking to the baby. I'm so sorry. In your mind, you know. Like, oh poor baby, you know, or then sometimes the medical side takes over like, oh, this baby's got really low-set ears or the head looks really funny. Maybe there was something really wrong with this kid or why didn't the mother not feel this kid moving? What was going on?

-Maya

Amidst a hectic emergency Cesarean section, Pamela used an internal dialog to try to answer her own questions and concerns.

[I was] very nervous internally like I knew that this woman is going to hang on by the string of life because... And thinking to myself constantly as I'm running back and forth, how will she ever - if she survives this, how will she ever survive this? Because she's in such toxic, massive shock, how will she ever get out of this? You know, they were planning on putting like colostomy, like an internal colostomy. How will she ever make it through that? With a C-section. How will this woman ever, ever, you know, survive this? And you like think in your head like, there's no way she can come out of this.

-Pamela

Similarly, during a maternal code, Vanessa found herself internally asking questions while actively working on concrete goal, which in this case was getting the baby out of the mother.

I mean, it's pure adrenaline at that point. During any code situation you want the best outcome and you're just thinking, Oh my God, like, I hope I save this person. What's wrong with her? Why is she coding? What's, you know, but at the same time, like, we gotta get this baby out and what's this baby's condition going to be.

-Vanessa

Instead of becoming emotional about a full-term intrauterine fetal demise, Jackie was busy trying to talk herself into the best way to prepare the baby's arm, which was dislocated during birth by the obstetrician, before presenting him to the mother.

Well, it was important, we always tried to take pictures and memorabilia and if they had hair, cut the piece of hair. He was bald. He didn't have any hair and so we just washed him up and his face looked good so he didn't look very... He wasn't dead for a long time, so, and I just remember the arm though and then trying to put the T-shirt, because like we wanted to put... We had these little shirts, and then wrap them in their blanket and it was important to me. I wanted to get this stupid shirt on so she wouldn't know about the baby's arm but all the time I'm thinking, oh my God, I hope this arm don't fall off. How would I bring him in there if he has no arm? What do I do? What do I do?

-Jackie

Finally, Carol described the internal legal discussion that went through her mind when preparing for a termination.

Where it was going to be a couple of hours before it was 24 weeks. Twenty-four weeks is viability. You're not allowed to terminate in the state of New York. So, my concern was, one, are you getting to the point where you're going to break the law because you're doing a termination, you know, where you're literally terminating the baby and then—

-Carol

Both during the traumas as well as after the traumas were over, the nurses' internal dialog morphed into **asking why** things unfolded the way they did as a way to process the trauma and self-evaluate. In all three of the following examples, the nurses explained how they are still internally tormented by questioning what they did during the trauma and wish they could go back and change their actions. This sense of feeling partially responsible for the trauma and the residual guilt they have from how they handled the situations is not easily forgotten, if it can

be at all. Bunny struggles with her decision to give a bullying doctor more than one vacuum for what should have been a non-interventional birth in her opinion.

Participant: I don't talk about it with other nurses and I certainly never tell them that I gave him two vacuums, if I do mention the stories.

Interviewer: Because you wish you hadn't.

Participant: And it was wrong. I mean, like, you're not supposed to. You're not supposed to give another vacuum. The guy had three pop-offs and there was nothing wrong with the vacuum. It wasn't defective and I shouldn't have handed him another one.

-Bunny

Maude can still not forgive herself for discharging a patient who eventually came back with an intrauterine fetal demise (IUFD).

So, anyway, I felt terrible, I felt like I made a big mistake. I felt that I tried to do everything that I could do. I should've never been pressured at work with busy-ness to feel like sending this patient home because it's against my better judgment even many years ago, and that's why I was really proactive about it, and it bothered me that same day. Hours later I'm thinking I shouldn't have sent that patient home...I felt like I did something wrong...To this day when I think about it it's hard for me to forgive myself.

-Maude

After an IUFD, Jackie still wonders to herself what she could have done differently to have ensured a better outcome.

Well what could I have done better? Like why couldn't I get across to her? So I felt like on some level I was a failure because why couldn't I get through to her? Why couldn't I make her see the importance of what she was doing? So, in some level healthcare failed her. Her doctor failed her, nursing failed her, because we couldn't get through to her. Yeah, she's responsible but in some way I think I felt responsible, and maybe because I got a little connected with her and we got a little close or whatever from when she would come into hospital. So I think that's why. Like, it was my own, like, what did I do wrong? Where did I go wrong? Why couldn't I get through to her? So I just kind of like was having my own thoughts.

-Jackie

Internally asking why was not always focused on self-blame or guilt on the part of the nurse, but also objectively asking why their trauma happened in general. Pamela asked herself questions while in the operating room during an attempted maternal resuscitation and

afterwards as to how the team could have avoided the tragedy. Her questioning was not to place blame on any one party, but wanting to know if they did all they could have done.

Yeah, and throughout the day she, you know, it was several hours before- that's why I'm saying like if they think back like could there have been something more done? Could she have been delivered and saved at that point? But I don't think - the way it looked to me... And we talk about things and, you know, like a couple days later we think back on, you know, what could've been done better, you know. The lab took a little bit long. Would it have saved her life? Probably not. I mean the way this bowel was... She came in dead on arrival. But, you know, you start questioning like could we have done something different? Could we ... Could things... Could they have gotten another consult? Could they have...

-Pamela

After a shift during which a patient was in disseminated intravascular coagulation (DIC), Baby Baby spent her whole drive home asking why what she had just witnessed happened. Her curiosity was not based on having guilt that she had missed something, but more on a desire to understand the pathophysiology behind something so terrible.

Participant: I was thinking about... My whole... No. I wanted to know physiologically what happens when you throw an embolism. How does that come about? You know what I'm saying? Where does it go? What does it do? Why does it cause your body to go into DIC?

Interviewer: So you wanted kind of answers?

Participant: Right. I wanted like, you know, I wanted to... I need to see, read, touch... That's how I learn, so I wanted to go home and go through the books and see what happens, you know, what happened, what triggered this, what triggered that because it ain't something that you caught, you go to DIC. Something happens, you know, physiologically that causes this to happen and I wanted to know, like, what happened, you know.

-Baby Baby

Carol wanted to ensure that a 23-week fetus was terminated for a reason when upon visual inspection it looked normal to her.

Then when that baby comes out physically it looks normal. I mean, I can't see what's in the brain. They never got back to me. I asked for an autopsy, you know. I mean you know why the patient... The patient didn't have to have an autopsy because you knew why the baby died because you did the cardiac puncture. I didn't really want an autopsy per se but what I asked for was verification that why you terminated the baby was actually the case... They never got back to me but it was very, very emotionally traumatic to be terminating a baby that large and that big.

Overall, no matter what the nature of the trauma, whatever was occurring internally for these nurses before, during, or after the trauma invariably made it a truly personal experience as they tried to make sense of what happened.

2. **Being faced with the unexpected**

The traumas experiences described during these interviews were often emergencies but even when they were not, they were always unexpected. In other words, these nurses did not go to work anticipating that they would experience a trauma that day. Three more subtle sub themes of being faced with the unexpected are: (a) **getting caught off guard**; (b) **still needing to take action**; and (c) **always being on your toes**.

When a trauma occurred, these nurses felt **caught off guard** by it even if momentarily. They never knew how things on their unit would typically unfold on any given day, but they did not expect or plan for trauma. Therefore when one did occur it was a shock for the nurse. Maude, who was on her first day back at work after taking time off to grieve the death of her father, was assigned a patient who was transferred from a nearby birth center. Maude was the first person to realize that the labor was not only a failure to progress, but that the fetus also had no heart rate. The maternal heart rate had been mistaken for the baby's while at the birth center.

Beautiful baby. Term, beautiful, healthy, but overdue and had a fever. The mother probably ruptured for a long time and nobody took her temperature. A lot of misses but I talked about that because it was like... I haven't seen a lot of babies... I mean, I've seen babies die and mostly demises but I didn't expect to have a baby die on me that day.

-Maude

Vanessa was completely surprised when a coworker interrupted her break with news of a maternal emergency.

I happened to be on my break [chuckle] and somebody came and told me that I needed to come out and I said, Okay, but she didn't say why. She just said, You need to come out, and I said, All right, and I was at the other end of the unit of where this was occurring, this incident, and a friend of mine, one of my colleagues, started running towards me and she told me to go to the postpartum floor to get the code cart and I was like, The what? [chuckle] I'm like, Huh? And she's like, Yeah, go get the code cart, and to be honest I really had no idea where it was [laugh].

-Vanessa

During the course of what was described as a typically busy and understaffed shift, Carol suffered a very serious and debilitating back injury while from moving beds and preparing for an emergency Cesarean section. Even though the context of Carol's trauma does not directly include a patient, the situation caught her off guard and was a significant trauma for her.

Participant: And this was like a cartoon because I went to bend down and couldn't get back up.

Interviewer: Oh no.

Participant: And I'm in the OR by myself and I can't call out for help because we only have two nurses and I'm the one running into the room to get ready for the...

Interviewer: Stat section.

Participant: For the stat section and then they come in and I'm just like holding this tray and then you have to basically drop the tray so that I can...

Interviewer: Try to stand up.

Participant: Try to stand back up and then finally, you know, after being out and going to the emergency room and realize that I have herniated three disks -

Interviewer: Oh my gosh.

Participant: - in my back because the first injury was moving the beds and then I just accentuated it even more by picking up the trays.

-Carol

Despite events being unexpected, these nurses expressed the need to immediately adapt to the situation because they **still needed to take action**, whether they knew what to do or not. In the following case of a prolapsed cord, Maya was obviously caught off guard, but continued to function and care for the patient. Maya immediately found herself on the patient's bed with her hand in the patient's vagina as she tried to keep pressure off the cord. Despite this scenario being unexpected and scary, Maya responded without hesitation by acting calm and reassuring the patient.

In that particular case I think the patient didn't lose it. She was okay. You know, it's just like, just keep breathing, we have to get you to the OR as fast as we can and if you keep breathing then you're going to get lots of air to the baby. You know, just over and over again. Just keeping a nice, soothing voice. In the meantime I'm like, ahhh!

-Maya

Vanessa describes how even though she did not really know what was going on when walking into the emergency situation of a maternal resuscitation, she jumped into action to do what she could.

What I was anticipating, I really don't know because her telling me to get the code cart was just something I never thought I was ever going to hear there [chuckle], so, you know, I was just wondering what the heck is going on and when I walked in and saw all those people and that she was intubated, I was just like, what? I just...I didn't know what was happening but my, you know, fight or flight kicked in or whatever and all I could think of was, what can I do for this patient?

-Vanessa

Despite the unexpected nature of traumas, these nurses expressed being well aware of the shock and immediate action that accompany trauma. These nurses described **always being on their toes**. In other words, while trauma was not assumed to take place, the chance of it was always anticipated deep inside these nurses. Pamela compared this nervous anticipation to what emergency room nurses may also face.

Maybe ER nurses and OB nurses could probably empathize with each other because I think for us it's more of an acute trauma as opposed to like oncology, you know they're sick, you know they, you know, there's a chance that they will pass and it's not like an immediate thing. For us, it's like if there's trauma, if there's like anything it's an acute thing. It's like, go. You have to like be on your toes as well as ER. You have to be constantly on your toes. We are a specialty. We are considered a, you know, an acute unit. An emergency acute unit because at any given moment I could have a patient rolling out from the street or from the ambulance ready to deliver or hemorrhaging or seizing because their blood pressure is high. You've got to be moving. You know?

-Pamela

Lily was always on her toes around a doctor with anger management problems, whose behavior caused one of her traumas.

Everyone walked on eggshells with him. You were afraid of what to say that was going to set him off that day.

-Lily

Being “ready for anything” brings with it a sense of calm, as Barbara explained, whether warranted or not. Barbara explains not worrying about taking an “odd” patient but eventually realized she could never have prepared herself for what was going to happen. Barbara’s patient, whom she later found out probably had dissociative identity disorder, wound up being emotionally and physically abusive with her.

[The patient’s] midwife came with her to care for her and I got report at 7:00 in the morning that she was a little odd but, you know, typically the ladies that came from the birthing center were not easy to deal with because their entire plan had changed and they were just angry, so I was ready for anything and I didn’t mind.

-Barbara

3. Going through the motions

During a trauma, these nurses expressed that the common and natural response is to retreat to a routine by going through the motions most familiar to them. They explained how this automatic reaction was necessary for them to get through the trauma, which was obviously not routine by any means. Going through the motions can be divided into four sub themes: (a) **trying anything to comfort themselves and others**; (b) **activating robot mode by compartmentalizing thoughts and emotions**; (c) **glossing over details**; and (d) **restraining emotions**.

One way the nurses in this study went through the motions during a trauma was to **try anything to comfort themselves and others** despite the extraordinary circumstances occurring around them. Adding a familiar routine to a trauma helped these nurses escape to something familiar and avoid what was really happening. At the same time, their actions were providing support to patients and colleagues. After an intrauterine fetal demise (IUFD), Maya

recollected trying to make the partially decomposed fetus look as much like a baby for the mother as she could.

I'm trying to make some semblance of this child to make it look like a child in five minutes so that the mother sees that there's a face and... But it was so de-... It was starting to decompose so that the, you know, it was very hard, gelatinous and skin falling off and, you know, eyes open, jaw hanging open, so we have a way, we know how to wrap them so that the jaw stays closed and, you know, we can present them with a baby and usually if we have more time we put baby powder on it, we make the baby smell like a baby. But this baby I don't even know if I put it in water what would've happened.

-Maya

Despite the circumstances, Maya was able to go through her normal routine of wrapping the fetus to present to the parents. Jackie also described an IUFD, from which she was emotionally affected, and how she did her best to make the baby look as normal as possible for the mother given the reality that the baby's arm was almost torn off during the birth.

so the baby comes out and we're all crying but, like, just tried to wrap him up the best I could. I just didn't want her to know, like, there was trauma to her baby like that and, you know, a lot of times they want to unwrap it and look at the baby and I remember doing it, like, in such a way that she wouldn't know there was any trauma to her baby because I thought, oh my God, if she ever knows. Like, it's bad enough she has all this other guilt. Now she's going to see this?

-Jackie

In the midst of an emergency section for the patient of a colleague, Baby Baby tried to do anything she could to help the patient and her colleagues make it through the situation.

Participant: Just to try to get things... Because it was so quick, just to try to make sure that nothing, you know, make sure that all the instruments [unintelligible]. I don't think anybody had a set thing because everybody was doing everything.

Interviewer: Doing something. Yeah.

Participant: But I just wanted to make sure that all the instruments was accounted for, the warmer was set up. Basically that was my thing. Make sure the warmer is set up and we have everything we need. We pull out the, you know, make sure that it was set up basically, you know, and call Peds and that was it.

-Baby Baby

Going through the motions also manifested for these nurses into **robotically** completing tasks while **compartmentalizing any thoughts or emotions** that might just get in the way during the moment. In other words, these nurses activated a mechanical, autopilot version of themselves that could complete the work that was needed without thinking about what was actually unfolding in front of them. These nurses used their tasks to help them avoid their feelings and enable them to maintain some sort of sanity. The nurses described emotionally shutting down and focusing on tasks until the trauma was over. Activating this robotic version of themselves helped these nurses avoid the reality of the situation at least for the moment and provided them with something to do other than thinking about the trauma at hand. Maya had to think about another patient while in the middle of her trauma experience with an IUFD.

Interviewer: Did you go back to your own patient?

Participant: Oh yeah, I had to, in between. You don't just stay there. It's like, okay, I gave the kid to the mother, I saw her start to unwrap her. I was like, Oh shit, and I left and then I, you know, checked my twins, you know, rode the residents who were getting ready for sign out before we do. What are we doing with these twins? Is this one walking? Can you look at this tracing? You know, you're racing to chart and then go back. You know, do you need anything else? You know, we just continue doing stuff.

-Maya

For Maya, the "continue doing stuff" related to tasks that she could complete robotically despite the emotional trauma that was still going on around her. Similarly, Pamela explained how she responded during her trauma experience of a woman "crashing" in the operating room. She did not allow the emotional toll from the trauma to set in until there were no more tasks to be done.

And I'm just going back and [forth]. I'm in the OR, I'm running out, I need blood, I need - I'm just like a robot. At that point we're all like... I'm in, I'm out, and I'm in shock and I'm, you know, and my surgeon, the assistant is about to pass [out]. As soon as that colon came to view she almost passed out. So I'm running now giving her ammonia and somebody else is running getting blood and I'm running out and saying I need plasma, I need blood, I need... Coming back and forth. You know, you don't - you're just going, and at that point, at the end, you know, she was coded. We coded her for 45 minutes... The whole experience was just, you know, as you're going through it like, you know, I felt like I was just like a machine, just getting things. You just don't even

think about it, but the minute she was pronounced I found myself just stepping out, going into like the recovery room and just breaking down and crying because suddenly it was like, that's it.

-Pamela

In another situation, when another nurse sensed her emotions taking over, she regrouped and went back to her routine.

I was afraid. I was very scared. I knew she was going to deliver. I knew they brought [the other patient] to the OR. I couldn't call for help. So, again, in my mind I go through the next thing, what I need to have done. I started her on oxygen. I set up. I did a setup for sure. I told her, I said whatever you do, do not push. I stressed that. Do not push. I had her on O2. I had her on the left side.

-Baby Baby

Despite being in physical pain, Carol put aside her personal thoughts and feelings in order to deal with the task at hand.

The pain was there but you, you know, you think about... When you're in the midst of the emergency and, you know, that patient rolls through the door from the maternity unit that's 28 weeks pregnant and has vaginal bleeding and she has to go immediately into the OR, you're working on adrenaline, you know. You're working on, don't die on me today, you know, not on my shift, not on my time.

-Carol

For these nurses, in the process of going through the motions, the detail of the trauma was **glossed over** or minimized. In fact, the nurses in this study routinely told their stories to the investigator as short, matter of fact incidents as though that is how they remember them, sometimes within a minute or two. It was only when the investigator slowed them down and asked them about details that other, quite powerful details were revealed. Although Maya and her colleagues were looking forward to who would be their New Years baby this past year, the first birth on their floor happened to be an infant who dies before birth. She speaks about the incident matter of factly and quickly, without detail, while labeling it "so mundane."

It was just like, oh, here we go, happy New Year. You know, that... And that may be the, you know, utility of telling that story is just that it becomes so mundane. It becomes so everyday so that you have to strip yourself down. If things as easy as that bothered me I couldn't be doing what I was doing. You know?...So it's easy for me at

this point to kind of... I leave, go home, and deal with my family. I don't really think about it that much except, you know, Oh yeah, well our New Year's baby was dead, you know, that's it.

-Maya

Barbara admitted that she had actually forgotten many of the details of one trauma, but she was still obviously affected, as illustrated by her emotional retelling of the story.

I am more surprised at how much I don't remember, like because this was hours. This was 7:00 to 1:00. I mean, there was a lot more detail that I don't remember at all, you know.

-Barbara

Vanessa only remembered details as she told the story of her experience. Well into the interview she suddenly remembered a very disturbing part of the trauma.

Yes. Yeah, that was terrible too. The...[laugh] I just thought of this. The woman went into DIC during this whole thing so she bled out terribly and she actually... There was so much blood on the floor in the labor room that they had to rip up the flooring and put new flooring down and I mean the bed was saturated and it was just an absolute... It looked like a massacre and, you know, we had to clean up that floor as much as we could so that we could just walk in there to be able to wrap her and do all that.

-Vanessa

Finally, these nurses expressed a tendency to purposefully **restrain their own emotions** surrounding the experience. They believe and have convinced themselves that the trauma they felt or continue to feel is not as important as other things such as the patient, their job, or the outcome of the trauma. Restraining their emotions could mean delaying them, curtailing them, and in some case completely neglecting them. Maya acknowledged how she purposefully delays her emotions until she gets home.

So, you know, you got your period, you only slept three hours, your kid at home's not sleeping. If any of the other things in your life aren't lining up, if all the plates are spinning well, that can push you over. You can just then - or you can hold it together at work but then when you get home then you can't cope. It's like...you have to hold it together at work but when you get home, you know, that's when you lose it. You realize you're not mad because, you know, your child wet the bed or your kid's failing

chemistry or whatever the issue is. You're mad because you couldn't save that baby or that girl went on break, you shouldn't have been wrapping the baby. Whatever.

-Maya

Remembering a trauma incident after which she was mocked and shamed in front of her colleagues by an obstetrician, Bunny said,

He's calling me stupid, you know, incompetent, and, you know, you want to cry. You want to just like break down and cry [tearful] but you can't because, you know, then what really happens? Then how good are you going to be, you know? No one wants to... You know, you lose respect. So, I just didn't want to but I really did feel like it and I think I did cry like all the way home.

-Bunny

Although Jackie did release some of her emotion through crying in the bathroom after sitting with and consoling a mother whose baby was dying in the neonatal intensive care unit, she quickly curtailed her emotional response so that she could get back to work.

I just remember going back upstairs and going in the locker room, the bathroom, and I cried a little and then, you know, you gotta get your act together and get back to work [chuckle]...So, yeah, so just go upstairs and in the bathroom, cry a little bit, dab your eyes and try to throw some water on your face and get back to work.

-Jackie

Pamela explained what she does with her emotions after traumas, implying that she may be neglecting them completely in order to continue with patient care.

I think it was just kind of like, put it back here and do what you're supposed to do and leave it back here and talk to your coworkers about it. I'm very much like a machine in that way, you know? I can just separate... I can separate work from home. Trauma at work from like, all right you need to get this done. Like there's still this patient you need to take care of so you need to kind of, you know, separate that.

-Pamela

Even during the interview for this study, Vanessa explained how she is purposely neglecting her natural instinct to be emotional about the maternal death she experienced.

Participant: Yeah, like I can feel, like my heart races a little bit, you know. The adrenaline comes back I think, thinking about it and, you know, I didn't cry but I had to fight it back at first, you know. It still is hard.

Interviewer: You mean today?

Participant: Yeah.

Interviewer: Okay.

Participant: So, you know, I've gotten over, I think, the crying about it but it still does choke you up a little bit.

-Vanessa

Carol summarizes this sub theme of restricting emotions as part of going through the motions as an obstetric nurse by explaining,

After a while you tend to devalue what your needs are and that's how you end up having a lot of nurses or people that end up with depression or end up because you have to find yourself after a while because eventually you do have to say if you don't put yourself first who's going to? But unfortunately until you finish the job, you can't.

-Carol

4. Feeling helpless

Another common theme among the traumas is the nurses' inability to take action when and where they see fit. This helplessness occurred because of varying contexts surrounding trauma situations: (a) **knowing your actions are futile**, (b) **being prevented from acting**, or (c) **realizing the consequences**. The helplessness manifested in nurses feel trapped and powerless because they could not achieve what they felt was best for patient care.

There was often a moment surrounding the trauma when her hands were tied as to what more she could do to help the situation. In these hopeless situations, watching a trauma unfold and yet **knowing your actions are futile** greatly impacted the nurse's experience. While trying to resuscitate a mother, Pamela remembered,

Come on, come on, as they're resuscitating her, everybody - come on. I know I was saying it out loud. Come on lady, come on. Yeah. And the anesthesiologist as he's pounding - come on woman. So... It was the most traumatic experience ever in my career.

-Pamela

Barbara was **prevented from acting** upon what she thought was best for her laboring patient by the patient herself. The patient presented to the unit having failed to progress at a birth center. Although Barbara tried to do her best to make the patient comfortable and help her with her birth, the patient was resistant, angry, and even violent with Barbara.

So, all right, she wouldn't move. She would sit straight up like this. This is how she was going to do it and there was nothing else. It was a fight to change any sheets. I left her after a while. I just didn't want her to lay in green gook, whatever...Why don't you try to roll over on your side and it was always she would turn and look at you in the face and talk evilly, like, [growling voice] I'm not doing anything you tell me. Okay fine.

-Barbara

When describing caring for patients with IUFDs or non-viable fetuses, Maya explained how she could not provide the attentive care that she wanted to provide, implying that she was prevented from doing so due to her patient load.

You can't pay attention to the baby or the mother - of course not the baby, the baby's dead, but the mother or the husband or the whole, the dyad or the triad or whatever's going on with the family if the baby's not viable. So it can be very traumatic.

-Maya

The feeling of helplessness surrounding traumas also occurred because these nurses felt forced to pull back the actions they initially saw fit after **realizing the consequences** that would ensue if they persisted. Bunny was assisting an obstetrician who she thought was inappropriately and dangerously intervening during a vaginal birth, but felt like she could not speak up.

I'm not saying it out loud because, you know, you have to protect... Even though [the doctor is] an asshole you still have to protect him and the institution. You have to protect your license. God forbid something does go wrong with this kid, they're going to come after you. He's already called me incompetent in front of her so she's definitely going to say it was something that I did, you know. So... there's a part of me that wants to say to her, you know, every horrible thing that he did that was wrong and like put it in writing so that she could sue him afterwards for her baby being, you know, in the NICU. But, you know, like I said, you can't, you know, so... You know, you want to do all you can for your patients but the hospital that you work for, you know, provides your insurance and it protects you and even though I'm saying that he did something wrong, it could come back on me as well because I was in there and I really didn't stop him from doing it,

which is my job. You know, I gave him another vacuum and they saw how many vacuums I gave him and if I go to court that's my license as well. So, you know, I felt liable too but, you know, it's hard to like say, you know, here's this information, go sue this guy, you know, he needs to stop practicing because, you know, that's your job. I need money and I have to support my family. So, I couldn't.

-Bunny

Maude was also upset about the way her patient was being treated by the doctors, but felt helpless as to what she could do about it since she did not feel like speaking up was a viable option for her given who was involved.

[The patient] wound up, she was 27 years old, granted it was her second baby, they had to do a hysterectomy. She just was bleeding and bleeding and bleeding. [The obstetricians] wasted a lot of time doing nothing. This was the chief of the department at the time and his partner. I mean, I'm not going to tell them what to do. These are the doctors.

-Maude

Even when Vanessa initially verbalized her clinical opinion during a maternal resuscitation, she was met with opposition. She explained how that felt.

I personally didn't feel a pulse on the mother and I stated this and they said, She has a pulse, she has a rhythm, and I said, Okay, you know, and it's hard. You're the nurse and the attending Anesthesia is telling you, no, it's fine.

-Vanessa

Lily probably would have reported a doctor for the unprofessional behavior that caused her trauma if she had not seen another nurse attempt to do so to no avail in the past. Instead, she was left feeling like there was nothing she could do about the situation.

I think it was feeling physically threatened, you know, that she felt physically threatened by him. Intimidated also, like I said. Then when these venues opened up where you could go and make a formal complaint then you just felt so helpless when, here you made the complaint and nothing was done about it, you know. It just made nobody want to do anything about anything. Because we've been saying for years we need to stop his behavior.

-Lily

5. Engaging others

In each case of trauma, these nurses attempted to engage with others regarding their experience to varying degrees. By engaging with others they were able to remember more details of the event, receive feedback, or just have an opportunity to talk it out. Engaging with others emerged in three different sub themes: (a) **talking it out**; (b) **feeling that no one really cares**; and (c) **outsiders will just never understand**.

Talking it out refers to experience nurses had in their informal interactions with close colleagues directly after the trauma. These discussions were overwhelmingly helpful and supportive for the nurses to help them cope immediately after the trauma. Interacting with colleagues who either went through trauma also or had previously been through something similar gave the nurse some comfort. Pamela described what it felt like to talk about a maternal death right after it occurred.

Participant: And some of the nurses who were not there, replaying it for them.

Retelling the whole story again.

Interviewer: And was that because it was so fresh at that point still? Was that helpful?

Participant: Yeah...No, it was helpful. Talking about it more and more was definitely helpful...Yeah, and getting everybody's input on things.

-Pamela

Also after a maternal death, Vanessa remembered her interaction with other nurses on her unit.

The nurses who wrapped [the mother], we actually sat in the room with her, you know. We actually, because we prepared her first for her husband to see her so she wasn't wrapped, you know, but we needed to clean her up, you know, so like I said we needed to clean all that blood and we needed to make the room look somewhat presentable. I mean, it was just a disaster in there. There was stuff all on the floor, all the equipment and everything and, you know, we all just sat in there with her and just... Like I said, I don't remember what we talked about but I know we talked.

-Vanessa

The act of getting their story out and speaking out loud about the trauma, even if there was little or no feedback, was helpful to these nurses. Knowing that someone was willing to listen

to them was almost enough to help them initially cope with the trauma. After an IUFD for which she felt partially responsible, Maude explained,

How I coped with it was this. No, but nothing formal. I just got back to work and I just kept working and I kept, you know, taking care of patients and, you know, because I think it was cathartic to me to talk to everybody. I was talking to everybody even before it happened. I was like, This patient I sent her home, what the heck did I do? I'm not supposed to be sending this patient home.

-Maude

Barbara took two weeks off after her trauma, but described what it was like to come back to work and interact with her colleagues.

So when I went back to work, anybody who would sit still, I'd regale them with a half an hour long story and that's how I got over it. Well I certainly never got over it but that is how I dealt with it. I just kept telling it over and over.

-Barbara

Jackie informally talked to a colleague about a disturbing birth.

Participant: Well we just talked about the delivery and how barbaric it was and how her doctor was such a jerk and she just sort of listened. So I guess like I vented and just got my own feelings out about it and...

Interviewer: Mm-hm. And how did that feel?

Participant: Yeah, it felt good. You weren't going to change who this physician was or whatever and... But, I guess it made me feel a little better that she was supportive and just listened because what could anybody do? Nobody could really do anything but it was just nice to have her listen for a little bit and be supportive and then it's on to the next patient, you know?

-Jackie

When Lily's job was being threatened for saying something about a doctor, supportive engagement was initiated from a more formal source: her nurse manager.

[The doctor] kept pursuing my boss. My boss said that she addressed it. She questioned me about it. I denied that I ever said anything, even though I did, and I was just so angry at him and how he took care of these patients all the time, you know? And, he really tried to get me fired and... But my boss was very supportive.

-Lily

After providing care through a maternal death about twelve hours before, Vanessa showed up to work only to learn that formal counseling had been set up for her and her colleague.

Yeah, and, like I said, as soon as I got to work the charge nurse, like I walked to the desk to get report, she was like, No, you're not taking report, you're going over here and you're going too and you're going to talk with this person. It was kind of like not optional [laugh]...you just listen to the mother hen and you're like, Okay [laugh]. So, you know, it was good.

She went on to say,

You know, it feels good. It's just, it's nice to get it out. I mean, you know, not have it cooped up and to have someone else hear what you've been through. It's hard going through something like that and... I don't know. It just makes you feel better that someone else kind of experiences it but, you know, no one will ever know unless they really go through it firsthand, but that does feel good to just talk about it. Let it out.

-Vanessa

Unfortunately, nurses were also engaged with others who left them with the **feeling that no one really cared** about what they had to say. These unsupportive interactions after traumas worsened their trauma because it made them feel irrelevant.

The manager called me aside. She didn't even bring me to an office. It was just like a two-minute talk about what happened. I heard what happened yesterday. Don't worry about it. This is how he operates, and you didn't do anything wrong, and it's okay. I said, well he was really nasty and he was mean, and she goes, you know, she goes, that's okay. What do you think should be done? And I said, well, shouldn't he apologize? And she goes, well, you're not getting that. And she goes, you know, don't worry about it, and you'll be off orientation soon and, she just walked away...The OB wanted to write me up and, you know, I explained to her what happened and she goes, okay well don't worry about it. It's not a big deal. But it wasn't a big deal for her but it was a big deal for me because, you know, he was at the desk, all the residents are there, I'm new, you know, it makes you kind of look bad.

-Bunny

After sitting down with her manager regarding the troubling aftermath of her trauma only for her experience to be trivialized, Carol explained,

I've never given her a hard time, disrespected her at any time and I felt like it was a big blow, you know. Then that's when you thought you were a person, you know, because I've been at this job for so long that, you know, you figure that you're around people, your coworkers like you and you do a good job. I always felt that I was an excellent nurse. Now you felt like you were just a number, you know. They just wanted somebody to be in the space and, you know, you're just a number.

-Carol

Lack of support or care did not only manifest itself in poor interactions with others, but also in the absence of acknowledgement of the trauma the nurses had just been through.

It's such a busy hospital that people are caught up with their own work and they just want to go home. It's, you know, let's give report and go...everybody moved on and really I understand why because everybody's dealing with their own little things there. I mean it's a large delivery room. It's understaffed. People are overworked and there are people waiting in triage to get beds and you need to get your patients delivered and out. And so, no one really cares about the trauma that's going on. They just want to get their shift over with and they want to get their deliveries done or have them last until the end of their shift so that they don't have to get more patients. You know, you could just see wheels turning all day long about how people are trying to like think about their assignments.

-Bunny

Unless a family member or friend was a nurse and could understand with some degree the nature of the trauma that these nurses experienced, the general feeling was that **outsiders will just never understand** the gravity of these nursing experiences. Pamela tried to explain why it was difficult to talk to outsiders (in her case her mother).

But my mom, you know, she couldn't... She, you know, the story, the information about it, you know, she was like taken aback by it but she can't comprehend like the intensity of it as much as like you could because you've been an OB nurse or my coworkers or like my friends who are in real estate cannot comprehend... They've probably never seen a dead person in their lives. So they can't really comprehend it. If I talk to them about a demise, oh, my God, it's so sad, but they can't feel what we feel. Like we just had a demise last week, a 35-weeker. They can't feel what we feel. You can say, you know, oh, that's terrible and sad, but you don't see the baby being delivered. You don't see if there's like a chromosomal like, you know, problem that you see this baby is born and does not look right. They'll never understand that.

-Pamela

Maya also shared what it was like to talk about her traumas with people who "don't get it".

...but the really heavy duty stuff, the stuff that you go home crying in the car because you can't believe, you know, that that baby died or that mother lost another baby or, you know, that you don't really share a lot because it's, I don't know, it just it's... I don't think they have a depth of understanding. You know, people are like, Oh, the baby died, but they don't get, you know...They don't get it.

-Maya

Although Barbara did share her experience with her husband, because he could not truly understand the situation enough he just did not understand why she was so upset.

Interviewer: And was your... Did you explain what had happened to your family or to anyone besides-

Participant: [interposing] Oh yes, my husband. I told him what was going on. He didn't quite get it but...

Interviewer: What do you mean?

Participant: Well he was like, Don't you deal with people in pain all the time? This was different.

-Barbara

Engaging with outsiders, or people outside of obstetrics, was therefore usually avoided because the interaction did not provide the nurse with any benefit. It was also difficult to speak to outsiders because they often assumed that obstetrics is a happy field all the time. The nurses explained how this is a common lack of understanding outside of the field of what obstetric nurses may go through on a daily basis, a frustrating component of engaging with outsiders about work.

And we try to keep everybody...you know, this is a happy place and everybody, you know, when you say to people, oh I'm a labor and delivery nurse - oh, you work in such a happy place. They don't know that there's that unhappy part of our job unfortunately.

-Pamela

You know, you tell other people you work in labor and delivery - Oh, how nice, you know, and here we were with an IUFD and we kind of split it by staff.

-Maya

Interaction with others was an essential component of trauma for these obstetric nurses.

Whether they were met with support or lack of it may shaped how they continue to process the trauma on their own. However, even if interacting with a supportive resource sometimes provided them with temporary relief from the trauma, they remain affected. Engaging with others was a temporary reaction to trauma. In fact, when asked during their interviews, participants revealed that speaking with the researcher about these experiences was a first for them since

their trauma had occurred, sometimes decades before. Despite the time lapse, the stories were still fresh and talking them out was a positive experience for nine of the participants.

It was good. It feels good to get it off of my chest, and I don't feel like you judged me for it, you know what I mean? Like you seem more supportive of it than anything else.

-Lily

You know, it feels good. It's just, it's nice to get it out. I mean, you know, not have it cooped up and to have someone else hear what you've been through. It's hard going through something like that and... I don't know. It just makes you feel better that someone else kind of experiences it but, you know, no one will ever know unless they really go through it firsthand, but that does feel good to just talk about it. Let it out.

-Vanessa

Although Bunny did not characterize our interview as having a negative impact on her, she did not indicate that it was good to talk about her experiences like the other participants did.

I mean even now I don't feel better talking about it. Just an incident that was bad and should have never have happened.

-Bunny

6. **A visceral imprint**

Traumas had a physical impact on these nurses that can be described using three sub themes: (a) the **initial physical reaction**; (b) the **sensory memory** from the moment; and a (c) **lasting physical discomfort** resulting from their experience. These visceral imprints have acted as permanent reminder of the trauma. Retelling the details of these stories of trauma brought back the physical senses as though these nurses were reliving the traumas again in the present.

The nurses described their **initial physical reactions** during the traumas. After sending a patient home and realizing she had made a mistake, Maude remembered,

I felt like I did something wrong. Yeah, and I started to like hyperventilate and I was like hysterical that night and the resident who was helping me he happened to be a friend of mine and he's saying, I'm sure it's going to be fine but like what can we, you know, we tried to get in touch with the patient, but, there were a lot of things that went wrong here and there was a lot of lying and blaming.

-Maude

Pamela's experience with a maternal death went home with her.

I didn't sleep as good. I remember that, but I did, I went home and got him to school and came back and took a shower and laid down and I had to come back that night. So I did try to sleep but I remember that I did not sleep very well because it still was playing in my head.

-Pamela

The following nurses explained how they physically broke down after a trauma was over.

Yeah. Like, I couldn't control it. And usually at work not much gets me riled up, you know, to the point where I cry but except for happy things like when a dad cries. [laugh]. A different kind of cry. Those things usually don't get me but this really got me. I just, I could not control it. I just had to step out and just accept it and just... And the acceptance just... I almost felt like from here down I just went [whooshing sound], you know, like a release of emotions.

-Pamela

I was by myself in the car, you know, and I have to drive at least an hour and a half home at the end of the night and it was horrible because, like, you relive the entire thing over and over again and then I hear him saying, you know, calling me the names and, you know, giving me the dirty looks and then, you know, I would see the patient looking at me and it was just, you know, I just started crying in the car and I thought, this was really bad and no one should ever feel like this, you know, leaving work. You're leaving work, you're going home, you should feel good. You left... You know, you got through the day. [Tearful].

-Bunny

When [the day shift] got there and just looked at all of us who looked dead ourselves, completely drained and exhausted from what happened, we all just broke down... They looked at us and said, you know, What's wrong? You guys are just... You know, What happened last night? You know, they could just tell something was not right and everyone just started crying and it was like, finally, okay, we're going to go home now and [chuckle] like just let it out, you know, but it was...

-Vanessa

Barbara shared how she completely physically shut down following a particularly devastating trauma.

So two weeks I didn't work. I sat home. I didn't participate in anything. I didn't go to my... I'm involved with my... I have a volunteer thing that I do. I didn't go. People came to my house to pick stuff up. I did not go... And I just stayed home for two weeks, you know, and breathed deeply and I probably drank too much and, yeah. I had high blood pressure for four months. Went to my doctor, I had hypertension for four months. Luckily it went away.

-Barbara

The nurses also had a distinct **sensory memory** from the traumas such as heightened memories of sights, smells, and sounds. For example, they could still remember what they saw during the trauma and their descriptions were vivid enough to help the reader imagine what it must have been like for them. The images are ingrained into their memory.

I still remember it. I can still see the patient. I can still see like his hands in her vagina, you know, kind of shredding it and, you know, sticking that vacuum so high up that you couldn't see where it was going.

-Bunny

That's the first time I ever saw a DIC. I had never seen it, you know, because you learn about it but do you think I said... This is my whole thing. You learn about something but until you're actually in that situation with a hands on, you know, and to see it, you know what I'm saying. You got blood like everywhere, you know what I'm saying? She was just bleeding. I mean we were counting the products. I actually in the interim had made a run to get some blood and I gave it to Phyllis and Phyllis and Elsie, the anesthesiologist, Elsie Carter was... They were, you know, going over and making sure it was the right thing, the right patient, this, that, and the next thing. We had a bucket full of empty packets of blood - all kinds of products that had went into this lady. She was still bleeding. I had never seen that in my life. Never seen that in my life.

-Baby Baby

And then we had to go into the back because he wanted to deliver her in the OR just in case they couldn't get the baby out because, you know, she's so big, the baby's so big and it was just such an awful, awful delivery. Oh my God, and then I remember, just like ripping the kid out and then when the baby came out like the arm was separated from the shoulder. It was the most disgusting thing and here he was this most beautiful little baby boy. He was gorgeous...But I often think of that delivery and it just makes me so... Yeah, it's just upsetting... Because it was awful and it was one of the most barbaric deliveries I've ever seen.

-Jackie

When explaining what she remembered from providing care after a termination, Carol said,

It is hard if the baby is alive and then you have to turn around and watch it just die...

-Carol

Often these visual memories were not the first thing that came into these nurses' minds when recounting the story of their trauma experiences. It was only when they began to detail the events that they were reminded of the deeper, more visceral memories.

Yes. Yeah, that was terrible too. The...[laugh] I just thought of this. The woman went into DIC during this whole thing so she bled out terribly and she actually... There was so much blood on the floor in the labor room that they had to rip up the flooring and put new flooring down and I mean the bed was saturated and it was just an absolute... It looked like a massacre and, you know, we had to clean up that floor as much as we could so that we could just walk in there to be able to wrap her and do all that.

-Vanessa

The sense of smell was another sensory memory that was explained by Pamela as staying with her after an emergency Cesarean section that resulted in a maternal death.

The doctor took out the uterus and at that point this like overwhelming, overtaking stench of death took over. She had dead bowel. When I say dead bowel, her entire colon was black. I had never in my life seen a thing like this...I mean I've never in my entire career, and I've as a student been in the ORs and observed and I've never in my life seen this, ever, and the smell that you will never forget, ever, of necrosis. You never forget that smell...Haunts you forever. Like if I God forbid ever have to smell that again, but I call it the smell of death...It was like probably this thick like, like say like a roll of bologna and black and the smell was death.

-Pamela

Another common sensory trigger was that of sound. These nurses explained still being able to hear what occurred during the original trauma. Maya described the disturbing sound of a woman's pain during an emergency Cesarean section.

Thank God that she was able to be intubated. Sometimes we have them and anesthesia's not there and they cut. They just, they give some lidocaine topically. You know, they inject some lidocaine, throw some Betadine on and just cut and then you can hear them screaming and that's... That I've done a couple times but not in several years and that sticks with you. Like the screaming sticks with you. It just, it makes you think of something in a horror movie which I never watch because I feel I have enough at work. It makes you go like that. You just hear it and you can't do anything, you know. So that's just horrible.

-Maya

Pamela explained the almost typical vocal reaction of a patient to being told her baby is dead.

Even though it might happen a lot, each memory is uniquely disturbing for these nurses.

I've had this happen. A 38-week patient coming in thinking she's in labor, meanwhile the baby's been dead for like probably two days because she's felt movement but it's been the baby moving around and the screech that you hear from these parents. You never

forget that. That happened last week also with the 35-weeker. The cry that the parents let out. You just... It's nothing like... You don't ever hear that again.

-Pamela

In the following quote, Barbara discusses a patient who had a history of being abused.

Witnessing and hearing this patient give birth was truly traumatic for Barbara as was exhibited by her breaking down in tears while telling the story.

It wasn't just normal screaming, you know. A lot of Chinese ladies will go, [unintelligible]. It was not that. She was chanting. She was chanting. Every time she had a contraction she would scream and chant the same thing over and over and over and over and over and then she would just lay still and then the next contraction would come and she would start chanting again over and over and over and over and over and I'm looking at the midwife and she's looking at me and we both knew what she was chanting. Please don't hit me, please don't hurt me, please don't hit me, please don't hurt me (crying).

-Barbara

It is not only patients that these nurses can remember hearing, but also other sounds that reminded them of the experience.

Yeah, just, you know, thinking about it. I have like a couple things that I, you know, remember as a nurse but that will... I will never, ever forget that. This was over two years ago and I can still remember it like it was yesterday. It was just way too traumatic to not [chuckle]... Like I said, I remember what I said, I remember just every little thing. I can picture it in my head. I can picture the scrub person running in with the trays, pulling one and pushing one and, you know, stumbling and the clatter of all the instruments and I can, like, relive that whole thing and I don't think that'll ever change because every time I think about it I just remember it, so I don't think it'll ever go away.

-Vanessa

You know what? This might sound a little crazy but what you remember more is how silent everything is. Like, it's overwhelming silence. Silence. It's like eerie that when you're... For me.

-Jackie

Traumas are not only memories for these nurses. There are **many lingering physical manifestations** of the traumas that serve as reminders to them of what they experienced. In other words, the traumas did not only stay with them psychologically and emotionally, but physically as well. The following quotes are some descriptions of what it physically felt like for these nurses to talk about their experiences during our interview.

Interviewer: How does it feel to tell the stories, I mean like physically how do you feel when you're telling them?

Participant: Emotional about it.

Interviewer: Yeah?

Participant: Like, yeah. Kind of an emotional charge about it. Yeah.

Interviewer: Anything in your body that feels different when you talk about it?

Participant: My breathing gets a little more intense or a little more respiratory effort.

[laughter]...Like my heart rate goes up a little bit just rethinking it.

-Pamela

I feel a little sick, you know, like in my stomach. You know, you get a little nauseous, like I want to throw up. And, that same kind of jittery feeling because I'm thinking someone's going to remember. Someone's going to find me. This woman's going to sue me one day. You know, just because I don't work there anymore doesn't mean that I've escaped.

-Bunny

Participant: I never got over that, and to this day - like I feel it right here like...

Interviewer: In your chest?

Participant: Yeah, I could start crying about it....I feel the same feeling like that pain in my chest, that lump in my throat feeling. It'll never go away. I mean, I can live with myself, you know. I'm sorry it happened. It never happened again. But, yeah, it's that same lump in your throat. That's what it is. It's not really a chest pain. It's like right here (pointing to throat).

-Maude

Participant: Yeah, like I can feel, like my heart races a little bit, you know. The adrenaline comes back I think, thinking about it and, you know, I didn't cry but I had to fight it back at first, you know. It still is hard.

Interviewer: You mean today?

Participant: Yeah.

Interviewer: Okay.

Participant: So, you know, I've gotten over, I think, the crying about it but it still does choke you up a little bit.

-Vanessa

The kid was like 4500 grams. Big. And I just remember the whole delivery, I could still till this day, and when he yanked, I remember, he pulled almost the whole baby's arm off the body. It was so horrible. Yeah, look, I get upset just thinking about it.

-Jackie

Baby Baby remembered physically feeling anxious during her trauma, and she actually welcomed reliving that feeling as a way to increase her awareness in practice.

Right. Right, and you know I never want to feel like I know everything and feel so sure like I'm going to go in and... That little anxiety... It's not overwhelming obviously but that little anxiety makes me... Like, I become super-aware like where things are, what to do. You know what I'm saying? That little bit of anxiety just gives me that extra little push to be on top... I don't know. Like I said, even in a normal vaginal delivery, everything goes smooth, I always feel that little anxiousness. Let me just be on top of your game Baby Baby, you know, be on top of your game... That gets me through my deliveries and whatever.

-Baby Baby

For Carol, whose trauma was a physical injury while providing care, the lingering aspect of the trauma is daily and much more pronounced.

It's rough. It's an everyday process. I wake up every day in pain.

-Carol

7. A damaged person

For the nurses in this study, their traumas had a negative, defeating effect on them. Living through their traumas affected (a) **the way they care for future patients** and (b) **their inability to forget**.

Trauma affected the way these nurses approached **their care of future patients**. For some, the confidence in their skills and decision-making was diminished.

Everyone second guesses themselves, you know, afterwards. You know, How did I not see? Nobody did an ultrasound. You know, you can't really see that abruption that well. How did they abrupt, or there was a base previa there. It wasn't diagnosed, you know. Nightmares that come in that you can't do anything about, so...

-Maya

Maude's trauma made her think that she was not capable of handling the same amount of responsibility.

For a while when I was not like... I told [the manager], I said, Don't put me in charge anymore, you know... For a while like I didn't really want to take on too much. Like I was always taking on a lot like, Oh, I'll take the patient, go to lunch, you know? Then I thought well maybe I was just taking on a little too much.

-Maude

After being reprimanded to a point of trauma for something she said to a patient's support person in the midst of a birth (something she thought was helpful) Lily has since changed what she says to patients to protect herself. It was obvious that this forced change bothered her.

I had such a comfort level where I was that I just felt I could say... You know, I know had to handle a situation but now that I'm not in that hospital anymore after all those years I just really think twice about who I say what to. Yeah. I really pull back myself...I don't want to get myself in this situation again...Especially because of the fact that I'm at the end of my career. I really just want to retire. I'm done. I'm so done. I still like being a delivery room nurse but there's so many other things that come into it now, you know. I just want to bide my time and be done. I do feel tearful. [laughter]

-Lily

Other nurses explained the same sort of diminished desire to be as interactive as they were prior to the trauma. For example, after being emotionally and physically abused by a patient in labor, Barbara remembered,

I usually bring the baby right back to the mother and do everything with the mother but I didn't want to go in there. I didn't want to see her, I didn't want to deal with her. I didn't want to be abused anymore. Oh my God, she was phys-... You know, she was emotionally abusing me. I'm like, Oh my God.

-Barbara

Jackie explained how her trauma made her turn inward, thus affecting her typical nursing care.

Well you have to go back to work because you have to take care of, you know, the patients that you have. So you come upstairs. Like I said, probably went in the bathroom, cried a little bit, then you just kind of get quiet. You take care of your patient but then probably not as interactive, not as talkative. Just go in the room, do what you have to do, come out. Kind of I remember, like, just sitting out in the hallway. Like I really... For me, I didn't want to talk to anybody then. I kind of stayed by myself and just do what you have to do for the other patient but, me, I like to talk with my patients, I kind of joke around with them all the time, but with something like that, like that day, no. Just quiet. Just quiet.

-Jackie

Among these nurses, it was also possible that the change is to becoming a more hypervigilant and more cautious kind of provider.

Every time I give a vacuum to a doctor, I remember that. I always ask where the head's at and I've kind of learned to do my own VE, so if I don't believe what they're saying I'll stick my own fingers in. I don't trust doctors for certain things and I mean I still believe that you could use a vacuum effectively. I just have to see a doctor use it first before I can be comfortable handing them a vacuum. And, I mean, so I'm a little hesitant when I

hand a vacuum over...Forceps, vacuum, any kind of instrumental delivery and I remember that. Any doctor...

-Bunny

These nurses still have difficulty **forgetting** the traumas they have experienced while in practice. While they are still able to continue functioning as obstetric nurses, they believe the memories of these traumas will stay with them forever.

So, but no I just, I had to deal with it and it was hard but, you know, life goes on and before you know it there's something else happening in the delivery room and nobody remembers that anymore but I've never forgotten it... Yeah, and then really that's probably why I'm crazy today is because I've taken on all these emotional traumas over the years...And that's why I'm on Wellbutrin [laughter].

-Maude

Not being able to forget the traumas and continuing to live with them makes it impossible for them to move on from them. After a traumatic interaction with a difficult patient, Barbara felt defeated and sad, which is a feeling that is obviously still present profound for her.

Participant: I didn't work for two weeks. [voice breaking, crying] I mean, I went home and I said to myself, I have wasted 26 years of my life and that's really how I felt...Because after all the things I've done to try and help, you know, women in general this is how I'm treated. Like, why am I bothering?

Interviewer: And what were your emotions when you retold the story? What were the primary emotions that you felt?

Participant: Helpless I guess. Sad. [voice breaking] It really felt like I wasted my life, like, what am I doing?

Interviewer: And it seems like that still -

Participant: Oh yeah.

-Barbara

B. **Collaborative reflection**

In addition to analyzing the in-depth interviews, I also had two formal discussions as well as several informal discussions about the essential themes with colleagues. The formal discussions resulted an overall sense that the themes resonated with people's own experiences in obstetric nursing and other specialties such as emergency nursing. Colleagues were engaged and provided further interpretive insights and ideas for discussion and exploration. During an informal conversation about the results, one colleague who is currently an obstetric nurse said

that she had not read the results until the day after “a very intense traumatic night” that involved “an unexpected fetal death”. She said after living through such an event, the results seemed even more relevant to her.

C. **Existential reflection**

Using the data from the interviews, the following examples illustrate four existentials of the lifeworld through which most people experience life: space, body, time, and human relation (van Manen, 1990). Thinking about the obstetric nurse’s experience in these categories (e.g. the way they experienced their space in the moment) may offer additional description and understanding to an outsider about what it is like to live through trauma.

1. **Lived space**

When describing her involvement in an emergency Cesarean section that concluded with a maternal death, Pamela described what the surrounding space was like as she moved from the operating room to the unit. She said, “The floor is jumping out there”. Since she was also in charge during that shift, she needed to multitask and change hats as she moved to each space. She remembers, “and as I was walking back and forth to the station I’m asking [the other nurses] what’s going on? Are you okay? Are you okay? Is everything okay?” Meanwhile, the resuscitation of the patient in the operating room continued. Pamela had to adjust to complete shifts of environments and scenarios within seconds. “The minute she was pronounced I found myself just stepping out, going into the recovery room and just breaking down and crying because suddenly it was like, that’s it.” In moving to another space, she instantaneously changed what she was thinking, saying, doing, and feeling. In other words, as she changed space, she herself changed as well.

2. **Lived body**

When doing chest compressions on a patient in a birthing room, Vanessa said:

they told the scrub tech to get in there with the tools and as I was still going chest compressions they started to cut her open and do a C-section right in the room...They did a vertical incision because it would have been the fastest." The doctor told her to "stop chest compressions so [he could] actually get into the uterus...and just for that little bit of time and once they pulled the baby out then we kept doing CPR on the patient and then this poor patient is also hanging wide open now. Literally her, you know, whole abdomen is open to the air just her insides, everything is swelling from the heart, you know, manipulation or doing everything.

This physical relation of the nurse's own body to her patient's, for example in what she is seeing and feeling, truly influences how she experienced and remembers this event.

3. **Lived time**

The lived or perceived time of a trauma affected what the experience was like for these nurse. When describing a traumatic vacuum assisted delivery, Bunny said:

It felt like forever and that's the part that really surprises me, like it was so short because it's like you're in this time warp, you know, and you're like, why is it so long? You know, it's like you look at the clock, you know, one of those slow days and like five minutes is a half an hour? That's what it was like. It was...I couldn't believe that it was so short.

During a trauma, time is not based on clock time or objective time, rather it is completely subjective based on the context of what is happening.

4. **Lived human relation**

Hearing how nurses engaged with others surrounding the traumas revealed a great deal about how human relation and community affect how nurses experience their trauma. Maya explained what it was like in general to interact with friends outside of nursing.

It does cause you to see things on the outside life much, you know, outside of the workplace as much more, you know...I'm very lucky. I live in a very nice area and we've done very well and I see women bitching about, you know, stuff that really, really...Really? Your lease is up on your Audi. I'm so sorry, you know, or they've had to downsize from the 20,00 square foot house to the, you know. They don't see what goes on every day...So it's an interesting life lesson.

Engaging in conversations with others allowed the nurses to transcend themselves and explore their trauma experiences in a new way.

D. **Linguistic reflection**

According to van Manen (1990), words we use to refer to a phenomenon have often lost their original meaning. However, if we are attentive to the etymological origins of these words, we may be able to “get in touch with an original form of life where the terms still had living ties to the lived experiences from which they originally sprang” (van Manen, p. 59). The main word used to refer to the phenomenon being studied in this research is “trauma.” The word is based on the Greek root *traumat-*, an alteration of *trōma* (wound), and akin to *titrōskein* (to wound), and *tetrainein* (to pierce) (Merriam-Webster, 2012). Gibson and Iwaniec (2003) identified the origin of “trauma” as coming from the Greek for “to pierce or puncture armor”. In the context of the nurses in this study this definition has significance and can help us think about the meaning of trauma for nurses. These definitions seem to resonate with the themes that emerged from the study. For example, we may think of the nurses’ “going through the motions” as their armor to protect themselves from being too exposed to traumas. However, despite their best attempts they are still physically wounded by the trauma that pierces that armor, leaving them ultimately as damaged people.

E. **Exegetical reflection**

Exegetical reflection is the process of studying related texts in search for additional insights or perspectives about the phenomenon (van Manen, 2011b). I considered my own stories of encountering trauma as an obstetric nurse (see Appendix T) as well as a poem by an obstetric registered nurse found on the Internet (see Appendix U). In both examples, all of the themes that emerged from interviews with participants in this study were present. Reading over my own text again after conducting this research allowed me to reflect more deeply on how I experienced my own trauma. As a former obstetric nurse, the stories from participants have

always resonated with me as I can remember feeling similarly. Revisiting my own story and seeing all of the themes was a confirmation of their validity, at least for me.

According to the description introducing it, a “frazzled night delivery nurse” wrote the poem that I found on an informal, public discussion forum. At first glance, it might be difficult to take something so casual seriously as a data source for this research, but as van Manen (1990) explains, “we cannot ignore the insights of others who have already maintained a conversational relation with that same phenomenon” (p. 75). Upon reading the poem, I found all of the themes strongly present throughout. At the end of the poem, O’Brien (1994) admits that despite the scenarios she sometimes finds herself in, she still loves being an obstetric registered nurse. No matter what happens to her, she still manages to come back for more. This sentiment was repeated in the participant interviews.

F. **Hermeneutic interview reflection**

Two participants have responded to the results to date. This process, also known as a member check, is intended to allow the participants to reflect on their own experiences in order to determine deeper meanings or themes of the experiences (van Manen, 1990).

Bunny said that the results were a “true representation” of the story she told, that she enjoyed reading them, and that she was glad she had the opportunity to be a part of the research. Jackie not only felt that the results were completely reflective of how she lives through trauma as an obstetric nurse, but also found it comforting to know that other nurses have had similar experiences and feel the same way she does regarding trauma saying, “it’s comforting to know we all go through the same thing”. Jackie also mentioned that after reading the results, her immediate reaction was that obstetric nurses, including her, do not speak to each other enough about trauma and she believes they need to be more compassionate towards each other surrounding traumas. She said she usually just wants to “move on or ignore it” and that nurses “don’t go to counseling because that would be seen as weak.” She hoped this research

would spark a dialog about the realities that obstetric nurses are exposed to throughout their careers. In fact, she shared the results with her obstetric nurse colleagues at work and they did indeed serve as an ice-breaker to stimulate a conversation of their own stories of trauma as well as a discussion about how they could better support each other.

G. **Phenomenological writing**

Using the seven essential themes, I wrote the following anecdote to illustrate what it is like to live through a trauma for the nurses in this study.

Martha arrived early to work wondering what craziness the day would bring. As she walked up to the nurse's station, she could sense that there was a problem on the floor. The unit clerk looked concerned and no other nurses were in sight. "Where is everyone? What is going on?" she thought to herself. She could hear commotion in one of the rooms and when she looked up at the central electronic fetal monitoring screen, she could not believe what she was seeing. She threw the breakfast she was just about to start onto the desk and ran into room 302. There were three nurses and two doctors in the room already. One nurse was holding a limp, blue baby. Everyone else was attending to the mother. It looked like a crime scene. She grabbed an ambu bag and began to help the baby nurse with resuscitation. In her head, she ran through the neonatal advanced life support class she had just attended the week before. Is this baby term? Who knows. Is the baby crying? Definitely not. Ok. We need to get it warm, clear the airway, and stimulate this kid. "Did someone call peds?!" she screams out to no one in particular. She is doing everything she can, but the kid is just not responding. "Where is peds? Come on, kid. Breathe!" She glanced over at the mother who is as white as a sheet and lying in a puddle of her own blood. She avoids eye contact. The smell of vomit and sweat permeate the room.

"What the hell just happened in there?" she asks a fellow nurse after the incident. They watch the baby being rolled to the NICU. "That was the worst baby we have had in a while. I'm definitely going to have nightmares tonight. Did we do everything right? Why was peds taking their sweet time?" Martha looked down. Her hands were shaking, and she started to get choked up. She ran to the bathroom, splashed water on her face, and took a deep breath. "Ok, Martha," she said to herself, "let's get this shift started." She spent the rest of the shift thinking about that blue baby and what more she could have done. She was so preoccupied in fact that she missed her own patient's call bell several times.

V. DISCUSSION

This phenomenological study explored the lived experience of trauma among obstetric registered nurses. Seven themes emerged from the data: (a) **An internal process**; (b) **Being faced with the unexpected**; (c) **Going through the motions**; (d) **Inability to take action**; (e) **Engaging others**; (f) **A visceral imprint**, and (g) **A changed person**.

Based on the findings, trauma is an unforgettable, deeply personal, and complex experience for these nurses. It is important that obstetric registered nurses themselves, as well as outsiders, recognize that trauma is ever present and real in obstetrics even if it is a specialty that is more commonly associated with the beginning of life and joyful memories. In addition, and perhaps more importantly, it is important to be aware that trauma is consequential for obstetric registered nurses on a personal and professional level.

A. An Internal Process

This study captured many different examples of what trauma is for obstetric nurses. Lam et al. (1999) included death and dying or serious injury of an infant, child, or adult, the handling of aggressive patients or patient visitors, or the handling of a dead body or body parts as the scope of work related traumas in their study of nurses. Based on the range of experiences that were relayed during this study, it is clear that while these examples are present, the scope of scenarios is certainly not limited to these experiences for obstetric nurses. For example, an important but potentially surprising finding of this study is that some of the traumas discussed in this study did not even involve a patient, despite having happened during patient care. One nurse's trauma was that she sustained a chronic back injury while moving patient beds. Not only did her story satisfy this study's definition of trauma, but it points to an area in obstetric nursing that needs attention. Investigators recently found that obstetric nurses perceive to be at a high risk for personal injury due to high exertion tasks such as moving patient beds, awkward postures during patient care, and a negative culture of safety (Stichler, Feiler, & Chase, 2011).

This indicates that the events perceived as trauma by nurses should be recognized and evaluated seriously.

Trauma is a very personal and internal experience for obstetric registered nurses. Even when the overall scenario was similar, for example in the five different intrauterine fetal demise (IUFD) cases, every nurse processed her experiences differently. In fact, for the one participant who described two separate IUFD cases as her traumas, those too were completely unique in the way she internally processed them. This means any event experienced in the obstetric setting may well be a trauma for one nurse while another nurse would not think twice about it. This does not make any one event more or less important because to the nurse experiencing the trauma, it results in an emotional or psychological state of discomfort or stress no matter what. This idea that trauma lies in the eyes of the beholder has also been found to be the case among birthing women who have experienced birth trauma (Beck, 2004a).

What happens internally for the nurse is very much reliant on the context of the trauma experience. For example, whatever is occurring in the nurse's own personal life will affect how she internalizes any trauma event. If the nurse has the time and ability to become very involved with a patient over time—for instance in cases of patients who spend time on obstetric units for observation, preterm management, or medical management—the nurse may be more affected by a trauma involving that patient because of the rapport and relationship that has been established. Also, if a nurse has the means and resources to cope with a given situation, the way the trauma is processed will certainly be changed.

B. **Being Faced with the Unexpected**

Although obstetric nurses do acknowledge that any type of case or incident can occur on their unit at any time, there is just no way for them to predict or plan for them. Obstetrics is a field where nurses are met with the challenge of balancing constant extremes. For example, the staff may be looking forward to their New Year's baby only to be met with an IUFD as the first

birth of the year; the unit might be quiet with patient care running at a manageable pace, when all of the sudden all of the beds fill up with emergencies; a nurse is trying desperately to save a 23-week pregnancy with tocolytics to stop labor in one room when her patient across the hall is having an elective 23-week termination; a nurse works with a provider who insists on a fast birth with unnecessary interventions while the next provider with whom she works has a more hands off approach. These extremes and contradictions are difficult to make sense of and illustrate why the theme “being faced with the unexpected” is so important to the trauma that obstetric registered nurses endure.

For the nurses in this study, being faced with the unexpected was a shock for them, even those with over 20 years of obstetric experience. Upon first glance at this theme, its sub themes (“getting caught off guard”, “still needing to take action”, and “always being on their toes”) may seem contradictory. For example, one might ask how can a nurse with twenty years in obstetrics be shocked by what she experiences or how can a person be caught off guard when they are always on their toes? One explanation for this is that despite the knowledge that a trauma is an eventual inevitability, it is still a shock when it actually happens. It is not that in the moment of the trauma that obstetric nurses are denying the reality of the situation by any means. They know full well what can happen in their specialty, and although traumas may not be daily, knowledge of their possibilities and consequences stays with nurses. They can try to prepare themselves for it, for example by keeping their skill levels current to be able to adapt to any emergency situation. However, they can never relax. This leaves them in a constant state of hypervigilance, whether on a conscious or subconscious level. In other words, without the ability to completely prepare or to predict when things might become out of control, nurses are left in a constant state of vigilant anticipation. This is not to suggest that we want obstetric nurses to be insensitive to what could happen on a unit, but we need to acknowledge the costs of asking them to maintain this vigilance. For example, we know that hyper arousal, persistent symptoms

of increasing arousal not present before the trauma, is one of the criteria for post traumatic stress disorder (PTSD) (American Psychiatric Association, 2000). Although based on this study it is impossible to suggest that obstetric nurses have hyperarousal symptoms, it is certainly worth further study given its severe implications. Hyperarousal has been studied in emergency department nurses (Asfour & Ramadan, 2011; Gates et al., 2011). Investigators who studied the impact of violence against nurses concluded that hyperarousal may impact the nurse's ability to communicate and relate with patients, to provide emotional support, and to concentrate (Gates et al.). Several of the nurses in this sample described traumas during which they were either verbally or physically abused by doctors or patients. Other researchers have confirmed that verbal aggression and minor physical incidents can cause significant distress in health workers (Walsh & Clarke, 2003).

C. **Going through the Motions**

Because the events the nurses in this study experienced were so far out of the realm of what an average person experiences in their daily or even life time experiences, they somehow needed to make their traumas more palatable than they really were or ever could be.

Interestingly, when the nurses were trying to take any action they could think of in order to cope with their trauma, they also happened to be taking actions that protected and respected the dignity of the patient or provided support to a colleague at the same time. For example, trying to wrap a dead baby up in a way that humanizes it, helping the mother deal with a difficult birth, or caring for and comforting a colleague in need may also be rituals that the nurse needs to cope with the same situation. In other words, those actions are not only comforting for the patient, but also help the nurse feel better with the situation despite the circumstances.

The concept of ritual, a process that is meaningful, intentional, and participatory (Kobler, Limbo, & Kavanaugh, 2007), has been studied surrounding death, dying, and end-of-life care (Holland & Neimeyer, 2005; Romanoff & Thompson, 2006). In the context of obstetrics, it has

been discussed from the perspective of women and families grieving the loss of a child (Brin, 2004; Capitulo, 2005; Kobler et al.; Pattison, 2008). Rituals may relieve anxiety, provide structure and familiarity in a time of uncertainty, and create a safe space to express emotions (Kobler et al.). Rituals allow caregivers to do something special for their patients, provide them with comfort, and help them find their own sense of meaning in their care (Macdonald et al., 2005; Papadatou, 2000). In addition, they allow health professionals the permission they need to experience and express grief, while avoiding it at the same time (Papadatou). It is important to acknowledge that what nurses do for their patients also has the potential to help them too.

Beyond the process of ritual, the nurses in this study almost became mechanical and also avoided the details of their traumas. It was almost as if they pushed a button and the robot version of themselves went through the motions without even thinking or feeling. This robotic state is second nature to them and acts like a safety wall to allow them to continue to physically work. While they are physically present, they seem to be emotionally distant. They know the work needs to be done, so regardless of the situation, they force themselves to go through the motions because if they do not, who will? This concept of 'autopilot' has also recently been described as a subconscious mechanism that helps palliative care nurses through physically and emotionally challenging terminal hemorrhages (Harris, Flowers, & Noble, 2011).

From a patient perspective, this nurse reaction to trauma may manifest itself as abandonment and disrespect, which can shatter a woman's expectations of what care should be like during birth and in turn lead to the laboring patients' own trauma (Beck, 2004a). Beck's main finding was that mothers perceived that their traumatic deliveries were glossed over if there was a healthy baby. However, even though the nurses in this sample may have appeared to be emotionally distant, their stories strongly suggest their keen desire to support and respect the patient, many times going out of their way to provide the best possible care despite being traumatized themselves. This brings up an interesting disconnect between the perceptions of

nurses and their patients. It is possible that even by acting in a way that is intended to be supportive, advocating, and respectful, nurses still appear to their patients as not caring and treating their births as routine. One reason for the possible confusion that was illustrated in the stories of this study is that nurses do not always share or show what they are feeling in front of the patient. Whether it is the fear of embarrassment or the perception that it is unprofessional, nurses often delayed their emotional response to trauma until they were away from the patient and the work environment. Whether or not there could exist a benefit to the patients from encouraging nurses to show their feelings is debatable. A qualitative synthesis of the literature concluded that women in labor expect continuous support by a competent, calm, and supportive nurse who meets their emotional and physical needs as well as advocates for them (Bowers, 2002). A “calm” nurse would not break down in tears in front of her patient.

This concept of restraining one’s own emotions, due perhaps to a lack of decompression time or a denial that decompression time is even needed, is an important one to consider. This is known in the literature as emotion work or emotional labor, or the purposeful control of one’s behavior to display only the emotions that are considered appropriate (Hochschild, 1983). It is possible, and it was seen in this study, that in the obstetric setting there is an understood rule that the staff regulate their emotions around patients and colleagues. Unfortunately, the link between emotion work and burnout among nurses and physicians has been documented (Kovács, Kovács, & Hegedüs, 2010). In reality, obstetric nurses may need time to process the trauma they are experiencing, but work and life do not seem to afford them the time or the luxury to do so. Therefore, the emotions from trauma experiences linger unprocessed as though they are stuck in that same moment as when the trauma originally occurred. When the next trauma unfolds, they do the same things so that their unprocessed emotions just build on top of each other. In addition to this accumulation of emotion, it is possible that holding back their feelings may also make light of their personal experience so that they start to believe their

emotions are not important. The nurses in this study did insist that the bigger picture of their stories was not about them, but the patient. This appears to be a form of self-sacrifice as nurses force themselves to hold it together, avoid their own emotions, and numb themselves for the sake of their patients. It may be important to note that avoidance/numbing, or the persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness not present before the trauma (APA, 2000), is another symptom of PTSD. Avoidance has also been shown to have a relationship between burnout among nurses (Iglesias, Vallejo, & Fuentes, 2010).

D. **Feeling Helpless**

The traumas discussed in this study brought with them a feeling of helplessness for the participants. The descriptions in their stories appeared to be strikingly similar to what is referred to in the literature as moral distress. Moral distress arises when a person knows the right thing to do, but because of institutional constraints it is nearly impossible to pursue the right course of action (Jameton, 1984). Moral distress also occurs when, in general, a person acts in a manner contrary to his or her personal and professional values thus undermining his or her integrity and authenticity (American Association of Critical Care Nurses [AACN], 2008). Corley (2002) said moral distress among nurses is knowing what is best for the patient while also knowing that course of action conflicts with what is best for the organization, other providers, other patients, the family, or society as a whole. Moral distress among nurses can lead to physical, emotional, and social problems, as well as reduced job satisfaction (Erlen, 2001), quitting (Corley, 1995; Lazzarin, Biondi, & Di Mauro, 2012), or leaving the nursing profession altogether (Corely, 1995). Moral distress can arise from working in environment where there are power differentials (Erlen, 2001), unsafe staffing levels (Zuzelo, 2007), and end-of life-care issue (Ulrich et al., 2007), all of which were seen in this study.

The hierarchical nature of the obstetric specialty and the power differentials it creates between nurses and other providers was illustrated when nurses felt they could not speak up for what they felt would be good patient care because they feared the consequences from doctors or management (being ignored, reprimanded, disciplined, or losing their jobs). Instead, they did or said what they thought was expected rather than what was necessarily correct, for example giving a doctor an extra vacuum or keeping quiet during an emergency. This fear was very real for some nurses because, as they explained it, they still needed to go home, pay the bills, and take care of their family so they could not risk their jobs. However, there are two significant problems with sacrificing what you know is right for fear of the repercussions: reduced patient advocacy and an accumulation of moral distress among nurses.

Advocacy for their patients has been identified by obstetric nurses as one of their more important roles (James, Simpson, & Knox, 2003) and the trust that women have in their obstetric nurses during birth greatly affects her self-trust and her abilities to birth her baby (Goldberg, 2006). Moreover, the Code of Ethics for Nurses (American Nurses Association, 2001) mandates individual nurse accountability for patient advocacy to ensure no harm. The hindering or preventions of advocacy by institutional constraints can negatively affect quality of care and patient outcomes. If nurses begin to question the role they have in their patients' care or their ability to fulfill their understood roles, for example in the midst of conflicting demands of hospital policy or other coworkers' behavior, this can lead to burnout (O'Brien-Pallas, Murphy, Shamian, Li, & Hayes, 2010; Wlodarczyk & Lazarewicz, 2011). In addition to losing their advocate role as a result of moral distress, nurses also must endure the unresolved effects of being prevented from doing the right thing, also known as moral residue (Webster & Baylis, 2000). Eventually, the accumulation of this moral residue after multiple encounters with moral distress creates what is known as the "crescendo effect", or a breaking point which potentially bears consequences with it: providers may become morally numbed or oblivious to ethically

challenging situations; providers may conscientiously object to situations in a unproductive manner; and providers may experience burnout (Epstein & Hamric, 2009). As we have seen from this study, although traumas did not occur constantly, they happened as much as once every month for half of the nurses in this study (see Table 4) making the crescendo effect and its consequences very real possibilities for the nurses in this study.

The feeling of helplessness among the nurses in this study also stemmed from poor or miscommunication between the nurses and other providers and differing professional perspectives on clinical management, both of which are confirmed in the literature (Kennedy & Lyndon, 2008; Lyndon, Zlatnik, & Wachter, 2011; Simpson, James, & Knox, 2006). This was illustrated in one of the stories from this study when a doctor asked a nurse for a vacuum to assist a delivery but did not give her the adequate information she needed to make an informed clinical decision as to whether that procedure was in the best interest of the patient; that nurse felt helpless and guilty. Given the range of primary practitioners in obstetrics (obstetricians, certified nurse midwives, nurse midwives, family practitioners, etc.), patient care and management techniques and beliefs are wide ranging. This may place an additional stress on nurses because they could be providing care to several different patients according to multiple care models during a singular shift, not to mention they have their own care models that may not match the practitioners. This can have implications on nurses, primary providers, and patients. Clear and consistent communication between all of the parties is essential, but it is not necessarily monitored. As evidenced by some of the stories in this study, even when lack of communication or poor communication was voiced to management by nurses, nothing was done. Problems with communication are complex and responsibility for addressing them needs to be shared.

Finally, staffing issues were also seen to contribute to the feeling of helplessness among the nurses in this study during their traumas. Several nurses indicated that the lack of staff was

a primary reason for the trauma that unfolded for them. Appropriate staffing levels are essential to enable obstetric registered nurses to support laboring patients and provide safe care, especially given the higher acuity levels and presence of high-alert medications on today's obstetric units (AWHONN, 2011).

E. **Engaging Others**

Talking out their traumas with colleagues was common among the participants in this study. Even if other people just listened, that was supportive enough. It is possible that merely having a supportive listener has a very positive affect on obstetric nurses in order to help them process their trauma, at least in its immediate aftermath. The benefit of talking to colleagues was also suggested in a recent study of emergency room nurses who experienced trauma during practice. Investigators revealed the importance of a supportive social support network, which usually consisted of a peer support system (Lavoie et al., 2011). Unfortunately, informal support such as this cannot be guaranteed and nurses may have to be self-motivated to seek it out. In addition, it was suggested by nurses in this study that informal discussions about trauma may be brief and only take place in the immediate aftermath of the trauma.

Only one nurse in this study had a formal intervention at her workplace after experiencing a trauma. Similar to the findings in this study, there has been evidence among health care workers of a lack of opportunity to formally process personal and professional responses after traumas such as the death of a patient (McCoyd & Walter, 2007; Serwint, 2004; Tubbs-Cooley, et al., 2011). However, the benefits of formal debriefing can include managing grief, the ability to maintain professional integrity (Keene, Hutton, Hall, & Ruston, 2010), reassurance and support (Omerov, Edman, & Wistedt, 2002). Because informal support cannot be guaranteed and because support from family and friends outside of nursing is not regarded as being as helpful by the participants in this study, positive formal resources of support may be essential for the obstetric nurse.

F. **A Visceral Imprint**

This theme in particular really illustrated clearly the impact that trauma can have on an obstetric nurse. The physical reactions described by the participants or the detailed and graphic nature of the words they used to describe their experiences (e.g. “shredding”, “massacre”) provide the reader with a strong and evocative sense of what it was like to live through trauma. Although one can never truly experience something unless he or she actually lives through it, the visceral qualities of the trauma experience give an outsider a glimpse of the essence of the experience. The participants’ abilities to recall and re-experience their visceral memories so easily, as though they were right back in the moment of the trauma is an indication that those memories are always present for them. This is reminiscent of what is known as intrusive recollections in the posttraumatic stress disorder literature, as it happens to be one of the criteria for a formal diagnosis (APA, 2000).

G. **A Damaged Person**

While all of the nurses in this study have expressed emotions suggesting that they have been negatively impacted to a certain degree by the traumas they have experienced, this does not imply that all nurses exposed to trauma are damaged. However, the current study provides enough suggestion that the ability for trauma to change a nurse should be taken seriously. The participants in this study were impacted emotionally both during and after the actual experience affecting their professional role and personal life. Whether their emotions were described as breaking down or crying after a trauma, or the residual guilt, depression, sadness or anger left over well after a trauma, the many instances of negative emotions and their potential impact on the work environment should be taken into serious consideration, especially since they have an influence on job performance (Teng, Chang, & Hsu, 2009) and job satisfaction. While positive emotions at the end of the working day significantly contribute to job satisfaction (Liu, Prti,

Perrewe, & Brymer, 2010; Meeusen, van Dam, van Zundert, & Knape, 2010), job satisfaction has been seen to be negatively associated with negative emotions (Liu et al.).

Just because these nurses do not always display their negative emotions does not mean they do not have them or are not affected by them. In fact, there is evidence that there are understood expectations of the kind of emotional display workers in health care should abide by, and that is to express positive emotions and suppress negative emotions (Brotheridge & Grandley, 2002; Diefendorff, Richard, & Croyle, 2006). Sometimes, as the participants in this study shared, they are not comfortable showing negative emotions because they feel it might be inappropriate. Instead, they put on a happy face and ignore their feelings until they are by themselves. While this may be necessary during a trauma in order to keep doing their essential, required work or to ensure that the patient is not harmed by the nurse's personal emotions, management needs to make every attempt to decrease the strain from sources of negative emotions (Diefendorff, Erickson, Grandey, & Dahling, 2011), especially since lack of team support and employer care are important reasons for nurses leaving their jobs (O'Brien-Pallas et al., 2010).

Traumas often left the obstetric nurses in this study with residual depression, sadness, or guilt. This is similar to research findings in other nursing specialties that job stress among nurses is correlated with depression (Lin, Probst, & Hsu, 2010; Welsh, 2009) leading to symptoms such as fatigue, pain, and trouble sleeping (Welsh) which could severely affect the nurse's quality of life. Self-blame, and the guilt associated with it, was certainly detected among this study's participants. Self-blame has been a coping behavior associated with personal and work-related burnout among nurses (Shimizutani et al., 2008). Researchers have also found that residual guilt after clinical situations among nurses inhibits their ability grieve (Gerow et al., 2010). One reason the nurses may be unable to forget their traumas is because of their inability to forgive themselves for what they think they did as wrong during the traumas. When people

are able to forgive themselves, their feelings, actions, and beliefs about themselves become more positive, and they are better able to heal and grow personally (Wohl, DeShea, & Wahkinney, 2008).

A nurse's emotional stability is also a predictor of patient safety (Teng et al., 2009) especially during crises or emergencies (Tett & Burnett, 2003). A common perception is that obstetrics is a happy specialty. Because in the occasions of trauma this is far from the truth, it could mean that any depressive symptoms that obstetric nurses may have from their trauma experiences may be that much more unsettling and damaging for them. In other words, because they are not expected to be sad or depressed, it might be even more difficult than being in a field more associated with sadness.

In addition to having an effect on quality of care, a lack of emotional stability among obstetric nurses could also significantly impact the patient's birth experience and their overall satisfaction with the care they received before, during and after birth. For example, while a nurse may be physically present to provide the necessary tasks, they may become emotionally distant from their patients due to prior trauma experiences as a way to protect themselves from further trauma. While some of the nurses in this study were aware of the toll their care suffered from the emotional impact resulting from their traumas, it may also very well be a completely unconscious reaction.

Another important characteristic regarding trauma among obstetric nurses is the fact that they are not merely solitary events. Rather, as was evident in this study, obstetric nurses may be continuously faced with traumas in their workplace. The participants in this study do not only live with the memories and consequences of past traumas, but they are still exposed to new traumas on as much as a monthly basis. The frequency of exposure may worsen the affects of trauma among obstetric nurses as compared to people who are only exposed to one traumatic event in their life. Instead, the nursing experience may be more similar to the frequency that

soldiers serving multiple deployments or people living in violent communities encounter trauma. There is limited and conflicting scientific data about the impact of multiple deployments on soldiers (MacGregor, Han, Dougherty, & Galameau, 2012). Researchers have found that soldiers who have had multiple deployments have significantly higher risk of mental health and/or work related problems compared to soldiers with fewer deployments (MacGregor, et al.; Polunsky, et al., 2009; Reger, Gahm, Swanson, & Duma, 2009). On the contrary, other investigators determined that frequency of deployments was not associated with higher prevalence of mental health symptoms (Rona, et al., 2007). Interestingly, Marines who had longer times at home in between deployments, also known as dwell time, were less likely to have PTSD suggesting that longer times away from the traumas of war may reduce the consequences exposure to it (MacGregor, et al.). Findings from research in the area of community violence (exposure to sexual assault, burglary, use of weapons, muggings, the sounds of bullet shots, and social disorder) (National Center for Children Exposed to Violence, 2006) indicate that the emotional distress from constant exposure to violence leads to psychobiological effects, PTSD, substance abuse, externalizing and internalizing problems, social cognition and peer relation disturbances (Lynch, 2003), and depressive and anxiety symptoms (Clark, et al., 2008).

Given this research, nurses exposed to repeated or frequent trauma may not have enough time to recover from their traumas and may thus endure a more damaging effect from them. In other words, knowing that another trauma can come at any time may influence a nurse's ability to process or recover from any individual trauma. While nurses might need time to process, their work and lives outside of work do not always afford them that luxury, so the trauma lingers as what it was the day it happened and they are metaphorically stuck in that trauma until the next one occurs. It may be possible that if nurses had more dwell time in between their exposures to trauma, they might be affected less. In fact, one nurse in this study

who is currently working part-time in obstetrics said, “you have a lot more reserve when you’re part-time...I’m only on for one [shift] and then I’m off for a week...It’s much easier to take.” In addition to time, there is evidence that resilience, the ability to overcome negative situations, is an essential characteristic for nurses in their work environment because it allows them to cope with emotional trauma (Jackson, Firtko, & Edenborough, 2007) and predicts psychological empowerment and job satisfaction (Larrabee, 2010).

H. **Recommendations**

Because the nurses in this study experienced their traumas internally and had little if any formal support after their trauma experiences, they may feel like they are alone or that they are uniquely affected by trauma. External acknowledgement that trauma is very prevalent for nurses in obstetrics is an important first step for institutions, nurse educators, researchers, and nurses themselves. This and future studies on trauma among obstetric nurses is important to enrich our awareness of the phenomenon and to begin a conversation about how to address it best to improve the work environment for nurses and the care they provide to their patients. More specific recommendations for practice, education, and research are discussed below.

1. **Research**

There are many directions for future research based on the results of this study.

Interventions such as debriefing and counseling (Keene et al, 2010; Omerov et al., 2002; Santiago & Abdool, 2011), or implementing rituals (Holland & Neimeyer, 2005; Romanoff & Thompson, 2006) have been used in other fields of nursing after stressful events in the workplace. Dietz (2009) suggested the use of various debriefing techniques, such as critical incident debriefing, with obstetric nurses after maternal deaths, but there is no evidence that such interventions have been tested in the obstetric population. A possible future study might explore the effect of immediate debriefing sessions with obstetric nurses and assess the resulting perceptions and feelings of the nurses in order to compare them to nurses without

exposure to debriefing after trauma. In this study, comfort was especially present when the nurses were able to talk to someone who seemed to understand and be sympathetic to their experience, such as their obstetric colleagues. They also did not respond as well when talking to outsiders who could not understand what they experience in an obstetric setting. This information can be used in future intervention research when deciding with whom nurses should debrief. Researchers have also found that rituals, such as daily spiritual experiences (Holland & Neimeyer), verbal and art-based methods (Romanoff & Thompson) may mitigate the consequences of constant exposure to death and dying among helping professionals such as nurses. Further research should explore what kinds of rituals obstetric nurses naturally do on their own and may also implement new forms of rituals to assist nurses with their traumas.

Future research should also explore the extent to which **potential consequences of trauma** including hyper vigilance, avoidance, intrusive recollections, emotional labor, or moral distress are present in obstetric nursing. In addition, research needs to be conducted to investigate whether or not these phenomena negatively impact quality of care and patient satisfaction in obstetrics. In regards to the symptoms of posttraumatic stress disorder (PTSD) that the participants in this study seemed to show (avoidance, hyper-arousal/hyper-vigilance, and intrusive recollections), the DSM-IV (APA, 2000) recognizes they are normal in the immediate aftermath of a traumatic event. Though it was beyond the scope of this research, it may be important to explore whether obstetric nurses who have experienced trauma have the symptoms for more than one month combined with a loss of function in their job or in their social relationships, which is the additional criteria needed for a formal PTSD diagnosis (APA). The prevalence of PTSD symptoms among nurses has been studied in intensive care (Baxter, 2004; Mealer et al., 2007), natural disaster (Battles, 2007; Zhen, et al., 2012), emergency (Kerasiotis & Motta, 2004; Laposa et al., 2003), and military (Carson, et al., 2000) contexts, but not in obstetric nursing.

Further research on moral distress can also be conducted in this population using The Moral Distress Scale (MDS) (Corley, Elswick, Gorman, & Clor, 2001), the Military Nursing Moral Distress Scale (MNMDS) (Hurley, Fry, Duffy, & Foley, 2011), or adapted versions, designed to measure moral distress. Given the recent flurry of women's health policy issues that will inevitably affect the obstetric nurse, such as the questions surrounding personhood and abortion (Rabiner, 2012), it is vital that research is done to prevent or minimize the consequences of moral distress that will most likely ensue for nurses.

Another area lacking in research is the process of **communication**, or lack thereof, during traumas in the obstetric setting. Because it is very possible each provider working with an obstetric patient believes their preferred way of care is the correct one, thus leading to frustration and trauma, it may be helpful to explore the experiences of primary provider-nurse dyads surrounding trauma to determine what feelings and perceptions overlap, and which ones contradict each other. Such a study may help to decipher if communication breakdown during traumas is preventable or explainable and that information can potentially be used to improve interdisciplinary communication and collaboration in obstetrics. Research on if and how the quality of obstetric nursing care is influenced by nurses' trauma experiences is also needed. Although Beck (2004a) found that patients often had poor perceptions of how nurses treated them during birth, the current study suggests that their actions may be in response to the emotional toll trauma has on them. A future study that followed nurse-patient dyads after traumas (as defined by the nurse or the patient) may provide insight on how the two parties experience clinical events both similarly and differently and may suggest possible areas where miscommunication or misinterpretation can be avoided and clinical care can be improved. Finally in terms of suggested avenues for future research, the phenomenon trauma in the obstetric setting is not limited to registered nurses. Research has already been conducted

among midwives, but there is still a need to explore the experiences of obstetricians, obstetric aids and technicians, and unit clerks.

2. Education

There are many ways that nurse educators and nursing education can potentially alleviate the obstetric nurse's experience with trauma. It is important for educators to prepare students for what they should expect in the field. For example, emphasizing the positive, happy aspects of obstetrics and ignoring the negative ones perpetuates a common and impractical myth that is not helpful for the students pursuing it as a career. Practical knowledge, such as examples of traumas that can occur, how to effectively deal with providers from various backgrounds and clinical philosophies, and how to communicate with various personalities will not only provide students with the tools they will need to succeed but will also make them aware of the realities of practice.

In this study there were several traumas that related to **miscommunication** between nurses and their colleagues. Nurse educators need to be aware of this and develop curriculum in which students can increase their expectations for such occurrences and their preparedness in how to deal with them. It may be valuable for there to be more exposure to interdisciplinary instruction on workplace civility while in the educational environment (AWHONN, 2012) so that all team members clearly understand what their roles and responsibilities will be when they get to their clinical practice sites. Effective team building improves the appropriateness of responses to acute situations, the comfort among team members to speak up if a problem is suspected, and the likelihood of incorporating team debriefing after an incident with or without adverse outcomes to help to identify ways to enhance future care (AWHONN). All of these improvements could have a positive impact on how trauma events unfold and how nurses process them.

Educators can also prepare students in **self-care** when they encounter trauma situations as well as ways to cope and recover emotionally. For example, instead of only talking about death and dying in a workshop (Liu et al., 2011) or in specialties that traditionally discuss end-of-life issues such as medical-surgical nursing (Dobbins, 2011) or geriatrics (Shawler, 2011), obstetric nurse educators should also expand their curriculum to include these concepts. Perhaps in learning about suffering in school, obstetric nurses will be better prepared for the realities they will face in practice. Another area that should be addressed with students regarding their own self care is to stress the importance of processing their emotions often so that phenomena such as emotional work and moral distress do not lead to more devastating consequences in the future. This is especially important given the evidence that formal support in the workplace is often lacking. This type of education should not only include didactic material, but also opportunities to practice such as time for reflecting and dialog, encouraging journaling about their experiences which has been found to help nursing students cope with their feelings (Eifried, 2003). For example, nurse educators should expose students to the fact that certain coping techniques, such as avoidance strategies (withdrawing, denying, disengaging) can actually lead to psychological distress after traumas and that approach strategies (seeking emotional support, planning to resolve the stressor, and seeking information about the stressor) may be more beneficial (Littleton, Horsley, John, & Nelson, 2007). Such education will not only benefit nursing students when they graduate, but will also be essential to them as they progress through nursing school. In the same vein, educators in nurse management should emphasize the usefulness of psychologically and emotionally supporting staff, especially in the midst of trauma.

Practicing nurses are usually unfamiliar with the term **moral distress** or how to recognize it (Hamric, 2000) and investigators recently suggested that undergraduate nursing education may not be any different than education in other fields in terms of sensitizing students

to moral distress (Range & Rotherham, 2010). If nurses are not taught about the concept of moral distress, they will not know how to react to it if indeed they face it in practice. However, if nurses are taught to detect moral distress, it can actually lead to positive change (AACN, n.d.). Nurse educators should teach what moral distress is, its sources, what it feels like, and barriers it creates. The American Association of Critical Care Nurses (n.d.) developed “The 4As to Rise Above Moral Distress”, a process to help nurses make an optimal contribution to patients and families. The cyclic process includes self-awareness and self-reflection (ASK), a commitment to address moral distress (AFFIRM), identification of sources of moral distress (ASSESS), and preserving one’s integrity and authenticity (ACT). One of the most detrimental aspects of moral distress is that nurses feel prevented from advocating for their patients, a key nursing role. Nurse educators need to empower future nurses early on in their careers with a commitment to advocacy no matter the potential boundaries. Students would also benefit from practical ways to combat barriers to advocacy and maintaining the desired change in practice. For example, discussions and lessons about the importance of whistle blowing and the completion of incident reports while in school are essential and practical tools that future nurses can take with them to practice settings.

3. **Practice**

Hospital administrations and management should consider providing **supportive resources** for nurses who experience trauma due to its potential consequences: moral distress, emotional work, post traumatic stress, etc. Debriefing, as discussed earlier, may be a resource that would be helpful for obstetric nurses, however there are logistical concerns in how to provide such services. Santiago and Abdool (2011) found that making the debriefing location convenient to the unit, advertising the session well in advance, providing incentives to attend, and allowing attendees to choose the topic or theme of the sessions increased participation in debriefing sessions.

An important implication of the personal and private nature of trauma suggested by this study is that it cannot be assumed that providing interventions only when a sentinel event occurs on the unit are sufficient. If services are only provided when they are perceived to be necessary by an outsider, such as manager or an administrative staff member, many of the traumas that quite negatively affected the participants in this study would be missed. At this point it is not possible to predict or understand what will be a trauma for any one individual. Without this ability and given the fact that obstetrical nurse's trauma is not routinely documented or formally assessed, institutions may need to consider implementing more regular interventions for obstetric nurses, such as weekly or monthly open debriefing sessions, to ensure that all nurses have an opportunity to get needed support. It may also be necessary to make services mandatory to ensure that all nurses have a chance to process their traumas. If services are only once in a while (e.g. sentinel events), many nurses suffering from the effects of trauma will fall through the cracks. Although those traumas may not seem consequential or traumatic to an outsider or may not even be recognized at all, they remain with the nurse. The participants in this study indicated that engaging with others on a regular basis after these traumas provided them with comfort. This information can be the basis for future research to develop obstetric nurse-centered interventions in the aftermath of trauma experiences.

Managers and administrators of obstetric practices should consistently evaluate the mental health of their nursing staff so they are able to address any concerns, if necessary. Trauma may get in the way of a nurse's ability to provide the best **quality of care**. This should make providing appropriate resources and a supportive work environment for nurses even more of an incentive for management in order to improve patient safety, patient satisfaction, and to reduce adverse outcomes. For example, we saw in this study that some of the participants had trouble advocating for the patient due to the circumstances surrounding their trauma. In another study, labor patients and their partners identified four key roles of the labor and delivery nurse

as that of a support person, an educator, a patient advocate, and provider of continuity (Brown et al., 2009). If trauma impedes on a nurse's ability to accomplish these roles perceived as essential by patients and their families, it is inevitable that their perception of care quality and patient satisfaction will also diminish.

Improving the obstetric environment should be another area pursued to ensure that moral distress is avoided. Although there has been a recent shift in healthcare to champion quality of care and ensuring mechanisms are in place to protect clinical decisions (Runciman, Merry, & Tito, 2003), it is important to note that many of the incidents discussed in this study during which clinical decisions were thwarted happened within the last five years, so work is still needed in this area. Part of the nursing experience of trauma in this study was the perception of a climate of fear and a feeling that they were silenced from doing the right thing. These concepts also appear in the literature (Jackson, et al., 2010). Fear may also prevent nurses from having a voice when it comes to reporting unsafe care. For example, whistle blowing is often stigmatized in the clinical setting (Yamney, 2000), thus preventing nurses from using it to protect themselves and patients from inappropriate or dangerous situations. Policies on whistle blowing need to be specific and widely distributed throughout the staff of hospitals so that everyone is aware of them. A safe and responsive environment is also essential to empower nurses that may hesitate to doing something otherwise. This would also help to alleviate moral distress among nurses. Other methods to reduce moral distress that have been suggested include implementing interdisciplinary strategies to recognize and name the experience of moral distress, creating support systems and interdisciplinary forums for employees, ensuring nurses' representation on institutional ethics committees, and providing education on how to manage and decrease moral distress in the workplace (AACN, n.d.).

Optimal maternal health outcomes are best achieved in an environment where there is effective communication, shared-decision making, teamwork, and data-driven quality

improvement initiatives (AWHONN, 2012). In the practice setting, this may be assisted with the use of communication tools, drills and simulations, debriefings and case reviews, and structured handoffs and beside rounds (AWHONN). Not only would implementing such strategies improve communication and patient care, but they would also have a positive affect on how the nurse perceives her own participation in clinical decision making. This, in turn, has the potential to reduce the stress caused by otherwise feeling helpless as a clinical provider.

I. **Strengths and limitations**

There were seven notable strengths of this research. (a) It provided the exploratory groundwork on a phenomenon that has not received enough attention despite its common occurrence and serious consequences. Based on the themes presented in this phenomenological study, we can more deeply understand the lived experience of trauma among obstetric registered nurses. This will have implications for nurses as well as researchers and administrators interested in issues of retention of nurses in the workplace, prevention of trauma (if possible), self-care education, and post-trauma management. (b) The participants in this study provided many applicable experiences to analyze in conjunction with the other forms of data described. (c) The sample size was manageable while large enough to achieve the desired results of a phenomenological study. (d) New York City was a practical and convenient location for the research, and it contained a dense pool of participants due to its population size. (e) Recruitment did not occur in any particular hospital, so participants hopefully felt more comfortable sharing their personal stories since their employers were not involved. (f) In-depth interviews had the potential to have a therapeutic effect for the participants in this study. People participating in interviews about sensitive topics have reported benefits including catharsis, an increase in self-awareness, a feeling of empowerment, a sense of purpose, and an opportunity to help others (Jorm, Kelly, & Morgan, 2007). (g) Finally, although the intensive nature of phenomenology as a research method had the potential to limit this research, my experience

with the pilot study and my participation in a phenomenology workshop with Dr. Max van Manen gave me the necessary skills I needed to successfully complete this research.

This study was also limited in some ways. (a) This study did not include midwives or nurse practitioners. These populations may have also had experiences with trauma in obstetric health care, but for the purposes of this initial, exploratory research, I wanted to concentrate on the unique perspective of staff nurses only. (b) Inclusion in this study required the participants' willingness to share their personal stories. There is a potential that this study did not capture the traumatized nurses who did not want to participate because of various reasons. For example, those who may have feared revisiting difficult situations from their practice, those who may still be in an acute phase of trauma and incapable of communicating about it openly yet, or those who may be in denial about their trauma may have been missed. (c) Because this study required face-to-face interviews, potential participants who would have preferred to discuss such personal stories over the phone may have been missed. (d) Pregnant obstetric registered nurses may have distinctive experiences with trauma due to their personal circumstances, but their stories were missed by this study's sampling method due to ethical concerns.

J. **Conclusion**

Although the small sample in this study prevents the findings of this study from being generalized to all obstetric registered nurses, this study has provided the groundwork with which to broach the subject of trauma among them. The lived experience of trauma among obstetric registered nurses consists of a number of feelings, responses, and consequences that overlap with each other over time. The findings suggest a wide-ranging definition of what trauma can be for an obstetric nurse and yet despite this variety, the uncanny similarities in what it means to live through it and its effects on the nurse. Though most of the nurses from this study continue in the field, they have been personally and professionally damaged by the traumas they have experienced. Consequently, there are many potential avenues for future research in this area

such as the development and testing of interventions specific to the needs of obstetric nurse. Educators in obstetric nursing should expand their curriculum to include improved preparedness and strategies for encountering the inevitable trauma their students will face in practice. While trauma may not be a daily occurrence on an obstetric unit, when it does occur it is significant to the nurse and cannot be ignored by clinical institutions. Ignoring that trauma is occurring not only places nurses and patients at risk, but can also affect business in areas of job satisfaction, job performance, job turnover, and patient satisfaction. Ultimately, this research has provided a tangible awareness of what it is like for the nurses in this study to live through trauma and has given a voice to obstetric nurses regarding a crucial area that has been neglected for too long.

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APPENDICES

APPENDIX A

Interview Probes

PI announces date, place, interviewer, interviewee's pseudonym and identification number.

PI: I know this meeting that we are having is called an "interview" but I want you to try to think about it more as a conversation. I don't really have that many questions for you, I just want to hear your story. I want to remind you not to mention the name of any institutions or names. If you forget, I will make sure to take them out so that confidentiality is preserved. Also, I want to remind you that this interview will not last more than two hours. There is a clock in the room. When we see that there is 15 minutes left, we will start summarizing what we have talked about up until that point.

Introduction question:

- Start off by developing a relationship of personal sharing, closeness, or friendliness before seriously opening up the topic/ice breakers such as:
Why did you choose to work in obstetric nursing?

Main question:

- **Can you tell me about a time when you experienced the worst trauma in your role as an obstetric registered nurse?**
 - Just to remind you, for this study trauma is the emotional or psychological state of discomfort or stress resulting from an overwhelming event or series of events while providing direct care.

Potential probes:

- Ask the person to think of **specific** instances, situations, people, events.
 - When exactly did this happen?
 - Where were you?
 - What were you doing?
 - Who was there?
 - Who said what?
 - What did you say then?
 - What happened next? Did that affect what you did next?
 - How did it feel? How did you feel about that?
 - What else do you remember about the event?
 - So, you said you felt uncomfortable about that?
 - Did anything you did or say make you uncomfortable?
 - Did anything someone else did or say make you uncomfortable?
 - Was there something done by someone else that made you or someone else that made you feel relieved?
 - What documentation/charting occurred surrounding the event? How/what did you document what occurred? How did you feel about your documentation? Others' documentation?
 - I have been hearing that nurses sometimes feel pressure to document in a certain way. Did you experience anything like that?
 - How did you act with the mother/father/baby/other nurses/doctors/midwives/your family?
 - How did the event end?
 - How did it affect you?
 - Do you remember what you did after the event? Was there any formal meeting about the event? Informal discussions? What was said/done?
 - How did you/Did you talk about the event with others?
 - Did you forget about the event? Did the event stay with you? For how long?

APPENDIX A (continued)

- Were there any legal issues that came up related to the event?
- Can you remember the next birth you participated in? Was it different? Did you act different? Did you feel different because of the experiences you had during the previous birth? Did you say something different? Did you intervene differently?
- You said X. Can you tell me more about that?

If the subject starts to **go off topic**, bring them back to the event itself.

If the subject begins to give **interpretations, explanations, or speculations**, guide him/her back to the event and what actually happened.

If the subject starts to **generalize** his/her experiences (i.e. “I would do X” or “I always...”), respond by asking,

- Can you give an example of a time that happened to you?
- What was it like? In what way?
- Do you remember a particular incident/specific moments?

When they finish with one story ask, “Would you like to share another experience within the remaining X minutes?”

With 15 minutes remaining: “Because we only have 15 minutes left, I want to briefly summarize what you have said....”

What was the most difficult part of this interview for you to talk about?

What was the least difficult part of this interview for you to talk about?

Is there anything else that you would like to add that we have not talked about or that I did not ask you?

Thank you very much for your time today. I really appreciate you telling me about your experiences. Your story/stories will be very useful and important for the profession because they enhance our knowledge of what nurses experience while providing direct care. However, given the nature of the stories, you may feel like you want to talk further about these things with someone else. I came up with a list of resources that you may find helpful and useful, and I encourage you to contact someone if you need to talk to someone after today.

Our interview will be transcribed and I will analyze it with the other interviews I am doing with other participants.

Would you like to see the summary of my analysis when I have completed it?

If yes: When it is completed, I will send you the summary to the address you give me in the contact form today. At that time, you will also have the option to send me feedback on the analysis. I will call you at that time to remind you about this option and ensure that you consent to participate at that time.

If you decide to send me feedback, you will be compensated for your time.

Potential question if recruitment is still needed: Would you be willing to give out this recruitment flyer to some of your colleagues to see if they also want to participate in this study?

APPENDIX B

Demographic Form

Case ID#:	
Date:	

Instructions:

Please answer the following questions to the best of your ability. You can use the reverse side of the paper to explain any responses. Please be assured that all responses will be kept confidential.

1. What is your date of birth? ____ / ____ / 19 ____
Month Day Year

6. What is your gender? (Please place a check "✓" by your response)

- ☐ Male
☐ Female
☐ Other

3. What is the total of number of years of education that you have completed after receiving your nursing license?

____ Number of years

6. What is the highest degree in Nursing that you have? (Check "✓" your response)

- ☐ Associate degree
☐ Diploma
☐ Bachelor of Science in Nursing degree (BSN)
☐ Master of Science/Nursing degree
☐ Doctorate/advanced degree (PhD, DNP)

6. Are you currently enrolled in school or an educational/certificate program?

- ☐ Yes Please describe the type of program _____
☐ No

6. How do you describe your race/ethnicity? (Check "✓" all that apply.)

- ☐ Hispanic or Latino/a
☐ Black or African American (not of Hispanic origin)
☐ White/Caucasian (not of Hispanic origin)
☐ Asian or Pacific Islander
☐ American Indian or Alaska Native

Other (Please describe) _____

APPENDIX B (continued)

Case ID#:	
Date:	

7. What is your religious preference? (Check "√" your response)

- ☐ Roman Catholic
- ☐ Jewish
- ☐ Hindu
- ☐ Buddhist
- ☐ Muslim
- ☐ Baptist
- ☐ Methodist
- ☐ Episcopalian
- ☐ Lutheran
- ☐ Seventh Day Adventist
- ☐ Presbyterian
- ☐ None
- ☐ Other (Please describe) _____

8. What is your current employment status? (Check "√" all that apply)

- ☐ Working full-time
- ☐ Working part-time
- ☐ Unemployed, laid off, or looking for work
- ☐ On temporary leave
- ☐ Retired
- ☐ In school
- ☐ Other (please specify) _____

9. How many years have you been in clinical practice (fill in number on appropriate line)?

Number of years as RN in obstetrics
(all institutions total) _____

Number of years as RN (total) _____

10. How would you best describe the type of hospital where your most recent obstetrical nurse job was? (Check "√" your response)

- ☐ Public (not-for-profit)
- ☐ Private (for-profit)
- ☐ Military
- ☐ Teaching

APPENDIX B (continued)

Case ID#:	
Date:	

11. What is/was the typical duration of your daily shift as an obstetric registered nurse? (fill in number of hours on the line) _____

12. Check "√" the response that best describes the number of trauma experiences you have as an obstetric registered nurse working in a hospital.

- ☐ at least once a week
☐ once a month
☐ once a year
☐ once every 5 years

13. Have you ever talked about trauma with anyone other than today's conversation? (Check "√" your response)

- ☐ Yes With who? _____
☐ No

Additional Comments: _____

THANK YOU FOR SHARING YOUR EXPERIENCES.
 YOUR PARTICIPATION IS VERY HELPFUL AND GREATLY APPRECIATED!

APPENDIX C

Point person E-mail

Dear (name),

I am doing a research study to try to learn what it is like for obstetric registered nurses to experience trauma. **Trauma is an emotional or psychological state of discomfort or stress resulting from an overwhelming event or series of events while providing direct care.**

I am looking for obstetric registered nurses who would be willing and able to speak with me about these experiences. I know you are connected to a large network of obstetric registered nurses in New York City. Would you be willing to contact them for me and share a recruitment e-mail and/or flyer with them? If you would be willing to do this, I can send you a more formal e-mail and flyer that you can just forward directly to your network.

The nurses' stories and this research will bring awareness to other nurses, providers, and hospital administrators about their perspective of these experiences. In the long-term, I hope this research will lead to interventions to help nurses in similar situations and ultimately improve the hospital birth experience for women, infants, and providers.

Thank you very much for your time. Please let me know if I should send you the recruitment e-mail and flyer.

Sincerely,

Jennifer Baxter, B.S.N., R.N.

University of Illinois at Chicago, College of Nursing

Department of Women, Children, & Family Health Science

APPENDIX D

Recruitment E-mail

Dear Obstetric Registered Nurses,

I am doing a research study to try to learn what it is like for obstetric registered nurses to experience trauma. In this study, **trauma is an emotional or psychological state of discomfort or stress resulting from an overwhelming event or series of events while providing direct care.**

In order to be eligible for this study, you must:

- (1) be a Registered Nurse in at least one jurisdiction
- (2) have worked full-time in obstetric health care
- (3) have experienced trauma as an obstetric registered nurse
- (4) be able to speak, read, and write in English
- (5) be able to participate in a face-to-face interview in the New York City or Chicago area
- (6) not be pregnant
- (7) not currently be a midwife or nurse practitioner (*students are eligible*)

If you are eligible and can remember experiencing trauma while providing direct care as an obstetric registered nurse, I would like to talk to you about your experience. Your stories and this research will bring awareness to other nurses, providers, and hospital administrators about your perspective of these experiences. In the long-term, I hope this research will also lead to interventions to help nurses in similar situations and ultimately improve the hospital birth experience for women, infants, and providers.

If you are interested in participating, we can determine a location and time that is most convenient for you. Everything you say will be confidential. Only my research advisors (Dr. Karen Kavanaugh, Dr. Carrie Klima, and Dr. Susan Vonderheid) will have access to the transcribed data, which I will share with them only after I have de-identified the data by removing names and any other identifiable information. Our time together will not last more than 2 hours. You will also have the opportunity to provide me with feedback after the preliminary analysis. You will be compensated for your time.

If you would like to participate or if you would like to learn more about this research study, please call me at 917-414-8214 or e-mail me at jbaxte2@uic.edu. Please leave a message with your name and phone number, and I will get back to you as soon as possible. Please feel free to forward this e-mail and flyer to other obstetric registered nurses in the New York City area if you think they may be interested in participating in this study.


I thank you for giving me some of your time.

Sincerely,

Jennifer Baxter, B.S.N., R.N.
University of Illinois at Chicago, College of Nursing
Department of Women, Children, & Family Health Science

APPENDIX E

Recruitment Flyer

 <p>UIC COLLEGE OF UNIVERSITY OF ILLINOIS AT CHICAGO NURSING</p>	<h2>Are you an OB nurse?</h2>	
<h3>Have you ever experienced trauma while providing direct care?</h3>		
<h4>Exploring the lived experiences of trauma among obstetric registered nurses</h4>		
<p>Trauma is the emotional or psychological state of discomfort or stress resulting from an overwhelming event or series of events while providing direct care.</p>	<p>To be eligible for this study you must:</p>	
<p>The purpose of this research is to explore the lived experience of trauma among obstetric registered nurses.</p>	<ul style="list-style-type: none"> • be a registered nurse • have worked full-time in obstetric health care • have experienced trauma as an obstetric registered nurse • be able to speak, read, and write in English • be able to participate in a face-to-face interview in the New York City or Chicago area • NOT currently be pregnant • NOT currently be a midwife or NP (students <u>are</u> eligible) 	
<p>Participants will be interviewed about their experiences for no more than 2 hours. All interviews are confidential. Participants will also have the opportunity to provide feedback on the initial findings.</p>	<p>If you are interested in participating, or have any questions about this research, please e-mail jbaxte2@uic.edu with your name and phone number.</p>	
<p>Compensation will be provided for participation.</p>	<p>Thank you!</p>	

APPENDIX F

Script for Flyer Distribution outside of UIC

Script:

A doctoral student in the University of Illinois College of Nursing is recruiting obstetrical nurses for a study about encountering trauma while providing direct care. If you are interested, please take a flyer. You are not obligated to take a flyer.

APPENDIX G

Script for Instructors regarding recruitment flyer

Please place the recruitment flyers on a table in an accessible part of the room.

Instructor script:

A doctoral student in the College of Nursing is recruiting obstetrical nurses for a study about encountering trauma while providing direct care. If you are interested, please take a flyer. You are not obligated to take a flyer. Your status as a student in this class or at UIC will NOT be affected by your participation or non-participation in this study.

APPENDIX H

Telephone Recruitment Script

Hello,

This is Jennifer Baxter from the University of Illinois College of Nursing. You contacted me about possibly participating in a study about obstetric registered nurses. Do you have time to talk now?

As you may remember from the e-mail/flyer, I am conducting a study to learn more about the obstetrics nurse's experience of trauma. Just to clarify, **trauma is an emotional or psychological state of discomfort or stress resulting from an overwhelming event or series of events while providing direct care.** If you qualify and agree to participate, we can arrange a time and a location most convenient for you. I will audio record our discussion. It will be up to you to decide how much you want to tell me and when our conversation should end. All information will be strictly confidential. Only my faculty advisor and I will have access to your transcribed conversation. After my initial analysis, you will receive a summary of it and have the opportunity to provide your feedback on it to me.

I would like to ask you a few brief questions to make sure that you can be included in the study.

- a) are you an RN?
- b) have you worked full-time in obstetric health care?
- c) have you experienced trauma as an obstetric registered nurse?
- d) can you speak, read, and write in English?
- e) are you able to participate in a face-to-face interview in the New York City or Chicago area?
- f) are you currently pregnant?
- g) are you currently a midwife or nurse practitioner?

Is this study something you think you would be interested in participating?

Optional question: Would you be able to remember the details of your worst encounter with trauma?

If interested, what day of the week would work best for you? [Schedule date, time, and location]. The first thing I will do is ask you to sign a consent form since this is a research study. Then we will proceed with the interview, which will not take longer than 2 hours. After the interview, you will be asked to fill out a short demographic form and a contact information sheet.

If not interested, thank them for the time to listen about this research study.

If not eligible, tell them why, ask them if they are willing to share the recruitment e-mail/flyer with some of their colleagues who may be interested in the study, and thank them for their time.

APPENDIX I

E-mail recruitment script

E-mail 1

Hello (name),

Thank you for contacting me about possibly participating in a study about obstetric registered nurses.

As you may remember from the e-mail/flyer, I am conducting a study to learn more about the obstetrics nurse's experience of trauma. Just to clarify, **trauma is an emotional or psychological state of discomfort or stress resulting from an overwhelming event or series of events while providing direct care.** If you qualify and agree to participate, we can arrange a time and a location most convenient for you. I will want to audio record our discussion. It will be up to you to decide how much you want to tell me and when our conversation should end. All information will be strictly confidential. Only my faculty advisors and I will have access to your transcribed conversation. After my initial analysis, you will receive a summary of it and have the opportunity to provide your feedback on it to me.

Can you please reply to this e-mail and answer the following brief questions to make sure that you can be included in the study?

a) are you an RN?

b) have you worked full-time in obstetric health care?

c) have you experienced trauma as an obstetric registered nurse?

d) can you speak, read, and write in English?

e) are you able to participate in a face-to-face interview in the New York City or Chicago area?

f) are you currently pregnant?

g) are you currently a midwife or nurse practitioner?

Once I hear back from you, I will be able to determine if you are eligible for the study. If you are, still interested and eligible, can you remember the details of your worst encounter with trauma?

Thank you again for your interest. I look forward to hearing back from you.

Sincerely,

Jennifer Baxter, B.S.N., R.N.

University of Illinois at Chicago, College of Nursing

Department of Women, Children, & Family Health Science

E-mail 2 (if eligible and interested)

Hello (name),

You are eligible to participate in my study.

During our interview, the first thing I will do is ask you to sign a consent form since this is a research study. Then we will proceed with the interview, which will not take longer than 2 hours. After the interview, you will be asked to fill out a short demographic form and a contact information sheet.

Can you give me an idea of dates and times that you are free to schedule an interview? We can meet at (give optional locations depending on city). Which location would you prefer?

Thank you for your time. I look forward to hearing back from you.

Sincerely,

Jennifer Baxter, B.S.N., R.N.

University of Illinois at Chicago, College of Nursing

Department of Women, Children, & Family Health Science

APPENDIX I (continued)

E-mail 2 (if not interested)

Hello (name),

Thank you for getting back to me. I understand that you would not like to participate in this research at this time. Thank you for the time you have taken to learn about study.

Sincerely,

Jennifer Baxter, B.S.N., R.N.

University of Illinois at Chicago, College of Nursing

Department of Women, Children, & Family Health Science

E-mail 2 (if not eligible)

Hello (name),

Unfortunately, you do not qualify to participate in the study because...

If you would like to, you can give my contact information to other obstetric registered nurses you know who may be interested in the study. I am also attaching the a flyer if you would like to share it with those interested in the study,

Thank you for the time you have taken to learn about this research study.

Sincerely,

Jennifer Baxter, B.S.N., R.N.

University of Illinois at Chicago, College of Nursing

Department of Women, Children, & Family Health Science

APPENDIX J

Initial Eligibility Form

Case ID#:	
Date:	

Are you an RN?

Yes

No

Have you worked full-time in obstetric health care?

Yes

No

Have you had an experience with trauma as an obstetric registered nurse?

Yes

No

Can you speak, read, and write in English?

Yes

No

Are you able to participate in a face-to-face interview in the New York City or Chicago area?

Yes

No

Are you currently pregnant?

Yes

No

Are you currently a midwife or nurse practitioner?

Yes

No

Best day of the week:

Date scheduled:

Time:

APPENDIX K

Interview Eligibility Form

Case ID#:	
Date:	

Are you currently pregnant?

Yes No

APPENDIX L

Contact Form

Case ID#:

Date:

Contact Form

Recruitment (date)

Feedback (date sent to participant):

Interview
(date/time/location)

Feedback (date received by PI)

Name: _____

Home Address: _____

Home Phone: _____

()

Other Number: _____

()

E-mail address

Correspondence log:

[illegible]

APPENDIX M

Feedback Request Form
(To be filled out at the end of the interview)

Case ID#:	
Date:	

1. Would you like to receive the summarized analysis?**Yes****No**

If Yes: Send summary, Appendices P and R, and Appendix K or L

If No: Do not send anything to participant.

APPENDIX N

New York Referral List

Center for Educational and Psychological Services- Teachers College

525 West 120th Street

New York, NY 10027

Monday through Thursday, 9am to 9pm. Friday, 9am to 5pm. Summer hours vary.

212-678-3262

<http://www.tc.edu/ceps/>

Sliding scale - \$5 to \$40 per session **Note:** The Center's services are not reimbursable under Medicaid, Medicare or other medical insurance plans.

"The Center for Educational and Psychological Services (CEPS) is a community service, training, and research facility operated by Teachers College, Columbia University. CEPS offers a wide range of educational and psychological services to the greater New York community at affordable rates. These services are provided by advanced graduate students who are enrolled in professional, masters or doctoral degree programs at the college. Members of the Teachers College faculty closely supervise the provision of these services."

Cognitive Behavior Therapy Services at Payne Whitney

425 E. 61st St.

New York, NY 10065

212-821-0775

\$50.00 - \$30.00 (slide depends upon income/ # of dependents), Medicaid, Managed Care.

N.Y.U. Postdoctoral Clinic

715 Broadway @ Washington Pl., NYC

212-998-7890

Psychoanalysis by postdoctoral students

\$20 application fee

Sliding scale of \$10 & up

The Training Institute for Mental Health

22 West 21st St., 10th Fl., NYC

212-627-8181

Psychotherapy and Medication management

\$35 for intake & therapy/ \$85 for medication visits

APPENDIX N (continued)

Chicago Referral List

UIC Counseling Center

Student Services Building, Suite 2010

1200 West Harrison

(312) 996-3490

8:30am - 5:00pm, Monday – Friday

InTouch Crisis Hotline is available 6:00pm - 10:30pm, every night (312-996-5535)

http://www.vcsa.uic.edu/MainSite/departments/counseling_center/home/

- All services are free to enrolled students who pay the health care fee, except for a nominal charge for some career testing. Members of the University community who are not students are eligible for outreach programs, consultation, and referral assistance.

Chicago Women's Health Center Counseling Program

3435 North Sheffield Avenue, Suite 206A

Chicago, IL 60657

(773) 935-6126 (x401)

<http://www.chicagowomenshealthcenter.org/counseling.shtml>

- An in-office intake is required to receive counseling services at CWHC. The fee for intake is \$35. The purpose of the intake is to learn more about you and what brings you to counseling as well as offer you the opportunity to ask any questions you may have about the way we work.

Cornerstone Counseling Center of Chicago

1111 N Wells St., Suite 400

Chicago, IL 60610

(312) 573-8860

<http://www.chicagocounseling.org/index.php>

- The Center has therapists who specialize grief, trauma, depression, anxiety. Their fees depend on services rendered. They work with most forms of PPO and POS insurance; however, they are not on any HMO panels. They are able to offer a sliding fee scale to those who would otherwise not be able to afford services.

The Chicago Center for Family Health

20 North Wacker Drive, Suite 1442

Chicago, Illinois 60606

(312) 372-4731

- CCFH Fellows and Affiliated Therapists provide comprehensive services including: case assessment and consultation; brief, problem-solving therapy; mediation; and intensive, long-term counseling to resolve a wide range of emotional, behavioral, and relational problems. Individuals, couple, family and group formats are offered. Self-pay, insurance, and Medicare payment are accepted. Fees are on a sliding scale for clients with limited resources.

APPENDIX O

Guide for Post Interview Summary Notes

Case ID#:	
Date:	

1. Problems arranging the interview.
2. What were the most salient themes of the interview?
3. What questions provoked the strongest responses? What new or remaining questions were stimulated by this interview? Comment on the ease difficulty with the questions.
4. Describe the attitude of the subject during the interview. Did the person seem to be engaged, distracted, sad, happy, etc? Describe specific behaviors that support your interpretation of the subject's attitude.
 - a. If you observed any noteworthy changes in the subject's attitude during the interview briefly describe the circumstances surrounding the change.
5. Where did the interview take place?
 - a. Describe the characteristics of the physical setting where the interview took place, including a brief description of the décor, the location, and the function of the room, and factors that might affect comfort; e.g., warm, cold, etc.
6. Did you have privacy? Did anyone leave or enter during the interview?
 - a. Were there any interruptions or distractions?
7. Comment on your reaction to interview.

APPENDIX P

Thank You Letter

Dear (name),

Thank you very much for your participation in my study today. It was very nice to meet you, and I really appreciate your willingness to share your stories with me. Once I have interviewed all of the participants, I will begin my analysis. I will be back in touch with you as soon as it is ready. Thank you again.

-Jennifer Baxter

APPENDIX Q

Letter with Analysis

(Sent with analysis to everyone who requested to see analysis at the end of his or her interview)

Dear Participant,

Thank you again for your participation in this important research about obstetric registered nurses' experiences of trauma. I have carefully analyzed what I learned from you and other participants. A summary of my findings, which you requested to see, is included.

I have arranged the summary into multiple themes that I found throughout my interviews. While all of the themes may not reflect your unique personal experience, you should be able to recognize your own experience in many of the themes.

If you would like to continue with your volunteer participation in this research by providing your feedback on the summary, you will find an additional letter in this package with directions on how to do so. If you chose to provide feedback, you will be compensated with a \$25 gift card. If you do not want to provide feedback, I will not contact you again, and your contact information will be destroyed.

If you have any questions or concerns, please feel free to contact me at 917-414-8214 or at jbaxte2@uic.edu.

Sincerely,

Jennifer Baxter, B.S.N., R.N.

University of Illinois at Chicago, College of Nursing

Department of Women, Children, & Family Health Science

APPENDIX R

Directions for Submitting Feedback

Dear Participant,

Thank you again for participating in this study: **Exploring the lived experience of trauma among obstetric registered nurses**. If you would like to continue your participation in my study at this time, you can provide me with feedback about the summary. If you do chose to complete this part of the research, you will be compensated with a \$25 gift card.

1. Please contact me by phone (917-414-8214) to let me know that you will be completing this portion of the research. I will review the informed consent form that you already signed and will need your verbal consent to continue.

2. If you would like to provide your feedback by phone, we will arrange a convenient time to speak. I will record our phone call to ensure that I capture your complete reflection.

3. If you would prefer to submit your response to the summary in writing, you can return your written response to the above questions to me in the provided stamped, addressed envelope or by e-mail (jbaxte2@uic.edu). ***Please call me (917-414-8214) prior to completing the questions so we can review the informed consent you have already signed.**

4. Here are some questions to consider when you are reading the analysis:

- What was your reaction when you read the summary?
- In what ways did the summary reflect your experience? In what ways did the summary not reflect your experience?
- What was accurate about the summary?
- What was inaccurate about the summary?
- What is missing from the summary?
- What do you think would be the reflections of other people (not participants) who read this summary?

5. I have also included a referral list of mental health providers for you in case during your reflection in the summary you feel like you need to talk to a professional.

For your participation in this feedback phase of the research, you will be mailed a \$25 gift card once I receive your response.

Please do not hesitate to contact me if you have any questions or concerns about the research. Thank you again for your participation thus far.

Sincerely,
 Jennifer Baxter, B.S.N., R.N., UIC, College of Nursing
Jbaxte2@uic.edu
 917-414-8214

APPENDIX S

Process Consent for submitting feedback

Hello,

Thank you for being willing to continue your participation in this research by providing your feedback on my initial analysis. Would you like to provide your feedback by phone or in writing?

I want to remind you about the informed consent that you signed at the time of our interview.

- The purpose of the research is to gain an in-depth understanding of obstetric nurses' experiences with trauma.
- For this phase of the research you will be able to call, e-mail, or write me with your feedback. This should not take longer than one hour.
- To the best of our knowledge, the things you will be doing have no more risk of harm than you would experience in everyday life. However, there is a small possibility that discussing this feedback may cause you to recall painful memories and cause sadness or stress. I will stop our discussion if it becomes too difficult for you to continue. No long-term effects are anticipated.
- ⊖ You may not directly benefit from participation in the research, but nurses participating in other studies like this one have said that it is helpful to talk about their experiences. This study is designed to learn more about the nurse's experience with trauma. The study results may be used to help other nurses, other obstetric providers, or childbearing women and their partners in the future.
- ⊖ You have the option to not participate in this study.
- The people who will know that you are a research subject are members of the research team. Otherwise information about you will only be disclosed to others with your written permission, or if necessary to protect your rights or welfare or if required by law.
- Our discussion about your feedback will have your unique identification (ID) number and pseudonym so your actual name will not be attached to any of the data. Paper data files with your ID number and/or pseudonyms will remain in a second locked safe until all the analyses and publications are complete at which time I will shred them.
- Audio recordings from this feedback session (if applicable) will only be available to me and the transcriber (if applicable). We will transcribe all audio recordings after they have been transferred to secure primary and back up flash memory data storage devices and erased from the audio recorders. The primary and back up flash memory data storage devices will remain in a locked safe when not in use. After checking the interview transcripts for accuracy, I will erase audio recordings from the primary and back up flash memory data storage devices.
- The feedback (if applicable) transcripts will be de-identified. All de-identified and password protected transcripts will remain on primary and back up flash memory data storage devices that will also be locked when not in use in the second safe with the other de-identified data. While analyzing the interviews, they will be stored on my laptop, but will be password protected. I will erase all electronic files when the analysis and publications are completed.
- When the results of the research are published or discussed in conferences, I will not include any information that will reveal the participants' identity.
- **Certificate of Confidentiality:** To help us protect you and the information we will be collecting from you, this study has been given a Certificate of Confidentiality by the National Institute of Nursing Research. This Certificate means that the researchers cannot be forced, even by a court subpoena, in any federal, state, or local civil, criminal, administrative, legislative, or other proceedings, to disclose any information that may identify you. The researchers will use the Certificate to resist any demands of information that would identify you, except as explained below.
 - The Certificate cannot be used to resist a request for information from United States government employees if the request is for auditing or evaluation of federally funded projects.

APPENDIX S (continued)

- The Certificate does not stop you or a member of our family from voluntarily disclosing to any person information about yourself or your involvement in the study. If you give your written consent to release study information to an insurer, employer or other person, the Certificate cannot be used to withhold this information.
- If the researchers become aware of possible child abuse or elder abuse, or that you may cause serious harm to yourself or others, the researchers may report this to the appropriate authorities without your consent.

Do you remember and understand these things? Would you like to continue?

(Continuing by phone)

1. What was your reaction when you read the summary?
2. In what ways did the summary reflect your experience? In what ways did the summary not reflect your experience?
3. What was accurate about the summary?
4. What was inaccurate about the summary?
5. What is missing from the summary?
6. What do you think would be the reflections of other people (not participants) who read this summary?

Thank you again for your time. For your participation, I will be sending you a \$25 gift card. Should I send it to the address that you already provided to me?

(Continuing by mail or e-mail): Please provide responses to the questions that were included in the package. You can e-mail or mail them back to me. Once I receive these responses from you, I will send you a \$25 gift card. I will send it to the address that you already provided to me unless I hear otherwise from you. Thank you again for your time.

APPENDIX T

I remember the couple. They were Hispanic. Only spoke Spanish. Usually when that would happen, people would look to me to help translate. I used to be fluent, even dreamed in Spanish when I was studying abroad, but now my Spanish is spotty. Still, it's the best on the floor.

I took the patient. I don't remember how old she was but she seemed older than the average patient. She was short and plump. She didn't really even look pregnant to me. I remember even putting on the toco. I kind of just guessed on where to put it. No defined belly at all. She was 23 weeks and four days and she was having contractions and was bleeding a little bit. Baby's heart rate was fine. Her husband was with her. They both looked really concerned. I did my best with the Spanish, but it was not great. Luckily, I remember that the peds staff on call spoke beautiful Spanish. Thank God. I don't even remember her name, isn't that terrible? But I always liked when she was on call. She was so sweet and calm. It always made me feel better when I saw her run to the floor when we had bad babies. For some reason I had so much confidence in her. Maybe it was because she appeared to be confident herself, in her own quiet way. Definitely not cocky, just a quiet confidence.

Anyway, as was the normal routine, I put the patient on the monitor, did her blood pressure, temperature, and did my best on the computerized intake form. I don't remember being nervous. I was still a new nurse, but we often had women come in early with similar symptoms (although the bleeding was unique this time) and we would give them some turb, a pitcher of water, and send them back on their way home contraction-free.

I called the resident in for her assessment. Again, thank God the resident spoke Spanish too. My lucky day. Bottom line, the woman was dilating and the resident could feel a limb coming through the cervix already.

Ugh. That was not good news. I was pretty nervous. I had never done a fetal demise, at least not on my own. I voiced my concern to the head nurse (Wendy) on the floor that night, who I just loved as a person, and she said not to worry, she would help me.

When the doctor explained the situation to the patient and her husband, they started crying. I hadn't really established a relationship with them yet because the triage had happened so fast given the circumstances of her early dates and the bleeding and the language barrier. I am always so embarrassed with my shoddy Spanish. Thinking back I wish I had tried harder to console her in Spanish, or say anything really for that matter. I only remember putting my hand on her shoulder and looking at her like 'I'm sorry' with my eyes. Pathetic, I know. Ugh. I even hate thinking about this story (although I think of it often even though I haven't even been practicing for four years). It makes me feel like I was a bad nurse, even though I know that's not true. I mean, I had not even done a fetal demise in English yet, let alone in a foreign language. But that's not the patient's fault, just her misfortune. I did my best. The most traumatic part hadn't even come.

The pediatrician came into the room to break the news to the couple that nothing could or would be done for the baby once it was born. At 23 weeks and 4 days, it was three days too early to being viable according to this hospital's cutoff, and the policy was that they did not even try to resuscitate babies less than 24 weeks. I don't remember what kind of interaction took place during this conversation, but I realized later that I don't think the parents were on-board with what had been explained to them. I think they

APPENDIX T (continued)

thought that the baby would be born dead. I have to admit, while I knew the baby was alive, I wasn't really thinking ahead to what it would be like to watch this baby die.

Since there was no stopping the labor, we just tried to make the mother as comfortable as possible. I remember the room they were in was one of my least favorites. It was one of the smaller rooms. We had three nice big rooms, one medium sized room, and three smaller rooms on the birthing until at this smallish community hospital. When our census was high, the small rooms had to be used for births. What a mess. So tight. When you would break down the bed there was no where to put the bottom half of it. Nowhere to move. It was a lot to get used to. As if knowing what to do as a new nurse wasn't tough enough, trying to organize yourself to a tiny room was a whole other story. I dreaded having deliveries in those rooms. I also felt bad for the couples in those rooms. It was pretty claustrophobic. We mostly reserved those rooms for antpartum patients like long-term bed rest patients on Mag or pre-term triages.

I dreaded every time that I had to go in the room to check on her. They seemed hopeful that she would stop contracting and that the baby would be fine. I remember talking to peds and asking about the policy. I mean, why couldn't they just try? But I knew that the complications would be severe for the kid. Still, the parents really wanted us to do everything we could, and isn't it their choice? Instead, the peds attending did not even come for the delivery. Just me and the resident. I wondered if it was because she was a clinic patient. Would they have tried (even if they knew it was in vain) if it was a private patient? The parents definitely weren't demanding. They were quiet and respectful with the doctors. But when it was just me in the room they would keep asking, Why we weren't going to try. There I was in my broken, feeble Spanish trying to explain something that I didn't really explain myself. I felt like I was apologizing for a hospital policy that I didn't understand or have any control over. I mean, I knew that that baby was not viable, but at least let them see you try. These people don't even know what "not viable" means. They think we are killing this kid! I felt like the least we could do was show them that we tried "everything we could". It was really difficult and awkward for me because I just did not know what to say to them.

Her bleeding got worse and it was eventually time for her to deliver. I told Wendy, and she said she would come in at the moment of truth. The baby was born. The room was quiet. The dad looked. I think they even both smiled through their tears. To be honest, I don't really remember their initial reaction. I think I was too terrified at that moment to remember any details at all. It was so small. About the size of a hand. Ugh. I didn't even want to look at it. It was definitely breathing. The parents wanted to hold it. I have no recollection of what I did. I don't remember if the head nurse helped me wrap it up or what, but I remember the parents holding it, talking to it, praying over it, touching it and crying. After cleaning her up, the three, or I guess four of us, were in the room alone. I remember the father holding the baby out to me and showing me that the kid was still breathing. Ugh. Yup. It was definitely still breathing. Struggling, but breathing and moving. Ugh. I hate to even think about it. The father's eyes were just crying out to me 'help.' I could understand everything he was saying to me. 'He is alive. He is breathing. Can't you just try to save him?' What do you say to that? No, I cannot try to save your baby. I became a nurse to help people, but not you and not your baby? It was terrible. I have no idea what to say. I remember leaving the room and telling my co-workers that it was still breathing. They said sometimes it takes a while. EVERY time I went in to check I was dreading seeing the dead baby, but it was still breathing! What the hell? I remember thinking please just die already. You are making liars out of us. We told the parents over and over that this child would not be able to live on it's own and here it was

APPENDIX T (continued)

proving us wrong minute after minute. There was a part of me that started thinking, well, maybe this kid is different. Maybe if we just try we can miraculously save it. The other nurses and doctors seemed sad, but not overly so. I mean, sure, it was terrible that this couple was losing the baby, but they seemed to be alright with the fact that it was out of their hands. I, on the other hand, was not alright with being so helpless. It was like when the couple was talking to the doctor, they accepted the fate of this baby, but when they had me to themselves, they were like, 'But you are going to try, right? You want to save the baby, right?' I definitely was not prepared for that baby to last so long!

That father held that baby for at least an hour before he called me in. Wendy came in with me. I think she said something to them like 'I'm sorry for your loss' but they didn't want to hear it. I don't remember saying anything in particular. We rolled the baby out in the bassinet to the med room. It was a pretty long walk down the hallway, past four active labor rooms. The med room was small but crammed with everything. Meds, IV bags, linens, supplies, a sink, a counter, birthing balls. The door is locked to protect the narcotics. You have to press a code on the lock in order to get in. The door slams behind you. It is cold all the time on the floor. We sometimes use warmed IV bags to warm ourselves up. This night was no different. At this point, the baby was covered with a towel. Wendy told me to get out the camera while she found the shroud to wrap the baby up. Trying to take nice pictures of a dead baby is really difficult. Every way you try it, it still looks like a dead baby. Why would anyone want these photos? I was a fine arts major in photography. That was my life before I became a nurse. I thought about how weird it was to be holding a camera in this new context. I didn't like it. This was not fun. In nursing school, I often tried to think about how I could incorporate my photography skills into nursing. Maybe forensic photography? Who knows. Well, at that point I knew that I did not want to do that. I took some photos. Hat on, hat off. Hands down, hands across. All creepy. All crappy.

I was surprised that we took off the clothes when we went to wrap it up. Wendy said they the clothes were for the parents—part of the memory box. Now for the wrapping. We went to the room in between the ORs, which were not in use, in case another nurse had to use the med room. We rolled out the blue, thin plastic shroud on the countertop. Inside the package there was also a long piece of string. Wendy said there was no real "way" to wrap it up. She just said that it should be pretty compact. It was an adult shroud so we cut it down, but it was still too big for just a little thing. Rolling it up was so creepy. I just remember thinking it was going to start breathing or moving again. Feeling it under my fingers with only the plastic in between it was such a terrible feeling. I think Wendy said something like, 'sorry little baby.' Once the plastic was wrapped, then we had to tie it. If there was no technique for the plastic, there was definitely no rhyme or reason to the tie up part. With every knot I made, I just felt like I was suffocating the thing.

When it was all nicely wrapped and tied, (and I'll never forget this), Wendy said, 'There, looks just like a little rump roast.' I felt disgusted. I looked at her, gasped and chuckled out of shock. "Oh my God, that is terrible, Wendy." But you know, she was right. That was exactly what it looked like. A roast, albeit a blue plastic one, all tied up and ready for the oven. It actually was easier to carry after that. Maybe because it looked like a roast or maybe because at that point there were so many layers of thin plastic between me and the baby that I couldn't even feel it anymore. But it was much lighter than a roast. It was definitely still a dead baby. We left it all wrapped up in the basinet and left it in that

APPENDIX T (continued)

lonely back room all alone. The tech said she'd take it down to the morgue on her way to lunch. I was so happy that I didn't have to. I felt sad leaving it all alone in there.

I never cried about it. I rarely cry about anything. I don't even remember discharging the family. I can still remember what it felt like to wrap it up though.

APPENDIX U

Ode to a Labor and Delivery Nurse OR, Maternity is NOT a Piece of Cake**By Martha Crowninshield O'Brien****September 25, 1994**

One cool and windy night, just shy of a raging typhoon,
 I inhaled sharply, full of fright, at the sight of the Harvest moon.
 But, onward toward maternity my fearful feet did tread,
 and as I passed delivery, that fear turned into dread....
 Red bags piled to the ceiling,
 amidst puddles of ooze and gore-
 it was glaringly apparent I had NOTHING good in store...
 The linen cart was barren-
 all bags were overstuffed,
 splitting at the seams they were,
 as if they'd had enough.
 Pausing at the double door,
 I loosed an anxious sigh, and shivered to my toenails
 as I went sulking by...
 Stealthily I tiptoed down the hall to take a peek-
 so completely overwhelmed was I that I could barely speak!
 Once in the inner sanctum,
 I was committed then, to stay-
 absolutely quite impossible for me to get away...
 Two nurses for six patients, in various stages of stress-
 counting all, the eight of us, were in a major mess!
 Someone up the hall always let loose a howl of pain,
 and I contemplated leaving since conditions seemed insane.
 Still observing, undetected, I checked the board for stats,
 when whirling into vision ran a maze of OR hats!
 "Hey!" yelled nurse number one to me (she of the evening crew),
 "Stat section now so listen up; I'll give report to you."
 "The girl in one is fully; rooms two and three, are eight,
 we're going to the OR and YOUR second nurse is late!" "Two labor checks expected and one is
 premature;
 there's some question of a third one but the doctor isn't sure."
 "Seems her last one took an hour once the water broke (stop laughing like an idiot cause I just don't get
 the joke!)
 To continue.
 "There's an induction in the morning, a supposed gravida four; it's an unexpected pregnancy and
 there's no pit on the floor."
 "Oh, the doctors' in a foul mood (so what ELSE is new?)"
 They say someone has to float and you'd better hope its you!"
 "The instruments are soaking, but only one table is set-
 FORGET about restocking; that's as far as I could get!"
 Then, off she dashed to the OR, followed by the coach-
 I assessed the situation to determine SOME approach...
 Retreat was not an option (though it sounded great to me),
 so, sizing up my patients, I triaged the active three...
 While the girl in one was pushing, room two's membranes burst-
 it had now become a contest of who'd deliver first.
 Just as room three vomited, and progressed from eight to rim,

the coach of number one yelled out that I should come back in!
 Still (thank God), some pushing; from two, a serious groan, interrupted the next instant, by the ringing
 of the phone.

"An ambulance is coming!" yelled my ER nurse friend Jane. "We know she's really active, but we don't
 know her name!" "She doesn't know her due date and had no prenatal care- no further information and
 they went off the air." " She'll be arriving shortly, as they are currently en route; ETA is anytime;
 consider her acute."

I took a breath, cursed HIPPA, and prepared the triage room,
 ripped the sheets off, pulled more belts,
 tried to shake the air of doom....

Just then the doors flew open, two EMTs in tow, more nervous than the patient, sheets soaked with
 bloody show.

As I mentally requested my heart remain inside my chest, I readied our last labor room for our most
 recent guest....

Thankfully, night nurse two arrived and the doctor too,
 having just finished the section,
 I crossed myself (thank you!)...

Room one delivered nicely, no time for an epis-
 we turfed her to post partum and continued with the siege.
 Of COURSE she is a negative and the cord blood is misplaced,
 so we rearrange priorities and locate it with haste.

In between this turmoil, its fully for room two-
 three is stuck at rim now, but feeling pushy too...

No abruption for our latest, and her ultrasound is fine-
 the BEST news of this nightshift is gestationally, she's on time...

Her ODU is positive (a "slight" problem with cocaine), so with double gloved palpation, I attempt to find
 a vein...

"I could help you with that, honey," (she stares with listless eyes),

"I know my veins by heart, and I note with some surprise,
 that for a millisecond, in the beating of a heart, that I actually considered SHE do her IV start!

But the worst news of this night shift is undeniably grim-
 no housekeeping is scheduled so we either sink or swim...

A happy, quick delivery for the couple in room two. Pitocin for room three now, to start at 2 mu.

Sadly, we now have a demise, and offer comfort care-

My heart is saddened for her, of course,

I wish she wasn't there,
 to hear the happy sounds of life,
 when her child is no more-
 but I pause only a moment,
 and gear myself for more...

Mad rush for extra IV pumps,
 suspicious grunting from room three-

NO time for any paperwork,
 no time at ALL, to pee...

Three is fully now, and pushing, with no clean delivery room,
 I swear there's a connection between us and that full moon!

Here comes the supervisor, to tell me I'm to float,
 I relay my reluctance- I know the speech by rote...

She is not at all impressed,
 after all, there are no problems on OB,
 So I refuse to listen,
 and she threatens to discipline me.

Well, I say in passing,
 Knock yourself out and then,

we hear some desperate screaming,
 and I am gone again....Nurse two and I are scrambling
 frantically here and there, and the doctors' pretty ornery,
 but we don't really care.
 "I want an IV started!" He barks, "I want it NOW!"
 Not even breaking stride I tell him not to have a cow.
 Face reddening with anger, he barely gasps a "WHAT?"
 so I remind him gently, that we're all the help he's got...
 "I need a cup of coffee, go make a cup for me."
 I stare at him with disbelief, "Sure, if you'll make one for me."
 "Or," I quickly offer, you might make some of your own."
 Disarmed only briefly, he quiets at my tone.
 Then,
 "Where are all our nurses?"
 "This is CRAZY!" he exclaims, and I, for ONCE
 agree with him, that managements to blame...
 They don't take us seriously;
 after all, we're ONLY sweet OB,
 no one sees the things we do.
 the things that THEY don't see....
 The critical HELLP patients,
 the serious social lore,
 the vast gamut of patients,
 with a child that she'll soon bore...
 They don't grasp the sadness,
 when a baby dies, or when,
 you hear the heartbeat one last time,
 and never ever again...
 The doc continues ranting,
 but I'm already gone,
 having long ago discovered
 to steadily press on...
 Finally the sun shines;
 our night is put to rest,
 but we still have our paperwork
 and an awful, slimy mess.
 We stay until we're finished,
 foregoing overtime,
 since management would argue,
 over every single dime.
 So seldom they say thank you-
 we rarely hear, "Nice work!"
 And there isn't any backing,
 if the doctor is a jerk....
 The OR wants us all to scrub,
 every single case,
 recover, assess, deliver too,
 in the MIDDLE of THIS pace....
 Every night's a challenge,
 where we are compelled to float-
 I hate to even go in;
 there's a tightness in my throat...
 We love our ER counterparts,
 but they turf expectant moms so quick,

that I'm puzzled they had any time,
 to determine she was sick...
 And as to OB nurses knowing nothing,
 when we are forced to float,
 we're more trained than most staff
 if I may pause to gloat...
 We have to recover patients,
 code them so we have ACLS and then,
 we have NALS and PALS to take,
 and SO much more, my friends...
 We have DVTs, and cardiac arrest,
 and I can handle emergencies
 with the best of all the best...
 Yep, we have our down moments,
 when patients are a healthy group,
 followed by catastrophe,
 when we rapidly regroup...
 If I hear, "Maternity is an easy place to work."
 One more time from some ignorant soul,
 I might go berserk!"
 I cannot spell, I'm tired,
 this night has whipped my a**,
 and we aren't even done yet,
 but there's daylight now, at last.
 The bottom line is obvious,
 at least it is for me,
 Delivery is an amazing place,
 as is all maternity...
 Despite occasional mayhem,
 and an unpredictable pace,
 we tolerate the madness,
 which is rampant in this place,
 because with every baby,
 there's new life in which to share,
 which is truly inspirational,
 and the reason we are there.
 So, whether we have chaos, catastrophe or strife,
 there is nothing more affirming
 than to greet a brand new life.
 Homeward I am traveling,
 thinking all the while,
 THANK YOU God, for guiding us,
 (I send a skyward smile),
 and although I'm VERY happy,
 to be exiting the "zoo,"
 I'll be back again tonight,
 just as good as new...

VITA

NAME: Jennifer M. Scotese Baxter

EDUCATION: A.B., Art History/Visual Arts, Princeton University, Princeton, New Jersey, 2001
B.S.N., Nursing, New York University, New York, New York, 2005

HONORS: 3rd Place in Poster Competition at the 2010 International Association of Forensic Nurses Scientific Assembly, Pittsburgh, PA, 2001

Chancellor's Student Service and Leadership Award
University of Illinois at Chicago, 2009-2010

Abraham Lincoln Fellow
Graduate College, University of Illinois at Chicago, 2007-2012

Pre-Doctoral Trainee- Health Disparities in Underserved Populations Research Training Program (T32)
College of Nursing, University of Illinois at Chicago, 2008-2011

Helene Fuld Leadership Scholarship
College of Nursing, New York University, 2003-2005

Greater New York Association of Nurse Recruiters Scholarship, 2004-2005

Dean's List
College of Nursing, New York University, 2003-2005

PROFESSIONAL MEMBERSHIPS: Sigma Theta Tau International Honor Society of Nursing
Midwestern Nursing Research Society
National Association of Hispanic Nurses
Association of Women's Health, Obstetric and Neonatal Nurses
International Association of Forensic Nurses

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