The Pennsylvania State University
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BEARING WITNESS:
INFORMAL LEARNING AMONG CRITICAL CARE NURSES
IN THE CONTEXT OF TRAUMATIC SUFFERING

A Dissertation in
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by
Patricia Holland Webb

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The dissertation of Patricia Holland Webb was reviewed and approved* by the following:

Fred M. Schied  
Associate Professor of Education  
Dissertation Advisor  
Chair of Committee

Esther Prins  
Associate Professor of Education

Davin Carr-Chellman  
Assistant Professor of Education

Leonard Lawlor  
Edwin Erle Sparks Professor of Philosophy  
Director of Philosophy Graduate Studies

Roy B. Clariana  
Professor of Education  
Director of Graduate Studies  
Department of Learning and Performance Systems

*Signatures are on file in the Graduate School
ABSTRACT

Secondary traumatic stress (STS), also known as compassion fatigue (CF), is a recognized source of suffering among nurses and many other types of human service workers who help people during or after traumatic life events. With regard to nurses, the field of study still lacks both conceptual clarity and theoretical grounding for identifying and responding to STS.

The present research adopted a critically and psychodynamically enriched learning framework to examine the experience of STS in nurses. It sought to deepen and enhance the qualitative understanding of STS through a close phenomenological investigation not only of the experiences of a sample of critical care nurses, but also through the discernment of essential structures of mental constitution and informal learning that were evidenced among them.

The study employed an adaptation of Giorgi’s (2009) modified Husserlian approach to phenomenological investigation. A triad of three critical care nurses who were employed in a single medical center were interviewed at length, both individually and in extended focus groups. Static data analysis was conducted consistent with Giorgi’s method, followed by an iterative process of genetic analysis that encompassed temporal and intersubjective dimensions of the nurses’ constitutional processes relative to their traumatic exposure. Essential structures of meaning were discerned and synthesized in relation to their experiences of STS. In addition, dynamic modes of informal learning were discerned.

STS in this sample of nurses was a shattering experience that resisted comprehension and necessitated sustained support by attentive and nonjudgmental peer companions in order for traumatic exposure to be integrated successfully in a nurse’s consciousness. Helpful learning in response to STS involved a willingness to embrace the emotional dimension of life: gradually to claim traumatic events as one’s own, while actively reevaluating and reconstituting their possible meanings and embracing the necessity of mourning in communion with trusted peers.
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FOREWARD

...Watch out now, take care
Beware of thoughts that linger
Winding up inside your head
The hopelessness around you
In the dead of night:
Beware of sadness...

—George Harrison, 1970, “Beware of Darkness,” from All Things Must Pass

Coming to the Question

I was a child of the sixties and grew up immersed in the consciousness of the Beatles—pre and post break-up. As a teen of the seventies though, I was anything but rebellious and certainly did not consider myself artful or creative. I was, in fact, just trying to stay alive. At the age of 17, I chose the profession of nursing because I knew I could always find a job and therefore would never go hungry like the “starving artists” and unemployed philosophers who were regularly disparaged at our dinner table. Beneath this rationale, however, lay timidity about competition and a distrust of workplaces where people had to continually justify their existence. In nursing, I reasoned, I would always know what was expected of me—to follow “doctors’ orders.” Little did I know this apparently safe and predictable professional existence would eventually catalyze the rebel and the artist within me.

So at the age of 22, my passage into adulthood took place in the halls of a cardiac critical care unit where sudden death, or near death, was an almost daily occurrence. In those days, I maintained a vague illusion of control over my life through each shift with the help of a fresh eight-and-a-half-by-eleven sheet of paper. On it, at the start of the day’s (or night’s) work, I transcribed the change-of-shift report, recording in precise, color-coded detail the facts of nursing
care needed by all seven patients for whom I and one other registered nurse would be jointly responsible in the succeeding hours. As long as I stayed focused on my neatly folded paper with its colorful notations, I could resist the temptation to panic over what might ensue at any moment before the shift was done.

What I didn’t guess then, but have since come to understand, is that I soon began suffering with a form of traumatic stress syndrome—something that in recent years has acquired the name of “secondary traumatic stress” or “compassion fatigue.” My appetite became unpredictable, and my sleep was chronically disturbed. (Constantly rotating shifts heightened the latter problem, of course.) My thinking was dull, my concentration lagged, simple decisions became complicated, and so my ability to assess and care for my patients was eventually impaired.

I also was miserable much of the time. I dreaded coming to work and “explored” rather desperate options. Getting admitted to a critical care unit, myself, somehow seemed preferable to being on the other side of the equation—part of a mechanistic team that that doled out life-saving heroics to bodies without voices—a team that compartmentalized their lives and anesthetized their feelings, “delivering” “care” to “patients” who were often deprived of their histories, preferences, memories, dreams, desires.

The pain with which I struggled was as invisible to me as it was to the nurses surrounding me—and no less so to supervisors and most other caregivers who filled the halls of the large university hospital where we worked. Or, if it wasn’t invisible, it was certainly never discussed. In fact, during the 30 years that followed, I do not once recall a discussion or even the mention of a concept like compassion fatigue or secondary trauma in the context of nursing care. Only the term “burnout” was familiar—an abrasive word that still evokes for me a spent cigarette butt crushed on stained pavement. Burnout indeed was rampant: a bitter end to human caring, a reason I saw nurses leave the hospital and the profession, trying hard not to look back.
Nurses with bills to pay, however, could not walk away so fast, no matter how burned out they were. I had just spent four years preparing to do something I found made me want to die. Now what? A prevailing explanation at that time for new nurse burnout was a problem called “reality shock” (Kramer, 1974)—the clash of cultures experienced by a new generation of professionally trained graduate nurses when they left the ivory tower of academic education and arrived at their first hospital job. I was such a nurse, having completed a four-year BSN degree with honors at a school that became the first College of Nursing in the country. I got my hands on Kramer’s book and tried to read it: aside from the appallingly juvenile and condescending cartoon illustrations it featured throughout, the book presented me with just one conundrum: it conveyed not a shred of insight into the quality of experience I was having. Rather, it attempted to reduce the major suffering of all new nurses to a clash of imbued values and bureaucratic demands.

Far from helping me, the book left me feeling more desperate and alone. So I tried “advancing my education,” but rotating shifts made class attendance problematic. And, the courses seemed tedious: perhaps I was too exhausted and depressed to undertake the mental effort required. I tried advancing my workplace relationships, but found that regularly meant drinking to excess, which I soon concluded made me feel even more miserable. Desperate, I tried advancing my spiritual quest, and this led me to begin reading anything I could get my hands on that seemed to comprehend my existential misery— theology, philosophy, classic literature, and even contemporary fiction.

It was then I stumbled onto a novel that may have saved my life: The House of God, by Samuel Shem (1978).

This biting, satirical novel about “life and death in an American hospital” directly addressed the context and the substance of my outrage and suffering. Shem’s story was bizarre but real, self-effacing, and profound. It mirrored my inner world and helped me begin to
constitute something more coherent from my desperate perception of drowning—something not present in my awareness before. It planted an idea that my experience could be approached and understood in a variety of ways—among them, most simply, as a story. A story that was hidden and complex, but one that had value. A story that was unfolding and ripe with possible meanings.

The fact that *House* primarily described the experience of a new doctor, not a new nurse, was irrelevant to me. It was the story of one who sought to care and was overwhelmed by social, emotional, and institutional forces in an environment that could not comprehend the conditions required for human caring. The rawness and harsh honesty of Shem’s imagination reflected back to me something powerful and essential about my own experience. In so doing, it transformed my sense of isolation, shame, and mute grief into solidarity, dignity, and utterable mourning—an experience of mourning in search of a witness and a sufficiently expressive art form to give it meaning and purpose.

Yet four years later, when I had begun a trajectory of study and practice in the literary fine arts, I began to distance myself increasingly from my life as a nurse. Within another four years, I was writing professionally and publishing occasionally. I went on to raise children and, though I maintained a toehold in healthcare, it was as a health writer and administrator. I assiduously avoided anything directly involving the practice of nursing…for 25 years.

What brought me back was a combination of curiosity and, yes, the need for a job. I wondered: Had the field changed? What had been the experience of other nurses through the years? Moreover—had I changed? *What had happened to me* so many years ago? Did I even know? Did I have the strength to take another look…with new eyes, perhaps?

It was about this time that I began the dissertation-stage of my work toward a PhD in adult education. More than 30 years had passed since my coming-of-age immersion in critical care. So once again, I read *The House of God*, and this time I laughed and cried more freely than before.
So it is that I have found within myself the strength to stay with my curiosity and follow through on my questions. I have, finally, found a way to be a nurse while resisting being “a good nurse” who follows orders and doesn’t rattle anyone’s cage. I have continued to find solace in both literary arts and philosophy, and to draw on them throughout this work. And so it is that this dissertation is an analysis and a story of three critical care nurses’ grueling experiences.

And it is a continuation of my own story.
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DEDICATION

This work is dedicated to:

Will, Arielle, and Ryan: magnificent people I’m privileged to know as my kids

Mark: a good doctor

Jeff Ritchey (1963 - 2014):
an inspirational teacher and friend,
without whom I would not have begun this journey

“Uncle Dan” Walden (1922 - 2013):
a mentor, friend, and beacon of light,
without whom I would not have found the strength to finish it

Yvonne, Constance, and Holly
and nurses everywhere.
And so, without even suspecting the danger, I fell prey to...the notion that there is such a thing as a detached researcher, that it is possible to discover and analyze and interpret without getting caught up and swept away...that I was going to climb up into that attic...and figure Moses Washington out, and once that was done, I was going to climb back down and go on about my merry way, unaffected, unchanged, unharmed.

—David Bradley, 1981, The Chaneysville Incident, p. 140
CHAPTER ONE
INTRODUCTION TO THE RESEARCH

I stood in the steamy heat outside a huge urine-colored building which a sign said was THE HOUSE OF GOD. A ball and chain were demolishing one wing…. Feeling like the ball and chain were swinging back and forth inside my skull, I entered the House and searched out the “function room.” I sat down as the Chief Resident, named Fishberg and nicknamed the Fish, was giving a welcoming speech. ... He was the liaison between the interns and everyone else, and he “hoped that you will come to me with any problems you might have.” ... Shifty, slimy, he oozed. Too cheerful. Not in touch with our dread....

“...and now it gives me great pleasure to present the Chief of Medicine, Dr. Leggo.” ...

[A] thin, dry-looking little man...walked stiffly to the center of the speaker’s table....

“The House is special,” said the Chief. “... I want to tell you a story...that showed me how special the BMS [‘Best Medical School (in the world)’] and the House are. It’s a story about a BMS doctor and a BMS nurse....”

My mind wandered. ... Neither the Fish nor the Leggo seemed to have a firm grasp on what went into being a human being.

The other speakers were more human. ... [T]he House Psychiatrist, a sad-looking man with a goatee, turned his pleading eyes on us and told us that he was available to help. Then he shocked us by saying:

“...Each year the graduating class of at least one medical school—maybe two or three schools—must step into the ranks just to replace colleagues who commit suicide—”

“HAA—RUMPH! HAAA—REMMM!”

The Fish was clearing his throat. He did not like this talk about suicide and was clearing his throat of it.

“—and even year after year right here in the House of God we do see suicides—“

“Thank you, Dr. Frank,” said the Fish, taking over, greasing the wheels of the meeting again so that it could roll on....


Background

Good research is as much an art as a science, and the finest literary artists may be counted among the finest qualitative researchers. Specifically, they are fine phenomenological researchers. Like Shem (a.k.a. Stephen Bergman, MD), they are capable of effacing experience: unfurling its
complex constitution and exploring the interior and exterior landscapes where structures of
meaning are synthesized—not just in the mind, but in the body, in geographical and historical
locations, and across the relationships and social institutions we embrace through our lives.

One of the central insights emerging from the last century in the philosophy of science is a
growing appreciation for the essential positionality and (therefore) relativity of knowledge itself
(Kuhn, 1970; Lewontin, 1992; Okasha, 2002). Like art, science is situated. Its truths—even its
laws—bend and morph to an extent depending on where a researcher is located. The articulation
of this insight can be traced as much to the work of breakthrough philosophers like Edmund
Husserl as to breakthrough scientists like Albert Einstein.

The present research explores this insight through the traditions of phenomenological
philosophy and critically informed psychodynamic learning theory. I strive to do so using a touch
of art as well as a good measure of science, but the process must also be grounded in self-
disclosure. For as the principal investigator in this study, my theoretical framework obliges me to
acknowledge salient personal, social, cultural, and historical dimensions of my experience
explicitly throughout the presentation of this work, so as to render it more accessible to critique
and interpretation. This is a necessary response to recognizing the relativity and positionality of
knowledge—and scholarship. Attempting to articulate the personal “lens” through which my
research is conceptualized and executed is a necessary step to enable others to evaluate,
challenge, and perhaps build on the methods and conclusions of this work.

Thus, I will provide throughout the succeeding chapters windows to my history, as it
shapes the constitution of meanings in this work. My academic journey has been grounded in a
post-positivist, critical, and interpretive framework of inquiry. From my earliest university years,
I was encouraged to question the basis for the knowledge I was being taught. This was so not only
for my studies in the social sciences and humanities, but in the science of nursing practice as well.
My bachelors program in nursing in the late 1970s emphasized a critical awareness of the constructs on which clinical nursing practice was built. We were taught the meaning of a theoretical framework and were implicitly given to understand that the roots of nursing knowledge within the medical model required continual interrogation.

Newman’s nursing theory of “Health as Expanding Consciousness” was developed in this period (Newman, 1994; Pharris, 2011; Smith, 2011) and reflects a similar constructivist vision. Newman’s work, in turn, has commonalities with major learning theories such as Engeström’s (1999, 2008, 2015) activity-centered theory of “learning by expanding” and likewise bears resemblance to Mezirow’s (1991, 2000) and Kegan’s (1982, 1994) theories of transformative learning, which also have their roots in the late 1970s. Mezirow and colleagues, along with many adult education scholars of the last half-century, were in turn heavily influenced by the philosophical tradition of critical theory, particularly work by Habermas (1979, 1984, 1989) and the Frankfurt School (a.k.a. the Institute for Social Research). Critical theory has thus explicitly shaped my thinking for more than a decade.

**Problem Statement**

The present research explores a dimension of nursing practice that is commonly neglected, to the serious detriment of nurses and their profession: the experiences of so-called compassion fatigue and secondary traumatic stress. Thirty-five years ago, the *Diagnostic & Statistical Manual of Mental Disorders (DSM) III* first formalized post-traumatic stress disorder (PTSD) as a discrete and treatable affliction of the mind, body, and emotions (APA, 1980). Fifteen years later, a seminal volume appeared, *Compassion Fatigue: Coping with Secondary Stress Disorder in Those Who Treat the Traumatized* (C. R. Figley, 1995) that opened a new trajectory in the emerging field of traumatology. Yet today, more than 20 years later, compassion
fatigue (CF) and secondary traumatic stress (STS) are still emerging as research areas outside the psychotherapeutic disciplines and remain unfamiliar concepts to many groups of helping professionals, including many nurses. This is so in spite of consistent U.S. government data indicating that healthcare professionals, including nurses (the largest subgroup within the healthcare labor force), are more likely than any other category of worker to encounter physical and emotional trauma in the workplace (Bureau of Labor Statistics, 2007, as cited in Gates & Gillespie, 2012).

With respect to nursing practice, in particular, research on secondary traumatic stress (STS) has only recently gained traction. Emergent research indicates that more than 30% of practicing nurses typically display symptoms of STS, at rates that are two to four times the incidence of primary traumatic stress disorders in the general population (C. R. Figley, 2012; Gates & Gillespie, 2012). Until recently, however, the small body of scholarship on STS in nurses remained preliminary in nature and was under-theorized to the point that even fundamental concepts and definitions remain contested more than 20 years after the first articles appeared on the topic (Joinson, 1992; Sabo, 2011). This state of affairs reflects a similar problem in the broader literature of STS among practitioners in other therapeutic disciplines. Further, Rothschild and Rand (2006) noted that psychometric research scales for CF and STS are limited, a situation that has improved somewhat in the intervening decade. Other scholars, however, have questioned the suitability of existing scales being applied to such a wide range of helping professionals in such a variety of therapeutic contexts (Boyle, 2011; S. R. Jenkins & Baird, 2002; Watts & Robertson, 2015).

Stamm and colleagues (Stamm, 2010) have produced the leading psychometric instrument for measuring the constructs of compassion satisfaction and compassion fatigue, including STS and burnout (BO) as subscales of CF. Known as the Professional Quality of Life Scale (ProQoL),
which is now in its fifth major revision, this tool is theoretically rigorous and has been tested extensively. Yet psychometric scales, by their nature, offer limited explanatory value for understanding phenomena as complex as primary and secondary traumatization. Such tools can generate a sketch from individualized “snapshots” of descriptive data on a phenomenon, but they are intrinsically constrained—temporally, relationally, and experientially—rendering them a rather blunt instrument for dissecting the intricate activities of consciousness that flow across horizons of perception, memory, and imagination. Even when administered and analyzed longitudinally through a series of measures over time, psychometric data is not capable of illuminating the complex, nuanced contours of mental life as it is embodied, socially situated, historically structured, dynamically reconstituted by particular caregivers in particular lifeworlds. Moreover, from the perspective of research sensitivity to the needs of participants, the administration of standardized survey instruments may not incorporate sufficient supportive or protective benefits to those participating in STS research. Such research thereby runs the risk of being insufficiently attentive to ethical obligations to protect the wellbeing of participants while eliciting data about their responses to traumatic exposure.

**Purpose Statement**

The purpose of this study is to illuminate the phenomena of secondary traumatic stress—that is, of “bearing witness” to others’ suffering—as well as modes of learning that may operate to protect and psychologically sustain those who bear witness. The research strives to fulfill this purpose through analysis of detailed intersubjective qualitative data in a manner that is critically engaged and psychodynamically enriched, and it probes the phenomena as they are described by a triad of registered nurses whose work exposes them frequently to intense physical and psychological suffering in their patients and patients’ families. The study is constructed around a
methodology that not only probes the kinds of resistance, contradictions, and vulnerabilities inherent in all trauma research, but which further attempts to transcend stated epistemic goals and provide a degree of psychic protection and support to the nurses who participated. Given the nature of traumatization and the risk of engendering re-traumatizing “echo effects” within the research process itself, I found such an approach ethically necessary.

Ultimately, the present study aims to advance a more useful conceptual understanding of secondary traumatic stress (STS) as it is experienced among registered nurses. Specifically, the study employs a psychosocial learning lens drawn from psychoanalytic and critical theory scholarship, in order to examine nurses’ responses to traumatic exposure as a type of situated learning activity. This perspective is in contrast to the dominant paradigm present in much of the STS literature, which derives from the medical model and places STS on a continuum of mental pathology that may (depending on severity of “symptoms”) require diagnostic and treatment interventions. Although it is well established that clinical depression, acute anxiety syndromes, and PTSD do manifest among nurses and other caregivers who work with heavily traumatized patients (Gates & Gillespie, 2012; Janda & Jandova, 2015; Mealer, Burnham, Goode, Rothbaum, & Moss, 2009; Roldán, Salazar, Garrido, & Ramos, 2013; Valent, 2002; Westphal, 2012), this recognition does not preclude a complementary approach to caregivers’ experiences that explores and elicits their capacity for innovative and adaptive learning. Moreover, such learning need not be conceptualized within formal settings only, such as classrooms, continuing education courses, psychoeducational “intervention” programs, or even scheduled critical incident stress debriefings (CISDs). On the contrary, the study explores how powerful and transformative kinds of learning may be cultivated—or stifled—subtly and implicitly throughout the daily flow of caregiving routines and caregiver relationships in clinical settings.
Adult education scholarship has developed a robust set of theoretical constructs for understanding critical, socially mediated, psychodynamic dimensions of informal learning as human activity that engages not just the mind, but the physical body, the emotions, and the cultural “lifeworld” as well (Bainbridge & West, 2012; Berry, 1990; Britzman, 1998, 2006; Fenwick, 2000, 2003, 2010, 2014; Forester, 1999b; Freire, 2005, 1973; Horton & Freire, 1990; Illeris, 2003b, 2010; Lave, 2012; Rule, 2004). My analysis of the empirical data generated by this study will be built on such scholarship.

**Research Questions**

This research seeks to answer the following questions:

1. What is the experience of a particular triad of registered nurses (“nurses”) who have practiced for at least six months in clinical settings where they are routinely exposed to primary traumatic suffering in patients to whom they provide direct care?
   1.1. What memories, sensory perceptions, and bodily sensations do they describe in characterizing their experiences?
   1.2. What stories do the nurses share and how do these stories develop over time?
   1.3. How do the nurses respond to each other as they describe their experiences?

2. How do these particular nurses conceptualize and articulate their secondary forms of suffering across time, individually as well as in relationship to other nurses with whom they share similar clinical conditions of caregiving?
   2.1. What language do they use to organize and constitute their experiences?

3. Do these nurses undertake forms of learning over time, in response to their experiences of bearing witness to suffering among their patients?
3.1. How do the nurses develop successively changing perspectives and responses to their experiences, both individually and in relationship with others?

3.2. Do the nurses learn to protect themselves from secondary forms of traumatic stress or suffering? If so, how does such learning occur?

3.3. Do the nurses learn to sustain themselves through short- or long-term effects of secondary traumatic stress or suffering? If so, how does this occur?

**Specific Aims**

This research seeks to accomplish the following objectives:

1. Elucidate in richly descriptive, evocative, and nuanced detail the structures of experiences evident among a purposively selected triad of nurses who have been exposed to significant traumatic suffering in patients to whom they provide direct care.

2. Using these descriptive phenomenological accounts, advance the conceptual understanding of secondary traumatic stress (STS) and related constructs identified in the scholarly literature, as they are evidenced among these nurses:

   2.1. Differentiate among related concepts of traumatic stress that are often discussed concurrently or as equivalents in the scholarly literature, including compassion fatigue (CF), burnout, and vicarious traumatization (VT) in relation to secondary traumatization (ST) and STS.

3. Elucidate dynamic modes of learning, including embodied and relational activities, which are evidenced over time and in social encounters among these nurses as they focus on their experiences of STS or conceptually related syndromes.

4. Elucidate obstacles to learning that are evidenced or described among these nurses prior to and during the course of the research.
Definitions

I follow a variety of scholars in my definitions of terms, and will employ these syntheses:

**Trauma:** Major upheavals, life-threatening events, or sudden catastrophes that create significant loss and suffering (Valent, 2012a, 2012b), which are characterized by a quality of felt significance that resists one’s attempts at comprehension and meaning-making even as the emotional force of the event(s) are felt (Pitt & Britzman, 2003).

**Primary traumatization (PT):** Physical, emotional and/or mental pain or suffering experienced by individuals or groups in response to their *direct* exposure to traumatic events; PT creates a risk of PTSD in the affected person(s).

**Secondary traumatization (ST):** Physical, emotional and/or mental pain or suffering experienced by individuals or groups, in response to their *indirect* exposure to traumatic events, such as living or working in close proximity and/or close relationship with people who have undergone direct traumatic exposure; ST is often used synonymously with STS.

**Vicarious traumatization (VT):** An experience of strong identification or solidarity with people who have undergone direct exposure to traumatic events, which may or may not involve close proximity or intimate relationships between the person(s) experiencing VT and the directly exposed individual or group; VT creates a heightened risk of STS in affected person(s).

**Secondary traumatic stress (STS):** Traceable and sustained physiological, emotional and/or psychological stress effects, demonstrated in individuals or groups who have undergone secondary traumatic exposure, with or without a perception of secondary traumatization.

**Compassion fatigue (CF):** Natural behaviors and emotions that arise from knowing about a traumatizing event experienced by a significant other; specifically, the stress and fatigue resulting from helping or wanting to help a traumatized or suffering person (C. R. Figley, 1995).
**Burnout syndrome** (BOS; also burnout): A state of pronounced and persistent exhaustion characterized by traceable and sustained physiological, emotional and/or psychological stress effects, demonstrated in individuals who are exposed to primary or secondary traumatization over an extended period of time and/or in multiple repeated contexts.

**Occupational stress** (OS): An employment-based form of stress characterized by traceable and sustained physiological, emotional and/or psychological stress effects in workers, where precipitating factors are perceived primarily to involve occupational responsibilities and power relations, to which workers perceives they have limited agency, influence, or control.

**Learning**: Following Fenwick (2000) predominantly, a situated, embodied, socially-mediated, and conflict-laden activity that presents traceable developmental moments in consciousness, characterized by discernible differentiation or successive change, or minimally, that manifests a discernible initiation of change within an individual’s or group’s perception of, way of being in, way of making meaning from, and/or way of interacting with their lifeworld.

Note also that a glossary of medical terms used throughout the document appears in Appendix G.
CHAPTER TWO

TRAUMATOLOGY AND SECONDARY SUFFERING:

WRITING TO RECLAIM EXPERIENCE

Law I of the House of God: Gomers don’t die.

As I walked onto ward 6-South the next morning, my fear tempered by expectation, I saw a bizarre sight: Potts sat at the nursing station, looking like he’d been shot out of a cannon, his whites filthy, his straight blond hair tangled, blood under his fingernails and vomit on his shoes, his eyes pink, a sick rabbit’s eyes. Next to him, strapped to a chair and still wearing the Rams football helmet, was Ina. Potts was writing in her chart. Ina freed herself, screamed: GO AVAY GO AVAY GO AVAY ... and took a swing at him with her left fist. Enraged, Potts—gentle Moliere-perusing Potts of the Legare Street Pottses—screamed: “Goddamnit, Ina, shut the hell up and behave!” and shoved her back down in her chair. I couldn’t believe it. One night on call, and a Southern gentleman had become a sadist.


This review of scholarly literature explores both theoretical and empirical research on secondary suffering among helping professionals who, like Potts, sometimes find themselves undergoing a similar quality of experience as the traumatized patients for whom they care. The incidence and correlates of secondary traumatic stress (STS) are gaining attention slowly outside the psychotherapeutic disciplines, and though scholarship remains sparse, it is growing. This is particularly so in the field of nursing, where the literature is now expanding more steadily.

In the following pages, I present a brief history of the field of traumatology, followed by a survey of nearly three decades of literature on secondary forms of traumatization with a focus on practicing nurses. Because of the persistently evolving and emergent state of theory in the field, this review emphasizes an analysis of the discourse surrounding STS along with a careful
examination of several closely related concepts, including compassion fatigue (CF), burnout (or burnout syndrome), vicarious traumatization (VT), and some less prominent concepts such as occupational stress (OS). Further, because of the conceptual flux present in the literature, this survey does not undertake a comprehensive systematic review, but rather engages the major strands of scholarship in order to summarize emerging trends in the research about STS among nurses. Accordingly, I present a broad critical analysis of work dealing with the constellation of stress-related syndromes, as they have been studied in nurses. I critique a number of assumptions that are frequently evident, particularly in the theoretical literature on CF and STS. In the final section, I survey articles presenting intervention programs aimed at ameliorating the effects of CF and STS. This provides a sketch of the current state of educational practice in response to STS and segues to chapter three, where I present a psychodynamically enriched theory of learning.

**Background**

The term compassion fatigue (CF; often used interchangeably with the term secondary traumatic stress, STS) has received considerable attention in the nursing literature in recent years. That literature, however, is embedded in a wider one dealing with a variety of psychological stress syndromes (Figley, 1995, 2012; Valent, 2002). Broadly speaking, these syndromes have been conceptualized in a variety of ways that include: burnout syndrome (e.g., Bakker, Le Blanc, & Schaufeli, 2005), post-traumatic stress disorder (PTSD; e.g., Mealer et al., 2009), secondary traumatic stress disorder (STSD; e.g., Figley, 1995), vicarious traumatization (VT; e.g., McCann & Pearlman, 1990; Tabor, 2011), and occupational or organizational stress (OS; e.g., Bloom, 2006). Capturing a distinct body of literature addressing the central phenomenon of CF and STS among a specific group of professionals is therefore problematic. For example, with regard to nurses, Beck’s (2011) systematic review of research on STS in nurses identified only seven
relevant articles over a 30-year period, despite the use of multiple databases and search terms. My initial 2012 search, by contrast, identified 13 articles with similar (but not identical) inclusion and exclusion criteria. Further investigation through secondary references yielded nearly 50 articles, more than half of which were published before 2010. Although I cast a somewhat wider conceptual net in that search (including the associated syndromes of burnout, CF, and VT), the results nonetheless demonstrated troubling inconsistencies in conceptual formulations of the topic, complicated by persistent metamorphoses in the use of terms and their definitions, leading to quite variable results in published systematic reviews and concept analyses.

The broader literature on STS among various types of helping professionals is, in turn, embedded within a now vast literature on traumatology. That field, which emerged in part from efforts to provide better psychosocial therapies to war veterans (such as in the aftermath of the Vietnam War), is marked by a powerful reflexive quality—an almost inescapable intertwining of intellectual subject matter with the emotional experience of trauma (and secondary trauma) itself. Valent (2012a) wrote that trauma is “overwhelming and unthinkable; its wordless energy resides in the deep recesses of the human mind” (p. 39). To the extent that traumatology has been a difficult field to advance conceptually, this is doubtless one reason: It is not an area of study that indulges clinical or theoretical detachment, but draws scholars into its penetrating grasp:

Trauma is the nemesis of our lives. Sometimes it swamps us; at other times it haunts us. It is the fracture that stops us from running as we would wish. The word trauma comes from the Greek word meaning wound, or penetration, as in stabbing. …[I]t always leaves a scar and a vulnerability. (Valent, 2012b, p. xxvii)

Those who work in this field are almost universally scholars and practitioners who have personally experienced some significant form of trauma (e.g., Figley, 2002; Levine, 2009a; Valent, 2002, 2012b). In many cases they are motivated to help others as they work to heal themselves. Yet as Pitt and Britzman (2003) showed, the very nature of trauma is “characterized
by a quality of experience that resists interpretation even as the affective force of the event can be felt” (p. 758). In the language of Caruth (1991, 1996), trauma creates “unclaimed experience,” a tendency to distance and dissociate from one’s own traumatic encounters in the lifeworld. This phenomenon makes empirical investigation of trauma—even theoretical work on the subject—exceptionally difficult to advance. Yet it also marks the field as one that demands self-reflective work on the part of scholars along with determination to penetrate their own mental resistance and to access the affective power of traumatic events. In other words, trauma studies are necessarily a kind of writing to reclaim experience—one’s own as well as that of people whose experiences comprise the research data. The present research has made such demands too (see chapter five).

**Evolution of Trauma Theory**

The recognition of both primary and secondary psychic effects of trauma is as old as civilization. Figley (1995) noted that the earliest extant record of trauma studies “can be traced to … medical writings in Kunus Pyprus … in 1900 BC in Egypt” (p. xiii). Hippocrates recognized emotional trauma from “violent alterations” in life circumstance to be one of the forces that create disease (Dubos, 1968, as cited in Figley, 1995, p. 22). The ancient Greek poet Homer situated both direct and indirect traumatic effects of war centrally within his epic poems of the Trojan War and its aftermath. His poignant depictions of emotional traumatization, contrasted with pastoral descriptions of rural Greek life, still offer an incisive polemic against war and help to explain why these poems remain compelling literature—and Hollywood material as in the film, *Troy* (Peterson, 2004). In contemporary life, explorations of primary and secondary emotional trauma are found across popular culture, from the 1970-80s television series *M.A.S.H.* to *ER* in the 80s-90s to, more broadly, *Lost* a decade ago. Less commonly, fiction like Shem’s (1978) probes the topic, though in the case of nursing narratives like Anderson’s *Nurse* (1978) or Heron’s series of
books (1987, and others) the level of urgency, artful complexity, and depth needed to convey the emotional violence of traumatic exposure tend to be lacking.

**Primary Traumatization**

In terms of scholarly literature, however, systematic explorations of trauma and its after-effects were uncommon before the 1970s. The field grew out of the psychotherapeutic disciplines where clinicians often deal with emotionally traumatic effects on victims of domestic violence, civil conflict, natural disasters, terrorism, and war. In 1980, the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM-III; APA, 1980) formally recognized a syndrome of primary traumatization for the first time: post-traumatic stress disorder (PTSD). In the context of war veterans, this had long been known by such names as “battle fatigue” or “shell shock.” It was endured in families and treated with limited success by family doctors (and occasionally psychiatrists), but the long-term effects of PTSD had not been a subject of systematic study. Its diagnostic classification was therefore seen as a landmark, establishing the field of traumatology.

It was clinical scholarship of the preceding decades, however, that had paved the way for this classification. That work included case studies and brief publications describing secondary as well as primary traumatization. For example, the gradual emergence of literature following World War II addressing the European Jewish Holocaust demonstrated not only the long-term effects of direct or primary traumatization upon survivors, but profound indirect or secondary traumatic effects among extended Jewish families and communities, even encompassing multigenerational impacts in families where the experiences of survivors had never been discussed (Kaplan, 2002; Rowland-Klein & Dunlop, 1998). Not unlike the trauma associated with incest and war, the
trauma endured by Holocaust survivors had long remained stigmatized and taboo, even in mainstream American healthcare (e.g., Baider et al., 2000; Levine, 2009a).

From a contemporary vantage point, however, it was experiences shared by Vietnam veterans and their families that catalyzed significant change in American perceptions of and responses to traumatization. Scannell-Desch (1992) is a registered nurse (RN) who enlisted in the Air Force in the early 1970s to serve as a flight nurse in combat zones during the last years of the Vietnam War. She later carried out one of few phenomenological investigations of military nurses who served in Vietnam. Her keen awareness of indirect emotional trauma experienced by these nurses was only recognized slowly among military leaders’ in the decades that followed. In 1989, the Congressional Research Service released a Report for Congress, *Post-Traumatic Stress Disorder in Vietnam Veterans* (Cooper, 1989)—but this appeared a decade after the first scholarly book appeared on the topic, Figley’s (1978) *Stress Disorder Among Vietnam Veterans*. That work, too, was a landmark credited with helping to establish the field of traumatology and influencing the DSM-III (APA, 1980) classification of PTSD published two years later.

As early as the 1960s, however, some psychiatrists and trauma scholars began alluding to secondary forms of trauma as an area of concern. Particularly notable in this regard are such works as the *Children of Crisis* series by Robert Coles (1967a, 1967b, 1967c) and the *Women of Crises* series by Coles and his wife, Jane Hallowell (Coles & Coles, 1989, 1990), along with early work by psychiatrist Judith Herman dealing with sexual traumatization (Herman & Hirschman, 1977) and books by psychoanalyst Alice Miller (1983, 1984, 1990a) dealing with direct and indirect forms of childhood trauma. By the 1990s, a new generation of helping professionals were entering practice, for whom the validity of trauma-related suffering was beyond speculation. It is notable that although Herman’s early work on incest and childhood sexual victimization was attacked by some scholars as “feminist” and overdrawn, she was nonetheless successful in
opening the way for a body of rigorous research on trauma among women—a literature that has grown and helped to reshape the landscape of women’s health (e.g., Chesler, 2012; Seaman & Eldridge, 2012).

As recognition of trauma grew across the psychotherapeutic disciplines, and provision of care steadily expanded in response, so grew the experience of secondary traumatization and stress among psychotherapists and other caregivers who became exposed indirectly to the traumatic experiences of their patients and clients (e.g., Sabo, 2006, 2011; Valent, 2002) Valent (2012a) a practicing psychiatrist and trauma researcher wrote about this phenomenon as a form of “bearing witness”:

Helpers and healers have always been privy to people’s sufferings and traumas…. Traumatology arose as the discipline whose concern was when, where, and how [psychic] wounds were to be witnessed, and what to do about them. In time, traumatology came to consider the cost to helpers of tending such wounds. (p. 38)

Thus, by the 1990s, with the field of trauma studies well established, it was no leap for the psychotherapeutic disciplines to examine and respond to traumatic stress in their own ranks.

**Secondary Trauma among Caregivers**

One of the earliest references to this phenomenon in the scholarly literature is by McCann and Pearlman (1990), who established the term “vicarious trauma” (VT), drawing on constructivist self-development theory (CSDT) for their framework. In the *Encyclopedia of Trauma*, Pearlman (2012) explained that they “coined this term…with specific reference to the experience of psychotherapists working with trauma survivor clients” (p. 783). Here, she attempted to differentiate VT from the other terms with which it has been associated:

Unlike *compassion fatigue*, VT is a theory-based construct. This means that observable symptoms can serve as the starting point for a process of systematically identifying contributing factors and related signs, symptoms, and adaptations…. Unlike *burnout, countertransference*, and *work-related stress*, VT is specific to trauma workers…. 
Work-related stress is a generic term without a theoretical basis, specific signs and symptoms or contributing factors, or remedies.… Secondary trauma … is different from VT in that the secondary trauma victim has a personal, rather than a professional, role with the primary survivor. (p. 784)

Having originally “coined” the term VT before Joinson (1992) or Figley (1995) introduced CF or STS, Pearlman seems intent on redirecting the scholarly discussion back to the roots of its nomenclature. Yet her stance above, written more than two decades into the development of a field that has been animated by ever more diverse scholars and concerns, provides limited value because she does not seem to appreciate the dynamic evolution of such nascent terms and—to draw on a Derridean philosophical perspective—their persistent iterability (Derrida, 1976, 1977, 1978, 2007). Unfortunately, it is unlikely that terms can be delineated so unilaterally, much less imposed on a global field of scholarship that now spans numerous realms beyond the psychotherapeutic disciplines.

Scannell-Desch (1992) used none of these terms in her original study of military nurses in Vietnam, though her findings implicated them. It was in the same year she published that research that Joinson (1992) published a brief report, “Coping with Compassion Fatigue,” which coined the term CF. Coetzee and Klopper (2010) explained its context and subsequent evolution:

Joinson…was investigating the nature of burnout in nurses in an emergency department and noticed that nurses in the unit seemed to have lost their “ability to nurture” (Joinson, 1992, 119). Joinson never formally defined the concept and, in 1995, it was adopted by Figley as a more “user-friendly term” for secondary traumatic stress disorder (STSD) (Figley, 1995). However, the synonymous use of compassion fatigue with STSD is far removed from Joinson’s original impression. (p. 235)

Stamm (2010), the lead developer of an extensively revised quantitative scale for measuring CF and STS, explained that the year 1995 marked a cornerstone for investigation of this constellation of stress syndromes. In that year,

three books introduced the concepts of the negative effects on caregivers who provide care to those who have been traumatized. The terminology was at that time, and continues to
be, a taxonomical conundrum. However, since that time, Figley, Stamm, and Pearlman together have produced over 50 additional scientific writings on the topic. Casting a broad net across the topic, over 500 papers, books, and articles have been written, including nearly 200 peer-reviewed papers, 130 dissertations along with various unpublished studies. (Stamm, 2010, p. 9)

Of the three books, neither Stamm’s text, Secondary Traumatic Stress: Self-care Issues for Clinicians, Researchers, and Educators (1995) nor Pearlman’s, Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors (1995) found the diverse audience and sustained recognition as did Figley’s (1995) edited volume, Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized. Interestingly, it was Figley who adopted Joinson’s term for his title because of its intuitive “user-friendly” quality. His text brought together work by 20 practicing scholars to offer a preliminary theoretical framework for CF/STS, and he is most widely credited with establishing this new trajectory of research within trauma studies.

As Stamm (2010) indicated, the field expanded rapidly across the psychotherapeutic disciplines, for it raised the profile of an already existing concern while simultaneously validating the observations and experiences of many clinicians and researchers. This is evidenced in the fact that, only months before the release of all three books, secondary traumatic stress disorder (STSD) appeared for the first time in the fourth edition of the Diagnostic and Statistical Manual (DSM-IV; APA, 1994) as a new classification distinct from PTSD. Clearly the construct of STSD had long been under theoretical and diagnostic consideration.

Construct evolution. Figley (1995) and others preferred the term CF over the APA’s diagnostic label STSD, for it was “more reflective of [clinicians’] lived experience” with its implicit notion about the “cost of caring” (Sabo, 2006, p. 138). Moreover, it seemed preferable to the highly pathologized DSM-IV label with its unsettling parallels to PTSD. Yet even as he
contended that CF is a “natural” empathic response and not a “disorder,” Figley (1995)

unfortunately aligned CF and STS from the beginning. He initially defined CF as:

the natural behaviors and emotions that arise from knowing about a traumatizing event
experienced by a significant other—the stress resulting from helping or wanting to help a
traumatized or suffering person. (p. xiv)

Yet he promptly added that CF “is identical to secondary traumatic stress disorder (STSD)” in
terms of its symptomatic course and recommended treatments, and further stated that it “is the
equivalent of PTSD” (p. xv). Unfortunately, equating all three terms in this way sowed early
seeds of confusion and concept redundancy in the formation stages of the field of study. Nor did
conceptual progress ensue in the 15 years that followed. Sabo (2011) summarized the situation in
this way:

What becomes apparent in reviewing the literature on possible adverse effects of
providing care is the level of complexity underlying the various types of occupational
stress. This may be due, in part, to the relatively preliminary understanding of compassion
fatigue and vicarious traumatization, concepts that began to emerge only in the 1990s…. As
of this writing there is no research to support a claim that any or all of these types of
occupational stress are concept redundant or interrelated. Sufficient evidence exists to
demonstrate the validity of each as a distinct concept. What is not known is the role each
may play in the development of the other. (p. 8)

(p. 9). He and colleagues acknowledged that their science was in “a ‘pre-paradigm state,’ as
defined by Kuhn (1962, 1970)” (Figley, 1995, p. 6). Indeed, they were writing not only in the
context of a brand new field of study but also within a brand new psychiatric classification. Yet it
is of serious scholarly concern that today—more than two decades later and despite growing
numbers of published empirical studies, literature reviews, and general concept analyses of
burnout, CF, STS, and VT—little progress is evident in terms of clarity or consistency of terms,
the scope of the constructs, or their conceptual relations. Further, no consensus is discernable on
the horizon (e.g., Coetzee & Klopper, 2010; Ledoux, 2015; Sheppard, 2015). In 2012, Figley and
colleagues addressed this problem in the first edition of the *Encyclopedia of Trauma: An Interdisciplinary Guide*. Under the entry for “Compassion Fatigue,” for example, Mathieu (2012) wrote explicitly:

Lack of agreement on terminology has clouded scholars’ ability to carry out effective literature reviews, as many different terms are used interchangeably to refer to compassion fatigue…. Even leaders in the field do not always use the terms with consistency…. Newer work on the topic suggests that compassion fatigue, burnout, secondary traumatic stress, and vicarious trauma are complementary terms that can affect a helper simultaneously, but that it is also possible for a caregiver or helping professional to experience one without the others. …Lack of agreement on definitions is a problem that needs to be addressed.  (2012, pp. 137-138)

Tabor (2011) engaged these contradictions when undertaking her research on STS among forensic nurses. She opens with a directive approach reminiscent of Pearlman (2012), asserting that the terms burnout, CF, PTSD, and STS have all “been incorrectly interchanged with the term vicarious traumatization” (p. 203). She then briefly reviewed published work on each term and offered definitions that are somewhat grounded in scholarship and augmented by her own insights. Her article took shape as an effort toward concept advancement, in which she developed a concept map to illustrate her assertion of a functional set of relationships among the various constructs, culminating with VT as she theorized it.

This literature-based model was published concurrent with Sabo’s (2011) expressed concern that no research to date can “support a claim that any or all of these types of occupational stress are concept redundant or interrelated,” much less what “role each may play in the development of the other” (p. 8). Though Tabor’s analysis of the literature is far from exhaustive, her move to ground her assertions in other published work provides a more substantive basis for her theoretical claims than Pearlman’s (2012) assertions appear to offer. Her concept map thus serves as a working model—one version of the possible relations among conceptual units within
secondary traumatic stress theory. Yet because Tabor’s model is derived without more systematic concept analysis or a foundation in original empirical research, its value remains limited.

Absent more robust engagement with the evolving literature and with practice settings where these concepts are discussed and applied dynamically, it is unlikely that conceptual clarity will improve. For example, Pearlman’s insistence on limiting the scope of VT to a syndrome affecting trauma therapists is problematic, considering subsequent literature that makes a strong case for a much broader conception of VT that encompasses social and cultural influences—such as the vicarious effects that visual media and real-time global reporting on events like natural disasters and terrorist attacks have had upon journalists and technical crews, not to mention media audiences (E. A. Kaplan, 2005; Sullender, 2010). Ultimately, the challenge of establishing clearer nomenclature will require an approach that transcends definition by a few scholars, but is instead built on theoretical concept advancement through qualitatively grounded systematic inquiry, such as that explicated and practiced by Penrod and Hupcey (2005; see also, Hupcey & Penrod, 2005) and by Sheppard (2015).

**Interrogating a dominant psychometric instrument.** Stamm (2010) concurred with Sabo (2011) regarding the lack of evidence for either a concept-redundant or concept-exclusive understanding of the relationship among the original “big three” terms—CF, STS, and VT:

There do seem to be nuances between the terms, but there is no delineation between them sufficient to say that they are truly different. …Papers that have attempted to ferret out the specific differences … have been largely unsuccessful in identifying real differences between the concepts as presented under each name. … The various names represent three converging lines of evidence that produced three different construct names. As the topic has matured, reconfiguration of the terms seems timely. (Stamm, 2010, p. 9)

Her assessment followed nearly two decades of work on concept analysis and design of psychometric instruments. As early as 1996, Stamm accepted an invitation from Figley to advance his original tool, the “Compassion Fatigue Self Test” (first developed in the late 1980s)
to create a statistically standardized, reliable, and valid instrument for assessing CF (Stamm, 2010). Having herself contributed the concept of compassion satisfaction (CS) in 1993, Stamm incorporated this into her initial “Compassion Satisfaction and Fatigue Test,” which then went through several iterations in the 1990s. By the end of that decade, when Stamm assumed leadership for work on the CF/CS instrument, she renamed it the Professional Quality of Life Scale (ProQoL). By 2002, the ProQoL was in its third version and in 2009, Stamm and colleagues released the current version, the ProQoL-V (Stamm, 2010). Stamm explained the early history of the instrument as follows:

Four scales emerged in the early research. Two of them ... were not specific to secondary [traumatic] exposure. They were used equally for people who were the direct victims of trauma as well as for those who were secondarily exposed in their role as helpers. ... Two measures emerged as specific measures for secondary exposure. The Compassion Fatigue Test in its various versions ... and the Secondary Traumatic Stress Scale. (Bride et al., 2004, as cited in Stamm, 2010, p. 12)

The ProQoL-V, however, evidences a major reconfiguration of the constructs to be explored by its metrics. That is, it no longer measures compassion satisfaction (CS), burnout, and CF/STS side by side via “three discrete scales that do not yield a composite score” (Stamm, 2005, p. 4). Instead, it is now an integrated scale with composite scoring based on differently theorized relationships among the key constructs (please see

Figure 1, next page). Given Stamm’s assertion that the literature has been “largely unsuccessful in identifying real differences between [major contested] concepts” (Stamm, 2010, p. 9), she appears to have proceeded with configuring them anew. Yet systematic concept advancement along the lines of Hupcey and Penrod (2005), Penrod and Hupcey (2005), or Sheppard (2015) is not evident in the literature supporting her work.
Whereas the 2002 ProQoL-III treated CF and STS as synonymous terms for one construct (consistent with Figley’s early writings) and measured them together in parallel with measures of CS as well as burnout (a three-part scale)—the ProQoL-V identifies STS as but one of two

![Figure 1. ProQoL-V Concept Map: Theorized relations of major concepts (© 2016. ProQoL.org. All rights reserved. Available at: http://www.proqol.org/Home_Page.php)](image)

constructs beneath CF, the other being burnout (VT has never been specified in the model). The scale thereby privileges CS and CF as a binary pair; not inverse poles of a continuum (i.e., when one goes up, the other goes down), but as linked indices of a more global “quality of life” construct relative to the professional work of caring (Stamm, 2010). Thus, the ProQoL-V theorizes neither CF nor CS specifically in the context of trauma exposure, as Figley had done for CF, but conceives them both as general responses to all varieties and levels of professional caregiving, regardless of trauma exposure. This is, caregiver trauma exposure has become one isolated variable in a broad assessment of “professional quality of life.”
Compassion fatigue has thus been rendered an umbrella term for two potential and generally “negative” outcomes of caregiving work. In addition, though burnout and STS are theorized as independent variables, they are constructed as a cumulative index of the experience of CF in caregivers: i.e., when using the instrument, CF is measured through a composite score obtained by adding the measure derived from the burnout subscale to that from the STS subscale.

According to Stamm (2010), burnout comprises “things like exhaustion, frustration, anger, and depression,” whereas STS comprises “a negative feeling driven by fear” (p. 8) due to trauma exposure that may be primary, secondary, or a combination of both. Little to no analysis is offered with regard to more than decade of prior literature that presented CF as a secondary-trauma-specific phenomenon.

This is a significant transformation given the history of these concepts. Far from being a user-friendly term for secondary or indirect traumatization, CF is no longer defined by the experience of secondary traumatic stress. Although this is actually consistent with Joinson’s (1992) original use of the term, assessment of secondary traumatization is now diluted and marginalized in the ProQol-V, tucked aside within a more global, but less focused set of concerns.

Stamm (2010) argued that “reconfiguration” was needed, and her work reflects a broad synthesis of analyzed findings and raw data from around the world, yet the ProQoL-V does not support the purposes of clarifying theory or advancing knowledge specific to the problem of secondary traumatization. On the contrary, it stands in opposition to understanding the term CF distinctly in this context, increases conceptual confusion in the field of study, and further undermines attempts to deepen empirical understanding and palliation for a troubling realm of experience—the indirect traumatization of health providers through the embodied practice of direct caregiving.

**Impact on STS research with nurses.** Even more concerning, however, is the silence in the literature since 2009 with regard to the implications of this theoretical shift underlying the
revised instrument. For in the case of published studies about nurses, quantitative investigations have relied increasingly on the ProQoL-V not only for measuring the prevalence of so-called CF syndromes, but for structuring the very design of research investigations. Yang and Kim (2012) reported that among studies involving nurses published from 2006-2011, “the most frequent approach [to the study of CF] was quantitative research with the ProQoL [as] the most frequently used instrument” (p. 38). My own review of the literature confirms this: 10 of 16 quantitative and mixed methods studies on nurse CF or STS used the ProQoL during the same years (62%). For the years 2012 to the present, my review found ProQoL use to be less prevalent (16 of 34 studies or 47%)—yet beyond 2012, study designs and nomenclature increasingly reflected the CS / CF conceptual binary regardless of the instrument used, and even in qualitative studies (Amin, Vankar, Nimbalkar, & Phatak, 2015; J. Berger, Polivka, Smoot, & Owens, 2015; Craigie et al., 2015; Hegney et al., 2014; Kelly, Runge, & Spencer, 2015; Kim & Choi, 2012; A. Li, Early, Mahrer, Klaristenfeld, & Gold, 2014; Mangoulia, Koukia, Alevizopoulos, Fildissis, & Katostaras, 2015; Meyer, Li, Klaristenfeld, & Gold, 2014; Multiira & Ssendikadiwa, 2015; Neville & Cole, 2013; Yu, Jiang, & Shen, 2016).

Meanwhile, research specifically into the effects of trauma exposure in nurses has become located increasingly at the margins of such studies. In some cases, this is reflected in minimal use of the terms secondary traumatization or STS by investigators—replacing them with the more euphemistic CF or the term burnout, or both (e.g., Craig & Sprang, 2010; Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010; Lamson, Meadors, & Mendenhall, 2014; Sacco, Ciurzynski, Harvey, & Ingersoll, 2015; Yoder, 2010). In other cases, relocation of STS as a subscale under CF appears to have resulted in confusion, as investigators may be unclear about the revised theoretical structure underlying the ProQoL-V or the distinct characteristics of secondary traumatization in the broader
context of nurse distress (e.g., Beaumont, Durkin, Hollins Martin, & Carson, 2015; Circenis & Millere, 2011; Tay, Earnest, Tan, & Ng, 2014; Young, Derr, Cicchillo, & Bressler, 2011).

The exceptions with regard to marginalization of trauma impacts in the literature include recent qualitative studies (Davies & Coldridge, 2015; Hubbard, Beeber, & Eves, 2015) as well as quantitative studies that declare a specific focus on traumatization of nurses via their professional activities (Adriaenssens, de Gucht, & Maes, 2012; Beck & Gable, 2012; Duffy, Avalos, & Dowling, 2015; Janda & Jandova, 2015; Komachi, Kamibeppu, Nishi, & Matsuoka, 2012; Maier, 2011; Mairean, 2016; Von Rueden et al., 2010). Interestingly, the latter researchers often turn to psychometric instruments other than the ProQoL in order to quantify STS. Most used is the Secondary Traumatic Stress Scale (STSS; Bride, Robinson, Yegidis, & Figley, 2004). Metrics on PTSD are also employed, but less frequently. This suggests that the ProQoL-V may not be perceived as a sufficiently sensitive instrument for exploring traumatic stress in nurses. Despite these problems, it remains a tool that many STS and CF researchers accept and apply without serious interrogation, to the detriment of science on secondary trauma in helping professionals. I will return to the ProQoL when discussing the empirical nursing literature in more detail below.

**The Literature of STS among Nurses**

**Accessing Nursing-Specific Literature**

A snowball technique was employed to identify relevant articles, chapters, and books dealing broadly with the topic of secondary traumatization and stress effects among nurses. Initial search results were examined for references to prior publications, and searches were conducted for later articles that cited them. In this way, a broad international survey of 103 articles spanning over two decades was compiled, all dealing with various conceptualizations of the problem of secondary traumatization experienced among nurses in the course of clinical work. To overcome
the terminology and conceptual challenges of the literature as discussed above, I chose to include articles addressing one or more of the following concepts: CF; STS; burnout or burnout syndrome (BOS); STSD; VT; and close variations on those terms such as or “work-related,” “job,” or “occupational” stress (OS).

Other specific inclusion and exclusion criteria were developed for the articles surveyed. Inclusion criteria were: the publication must have been written by nurses or published in a major peer-reviewed nursing journal and, in addition, nurses comprised the primary focus of the research. Empirical studies, literature reviews, conceptual articles, and major editorials were all included. Exclusion criteria were: non-nurse generated studies, book reviews; empirical, theoretical, or review articles in which nurses comprised a small or non-specific proportion or focus of the research, as well as publications with a predominantly cross-disciplinary emphasis.

**Overview of Nursing-Specific Literature**

The selected literature (n=113) was published over a 24-year span, from 1992 to 2016. Seventy-one (71) publications report empirical studies, 32 articles make conceptual contributions, and 10 focus on educational intervention programs for STS-related syndromes (see APPENDIX A for a brief overview of the literature surveyed).

Conceptual publications span 24 years and include reviews of literature, editorials, concept analyses and advancement, theory development, and policy recommendations. Following Joinson’s 1992 article, the first scholarly concept paper was Blair and Ramones (1996), followed by just two papers in the next six years (Little, 2002; Schwam, 1998). It was not until 2008 that publication frequency increased, peaking in 2011 (n=6) when a scholarly nursing journal devoted an issue to CF. During the eight years from 2008 to 2015, an average of three articles were published annually (n=23), though overall, 78% of the conceptual literature was published in the
last decade. This work began and has remained predominantly North American in origin. United States researchers contributed 60% (n=19) of the total publications surveyed and Canadian authors contributed 9% (n=3). South African scholars contributed two papers and the remaining eight articles originated in Europe, Australia, New Zealand, and Korea.

Empirical publications span 19 years and include qualitative, quantitative, and mixed methods investigations. The first scholarly report that was identified, published in 1997, did not conform to standard terminology as above, but studied “grief experiences” qualitatively among pediatric intensive care nurses—yet it attended to nearly identical concerns as the STS and CF literature while using different nomenclature. The next paper arguably dealing with STS was published in 2001, an international study authored by Greek researchers who were likewise exploring nurses’ experiences of caring for dying children. There followed, in 2002, a paper dealing with New York nurses’ experiences following the events of 9/11 in Manhattan. The terms burnout and CF began appearing in scholarly literature by 2003, but not prominently until 2005 in a Turkish-authored study and 2006 in an U.S. research report. Starting in 2009, however, six major articles were appearing annually, featuring the terms of burnout, CF, STS, and VT. These papers originated predominantly in North America (78%, n=14). Yet from 2012 to the present, a dramatic shift occurred in which the number and sophistication of scholarly publications steadily increased as the predominant origin shifted from away from North America and other English-speaking nations to other continents—primarily Europe and Southeast Asia, but also South Asia, Central Asia (the Middle East), and Africa, as well as Australia and New Zealand. In 2015, 80% of published research was conducted and authored outside North America (n=11), and the four articles published in the early months of 2016 were all international in origin (two from China, one from Portugal, and one from Spain). A brief discussion of significant features of the literature follows, organized by conceptual and empirical categories.
**Conceptual research literature.** In the early years, this work was limited to brief literature reviews of emergent terms and concepts. VT was examined by Blair and Ramones (1996) and by Hafkenscheid (2005), whereas Collins and Long (2003) made an early attempt to differentiate among VT, STS, PTSD, burnout, and CF. In 2006, Sabo drew on nursing theories of compassionate care to shed light on how embodied nursing work may affect nurse wellbeing. Sabo was the first scholar to highlight limitations of current psychometric instruments for CF such as the ProQoL. Meanwhile, Embriaco (2007) reviewed interdisciplinary European research on burnout among ICU workers that employed the Maslach Burnout Inventory (MBI); they concluded that significant determinants of burnout are amenable to prevention.

Gates and Gillespie (2008) were the first nurse researchers to focus specifically on STS, drawing from the extant literature to present an overview of its risk factors and consequences, and then make a case for workplace interventions and organizational policies that would reduce STS prevalence among nurses and improve patient outcomes. Concern with patient outcomes arises with regularity in the literature, alluding to the many costs that flow from deterioration of nurses’ psychological wellbeing. Braithwaite (2008) echoed this rationale for attention to burnout and OS (occupational stress) among neonatal intensive care unit (NICU) nurses.

In 2009, the orientation of the conceptual literature evidences a fairly abrupt shift toward the construct of CF, such that more researchers emphasized this term and adopted this framework, consistent with the reconfigured ProQoL, than all other constructs combined. Thus, a broad, although general, review and synthesis of CF research is undertaken by Bush (2009), Stewart (2009), Abendroth (2011), Boyle (2011), Jenkins & Warren (2012), Lynch & Lobo (2012), Wentzel and Brysiewicz (Wentzel & Brysiewicz, 2014), and Ledoux (2015). Coetzee and Klopper (2010) contributed a more rigorous review and concept analysis of CF, integrating 55 papers and implicitly challenging the ProQoL model by proposing a stage theory of CF.
manifestation. By contrast, Lombardo and Eyre (2011) explored both personal and institutional costs of CF and advocated for preventive approaches to minimizing its impacts, yet they advance a reductionist, individualized binary of “reactive” versus “proactive” nurses. Their framework unfortunately places the burden of prevention onto individual nurses, with inadequate exploration of organizational forces that constrain proactivity. Individualized orientations were implicit in a number of papers, but were more striking in the empirical literature (see below). Finally, Yang and Kim (2012) provided an extensive, international, systematic review of the literature on CF, STS, and VT as studied in nurses. Their work remains the most extensive and detailed overview of research on the topic available to date.

Meanwhile, a few researchers have maintained a focus specifically on traumatic stress effects (STS or VT) in nurses beyond the 2009 shift toward CF, and these scholars continue to note the conceptual and taxonomical confusion in the field (e.g., Beck, 2011; Boyle, 2011; Leinweber & Rowe, 2010; Pearson, 2012). Of particular note, Freshwater and Cahill (2010) proposed an alternative framework for the group of OS syndromes that is grounded in a nursing theory of caring and a methodology for negotiation and compromise. They propose a spectrum model for OS, and their work remains significant for the less individualized, more sociological perspective they adopt toward OS. Indeed, they link OS to the global climate of the healthcare industry, especially its heavy financial and workforce constraints. Similarly, Sabo (2011) suggested a continuum model of OS, along which she located not only CF, but other stress syndromes including burnout and VT. Like Freshwater and Cahill (2010), Sabo provided a more synthetic alternative to the static and compartmentalized ProQoL-V structure. She remains one of few nursing scholars to have consistently questioned structural assumptions present in major psychometric instruments and in the wider nursing literature of CF-related syndromes.
Implications for empirical research. Numerous concerns are thus raised by Stamm’s 2009 revision of the ProQoL scale and the theoretical model underlying it. These concerns are reflected in the evolution of debate in the nursing literature; moreover, they anticipate some findings in more recent nursing scholarship (see also Empirical Research, below). Indeed, another significant shift is evidenced in 2014-15, as three scholars from two continents published papers interrogating the CF construct and the ProQoL-V with renewed vigor. Sheppard (2015) presented a brief, yet lucid concept analysis of CF enriched by a qualitative data phase, in which she tested the concept definition drawn from the literature against the accounts of 16 practicing trauma nurses. She concluded that the dominant concept definition of CF and the ProQoL’s construction of it are able to capture only part of the experience of STS in nurses. She concluded that the term and the scale both miss important dimensions: specifically, the depth of nurses’ existential suffering (“life is unfair” and involves “endless suffering”), the obsessive and addictive qualities of the work, and the desire to glean psychological support while simultaneously pushing people away. Sheppard also found that the very term CF bore stigma for many of the nurses interviewed, as it implies a lost capacity for compassion.

In a similar vein, Ledoux’s (2015) concept analysis of CF found so many persistent contradictions around the construct that she concluded it begs a prerequisite concept analysis for the notion of compassion. Undertaking such an analysis, however, she found a dearth of nursing scholarship on compassion and, moreover, found that the concept as defined outside the nursing literature does not match the understanding of compassion implied in CF. This line of argument, although valuable and incisive, misses one significant point: that so-called “compassion fatigue” was coined by Figley in 1995 as little more than “user-friendly” street lingo for STS, not as a primary scientific term. Finally, in the same year, Watts and Robertson (2015) published a study of psychometric tools for assessing STS in nurses and concluded that the ProQoL, though still the
most-used instrument, has been insufficiently evaluated with nurses to be a reliable measure in that professional context. Consequently, they recommend use of the Secondary Traumatic Stress Scale (STSS; Bride et al., 2004) for STS research with nurses.

**Empirical research literature.** The empirical literature encompassed by my review spanned the years 1997-2016 and was predominantly quantitative (n=53 or 75%), though most of that work is relatively recent: two-thirds of identified quantitative papers (n=35) were published in just over four years, from January 2012 to mid-April 2016. The majority of quantitative studies followed cross-sectional descriptive designs, many included correlational analyses, and a few also undertook causal-comparative, multiple regression analyses. Four studies employed longitudinal rather than cross-sectional designs (Adriaenssens, De Gucht, & Maes, 2013; Collins & Long, 2003; A. Li et al., 2014; Meyer et al., 2014).

Qualitative research comprised only 12 of the 71 empirical studies (17%) and spanned the years from 1997 to 2015. Five papers were published before 2006 and three appeared in a single special issue of a nursing research journal in 2011. All employed a variation of thematic content analysis (TCA) applied to one-time interviews or focus group sessions. Two qualitative studies applied specifically hermeneutic phenomenological analysis to interview content (Dickerson et al., 2002; Rashotte, Fothergill-Bourbonnais, & Chamberlain, 1997), and one undertook a grounded theory analysis based on preliminary TCA (Papadatou, Martinson, & Chung, 2001). Six of the 71 studies employed mixed methods (8%), and these combined descriptive statistics, basic correlational analysis, and basic TCA of relatively brief interviews and/or focus groups.

**Prevalence of STS.** The reviewed body of empirical research suggests a broad incidence of STS, CF, and burnout in nurses. Elevated measures were found in at least one-quarter to one-third of practicing nurses sampled. This held across most specialties and in every nation and culture studied, as well as across conceptual constructs throughout the 15 years of empirical work.
Most studies focused on the construct of CF, usually together with CS (n=24 or 34%); twelve (12 or 17%) specifically examined forms of nurse traumatization (STS, PTSD, or VT); nineteen (19 or 27%) focused on burnout and these often employed the Maslach Burnout Inventory (MBI); and sixteen (16 or 22%) explored a combination of constructs, usually with the goal of discerning relationships among them. Three studies found no evidence of elevated stress effects relative to the general population: one involved a small sample of nurses working in a United States surgical ICU (Mason et al., 2014); a second involved nurses having a single, short-term trauma exposure while engaged in temporary post-hurricane relief efforts (Frank & Karioth, 2006); and a third (Yoder, 2010) found a lower prevalence of stress effects (15%) among nurses in a small Midwest community hospital.

It is worth noting that the incidence of various stress syndromes shows no improvement during more than two decades of scholarship and professional discourse. The research surveyed almost universally demonstrates ongoing prevalence of STS and burnout (at least 25-35%) among nurses working in a wide variety of settings through 2014. Some studies found higher rates of moderate or severe STS effects as high as 50-85% (Abendroth & Flannery, 2006; Dominguez-Gomez & Rutledge, 2009; Duffy et al., 2015; Hooper et al., 2010; Maier, 2011; Mealer et al., 2012). Alternatively, investigations of primary traumatic stress effects, consistent with criteria for PTSD rather than STS, found lower incidence in nurses sampled, between 10-25%, though well above the national average for PTSD (Beck & Gable, 2012; Lauvrud, Nonstad, & Palmstierna, 2009; Mealer et al., 2012, 2009).

It is symptomatic of the conceptual problems in the field that a number of studies purportedly investigating STS and CF in fact used PTSD psychometric instruments to obtain quantitative data (e.g., Von Rueden et al., 2010). Given the broad conceptual and instrumentation
difficulties across the field, most empirical research findings at this stage in the evolution of nursing STS research are best interpreted with caution.

**Consensus and Conclusions**

While little consensus is evident in the nursing literature about conceptual frameworks for understanding CF or STS, the interactions among such concepts, or optimal psychometric tools for quantifying them, most scholars surveyed do agree about a few things. First, traumatic exposure and occupational stress are seen as a consistent feature of nursing practice in a wide variety of specialties and practice settings. Nurses are found to be exposed to a great deal of traumatic material indirectly or vicariously through the primary suffering of patients for whom they care, and this exposure is seen as a source of potentially chronic harm to nurses. Further, as a profession, nursing is highly vulnerable to, and heavily affected by, the short- and long-term effects of STS. That is to say, it is not overreaching to conclude that the very profession has been shaped historically by such exposure, even as it may not have recognized the force of this impact.

**The ProQoL-V Model**

Several broad conclusions may be drawn from the conceptual and empirical cross-currents in the nursing research literature. First and foremost among these involves psychometric instruments and underlying models upon which studies increasingly rely. Unfortunately, after 14 years of cross-disciplinary scholarship that equated CF and STS (1995 to 2009), the revised ProQoL conceptual model has created further confusion about the meaning and relations of CF and STS, particularly for researchers who are not well acquainted with the history and evolution of these constructs.

Second, by compartmentalizing and subordinating both STS and burnout under CF, the ProQoL-V not only blurs both constructs, it operates at cross purposes with evidence that burnout
and STS intersect and may be experienced synergistically in a variety of complex ways, as suggested in several investigations of trauma exposure and burnout in nurses (e.g., Abendroth & Flannery, 2006; Maier, 2011; Mealer et al., 2012, 2009; Poncet et al., 2007; Townsend & Campbell, 2009). The reconfigured scale thus holds diminished capacity to detect and explore such nuanced possibilities via dynamics between the two theorized experiential states.

Third, the placement of burnout as a subscale of CF is inconsistent with scholarship on burnout that characterizes it as an entrenched and debilitating state having both psychological and physiological effects, which induces suffering far beyond what is typically imagined by a word like “fatigue” (Adriaenssens et al., 2012, 2013; Adwan, 2014; Bakker et al., 2005; L. Li, Ruan, & Yuan, 2015; Mealer et al., 2012, 2009; Poncet et al., 2007; Sabbah, Sabbah, Sabbah, Akoum, & Droubi, 2012; Skefales et al., 2014; Townsend & Campbell, 2009; Yavello, 2014). Further, Meyer and colleagues (Meyer et al., 2014) theorized and empirically studied STS as a mediating factor that acted as a catalyst—intensifying “simple” CF to the level of burnout and more severe forms of traumatic stress. By subordinating burnout and STS in tandem under the more inclusive yet vague CF construct, the ProQoL-V further impedes direct investigation of interactions between both constructs and other types of variables, particularly systemic factors like workplace relationships, unit cultures, and structural features of a healthcare organization (e.g., R. Berger & Gelkopf, 2011; Burston & Stichler, 2010; Duffy et al., 2015; A. Li et al., 2014; Mealer et al., 2012; Neville & Cole, 2013; Townsend & Campbell, 2009; Ward-Griffin, St-Amant, & Brown, 2011).

Moreover, the ProQoL-V evidences a conceptual tendency that has plagued the nursing literature on STS: namely, a heavily individualistic orientation that too often misses or dismisses sociocultural and systemic impacts on nurse wellbeing (e.g., Chakraborty, Chatterjee, & Chaudhury, 2012; Hegney et al., 2014; Tay et al., 2014). Questions in the ProQoL are tailored to
measuring individualized experiences of satisfaction, fatigue, burnout, and stress at work and very few prompts elicit data on social and structural aspects of experience. Yet social and organizational forces are integral factors in workers satisfaction and effectiveness—no less for nurses than others (Bakker et al., 2005; Burton & Stichler, 2010; Davis, Lind, & Sorensen, 2013; Lang, Pfister, & Siemens, 2010; A. Li et al., 2014; Meyer et al., 2014; Neville & Cole, 2013).

Finally, although the term CF once provided a palatable euphemism for STS in day-to-day conversation, it obscures the damaging levels of long-term personal suffering and serious relationship dysfunction that may result from STS, burnout, and OS generally in the workplace (Adriaenssens et al, 2013; Mealer, 2009, 2012). Moreover, as Sheppard (2015) found, it may further be misconstrued as an accusation of failed compassion in those who already are suffering the effects of caregiving stress. On the other hand, the binary of CS-CF, with STS linked only to CF, undermines further investigation of evidence that secondary traumatization (not BO) may also have long-term beneficial effects (e.g., R. Berger & Gelkopf, 2011; Dickerson et al., 2002; Healy & Tyrrell, 2013; Neville & Cole, 2013) by catalyzing not only “satisfaction,” but personal and professional growth and the cultivation of “resilience” (e.g., Drury, Craigie, Francis, Aoun, & Hegney, 2014; Hegney et al., 2014; Mealer et al., 2012) as well as individual and group qualities of “hardiness” (e.g., Garrosa, Moreno-Jiménez, Liang, & González, 2008; Hurst & Koplin-Baucum, 2005).

A Need for Better Learning Models

Unlike the response to STS and VT research among professionals in the psychotherapeutic disciplines, who have emphasized psychodynamic theory and “tools of the trade” for healing among their colleagues, the response among nursing professionals to STS research almost invariably includes recommendations for “education” and “intervention” programs that are aimed
at prevention of CF and related syndromes (e.g., Baverstock & Finlay, 2015; R. Berger & Gelkopf, 2011; Bloom, n.d.; Healy & Tyrrell, 2013; Lombardo & Eyre, 2011; Meadors, Lamson, & Sira, 2010; Potter et al., 2013; Zadeh, Gamba, Hudson, & Wiener, 2012). Yet the extent of knowledge about learning reflected in these proposals, and in preliminary pilot programs for CF or STS that have been researched, is unfortunately rather meager. Similar to learning programs in many sectors of the popular self-help movement, talking and teaching are treated as virtually synonymous activities, as are reading / writing and learning. So-called psychoeducation is often little more than teaching by talking in front of groups of people, perhaps augmented by “case studies” and handouts illustrating psychological concepts. Problem-posing interaction of the kind Freire would advocate, or introduction to the critical arc of reflective action (praxis), are rarely alluded to or considered. Even less attention is given to perceptions and experiences of the body, to culture or relationships, or to the powerful nuances of memory and imagination.

Even where the application of learning theory is more rigorous in programs to resolve psychic suffering, such as the development of Dialectical Behavior Therapy (DBT; Linehan, 2013), conceptual elucidation of learning itself takes a back seat in the effort to theorize, test, and disseminate a particular modality as a scientifically (and economically) sustainable form of care within the structure of the medical model. This problem has important implications when it comes to learning models that could benefit nurses, for the same paucity of applied learning theory that weakens self-help programs and psychoeducation initiatives for the general public likewise undermines workplace support for caregivers facing traumatic exposure and stress effects. Moreover, discipline-specific scholarly literature addressing integrative responses to STS, where an understanding of adult learning might have a prominent role, often give little more than lip-service to learning or else represent it in ways that are reductionist and naïve (e.g., Meadors & Lamson, 2003; Nelson, 2013; Potter et al., 2010). In the next chapter, I will examine adult
learning scholarship that introduces a rich and potent framework to conceptualize learning in relation to STS.

Finally, a key question raised by secondary trauma theory and research is whether, and how, the “echo effect” of psychic trauma can be interrupted. As long as trauma exists in the world and some people reach out to help affected others, the caring professions and society itself will be faced with the problem of STS and its effects. Research to date has attempted to define diagnostic characteristics, risk factors, and alleviating factors for various traumatic and stress-related syndromes, as well as to determine how they are related and interact—conceptually and functionally—in caring professionals. Within a nursing context, however, much work remains to be done, if the profession is to gain more effective insight, not only regarding the dynamics of secondary traumatization, but the interplay of factors that alleviate and aggravate its impact and potential “contagion” effect (Bakker et al., 2005). Such scholarship need not, and ought not, be approached only using a “disease” model, as implied by the DSM-IV diagnostic categorization of STSD. On the other hand, fuzzy references to the phenomenon using terms like CF do not bring us closer to addressing the problem. Throughout this research, my premise is that the phenomenon of STS among nurses requires a multi-dimensional model that incorporates a complex understanding of adult learning and can account for a range of factors active within the lifeworld of nurses, all of which shape their experience of and response to STS.
CHAPTER THREE
ADULT LEARNING: POWER, COMMUNITY, AND THE UNCONSCIOUS

Law XIII of the House of God: The delivery of medical care is to do as much nothing as possible.

Having been pushed around for five steaming weeks with Jo, Chuck and I had learned a lot. ...[We] had learned to hide what we were actually doing with the gomers from Jo, since what we were actually doing was doing nothing, more intensely than any other tern in the House. Time and again, reading about our prodigious efforts on the gomers in their charts and then seeing how well the actual gomers were doing, Jo would turn to Chuck and me with pride and say, ‘Good job. By God, that’s a good job....’

... And so the Leggo decided that Chuck and I would be rewarded.

“How will they be rewarded?” the Fish asked the Leggo.

“...We’ll give them the toughies....”

... “They’re giving you the toughies,” said Jo to us.

“The toughies?” I asked. “What are they?”

“The toughest admissions to the House.”

“What? Why?”

“Yeah, man, what all did we do wrong?”

... “Nothing. It’s the Leggo’s way of saying thanks, to challenge you with the toughies. You should see the cases we’re going to get now.”

Soon we saw the cases we were going to get then. They were the worst. ... And so Chuck and I hung ourselves.... Without realizing it, without choosing it, and in fact choosing the opposite at every turn, we had to learn to handle the worst disease the House could dish up. We sweated and we cursed and we hated it, but we used each other ... and we risked, and we learned.


What Shem suggests here is sometimes designated by educators as the “hidden curriculum”: a tacit, unplanned, and often unintended dimension of instruction in educational and training contexts that is communicated indirectly by way of students’ lived experience of the social and structural environment in which their learning is set. Shem’s description also reveals how quite ingenious strategies for resisting the hidden curriculum can backfire on the learner.
Background

This research is grounded in a learning approach rather than a diagnostic and treatment approach to trauma exposure and its effects among nurses. My gradual turn from nursing theory to studies in adult education arose in part from a long-standing interest in the role of learning in human experience—particularly in relation to human responses that arise in the wake of psychic trauma. I came to the field of adult education much as bell hooks (1994) writes that she came to educational theory: I was in pain.

Brookfield (2005) affirmed this motive when he wrote of the “utility of theory” for navigating life and learning in a pain-ridden world (p. 4). He draws on hooks’s (1994) confessional words in *Teaching to Transgress*:

> I came to theory because I was hurting—the pain within me was so intense that I could not go on living. I came to theory desperate, wanting to comprehend—to grasp what was happening around and within me. Most importantly, I wanted to make the hurt go away. I saw in theory...a location for healing. (hooks, 1994, p. 59)

I saw possibilities for healing located within learning—specifically, in a type of learning that is informal, reflectively enriched, emotionally engaged, and critically informed. I had long resisted advanced studies in the field of nursing because, as in Shem’s narrative, I had experienced too many settings of nursing practice that were demoralizing and damaging. In adult education scholarship, I quickly encountered the tradition of emancipatory learning most famously expressed in the life and work of Freire (1973, 1994, 2005). It was then I recognized another source of my earlier aversion that is well illustrated by Shem: the propensity of healthcare professional education to contain and control—in Freire’s terms, to domesticate—not just knowledge, but ways of learning and of enacting practice among its students and clinicians.

While Freire’s work focuses on the domesticating effects of formal and non-formal education, which he terms “banking education,” his landmark book *Pedagogy of the Oppressed
(1970/2005) gave me a vocabulary and a set of concepts with which to begin problematizing institutional forms of healthcare practice and training. His writing further helped me to examine the role of relationships, informal caring, and structural power imbalances on the work that nurses enact day-to-day in a variety of practice settings. Freire drew heavily on the emancipatory concerns expressed in critical theory—not only its familiar application of Marx’s work, but Erich Fromm’s (1941, 1951, 1955, 1959, 1970) application of Freud’s psychoanalytic concepts within Frankfurt School critical theory as well. In *Pedagogy of the Oppressed* (2005), one of Freire’s core concepts, the “fear of freedom,” was in fact the title used for the British edition (1942) of one of Fromm’s most famous books, *The Fear of Freedom*, which had been published under the title *Escape from Freedom* (1941) in the United States the previous year. Roazen (2000) argued that this text not only “became central to the professional education of [a] generation of students of politics, but it also once had an immense influence within fields like sociology, anthropology, and clinical psychology” (p. 239). Likewise, it had a significant influence on the field of education and adult education through the Frankfurt School and Freire.

Lake and Dagostino (2013) made a persuasive case for Freire’s intellectual debt to Fromm, yet they argued that his pedagogy is insufficient to help adult learners achieve liberation from oppression as long as it continues to emphasize awareness of external or structural forms of oppression and its causes, without also attending more fully to internalized or psychodynamic effects of systemically oppressive social conditions. Earlier, Dagostino (2007) argued that Freire falls short in articulating Fromm’s insights about the conflicted nature of consciousness, and contented that his pedagogy must go further to address the problem of “psychological attachment to the oppressor and the oppressor’s ideology” (p. 10). In this, she followed Elias (1994) who observed that “a complete understanding of human nature demands thoughtful consideration of … evidence that humans do not spontaneously do what is considered good and just, once they are
freed from certain [external] restrictions” (as cited in Dagostino-Kalniz, 2007, p. 15). Invoking Fromm, she goes further:

A more complete theory of liberation, while it does require becoming critically conscious of oppression, also requires critical consideration of the inner machinations of the psyche. It is not enough to critically reflect on the oppressive nature of the social order when distortions of internal cognition also blur the individual’s conception of the world. The challenge is to undertake critical reflection upon what is happening within the individual’s psyche with the same scrutiny as Freire applies to developing critical awareness of [social] oppression. (Dagostino-Kalniz, 2007, p. 17)

Thus, although Freire affirmed and adapted a number of Fromm’s key ideas, he failed to explore their implications in depth, nor did he point his readers toward Fromm’s work. In one of Friere’s final manuscripts, he recounted: “I heard from Erich Fromm in his house in Cuernavaca, his blue eyes flashing: ‘An educational practice like [yours] is a kind of historico-sociocultural and political psychoanalysis’” (Freire, 1994, p. 90). It may be added that Fromm’s work makes possible a psychoanalytically informed pedagogy of even greater depth than Freire’s.

Thus, critically informed psychoanalytic theory has come to figure prominently in my own understanding of adult learning. Yet this is no longer an isolated or unusual perspective (e.g., Bainbridge & West, 2012; Britzman, 1998, 2006, 2011, 2013; Fenwick, 2000; Green, 2012; Pitt & Britzman, 2003). Moreover, the recognition of alignment between Freud and Marx is far from limited to Fromm or Freire (e.g., Marcuse, 1969, 1970; Vygotsky & Luria, 1994) and is perhaps best explicated by Guess (1981, also cited by Brookfield, 2005), who argued that Freud and Marx present, philosophically, two “instances” of the same breakthrough form of knowledge. Guess (1981) elaborated:

The members of the Frankfurt School think that Freud … was a conceptual revolutionary in more or less the sense in which Marx was, and that the theories of Marx and Freud exhibit such strong similarities in their essential epistemic structure that from a philosophical point of view they don’t represent two different kinds of theory, but merely two instances of a single new type … ‘critical theory.’” (p. 1)
According to Frankfurt School scholars, what is so valuable about critical theory is its distinct structure for undertaking inquiry: an epistemic structure that is distinguishable from classical theory in three respects. First—as is evident in Freire’s work—Guess (1981) maintained that “critical” theories are capable of yielding guidance for human action aimed at intellectual “enlightenment” and the possibility of psychological and social “emancipation” (p. 2). Second, according to Guess, critical theories are cognitively rooted in substantive content: that is, they do not emphasize conceptual abstraction, but engage in culturally and historically grounded analysis. Third, critical theories challenge the objectifying processes of philosophical positivism (such as that advanced by the Vienna Circle in the last century). They accomplish the latter by undertaking a “rehabilitation of ‘reflection’ as a category of valid knowledge” (p. 2).

By this account, critical theory thus makes possible a new type of epistemic goal in social research—the production of a “critically reflective” form of knowledge as a distinct and valid complement to the familiar descriptive, explanatory, and predictive forms of knowledge that are accessible through scientific research. This presents the crucial possibility of exploring topics and types of learning that are not engaged by people primarily at a rational level of consciousness. Drawing in part on the psychoanalytic dimension of critical theory, the present chapter articulates a framework for learning theory that is equipped to comprehend experiences such as trauma exposure and the complex human responses it evokes. My application of psychoanalytic theory aims to illuminate dimensions of learning that may be understood as interference with dominant currents of knowledge and social practice, as well as resistance to such interference.

These ideas are explored specifically within a critical theory context and not the context of psychoanalytic psychology practice. Accordingly, the literature review that follows incorporates work by adult learning theorists and critical theorists who emphasize situated, embodied, relational, interference, resistance, and developmental dimensions of learning and relationships.
This scholarship tends to focus in common on informal modes of learning, which flourish in the unmonitored spaces and unscheduled moments of daily life—and in more formal educational settings too. Informal learning thus infuses formal learning contexts such as professional training programs and practice settings with potent forms of counter knowledge. I explore applications of psychoanalytic theory to teaching and learning in this context, with particular attention to the work of psychoanalyst and Frankfurt School critical theorist Erich Fromm. Finally, I propose a working definition of learning that synthesizes these perspectives. This conceptual framework aims to provide an integrative foundation for approaching data that are analyzed in later chapters.

**Informal Learning in Adult Education Scholarship**

Traumatic exposure makes powerful psychic demands on people and evokes a survival response. This response represents at least a rudimentary instance of learning. Transcending physiological survival, however, requires a more robust form of learning: one that is sufficient not only to sustain life in the face of physical or psychic threats, but also to reclaim and reintegrate lived experience so as to continue life informed by past threats. It requires a practice of learning that is a location for healing (hooks, 1994, 2003). As an educator, hooks linked healing from pain to theory-making, which she connected with teaching and learning, and then further connected to larger human concerns like achieving freedom from oppression. In the tradition of Freire and Fromm, she described an emancipatory process of education wherein a central task is to generate functional understandings of cultural and historical structures that shape people’s hope and their sense of meaning and safety in the material world. It is this critical enterprise that hooks calls theory: the development of usable meaning structures that are derived—often painfully—from confusing, chaotic, even frightening encounters in the lifeworld, yet can be forged into tools for more successfully navigating future experience.
This is hard-won knowledge, what Pitt and Britzman (2003) called “difficult knowledge” gained at the cost of personal suffering. Such learning is not formal, perhaps not even recognizable as “education,” yet it is practiced throughout the encounters and activities of our lives. This is illustrated vividly by historical novelist David Bradley (1981) in his award-winning story, *The Chaneysville Incident*. Here, Bradley characterized research as a type of learning to survive after being psychically injured by traumatic experience, then “falling prey” (p. 140) to the seductive hope that knowledge is a discrete object that can be appropriated for personal objectives. Yet Bradley’s protagonist John Washington learned that difficult knowledge about his deceased father resisted being “figured out”—it refused to be snatched from the “attic” of history and embodied memory:

I fell prey … to the notion … that it is possible to discover and analyze and interpret without getting caught up and swept away … that I [could] climb up into that attic … and figure Moses Washington out, and once that was done, I [could] climb back down and go on about my merry way, unaffected, unchanged, unharmed. (p. 140)

On the contrary, psychically difficult work discovers and analyzes the one who would perform it, taking them away from what they “figured” they knew or had learned and catalyzing a mental journey that is a survival experience in itself. This passage changes us even as it causes us pain, but if that pain can be crafted into knowledge and theory as hooks maintains—if it also has the potential to teach and to heal—then how does this happen?

**Situated and Relational Learning**

Berry (1990) contrasted formal teaching with informal learning in situated communities, comparing the latter to seasonal cycles of flora that assert themselves perennially through the landscape—even through systematically plowed fields that he likened to institutional education. Extending his metaphor to the soil that supports plant life, Berry aligned “the law of the woods [where] the growth of the years must return … to the ground to rot and build soil” with a “good
local culture … [where a learned] collection of the memories, ways, and skills [of its people] preserve and improve the local soil” (pp. 154-155). The cultures of local communities, he argued, are both supported by and support informal learning, which sustains not only relationships, but also livelihoods, regional culture and organizations. Without this “grassroots” form of intelligence, Berry contended that communities will be impoverished intellectually, socially, and economically too.

Following Berry, the notion of grassroots activism has become a familiar metaphor for distributive social change movements. Yet Berry’s “law of the woods” also evokes the growth that follows large traumas in the natural world—from wildfires and floods to the manufactured traumas of war and accelerated climate change. Berry’s work suggested that cultivating socially embedded, informal modes of learning are crucial avenues of response to assist people with traumatic experience, in concert with adaptive formal learning structures.

In a similar vein, but one specifically attentive to the relation between trauma and learning, Forester (1999b) documented the shared histories, practices, and stories that draw stressed neighborhoods together and help them persevere through tumultuous periods of change. Forester has studied the transformations required when neighborhood groups must face contentious urban disputes that are literally close to home, in order to negotiate and enact urban development projects. He speaks of the loss of trust that occurs with an erosion of common social practices, which particularly haunts marginalized and traumatized inner-city neighborhoods. In this, he echoed Berry’s (1990) warning that “as the exposed and disregarded soil departs with the rains, so local knowledge and local memory move away … or are forgotten … [as neighbors] no longer know one another. How can they … if they have forgotten or have never learned one another’s stories?” (p. 157).
Beyond reason: The power of ritual. Drawing on Habermas’s (1979, 1984, 1989) theory of communicative action, Forester used critical theory in the Frankfurt School tradition to analyze power dynamics in urban planning meetings. He departed, however, from Habermas’s predominantly individualistic and rational theory of communication and turned instead to socially and emotionally mediated learning as well as to trauma theory like the work of psychiatrist Judith Herman (Herman, 1992; Herman & Hirschman, 1981). In a chapter notably titled “On Not Leaving Your Pain at the Door,” Forester (1999a) argued that intentionally relational, embodied, and emotionally engaged activities help people to create a social learning environment that fosters constructive planning sessions.

Drawing on his own empirical research, Forester (1999a) illustrated how painful emotions may lead to dismissive attitudes and actions, further entrenching neighborhood disputes and fracturing agreements—thereby reinforcing trauma among participants. On the other hand, he showed how emotionally engaged negotiation may lead to breakthroughs in understanding. Here, he demonstrated the pivotal role of intentional social practices—activities that he ultimately called shared “rituals.” These practices create material social spaces in which community members encounter each other in new ways and so acquire new perceptions of each other. In this way, he contended, rituals alter not only the cognitive substance but the material and emotional landscape of public meetings. They cultivate tolerance and a greater willingness to explore novel participatory modes of action.

But Forester (1999a) did not stop there. Seeking to comprehend the stabilizing function of ritual practices, he turned to the work of Holocaust historians and psychoanalysts to explore both the dangers and the necessities of social rituals. He suggested they make possible a more fluid “re-presenting” of painful experience, rather than “repressing” or rigidly “reproducing” past suffering and loss among community members (p. 217). Following Friedlander (1992), Forester
argued that effective social deliberation requires participants to learn how “to open ourselves up, to listen closely, but to protect ourselves at the same time” (as cited by Forester, 1999a, p. 213).

He found that public rituals offer a structure in which crucial learning can occur even among stressed groups of people. This yields more than informed debate or successful negotiation—it produces transformational learning outcomes. Forester concluded:

> If we do not ask citizens to leave their pain at the door, and we reshape our deliberative processes … we might better enable both voice and mourning, mutual learning and public action that recognize and respond to [people’s] needs and interests. (p. 220)

Voice, mourning, learning, and action form something of a tetrahedron in Forester’s work on local communities—a construct that holds promise for possible ways nurses might approach surviving and transcending the experience of secondary traumatic exposure.

**Beyond ideas: Learning in embodied relationship.** Lave and Wenger (1991) forged a situated theory of learning that has some points in common with Forester’s conceptions above. Though Wenger is best known for theorizing learning as a social phenomenon enacted in so-called “communities of practice” (Wenger, 1998), Lave’s (2011) detailed anthropological studies of apprenticeship learning made foundational contributions to learning theory, dispelling myths that were based on institutionalized education models and demonstrating how informal learning is enacted within and is inseparable from the social and cultural contexts where it arises. Illeris (2003a, 2004, 2010) represented such work as pivotal within a tension field of learning theory that he conceptualized as bounded by three dimensions of learning—cognitive, emotional, and social (Illeris, 2004, p. 237). Corresponding to these dimensions, Illeris described three major conceptual orientations expressed by learning theorists of the last century, each of which focus primarily on two of the three dimensions:

- a developmental psychology orientation, which emphasizes cognitive and emotional (affective) aspects of learning;
• an activity theory orientation, which emphasizes cognitive and social aspects; and
• a societal (or cultural) orientation—which emphasizes emotional and social aspects.

Though Illeris suggested that Wenger engaged all three dimensions and orientations, Lave’s empirical work and her resulting theory tend toward an activity theory orientation that I find more substantive, as it explicated embodiment in learning and explored the significance of sustained relationships in forms of learning that are enacted as shared practices.

For Lave, Forester, Berry, hooks, Brookfield, and Freire, learning is not an abstract, invisible process that occurs in the behaviorist’s black box of the mind. Rather, it is a material, embodied form of activity that is historically shaped, culturally enacted, and socially mediated. Learning is thus woven into the fabric of our actions, our relationships, our memories, and our reflections—in all our experiences of day-to-day life. That is to say, in alignment with Husserl’s phenomenology, learning may be understood as an activity of knowledge production generated by the constitution of meaning structures derived from situated experience. I will explore these connections between informal theories of learning and Husserl’s formulations of the constitution of experience in more depth in the following chapters. First, however, I will examine how experience is understood by adult learning theorists and what frameworks can be useful for exploring it. In this, I strive to show that my emphasis on critical psychoanalytic theory as a framework for learning is consonant with an embodied activity orientation toward learning and that these frameworks, taken together, can efface ways of learning that are otherwise opaque and inaccessible in the context of traumatic experience.

**Experiential Learning**

The notion of experiential learning comprises a major branch of adult education theory and practice. Fenwick (2000) presented a valuable analysis of assumptions made about the nature
of experiential learning in scholarly literature and educational practice. She did so as a preface to reviewing five leading conceptual perspectives on experiential learning, and her observations remain incisively relevant:

What manner of learning can be conceived that is not experiential …? Experience embraces reflective as well as kinesthetic activity, conscious and unconscious dynamics, and all manner of interactions among subjects, texts, and contexts. Experience flows across arbitrary denominations of formal and informal education, private and public sites of learning, and compliant and resistant meaning formation. (pp. 244-245)

Following Alheit (1998, as cited by Fenwick, 2000, p. 244), and reminiscent of Bradley (1981), she went further and confronted naïve and presumptive uses of the concept that ignore struggles for power in organizations and social groups, with the resulting potential for educational initiatives that are coercive, even abusive. Fenwick asserted that “the appropriation of human life experience as a pedagogical project to be managed by educators is highly suspicious” (p. 244) and then issued a warning particularly relevant for the present research:

In a time when an understanding of managed experiential learning is ascending as a primary animator of lifelong learning, the need to disrupt and resist reductionist, binary, individualized notions of experiential learning and pose alternate conceptions becomes urgent. (p. 244)

Nursing literature on “secondary traumatic stress” (STS), as well as the data of this study, provide evidence that “managed experiential learning” is indeed a strategy being explored as a tool for ameliorating the effects of STS in clinical nursing practice settings (e.g., Graham, 2012; Healy & Tyrrell, 2013; Meadors et al., 2010; Meadors & Lamson, 2003; Potter et al., 2013). Assumptions and implications of such strategies are rarely questioned or critically examined, yet the ramifications of implementing learning programs or debriefing sessions to “manage” STS are profound—for nurses individually and for nursing as a profession.

“Uncanny” learning. Fenwick (2000) sketched five theoretical frameworks that she found promising as emergent conceptions of experiential learning. Among these, she presented
psychoanalytic formulations of learning derived from Britzman (1998) and Pitt (1998). According to such theory, when unconscious aspects of mental life assert themselves, they interfere with conscious perception, experience, and learning—producing “breaches” that may “bother the ego” and disrupt mental functioning. Fenwick (2000) characterized these breaches as psychic events that are evidenced in:

random paradoxes and contradictions of experience and uncanny slips into sudden awareness of difficult truths about the self. These truths are what Britzman … calls “lost subjects,” those parts of our selves that we resist and then try to reclaim and want to explore but are afraid to. True knowledge of these lost subjects jeopardizes the ego’s conscious sense of itself … But for the self to be more than a prisoner of its own narcissism, it must bother itself and notice the breaches between acts, thoughts, dreams, waking, wishes, and responsibility. We learn by working through the conflicts of all these psychic events. (pp. 251-252)

Relying further on Britzman (1998), who drew on Anna Freud’s work, Fenwick (2000) termed this an interference model of education because learning results from the “interference of conscious thought by the unconscious” (p. 251). Elsewhere, it is termed a resistance model, as conscious mental functioning is understood to resist such interference by the unconscious (Pitt, 1998). Whereas psychoanalytic theory focuses on the nature of this conflict, particularly its origins and lifeworld effects, educators like Fenwick, Britzman, and Pitt focus on how learning is shaped by such forces. Fenwick asserts that these “disturbing inside-outside encounters are carried on at subtle levels and we draw on many strategies to ignore them. But when we truly attend [to] the encounters, we enter the profound conflicts, which [constitutes] learning” (p. 251).

Learning like this, as an outcome of engaging with profound “inside-outside” conflicts, is evocative of the first and third of Guess’s characteristics of a critical theory: it must provide guidance toward enlightenment or emancipation, and it must support the rehabilitation of reflection as a valid form of knowledge. Considering self-knowledge as a dimension of knowing, this is precisely how Freud and many later psychoanalysts describe the emancipatory potential of
psychoanalytic transformation, which I will explore later in this chapter. Yet a pedagogy like this raises difficult questions of agency and power, because notions of enlightenment and emancipation are heavily contested and, as Fenwick (2000) rightly observed, are highly subject to binary, reductionist, and coercive uses to manage learning toward domesticating ends. The following section surveys and examines critically grounded conceptions of psychoanalytic theory and examines their application to theories of learning within the critical theory tradition.

**Interference and Resistance: Critically-Enriched Psychoanalytic Theory**

As early as 1925, Vygotsky introduced a Russian translation of Freud’s *Beyond the Pleasure Principle*, affirming that he saw in Freud a similar emancipatory potential as evidenced in Marx (Vygotsky & Luria, 1994). Drawing parallels between the two thinkers who “severely infringed age old traditions of bourgeois morality” (p. 10), Vygotsky argued that Freud proposed a “revolutionary” psychology “in the spirit of dialectical materialism,” which recognized a new material construct: “the death instinct … a basic primordial and universal principle common to all living matter” that is attributable not just to mental processes, but “to chemical and physiological processes” as well (pp.10-14). Although Freud’s theory of the death instinct did not enjoy a sustained following in most academic and psychoanalytic circles (Green, 2012), the relationship of Freud’s work to that of Marx remained evident to some—but was overlooked by many more scholars, even among critical theorists.

This was so despite extensive work in the succeeding decades by psychoanalytically oriented Frankfurt School theorists, most notably, Fromm (1941, 1942, 1955, 1959, 1970). For example, Brookfield’s (2002) examination of Fromm’s critical theory focused almost entirely on Fromm’s analysis of Marx, barely touching on his enormous contribution of infusing a critical revision of psychoanalytic thought into a critique of modernity. The closest Brookfield comes to
exploring Fromm’s psychodynamic focus is in acknowledging his assertion that participatory
democracy can be effected only through more deeply relational human activity, in which “the
conversation ceases to be an exchange of commodities (information, knowledge, status) and
becomes a dialogue in which it does not matter anymore who is right” (Fromm, 1976, as cited in

Freire (1994, 2005), as we have seen, drew substantially on Fromm’s thought, but
provided little substantive exploration of the latter’s contributions to a psychoanalytically
informed critical theory and its relevance for adult learning. Lake and Dagostino (2013)
contended that Fromm’s work is a neglected key to analyzing and addressing some of the most
difficult challenges presented by the emancipatory goals of critical theory when applied to adult
education. Contemporary neglect of Fromm’s work may relate to his strained departure from the
Frankfurt School in 1939, to Marcuse’s later rejection of Jungian theory (Steuernagel, 1979), and
Marcuse’s later ambivalence toward Freud (Marcuse, 1970). No doubt the theoretical divide was
exacerbated by the hostile public debate waged between Fromm and Marcuse well into the 1960s
with respect to “revisions” of Freud’s work (Fromm & Funk, 1992). Yet a simpler perspective is
also worth noting. In his master’s thesis, Farewell to Freud: The Frankfurt School and
Psychoanalysis, Floyd (2007) offered a significant insight when he remarked that “Frankfurt
theorists incorporated [the] weaknesses as well as strengths of Freud’s contentions … resulting in
[eventual] abandonment of much of Freudian thought” (p. 1).

Those weaknesses are plentiful (Dufresne, 2007; Geller, 2007; Marcus, 1999; Masson,
1984; Roustang, 1982), ultimately including such constructs as the death instinct (see Green,
2012, regarding Lacan), yet the strengths of Freud’s work have continued to garner significant
attention (Bainbridge & West, 2012; Breger, 2000; Britzman, 2011; Ekstein, 1989; Fromm, 1959;
Sorrell, 2006). Freud’s own logical errors as well as his pattern of cloistering students and
colleagues (and their knowledge production) from cross-disciplinary critique had the unfortunate effect of undermining more sustained and creative scholarly engagement with his work. This pattern combined with Freud’s rigid demands for personal and theoretical loyalty (e.g., Breger, 2000; Fromm, 1959; Geller, 2007; Masson, 1990; Roustang, 1982) are dramatized in the succession of students whom Freud initially embraced, then rejected when the student asserted ideas not consistent with his own notion of orthodoxy. Thus, early 20th century psychoanalytic thought did not evolve (as did, for example, the nascent fields of psychology, phenomenology, and sociology) in the context of widely attended university lectures and debates in major scholarly publications. Instead, for more than half a century, it was forged at small gatherings of fledgling psychoanalytic societies attended by select groups of “the faithful”—students and colleagues deeply loyal to Freud. Nevertheless, as academic scholarship has proceeded beyond the lifetime of Freud (and of his daughter, Anna), a new quality of critique and a rekindling of interest have begun to emerge.

**Fromm’s Critical Revision of Psychoanalytic Theory**

Fromm engaged Freud’s thought in great depth over the course of a varied and resilient career that extended from 1920 through the 1970s (Fromm, 1941, 1942, 1951, 1955, 1959, 1970). His graduate education as a sociologist preceded his training as a psychoanalyst in the early 1920s, and this is reflected in the overarching sociological orientation of his scholarship. Fromm articulated in sustained, incisive detail the social potential of psychoanalytic theory and practice to support human enlightenment and transformation—at the level of society as well as the individual (Cortina & Maccoby, 1996). He demonstrated “for the first time,” in his words, “the applicability of psychoanalytic theory to social-cultural problems” (Fromm & Funk, 1992, p. xiii).
Over his long career, Fromm thus addressed human issues of pain, power, and liberation through research and theory-building that was frequently unorthodox. In *Escape from Freedom* (1941, published as *The Fear of Freedom* in 1942), Fromm responded to the events of 1930s Europe by examining the deep human ambivalence evoked by notions of emancipation and enlightenment. He was unusually skillful at effacing psychoanalytic concepts for a non-psychiatric (or “lay”) readership. In his 1951 book *The Forgotten Language*, for example, Fromm pointed to the broader relevance of dream interpretation in terms of the dynamics of daily life:

Freud’s dream interpretation is based on the same principle as that which underlies his whole psychological theory: the concept that we can have strivings and feelings and wishes which motivate our actions and yet of which we have no awareness. … We repress such strivings, the awareness of which would make us feel guilty or afraid of punishment…[but]…this does not mean that they cease to exist. In fact they continue to exist so vigorously that they find expression in numerous forms, but in such a way that we are unaware of their having [passed] through the back door, as it were. (1951, p. 48)

This construct, known as repression and explained here succinctly by Fromm, is key to a psychoanalytically informed theory of learning that involves the forces of interference and resistance. I will return to this below; the preliminary issue, however, is that Fromm’s very public and accessible writing on a critical theory of psychoanalysis was at the forefront of work to expand and reframe psychoanalytic theory from a system focused on sexual drives and biological instincts to one concerned with the social unchaining of the human psyche. In a forward to the posthumously published collection of essays, *The Revision of Psychoanalysis*, Fromm’s editor, Rainer Funk (1992), noted:

It was Erich Fromm’s conviction that psychoanalysis needs to retain Freud’s essential insight into the unconscious while replacing his mechanistic-materialistic philosophy with a humanistic one. …Fromm presents such a revision of psychoanalysis, one that is both humanistic and dialectical. (p. 135)

Yet as a result of this gradual “revision,” Fromm was regularly attacked during his career by Frankfurt School theorists and psychoanalysts alike (Anshen, 1974; McLaughlin, 1998;
Schaar, 1961). Unlike Marcuse and most orthodox psychoanalysts of the time, Fromm (1992) adamantly rejected the core tenets of the death instinct and drive theory, which he referred to as “the idealization of hopelessness” (p. 125). He challenged, for example, the deterministic premises of drive theory by tracing them to their logical conclusions. Referencing Freud’s *Civilization and Its Discontents* (Freud, 1961), Fromm argued:

> [Freud] assumed that civilization is based on the repression of the libidinous instinct and that it results from a sublimation or reaction formation, for which this repression was a condition. Accordingly, [Freud] believed, man is confronted with the following alternative: Either no repression and hence no civilization; or repression and hence civilization but, in many cases, also neuroses. (Fromm & Funk, 1992, p. 113)

Funk (1992) maintained that “in Fromm’s view, the basic connection between primitive drives and sexuality is of no significance” (p. xii). Yet such components of Freud’s thought—once celebrated by Vygotsky for their biological focus—continued to influence the field of psychoanalysis into the 1970s. Fromm viewed this orientation as nihilistic and a major reason that Freud (and many of his own colleagues in the Frankfurt School) “despaired of all social change for the better” (p. 112) following WWI and, especially, after Hitler’s rise to power.

I am persuaded by Fromm’s assessment of this flaw in early psychoanalytic thought and concur with his conclusion that its associated deterministic premises are fundamentally contradictory with the emancipatory promise within psychoanalytic theory and the broader project of critical theory. Funk (1992) explained that Fromm’s revision shifts the theoretical foundation of psychoanalysis in a fruitful emancipatory direction, replacing a significantly biological cornerstone with one that is socially and historically constructed:

> Fromm replaced the Freudian concept of man and its related theory of drives with a fundamentally different metapsychology: Man is to be understood primarily as a social being; the unconscious is mainly of interest in terms of the social unconscious and social repression; and the fact that man is driven is [due]…to his dichotomical situation as [an individual and a member of society, which is] understood by Fromm as a historically conditioned antagonism [not a material or instinctual one].” (pp. xiii-xiv)
The centrality of the social dimension of human experience highlighted here further aligns Fromm’s work with learning theorists from Berry to Lave to Forester. Yet as Fromm’s critical voice became marginalized in the academy, from the 1970s to the present day, Freud insidiously was “reduced to the liberator of sexuality and … silenced as the pathfinder into the individual [and social] unconscious” (Fromm, 1992, p. 121).

Trauma and Repression: The Landscape of Interference and Resistance

What becomes evident in Fromm’s work, as in that of many psychoanalytic writers, is a set of premises regarding traumatic experience that comprise a backdrop to psychoanalytic theory. More often implicit than explicit, these premises include the notion that mental and emotional traumas are fairly ubiquitous; that trauma often creates profound conflict in the context of social relationships; that these conflicts present a major source of mental and behavioral turmoil; and that the interactions of these forces generate the psychological dynamic Freud termed repression.

According to psychoanalytic theory, repression is an adaptive mental tool for partitioning disturbing and disruptive contents of consciousness—when necessary, creating something like a psychic isolation chamber to exclude the most highly-charged and emotionally-destabilizing content from routine awareness, thereby minimizing its disruptive effects. Yet, as Fromm explained so succinctly (described above), certain elements within consciousness can nonetheless be found actively and incessantly striving to express the repressed content over time “through the back door, as it were” (Fromm, 1951, p. 48). Britzman (1998) characterized this activity of consciousness as “lost subjects,” i.e., those parts of experience that are lost through repression—no longer accessible to our sense of identity and agency—the price we pay for an illusion of conscious mental stability and emotional serenity.
Swiss psychoanalyst Alice Miller (1981, 1983, 1984, 1990a, 1990b) has explored the dynamics of repressed trauma in great depth and, like Fromm, has written extensively for a lay audience. She explained how Freud’s notion of the “repetition compulsion” may be understood as successive attempts by the unconscious to retell the story or re-enact the “drama” (1981) of repressed psychic injuries (i.e., traumas). Writing with striking compassion for the dilemmas faced by the internally divided self in search of its so-called lost subjects, Miller asserted that we express our stories insistently “through the back door” for several reasons. Whereas Fromm maintained that these retellings are expressed covertly due to a hidden sense of guilt or a fear of punishment, Miller addressed the question of why, then, does consciousness undertake to express repressed content in the first place. In answer, she suggested that consciousness insists on these dramatized representations of banished content not only to recover lost subjects within itself, but also to counteract the isolation that comes with banishing mental content that involves powerful life experiences (Miller, 1990a).

Further, Miller (1990a) argued that we reenact traumatic contents of consciousness in the hope of finding what she termed “enlightened witnesses” to our suffering. These are people who help us end our sense of isolation through their willingness—and capacity—to bear witness to our hidden story with empathy and insight, without anxiety or judgment, while affirming our common humanity with theirs. In a line of reasoning that is consonant with Forester’s (1999) conclusions regarding public deliberations, Miller contended that having even one such person bear witness empathically to another’s experience helps to precipitate a different outcome of the hidden story—possibly a more open, integrated, and adaptive psychic response to long-repressed trauma.

Nothing in Miller’s work would suggest she uses the term “enlightened” in a spiritual or religious sense. On the contrary, she deemed religious childrearing manuals of the 18th and 19th centuries to be “poisonous pedagogy” (1983). Rather, Miller evoked the notion of enlightenment
in the sense of one who is free enough from the need to escape their own repressed traumas that they are relatively unafraid to behold the trauma of another. How does one become so liberated? According to Miller (1981, 1990a, 1990b), Fromm (1955, 1976), and a host of other psychoanalytic writers (e.g., Britzman, 2011; Sorrell, 2006), this is accomplished by performing the slow, reflective work of unearthing buried memories, reengaging with painful experience, and readmitting banished knowledge into awareness. This is the struggle of interference and resistance described by Fenwick (2000), Pitt (2003), and Britzman (1998, 2013), enacted between conscious and unconscious dimensions of mental life. As the struggle progresses, banished content may be reevaluated and integrated as a functional part of consciousness. Miller’s poisonous pedagogy is precisely an ideology or set of practices that obstructs such work. In this way, a capacity for ideology critique becomes central to psychoanalytic work.

**A Critical Psychoanalytic Theory of Learning: Conundrums of Emancipation**

Thus, a major core of Freud’s groundbreaking work sought to build within consciousness a capacity for ideology critique, consistent with critical theory—despite the ironic counterpoint of Freud’s personal authoritarian qualities (Roustang, 1982). This is evidenced in both Miller’s and Fromm’s scholarship, as well as in psychoanalytically oriented learning theorists like Britzman. As Fenwick (2000) asserted:

> For the self to be more than a prisoner of its [superficially constructed notions of itself], it must bother itself and notice the breaches between acts, thoughts, dreams, waking, wishes, and responsibility. We learn by working through the conflicts of all these psychic events. (p. 252)

That is to say, we learn through a slow but steady growth in our capacity for awareness, reflection, and critique of the psychic as well as social forces affecting us.

This is the weakness in Freire’s pedagogy identified by Lake and Dagostino (2013), which results from insufficient depth in applying Fromm’s scholarship to his own emancipatory
educational theories. Such psychic work employs critical reflection as an activity capable of generating new meanings from experience—thereby, generating new psychic tools for liberation from ideals that once held us captive to a constrained and superficial presentation of the self. It thus engages the first and third of Guess’s (1981) markers for identifying a theoretical framework as uniquely “critical”: an interest in human enlightenment that leads toward social and psychological emancipation and a capacity to undertake a “rehabilitation of ‘reflection’ as a category of valid knowledge” (p. 2) in support of emancipatory aims.

In addition, Freud’s determination to address the sordid underbelly of human activity and imagination engaged Guess’s (1981) second marker of a critical theory, a substantive concern with the material conditions of human existence, and was likewise aimed at precipitating emancipatory processes—not abstractly, in consciousness alone, but in the lifeworld—across the day-to-day material activities and relationships of people’s lives. Thus, by Guess’s characterization of the epistemic form known as critical theory, psychoanalytic thought as advanced by theorists like Fromm and Miller qualifies as an instance on all fronts.

**Emancipation and Ambivalence**

In very practical terms, then, psychoanalytic theory attempts to offer not only an explanatory framework for why people do what they do—often contrary to their own interests and conscious intentions—but also attempts to build an emancipatory framework that includes functional mental tools to help people do things differently. Yet along with the evidence that Freud sought to advance emancipatory principles through his material engagement with the substantive focus of people’s lives, and to rehabilitate reflection as a powerful tool in accomplishing this work, there is also evidence of his ambivalence about its implications.
In *Freud and Education*, Britzman (2011) framed her discussion of Freud’s relevance to education within the nature of meaning-making as a human preoccupation that undergirds experience and learning alike:

Freud’s psychoanalysis is a capacious theory of interpretation. His approach reads between the lines of congealed experience, reaching into the trouble with having language at all. One consequence of his interest with the breakdown of meaning is that he returned to science what at first seems an anathema to its focus: questions of affect, myth, and desire. (p. 4)

Yet Freud himself was not immune to this breakdown of meaning—or the anathema it makes possible. In his landmark book, *The Interpretation of Dreams* (1999; first published in German in 1899), Freud made a ground-breaking move in the second major edition published in English in 1914. There, for the first time, he located ultimate agency for dream interpretation not with the tacitly presumed and privileged interpreter, the doctor/psychoanalyst, but rather with the dreamer who creates the dream. In the opening pages of chapter two of *Dreams*, Freud (2006) critiqued the limitations of two dominant historical approaches to dream interpretation—symbolic and decoding methods. This discussion has relevance to the possibility of reclaiming traumatic experience by way of interpretation and even through the possibility of learning. Freud explained that the *symbolic* method:

considers the content of the dream as a whole and seeks to replace it by another content which is intelligible and…analogous…. [However, this method] breaks down when faced by dreams which are not merely unintelligible but also [logically] confused. (p. 129)

The *decoding* method, by contrast, is more adaptable to complex, seemingly illogical dreams, “since it treats dreams as a kind of cryptography in which each sign can be translated into another sign having a known meaning, in accordance with a fixed key” (p. 130). Freud then wrote:

Artemidorus of Daldis … left us the most complete and painstaking study of dream interpretation as practiced in the Graeco-Roman world. … The principle of his interpretative art [is] association. A thing in a dream means what it recalls to the mind—to the dream-interpreter’s mind, it need hardly be said. … *The technique which I describe*
in the pages that follow differs in one essential respect: it imposes the task of interpretation upon the dreamer himself. It is not concerned with what occurs to the interpreter in connection with a particular element of the dream, but with what occurs to the dreamer. (p. 130; emphasis added)

Freud did not propose this idea in the original version of *Dreams* published in 1899, but rather as one of numerous addenda presented in the revised and expanded second edition. Unfortunately, judging by the larger corpus of his writing, this attribution of agency to his patients (the dreamers) is not a principle he typically followed in his psychoanalytic practice. It is further ironic that Freud added this methodological point as a footnote, not in the main text. It remains to this day as a testament of the historical ambivalence as well as the socio-political implications of extending to others the power to interpret—even “just” the power to interpret one’s own dreams. For out of such interpretation may flow the power to render new meanings in other realms of private thought and public action, even events on the world stage. Interpretation, the rehabilitation of reflection, ideology critique, and the synthesis of new insight all have powerful material consequences in the world and may be understood as activities of learning and enactments of power.

**Dangerous learning.** Indeed, the material consequences of such learning are by no means predictably “good” in a normative sense. Psychoanalysts and scholars from Freud to Fromm, Miller to Zimbardo have shown there is no guarantee that struggles with repressed suffering will lead to a fruitful reclamation of lost aspects of awareness. They may rather produce mental recoiling and a redoubling of isolative psychic repression. Miller (1983, 1984), for example, contended that Fromm’s “backdoor” expressions of potent repressed traumas comprise, in her words, “final acts” in some of the most destructive dramas of history. Among her book-length explorations of this phenomenon, she examines religiously institutionalized abusive childrearing practices that were promoted for more than two centuries across industrial Europe in *For Your Own Good: Hidden Cruelty in Childrearing and the Roots of Violence* (1983). Labelling these
childrearing manuals as examples of poisonous pedagogy, Miller argued that multi-generational repressed psychic trauma resulting from these patterns of systemic familial abuse functioned to normalize and perpetuate cultural cruelty and the intentional infliction of suffering in many sectors of European life.

Whereas Fromm (1941, 1942) explored the complex historical conditions that culminated in widespread complicity with authoritarian leadership across Europe in the 1930s as an “escape from freedom,” Miller explored the intimate familial traumas that were reflected in brutal political and social policies. This consonance, she maintained, contributed to a psychosocial climate, at both macro and micro levels of culture, where abuses of power were experienced as normative and, further, where unclaimed and displaced rage in large subsets of society functioned like cultural tinder to help ignite ubiquitous horrors, from the Nazi Holocaust to Stalin’s reign of terror. On a much smaller scale, Zimbardo (2007) revisited his experiences with the 1973 Stanford Prison Experiment (Haney & Zimbardo, 1998) and concluded that (even absent a cultural context of systemic cruelty as Miller argued existed in Europe a century ago) social learning can be deeply problematic, even dangerous—as it was among students who informally enacted the role of prison guards and whose actions necessitated an abrupt end to the study.

The Power of Symbolization

For Britzman (1998, 2011, 2013) and Fenwick (2000), the activity of working through contested interpretations of experience is a kind of learning. These competing structures of awareness are Britzman’s “contested objects,” involving conscious as well as emergently conscious mental content and the structures of meaning they represent. Critical reflection on such content engages passive as well as active layers of what we think we know, what we wish to know, what we are afraid to know and so hide from awareness—and also what we seek to prevent
others from finding out. These dynamics raise difficult questions about learning as interpretation—among them, the distribution of power among possible agents of interpretation, which have powerful implications for the notion of learning one’s way through traumatic experience.

Pitt and Britzman (2003) explored this conflict in an article on “difficult knowledge in teaching and learning.” There, they defined trauma as an experience “characterized by a quality of significance that resists meaning even as the affective force of the event can be felt” (p. 758). They drew on the work of literary scholar, Cathy Caruth (1991, 1996), who “uses the term ‘unclaimed experience’ to suggest the paradox of having painful experience but being unable to know just what has happened or why it is important” (Caruth, 1996, cited by Pitt & Britzman, 2003, p. 758). Further, they present the psychoanalytic construct of “deferred action”—a notion that traumatic events are “felt before [they] can be understood” and are felt not only in relation to the present, but in direct relation to prior experience as well. Pitt and Britzman then submitted that meaning-making in terms of “emotional significance is constituted [not in chronological time but] in the time of deferred action” such that one’s “understanding … is not a feature of experience but a problem of symbolization” (p. 758-759). In other words, an understanding of traumatic experience relies fundamentally on interpretation—and not merely linguistic, but symbolic interpretation. Further, such interpretation is temporally and imaginatively extended, not in a linear fashion, but such that consciousness reaches across time, space, memory, and imagination in ways that confuse naïve notions of chronology, presence, cause, and effect. By implication, symbolic interpretation is not entirely rational, as dreams are not, yet reflects constituted structures of meaning and memory that are active within consciousness nonetheless.

Symbolization like this, Pitt and Britzman (2003) suggested, is a type of learning too. Moreover, as I will show in the next chapter, it is evocative of Husserl’s rendering of mental constitution across the “flow” of bodily and mental perception, such that Husserl’s work offers
rich possibilities for exploring learning like this in greater depth. In terms of Pitt and Britzman’s psychodynamic analysis of difficult learning, however, they concluded that such complexities as unclaimed experience and deferred action in the context of traumatic experience means that “there can be no original moment … that gives birth to interpretation” (p. 759): interpretation and symbolization are integral to experience itself. Thus, there are no clear lines distinguishing perception from description from interpretation from experience from theory: learning through symbolized meaning-making engages all of these simultaneously.

Ten years after publishing her article with Pitt, Britzman (2013) returned to better understand her own research experiences of 2002-2003—applying the same conceptual tools, but this time to reflect on her earlier work and her own learning:

With the question of what [lies] between psychoanalysis and pedagogy, this essay presents a psychoanalytic frame for thinking about the … education of the author and her notion of “difficult knowledge.” … [It] returns to what could not be known from the immediacy of felt experience and that only later can be narrated as a story of the disparities, accidents, vacillations and fragmentary impressions that come to compose the problem [of] education as an emotional situation. (p. 95)

Very little scholarship in adult education seems inclined to examine learning “as an emotional situation.” Here, Britzman implicitly reaffirmed her 2003 assertion that the capacity to understand painful experience—to encompass its emotional significance—is not a problem of cognition or reason, but of interpretive symbolization. Such experience cannot “be known from the immediacy of felt experience,” she stated, but can be known only later, in the time of deferred action, and so “narrated as a story” (p. 95). Meaning thus becomes implicated in narrative, as if known from outside of an experience that is held apart, yet can henceforth be claimed, and so retold. Her reflective essay led Britzman (2013) to draw the provocative conclusion that all learning necessitates a degree of “ordinary yet ubiquitous trauma” (p. 770). That is, learning is inseparable from a degree of pain, suffering, and loss, but is also inseparable from the possibility of healing
through the activity of consciousness in reclaiming and restructuring symbolized memory and meanings—that is, healing through a kind of learning.

Britzman’s own work serves as a productive model for the rehabilitation of reflection (Guess, 1981) as a form of inquiry that effaces important aspects of learning that are too little acknowledged or discussed in adult education theory—namely, the emotional complexity, precariousness, pain, and trauma involved in disrupting one’s state of knowledge or awareness and questioning the meaning of one’s own experience. Indeed, the possibility of vulnerability and trauma is raised even in acknowledging interference by uncanny disruptions and psychic breaches—and more so by choosing to explore rather than resist them, thereby inviting new and possibly less certain ways of knowing. Bainbridge and West (2012) significantly expanded the discourse on a critical psychoanalytic theory of learning when they released their edited volume, *Psychoanalysis and Education: Minding a Gap*. Yet, as we have seen, this approach to learning theory is deeply consistent with emancipatory learning advocated by many other critical scholars of adult education. It is perhaps time for the next generation of adult education theorists to acknowledge and engage the psychoanalytic tradition in critical theory.

**A Definition of Learning**

The work of critical care nurses is physically potent—it involves hands-on care of people’s bruised and bleeding bodies, their physical and emotional pain, compromised limbs and organ systems—the literal blood and guts of human life. This project thus required a definition of learning that encompasses embodiment. At the same time, because the nursing profession is situated centrally within a multi-billion-dollar industry comprised of powerful, often competing, actors and agendas, this project required a definition and theory of learning that engages power and resistance in cultural and organizational contexts. The psychic pain and conflict produced by
trauma further necessitates a definition of learning that is not naïve, either cognitively or emotionally, but able to comprehend interference, conflict, and incongruence between claimed knowledge, felt experience, and perceived learning outcomes.

In her article on experiential learning, Fenwick (2000) approached a definition of learning not as a process or an outcome, but as a construct: a “pedagogical frame,” that is, a theorized perspective that helps us think systematically about a particular dimension of experience. Such a framework, she contended, allows us to consider an “intersection” between people and an environment in which there occurs “a traceable developmental moment” (p. 245). By the word “traceable,” I understand Fenwick’s notion of learning to be situated in multiple ways—bodily, spatially, temporally, and relationally. By the word “developmental,” I understand her learning to be situated psychically—both cognitively and emotionally—and also historically and culturally. Fenwick’s learning, then, is transitive. It is not a process or an outcome, but moves toward an outcome through embodied and socially mediated activity. That movement is not invisible (a mental process), but manifest, material, witnessed, capable of being traced and reflected upon. Neither is that movement linear, necessarily, nor its outcomes predictable and determinate. Indeed, manifest outcomes within such a definition may interfere with or resist any number of pedagogically desired results.

Fenwick (2000) does not define her use of the term “developmental,” which has a meaning in the field of psychology quite different than in education. Illeris’s (2004, 2009) integration of learning theory substantiated a scholarly use of the term, but a dictionary definition of the intransitive verb “to develop” is also useful here: it signifies activity by a subject characterized by differentiation, gradual manifestation, evolution through successive change, or a gradual initiation of being (“Develop,” 2013). I thereby conclude Fenwick’s notion of development as signifying bounded, traceable moments characterized by discernable
differentiation, manifest and successive change, or an initiation of change in one’s way of being in or interacting with the world of one’s experience.

Moreover, Fenwick’s (2000) definition is built on a critical appreciation of power and how it can be misused in education. Composed for the project of analyzing varied conceptions of experiential learning, her definition predated work I have examined by Pitt and Britzman (2003) and Britzman (2013), and Fenwick’s scholarship in the years since 2000 has not focused on psychodynamic (or interference) learning models, but has explored other areas of theory and practice. Thus, her definition, from which I work, does not evoke conceptions of learning expressed by Britzman or Pitt, as symbolized meaning-making within such temporal constraints as deferred action. Yet Fenwick’s definition indeed alludes to a notion like deferred action in the very structure of its transitive form. It further alludes to Britzman’s (2013) conclusion as to the narrative quality of such learning, which cannot “be known from the immediacy of felt experience and that only later can be narrated as a story of the disparities, accidents, vacillations and fragmentary impressions that come to compose the problem [of] education as an emotional situation” (p. 95). What is narrative, after all, if not the tracing of development?

Thus, following Fenwick, I define learning here as embodied, situated, socially mediated, and conflict-laden activity that presents “traceable developmental moments” characterized by discernible differentiation, successive change, or a manifested initiation of change in an individual’s or group’s perception of, or way of being in and/or interacting with, their lifeworld. This traceable development includes discernable change in an individual’s or group’s manner of structuring and symbolizing meaning in relation to felt experience, as well as manifest change in an emotional as well as cognitive capacity to claim experience as one’s own.

This definition is able to encompass many kinds of agentive activity that may lead to differentiation or development of various types while still being recognizable as instances of
learning. It is particularly suitable for a study of learning in the context of trauma because it conceives learning as contextually emergent and malleable, as subject to a myriad of influences, including conflict, suffering, and loss. It can thus encompass possibilities for manifest learning that are not good in a normative or ethical sense, but rather are experienced as stressful, harmful, destabilizing, and capable of generating confusion, hostility, even violence. In the next chapter, as I present phenomenology as a philosophical system and a framework for qualitative research, numerous correspondences will become evident between the activity of consciousness as formulated by Husserl and the conceptions of learning presented here.
CHAPTER FOUR
HUSSERL’S PHENOMENOLOGY: CONSTITUTING EMBODIED EXPERIENCE

Law IX of the House of God: The only good admission is a dead admission.

With the sweat dripping from my brow onto Jimmy’s chart and the flu dripping through every muscle and bowel villus in my body, I finished my write-up and sent...it to the SICU. I sat for a moment musing: Well, this has been the worst night of my life, but now it’s over, and now I can go to sleep. They can’t get me now. Through the window came that comforting smell of fresh rain on hot asphalt. The nurse came in and said, “Mr. Lazarus just had a bowel movement that’s all blood.”

“Hey that’s really funny Maxine....”
“No, I’m serious. The bed is solid blood.”

They wanted me to go on and I could not. The world became the world just before the head-on crash. It could not be what it was. “I can’t do anything more tonight,” I heard myself say. “I’ll see you in the morning.”

“Look, Roy, don’t you understand? He’s just bled out a gallon of blood. He’s lying in it. You’re the doctor, and you have to do something for him.”

Filled with hate, trying to get rid of thoughts that Lazarus wanted to die and I wanted him to die and I had to break my ass to stop him from dying, I went into his room.... On autopilot, I went to work. My last clear memory was putting a naso-gastric tube down....

Just after Lazarus, just before dawn, Dr. Sanders came back in, bald from the chemotherapy, infected and bleeding....

“I’m glad you’ll be taking care of me again,” he said weakly.

“So am I,” I said, wondering if this admission would be his last, and realizing how attached to him I felt.

... And I realized that they could never hurt me more than they had just hurt me that night.


Shem turned to the creation of narrative as a path for healing his hurt, even as hooks (1994) turned to theory as a way of healing hers. This research asks what it is that nurses do. How do nurses survive the head-on crash of experience while handling the blood and guts of human suffering? How does their hurt shape their actions and their learning? And of further concern in this study and this chapter: What tools are available to help researchers penetrate the intimate embodied and psychic dimensions of such experience with sensitivity and methodological rigor?
Background

Edmund Husserl (1859-1938) developed the philosophical form known as phenomenology in order to generate an alternative to deterministic analytic disciplines of his day. He was motivated to do so because the contents of human consciousness comprise a complex, yet indeterminate, system that can be effaced only in limited ways by material instruments of measurement drawn from the natural sciences; yet it is richly accessible by way of rigorous reflection and description (Giorgi, 2009). Phenomenology has been adapted widely by qualitative empirical researchers, particularly those in the psychosocial (or human) sciences where the investigator’s ability to account for the activities of consciousness becomes an inescapable prerequisite to making any type of knowledge claims (Barkway, 2001; Carel, 2008; Cornell, 2008; Dowling, 2007; Drummond, Mclafferty, Hendry, & Pringle, 2011; Giorgi, 1970, 1985, 2000, 2009; Henry, 2008; Larrabee, 1976; Polkinghorne, 1983). In the fields of psychology as well as adult education, Husserl’s theoretical system comprises a crucial counterpoint to mechanistic models of the brain/mind and psychometric research tools that attempt to quantify experience. In fact, from his early philosophical explorations, particularly Logical Investigations first published in 1900, Husserl (1970a) sought to correct the errors of psychologism and transcend behavioral approaches to consciousness by penetrating the black box of mental life (Feest, 2012; Kochan, 2011; Liberman, 2008; Welton, 1982; Zahavi, 2003).

For the task of comprehending mental trauma, a phenomenological account of experience has particular relevance. I have discussed (see Chapter 3) how the work of meaning-making, as effaced in critically grounded psychoanalytic theory and psychodynamically enriched adult learning theory, is crucial for grasping the nature of trauma. Phenomenological investigation, with its interest in meaning-making within constitutional activity, provides a fitting and systematic avenue for inquiring about the psychical and embodied constitution of traumatic experience.
British medical philosopher Havi Carel (Carel & MacNaughton, 2012; Carel, 2008, 2009, 2011, 2012; Malpass et al., 2012) argued that phenomenological philosophy has particular relevance to exploring another form of trauma, the experience of serious illness. Indeed, phenomenology’s tools for examining the constitutional process are pivotal to effacing how it is one even comes to “know” that they have experienced trauma in the first place (Britzman, 2013; Caruth, 1996; Pitt & Britzman, 2003). In addition, my study of Husserl’s phenomenology alongside Freud’s psychoanalytic thought suggests a number of interesting conceptual parallels in the structure of each, which are likewise relevant to exploring the nature of trauma (e.g., Brenner, 2001; Gupta, 2004; Levine, 2009b; van den Berg, 1972).

I have thus chosen to follow a “modified Husserlian” (Giorgi, 2009) descriptive phenomenological method in this study, as explicated in depth by Amedeo Giorgi (1970, 1985, 2000, 2009). Giorgi is recognized internationally as a foremost scholar of applied phenomenological research who has articulated a detailed empirical scientific methodology for qualitative human science inquiry—an approach associated with the Duquesne School (or Duquesne group) of phenomenology, after the university where Giorgi and colleagues collaborated for over three decades and where portions of the massive Husserl Archives reside. Giorgi’s approach has been applied well beyond the field of psychology to numerous other realms of human science inquiry (Polkinghorne, 1983), including nursing research (Dowling, 2007; Giorgi, 2000).

I wish to note at the outset of this discussion that I have not relied on thematic content analysis as the centerpiece for qualitative data analysis in this study. Nor have I sought to undertake a specifically transcendental (Moustakas, 1994) or hermeneutic (van Manen, 1997) phenomenological approach. My study of phenomenological philosophy suggests that rendering these approaches as binary opposites reflects a fairly superficial understanding of Husserl’s work.
Instead, based on the understandings presented in this chapter, I have sought to generate a more integrative methodology that appreciates both descriptive and interpretive activity (e.g., Carel, 2008; Lohmar, 2012; Morse, 1994; Rojcewicz & Lutgens, 1996). Following Giorgi, however, I focus on the work of Husserl as the founder of phenomenological philosophy. Also following Giorgi, I focus on explorations of Husserl’s work as it has been applied to the scientific method generally (e.g., Feist, 2004; Kochan, 2011; Liberman, 2008) and to human science or “caring” research in particular (Carel, 2008, 2011, 2012; Giorgi, 2000; Polkinghorne, 1983). In so doing, I have concluded that Husserl’s work invites a broad examination of the nature of human science research as well as a fundamental reassessment of the mental activities underlying all types of scientific inquiry. This implies a richer scope of application for his thought than some phenomenological research texts seem to imagine (e.g., Moustakas, 1994; van Manen, 1997, among others). In other words, I find that Husserl’s philosophy pertains to the entire research project, not merely to qualitative data collection and analysis, even though it is the latter realm where most phenomenological research scholarship has focused.

This chapter thus presents a survey and analysis of key elements of Husserl’s phenomenology. Within this discussion, I also explore Husserl’s so-called “genetic” refinements of his early work and their relevance to the study of traumatic experience. I suggest that a renaissance of sorts is underway in Husserl scholarship by way of the steady progress in publishing and translating his later writings (including tens of thousands of pages of working notes and drafts)—significant portions of which anticipated and addressed problems in his early philosophical formulations. Those problems were the focus of much philosophical criticism of Husserl’s phenomenology in the half-century following his death. Yet scholars like Zahavi (2003, 2012) and Giorgi (2009) argued these critiques are often misplaced, for Husserl himself reached similar conclusions and refined his thought considerably in the last two decades of his life.
In addition, Husserl’s later thought on mental constitution and meaning-making through eidetic work provide a unique set of tools by which to understand the experience of traumatic life events as they are situated dynamically in time and across relationships, within cultures and histories, as well as set in particular material lifeworld conditions (Lohmar, 2012). As I will present below, I am persuaded by Zahavi (2003, 2012) that Husserl’s work ultimately develops a sociological dimension that supports complex analysis of individual as well as group trauma. Further, as mentioned above, Husserl’s later formulations also exhibit striking similarities with select psychoanalytic principles for understanding human experience—for example, in such constructs as free association (Husserl’s free imaginative variation), transference / counter-transference (Husserl’s intersubjectivity), and the dynamics of the unconscious (Husserl’s passive synthesis). In later pages, I thus trace parallels between Husserl and Freud as they have informed my methodology. Yet just as Freud and Husserl were motivated by different concerns and directed their efforts toward different ends, this research is directed toward a different purpose than psychoanalysis or phenomenological philosophy.

Therefore, while it is beyond the scope of this work to provide a full overview of phenomenology, I do seek to present the philosophical conclusions that guided my empirical decision-making. Similarly, it is not my aim to render a psychoanalytic reading of experience, generally, or of my research participants’ experiences in particular. I do, however, seek to understand the experience of secondary trauma among nurses in a manner informed by critically grounded psychodynamic insights into suffering and the learning that may accompany it.

**Roots of Phenomenological Philosophy**

What is known today as “phenomenology” has its origins, well over a century ago, as a philosophical movement inspired primarily by the work of the Austro-Hungarian philosopher
Edmund Husserl (Albertazzi, Libardi, & Poli, 1996; Luft & Overgaard, 2012; Rollinger, 2008; Zahavi, 2003). Husserl was a young mathematician in Berlin in the early 1880s with a strong interest in the time-space continuum and the functioning of the mind (Albertazzi, 1996), themes which were central to his later phenomenological investigations. His turn to philosophy, however, occurred after a move to Vienna in 1884, where he became a principal student of the German philosopher Franz Brentano (1838-1917), whose work paralleled Husserl’s interests and provided many ingredients of the latter’s eventual phenomenological “method,” such as its concern with the nature of mental perception, precise observation and description of phenomena, and its theory of intentionality (Albertazzi et al., 1996). Brentano’s philosophic investigations so delved into the structure of consciousness that he is noted to have used the terms “descriptive psychology” and “descriptive phenomenology” interchangeably (Rollinger, 2008; Simons, 2012), a practice Husserl continued briefly before differentiating the two prior to his publication of Ideas I in 1913 (Albertazzi, 1996; Zahavi, 2003).

Brentano is thus considered not only the forerunner of Husserl’s philosophy, but also a seminal scholar who shaped the modern field of psychology. Albertazzi and associates (1996) noted that Brentano’s work:

marks the transition between the Aristotelian doctrine that psychology was the science of the soul, where soul is defined as … the underlying substance of presentations, and the new doctrine that held that psychology was the science of psychic phenomena understood as such without…resort to the device of an underlying substance. (p. 12)

Phenomenology, then, began a branch of human science scholarship with significant linkages to the fledgling field of psychology (Husserl, 1900/1970). Yet for Husserl, it soon became a broader project, which he defined as “the science of pure consciousness” (Mohanty, 2008, as cited in Earle, 2010, p. 287) and as a “mode of inquiry…seeking an indisputable basis for all human knowledge” (Husserl, 1969, as cited in Barkway, 2001, p. 192). Following Husserl,
phenomenology has been described as “a critical methodology that invites us to revisit our conscious experience” (Barkway, 2001, p. 192), “a descriptive method aimed at discerning acts of consciousness” (Carel, 2012, p. 97), and studies in the origins of how phenomena are constituted in consciousness (Rojcewicz & Lutgens, 1996).

What is seen in these characterizations is also evident throughout the literature—namely, that phenomenology is simultaneously concerned with two related projects. It seeks to create:

1) an ontologic framework for addressing questions about the nature of being human with a human consciousness, and how it is that humans exist in and are capable of engagement with the “lifeworld” (a term Husserl, following Brentano, used widely); and

2) an epistemic framework for addressing questions about the nature of knowing: that is, how human consciousness is able to know (and, implicitly, learn) about the world and thereby generate a sound mental basis for inquiry and action.

This dual concern has spawned a degree of confusion in some disciplines as to whether, as a branch of philosophy, phenomenology is more relevant for exploring ontological questions of being or epistemic questions of knowing, or both. Indeed, Husserl’s own career was wide-ranging and engaged both sets of questions. Feist (2004) observed that, beyond his roots as a mathematician, Husserl “lived through a dynamic time for the sciences,” when momentous changes took place in physics and mathematics across Europe, and “some of the greatest practitioners of these disciplines were pursuing foundational questions with an unprecedented depth and rigour” (p. 1). Those researchers not only pressed the boundaries of thought within their own branches of science; they challenged the philosophy of science in ways that were unprecedented since the classical period of Aristotle (Philipse, 2004). Dodd (1996) contended:

Husserl, perhaps more than any other philosopher of the early decades of [the 20th] century, represents a transition from one philosophical culture to another … [and he was] an intellectual creature of both these worlds…. Husserl’s philosophy…accepts that
reason is basic, yet develops a critical apparatus wherein what this ‘reason’ means, or
could mean, is problematic.” (p. ix)

Phenomenology as a Comprehensive Philosophy of Science

Thus, Husserl lived and worked at a scholarly, geographical, historical, and cultural
convergence that is reflected in the immense philosophic and methodologic framework he sought
to develop (Albertazzi, 1996; Feist, 2004; Zahavi, 2003). Indeed, phenomenology may be
understood not just as a method for inquiry, but as a rigorous philosophically grounded approach
to systematic knowledge creation. Giorgi (2009) went so far as to claim that the scope of
Husserl’s phenomenology is “sufficiently comprehensive to [form] the basis for a complete
philosophy of science” (p. 79). Yet positivism and logical positivism, particularly as advanced by
the Vienna Circle in the early 20th century, continue to be privileged by researchers across many
disciplines in the academy.

Contemporary phenomenological researchers like Giorgi (2009), however, argued against
a conflation of positivism and empiricism, thereby challenging what they consider to be
misplaced critiques of a Husserlian phenomenological philosophy of science. Giorgi’s own
carefully articulated guidance for conducting phenomenological human science inquiry (2009),
which he terms a “scientific phenomenological method” (p. 67), invites study of the growing
secondary literature focused on reexamining the evolution of Husserl’s thought. Such study has
been important, for the mature portion of Husserl’s massive corpus (i.e., that produced from the
1920s through the end of his life in 1938) has been difficult to access and was widely overlooked
until recent decades. Zahavi (2003) reported that “when [Husserl] died on April 27, 1938, [the]
so-called research manuscripts (together with his lecture manuscripts and still unpublished books)
amounted to 45,000 pages,” which to this day makes it “unlikely that any one person has ever
read everything he wrote” (p. 2). Zahavi draws on these unpublished manuscripts in his own
work, arguing that Husserl’s later writing, in particular, offers pivotal critiques and expansions upon his earlier work and are therefore are necessary reading to understand his mature thought.

He argued that Husserl:

frequently remarked that the most important part of his writings were to be found in his manuscripts. For instance, in a letter ... [of] April 5, 1931, Husserl remarks: “Indeed, the largest and, as I actually believe, the most important part of my life’s work still lies in my manuscripts, scarcely manageable because of their volume” (Hua 16/lxvi; cf.14/xix).

(pp. 4-5, emphasis added)

Stroker (1993) also alluded to the lack of definitive edited, published (not to mention, translated) renderings of these manuscripts—despite which, she comments that the available “literature on Husserl has long since threatened to become impossible to survey” (p. xxvii).

Nevertheless, Stroker contended:

Not only the unusual circumstances surrounding the availability of his work, but also the characteristic peculiarities of the work itself, Husserl’s mode of working, and his manner and form of publishing (or only planning to publish) have repeatedly abetted a fragmentary reception of his philosophy … [which], however, runs wholly contrary to the very idea and method of Husserl’s philosophy. (pp. xxv-xxvi)

Giorgi (2009) goes even further, stating:

One consequence of this state of affairs is that Husserl often had analyzed in some detail issues that were buried in the [more than 40,000 pages of unpublished] manuscripts, [but] were not explicitly discussed in published texts, and as a consequence his critics often got wrong impressions of his views. In addition, Husserl kept revising his views as he saw limitations in his earlier writings and so critics were often attributing to him positions that he outgrew. (p. 4)

A Compromised Legacy

Zahavi (2003) agreed with Giorgi (2009) that much contemporary criticism of Husserl’s scholarship still suffers from inadequate familiarity with the intricacies of his work. Naberhaus (2007) satirized such critiques by arguing that Husserl is often portrayed as an obsessed “stock character in those narratives of modern philosophy which see it as having been dominated by a poisonous Cartesian subjectivism prior to the arrival of one or another of philosophy’s great...
twentieth-century saviors (typically one chooses either Heidegger or Wittgenstein here)” (p. 247). Underlying such polarization, however, Husserl’s legacy and the sustained investigation of his work was impeded by political and historical events, for his Jewish ancestry made him a target under the National Socialist (Nazi) party in Germany during the 1930s. Most significant, perhaps, Husserl’s leading student and then colleague Martin Heidegger (1889-1976), who assumed Husserl’s endowed chair at the University of Freiberg upon Husserl’s retirement in 1929, allied himself with the Nazi party during the 1930s. In 1933, Heidegger was named rector of the university and became complicit in excluding Husserl from the university libraries. Whereas the two philosophers had long disagreed on a number of tenets within Husserl’s transcendental phenomenological approach, Heidegger was instrumental in suppressing Husserl’s work from 1933 to the end of Husserl’s life. Husserl died only weeks after the military annex of Austria by Hitler’s army, and Zahavi (2003) reported that trunks of his unpublished manuscripts were successfully smuggled into Belgium, where the Husserl Archives were founded at the Institute of Philosophy in Leuven in the years following 1942.

Thus, Heidegger effectively marginalized Husserl’s scholarship for more than a decade, from the early 1930s to the end of World War II, by which time an impressive group of third-generation phenomenological philosophers were coming into prominence—among them Sartre, Levinas, Arendt, and Merleau-Ponty. These scholars built on Heidegger’s work at least as much as they did upon the available (published) portions of Husserl’s writing. In this way, successive generations of scholars who advanced the phenomenological movement too often did so with limited awareness and little mastery of the depth and scope of Husserl’s thought.

Since the 1970s, however, Husserl scholarship has been steadily growing, as these texts become more widely accessible. Giorgi, having spent more than three decades at an institution that houses a significant portion of the Husserl Archives, is one such scholar who has been able to
integrate and articulate a broad synthesis of Husserl’s work. The next sections briefly discuss the contemporary state of phenomenological nursing research practice before examining key concepts within Husserl’s phenomenological method of investigation.

**Phenomenology in Nursing Research: Critiques**

Phenomenology has been widely employed as a method for nurse researchers to access the experience of illness and suffering: not only among patients, but in their families and caregivers too (e.g., Dowling, 2007; Mackey, 2005; Perry, 2010). Yet for two decades, objections have been leveled toward nursing literature that employs phenomenological methods. In the 1990s, Paley (1997, 1998) published two articles that soundly criticized not only the methods practiced in a number of nursing studies but also the epistemic goals undertaken and the conceptual mastery demonstrated by nurse researchers’ work. From both a Husserlian and a Heideggerian perspective, Paley (1997) argued, the philosophical concepts attributed by nurse researchers to these philosophers bore “little resemblance to the original” work (p. 187). Further, he contended that as misconstrued in nursing studies, “lived experience research constitutes not a realization, but rather a betrayal of Heidegger’s phenomenology” (Paley, 1998, p. 817).

A year before Paley’s first critique, Crotty (1996) published a book-length study, *Phenomenology and Nursing Research*, which in the words of McNamara (2005), “took nurse researchers to task for misinterpreting and misusing the methodology and methods of phenomenology” (p. 695). Meanwhile, Draucker (1999) conducted a review of nursing studies relying on Heideggerian phenomenology and concurred, drawing on Annells (1996): “Nurse researchers have offered ‘limited critique and a dearth of cautionary advice regarding the use of hermeneutic inquiry’” (Annells, 1996, as cited in Draucker, 1999, p. 360). Although I disagree with some of Draucker’s characterizations of Husserl’s (and Heidegger’s) philosophical goals and
accomplishments (and the differences between their approaches), I agree with her challenge to phenomenological nurse researchers—namely, that they must “strengthen their partnerships with philosophers and other scholars” (p. 360) who can help them refine and improve their methods while providing more “robust description of the processes of interpretive research” (p. 371).

The Complex Demands of Human Science Research

In 2000, Giorgi weighed in, arguing that “caring research” presents unique challenges to clinician-researchers (including nurses), and thereby forces certain adaptations and distinctions in the clinical use of phenomenological methods. Giorgi’s own research was among the work “taken to task” by Crotty, and he in turn takes Crotty to task for failing to address what Giorgi claims are legitimate differences among therapeutic disciplines, which necessitate changes to the practice of phenomenological research, as a method. Elsewhere, Giorgi (2009) is explicit in stating that a fully developed exposition of phenomenology as a method of scientific inquiry has not yet been systematically articulated. Thus, Giorgi challenged Crotty’s unitary “philosophical” rendering of the framework of phenomenology and raised compelling substantive questions about Crotty’s explication of the method in general, and of Husserl’s work in particular.

Barkway (2001) adopted a broader perspective in her engagement of the debate “as to whether Crotty’s work is a scholarly, reasoned critique or a severe, judgmental, fault-finding” mission (p. 191). After reviewing the development of the phenomenological movement in philosophy, she affirmed a point made by Luft and Overgaard (2012), namely, that phenomenology was developed by Husserl to give an account “not of the world as such but of the experience of the world from a first person perspective” (p. 11). She agreed with Giorgi that its use as a vehicle for social research creates a new set of methodologic demands:

[I]n the North American context, [phenomenological methods] came to be applied to the study of other people’s experience, which is reported in the third person.... Crotty
describes [this] tradition as a strong cohesive one, in which pragmatist philosophy, symbolic interactionism and humanistic psychology make important contributions. (Barkway, 2001, p. 192)

Barkway allowed that Crotty is primarily and legitimately concerned with the shift evidenced in this tradition from a critically reflective first-person focus to an uncritical third-person focus:

[Crotty] suggested that an uncritical acceptance of the participant’s account of the experience would not shed new light on the phenomenon under investigation—that a person’s experience of a phenomenon is not the phenomenon and that this subjective approach was impoverishing to nursing research. (p. 193)

She concluded that although “there is no argument here about the tone of [Crotty’s] writing being disparaging … it clearly is … one must be careful not to dismiss what Crotty is saying on the basis of how he says it” (p. 194). Thus, Barkway affirmed Crotty’s critique that phenomenological human science inquiry must far exceed re-presenting participants’ accounts and undertake a critical analytic process that engages the qualitative nature of phenomena in the lifeworld.

In 2005, four major papers addressed these issues. In response to calls for nursing to reengage with the philosophical scholarship that underpins phenomenological research methods, Mackey (2005) offered a review of Heideggerian “interpretive phenomenology” in service of that end, and McNamara (2005) published a discussion paper that renders more visible the deliberative process of crafting such a methodology by chronicling “how the critique of phenomenological nursing research was used to inform a research project…[focused] on the implications of a sound understanding of the notions of bracketing and intentionality for the research process” (p. 697). In the same year, Paley (2005) renewed his critique of a decade prior, this time advancing a different concern—that the prevailing “rhetoric” of phenomenological nursing research attempts to support “an alternative to ‘science’, differing in its presuppositions, its methods, and its objectives” (p. 107) even as the published reports of this alternative approach often “appropriate scientific prerogatives illegitimately” (p. 113). This discrepancy between
avowed principles and practices, Paley concluded, results in a continued state of affairs where phenomenological (and other qualitative) nurse researchers are “saddled with a philosophy… which is disabling, because it renounces [scientific goals of objectivity, generalizability, and theory-generation], and says that they can only talk about perceptions and experience, meanings and uniqueness” (p. 113). Yet, he argues, many of the articles he reviewed eventually re-appropriated those renounced goals, by the back door, so to speak. Finally, Allen and Cloyes (2005) analyzed contexts and variations in nurse researchers’ use of the word experience (e.g., as part of the phrase lived experience that is widely used as a marker for empirical phenomenological research practice). Consistent with Paley, they found the use of the term experience revealed contradictory implications about “ontological commitments, visions of the…self and its relation to ‘society’, understandings of research methodology, and the politics of nursing. Our conclusion is that this is too heavy a load to expect a single word to bear” (p. 98).

More recently, Dowling (2007) published a review of phenomenological approaches used in nursing research, and Bradbury-Jones (2012) published a response to a review article by Earle (2010) that was a direct attempt by the latter to address variant understandings about the nature of “phenomenology” as outlined above. Although I find Earle’s overview to be helpful (albeit, brief), it emphasizes hermeneutic (Heideggerian) methods—focusing heavily, for example, on van Manen’s rendering of Heidegger’s philosophical work in a fairly prescriptive presentation of linguistically based analysis. Earle does not explicitly answer the rhetorical question posed in her title: i.e., whether phenomenology is a “research method” or a “substantive metaphysics” (p. 286). Presumably, we are to understand that her answer is “yes” to both. Yet I find Bradbury-Jones (2012) persuasive in her response: The key difficulty she identifies with Earle’s question is its assumption that nurse researchers are sufficiently familiar with the philosophical foundation of qualitative inquiry—both metaphysical and empiricist—that they are equipped to debate the
question posed in the article’s title. She contends that the reason “why nurse researchers appear to struggle with phenomenology—the reason why they get it wrong … [is a] failure on the part of many researchers to access primary phenomenological texts and their over-reliance on secondary sources” (p. 225).

Responding to the Critiques

The critiques above raise the question of how appropriate it is to apply a philosophical system (phenomenology) built on first-person subjective experience to the realm of scientific inquiry built on third-person objective observation. I have tried to anticipate this problem generally by discussing the relevance of Husserl’s phenomenology to a broad philosophy of science. I will later discuss contemporary analyses of Husserl’s notion of intersubjectivity and its implications for revising the binary system so widely accepted in the academy: the objective / subjective divide. Giorgi (2009), however, addresses the first-person / third-person quandary head on in terms that are responsive to Barkway’s (2001) observation (and consistent with Crotty (1996)) that “an uncritical acceptance of the participant’s account of…experience” does nothing to illuminate a phenomenon scientifically, and that “a person’s experience of a phenomenon is not the phenomenon” (p. 193). Giorgi (2009) explained that the methodological locus of “experience” in an empirical context, as well as the locus of constitution and analysis lies not with the research participant, but within the consciousness of the researcher. He wrote:

Phenomenological analyses are not dependent upon the self-report, regardless of how frequently it is used. One can apply the phenomenological method to the behavior and actions of others. What is [consistent] is that the phenomenon must present itself to the experience of the phenomenologist, but the mode can be indirect as well as direct. A rich, concrete description of an experience by another can be the basis of my phenomenological analysis of that experience because the meanings being awakened by my analysis are being given directly to my consciousness and even being constituted by [my consciousness]. … Thus to work on the basis of the other is a concession to the tradition of scientific research. (p. 112)
He proceeded to argue, in detail, that it is an acceptable concession—one that holds up under both philosophical and scientific methodological scrutiny.

More broadly, texts by highly respected secondary philosophical scholars of Husserl (or of Heidegger), such as those I have relied upon here, are also a necessary tool (along with the study of primary texts) in order for non-philosopher investigators to become adequately educated to undertake a phenomenological research approach in a credible manner. Primary philosophical texts are difficult to master, particularly in a scholarly environment that rewards empirical investigation and complicates direct input from academic philosophers. Giorgi, on the other hand, benefitted from a rich cross-disciplinary environment of phenomenological scholarship that included generous engagement with philosophers where he spent much of his career (Duquesne University and the so-called Duquesne School, see Dowling, 2007). Lacking substantive scholarly interaction of this kind, it is unlikely that empirical researchers in the social sciences can find sufficient avenues for developing mastery of phenomenological philosophical texts, so as to apply them in a manner that appreciates the complexity, precision, and evolution of the method.

I have found that broad, deep, and sustained engagement with the work of a variety of leading secondary philosophical scholars is imperative to achieving a strong working knowledge of the philosophical and methodological dimensions of phenomenology. Broad, general review of a limited number of primary philosophical texts is not adequate. Thus, although I agree with Bradbury-Jones that researcher engagement with primary philosophical texts is important, I would add that the quality, diversity, and tenacity of a researcher’s engagement with a variety of leading texts, as well as with a community of scholars in phenomenological philosophy, is crucial.

The following sections aim to clarify the philosophical concepts I have distilled and applied to the empirical methodology developed for this study. After outlining the significance of
Giorgi’s contributions to phenomenological research scholarship, I present key structural components of Husserl’s phenomenological method.

**Overview of Husserlian Phenomenology and Giorgi’s Adaptations for Human Science Inquiry**

My review of Husserl’s phenomenological philosophy and its use in empirical human science research will, from this point forward, rely centrally on the work of Giorgi (1970, 1985, 2000, 2009). Giorgi (2009) took great pains to defend Husserl and Husserlian phenomenology against what he considered insubstantial or misguided critiques based on insufficient mastery of Husserl’s mature thought. In so doing, he noted that phenomenology is quite young as a philosophical movement—as is his own discipline of psychology—and the same may be said of adult education too. Any research conducted under a conceptual umbrella combining such relatively nascent traditions will surely be contested. The scientific method itself, after which most social science research is presently modelled, only has a history of a few hundred years—meager relative to the Greek mathematics tradition alongside which Husserl developed his “eidetic science” as a basis for phenomenological investigation.

In short, Giorgi (2009) argued that an empirical phenomenological methodology like that which he has adapted from Husserl’s work, is philosophically sound, even though he (and all empirical phenomenological researchers) are attempting to operate:

within a phenomenological theory of science that has not yet been systematically articulated. It is implicit in the writings of Husserl (1970, 1983), and other phenomenologists … but a full-blown, articulated exposition does not yet exist. Authors have spoken about it in passing and have treated specialized themes, but not systematically and comprehensively. (p. 68)

In his 2009 text, Giorgi attempted such a synthesis of the three necessary elements he identified in all empirical phenomenological research: 1) phenomenological philosophy, 2) the human science
tradition, and 3) a specific disciplinary perspective (e.g., psychology in Giorgi’s work). In my case, the discipline is education generally, and adult learning in particular.

Having asserted that “at a high level of abstraction … scientific knowledge is knowledge that is: (1) general, (2) systematic, (3) critical, and (4) methodical” (p. 110), Giorgi added that scientific knowledge must also be “as stable as possible” and “requires that the critical other [i.e., the scientific community] have [access to] the method, procedures, and strategies of the analysis performed by the researcher” (p. 113). Thus, scientific knowledge must be sufficiently stable (invariant) and transparent (replicable) that it can provide a basis for further analytic and empirical inquiry.

Notions about the Structure of Consciousness

In his early efforts to develop such a synthesis for his own research, Giorgi (2009) began to question “whether or not ‘method’ was the chief difficulty” or whether broader conceptual issues that confound many qualitative researchers were in fact more fundamental:

My reflections led me to the belief that the major problem…was not the method [used] as such but the philosophy behind the method (Giorgi, 1970). If one could articulate a different philosophy of science necessitated by the encounter with a different type of subject matter [conscious experience], then a different method could emerge. The debate had to take place at the level of what I called “approach” and not at the level of method itself. (p. 120)

He explains that his search for a more fitting, yet equally robust, philosophy of science was only satisfied in Husserl’s “theory of meaning”:

One of the chief contributions of Husserlian phenomenology is that it provides an eidetic science to support empirical findings of a qualitative nature. Mainstream approaches have statistics and probability theory [e.g., quantitative inquiry] or the rules of logic [e.g., philosophical inquiry]. Husserl added morphological essences which help give stability to the contents of experience. … [Husserl’s] genuine contribution [lies in] how to shore up the intrinsic corrigibility of qualitative empirical data with eidetic support. (p. 121)
Eidetics may be defined as the science of discerning or “intuiting” (i.e., “seeing”) essential (invariant) structures that may be discerned throughout a variant range of data. I will discuss this aspect of Husserl’s work, and Giorgi’s application of it, under the second (or eidetic) reduction below. First, I present elements of Husserl’s method of inquiry that precede the eidetic reduction. Philosophically, these begin and are founded upon Husserl’s theory of intentionality.

**Intentionality of perception.** Albertazzi (1996) noted that it was from Brentano that Husserl received the understanding that “consciousness is intentional in character… it is always structurally consciousness of something” (p. 13; emphasis added). According to Brentano, “‘intentionality’… simply meant the directing of consciousness” (p. 14), and this became one of the earliest major features of Husserl’s phenomenology: “the correlation between first-person experience and its content” (Luft & Overgaard, 2012, p. 12). But Husserl did not adopt Brentano’s notion without refinement. Zahavi (2003) contended that Husserl maintained “the intentionality of consciousness is not caused by an external influence, but is due to internal moments in the experience itself” (p. 22). He elaborated, examining Husserl’s manuscripts:

> In contrast to Brentano, Husserl would [maintain that] the core of intentionality consists of the interpretation of something as something. As Husserl writes: ‘[T]he objects of which we are “conscious”, are not simply in consciousness as in a box, so that they can merely be found in it and snatched at in it; …they are first constituted as being what they are for us, and as what they count as for us, in varying forms of objective intention’ (Hua 19/169 [385]. Cf. Hua 2/71-75). (p. 27)

> Though Libardi (1996) considered it one of “Brentano’s most significant achievements…to reintroduce the theory of intentionality into philosophy,” he acknowledged that “its subsequent development into a more complex theory…was the work of his pupils” (p. 59)—Husserl, in particular. Moreover, Husserl’s innovations do not merely link internal consciousness to external objects, but to the inner “constitution” of the objects of experience—a process that by Husserl’s own account is, in part, an interpretive (imaginative) process. This conceptualization of
the nature of experience, as imaginatively constituted, has profound significance in the context of trauma studies, as I will strive to show. Yet Albertazzi (1996) argued that Husserl went further:

Husserl’s most striking innovation vis a vis Brentano was his analysis of the structure of intentionality, which for Brentano was simply the *property of the act* directed towards something. … According to Husserl, in fact, Brentano failed to consider the dynamic structure of the [intentional] act itself, i.e., of the flow. …Prompted by his readings of Twardowski, Husserl developed a systematic theory of intentionality which distinguished it into two different kinds. In Husserl’s analysis, the stream of consciousness flows in two different directions…[which] account for the phenomnic or perceptive continuum: that of continuous change (of the so called flow of consciousness) and that of succession [i.e., stability] of discrete perceptions…(sounds, colours, movements, events in general). (pp. 187-188)

This notion that the “stream of consciousness flows in two directions” is both rich and startling when considered as a feature of Husserl’s thought. Analyses like this fly in the face of those representations of Husserl satirized by Naberhaus, and evoke literary experiments like Joyce’s *Ulysses* (1922/2002)—which was in fact written near the height of Husserl’s career. Similarly, the claim that, for Husserl, intentionality encompasses the constitution of meaning—i.e., acts of imagination and interpretation—challenges the belief (widespread in the hermeneutic phenomenology community) that it was Heidegger who first liberated phenomenology from its Cartesian prison by rendering it an interpretive affair.

**Beyond empiricism.** Giorgi (2009) maintained that the expansiveness of phenomenology extends its reach well beyond that of philosophical empiricism, for it encompasses not only the visible, measurable, determinate lifeworld, but invisible and irreal acts of consciousness too. Along with its sensitivity to the ways in which objects and events are “given to” (or “intuited” in) consciousness, this is a fundamental in Giorgi’s apologetic for phenomenology being a crucial methodology for human science research. Thiel (2001) agreed and argued for the legitimacy of Husserl’s most fundamental guiding principle, the “appeal for ‘going back to the things themselves’ [as] a foundation of all science and philosophy in a clearly understood ‘life-world’”
a principle that places human experience at the center of inquiry. This does not mean, however, that Husserl equated or reduced the phenomenal lifeworld to the subjective experiences of consciousness (an assumptive misunderstanding implied in some phenomenological nursing research). Rather, “Husserl is respectful and trusting with respect to experience,” (p. 69) as an entry point to investigating the lifeworld. Giorgi points to Husserl’s “principle of all principles”:

‘that every originary presentive intuition is a legitimizing source of cognition, that everything originary (so to speak, in its ‘personal’ actuality) offered to us in ‘intuition’ is to be accepted simply as what it is presented as being, but also only within the limits in which it is presented there.’ (1983, 44). (as cited in Giorgi, 2009, p. 69; emphasis in Husserl’s original)

Husserl’s philosophical project thus reflects a conviction that “all disciplines [have] their roots in the ‘lifeworld’ … [necessitating] a general philosophy that [can] account for the gamut of human experience” (Feist, 2004, p. 4). Giorgi (2009) made the case that a phenomenological account of perception is not only as rigorous as empirical study in the natural or “physical” sciences, it is in fact more encompassing. He thereby turned the tables and converted physical science empiricism into a subset of phenomenological investigation. Specifically, Giorgi argued that phenomenology:

is more comprehensive than empiricism insofar as it allows for irreal objects as well as real or empirical ones. … Ideas … meanings … dreams, memories, and images are … phenomena that would not be considered real in the strict [empirical] sense, but they are experiential. (p. 67)

Zahavi (2003) agreed, explaining that the phenomenological concept of perception holds more promise than that offered by the standard empirical framework of inquiry:

Husserl’s concept of experience is far more comprehensive than the one bequeathed to us from empiricism. We not only experience concrete and particular objects, but abstract or universal ones as well. As Husserl once put it…one of the tasks of phenomenology is precisely to overcome and replace the narrow empiristic concept of experience with an enlarged one, and to clarify all of its different forms… (Hua 9/300, 3/44-45). (Zahavi, 2003, p. 37)
Giorgi (2009) explained that because “irreal objects” of investigation such as ideas, images, dreams, and memories do not “exist” in the physical, measurable world of space-time, they cannot be investigated outside of consciousness itself, and are consequently not accessible to inquiry within the natural science paradigm. Yet the scholarly community agrees that such phenomena do exist in human consciousness and are worthy of study. Phenomenology thus provides a sorely needed framework for understanding the irreal (non-empirical, in Giorgi’s terms) experiential phenomena of consciousness, which include traumatization. Giorgi asserted:

Phenomenological phenomenology makes explicit that it considers everything to be studied [as being permeable to study] from the viewpoint of consciousness…or subjectivity… A corollary of this thesis is the understanding that the meaning of what is ‘given’ to consciousness is influenced by its manner of givenness. Consequently, phenomenology is interested in describing both—what is given…and how it is given.” (p. 68)

**Constitution as interpretation.** Phenomenology inquires, then, not only about what is “given” to consciousness, but also how objects—real or irreal, material or imagined—are given to consciousness. And here lies, for Giorgi, a key dimension of meaning-making: for the essential structures of meaning that result from the constitutional process are influenced not merely by the “what,” but the “how”—the “manner of givenness” of the intentional object of consciousness (Giorgi, 2009, p. 68). Just as Husserl’s rendering of intentionality understands perception as active (not merely as caused by external objects) and problematizes experience as a phenomenon that “flows” in more than one direction, so experience itself is not to be understood as merely caused by lifeworld objects and events, but rather as “constituted” internal and external to consciousness—and that constitution is shaped by the way in which lifeworld objects and events are given or “appear” or are “intuited.” Zahavi (2003) elaborated the specific structure of these operations, as set out by Husserl in his first major work, *Logical Investigations* (1900/1970):

[O]ne can analyze every intentional experience from three different perspectives. One can focus on the psychical process, and analyze the immanent content of the act. One can
analyze the meaning of the experience, and thereby investigate its intentional content. Finally, one can focus on that which is intended, that is, on the intentional object that the act is conscious of. (Zahavi, 2003, p. 22; emphasis in original)

Whereas Husserl maintained that both immanent and intentional content are active within consciousness, Zahavi (2003) showed that, for Husserl, the intentional object is external and experienced as substantive—and he argued that Husserl’s conception of this basic structure did not change over his career. It is partly on this basis that Zahavi (2003) and Naberhaus (2007) asserted that Husserl’s philosophy is not merely another case of metaphysical idealism falling prey to Cartesian duality, by singularly assigning the “reality” of experience either to the external “objective” realm of the material world (philosophical realism) or to the internal “subjective” realm of immaterial consciousness (philosophical idealism). Rather, Zahavi argued that Husserl always maintained experience is constituted through the engagement of the two realms with each other. In my reading, it is with the middle operation, the investigation of intentional content, that Zahavi suggested meaning-making activity provides a bridge in Husserl’s conceptual structure, linking the manifest or material realm (intentional objects) with the immaterial realm of consciousness (immanent content) through substantive, materially-grounded mental activity.

Similarly, Giorgi (2009) affirmed that for Husserl, “meanings are originated in acts of consciousness … [and] are usually discussed in phenomenology within the context of intentionality” (p. 80). As Giorgi characterized Husserl’s thinking on the interrelation of these concepts, however, it becomes unclear whether he agrees with Zahavi that Husserl locates meaning-making with the middle operation of intentional content, and thus sees that operation as distinct from the directed acts of consciousness and the intended objects of the lifeworld. Alternatively, Giorgi at times seems to view meaning-making as tethered to the former or latter operation. Here, for example, Giorgi began by distinguishing “three terms” (similar to those
Zahavi outlines above), then argued that meaning is not a third term but is always “attached” to intended objects:

At least three terms have to be involved: the act of consciousness, the object toward which the act is directed, and the meaning of the object. Conscious acts are directed toward objects, and upon reflection one can discover that the directedness toward the object was determinate and specific or particular, and that particular quality is the meaning. ...[O]ne lives the relationship to the object directly [i.e., transcendently], and the meaning is, so to speak, attached to the object and can be discerned upon reflection. The key point is that the meaning is not a ‘third term’ between the act and the object but the particular way the object is experienced. ... The meaning transcends the act just as the object does and so its identification can be established and repeatedly referred to. This means that meanings can be objectively understood even if they are subjectively established. (p. 80)

Giorgi (2009) thereby argued that meanings can become objectified in this way—capable of being contemplated via reflection as one might contemplate their image in a mirror.

I conceptualize this integrated movement of consciousness across the three operations as involving a play of intentional, perceptive, apperceptive, and meaning-making acts by the subjective “I.” I further understand this movement to be the constitutional process Husserl described, which ultimately yields what we call “experience.” Yet by way of my exposure to the work of Derrida (1976, 1977, 2007) I understand the operation of meaning-making, even as Giorgi explained it, to be essentially interpretive, not merely descriptive nor altogether fixed and attached to objects. I find this consistent with Zahavi (2003, 2012), and I am further persuaded by Derrida even while I consider meaning-making to be an activity that does function to stabilize and objectify the contents of consciousness somewhat. As Zahavi wrote, it is the act of making “meaning or [making] sense that provides consciousness with its object-directedness” (p. 23), and not the reverse. In other words, meaning-making does not result from the object-directedness of consciousness and so is not altogether determinate, even though it is integrally shaped by the intentional posture of consciousness. Thus, in my view, Husserl’s framework does not preclude a
certain fluidity or, in Derrida’s terms “iterability” of the intentional contents of consciousness generated through meaning-making activity.

**The Phenomenological Reduction: The Epoché**

For Giorgi (2009) and others, the epoché or “reduction” is the methodological cornerstone of phenomenology and represents a mental posture or attitude as much as it does a series of mental operations. Giorgi wrote that, simply stated, the reduction represents an effort to resist the tendency to “naively prejudge the nature of our experiences,” and that it is accomplished through a practice of describing them “simply as they present themselves … without taking the further step of stating … that they are what they mean to us” (Giorgi, 1985, p. 43). Albertazzi (1996) commented that in a note to Ideas I written in 1930 (17 years after its initial publication), Husserl:

stated very clearly that although the aim of phenomenology was to be descriptive, this could only be made possible by altering one’s normal attitude, i.e., by adopting the particular method of ‘phenomenological reduction’…. [T]he reduction therefore constituted the main key to phenomenology. (p. 198)

**Husserl’s “Copernican turn.”** Husserl first presented the reduction, also referred to as the epoché, in Ideas Pertaining to a Pure Phenomenology and to a Phenomenological Philosophy, Book 1 (Ideas I; Husserl, 1913/2014). Commonly referred to by empirical researchers as “bracketing” (e.g., Ahern, 1999; Dowling, 2007; Moustakas, 1994), the epoché is more specifically the central movement in Husserl’s “transcendental phenomenological reduction,” occasionally referred to by Husserl as phenomenological reflection. Albertazzi (1996) explained that for Husserl the “reduction… performed the specific task of bracketing the entire precategorical realm of perception” (p. 197). Yet the reduction transcends technique and implicates the global ontological framework that Husserl was constructing in phenomenology. Luft (2012) elaborated its philosophical significance:
The reduction marks a significant rupture within Husserl’s thought.... Pre-transcendental phenomenology—prior to the reduction—can be characterized as a form of realism consciously employing an anti-metaphysical and anti-transcendental method of ‘simply’ describing mental phenomena in their givenness to consciousness...[which Husserl] later considered naïve. …‘The reduction,’ then, may be seen as Husserl’s version of the Copernican Turn in the phenomenological context. (p. 243; emphasis added)

His later research manuscripts are evidence that Husserl made significant, sophisticated refinements to the entire framework for the reduction over the 25 years following his publication of *Ideas I*. Yet its initial introduction in 1913 demonstrated his first move away from the empiricist realism of his former teacher, Brentano, toward a more complex rendering of perceptual capabilities and constraints by which consciousness encounters and interfaces with what Husserl increasingly referred to as the “lifeworld.”

Luft (2012) maintained that European philosophers in the tradition of Kant welcomed this move to a seemingly more metaphysical stance that sought to overcome naïve empiricist renderings of experience. On the other hand, Heidegger and other philosophers were ambivalent at best—eventually challenging Husserl’s work by taking phenomenology in one of two directions: either hermeneutic (e.g., van Manen, 1997; van Manen, Higgins, & van der Riet, 2016) or material (e.g., Henry, 2008). The more familiar hermeneutic phenomenology was built initially on Heidegger’s writing that sought to “correct” Husserl’s early transcendental orientation by foregrounding the primary and (seemingly) more immanent tool of all philosophy and social science: language itself. Third-generation phenomenologists like Sartre (1956) interrogated language as an existential problem, while Derrida (1976), as a fourth-generation philosopher in the phenomenological tradition, interrogated the structural stability of language as a ground for establishing meaning—whether in spoken or written form. Derrida’s work, in particular, demonstrates the impossibility of description without “traces” of interpretive mental action.
More than “bracketing.” For Giorgi (2009), however, the reduction strives to attain “pure, flowing, essential consciousness, [a] mode of consciousness [that] is capable of being intuited, [or] experienced with the proper attitude” (p. 88). That is, Giorgi argued that the reduction as Husserl imagined it requires that one undertake an *ontological* shift in one’s sense of being—that is, in relation to one’s own consciousness as much as to the object of study. This shift is rarely explored in depth across phenomenological research scholarship. Yet I find that in terms of qualitative techniques used for data collection and analysis, engagement with this ontological dimension of the reduction is prerequisite to epistemic work. Albertazzi (1996) wrote:

By bracketing the natural realm in which phenomena are given to the mind, Husserl intended to uncover the pure phenomena of global consciousness. *Being as consciousness precedes any possible foundation*—*i.e., analysis*... of the objects of the empirical world. And from this point of view Husserl’s ‘transcendental shift’ was perfectly justified because it was not a deviation, but a careful and radicalized version of descriptive [activity].... Phenomenological idealism, in fact, did not deny the existence of the world, but rather sought to clarify its meaning and legitimacy. (p. 198; emphasis added)

Yet if the reduction was controversial at the outset, among even Husserl’s closest colleagues, it remains so to this day—another reason he has been marginalized as naïve and Cartesian, a philosophical “idealist.” Even Merleau-Ponty (1952) wrote, “The most important lesson which the reduction teaches us is the impossibility of a complete reduction” (as cited in Giorgi, 2009, p. 92). Zahavi (2003), however, along with Naberhaus (2007) and Giorgi (2009), maintained that these critiques are misplaced, once again the result of inadequate familiarity with the evolution and increasing complexity of Husserl’s formulations. Lohmar (2012) argued that even Husserl’s early characterizations of the reduction provide a basis for anticipating and understanding the so-called “genetic” evolution of his later thought. That is, Husserl’s refinements of the reduction, as well as his explication of perception and the constitution of experience, ever more situate the subjective “I”—the experiencing consciousness—within a flow of history, culture, and societal relations, as well as in a “flow” of time and increasingly complex
and nuanced mental work that includes activity akin to Freud’s unconscious: passive synthesis (Husserl, 1926/2001).

This assessment of the reduction as an emergent, even iterative, movement in Husserl’s philosophical practice of mental investigation and constitution is responsive to Derrida’s (1954/2003) earliest major philosophical work—his Master’s thesis or Memoire—in which he found Husserl’s notion of meaning-making to be confounded by a problem of “genesis”—that is, by problematic assumptions about the ultimate origins of sense-making in consciousness. On the basis of these insights, I conceptualize Husserl’s reduction more closely in alignment with Zahavi (2003), Lohmar (2012), and Giorgi (2009), who argued against attributing such naïveté to Husserl’s mature thought as did Merleau-Ponty at one time. That is, I find that what Husserl invited was not a “complete reduction” in the sense of one that is final and determinate, but rather a reduction that is emergent and iterative in nature. Stated differently, unlike popular conceptions of “bracketing,” which suggest a determinate act by an observer who is separate from the lifeworld and from the “object” being perceived, I consider the reduction to be an indeterminate and continually evolving practice of becoming perceptually more present to an experience as it is “given” and unfolds over time and in relationships. In broad terms, this is consistent with Derrida’s (1976) formulation of meaning-making in consciousness as emergent and “always already” both present and absent—i.e., iterative and unstable.

**Three movements of the phenomenological reduction.** For purposes of empirical research, Giorgi (2009) further dissected the reduction by articulating multiple “movements” that can serve to aid in its lifeworld practice. He asserted that a “scientific phenomenological reduction” (p. 98) is not accomplished in a single step, but that Husserl, in fact:

allows for a number of levels of the reduction...[the first being] that the object presented to consciousness must be understood as something that is present [to consciousness] ... exactly as it is experienced [without any] claim that it exists exactly the way it is
experienced. That is, one does not posit the existence of the object but sees it simply as a presence to be explored. (p. 90)

Through the ontological attitude of “being present” to or “exploring” the presence of an object or event, the initial movement of the reduction paradoxically expands the body of data that becomes available to consciousness, whereas the second movement (the epoché or bracketing) limits it. Giorgi noted that the epoché “is sometimes considered a separate step and sometimes [is considered one] part of the reduction” (p. 91), but he favors the latter interpretation as do I, for the prerequisite ontological attitude may be lost when the epoché becomes equated with the full reduction. A third movement is identified by Giorgi when failures in the exercise of the epoché are identified by the investigator. Although they are not isolated, Giorgi explores these three distinct yet interrelated movements as a foundation for the practice of data collection.

**First movement, “presence.”** For Giorgi (2009), this is the phenomenological attitude: a mental posture or a stance consistent with the reduction. It describes an intentional mental focus on the lifeworld description provided by the participant, as it presents itself to the researcher’s consciousness, without adding or subtracting content nor attempting to resolve ambiguities. It thus evokes the notion that a researcher can and should strive actively to “be present” in the sense of being fully attentive to material experiences and relationships that become manifest in a study, by witnessing and engaging with them as fully as possible.

While the notion of presence has been problematized Derrida (1976, 1977), Zahavi argued that Husserl’s mature approach does not rely on naïve formulations of presence as transparency or stable immanence of perceived experience. This is an aspect of phenomenological research that merits further scholarship, but I have found Zahavi (2003, 2012) persuasive. Accordingly, I sought to embody an intentional form of presence in conducting the study that I elaborate in the next chapter on methodology. If, as Zahavi maintains, Husserl ultimately understood
consciousness as a flow of awareness that constructs (constitutes) experience in multiple
directions and ways that are not immanently predictable nor fixed, then what Husserl calls
intuition (i.e., “seeing”) within the reduction is not a directive so much as an invitation to bring
intentional reflective consciousness (not merely habituated, unreflective awareness) to bear upon
an object of consciousness. Further, this invitation extends beyond mere seeing or intuiting, to
encompass a form of meta-intuition—reflective contemplation of one’s own intuitive acts.

**Second movement, the epoché.** The second movement of the reduction involves the
mental activity of noticing, filtering, and “setting aside” (suspending or “bracketing”) as many of
one’s preconceptions, prejudices, preferences, wishes, and needs as one can. Giorgi (2009)
explained that “Husserl was motivated to introduce so-called bracketing of past knowledge about
the phenomenon being researched so that critical attention could be brought to bear on the present
experience” (p. 91), and he discusses two common difficulties with the conception and practice of
bracketing. These are: (1) a mistaken belief that Husserl intended bracketing to mean “forgetting
everything one knows” about a phenomenon, and (2) concern with the impossibility of executing
“a complete reduction” (p. 92) as expressed by Merleau-Ponty. Regarding the first, Giorgi
maintained that Husserl intended only that the investigator “put aside” or “hold in suspension”
corollary experiences, tempting pet theories, and comfortable interpretations of the phenomenon
as it presents to consciousness, and instead to “systematically note and explore the ongoing
occurrences as they are unfolding” (pp. 92-93).

Accordingly, for an empirical phenomenological researcher, the object of intention during
data collection is not the participant’s experience of the phenomenon under study, nor is it the
phenomenon under study in itself. Rather, the object of an empirical investigator’s intention
during data collection lies specifically with her own material encounters in the lifeworld, as these
unfold over the course of proposed research activities, approached with an open mental posture.
Third movement, self-reflective practice or praxis. When the researcher identifies failures to sustain a posture of open attentiveness to objects and events as they are being given to consciousness in the course of an investigation, then critical decisions are required on how to respond to these perceived lapses. Hence, the third movement within the reduction links it directly to the second movement, as well as to the next step in the phenomenological method that Husserl elaborates—which I call, after Giorgi (2009), the second or “eidetic” reduction. The types of responses required within consciousness here involve reflection, insight, critical judgment, and interpretive acts, as well as the imaginative creation of alternatives to the perceived failure. Yet although this third movement constitutes a bridge into the eidetic reduction, it does not belong to eidetic mental work per se, for it serves a different purpose—that of returning the researcher to a posture of open attentiveness toward and willing engagement with the research process.

The Second or Eidetic Reduction

My application of phenomenological investigation in this study is further consistent with Giorgi (2009) in that I have practiced not one, but two reductions: the “the transcendental phenomenological reduction and the eidetic reduction” (p. 89). Giorgi elaborated:

The transcendental phenomenological reduction sees the object from the perspective of generalized, pure consciousness. The eidetic reduction is a process whereby [the] object is reduced to its essence. … [To accomplish the latter.] the method of free imaginative variation is…applied to the object so that its essence may be discovered. Finally, when that essence is determined, it is carefully described, which includes, when possible, the relationships the essence has with other phenomena. (pp. 89-90, 93)

In the second reduction, Husserl reintroduces the investigator’s corollary experience, substantive knowledge, and imaginative capacities. Although I would not speak of “discovering” essences (which could construe them as akin to Platonic forms—i.e., pre-existent and independent of consciousness), I have practiced the reduction and description of so-called essences as a distinct undertaking from the epoché in the phenomenological reduction.
**Phenomenological eidetics.** Like much of Husserl’s work, his theory of essences and his notion of intuition are controversial and sometimes critiqued as naïve. Sowa (2012) wrote:

Husserl’s early phenomenology … was widely identified with the ‘doctrine of essences’ (…‘eidetics’) and its alleged method, the so-called ‘seeing of essences’ [or] ‘eidetic intuition’…. Husserl was “the only phenomenologist who truly developed a theory and methodology of eidetics. (p. 254)

Eidetics or a “theory of eidetics” may be defined as a method for ascertaining or “seeing” the invariant structural quality of an object of experience, without which it would cease to “appear” to consciousness as discrete and recognizable. Stated philosophically, an essence is the composite of those characteristics of an object or action, as apprehended by consciousness through experience, such that the composite structure integrates characteristics of the whole that are necessary, invariable, and therefore “essential” to its recognition. More simply, an essence represents the stable, invariant elements of an object of consciousness that are present across an experienced or imagined variation of encounters, in which the structure of the invariants present a quality of necessity (L. Lawlor, personal communication, June 3, 2013).

It becomes evident that one of Giorgi’s central contributions to phenomenological research scholarship is his demonstration of the thoroughness, nuance, and analytic power of Husserl’s explication of the eidetic sciences. Giorgi (2009) wrote:

Husserl understood that a sheer description of the flow of mental experiences could not offer a sound basis for stable knowledge (Husserl 1983, 16-61; Zahavi 2000). The description of the flow would have to be raised to an eidetic level, that is, to the level of a series of ideas, essences, or invariant meanings whose primary achievement would be to capture a great number of the variations of which the flow consists. (pp. 74-75)

Among the eidetic sciences, Giorgi explained, the “mathematical disciplines [e.g., geometry, logic] are the most well-established” (p. 75). Yet, as a mathematician himself, Husserl rejected mathematics as a basis for the discernment and constitution of stable (invariant) structures of consciousness in the study of mental life:
Husserl first makes a distinction between formal and material eidetic disciplines, and he eliminates all the formal eidetic disciplines [including mathematics and logic] because the formal disciplines disregard content, and the content of the experiential flow is important for understanding it. Consequently, Husserl was seeking a material eidetic discipline to help found a science of mental life. (p. 75; emphasis added)

Giorgi (2009) then noted that “Husserl (1983, 162) also distinguishes between concrete and abstract sciences” (p. 75), and he adds that many social science disciplines (psychology and education, for example) span this distinction. In the field of adult learning, Fenwick’s (2000) term “traceable developmental moments” describes mental events that include logical, emotional, and imaginative abstractions, yet are intimately tied to perceptual experiences relating to concrete objects and material encounters in the lifeworld. Given the complexity of investigating phenomena that span these realms, Giorgi (2009) maintained that Husserl “makes the argument that the historically existing mathematical sciences should not be models [for] phenomenology” (p. 75). He quoted Husserl’s assertions in Ideas I to support this claim:

It is only a misleading prejudice to believe that the methods of the historically given a priori sciences, all of which are exclusively exact sciences of ideal objects, must serve forthwith as models for every new science, particularly for our transcendental phenomenology—as though there could be eidetic sciences of but one single methodic type, that of “exactness.” Transcendental phenomenology, as a descriptive science of essences, belongs however to a fundamental class of eidetic sciences totally different from the one to which the mathematical sciences belong. (Husserl, 1983/1913, as cited by Giorgi, 2009, pp. 75-76)

Giorgi also turned to Merleau-Ponty (1964), who he says argued that the eidetic reduction requires the researcher to penetrate or go beyond the facts of various participants’ situations and lifeworld contingencies in order to intuit—i.e., to see, to perceive, or to be present to—a meaning or constellation of meanings that are in common across all known expressions of variability.

**Distinction from thematic content analysis.** Husserl’s eidetic reduction is therefore not equivalent to thematic content analysis (TCA), for it does not aim to distill a series of discrete conceptual “themes” from qualitative descriptions. Rather, it intends to engage imaginatively with
the structure of the experience that is given to the researcher in qualitative descriptions, so as to
generate complex and dynamic, but general, structural representations—holographs, one might
say—that are true to essential or invariant characteristics of a phenomenon. Further, by
emphasizing the varied relations that an essence may have with other phenomena in the described
horizon, Giorgi (2009) showed how the presentation of structures is key to elucidating the
dynamic and intersubjective quality of essences, thereby distinguishing them from mere themes,
which unfortunately, in some qualitative research, amount to little more than linguistic tags.

Indeed, Giorgi (2009) found TCA inadequate to the phenomenological task of imparting a
holistic, essential (complex, yet stable) structural representation of a phenomenon as it is humanly
lived and experienced. Giorgi wrote that the task of Husserlian phenomenological analysis is one
of “making as explicit as possible the assumptive network” that informs acts of consciousness, and
this “depends upon making explicit relevant aspects of the horizon” (p. 82). In other words,
presenting essential structures requires one to elaborate the palpable yet nuanced matrix of
assumptions, expectations, bodily states, and intersubjective perceptions that shape the
constitutional process, and thus meaning-making. Giorgi elaborated by contrasting this with the
analytic process of “breaking down” descriptions into parts:

Explication refers to the process of making explicit the assumptions and horizontal
features of the intentional act so that a more…clarified understanding of the experience
can be obtained. This procedure is quite different from taking the main moment as a whole
and breaking it down. Rather, the main moment [i.e., the intended object of
consciousness] is seen as a part of a larger whole [i.e., as a subset of the conscious
stream], and the task of explication is to understand the moment’s role in the larger
context. (p. 82)

Explication foregrounds the interwoven nature of the parts or “moments” within lifeworld
descriptions that “cannot stand alone independently of the entire conscious stream and … are
fleeting rather than static, and so cannot be held steadily” (p. 81). For, in contrast to natural
science investigation, Giorgi argued:
The contours that separate different moments of the experiential stream are not as evident as [contours of] physical [phenomena] and are often embedded in marginal states [e.g., passive synthesis or “unconscious” thought] that contribute to the meaning of the significant moments. … Thus, the standard strategy of breaking down the [experiential phenomenon] of interest becomes complicated. (p. 81)

Thus, in Giorgi’s (2009) rendering, the goal of phenomenological data analysis is to discern neither hermeneutic nor transcendental themes, but to establish more dynamic meaning structures. This is accomplished through systematic application of the first and second reductions, the latter of which involves Husserl’s process of free imaginative variation. It produces, first, the discernment and description of the experience of a phenomenon in terms of a participant’s “manner of being present to a situation” (Giorgi, 2009, p. 82), and second, the discernment and description of the structure of a phenomenon, as it is experienced by an individual or group.

A “material” eidetics. Giorgi explained that, in Husserl’s view, the difference between mathematical and material eidetics rests on two distinctions: (1) “the mode of operating of the mathematical sciences is not descriptive” (rather, it is based on measurement and proportion); and (2) mathematical reasoning “proceeds by way of deduction from a finite [determinate] number of concepts and proportions” (p. 76). Giorgi maintained that Husserl interrogated whether the phenomena of consciousness lend themselves to determinate or finite analyses that yield “ideal concepts” and “exact essences” (p. 77), and he concluded that, on the contrary, the contents of consciousness comprise “an open, indeterminate system” (p. 77) of experience that is accessible by way of rigorous description, but not exact measurement. Husserl’s phenomenology is thus constructed on a material understanding of consciousness and a material eidetics required to discern its contents.

On the other hand, Giorgi (2009) maintained that the eidetic method of discerning and describing essences may be seen as a direct extension of the phenomenological reduction, identifying it as an integral part of phenomenological description. In this way, he differentiated
phenomenological description from interpretation, construction, and explanation. As discussed earlier, I depart from this facet of Giorgi’s thought and follow Zahavi (2003) in considering acts of interpretation as integral to the process of mental constitution—including a phenomenological researcher’s rendering of experience—on which basis eidetic findings are generated.

**Intersubjectivity.** Husserl’s more mature work is sometimes characterized as genetic because it explores more broadly the genesis of the subjective constitution of experience—not only in contexts of time, space, physical mobility, and the structures of consciousness, but also in contexts of history, culture, community, and intersubjective human relations. Of particular relevance to this study, Husserl’s explorations of intersubjectivity create a framework for inquiring about what happens between people when they spend time in each other’s physical presence, when they speak with each other, and when they undertake shared experience.

For Giorgi, too, discerning the structure of an experience of a phenomenon flows not only from constituted meanings that are evidenced within participants’ descriptions. It relies, too, on meanings constituted by the researcher throughout the analytic process. I have alluded to the thorny question of just whose experience can ultimately be discerned and described by empirical phenomenological research. Like the proverbial hall of mirrors, much of human social science research involves the use of consciousness to illuminate consciousness itself—thereby demanding a highly disciplined system for tracking multiple dimensions of mental perception and reflection as they appear to, are structured in, and are imaginatively reconstituted in consciousness over time throughout the course of an empirical investigation. I have concluded, with Giorgi, that the only qualitative experience an empirical human science researcher can definitively constitute, analyze, and report is the researcher’s constitutional experience of the data—and yet, this result is “by no means an individual, private, or solipsistic affair” (Luft & Overgaard, 2012, p. 10). Rather, and precisely as a result of the workings of intersubjectivity within the empirical process itself, the
researcher’s experience comes to incorporate and reflect a multi-axis intersubjective matrix of material encounters with participants and reflective mental activities throughout data collection and analysis, thereby embodying and expressing the phenomenon under study through a socially and temporally situated, emergent constellation of meaning structures.

The clarity and detail of Giorgi’s insight here is what sets his work apart from many other scholars’ attempts to articulate a phenomenological approach to human science inquiry. He makes clear that it is not enough for the phenomenological researcher to delineate so-called essences or themes in terms of discrete meanings (i.e., hermeneutic or substantive themes). Giorgi argued that phenomenological praxis makes it possible to analyze the intra-phenomenal structure of an experience—and that it further provides tools for postulating inter-phenomenal structures experienced among a group of people. In addition, he brings a well-honed philosophical appreciation of the role of the researcher’s consciousness in data analysis, which includes careful intra-subjective exploration by the researcher of her own constituted meaning structures in relation to those presented by research participants. He thereby goes further than most phenomenological research scholars in articulating philosophical and practical frameworks by which an investigator may relate the contents of her own consciousness to the subject of study. He also goes further in clarifying how this activity supports the eidetic reduction—the creation of generalized structures of meaning, mediated by acts of imagination and constituted from a mass of research data, all of which reflect intersubjective researcher-participant interactions.

**Interrogating essences.** Thus, Giorgi argued that, applied to human science research, an “essence” may be construed as a “structure of meaning” and such structures are intrinsically and permissibly inexact. To support this claim, Giorgi (2009) quoted at length from *Ideas I,* concluding that Husserl’s phenomenology provides:
a manner of describing the contents of experience in a stable way through description of essences or invariant meanings (material eidetics), and a way of making the study of the quality of phenomena more rigorous, by systematically differentiating descriptive sciences from formal sciences and demonstrating how descriptive sciences function. (p. 79)

Giorgi also made a crucial claim that runs to the heart of what I consider a false dichotomy between so-called “transcendental” and “hermeneutic” phenomenology. First, he acknowledged objections sometimes raised by empirical researchers regarding the usefulness and legitimacy of the notion of “essences” in the context of scientific investigations. He then countered a major objection by suggesting a structurally interpretive way of understanding the notion of essences:

The idea of essences is sometimes denied within philosophy … [but] is more problematic within scientific contexts. The word often triggers Platonic connotations (although such implications are not intended by Husserl), and most scientists react negatively to these connotations. So, instead of searching for essences … I seek the structure of the concrete experiences being analyzed through the determination of higher-level eidetic invariant meanings that belong to the structure. (p. 100)

Highlighting what he characterizes as a distinction between philosophic and “scientific” phenomenological praxis, Giorgi explained further:

There is a fundamental difference between the essence obtained by [phenomenological] philosophers and the structure described by [human science researchers]. When seeking essences, philosophers always seek the most universal essence, that is, those characteristics without which the object would not be what it is. (pp. 100-101)

But Giorgi maintained that universalizing in this way transcends human science interests—it generates statements that may not be sufficiently descriptive or material so as to reveal the lived qualities of a phenomenon (that is, how it is experienced humanly though embodied, temporal, social, cultural, and historical encounters) or to demonstrate the significance of the phenomenon from a particular disciplinary perspective (in the case of this study, adult learning).

Just as important for examining the phenomenological notion of essences, Giorgi implicated the growing body philosophical work exploring Husserl’s later, previously unpublished manuscripts. Citing one such scholar’s work, Giorgi (2009) argued that “Husserl
allowed for different types of essences” (p. 101), which include what I find to be a fundamentally interpretive formation of the notion of an essence:

Mohanty (1985) shows that while Husserl began with the description of essences as one of the goals of phenomenology, in later works he began to speak about clarification of meanings as an equally important goal. ...Husserl never gave up his quest for essences, but [Mohanty] notes that ‘the specific phenomenological enterprise of clarification of meanings ... slowly moves to the forefront’ and ‘the concern with meanings brings [phenomenology] closer to the empiricist tradition.’ Following this reasoning, one could assert that the structures of experience obtained by the scientific phenomenological method are clarifications of the particular lived meanings discerned in concrete descriptions from a [particular disciplinary] perspective, eidetically raised to a level of general [structural] invariance. (Giorgi, 2009, pp. 101-102; emphasis in original)

Giorgi’s rendering of Husserl’s notion of essences, for purposes of human science research, as discernable structures of lived meaning within and across participant accounts is thus carefully reasoned and well supported. This conceptual frame is also well suited to the study of traumatic experience, given the centrality of meaning-making in the trauma literature.

**Free imaginative variation.** A phenomenologist seeks, in Giorgi’s (2009) words, to “discover an essence—or invariant structure—that can comprehend multiple situations” (p. 84).

In Husserl’s writings, this is accomplished through a process Giorgi translated as “free imaginative variation,” an activity that makes possible an elucidation of invariant structures. Giorgi explained:

A ... key principle that guides research is the method of free imaginative variation, which Husserl illustrates with respect to the discovery of essences (Husserl 1983, 157). Husserl makes clear that the point of departure for philosophical investigations does not have to be factual, but could also be fictive. ...Free imaginative variation requires that one mentally remove an aspect of the phenomenon that is to be clarified in order to see whether the removal transforms what is [given] in an essential way. If the given appears radically different because of the [imaginative] removal of a part, [then that part] is leaning toward being essential. If the given is still recognizable as the same after the removal of a part, it is most likely a contingent part. Obviously, each of these decisions has to be critically evaluated by the researcher through further imaginative effort before a final assessment can be made. (pp. 69-70)
Lohmar (2012) translated Husserl’s term slightly differently, as phantasy variation, and contended that this represents one of Husserl’s many genetic refinements of his methodology—in this case, of his original eidetic method:

The eidetic method is used in [Husserl’s] phenomenology from the very beginning to the end…. In the … beginning … acts of phantasy modifying the starting example were allowed but not essential. Already in Ideas I [1913] the role of phantasy is strengthened, and in a lecture course from 1925, this relation changes to the priority of phantasy variation in the process of seeing essences…. Trying to incorporate “free” phantasy in the form of variations means to take up positively the impact of the formation of types in one’s own experience and in intersubjective normative influences. (Lohmar, 2012, pp. 271-272)

As a descriptive science, then, phenomenology must proceed by way of what Husserl calls “intuition” or “seeing,” which leads to a material eidetic practice in which the consciousness of the investigator (the philosopher or human science researcher) becomes self-aware and “present to” its own constitution of experience through the activity of free imaginative variation. In the context of the scientific phenomenological method, Giorgi stated that the goal is not a universal essence but a transformation of the data so as to arrive at generalized meaning structures, such that “meanings achieve a level of invariance that can comprehend multiple facts” (p. 132). Giorgi added that, “unlike in philosophy, this procedure is not pushed to the level of universality, but only to a level of generality” (p. 132), which is sufficient to support discipline-specific knowledge claims. Key to this argument, Giorgi’s contended that “Husserl (1983[1913], 166-68) acknowledges that the concrete phenomena of mental life are vague and inexact, and he calls the essences derived from them ‘morphological essences,’ meaning that they are, in principle, inexact, but essences nevertheless” (p. 78). On the basis of this reasoning, Giorgi argued that the constitution of generalized structures of meaning from the contents of mental life is a form of phenomenological analysis consistent with Husserl’s philosophy and also with the demands of qualitative human science research.
This is not a process, he explained, of deduction as employed in mathematics and the classical scientific method, but rather a process of “unfolding and describing the senseful implications within the horizons of the concrete phenomena” (Giorgi, 2009, p. 77). Although Giorgi denies this is an inductive process, I find it to be inductive in part, even though the invariant structures being sought are not determinate, nor are they pursued to a level of universality. As Giorgi stated, “an eidetic manifestation…is intrinsically general,” and this practice of eidetic generalization requires mental activity more akin to inductive than deductive reasoning. Thus, intuition apprehends the intentional quality and substance of an object, from which morphological essences—that is, descriptions of (relatively) stable meanings as “manifestations of experiential phenomena” (p. 77)—can be drawn.

My difference with Giorgi, then, primarily involves his elaboration of the nature of meaning-making within the phenomenological as well as eidetic reductions, which I find to be more interpretative than he allows. Consequently, I find the conceptualization of meaning structures to be somewhat less determinate than Giorgi seems to find them. This distinction rests on my understanding of morphological essences. The Oxford online dictionary defines morphological as relating to the form of things, including relationships among structures within a larger form, and I comprehend them as capable of a certain plasticity—that is, as intrinsically iterable—yet not so unstable that they are resistant to temporal analysis or are incapable of presenting discernable and communicable meanings.

Thus, the eidetic reduction is the final phase of phenomenological analysis and, paradoxically perhaps, it involves imaginative and intentional “play.” Within this play is the movement of consciousness through prior knowledge and experience, through interpersonal relationships, through geographic spaces and embodied cultural practices, as well as through tangentially associated, even bizarre or seemingly irrational associations. These enriched eidetic
dimensions of phenomenological reflection were incorporated into the reduction by Husserl gradually, through his genetic expansion of the methodology during the decades following his publication of *Ideas I* (Lohmar, 2012).

**Alignment with Trauma Studies: Phenomenology and Psychoanalysis**

Husserl and Freud were born just three years apart in Austria. Both studied in Vienna as young men during the 1880s and both were (briefly, in Freud’s case) students of Brentano (Albertazzi et al., 1996). Askay and Farquhar (2012) argued that although Freud and Husserl studied with Brentano several years apart, they were surely “aware of one another’s work. Furthermore, Freud must have had some exposure to Husserl’s ideas through [friends and colleagues] … yet he made no references to Husserl during his entire career” (p. 596). Husserl, for his part, made no reference to Freud, though aspects of their work developed in parallel during the decades from 1900 to the 1930s. Askay and Farquhar elaborated:

> Although traditional interpretations of Husserl often exclusively focus on his analysis of consciousness, his “passive genesis”… shared significant commonalities with Freud’s unconscious…. Both disciplines recognized the primacy of the unconscious over consciousness via the dynamics of meaning in operation. Indeed, in 1913-14, Husserl … and Freud … had nearly simultaneously formulated their theories of the unconscious in an explicit way. (p. 596)

Similarly, Feest (2012) noted Husserl’s abiding concern with psychological theory, beginning with his forceful critique of psychologism in *Logical Investigations* (Husserl, 1970a). In his final published work, *The Crisis of European Sciences and Transcendental Phenomenology* (Husserl, 1970b), written in the mid-1930s, Husserl again gave significant attention to “the relationship between [his] own phenomenological psychology on the one hand, and the kind of naturalistic psychology that he saw practiced … around him,” such that Feest (2012) argued, “what Husserl variously calls the crisis of European science … and of European humanity … was for him, at heart, a crisis of psychology” (p. 493, emphasis in original). Although I find the heart
of Husserl’s concern to be not psychology itself, but the dynamics of consciousness that make possible psychological life and inquiry, I concur that Husserl’s work shares far more in common with Freud’s than with the behavioral and experimental psychology movements that grew in prominence during both their lifetimes.

Indeed, the theory for which Freud is most famous, that which describes the dynamic landscape of unconscious mental life, is viewed by some as a breakthrough to be shared with Husserl, among others (Ellenberger, 1970). Merleau-Ponty (1969), too, pointed out alignments between psychoanalysis and phenomenology in probing the nature of consciousness in terms of specific structures (e.g., the ego) and in terms of dimensions of experience (e.g., temporal, embodied, relational). Further, both explore not only so-called conscious awareness, but passive, latent, or unconscious dimensions of consciousness too (e.g., Askay & Farquhar, 2012; Wertz, 1993). Specifically, Freud’s descriptions of unconscious mental processes show parallels with Husserl’s descriptions of “passive synthesis.” Even Freud’s so-called “royal road to the unconscious”—the tool of free association in the interpretation of dreams—bears striking similarity in practice to Husserl’s free imaginative variation as the tool by which the philosophical investigator discerns essential structures of meaning.

It turns out these parallels between phenomenology and psychoanalytic theory are particularly well illustrated in the case of trauma. Ira Brenner’s (2001) psychoanalytic text, *Dissociation of Trauma: Theory, Phenomenology, and Technique*, explicates phenomenological practice not explicitly, in a philosophical sense, but implicitly, as he highlights Husserlian principles in discussing the constitution of traumatic experience. For in both phenomenological and psychoanalytic inquiry, experience is understood as a construction of consciousness, not as a discrete object that is transparently or naïvely given to awareness. Moreover, Husserl’s phenomenological reduction shares many features with the extensive review of experience that
constitutes psychoanalytic labor. Wertz (1993) and Van den Berg (1972), both psychodynamic psychiatrists, provide detailed accounts of the consonance between psychoanalytic and phenomenological approaches in terms of learning to become present to and thereby reconstitute one’s perception of experience. Similarly, psychoanalytic “witnessing” of the kind Miller (1990a) evokes and phenomenological observation have much in common.

Equally notable are alignments between, on the one hand, Husserl’s conceptual progression from early studies of individual consciousness to intersubjective investigations and studies of cultural and historical dimensions of constitution in human consciousness and, on the other hand, Freud’s progression from individual psychoanalytic case studies to broader cultural-historical studies applying psychoanalytic principles to social and historical analysis. As Husserl further refined his conception of intersubjectivity later in his life, it too demonstrated alignment with Freud’s constructs of transference and counter-transference, although the two concepts were developed for entirely different ends.

My application of phenomenological philosophy to this investigation is thereby not limited to a methodology in terms of research design. Rather, my approach to method strives to encompass underlying concerns that are shared by phenomenology, psychoanalysis, and critical theory as well as adult learning praxis. In the present study, I undertake to integrate a Giorgian application of Husserl’s phenomenology with a revisionist reading of psychoanalytic theory applied to adult learning advanced within a critical theory framework. Thus, for purposes of this research as presented in the following chapters, I seek to elucidate:

1. a material understanding of the human experience of trauma exposure as a cognitive, emotional, and embodied struggle with meaning-making in social contexts, and
2. an emancipatory understanding of the human capacity to comprehend trauma exposure through:
(a) learned practices that cultivate the rehabilitation of reflection, and
(b) learned practices that cultivate ideology critique.

I further seek to elucidate each of these concerns specifically in the context of meaning-making as a dimension of the intersubjective constitution of experience—and in tension with repression, interference, and resistance as psychic forces at play throughout the enterprise of adult learning.

For in addition to the pivotal role of meaning-making in Husserl’s phenomenological methodology, this examination of his work indicates an evolution of thought that suggests increasing sensitivity to the role of embodied relationships in the reflective work of consciousness. This includes a recognition of the powerful flow and flux of intersubjective sensation and perception in varied social contexts as mental life is constituted. If Husserl’s work argued that actionable scientific knowledge is generated not only by way of the scientific deductive method, based on determinate observation and measurement, but that it can be generated also by a more inductive form of reasoning that emerges from reflection and imagination, relationships and play, then such a pivotal role for intersubjectivity through culturally and historically grounded relationships suggests something more too. It suggests that knowledge production is not limited to fully conscious forms of rational inquiry. It implies that scientific knowledge may be built on interactive abductive leaps of reason, on non-rational and so-called subconscious forms of reflective work, on illogical, perhaps even incredible types of perceptual evidence. The latter point is one Freud was compelled to defend repeatedly. In the words of Britzman (2011): “Freud would always be working experimentally against the tide of his own ambivalence, credibility, [and] scientific education…. [H]e admitted freely that his theories were beyond belief, but felt that was no reason to abandon them” (p. 4). Perhaps Husserl felt he sometimes worked against a similar tide.
CHAPTER FIVE
ENCOUNTERING THE WORK OF CRITICAL CARE NURSES:
DESIGN AND EXECUTION OF THE STUDY

Law VIII of the House of God: They can always hurt you more.

Potts stood before me in the darkness of two A.M. in Gomer City, and mirrored in his gray
face was, as always, the Yellow Man.

“What are you doing here at this hour?” I asked, but he didn’t reply, he just stood there
staring. Again I asked what was going on.

“The Yellow Man just died.”

I felt a chill. Potts looked white and chill, and his eyes looked dull and dead, and I said,
“I’m sorry. I mean, I’m really sorry.”

“Yeah,” said Potts, fidgeting as if he wasn’t really in the same world with me any longer,
“yeah, well, he was going to die, it was just a matter of…of time.”

“Yeah, he was,” I said, and I thought about how much torment Potts had gone through
every day that the Yellow Man had been alive. “Are you all right?”

“Who, me? Oh, yeah, I am. It’s just a little hard…. You know, I should have given him
the [steroids].”

“Stop it. Nothing would have helped.”

“Yeah, well, steroids might have helped.” ...

...I watched him slip away down the corridor and disappear into the up elevator....

I realized suddenly what was going to happen. Fool! I ran to the elevator and pounded on
it ... I raced up the stairs to floor eight, and I kept cursing myself for not realizing it in time and
praying that I had or that I was wrong.

I was not wrong. ...Potts had taken the elevator straight to floor eight, had opened a
window, and had thrown himself out to his death. ...[B]etween my panting for breath and
shivering in the chill draft I heard the first siren squeal, and I leaned my forehead on the sill, and
I sobbed.


In The House of God, Shem makes visceral what trauma and secondary trauma feel like—
how they dissolve the tacit boundaries defining what has happened to whom, who is experiencing
what, submerging people and relationships into a fog of shock, horror, pain, then numbness, grief,
and emptiness … unclaimed experience.
Both the literature and scholarly experience suggest any presumption that a researcher can investigate trauma while remaining unaffected, unchanged, unharmed, is foolish. This research and its methods have been an exercise in self-awareness and self-preservation in equal parts as a practice of phenomenological observation, analysis, and reporting. In this chapter, I set forth not only my study design and execution, but the process I undertook to engage humanly with the research aims and data—to “see” and hear and feel the presence and the stories of my participants, to allow the resulting impact, to reflect, synthesize meanings, and offer conclusions—all the while attempting to maintain my own psychological integrity and stability.

**Research Questions**

This study is concerned with the nature of secondary trauma encountered by nurses and the ways in which learning might penetrate, even transform, that experience. Specifically, the research sought to answer the following questions:

1. What is the experience of a particular triad of registered nurses (“nurses”) who have practiced for at least six months in clinical settings where they are routinely exposed to primary traumatic suffering in patients to whom they provide direct care?
   1.1. What memories, sensory perceptions, and bodily sensations do they describe in characterizing their experiences?
   1.2. What stories do the nurses share and how do these stories develop over time?
   1.3. How do the nurses respond to each other as they describe their experiences?

2. How do these particular nurses conceptualize and articulate their secondary forms of suffering across time, individually as well as in relationship to other nurses with whom they share similar clinical conditions of caregiving?
   2.1. What language do they use to organize and constitute their experiences?
3. Do these nurses undertake forms of learning over time, in response to their experiences of bearing witness to suffering among their patients?

3.4. How do the nurses develop successively changing perspectives and responses to their experiences, both individually and in relationship with others?

3.5. Do the nurses learn to protect themselves from secondary forms of traumatic stress or suffering? If so, how does such learning occur?

3.6. Do the nurses learn to sustain themselves through short- or long-term effects of secondary traumatic stress or suffering? If so, how does this occur?

**Specific Aims**

This research sought to accomplish the following goals:

1. Elucidate in richly descriptive, evocative, and nuanced detail the structures of experience evident among a purposively selected triad of nurses who have been exposed to significant traumatic suffering in patients to whom they provide direct care.

2. Using these descriptive phenomenological accounts, advance the conceptual understanding of secondary traumatic stress (STS) and related constructs identified in the scholarly literature, as they are evidenced among these nurses:

   2.1. Differentiate among related concepts of traumatic stress that are often discussed concurrently or as equivalents in the scholarly literature, including compassion fatigue (CF), burnout syndrome (BOS), and vicarious traumatization (VT) in relation to secondary traumatization (ST) and STS.

3. Elucidate dynamic modes of learning, including embodied and relational activities, which are evidenced over time and in social encounters among these nurses as they focus on their experiences of STS or conceptually related syndromes.
4. Elucidate obstacles to learning that are evidenced or described among these nurses prior to as well as during the course of the research.

In the last chapter, I articulated a specific understanding of Husserl’s phenomenological method in the context of his broader philosophical project by examining Giorgi’s (2009) detailed application of Husserl’s work to the unique demands of empirical human (social) science inquiry. In this chapter, I lay out the procedures I employed to investigate the research questions above. Specifically, I describe my methods for:

- recruiting and selecting nurse participants from within clinical institutions;
- scheduling meetings and interviewing participants, as well as processing the personal impact of those interviews, while employing the phenomenological (first) reduction;
- transcribing interviews, following-up with participants, and arranging focus groups;
- processing the personal impact of focus groups and transcribing these sessions, again practicing the ongoing dynamic movements of the first reduction;
- practicing and adapting Giorgi’s (2009) analytic procedures to the transcript data;
- employing the eidetic (second) reduction to constitute static meaning structures for each of the three nurse’s accounts (i.e., individual interviews), and then constitute a single collective meaning structure from the individual structures; and
- analyzing temporal and intersubjective transformations of meaning-making, as evidenced by focus group data, to constitute holistic, genetic meaning structures reflecting this data.

Units of Observation, Sampling, and Participant Recruitment

Qualitative research does not aim for generalizability (i.e., to populations), for it is not concerned with illuminating universal (or standardized) patterns or tendencies that may be
revealed through macro analysis of large data samples. Rather, qualitative research aims for strategic transferability (Marshall, 1996) through a very different type of analysis: namely, micro illumination of unique peculiarities in the data, which is often drawn from relatively small, purposeful data sets (in qualitative social science research, these may range from several participants to several dozen, sometimes more), with the intent of bringing a rich landscape of conceptual meaning into focus, one that is sufficiently stable and robust to comprise the basis for transferable understandings, hypotheses, even theories.

**Units of Observation**

Data to fulfill the aims of this research required face-to-face (i.e., embodied) encounters with selected nurse participants. Consistent with an enriched genetic phenomenological framework, the data further required a series of meetings over time, with group interactions and an explicit element of self-reflective practice. Nurse participants were asked to participate in at least one focus group after the individual interviews; they were then given the option of meeting for a second focus group session. Thus, the data I sought included three categories of observation:

1. embodied first-person accounts of experience:
   a. one-to-one, face-to-face interviews to obtain individual nurse accounts,
   b. one or two follow-on focus group meetings to obtain temporally and intersubjectively layered accounts from the nurses;
2. researcher observations of nurse-participants, including non-verbal communication, physical embodiment of verbal accounts, and nurse interactions during focus groups; and
3. researcher self-observation and self-reflection, practicing the phenomenological reduction as a specific form of critical research praxis consistent with the epoché and with emancipatory learning praxis.
As I conducted the study, however, I found it more coherent to structure these units as levels or dimensions of data, as follows:

**Primary level of observation.** These were comprised of the nurses’ individual accounts of their experiences bearing witness to patients and families in crisis, as described during one-to-one interviews. Consistent with the epoché (Husserl’s transcendental reduction), these units also included my descriptive accounts of the interviews (field notes) as they initially presented themselves to my awareness, along with initial analytic notes.

**Secondary level of observation.** These were comprised of the nurses’ intersubjectively constructed accounts of their experiences, shared during focus group sessions and in relationship to me directly over time. Follow-up emails and other post-interview reflective communication from or among the nurses were included as secondary observational units.

**Tertiary level of observation.** These were comprised of my private accounts of self-reflective praxis compiled over time with an acute awareness of my body, my evolving relationship to the nurses, and my changing relationships with colleagues and friends. Guided by the epoché, these units of data were intended to support critical scrutiny of the phenomenological and eidetic reductions as I practiced them throughout data analysis. That is, documentation of self-reflective praxis in a phenomenological study offers data for understanding the lens of consciousness by which data analysis was conducted. This in turn strengthens scientific transparency, accountability, and the trustworthiness of findings.

I did not anticipate, however, the volume or urgency with which the tertiary dimension of perceptual data would assert itself in my unfolding experience of the study. Certainly, this reflects the traumatic nature of the data itself, as well as its relation to my own history as a critical care nurse. It became evident before data collection was complete that I would have to limit my documentation and exploration of this category of data if I were to maintain sufficient focus on
the experience of my participants. Nonetheless, it served as a reference point for considering my
complex embodied, temporal, and intersubjective constitution of the data, and the inevitable
impacts this had upon the static and genetic results of my analysis.

**Sampling Considerations**

Consistent with Giorgi’s (2009, p. 198) suggestion that trustworthy eidetic meaning
structures can be constructed based on extensive data drawn from three or more participants, a
final sample of three (n=3) critical care nurses was selected from among an initial sample of six
nurses, all of whom were interviewed extensively. The final triad was drawn from a semi-rural
hospital system in the Eastern United States and, as explained below, the initial sample consisted
of two triads of nurses, all of whom participated in at least one focus group. The sample was
narrowed following data collection to support fuller depth and complexity of data analysis.

Purposeful sampling was guided by the goal of obtaining varied, nuanced, richly detailed,
and cognitively as well as emotionally engaged qualitative content from nurses who had been
exposed to a variety of practice-related traumatic experiences. Such data is capable of generating
complex, transferable analytic insights (Giorgi, 2009; Marshall, 1996). Accordingly, inclusion
criteria were as follows:

- variation in the nurses’ personal demographic and sociocultural characteristics;
- variation in their duration of practice experience in critical care settings (with a
  minimum duration of six months);
- variation in the types, frequency, and severity of primary traumas witnessed;
- variation in the normative features of their clinical settings (i.e., department
  characteristics) governing their conditions of practice.

Exclusion criteria were as follows:
• less than six months’ duration of practice within a critical care setting of practice;
• recent history of a major physical or mental health diagnosis requiring hospitalization or other acute care for stabilization and recovery;
• discomfort with emotional disclosure in relation to the investigator and/or other nurses in the study, specifically in relation to the focus group stage of data collection.

The study’s design required recruitment of at least one triad of nurses willing to meet with the investigator for individual in-depth interviews, and then to meet collectively for one or two temporally and intersubjectively enriched focus group sessions.

**Nurse Recruitment**

Following ethics review and approval of the study protocol (see APPENDIX B), clinical contacts for participant recruitment were approached at six different hospital systems in five eastern states of the United States. Word-of-mouth, phone calls, and emails were all used to identify interested nurses and possible settings. It quickly became evident that most healthcare institutions I approached were unwilling to permit access to their nurses for a study of this kind. Other institutions were accessed “under the radar,” through unofficial posting of flyers within public areas of medical centers by employees who were my personal contacts. These efforts drew no inquiries, however. Eventually, two regional medical centers were found that agreed to facilitate nurse recruitment.

With assistance from nursing administration, individual nurses were recruited through email distribution of an invitational flyer (see APPENDIX C) and a brief study overview. Only nurses working in critical care areas were contacted: those in emergency departments (EDs), intensive care areas (including all specialty ICUs), advanced cancer units, and acute psychiatric units. Interested RNs were directed to contact the researcher by phone or email and most did so
within hours or a day of receiving the invitation. Thus, once the emails went out, I quickly received more than half-a-dozen calls from interested nurses using the phone number provided on the flyers. I employed these phone conversations as a means to answer the nurses’ questions as well as to screen each nurse for suitability and exclusion criteria. Snowball referral and recruitment was also employed with the help of early-responder participants. This process successfully engaged three participants at each of two healthcare systems. A fourth nurse at the first setting (known in this report as All Saints Medical Center or ASMC) expressed strong interest in participation, but was unable to free her schedule for the required meetings.

**A Nurse Triad: Data Collection and Management**

Individual interviews lasting between 75 and 120 minutes were conducted with the nurses from each of the two healthcare systems in different regions over a seven-week period. The ASMC nurses elected to meet for a second focus group session, whereas the nurses from the other health system chose to meet for one focus group. Individual interviews were audio-recorded and focus group sessions were both audio- and video-recorded. All the nurses agreed specifically to the archiving of their data for future analysis and synthesis with other study results. All recordings and transcripts were labelled with coded identifiers and uploaded to a password-secured virtual storage site. Analytic documents were likewise coded and stored securely.

**Narrowing the Data Set**

I immersed myself initially in the full data set drawn from all six original participants by making field notes, reviewing and transcribing all six individual interviews sequentially, all the while exercising ongoing self-reflective praxis (the phenomenological reduction) throughout the two-month interview process. The volume and complexity of the data gathered, combined with the complexity of genetic phenomenological analysis as it unfolded, led me to concur with Giorgi
(2009) that a three-participant sample was more than sufficient for this research. Although it was difficult to narrow the data field by selecting just one triad of nurses, it was a strategic decision made to support richer analysis. I chose the ASMC nurse triad as the participant group largely due to the depth and complexity of data evoked at the focus group level of inquiry.

Racial diversity was not achieved in the research sample, for all nurses self-identified as White. The intent to achieve socio-economic diversity was likewise not met, for all identified as middle class. Further, they all described family systems and economic resources that were stable and adequate. In addition, nursing remains an almost entirely female profession and the sample of nurses was indeed all female. In other respects, however, these nurses offered a varied sample in numerous valuable respects relative to the purposes of this study:

- their ages spanned two decades,
- their patients’ ages ranged from birth to the end of life,
- their education ranged from diplomas through undergraduate degrees,
- their tenures in nursing ranged from brand new to the profession, to being settled in nursing, to being long-seasoned in practice,
- their critical care tenures varied from two to almost 20 years,
- they had no children, had young children, and had grown children,
- they were newly married, unmarried, and divorced / remarried,
- they had lived and worked in urban, rural, and suburban settings in multiple states, and
- they had turned to nursing both as first and second careers.

**Introduction to the Nurse Triad**

At the time of data collection, the ASMC nurses were employed within intensive care or trauma units of the medical center, but the three had never spent time together before the study.
All stated on the phone or in individual interviews that they were highly motivated to participate due to their own experiences with “compassion fatigue,” “burnout,” and the personal “trauma” involved in critical care nursing practice. Their selection thus fulfilled the study’s objective to find a triad of critical care nurses from a single institutional setting who possessed diverse lifeworld experiences, heavy workplace trauma exposure, and personal reflective capacities along with a willingness to share their experience with other nurses and the researcher. Table 1 provides an overview of the nurses’ pseudonyms and key characteristics.

Table 1

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<tr>
<th>Participant Characteristics</th>
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<tr>
<td>Names</td>
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<td>Yvonne</td>
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<td>Constance</td>
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<td>Holly</td>
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The description of participants that follows is drawn from interview data, but is altered in various ways to disguise their identities without altering characteristics significant to the study.

Yvonne began her career as an LPN and completed an RN Associate Degree program during her first several years of practice on critical care units. She settled into nursing on a neonatal intensive care unit (NICU) because she loved the professional growth it offered her, as well as the central role that family education played in the work. After a few years, however, she became weighed down by the many sad “predictable” outcomes and concluded this was no longer “a good fit” for her. Yvonne then turned to pediatric ICU (PICU) settings where she remained for
more than a decade, up to the time of the interviews. She had worked on a single unit for several
years, but moved to begin work at ASMC just a few months prior to the study. She was warm and
engaged during both the interview and focus group sessions, saying she was “very happy to help
out” for she believed that “compassion fatigue” is “so, so prevalent” and very damaging to nurses.

Constance was a relatively new nurse, having completed her nursing training less than
three years earlier, but she was the senior nurse in terms of age. She came to nursing after a
20-year career working in the utility industries in several regions of the United States. There, she
had “made more money and had better health insurance” than she did as a full-time trauma nurse.
But Constance said she wanted to “make a difference in people’s lives,” so when jobs were being
cut in her industry, she accepted an opportunity to retrain. She had long been interested in nursing
and upon her licensure, Constance completed a nursing residency in preparation for her intended
transfer to the emergency department (ED). She “fell in love” with ED work during nursing
school and became determined that she would “become a level-one trauma nurse”—but having
attained that goal, Constance found herself thinking she had made a mistake. At the time of the
interview, she had been working in ASMC’s ED for 20 months.

Holly was the youngest of the three nurses, but she possessed the median tenure in critical
care nursing—five years working in two quite different PICUs in different regions of the Eastern
United States. Holly was attracted to critical care nursing during her bachelor’s degree program in
nursing. She went to work in a very large PICU directly after completing her degree, for she loved
the science that underlies critical care practice. In the succeeding years, she married and adopted
children, as well as giving birth to a biological child. Becoming a mother altered her experience
of PICU nursing significantly, yet she continued to love many aspects of the work, particularly
the opportunity to provide emotionally engaged end-of-life care to the families of terminally ill
children. At the time of the interview, Holly had worked the longest at ASMC of the three nurses,
progressing from staff nurse to charge nurse to an acknowledged leader in pediatric critical care as well as in palliative (comfort) care for families with children approaching the end of life.

Yvonne and Holly worked in the same PICU, yet because Yvonne had recently moved to the region and she worked a very different shift schedule than Holly, the two had never spent time together before the study. In the interviews, however, both said they were aware of and thought highly of the other, based on their limited awareness. Both also stated (independently) that it had been an especially hard few weeks on the unit recently, with an unusually high number of “unexpected, shouldn’t happen” types of deaths in a short time span.

**Participant Protection and Retention**

I was acutely aware of the potential emotional risks as well as job risks that could develop as a result of these nurses’ participation in the research. Further, I was seeking out nurses who were at high risk for STS, but who might have little awareness of the concept, much less have been helped to cope with it. On the other hand, I hoped that the self-selection process I used to recruit nurses would foster responses specifically from those who possessed motivation, strength, stability, and openness to exploring their experiences with others.

Nonetheless, I added protections wherever I could. In telephone screenings, I inquired with each nurse respondent about her comfort level discussing difficult experiences in detail. I inquired specifically about the nurse’s comfort with focus group meetings involving nurses from other departments. I asked each nurse whether she felt her personal and professional life was sufficiently settled to support her through potentially stressful discussions about her work. In these screenings, I listened for signs of ambivalence or implied concerns. Yet each nurse who contacted me expressed steady interest and apparent comfort with the study’s requirements.
continued to take protective measures throughout the course of the project, restating my ongoing availability for questions or concerns, and my commitment to confidentiality.

**Structuring Research Relationships**

The project involved a series of two to three meetings with participants, so I was concerned about attrition should any of the nurses feel uneasy as a result of the first interview or focus group. Yet despite their very busy schedules and personal lives, and the emotional depth of their accounts, none of the nurses withdrew from the study or failed to stay in touch for follow-up.

The literature on STS indicates that a felt lack of agency and control in the workplace is a common corollary that aggravates stress and burnout among nurses. In order to obtain the richest possible data, I concluded it was crucial for the structure of the study to contrast rather than mirror such conditions. I invited the nurses to suggest the meeting locations for our interviews, so as to create sociable and (when possible) familiar surroundings for them. Independently, each nurse chose a favorite local restaurant or cafe. Conducting interviews over a meal or a favorite beverage created an ambient, even intimate atmosphere for our discussions. The study provided no compensation for the nurses’ time, but I did pay for each nurse’s food at our meetings.

**Practicing the reduction.** Interpersonally, I took pains to situate myself as a peer or colleague, rather than as a researcher or academic authority figure. Phenomenologically speaking, I constituted for myself a position consistent with the epoché, in which I attempted to enact the role of compassionate witness to the nurse’s accounts. In Miller’s terms (1990), I sought to function as an enlightened witness, offering my common background as validation of their experiences together with my open, nonjudgmental interest in their spontaneous accounts. In this way, I found that I was experienced by the nurses as both inside and outside of their experience. I thus could elicit detailed accounts of their caregiving and their inner worlds, in which they did not
assume I possessed detailed knowledge of their worlds, but also did not feel compelled to explain such minutia as medical terminology or basic treatment protocols.

Throughout my meetings with the nurses, I brought my internal awareness to bear not only on their accounts, but also on acknowledging my own intermittent difficulties with sustaining an open mental posture and engaged attentiveness to their presence and their stories. I responded internally to these acknowledgements by employing a problem-solving approach founded on critical reflective practice. For example, I asked myself: “What’s going on with me here, in this moment?” “Why is this happening?” “Why now?” “Can I discern where my attitudes or responses are coming from?” “Can I find an alternative posture, internally, that allows me to be more present to my participants and to the data they provide?”

Of necessity, in order to answer such questions, I permitted myself a measured reintroduction of my personal past, professional background, academic knowledge, social relationships, and emotional insights into my perception and constitution of the experience of data collection. I allowed these contents room for play in my awareness, specifically for the purpose of enhancing my own relational engagement with my participants during interviews and focus groups. Indeed, I would argue that no alternative actually exists in the flow of the lived experience—the “stream of consciousness”—of conducting empirical human science research, except for the unacceptable alternative of veiling this complexity in one’s own consciousness, and so becoming less reflective and ultimately less honest with oneself. By contrast, I found that the readmission of particular mental content into conscious awareness was a crucial element of data collection, and I considered any potential “cost” of such mental play (in terms of the resulting data and its analysis) to be more than offset by the benefits of enhancing rapport with my participants and heightening my critical capacity to analyze the data with a higher level of intersubjective self-awareness, openness, and insight.
Participant responses. Implicitly as well as explicitly, all the nurses were highly receptive to this construction of our relationships. I made a conscious effort to convey calm acceptance and respect in response to their accounts—maintaining steady eye contact, indicating comprehension, steering clear of interrogation, and communicating empathy both verbally and nonverbally. The 100% retention rate over a three-month period suggests the effectiveness of these strategies, though the nurses also indicated that my own identity as a nurse, as well as my background in critical care nursing, significantly enhanced their trust in the research process and in me as an investigator. I was someone who, in their words, was able to “get it.”

Thus, although I entered this project with trepidation about triggering distress among my participants by eliciting their stories, I found something more complex resulted. Despite obvious emotional stress and pain during some of their accounts, the nurses all stated they found the interviews and focus groups supportive, even therapeutic. In the first focus group, Yvonne stated:

I was kind of surprised after our first meeting that I was, like—Wow, I think I actually got more out of that than … she got out of me! You know? ’Cause it just felt good to talk. And you’re a good listener. (FG1:5)\(^1\)

Intersubjectively, Yvonne voiced as a certainty something that Constance first expressed as a question—that there are very few people with whom they can talk about their work:

Constance: Have you had that before? Have you had a time where you’re just talking to somebody close to you, and then you realized that you have to, that….


C: I don’t talk to many people about my job …

Y: Nm-mmm. [shakes her head, indicating she doesn’t either.]

C: … because I think people would look at me pretty weird.

\(^1\) See Table 2, below (p. 148), for the key to transcript references.
Y: Yeah, a lot of people, once they hear what I do, they’re like … how do you do that? And … they don’t—that’s all they want to know is—okay—no more discussion here.

C: You could—they want to know how you do it, but they don’t really want to know the details.

Y: Well, they don’t really want to know how I do it. They just want to say—oh my gooodness … and don’t want to—yeah. Yeah.

C: Yeah. (FG1:9)

The nurses not only expressed appreciation for the opportunity to be heard; they enacted this through demonstrations of significant vulnerability in the powerful feelings and perspectives they voiced during our interviews. It became apparent that my enactment of the role of the researcher as one who bore witness compassionately to their experiences was protective for them during the course of data gathering. For example, in the first focus group session, the two nurses expressed surprise that I didn’t show distress or dismay in response to their accounts:

PI: It sounds like part of what … surprised you—that was helpful—was the fact that I didn’t cringe…

Yvonne: Uhm-hmm. [agreeing]

PI: …or, wasn’t shocked or squeamish…

Y: Uhm-hmm. [agreeing, as Constance nods]

PI: … you didn’t pick-up from me—“Oh my God…."

Y: No—yeah—that—‘Well, I can’t talk anymore. I’ll be quiet now.’ Yep … not at all. You were good.

PI: Well, I didn’t feel any of that … but …

Y: Yep—it was very nice to just be able to talk about things.

PI: And that’s quite rare for you guys …

Both: Uhm-hmm!

Constance: Yeah. (FG1:10)
Gathering Appropriate Data

Face-to-face Meetings with Nurses

All meetings with the nurse participants were conducted in relaxed, sociable, and when possible, familiar surroundings. Two compact forms of digital recording equipment were used during each interview to provide a back-up recording should one device fail. Giorgi (2009) advised that the research situation should be an “analogue” to the lifeworld situation the researcher is seeking to understand (p. 114). Any phenomenon under study occurs spontaneously within a lifeworld context, but whereas an experimental science approach attempts to reproduce key lifeworld conditions within a fabricated setting that controls for major variables, a phenomenological approach emphasizes lived contexts and horizons of experience. Giorgi wrote that “since contexts matter so much in human affairs, it is important to try to approximate as much as possible the situations in everyday life where the phenomena we are trying to understand actually take place” (p. 115). This is necessary, he explained, because the stream-of-consciousness from which “experience” is constituted consists of (what Husserl called) “dependent parts” or “moments” that are intimately interconnected. They cannot stand alone because they comprise mutual “horizons” of perception, like interlocking puzzle pieces. Such “moments” are not merely “units” of data, but are crucially interdependent for determining particular participants’ uniquely constituted meaning structures with respect to an experience. This insight is, in fact, a major reason I rejected thematic content analysis (TCA) as a tool (as typically employed in hermeneutic phenomenological analysis), for such a practice risks dismembering and decontextualizing the intricate fabric of lived moments as conveyed within each account. Further, I found TCA offered limited tools with which to analyze the mutually constituted structure of such moments.
**Individual interviews.** Face-to-face nurse interviews ranged from 75 to 120 minutes. Consistent with Giorgi’s (2009) recommendations, I invited the nurses “to focus upon … specific situation[s they] actually experienced” (p. 124) and to “portray figural aspects” of those experiences so that the “phenomenal world” of each nurse could reveal itself sufficiently that their “manner of being present to a situation while experiencing a specific phenomenon [could] be discerned, and the structure of the phenomenon described” (p. 125). Thus, I was not merely listening to the nurses’ accounts of their experiences. More to the point, I was watching for their “manner of being present” to the situations they described—and even more immediately, their manner of being present to themselves and to me as they undertook their descriptive accounts. In this way, the interviews provided not just accounts of past events, but face-to-face, present-time data about the structure of the phenomenon as they re-experienced significant events in the act of their descriptions to me, a fellow nurse. (See APPENDIX D for the interview guide.)

**Focus groups.** Qualitative researchers typically convene focus groups to elicit a generous number of varied accounts and interpersonal responses among several participants (e.g., Bradbury-Jones, Sambrook, & Irvine, 2009; Penrod, Farcus, Loeb, & Hupcey, 2004; Polkinghorne, 1983). Such groups have the advantage of facilitating data collection from multiple participants within a relatively short time span and with minimal travel to individual meeting sites. In other words, they comprise a logistically pragmatic data collection strategy, more so than an epistemic or analytic framework.

This study differed in its rationale for employing focus groups. Here, my objective was to build upon the individual interviews in three specific ways: temporally, interpersonally, and substantively, specifically for the purpose of discerning learning, as I have defined it, among the nurses in real time as the focus groups progressed. Pitt and Britzman’s (2003) discussion of “deferred action” and Caruth’s (1996) notion of “unclaimed experience” suggest that there occurs
both temporal and relational disruptions in the constitutional processes that unfold in the context of traumatic events. Further, Britzman (2013) demonstrated how learning through reflective action is temporally structured. I was interested in how the passage of time might shape the nurses’ successive accounts of their experience, and I was further interested in how the availability of peers with whom to share their stories might shape these descriptions and present-time constitutional processes during group sessions. Finally, I was interested whether forms of learning could be identified within the course of these group interactions—that is, I hoped to witness learning rather than merely to hear accounts of it.

Like the individual interviews, the nurses helped to choose focus group locations in sociable, but discrete settings, and both focus groups took place in partitioned areas of local restaurants: the first near the hospital where one of the individual interviews had been conducted; the second at a restaurant in a small town located midway between the three nurses’ homes. Both audio- and video-recording equipment was used to capture verbal and nonverbal dimensions of the nurses’ interactions. Yet for the second focus group, both the audio and video recordings were afterward found to be flawed or have malfunctioned: they were either digitally corrupted or almost impossible to hear and transcribe. Consequently, although the first focus group was fully transcribed and analyzed according to the general method described here, the second focus group could not be transcribed or analyzed beyond the first five minutes. It is therefore not incorporated into the analysis of the study with the exception of a few general comments and one quote.

Another challenge that arose was that only two of the three nurses, Yvonne and Constance, were able to attend the first focus group session. Although this concerned me a great deal at the time, the quality of interaction that transpired between the two nurses was rich, nuanced, and quite profound. The absence of Holly’s embodied voice and presence was a significant loss, and certainly would have made possible a very different meeting of participants.
Yet my design objective, of introducing temporal and intersubjective axes of experience into the data, was nonetheless achieved in this two-participant session. I thus drew the conclusion that despite the loss of a more complex three-way participant interaction, temporal and intersubjective dimensions of data collection and analysis were achieved, though within a more modest scope.

In the opening moments of the focus group meeting, some physical tension was evident between the Yvonne and Constance, who had at that point never before met. Yvonne initially leaned back with squared shoulders and directed a series of questions toward Constance. In contrast, Constance was more animated, though just as intensely focused, and she responded conversationally with high energy. Both nurses maintained steady, perhaps even watchful eye contact over the first 10 minutes. Soon, however, this edge of guardedness dissipated as both nurses made numerous verbal and nonverbal gestures of mutual interest and affirmation:

Constance: …we got here when [my son] was about three. I went back to out west for a year, and then brought him back here. It’s just so much nicer here.

Yvonne: For kids, yeah, for sure.

C: It is—for raising them—I got out there and I was like, ‘Oh….’

Y: Yeah, yeah. (FG1:1)

And a few minutes later:

C: They lay off people and move jobs overseas, so the union stepped in and said …

Y: Yeah … you have to do something …

C: … you have to do something [spoken almost simultaneously, an echo]. Yeah.

Y: So now, you’re taking your BSN … at All Saints?

C: Well, at—I go to Southampton campus.

Y: I need to start that whole process…. (FG1:2)
In less than an hour, they had become confidants of and advocates for each other (e.g., see focus group analytic sample, APPENDIX F).

Although data capture was not successful for the second focus group, it did bring together all three nurses and the gestalt among them quickly resembled a reunion of old friends. During the four weeks between focus groups, the nurses had been in email contact as we selected a meeting date, time, and location. More significant, perhaps, they had come to realize how their paths had crossed in several ways within the medical center. At the very start of the session, Constance and Holly discussed one of these mutual connections:

Constance:  My girlfriend just transferred there, a couple months ago, to the PICU [asking if she knows the girlfriend]—

Holly:  Oh, yeah, yeah-yeah!

C:  She’s a good friend. We went through residency and stuff together.

H:  Really? Yeah, she’s awesome. I really like her.

C:  She is. I really—I knew when she told me—

H:  She’s doing a really great job.

C:  I knew she would. When she said she was gonna go to the PICU, I said, that’s perfect. And she keeps trying to talk me into coming….   (FG2:1-2)

By the end of that meeting, both Holly and Yvonne were attempting to convince Constance to join them by transferring to the PICU. Yet it is possible that the research study, itself, was by then the most significant experience they shared in common, for all cared a great deal about the broad problem of STS among nurses and wanted to see their experiences benefit others.

Scope of the data. As detailed above, the present analysis is confined to data drawn from the three ASMC nurses, consistent with Giorgi’s (2009) indication that systematic analysis of extensive data from three participants is sufficient to produce robust, verifiable, and trustworthy phenomenological meaning structures (p. 198). In contrast to thematic content analysis, Giorgi’s
modification of Husserl’s method depends less on the number of participants (he recommends at least three) than on the contextual richness and complexity of the descriptive accounts obtained. In addition, the analysis in this report is confined to the three initial face-to-face interviews and the first focus group session that involved Yvonne and Constance only. The longitudinal nature of the data I gathered, combined with the depth and complexity of static, then genetic (temporal and intersubjective) analysis I undertook, was supported by this focus on a relatively small, cohesive group of participants whose experiences were characterized, to the greatest possible extent, by shared horizons of perception and mutually interconnected “moments” in the flow of their perceptions. By delimiting the data in this way, I found that my constitution of rich, nuanced, and dynamic meaning structures through phenomenological analysis could be more fully realized.

My observation of the nurses during our initial interviews indicated that each was very interested and fully attentive to our dialogue. None cancelled our appointment and none changed plans on short notice, indicating to me that their commitment to participating outweighed other demands in their lives or any ambivalence they felt about sharing their stories. The nurses dressed casually and comfortably. Without exception, their body language was engaged—facing me, making generous eye contact, often leaning in, gesturing and nodding, laughing, and sometimes crying. Whereas one nurse, with the longest career, spoke calmly in measured phrases, the other two nurses spoke remarkably quickly. Constance, whose tenure in critical care nursing was the shortest (20 months), demonstrated a speech pattern that was often pressured with anxiety or excitement early in the interview, giving way to a somewhat more relaxed pace of speech with expressions of sadness, profound pain, and even fatigue as the interview progressed. Yet all three nurses were highly articulate, expressing themselves thoughtfully and spontaneously. They further demonstrated a keen commitment to understanding my questions and responded in ways that impressed me as sincere, insightful, and courageous.
While I initially hoped to access my participants’ critical care practice settings to observe them at work, I quickly realized this would serve neither phenomenological perception nor analysis. Even setting aside patient privacy issues, it would have been impossible to function as an effective research observer in such specialized settings where my physical presence would be sorely out-of-place. My chosen alternative to direct observation of the nurses’ work settings was to create an analogue of the psychosocial settings in which critical care nurses confide in one another about their work and their inner lives. Again, my self-identification as a one-time critical care nurse supported the construction of this analogue setting, and the nurses gave every indication that they felt safe and willing to confide in me similarly to ways they might do with sympathetic colleagues and companions elsewhere in their lives.

Finally, as shown above, the three ASMC nurses whose accounts are analyzed in this study presented a surprisingly integral tapestry of experience. Their descriptions revealed unexpectedly interwoven horizons and intersections in their work worlds while simultaneously presenting substantial variation in their backgrounds and perspectives prior to the time of the study. For example, Yvonne and Holly both worked in the same large pediatric intensive care unit (PICU), but on different shift schedules. Since Yvonne was new to the unit, she had rarely even seen Holly, much less spent time with her. Yet they both were familiar with the recent series of heart wrenching deaths on the unit. Constance, who worked in the emergency department (ED), had personally transferred a number of pediatric trauma patients to the PICU, and so had spent some time interacting with nurses and families there. Further, she had a strong interest in pediatric critical care and her closest colleague and friend had recently transferred to work in the PICU, giving Constance greater awareness of its milieu and stress levels.

This unplanned coincidence of interdependent moments in the experiences of the participants enhanced intersubjective levels of data collection and analysis. Their shared horizons
further enriched their mutual capacity to question, comment on, and validate each other’s perceptions. In this way, more refined and nuanced renderings of their shared phenomenal world could be constructed, making possible a richer structural portrait of their “manner of being present” to their patients’ traumas and to their own suffering as well.

**Working with the Data**

I will undertake a fairly detailed explanation of my procedure in the final section of this chapter. In mundane terms, I chose even my concrete methodological tools carefully (e.g., writing implements, notebooks, and digital tools), for I wanted to preserve as fully as possible the immediacy of my experiences of the data and my engagement with its human impact. Language itself structures and distances experience, and so each linguistic or analytic tool employed to work with the data would increase this distance. As a fledgling qualitative researcher, I chose not to employ a qualitative software package such as NVivo for this reason, but used tools that I found most familiar and intuitive—those already established synthetically in my ways of relating to and working with language. In preface to detailing my procedure, several conceptual issues that framed my data analysis deserve explanation, including how my praxis departed at times from a strict Giorgian descriptive phenomenological adaptation of Husserl’s methods.

**Three Assumptions**

I followed Giorgi’s analytic approach quite closely to render interview data into static phenomenological meaning structures (as opposed to essences). My practice departed somewhat from Giorgi’s conceptual framework, however, in that I operated on the understanding that any so-called descriptive phenomenological account of meaning structures by the researcher is ultimately and always simultaneously an interpretive account to some extent (see Chapter 4). Thus, I held to three fundamental assumptions throughout data analysis:
1. The constitutional process is ultimately and inescapably interpretive in nature.
2. Distinctions between (a) “natural perception,” (b) the phenomenological reduction, and (c) the eidetic reduction (that is, the constitutional process that yields stable structures of meaning) are not distinctions of interpretation versus description—each involves both. Rather, their distinctions lie in their relative potential to express varying degrees of self-reflective critical awareness as the constitutional process proceeds.
3. In empirical phenomenological research, there is no firm or fixed demarcation between the constitutional processes of the study participant and that of the researcher—they are inevitably layered and interwoven during data collection and analysis—which is to say, they are intersubjective. There is, however, a potential demarcation in the relative degree of transparency and critically reflective praxis articulated relative to descriptive and interpretive activities embedded within the constitutional process.

It is this demand for transparency that marks the primary distinction between researcher and participant. For although openness and transparency is requested of the participant, it cannot be required. For the researcher, however, it is a necessary condition of the research process, if she is to generate trustworthy, verifiable, and useful phenomenological results. It is thus a burden the researcher bears, to make her own constitutional process with the data as open to outside analysis and reflective critique as possible. Indeed, this is a cornerstone of the scientific method itself and a prerequisite to further study in any field of scientific study. The practice of transparency, which Giorgi (2009) highlighted as one basis for his term “scientific phenomenological reduction” (p. 98), is in large part what establishes the credibility of this research method in the context of its subjective and interpretive characteristics.

I thus hold that the product of phenomenological research is not only descriptive, but interpretive and imaginative, and that it is intersubjective more so than subjective. I further
maintain that this is the foundational nature of human perception, inquiry, constitution, and action in the world—whether executed consciously as a part of sustained and systematic inquiry (research) or executed over the course of mundane daily life. Indeed, this seems a conclusion that Husserl worked tirelessly to demonstrate over his career (see Chapter 4). Thus, whether phenomenological findings are useful or useless, whether they demand attention or are readily dismissed depends not on their objectivity or traditional validity, but on the critically and transparently reflective capacity demonstrated by the researcher to efface the analytic process, with all its strengths and foibles, as a comprehensible and systematic method that proceeds from well-reasoned and verifiable actions.

Units of Analysis and General Analytic Procedure

Units of analysis are distinct from units of observation. I described above my congregation of data based on three observational units:

- embodied nurse-participant accounts of their experience gathered individually through interviews as well as intersubjectively through focus groups;
- embodied researcher accounts of my experience of these meetings, including my perceptions of nonverbal communication, physical embodiment of verbal accounts, and nurse-to-nurse interactions (including interactions with the researcher);
- researcher self-observation and self-reflection, practicing the phenomenological reduction as a specific form of critical research praxis.

During data collection, however, I restructured these units into three levels or dimensions of observational data.

1. The primary level of observation comprised the nurses’ descriptions of experience in the individual interviews.
2. The secondary level comprised the nurses’ temporally and intersubjectively layered accounts of experiences in the focus group sessions.

3. The tertiary level involved my own accounts of self-reflective praxis, derived over time, to support scrutiny of eidetic analysis as well as to extend the intersubjective axis of analysis, so as to enrich the study’s insight into the nurses’ meaning-making.

These primary, secondary, and tertiary perceptual layers, structured over the course of data collection, were well matched to the requirements of phenomenological analysis as I practiced it in the study. Accordingly, the units of analysis to which I applied a modified Giorgian (static) and then emergent genetic form of analytic practice were as follows.

**Primary level: Static analysis of individual nurse interviews.** First, I analyzed the data of the individual interviews, which reflects the core process that Giorgi explicated (2009) to yield what I term static meaning structures pertaining to each of the three nurses. I then applied Giorgi’s analytic procedure to create synthesized structures of meaning responsive to the research questions, based on the discrete individual structures I had established.

**Secondary level: Genetic analysis of focus group sessions.** Second, I sought to extend Giorgi’s method to undertake what I call a genetic dimension of analysis. I followed his core method to analyze the focus group data while simultaneously working to appreciate and highlight temporal and intersubjective impacts resulting from the congregation of nurses sharing their experiences in the groups. These results attempt to capture the complexity of lived meaning structures: not only the multiple “directions” in which the stream of consciousness flowed in and among the nurses, but the layered, interwoven, even entangled aspects of their conscious experience, and the patterns I found discernable among these movements and entanglements.

**Tertiary level: Genetic reassessment of static structures.** Finally, I re-approached the primary static meaning structures together with insights from the focus group level of analysis.
Here, I considered further implications of the intersubjectively enriched, temporally extended findings from genetic analysis in relation to the static structures. Accomplishing this step required a renewed effort to practice the first reduction, with the epoché, to consider forces at work in my own consciousness and in my eidetic activity—as a fourth nurse who has also experienced secondary trauma in my career. In most cases, this level of analysis was then integrated with the evidentiary discussions of primary data analysis, where it could be more readily understood.

Thus, in addition to this departure from a strict reading of Giorgi’s approach, I attempted to penetrate the limitations of static meaning structures that may strand phenomenological findings in relative isolation from the evolving impacts of time and relationships. My attempt was motivated by two factors. As we have seen, studies in the nature of trauma belie any illusion that human meaning-making yields fixed or static mental frameworks. Trauma morphs, even shatters the most stable perceptions and beliefs, creating instability and uncertainty, yielding breaches and haunting voids—what Caruth (1996) called unclaimed experience. Further, as we have seen, studies in situated, relational learning show how temporal and intersubjective factors are powerful mediators, from Freire’s (1973, 1994, 2005) rural literacy programs to Forester’s (1999) urban planning meetings, and from Lave’s (2011) ethnographic studies of apprenticeship to Britzman’s (2013) difficult learning in the context of deferred action.

Researching the intersections of trauma and learning thus requires a methodology capable of exploring not just the constitution of relatively stable meanings, but an exploration of multiple axes of lived experience within which constitution is shaped, possibly shattered, and then reformulated. These axes include not only time and relationships, but culture, history, and each individual’s unique mental and physical characteristics. I have, however, limited the scope of genetic analysis in this study to encompass temporal and intersubjective axes only, while still grounding my work in Giorgi’s modified Husserlian approach. I thus proceeded in phases from
static to genetic analysis, exploring the roles of time and relationships upon the data as it evolved. Bridging the primary, secondary, and tertiary levels of analysis made it possible to offer findings that are more than a phenomenological “slice of life,” but something akin to an unfolding holographic narrative of the experiences being investigated. The structures I attempt to describe in the next chapter are thereby dynamic or iterable—inherently unstable and capable of change—yet they are capable of change that may itself provide evidence of patterns and frameworks, albeit elusive ones.

Sample data analysis. In order to illustrate the first major dimension within the process I followed, I provide sample pages showing analytic transformations of the data toward meaning units and, ultimately, toward structures of meaning (see APPENDIX E). The logic of the sample content requires brief explanation. I present four excerpts: one drawn from each of the three face-to-face interviews and one from the first focus group. I follow Giorgi’s general procedure for data analysis, showing this process through the use of aligned columns. Thus, each sample has four columns with the following headings from left to right:

- ‘Raw’ transcript (of the interview),
- First analytic step—3rd person voice,
- Second analytic step—Initial eidetic transformation, and
- Third analytic step—Further eidetic transformation.

In practice, analysis of the data required far more than three discrete analytic steps. Giorgi (2009) suggested performing as many steps (or transformations) in the process of eidetic reduction as the researcher deems necessary to arrive at a general structure of meaning based on the data. These samples are thus intended to be illustrative of the nature of eidetic transformation and, in particular, how it differs from thematic content analysis.
The first column, as stated, is a direct excerpt from a transcript. The remaining columns follow the analytic procedure, visually aligned from left to right (roughly, not precisely) with the raw transcript. That is, each column represents a progressive departure from the language and structure of the interview, moving toward constituted structures of meaning that are phenomenologically derived. In addition, my process ultimately moved from discerning static structures toward genetic ones, which at times is evident in the fourth column, particularly in the focus group sample. The columns thus reflect my constitutional process of transforming my experience of the nurses’ accounts into generalized meaning structures that I find true to the substance of their accounts and responsive to the research questions posed in this study.

These samples, however, do not represent the only form of constitutional and eidetic processes I followed in my analysis of data. In some cases, it was appropriate to constitute fairly compact meaning structures from many pages of data—for which columns were simply inefficient. In other cases, I undertook a process of synthesis that was also not amenable to linear columns, but required a more radical departure from the structure of content within the interviews toward a different format that better expressed the intra-phenomenal meaning structure of the experience being related. Nevertheless, the samples offered in APPENDIX E do indicate the general nature and direction of my practice of the eidetic reduction through the use of free imaginative variation. I hope they also clarify how my procedure differs from the usual practice of transcendental and hermeneutic phenomenological data analysis.

**Researcher Constitution of Experience: Applying the Phenomenological Reduction during Data Analysis**

Analysis began with my profound immersion in the data—the initial experiences of meeting with all six nurses, the relationships that unfolded, the substantive content of our conversations—all with attention to my practice of the first reduction, Giorgi’s “scientific
phenomenological reduction,” more commonly known as the epoché or bracketing. Throughout the data collection stage of the study, I kept an analytic journal, a reflective journal, and made field notes (memos) on my meetings with the nurses. Field notes pertained to my direct observations, along with questions I had about the nurses’ accounts. Analytic notes pertained to my responses, questions, and insights regarding the interviews and the eidetic analysis I would ultimately undertake. Reflective notes documented the inner world of my experience of the research process and my efforts to practice the epoché. In addition, I kept records of all meetings with my adviser and other colleagues as I processed the impacts of the data. All these practices with the epoché began upon my first visual contact with the first nurse participant and continued through the course of individual and group meetings.

**Preliminary Constitutional Steps**

In pragmatic terms, all-the-while exercising the movements of the first reduction, I enacted the following research practices. Each digital recording of meetings with nurses was given standard “visual stabilization” for purposes of scientific discourse (Giorgi, 2009, p. 125). I listened to each interview carefully and repeatedly. I included within the final transcripts both spoken words and nonverbal communication that I deemed significant: vocal tones, crying, extended pauses, body language like tapping, and other signifiers of nuanced meanings that I perceived being expressed (e.g., see APPENDIX E). In addition, I used italics to indicate particularly strong verbal emphasis conveyed by the nurse-participants in their descriptions. The transcripts were paginated, and each of the quotes presented in the succeeding chapters of findings indicates the source of the quote using the study’s pseudonym for the nurse, the data session of origin, and the transcript page(s) on which the quote appears (e.g., “Y:II:18-19”), according to a key outlined in Table 2 (see next page).
Following transcription, each interview transcript was then forwarded to the nurse who provided the interview, to be reviewed for errors or misconstrued terminology, or other obvious problems. I invited the nurses to voice any thoughts, questions, or major concerns they might have at this stage, and none voiced any, while all reported that they felt the transcripts reflected our conversations as they recalled them. Meanwhile, I began to read each interview for a “sense of the whole” while further assuming a phenomenological attitude (Giorgi, 2009, p. 87).

Similar to other qualitative analytic methods, my first impressions of meaning units were delineated at this stage, with specific attention to the study’s research questions. This step relied, consistent with the first reduction, upon a mental focus intent on identifying those descriptions from the participants’ accounts that were, in my perception, especially evocative of the phenomena under investigation. Accordingly, my delineation of meaning units was grounded in my intentional assumption of the study’s conceptual framework with its particular integration of disciplinary perspectives. I sought to demarcate these units without adding or subtracting content to the nurses’ accounts, and without attempting to resolve ambiguities. I also worked to impose as little as possible of my own history or scholarly expectations upon the data (e.g., personal memories or intellectual hunches) as I experienced the nurse’s accounts through the constructed lens of the research objectives.

Table 2

<table>
<thead>
<tr>
<th>Nurse</th>
<th>Abbreviation</th>
<th>Data Session</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yvonne</td>
<td>Y</td>
<td>Individual Interview</td>
<td>II</td>
</tr>
<tr>
<td>Constance</td>
<td>C</td>
<td>Focus Group One</td>
<td>FG1</td>
</tr>
<tr>
<td>Holly</td>
<td>H</td>
<td>Focus Group Two</td>
<td>FG2</td>
</tr>
</tbody>
</table>
In his adaptation of Husserl’s method to meet the demands of empirical human science research, Giorgi (2009) recommended implementing three sub-steps so as to practice the epoché while identifying units of meaning in this stage of analysis. The steps, he argued, support the phenomenological attitude of the reduction by creating a necessary, discriminatory distance between the participant’s account and the researcher’s analysis. They also comprise the beginning of the researcher’s constitutional process, which continues more fully in the eidetic reduction (see below). The three adjustments, which are to be made to the raw transcript of each participant’s account, are as follows:

1. A grammatical adjustment from first-person to third-person voice,
2. A stylistic adjustment from the interview format to a narrative format,
3. A structural adjustment of the narrative into meaning units, using visual markers.

The first two of these adjustments are evident in the analytic samples provided in APPENDIX E. Identification of meaning units, however, is more implied than explicit in the samples, such as through the use of paragraphs in columns three and four. Early analytic designation of meaning units (in columns one and two) created visual confusion when rendered into these compressed sample pages. Consequently, the initial demarcations are not shown.

Giorgi (2009) supported these methodical adjustments by explaining that in human science investigations, unlike philosophical investigations, “the phenomenological researcher is doing an analysis of another’s experience rather than one’s own” (p. 153), and although the researcher must be “sensitive to the viewpoint of the other … identity with the other is not the goal” (p. 154). The first two adjustments specifically address this difference by making linguistically evident the third-person nature of the data. In addition, though it is indeed “the viewpoint of the [participant that is] to be discerned,” it is nonetheless “discerned from the perspective of the researcher’s consciousness” (p. 154), and the adjustments support that
distinction by bringing into play the researcher’s consciousness through her “voice” in the narrative construction of the data. In this way, the researcher’s narrative activity within the analytic process is made more evident, thereby increasing the transparency of the analysis.

The third adjustment, the introduction of meaning units into the transcript, reflects the researcher’s aims in carrying out the study, including her particular disciplinary perspective and a constructed theoretical lens. Yet these conceptual frames do not contradict the reduction—indeed, absent them, there is no form of investigation (philosophic or scientific) that could possibly be achieved. That is to say, the first reduction does not require the obliteration of such conceptual structures in the researcher’s consciousness. Rather, it necessitates exercising sufficient self-awareness as to hold them in distinction and intentional suspension from the perceptual experiences presented by the data. And it requires a rigorous level of transparency in the investigator’s articulation of her movement between the data and these scholarly frames.

My Praxis of the Reduction

As a one-time critical care nurse, my practice of data collection ejected me through a space-time continuum to my earliest experiences as a nurse. My experiences were mirrored by the experiences in Shem’s novel (1978), for I was at first frightened and overwhelmed, then possessed and haunted by the rawness of caregiving and caregivers—yet I was also driven to master the environment. Nevertheless, I soon found that I disliked my work and sought ways to escape it. I struggled against psychological despair and numbness while simultaneously finding myself heavily preoccupied, sometimes even obsessed, by relations with my coworkers, patients, and the hospital as a whole.

Consequently, the data collection process exacted a powerful toll: physically, emotionally, and mentally. During the weeks that I conducted individual face-to-face interviews, I found
myself feeling increasingly disoriented and stressed. Many nights, I became aware of my body stretched rigid on my bed, muscles set, arms grasping the pillow like a feebler branch protruding from a cliff. Over and over at night, I would find my teeth clenched or my breath held—waking sometimes with a panicked gasp—at which point I would coach myself through a series of deep inhalations and a full-body relaxation process. Minutes or hours later, the process would repeat.

Meanwhile, in the daylight hours of the research, embodied memories that were more than 25 years in storage returned to me, sometimes insidiously and sometimes in force: the icy car ride to work before dawn in winter; the dim, silent hospital lobby at night; the swift ride up the elevator to the medical ICU; its softly lit rooms in the night, echoing the beep of monitors and whoosh of respirators; the smell of body fluids and the weight of unresponsive limbs; families’ searching eyes, hoping to grasp what was happening within those walls.

My initial response to this montage of meetings and memories was a powerful sense of exhaustion and an urgent need to sleep immediately after each interview—despite my body’s physical tension during these weeks of interviews and focus groups. On arriving home from trips to the individual interviews, I often had a sensation of leaving my body, as if my consciousness relocated itself elsewhere in the room to observe my body landing on the bed, sinking into the covers, eyes closing in a wish to hide. Some days, I concurrently relived my younger self coming home after a 10-hour night shift, felt the old cloying for creature comforts: ritually eating a bowl of cereal, climbing between the sheets in daylight, perseverating the events of the night, eyes and mind on edge, then drifting, waiting for sleep to come. In such tangled moments of data collection and memory, it was sometimes fundamentally unclear to me whether my consciousness resided nearer to the present research or to those long ago days when I struggled psychically to survive.

It was through this entangled mental fog that I listened to the nurses, made notes, dictated reflections, transcribed recordings—and also spent time with people I hoped could ground and
stabilize my distressed body and mind. I worried and complained and sometimes cried. I used journaling as a tool to separate, objectify, and distinguish my inner world from the world that my participants were presenting to me. I worked daily to be intentionally “present” to my experience of each nurse and each meeting—the first movement of the reduction—not only as these encounters presented themselves face-to-face, but through hours of transcription too. I began transcribing as swiftly as I could after the interviews, laboring to create a mental space to exercise the epoché consciously and consistently as I relived each meeting. I made critical choices about when and how to capture nonverbal content and potent emotions. I strove to question my assumptions and responses, and to scrutinize my decisions. And I returned again and again to the mental position of an intentional compassionate witness—i.e., Miller’s enlightened witness, one who attends to and respects the experience of another without guardedness or judgment.

This summarizes my approach to and initial experience of the data, and my use of the first reduction: to practice attentiveness toward the nurses’ descriptive accounts; to undertake the epoché within the framework of my disciplinary and conceptual perspective; and to exercise reflective self-awareness and self-corrective activity through critical consciousness toward my praxis of the foregoing movements. All these activities remained foundational through the next phase of data analysis, the eidetic reduction, in which free imaginative variation was introduced to generate relatively invariant structures of meaning for the phenomena under study.

**Researcher Transformation of Data:**

**Applying the Eidetic Reduction to Yield Phenomenological Findings**

As discussed in the previous chapter, the goal of Giorgian (2009) phenomenological analysis is not to identify themes in content, but to discern generalized structures of meaning. This includes two dimensions of analysis:
1. discerning and describing each participant’s experience of a phenomenon via their manner of being present to a situation (Giorgi, 2009); and

2. discerning and describing an invariant structure of the phenomenon as it is experienced by the participant.

For Giorgi, the experience of the phenomenon includes constituted meanings evidenced in participants’ descriptions, and it also includes meanings constituted by the researcher throughout the analytic process. But the goal of analysis goes beyond descriptions of meanings to include the \textit{intra}-phenomenal structure of an experience for each participant, as well as the \textit{inter}-phenomenal structure of an experience across participants’ accounts—where such a structure can be discerned. These structures are derived using the process of free imaginative variation.

\textbf{Analytic approaches and products}. I thus worked to establish what Giorgi (2009) called “morphological essences” (p. 121) or “generalized meaning structures” (p. 100-102) as findings of the research (see Chapter 4). As discussed, these are not merely discrete units of constituted meaning, but integrated constellations of meanings that individuals organize mentally in specific ways for specific reasons, and that congregate into mental frameworks of understanding. Thus, to qualitatively understand the experience of nurses bearing witness to trauma, it is crucial not only to find and claim particular qualities of the experience, but also to locate and associate them in ways that reflect the integrated consciousness of those whose experiences are being studied. This necessitates creating an integrated portrait of complex, sometimes contradictory, actively unfolding experience in its temporal and relational contexts.

My own practice of the eidetic reduction is difficult to articulate, except to say that despite my use of columns for structuring the analytic process, my mental activity often was not so linear as columns suggest. My practice of free imaginative variation indeed necessitated imaginative leaps that could not always be accounted for logically. Ultimately, I relied on the dynamic of
intersubjectivity in meaning-making, as it had developed between myself and the three nurses over the course of our meetings, in order to evaluate critically my progress toward articulating general structures of meaning that were faithful to their accounts and to the intersubjective dimension of our meetings.

Thus, my results (presented in the next two chapters) comprise descriptively integrated accounts of matrices of meanings—that is, meaning structures—that I perceived and constituted over the course of my analysis of the three nurses’ accounts of bearing witness. Structures are presented in response to each of the major research questions. In chapter six, structures are presented for each participant individually and, following Giorgi, these structures are written so as to signal the movement toward eidetic abstraction and generalization through the use of first letters only and within brackets in place of each nurse’s study pseudonym (e.g., [Y] rather than Yvonne). Chapter six concludes with more generalized structures that span all three nurses’ accounts. In chapter seven, a single temporally and intersubjectively more sensitive structure is attempted, responsive to the three major research questions, but with an emphasis on learning.
CHAPTER SIX

THE EMBRACE OF MOURNING:

THE STRUCTURE OF TRAUMATIC EXPERIENCE

Law III of the House of God: At a cardiac arrest, the first procedure is to take your own pulse.

I was restless. I missed something. I was not doing well. I didn’t want Marcel Marceau, I wanted the [ICU]. ... It wasn’t until the hermetic doors shushed shut behind me...and I settled into a chair in Pedley’s room, that I felt calm again.

That calm was not to last. Berry appeared, dressed to kill, and said, “Roy, what the hell are you doing here? We’re supposed to see Marcel Marceau. You bought the tickets, remember? ... It’s either this or me....”

I heard myself say, “It’s this.”

That’s what I thought you’d say,” said Berry, “and I don’t buy it....” She made a motion...and in walked the two [ER] policemen, Gilheeny and Quick. Following them were Chuck and the Runt. ... “What the hell are you doing here?” I asked suspiciously.

“Your girlfriend said that you have been crazy and were refusing to leave this Unit and go to the show with her,” said Gilheeny.

“I’m not going,” I said. “It’s ROR [relationship on rocks] with her and me.” ...

Trespassing is an offense,” said Gilheeny, “and so we shall remove you.”

With a good deal of furious struggling and cursing on my part, under Gilheeny’s direction, Quick, Chuck, the Runt, and Berry hoisted me up and carried me out, ushered me down the stairs, and helped me into the police car, which, sirens blaring, raced through the downtown traffic and delivered Berry and me to the theater door. I sat there, bullshit. While I thought I’d escape...once again I had underestimated these policemen.

“You’re coming in with us?” I asked, amazed.

“We’re admirers of true genius,” said Gilheeny. ...

“How the hell did you get tickets on such short notice?”

“Graft,” said Quick simply.

With Berry and me sandwiched tightly between the bulky Gilheeny and the sinewy Quick, I...resigned myself...yet, as Marceau went on, with Berry pressing my hand and the policemen reacting with all the spontaneity of kids, I couldn’t help getting interested. ... All of a sudden I felt as if a hearing aid for all my senses had been turned on. I was flooded with feeling. ... And along with this burst of feeling came a plunging, a desperate clawing plunge down an acrid chasm toward despair. What the hell had happened to me?

Findings I: Static Analysis and Individual Meaning Structures

Thirty-five years after Shem’s publication of *The House of God*, the phrase “not doing well” continues to circulate among critical care health providers as a euphemism for what might be understood as fairly extreme states of internal pain, agitation, numbness, and obsession, along with self-defeating, even self-destructive behavior that too often accompanies those states. All three critical care nurses whose accounts are explored here independently used that very phrase. This chapter and the next essentially strive to answer the question, “What the hell happened to me?” specifically with regard to these nurses and their experiences of secondary traumatic stress.

In this chapter, I present static (descriptive cross-sectional) structures. In chapter 7, genetic (temporally and intersubjectively enriched) meaning structures are proposed.

Following Giorgi (2009), this chapter presents a set of descriptive (yet nonetheless interpretive) general meaning structures derived from each of the three nurses’ accounts of their experiences with secondary traumatization (ST). These findings are consistent with a static understanding of Husserl’s work that explicates the mental constitution of morphological essences (Giorgi, 2009)—structures of meaning that are constituted through lifeworld encounters. Structures are presented in response to each of the three major research questions of this study.

Specifically, I provide a descriptive meaning structure for:

1. each nurse’s experience of secondary traumatic stress (STS);
2. each nurse’s ways of naming and speaking about STS, which I call “languaging”; and
3. each nurse’s ways of learning in response to identified experiences of STS.

These structures are generated after first presenting evidence from the individual interviews, with some allusion to focus group sessions, in support of the derived structures. The evidentiary sections, subtitled “Analysis of Meaning-Making,” are not intended to be comprehensive of the data, but rather representative of it, such that certain elements may appear in final structures that
are not discussed in depth in the supporting section. For each nurse, following the evidentiary section and, consistent with Giorgi’s (2009) method, reduced structures of meaning are presented, responsive to each of the three major research questions. These structures, as abstractions from the data, use single letters inside brackets (i.e., [Y], [C], and [H]) to designate the individual nurse as the source of the structure.

Following the individual structures for each nurse, I conclude the chapter by undertaking synthesized structures of meaning that are more general and incorporate invariant elements of all three nurses’ derived meaning structures relating to the three major research questions. Chapter seven will extend the analysis to examine the focus group session involving two of the three nurses, Yvonne and Constance, with a focus on the emergence of learning through the temporal and intersubjective axes of their participation in the research.

**Analysis of Yvonne’s Meaning-Making**

**The experience of secondary suffering and traumatic stress.** Yvonne’s account evidenced that the experience of bearing witness to suffering had effects that were insidious, powerful, and at times quite destructive, despite her tenure in a hospital that was “very proactive with debriefings, and checking on nursing and critical stress incidents, and things like that.” In the beginning of her career, Yvonne recalled feeling “forgive the expression—balls to the wall”—overwhelmed and frightened by the critical care environment. Yet, she was also attracted to the challenges there and quickly found herself “100% heart and soul in” (Y:II:1-2). Starting as a licensed practical nurse (LPN) in a special care nursery, Yvonne was motivated by a passion to learn and make deeply personal impacts on the lives of sick children and their families.

After two years, she accepted a position at a larger regional hospital in the neonatal intensive care unit (NICU), and she began studies for RN licensure. During the course of four
years there, however, she found that infant outcomes were often so sad, and so predictable, that she “just couldn’t do that anymore.” She transferred to the pediatric intensive care unit (PICU) at the same hospital where a very good friend was already working, and there she excelled. Within a few years, she was a senior nurse clinician as well as a hospital leader in palliative and end-of-life care. During the course of 10 years in which Yvonne worked in this PICU, she also co-chaired the hospital’s pediatric palliative care team for a time and helped to guide broad nursing education initiatives, some of which were taken to the level of national conferences.

“How a bad day really goes.” Yvonne’s experience of critical care nursing began to deteriorate, however, after several years of welcoming greater and greater responsibility in this setting. Her account of this period was at times disjointed and confusing during our interview, as she mentioned, moved away from, and then returned to elaborate on several key events before describing them in depth. This way of representing her experience comprises a dimension of the structure evident in her meaning-making, but it also illuminates some of the intricacies of the experience of secondary traumatic stress and its consequences. Thus, along with the excerpt from our interview (see APPENDIX E; presented in part below), I present one other extended excerpt below to illustrate the horizons of her perception, patterns in her narrative constitution of events, and early traces of temporal and intersubjective influences on her descriptions.

The first key passage may be read in its entirety in APPENDIX E. Of particular significance is Yvonne’s allusion to events that she described more fully later in the interview:

Yvonne: And by then I’d been a nurse for quite a while and recognized the symptoms in myself. But I was a little sad that, other than my director calling, my other supervisors didn’t recognize any signs. I was a little short with another mom, like, a few weeks later. And I was actually a little short with a mom who was there because her little one had a submergent [drowning] injury, and she was like, ‘Well, this alarm—’ And I was a little short with her. I was a little short with some of my other staff. I was not as patient with newer nurses. Um…. I didn’t have that ability to focus as well. And I guess, afterwards I figured it out.
But I actually even got called in about something that happened with one of our newer nurses, and it was—and nobody recognized at all that I was like—wow—you know. I’d been a nurse for like eight or nine years in this particular unit, maybe eight. And had seen a lot, and I was in charge a lot, and I was responsible for a lot, and I’d always get the worst of the worst kids. I’d always hear, ‘You’re doing fabulous end-of-life care’—so I got all the end-of-life kids. ...

So, I guess, after—in retrospect, I was a little, “Hmm…” that nobody recognized that. They were just like, well, something must be going on at home with her…. 

PI: So you figured that out gradually.

Y: Yeah.

PI: It had to be you figuring it out.

Y: I figured it out and I adjusted it. Which is why, I guess, I’m so sensitive, with watching other nurses, and seeing what I can do to help them, because I can see—you know, we’ve had a lot of bad cases in our unit—we’ve had eight deaths in three weeks. …

And, you know, there’s a couple of the nurses who keep getting these kids. And they just come into the break room and they are just, like, wiped out. Completely wiped out. And there is—you know, we’ve got to take care of those girls ’cause they are a mess! They are not doing well right now either. You know? (Y:II:10-11)

The phrase “not doing well” is revealed here as a reference to intense suffering in the face of recurrent death and mourning. This kind of understatement shows up in Yvonne’s account like a counter-balance to the extremity of her professional experiences. Her repeated use of the phrase “a little …” regarding to her feelings of being “sad” or “short” is striking, as is her phrase, “I guess …” regarding her eventual capacity to identify STS and her disappointment with supervisors who could not. This language allowed Yvonne to maintain a calm demeanor in the present moment while intimating that, despite not doing well herself at that time, her emotions had been moderated and reasonable. She situates being “actually … called in” within a context of her supervisors’ failure to recognize signs of her stress and emotional exhaustion. Yet she is vague about the depth of pain she was experiencing—evidenced in the flow of her language from
clear statements like “nobody recognized at all that I was …” to disjointed phrases that trail off: “… like—wow—you know” and “I guess, after—in retrospect, I was a little, ‘Hmm…’”

Yvonne’s language also had the intersubjective effect of creating conceptual breaches that beckoned for a more determinate response, which I found myself at times unable to resist supplying, such as when I stated, “It had to be you figuring it out.” On the other hand, Yvonne departed quickly from her mention of being “not as patient with newer nurses” and getting “called in”—moving on to express the growth in her awareness and her present concern for other nurses’ pain. On my further query to understand the events leading up the prior stress and exhaustion, however, she again mentioned a newer nurse and, following some perceptible hesitation, she detailed graphic events from an unforgettable day:

PI: If I have the timeline right, when you describe that point after eight or nine years on the PICU, when you realized that you were ... pretty frayed…

Y: Um-huhm…

PI: …that was not long before you made the move to ASMC [All Saints Medical Center]? Or was that a while back?

Y: Maybe it was...about two or three years—because I went overseas about two years ago, and it was before that. And I was having some issues with maybe some of— There was one particular nurse that was new in our unit. And, I remember one day and I had a— I was just thrown so many things. And she was new and she didn’t get a lot of the potential problems that could very easily and quickly spring up on our unit. And she quite frankly was horrible to work with that day. She couldn’t figure out why I was worried about things. And of course, that was [when] I was usually the whole hospital’s IV team, and I was in charge, and we didn’t have a secretary—all our secretaries got called off, our staff got called off—and I was calling people who didn’t want to come in.

And we got this little boy brought over [whose] fontanel was bulging, just huge. [And I had to go with the boy for a CAT scan] and I said, ‘I want this room set-up for him when I come back, please.’ Well, the girl ... decided that she was going to set him up in an isolation room, which is a horrible room—it’s small—running a code in there would be ridiculous. And so she had that room all set up [when I got back] and I said, ‘No that’s not the room I wanted.” And she was just, ‘Oh—of course, it always has to be your way….’ Blah, blah, blah…. And she said ‘Well, I had that room all set up for you!’ And I said ‘Yes—and we’re coming back from an MRI to do a lumbar puncture and there’s great
potential that kid was going to herniate as soon as they stuck a needle in his back because of the pressure in his head, and I was not coding him in that little room!"

And I got called to task because she didn’t think I was being ... nice enough to her that day. But that was like the end of my—oh my goodness, I’m so burned out, I can’t deal with this sort of thing right now! [laughs] So, I had a little meeting there [with her nurse managers], and fortunately then I went away for almost three weeks overseas—got a really awesome perspective about things…. (Y:II:11-12)

Yvonne began by attempting to recall a chronology from a very stressful period of her work life. She undertook this reconstruction by linking together key events, in particular, her trip overseas that seemed to function like a stabilizing anchor in her memory. The recollection of this event brought Yvonne to a particular day that she voiced tentatively at first, “I was having some issues with maybe some of—” then broke off, perhaps giving herself a moment in the flow of conversation to deliberate how much she wished to reveal. When she chose to be more specific, an incisive and vivid description emerged for the first time in the interview: “There was one particular nurse that was new in our unit. And, I remember one day…. “

At this point, her account of the day flowed without hesitation. She held me in a clear, steady gaze and spoke with growing animation until she reached the climax of her description of the day’s events: “and I was not coding him in that little room!” Previously, Yvonne had evaded sensitive self-effacing details of “horrible” days like this through the use of generalizations, or by intermittently employing her altruism like a veil to blur such vulnerable content. Now, she began to take greater interpersonal risks in the interview.

Turning next to discuss her supervisors’ censure in the “little meeting,” Yvonne laughed, implying that their actions were so off the mark as to be ridiculous: “Oh my goodness, I’m so burned out, I can’t deal with this sort of thing right now!” This dismissiveness was the closest Yvonne came to expressing anger or resentment toward her nurse managers at any point in the interview. Although her account, as a whole, provided a general critique not only of her
supervisors but certain members of hospital administration, she never explicitly criticized or voiced strong emotion with regard to their actions. By contrast, regarding her frustration with the inexperienced nurse, Yvonne was able to voice more freely that, in her experience, the new nurse “quite frankly was horrible to work with that day.”

Focus group data during the study (see the focus group excerpt provided in APPENDIX F) demonstrated Yvonne’s exceptional capacity to empathize with and provide support to a newer nurse (Constance). It also evidenced her commitment to advocacy in terms of validating another nurse’s pain while offering a normative and non-judgmental perspective with practical guidance. If this study were focused on general thematic content analysis, then Yvonne’s highly developed commitment to the welfare of newer nurses would emerge as a major theme of her account. Labelling such a theme, however, does not help us to understand how it was possible to her to develop these capacities, nor does it efface the subtle relations between this and other elements of her experience. Addressing the latter requires closer examination of the horizons of her experience and the evolving relationships among meanings she has constituted. The following discussion undertakes such an examination.

First, however, it should be noted that there were multiple events that coincided to create her unforgettable day—and many were factors over which supervisors and hospital administration exercised primary responsibility and control. For example, the severe shortage of nursing staff and administrative staff on the unit that day, the lack of a dedicated IV team for the hospital, and the possibly limited mentoring, guidance, and feedback mechanisms in place for new critical care nurses. Moreover, Yvonne’s account leaves no question that she was by that time a senior nurse in the PICU who bore heavy professional responsibilities—she “had seen a lot,” “was in charge a lot,” “was responsible for a lot”—and as a result of consistently “doing fabulous end-of-life care,” she would “always get the worst of the worst kids.” Thus, despite the fact that by her own account
the hospital was “very proactive with debriefings and checking on nursing and critical stress incidents,” it seems plausible that both hospital and unit leadership were in fact not proactive or even particularly astute regarding chronic, structural stress and its effects on nurses. Even Yvonne’s peers, in her experience, evidenced little insight at key moments when she was not doing well: for example, generally attributing her growing stress and irritability in the months before her trip abroad to “something ... going on at home,” rather than considering how they might be related to all that was going on at work.

“We will run from an end-of-life situation.” Following Yvonne’s disclosure of this head-on crash of experience with the difficult new nurse, I queried her further as to chronology and the perceptual connections in her awareness among various events. At this point, Yvonne began to recount an entirely different series of experiences, which preceded those above by several months to a year. Although Yvonne did not make any direct connection between the two sets of events (she merely related them in response to my probing), I find their juxtaposition suggests a strong causal relationship within the structure of her experience. I will paraphrase the circumstances she described next.

As part of her leadership role in pediatric palliative and end-of-life care at the hospital, Yvonne explained that she chose to write a small, but fully referenced handbook for her fellow PICU nurses that dealt with every aspect of hands-on care, along with psychosocial support of families, signs and symptoms of compassion fatigue (CF), and the importance of nursing self-care. During that period, Yvonne also happened to go on a six-week medical leave from the unit to recover from surgery, and she devoted her free time to researching the handbook. As she learned more and more about nurse burnout and CF, Yvonne said that she saw her own internal experiences reflected in what she read:
So, of course, when you learn about that, you learn, ‘Oh—wow—that sounds just like me.’ [laughs a full laugh] ‘Wow, that really sounds just like me!’ Hmmm…. So, that whole writing of the book may have been a good ‘Ah-ha’ moment for me, too, as far as figuring out that maybe I did have a little bit of an issue, just, you know, reviewing some of those signs and symptoms. Or, you know, sometimes you can hear and read things and they don’t ‘Ah-ha’ you, and sometimes they’re just applicable in your life and you go—‘Okay, I can hear this now…. I’m seeing it, this is me, absolutely.’ (Y:II:12-13)

Again, Yvonne’s tendency to understate her experience is evident here as she states that “maybe” she did have “a little bit of an issue.” And although she identified CF in herself without apology or hesitation, she chose not to elaborate on her feeling states at the time.

Yet the events she described next, following her completion of the manuscript, Yvonne claimed to have experienced as “a little frustrating,” for the handbook “got torn apart by media personnel and our CNO” (chief nursing officer) over issues like its use of the word “dead.” She recounted that her administrative superiors told her: “It’s hard to read about that,” and she responded, “Of course, it’s hard,” and explained that she was not suggesting “people sitting in the waiting room read this book.” It was intended for other PICU nurses to have on the unit as a resource. Nonetheless, she was instructed to remove entire sections of text—including those covering therapeutic conversations with families and nursing self-care—parts that she believed “were the most important.” Yvonne ended this portion of her account by characterizing the events mildly as “quite disheartening.” She added that she never saw the book printed or used in the hospital and, at the time of our interview, she had no idea whether her work had been made accessible to nurses there in any form.

Whereas Yvonne’s manner of being present to her account of the horrible day was direct, personal, and emphatic, her manner of being present to this description was again relatively muted and cautious. Her admission that the events were “a little frustrating” and that she “felt a little astonished” this could have happened were reminiscent of her earlier admission to feeling “a
little sad” that her supervisors had not shown greater insight and support. Only as she revisited her concern for other nurses did Yvonne’s speech regain a more spontaneous tone of conviction:

I was just like, “Really?!” ‘Cause that was my whole purpose, was helping nurses communicate with their families and knowing what’s going on in themselves. ... I actually think that’s one of the most important things an ICU nurse can do for themselves. Because we learn and read about ICPs [intracranial pressure readings] and how to do chest compressions, and we’re always going to conferences on ALS [advanced life support] and how to run vasoactive drips. But I know many nurses that—they’re the best clinical nurses you can see, but they will run from an end-of-life situation. (Y:II:13)

The pattern that had emerged was one of consistently strong intellectual engagement, but varying emotional expressiveness in relation to her descriptions. With respect to the latter, Yvonne showed consistent, spontaneous emotional engagement as she spoke of the suffering of patients’ families and fellow nurses. When she spoke of her own distress and suffering, however, Yvonne consistently distanced herself in terms of the language she used to describe her feelings, and she carefully managed the emotions she allowed to become visible in our conversation.

These patterns are not surprising, and her capacity to manage her feelings may reflect the length of her critical care tenure and her extensive practice at channeling emotions in specific ways. What is striking, however, is that while Yvonne expressed herself clearly—verbally and affectively—when critiquing a difficult fellow nurse, she did not do so when critiquing her clinical and administrative superiors. Nonverbally, Yvonne’s intellectual astuteness was apparent through her entire account: she maintained penetrating eye contact, she was typically very articulate, and she was attuned to my responses. Yet with regard to her own managers and supervisors at her former hospital, she never explicitly voiced anger, hostility, or resentment toward any nurse or administrator to whom she reported.

A third time, as I probed further into chronology and reflected back to her the implicit emotional dimension of her account, Yvonne recalled that “it was almost a year later that I went
away [overseas]….’” That is to say, the events involving the handbook culminated several months before the horrible shift with the new nurse, which Yvonne identified as her most fatigued and “burned out” point in her nursing career. Structurally then, her months of work on the handbook, followed by its ongoing marginalization by hospital administration, was a proximate backdrop in her self-described devolution toward CF and even “burnout”—a term she used even though she disliked it. She had in fact identified CF within herself during the time she was still writing the handbook, and the portions addressing CF and nursing self-care must have functioned as a strong message to those administrative personnel reviewing the manuscript: i.e., that CF was a significant problem among critical care nurses, and implicitly, that Yvonne herself was at risk. Yet this information seems to have fallen on deaf ears and was evidently dismissed.

One must wonder how the rejection of these specific portions of the book would have been experienced by Yvonne at the time—not just psychologically, but in her body, at a visceral level. She did not detail this level of her response. Yet it would have been during the months of frustration over the manuscript that she made the decision and made her plans to take the extended vacation overseas with a close friend. When the stand-off with her immediate supervisors ultimately occurred, catalyzed by the unforgettable day with the difficult new nurse, Yvonne had already prepared a path for herself to gain distance and some desperately needed perspective. Nevertheless, at the time of our interview, she was somewhat uncertain about the temporal relations among all these events and, more significantly, she voiced no direct awareness or reflection regarding causal connections among the events with respect to the intricacies of her suffering prior to the time of her trip.

The language of traumatic suffering. Early in her career, Yvonne said she “didn’t have a language” for what was happening to her. As she explained: “I never thought about it back then, I
never thought of compassion fatigue or anything back then, because that was just not in my vocabulary. I was too young of a nurse … and then these experiences hadn’t happened to me.”

She encountered the term more than a decade into her career, when she was a senior PICU nurse at her prior hospital. Though CF became the preferred term there, she evidently learned most about it through her own research for the PICU handbook. On the other hand, Yvonne was also primed relationally for awareness of this concept through a sustained friendship from her days in the NICU: a fellow nurse who eventually pursued psychological studies, including intervention for CF / STS among nurses and physicians (also see the next subsection on learning). This friendship appeared to help catalyze her interest and research into the topic:

My girlfriend … was going to psych school to work with nurses and, um, medical staff with compassion fatigue. … But that actually helped me to do research on different areas of nursing, compassion fatigue, um…. I’d gone to a conference in Boston, also…. So, that [hand]book was helpful in having me look for more terminology…to help other nurses. (Y:II:12)

Whereas “burnout” carried a connotation for Yvonne of irresponsibility and perhaps self-abuse, “like hippies in the ’60s,” she came to consider that “compassion fatigue is just a fact.” The latter term bore no shame or judgment for her, but it did help to create awareness and acceptance:

…compassion fatigue is just something that can happen, and you have to acknowledge that it’s happening, figure it out, step back, and maybe adjust yourself and let your supervisors know that, you know, I just can’t do this today. Or, you know, I’m just … I just need some time. And then go take care of yourself. (Y:II:1)

These words are striking for two reasons. First, Yvonne had made it quite clear that her own supervisors were not very helpful when she was experiencing her own worst period of CF, yet she alludes here to a nurse confiding in supervisors and seeking support. Nonetheless, I found this distillation of her insight striking for, in very rough terms, it evidences parallels with Husserl’s mature formulation of the phenomenological reduction, as follows:

- “acknowledge it’s happening” (apply focused attention to the phenomenon as given)
• “figure it out” (adopt the posture of the epoché to become aware of existing assumptions)
• “step back” (work to “bracket” assumptions and to approach the phenomenon anew)
• “adjust yourself” (become willing to reconstitute a different, perhaps more essential understanding of the phenomenon by restructuring meanings derived from experience)
• “go take care of yourself” (apply these reconstituted structures of meaning in the material lifeworld, so as to undertake relationships and substantive actions anew).

Yvonne’s words may thus be understood to suggest the essence of a situated or material way of comprehending learning that is transformative, which parallels the phenomenological process. I will revisit this conceptualization of learning in the pages ahead.

**Learning in response to traumatic suffering.** Consistent with the research questions, my interest was not in formal education about CF and STS that the nurses may have undertaken. Rather, I was concerned with discerning informal or tacit ways of learning to cope with STS, which were not necessarily intentional or even conscious for the nurses themselves. Yvonne, however, explicitly recounted occasions of formal educational that were relevant in her learning to manage CF, and she recommended such “education” for other nurses:

…if you’re in a situation .. .and you have any doubts that you were able to do the best thing for the family ... it can really play on your mind. But … educating yourself so you recognize—okay—I need a warm bath right now, I need a glass of wine, I need to go for a walk, I need a beach, I need time by myself, I need to go talk to somebody ... I think educating yourself to know that you even need those things is important.  (Y:II:14)

Earlier, she explained:

I’ve gone to conferences specifically on end-of-life situations, where they do talk about how to therapeutically communicate with … families. And then, of course, as with any nursing skill, practice is what makes it better. And the more you know about this, the more it makes it easier. So, I found that learning as much as you can….  (Y:II:14)
People “you feel comfortable talking to.” On closer examination, however, despite Yvonne’s references to conferences and classes, what she alluded to more often and with more passion were informal conversations that took place in the context of sustained relationships, both within and outside the hospital. For example, in the passage above, Yvonne went on to relate her ways of learning at a professional conference to her learning through deepening relationships with the families of her PICU patients:

So, I found that learning as much as you can, learning about therapeutic conversation and really being able to get in with those families, and get them talking and get them expressing, is one of the best therapies for me, as opposed to running out of the room, and not being able to deal with the families. (Y:II:14)

This pattern of action appeared frequently in Yvonne’s account. She said that she understands the impulse among newer nurses to “run out of the room” in end-of-life situations. Yet she affirmed that she herself learned through attentiveness and reflection on her own experiences, and that she found staying present to such experience over time allowed her to benefit from a deep human connection with the patients and families to whom she was responsible for providing care. This sense of connectedness through significant conversations, in turn, helped Yvonne to feel comfort and to find protection, in her words, from having “doubts that you were able to do the best thing for the family ... [which] can really play on your mind.” Elsewhere, Yvonne described numerous relationships to parents of former patients, particularly mothers, with whom she stayed in touch and from whom she learned much through their deepening reflections and perspectives over time.

Outside the PICU, Yvonne’s 14-year friendship with her former NICU colleague provided a different relational context where she could draw near to the pain involved in her work with someone else similarly capable of staying near to loss, rather than running from it:

Yvonne: I am very blessed to have—one of my very best girlfriends is a—she was a NICU nurse for many years, she was our bereavement coordinator for children that died in
our hospital—and now she’s a psych and a family practice [counselor]…. So, she’s a wonderful wealth of comfort.

PI: You call her sometimes, and you still talk…?

Y: Oh, I see her all the time.

PI: She’s here…?

Y: No—she’s back home, but I go back there all the time. ... When I was on the palliative care team, those folks were always very helpful to talk to, but it’s very rare and uncommon to have someone to talk to that will listen…. Yeah, it’s very uncommon…to have someone interested in the whole topic. …So it’s good for me to have someone to talk to [now, in the study], because nobody wants to hear about it. (Y:II:15)

The trust and camaraderie Yvonne and her NICU friend had developed through the years may help to account for Yvonne’s quite profound capacity to support other nurses, such as Constance in the second focus group of the study. Here, Yvonne’s account also flowed readily into other relationships, such as members of the palliative care team at her prior hospital.

At home, by contrast, Yvonne described having formerly been with a partner who, when she came home and talked to him “after a bad day at work, he’d be crying. And I’m like, ‘Really?!’ [laughs] ‘Really?!’ [then mimicking his distressed voice] ‘Oh, I can’t deal with hearing that babies are dying…!’”—‘Really? …Really!?! Just go away from me...’” (Y:II:12).

The very manner of this description, years after the event, embodied the pain with which she still experienced this lack of a strong, supportive presence in a key relationship at that time of her life. At the time of our interview, however, she recounted being with someone who was able to listen well and stay emotionally present. Having just moved a considerable distance from her home of many years, however, she was also explicit about the importance of finding other “nurses that you feel comfortable talking to”:

Yvonne: [My partner] is a police officer, so he can understand a lot of things that other people can’t about how a bad day really goes. ... So he’s very attentive, listens…. Some days are better than others, of course.
PI: …Is that an important part for you of the picture of dealing with—being able to talk with someone?

Y: Yes.

PI: And is he the main person? What is it like with some of the other nurses you work with?

Y: It’s interesting to find, and I think very important to find, a few nurses that you feel comfortable talking to, ’cause even someone that, say is in another profession that’s a lot of high stress, it’s different than our high stress. Cuz, no matter what, there are very, very few people who truly want to hear about sick or seriously ill children. No matter what their good intentions are, they don’t really want to hear about it at all. So, the only other people who understand are other people who work with seriously ill children…. So finding some folk at work is extremely important. Or being that person for someone else. (Y:II:6)

Finding such folk means finding people who “get it”—another term that recurred among the three nurses’ accounts—that is, people with whom there are significant unspoken understandings and a common grasp of the extremity of the work—without the need for explanation or justification. This is quite different than finding someone who is empathic or “therapeutic.” Thinking of her close friend, Yvonne laughed and said that “sometimes I have to look at her and go, ‘Would you stop!!?’ …She totally gets where I’m coming from—she does bereavement—I mean, she totally gets it, but sometimes I have to go, ‘Would you stop!??’ You know, ‘I want to talk as a friend, you don’t need to fix me.’”

“Being that person for someone else.” Yvonne came to realize quite early in her PICU career that helping others actually helped her. One of the first ways she applied this knowledge was by providing preventive educational services to the general public. Doing so helped her feel less powerless about the most common childhood injury she saw in the PICU: near drownings. She found it helpful to encourage her fellow PICU nurses to join her as well:

One thing I did actively ... was drowning prevention days in the community. And I know that was helpful and I would recommend to the other girls in my unit—‘Come do them, they’re really helpful. They’re so helpful to you, to go out and be able to do something
other than CPR when the kids get here,’—is go talk to the families, go provide education. I even did education for lifeguards. But to me, that was very helpful. (Y:II:10)

Again, for Yvonne, this was a practice of psychological self-protection via community service, which she discerned to be helpful for her through a practice of action and reflection. She also recounted situations that illustrated her current support and mentoring of other nurses, but this capacity was displayed most powerfully in the focus group session (see APPENDIX F). However, her long-term, tenacious efforts to complete the PICU handbook exemplified this commitment to fellow nurses in a structural way that was not limited to her physical presence on the unit. I asked Yvonne if she found there to be difficulty among nurses with acknowledging their needs and giving themselves permission to ask for support. She replied:

Yes. There is. Because I think a lot of nurses feel that they should just be able to handle it, but to absolutely know that is an essential part of your job to be able to say, ‘I’m tired; I need quiet; I need peace; I’m burned out; I need to talk; um, I need to not take that kind of kid for a little while.’ Having the permission or even the knowledge that you're not abnormal, or a bad nurse, because of those things, is very important. (Y:II:14)

Yvonne described her own process as “an evolution,” by which she came to know these things and give herself permission to take care of herself. She represented this knowledge as having emerged, in part, through intentional reflection on her PICU experiences and growing awareness of internal fractures in that experience—conflicts in her feelings, needs, and responses to people and events that she encountered both at work and elsewhere. To invoke Fenwick (2000), Yvonne bothered herself to “notice the breaches between acts, thoughts, dreams, waking, wishes, and responsibility,” and she learned “by working through the conflicts of all these psychic events” (p. 252). This reflective practice, or praxis, in turn led her to explore a variety of strategies for coping, from community education to listening intentionally to the grieving families of her patients, as well as engaging with the grieving of fellow nurses. As she undertook these activities, Yvonne examined their effect alongside her own sense of wellbeing. Eventually, she became able
to recognize her situation as one involving acute psychic suffering, often without a witness. Recognizing this, she could begin to intervene more effectively on her own behalf.

Once again, it must be recalled that all this occurred in a hospital where Yvonne maintained “they were very proactive with debriefings and checking on nursing,” and where the “docs were amazing and … would talk … and even share their feelings about an end of life” situation, and “if a nurse was having trouble, [they would go with her] out the room to talk” and offer support in private. This part of Yvonne’s account raises a question as to whether such openness and concern expressed specifically by members of the physician staff of her former hospital played a key role in her experience of support there. Unfortunately, it is a question I did not ask. Nevertheless, such a statement further underscores how Yvonne’s learning to deal with CF and STS was mediated by relationships extending beyond her nursing colleagues. For although several significant supportive relationships clearly played a role in her learning to cope, critical stress incident debriefings (CISDs) emerged as a particularly significant, interdisciplinary venue. Yvonne had much to say about “a proper debriefing” during the focus group session with Constance. In our interview though, she emphasized that CISDs are not cookie-cutter events. A crucial element is that they must establish an authentic, perceived “safe space” for the mutual sharing of emotions, including across professions such as between nurses and physicians. This requires that they steer clear of intellectual critique about clinical or technical matters:

…because I’ve seen a lot of these turn into clinical, ‘Well, what could we have done better in this code?’ As opposed to, no, we should not be talking about that at all—[it’s not that] type of thing where we want to fix the clinical part. But it’s like, ‘No.’ No-no-no-no-no-no—we need to have at least one arena [tapping the table with her finger] where nothing technical gets talked about [more tapping], but just purely emotional…. (Y:II:16-17)

Yvonne’s emphasis here on the primacy of emotional content evokes Britzman’s (2013) focus on “education as an emotional situation” (p. 95) and Forester’s (1999) emphasis on the
importance of “not leaving your pain at the door” (p. 201). This emphasis deepens the meaning of her formulation about effective coping with CF (as she terms her experience of STS), when she says that “compassion fatigue is just something that can happen, and you have to acknowledge that it’s happening, figure it out, step back, and maybe adjust yourself…. And then go take care of yourself” (Y:II:1). That is, for Yvonne, a significant dimension of self-care is emotional self-awareness and self-care, particularly as accomplished through trusting, sustained relationships.

Static Meaning Structures for Yvonne: [Y]

The structure of secondary suffering and traumatic stress. For [Y], the experience of secondary suffering through bearing witness to trauma involves a progression from shock to intense commitment, despite the fact that “you never know what’s coming,” “what you will get,” or “what will happen.” There is a continuous awareness of the immanence of life-and-death events and one is sometimes haunted by doubts as to whether or not “you did the best thing.” Periodic anxious dreams and unpleasant perceptions in the body and mind are common, ranging from physical tension, a racing heart, and abdominal “twinges” to hypervigilance and trouble concentrating. Being thrown too many things in a day, with minimal support to respond adequately, is normative and produces intense frustration. Likewise, contradictory and confusing messages from supervisors are normative and frustrating. Behavioral responses to such conditions range from “bursting into tears,” on the one hand, to becoming impatient and hostile toward others in one’s life, on the other hand. Directly expressing anger toward others who are peers (both in and beyond the workplace) can serve as an outlet for emotional pain, but expressing anger toward clinical and administrative superiors is risky. Eventually, a nurse must forge a way to “acknowledge what’s happening,” “figure it out,” “step back,” and learn how to “go take care of yourself.” Counting on nurse managers and hospital leadership to provide guidance or
authentic support in this process is likely to disappoint. Generally, a nurse must figure it out on her own and make needed adjustments with the help of key friends and confidants. Finding and staying close to such people—who “get it,” who are interested, and who are able to embrace attentive listening and non-judgmental presence—is ultimately the only way to survive.

**The structure of language for understanding traumatic suffering.** For [Y], developing a vocabulary for secondary suffering is essential to understanding one’s own experience. It is also essential for developing a sense of perspective and an ability to protect oneself, for the language one uses matters: It can mark the difference between a nurse feeling like a casualty or a victim, or recognizing her experience to be normative and shared. Forging a language for STS creates a framework from which to explore ways of responding to the pain it evokes. The key lies in using language as a tool to support self-understanding, self-empathy, and constructive self-care.

**The structure of learning in response to traumatic suffering.** For [Y], learning to cope with the experience of secondary suffering takes place through an evolutionary process that includes acquiring a range of clinical exposure combined with educating oneself cognitively while also embracing one’s emotional life and forging close supportive relationships. Such relationships may include colleagues or friends who are willing to listen—and who can bear to listen—that is, who can find it within themselves to bear witness to the nurse’s experience. Over time, through such activities and relationships, which include the nurse bearing witness to others as well, she can develop the insight needed to recognize what is happening to her. She may then respond with reflective action to step back and analyze her situation, explore her needs, and identify necessary changes to her life and her ways of caring for herself. Thus, a nurse can learn to care for her own needs in tandem with those of her patients, and to make thoughtful decisions that will benefit her long-term wellbeing—even a decision to leave a setting that is “not a good fit” for her any longer.
Analysis of Constance’s Meaning-Making

Of the three nurses, Constance’s account was the most raw, and it was somewhat more complex and layered than the other two nurses’ accounts. This made sense, for she was newest to the practice of nursing and very new to critical care—having worked in the emergency department (ED) just 19 months at the time of our interview. Thus, her sensate impressions and embodied responses were still sufficiently unfamiliar that, phenomenologically speaking, her experience and descriptions presented a spontaneous quality that was more proximate to “the things themselves” in Husserl’s terms—as one who is first encountering a powerful phenomenon. For example, notice the quality of description in this moment of her account:

…It was my first really rough trauma. And I’ll never forget because his feet, when he came in on the gurney, your feet usually are like this—his feet were upside down. And I’ll never—and I remember him going past me, and I was writing, and I remember thinking, “Feet shouldn’t look like that.” And it was bad.…  (C:II:9)

Chronologically, however, Constance was the oldest of the three nurses and brought a prior career and a wide range of experience to bear on her descriptions. The resultant facets and layers embedded in her account were sometimes not apparent until the focus group stage of the study, when she described new dimensions of events, shared new details she omitted from our interview, and reflected on her experiences in new ways.

The experience of secondary suffering and traumatic stress. Initially, Constance offered a breathless moment-to-moment narrative of her most recent emergency department (ED) shifts, describing the unrelenting pace, the complex and competing priorities, and the punishing physical demands—like the difficulty nurses often had just finding time to “pee”:

Constance: There’s times when I’m going into work that I could feel my anxiety. One of the worst things that happens before I go to work is I get a text that says—‘Needs for the day, three RNs…’ for this and this time—nurse [numbers] are down. And I’m just sitting there like, ‘Oh my gosh, I’m going in and—we’re short…’
PI: What do you notice in your body?

C: My heart, sometimes my heart will race a little. Um, there’re some days I don’t even think about it…. Now that I’ve been down there a year and a half, I don’t get scared anymore. I’m not … [but] the anxiety was so bad when I first came down there. It was sssoooo—that tightness in my chest was sssoo bad. There were times when I was going in and—I remember one of the new nurses, I walked into the [staff room] … and she was just crying, because—you know, the anticipation, the anxiety of going out there … it’s overwhelming. (C:II:7)

Constance soon began to speak of a conflict that arose in varied forms throughout her account—how she “fell in love with the ED” in nursing school, but now thought she’d “made a mistake.” She contrasted the extreme conditions of ED work to the tame routines of her first career in the utility industry, then ruminated on what her next career steps should be. Still, she was unequivocally proud of her identity as a level I trauma ED nurse:

I have such pride, and I wanted to get there. I wanted to be a level I trauma ER nurse. I am a level I trauma ER nurse. I don’t want to say that I’m a nurse at a … long-term care facility. And that’s awful. Sometimes you feel like … it is—it is ego. (C:II:35)

“I just couldn’t let it go.” The mental and emotional force of Constance’s descriptions, however, resided in the series of gut-wrenching, life-altering trauma cases she recounted from her 19-month tenure, for each of which she had been a member of the team giving emergency care. Her description of the most difficult of these, “the worst of the worst” as she called it, is excerpted in APPENDIX E to indicate the searing depth of data she offered. (I will return to this below.)

Yet her descriptions reflected a fundamentally narrative structure of thought and meaning-making throughout her account. Rarely did she summarize or speak in conceptual terms and abstractions. Rather, every concept was embedded in a story of patients and colleagues, as here:

I was off for 10 days, I come back, and my first day back was just…awful—and trauma after trauma and busy and just … people just … sccrrreeaming…. And that’s when I texted my husband and said, ‘I don’t like my job anymore—I made a mistake.’ [she laughs] ‘I made a mistake, I should not be doing this—this is not….’ And my back hurt—my back hadn’t hurt for the 10 days I was off….
But then, you get through that, and yesterday, I was—yesterday was busy and crazy, but I was sitting with this group of nurses that ... I just like. And I can’t imagine—I don’t know where I’ll go now. ...Because now I’m used to—we have such autonomy in our job. I put in [orders for] chest rays, and lab work, and urine tests.... And I—like, I am completely addicted to—what did I say? [laughs] I said this to Susie yesterday. She said there was ... what did...? Her patient, he had a GI bleed—he was an air traffic controller ... but he’s no longer an air traffic controller. And Susie said, ‘Why?’ And he said, ‘They told me I’m too old, I had to quit.’ And I’m like, ‘Susie, that’s gonna be you and me!’ [laughs again] ‘We’re gonna be in the trauma bay, and they’re gonna go—“You guys are too old. Get out.”’ [more laughter] And [Susie] said, ‘You’re right.’ And that’s a 24 hour difference. Like—I was sitting there [the day before] saying, ‘I want to quit.’ It’s this awful love-hate—it’s an absolutely love-hate relationship with my job. ...And it is addictive. ’Cause we’re—we all have that personality there. (C:II:27)

Eidetically speaking, this passage manifests an essential (invariantly evident) struggle within Constance between opposing embodied responses to her work: pain, exhaustion, and repulsion on the one hand; camaraderie, satisfaction, and pride on the other. Yet there is a more subtle message embedded in her brief story: that this clash of opposing experiences creates an addictive attachment so powerful that she envisions herself becoming unable to separate herself from the work and will one day have to be told to “get out.”

As well, the passage exemplifies the types of breaches that appear in Constance’s narrative—a further clue to the layers and cross-currents in her awareness. When she mentions being “completely addicted to—” she breaks off her sentence and verbalizes her lost train of thought with a laugh. Yet the breach has sufficient force to interrupt her narrative flow again, barely a sentence later. After recounting the humorous banter with her patient and fellow nurse, she returns to affirm that she indeed experiences her work as addictive at times. Significantly, Constance became increasingly open about such breaches and the cross-currents they represent over the course of the two-month temporal axis of her data, for she reflected on her own account and interacted substantively with the other nurses in the study about these concerns.
In particular, she spoke more than once of a general concern about addiction and her unwillingness to rely on addictive medications to manage her initial anxiety at work, the ongoing stress of events she faces there, or even the more recent back injury she had sustained. Instead, she explained that she has persistently sought out non-pharmacologic modalities, such as “mind-body” approaches or energy medicine to help herself manage the intensity of her work:

Constance: So before [the trauma victims arrive], everybody’s real quiet, and you just go… [she takes long deep inhale, then exhales]. And I just center myself, and I do that, ‘Okay, okay…,’ because you can’t … you can’t do –

PI: Where did you get the idea to do that?

C: Yoga. It’s one of the things that stopped me from the anxiety I used to have. Yeah.

PI: You started taking yoga….

C: And meditating. That was the only thing. I didn’t take meds, because I always said, as a nurse, if—you have to be really careful. When you deal with this type of stuff, if you start taking Xanax or Valium or things, you’re on a— And I’m already struggling because of my back injury, not taking pain medication, doing it as limited as I [can], because I know where you can go with it. Oh yeah, you have to be, I have to be—and I know that…. You know, I drink, sometimes. I always say, ‘Oh—I’m gonna go home and drink six beers!’ And I’ll drink one. [laughs] I talk a lot bigger than I actually am! [laughs again] Or sometimes I sit there and I’m so tired, I don’t even want that—I don’t even have the energy to lift a glass of wine to my lips. But...I knew that I had to find something to get this [pain] out. And it was after my first pediatric trauma—well, and Reiki, I do energy medicine—and now I’m ... [certified] to do energy medicine. But Reiki was the first thing that took away that pain in my chest. (C:II:13-14)

The physical chest pain to which Constance refers here was, by her account, largely of acute psychogenic origin, triggered by the immense suffering she was witnessing at work—for which she was finding grossly inadequate resources to help her maintain mental and emotional resilience. It is difficult to grasp the magnitude of this human pain other than by engaging with examples from the graphic content of her descriptions. For even before the “worst of the worst” trauma case (excerpted in APPENDIX E), involving a train accident, Constance drew a direct link
between her own experience of physical chest pain and her nursing role in a pair of earlier
traumas. The following passage describes one of these:

And it was, like, midnight. We knew the baby had died on the scene…. And then, I had
[the uncle] in the trauma bay, and he kept asking [about the baby] and we knew, but we
didn’t say anything. And we got [the uncle] into a room…. And … I remember—I was on
the other side of the ER, had just handed [the case] off to the nurse that was taking him,
and I heard it, and I knew—there’s this sound that you hear from somebody that, you just
know—and I knew he had just [been told his nephew died]. And I walked around the
corner, and [the nurse coming on duty] walked out of the room—she was crying. She
like—couldn’t—she—just couldn’t do it. Yeah. And she walked out of the room, and I
walked into the room. And there was a police officer standing there, and the chaplain. And
[the uncle’s] heart rate was, like, 150. I remember looking at the monitor, and I grabbed
his hand—

…And he was just screaming, and the policeman grabbed his hand and started to pray
with him. But he had just read him his rights, because they were, you know, charging him,
because the baby died—it wasn’t in the car seat. …And … [long exhale] … that was when
I finally went to the Reiki session—I was having, like—I could not get rid of the pain.
And I remember grabbing his hand and just holding his hand, while he screamed. And I
developed an ache in my chest for—it was the baby, and then him, and it was—for a
month. And I just couldn’t let it go. (C:II:14)

It is impossible to read such an account with attentiveness and not feel some of the pain
Constance felt—and some of the pain the uncle felt, too—just as it is impossible to read Shem’s
novel and not feel some of the pain that his protagonist and the fellow interns experienced. This is
the nature of bearing witness. The trauma literature evidences that the psychic echo created when
suffering is witnessed is not merely a symptom to be managed (Figley, 2002; Levine, 2009b;
Valent, 2002, 2012b). Neither is it a mental weakness to be overcome, nor a lack of understanding
to be remedied by education. Psychoanalytic theory designates this deep and mutual
psychological identification by the terms transference and counter-transference and recognizes it
as a universal feature of searching and intimate interpersonal work.

Alternatively, in the realm of phenomenology, Husserl’s student Edith Stein wrote her
doctoral dissertation on the phenomenon, calling it “the problem of empathy” (1917/1989).
Husserl himself and most contemporary phenomenologists identify the phenomenon more generally within the construct of intersubjectivity—thereby understanding it to be a foundational, characteristic of consciousness itself. In adult education, Britzman (1998, 2011, 2013), Brookfield (2005), Fenwick (2000, 2006, 2014), Forester (1999), Freire (1994), and hooks (1994, 2003) are among those who locate the emotional resonance of trauma, along with empathy, pain, and mourning, as foundational dimensions of learning, as they are of life.

Each of these fields of inquiry thus suggests that, to the extent another’s experience is witnessed, it is also in some sense shared. Any educational project designed to limit or somehow counteract this phenomenon in consciousness is thereby misguided, at best, and potentially harmful at worst. This insight is consistent with Fenwick’s (2000) warning against managed experiential learning that would presume to intervene in and redirect another’s experience for a pedagogical (or institutional) end. It is also consonant with Forester’s (1999) warning against leaving one’s pain at the door, which presumes the experience of emotions such as empathy, anger, or mourning can be detached from consciousness and deposited somewhere “else,” “thrown away” as it were from the intellectual realm of reason.

Neither these theorists, nor the trauma literature, nor psychoanalytic theory, nor phenomenological philosophy suggest that the extreme pain involved in traumatic experience can be so compartmentalized and managed. Yet all these scholarly disciplines suggest in different terms that traumatic suffering can be borne—possibly even be transcended—through temporal and intersubjective engagement in culturally mediated activities of psychic and embodied reconstitution of experiences and their attendant structures of meaning. This is a very different learning objective than the prevention or dissolution of secondary trauma.

Constance stated more than once in her account that she and other ED nurses “needed debriefing” after the worst trauma cases—and the sooner the better. Yet the one formal debriefing
she attended during her 19 months in the ED didn’t “go anywhere,” because the chaplain who led it “doesn’t understand” the nature of her experience as an ED nurse (see APPENDIX E). Further, not only did this debriefing *not* help her; she described being more traumatized and feeling more alone afterwards than she had before. (This is explored further in the next chapter’s genetic findings.) Had it not been for her friend and informal mentor in the ED, Penny, Constance could not imagine how she would have survived the events psychologically:

I didn’t get off my couch for two days. And I would call Penny and cry, and we would talk, and—now that I remember it, she—she, she actually got there during the trauma, because she worked on the mom, when they delivered [the baby]…. Yeah ... but, she—it...I couldn’t talk to...anybody else. It was just her and I.

And then, what we did was, her and I and there was, one of—we came here [the restaurant she had chosen for the interview]. Um, it was a couple days later, we were back at work—we came, ate and ate—I lie!—that day I came here with them, and had ice cream. We filled up the table with junk food. We did. Because my husband was not home, and I didn’t want to go home….  

Significantly, whereas Constance found the formal debriefing to be hurtful and a source of further traumatic impact, she was helped immensely by her relationship with her informal, tacitly designated mentor in the ED, Penny. She was also helped by the casual, spontaneous time she spent with fellow ED nurses in a mundane lifeworld environment, where comfort foods and the comfort of proximity to ordinary people who were living ordinary lives assuaged the material and relational horrors of the preceding hours.

It should be noted that although this portion of her account demonstrates the interference that trauma exacts on memory, Constance was gradually able to reconstruct a coherent narrative of relevant events to her own satisfaction as she verbalized her story. Her interjected exclamation “I lie!” indicates the value she placed on honesty and accuracy during the interview. Whether she, or the other nurses, in fact reconstructed all the details of their accounts accurately is not a question that is directly answerable by this study. On the other hand, the study’s temporal and
relational exploration of the nurses’ experiences, as they described these over time and in
dialogue with each other, offers a degree of intersubjective confirmation of each account. This is
a different approach than fact-finding to address questions of reliability in the data. It makes
possible a dynamic discernment and progressive testing of the nurses’ accounts and the associated
meaning structures developed within their consciousness—structures that ultimately function
independent of factual details. Thus, while considering the factual accuracy of their accounts is
certainly not irrelevant, it is only one way to understand how the nurses perceived and constituted
their lifeworld encounters in consciousness, then structured their understandings of events.

“Because we get it.” The comfort and reassurance Constance found in shared activities
and a shared sense of identity with other ED nurses was not limited to experience with severe
trauma cases. It was a milieu of connectedness that she noted in stark contrast to the work itself:

That’s why I say [ED nurses are] very close and [there’s a] camaraderie—because we get
it. It’s a completely different type of nursing. It’s violent. It’s loud. It’s awful ... and we
can’t say [we’re full—we’re closed]. I would love for [non-ED nurses] to understand that
we’re, you know, in a war zone sometimes down there, is what it feels like. (C:II:21)

Constance’s phrase “we get it” (like Yvonne’s, “she gets it”) emerges as a key structure within
her account. The term arose often in a variety of contexts and indicated not only that non-nurses
would have trouble fathoming her experience, but that she and her fellow ED nurses experience
things that other nurses do not “get”—even other critical care nurses. This sense of “getting it” in
common was inseparable from the camaraderie and comfort Constance felt in the company of her
ED colleagues—a sense of presence that she compared at one point to the camaraderie described
by military service members who go through combat experience together.

It is significant, however, that the mental structure demarcating those who “get it” from
those who “don’t” functioned not as a way by which Constance included or excluded others from
a kind of ED nursing club. Rather, it appeared to function as a critical tool for creating and
sustaining a sense of psychic safety. Constance’s account of the single debriefing she attended, for example, made evident that neither she nor Penny found the chaplain capable of “getting it”—and Constance emerged from the debriefing more traumatized than before. In Constance’s words, the chaplain “doesn’t understand” the often “violent … loud … awful,” even war-like nature of ED nurses’ embodied interactions with trauma patients, and the chaplain further showed no capacity to develop such understanding during the debriefing, given that she was “talking and talking and talking and talking and talking…. “ Perhaps the chaplain was herself aware that she did not get it, even as she talked and found it difficult to allow the nurses to speak. Unlike Miller’s enlightened witness who is able to attend to the pain of another because they do not fear what this will awaken within themselves, the chaplain could not attend to the nurses’ experience, much less create what Yvonne termed a “safe space” for them to express powerful and vulnerable mental content. Instead, the space she created was experienced as unsafe and even wounding for Constance and, by her account, for Penny as well.

Thus, “getting it” operated for Constance as a marker of intersubjective safety. One who gets it is one who is able to mirror internalized sensibilities, demonstrating the their recognition of and respect for the impact of similarly overwhelming experiences. This recognition relieves the necessity of detailing horrifying experiences in order to receive the comfort and solidarity of a shared lifeworld. For how does one describe or explain experience that exceeds description—experience that exceeds the boundaries of what one’s very consciousness is able to comprehend and claim as its own? Recall Pitt and Britzman’s (2003) definition of trauma as an experience “characterized by a quality of significance that resists meaning even as the affective force of the event can be felt” (p. 758) and their adoption of Caruth’s (1996) term unclaimed experience to explore the difficult “paradox of having painful experience but being unable to know just what has happened or why it is important” (p. 758). To this very point, Constance said:
I had the [pediatric] gunshot victim last week. I took that baby upstairs [to the PICU] and I stayed with him, and the nurses just kept looking at me. And I left there, and I came back downstairs, and I kind of was just walking around in a fog. And I sat down and I’m like, ‘Okay, I have completely ... checked out. I’m not here anymore.’ …And there’s something not right that we’re put back into work, and we’re not.... [she does not finish her sentence] (C:II:26)

Constance’s description closely matches Pitt and Britzman’s characterization—she felt the force of the experience and its pain, yet simultaneously felt detached and alone, as if she had “checked out” and was “walking around in a fog,” isolated from herself and others such as the nurses who “just kept looking at me.” She was, in short, not there—not able to connect with nor to claim experiences that had nonetheless claimed, changed—indeed, harmed her.

Theoretical formulations like Britzman’s provide a powerful explanatory framework that unfurls the immense pain of caregivers like Constance—the tumultuous mental cross-currents and layered struggles of mental resistance, interference, and efforts at constitution that underlie nurses’ attitudes and actions. From this perspective, overburdened references to people who get it and who don’t—which might otherwise be considered cliquishness, arrogance, or in Constance’s words “pride” and “ego”—may instead be understood (among other possibilities) as a pivotal survival tool. Through the hours and weeks and years required for one to return and reflect meaningfully on traumatic experience, the practice of assessing who gets it and who doesn’t serves as interim code for determining the psychic trustworthiness of others. Note that a full decade transpired after Britzman authored the article on difficult knowledge with Pitt (Pitt & Britzman, 2003), before she returned to reflect on “what could not be known from the immediacy of felt experience and that only later [could] be narrated as a story of the disparities, accidents, vacillations and fragmentary impressions that come to compose the problem [of] education as an emotional situation” (Britzman, 2013, p. 95). Britzman can arrive at this conclusion because, like
Forester, she does not consider emotions as detached or detachable—capable of being left at the door—but as integral to mental life and learning.

“She’s the only one who said it.” These analytic insights, however, suggest a second dimension of the phrase, “we get it,” embedded within and operating in tension with those explicated above. When Constance returned to the ED after transferring the pediatric gunshot victim to the PICU, she was unable to speak of her experience for a variety of reasons, including the need to resume her ED treatment responsibilities. In this environment characterized by so little energy, time, or structural support for emotional labor (e.g., Huynh, Alderson, & Thompson, 2008; Mauno, Ruokolainen, Kinnunen, & De Bloom, 2016), Constance recounted that there was one fellow nurse who was able to help her—within a time span of just a few moments, and with very few words being exchanged:

The one nurse that led the debriefing on the SIDS baby ... she said, ‘Oh Constance—!’ She looked at me, and she’s the only one who said it to me. And she said, ‘What’s wrong?’ And I told her, I said, ‘I had a three-year-old that was shot in the back of the head with a gun, and I just took him upstairs ... and I’m not here right now.’ And she said—“Oh, I’m so sorry.” And she’s the only person that said it to me ... because it’s business as usual—you’ve got to go back to work—it’s the nature of our job. What else are you gonna do? You don’t have staff to take care of everybody else. (C:II:26)

Juxtaposed with her sense of camaraderie among her ED colleagues, Constance felt that very few of her fellow nurses “got” her suffering that day. Yet one nurse acted as an enlightened witness to her while using very few words. This nurse did not call forth a detailed narrative from Constance to ease her sense of isolation and pain, yet in a few moments’ time, a code of deep understanding was exchanged. It consisted of a brief exclamation of empathy, a short description of an event, and a brief compassionate reply: “I’m so sorry.”

Here, “getting it” meant accessing a common landscape of consciousness that appreciated the profound impact of raw, unspeakable loss and pain, yet also carried an awareness that
traumatic experience demands a degree of cognitive and emotional distance, even as it calls for empathic recognition and response. Recalling Britzman, Pitt, and Caruth, the force, meaning, and significance of traumatic events are all resisted in consciousness. Consequently, words may not only be lacking—they may be resisted actively as a matter of psychic survival. Constance described this at several points, not only in herself but among younger, newer nurses too:

[Earlier] this year, they had two pediatric codes going at the same time, and [both children] died. And ... those nurses, aaghh, makes me ... hurt so much because the next day, I was sitting there ... and Judy [a young ED nurse] came to me—when I—when she got there—and she was just...devastated. ...

And then at 7 pm, the next nurse that came on—she sat down next to me and I said, ‘How you doing?’ And she said, ‘Last night was really bad.’ And I said, ‘I know, I’m really sorry to hear what happened—’ And she’s like— ‘Don’t talk to me.’ And then she, she just breathed. And I could see the tears welling up in her eyes. This was another one that had been there the night before. And they’re hammering me with these emotions.... And I walked into the locker room to get [my] stuff [at the end of the shift], and I looked at one of the nurses that had been there a while, and I’m like—somebody needs to go deal with this. These nurses are devasted right now. I said, it’s been, you know ... 18, 20 hours since they coded these kids, and they’re not doing well with it. (C:II:22, 24-25)

Relational distancing by means of resisting speech with statements like, “Don’t talk to me,” may be understood in a number of ways—the most immediate being a strategy to maintain control of one’s emotions, for Constance could “see the tears welling up in her eyes.” Yet Sheppard (2015) found through qualitative field work that distancing like this was a characteristic marker of secondary traumatic stress in nurses—and one not recognized or probed by the ProQoL-V.

Such action may be understood in other ways, too. Britzman (2013) testified that, in her own experience, “difficult knowledge” such as this “could not be known from the immediacy of felt experience [but] only later [could] be narrated as a story…” (p. 95, emphasis added). That is to say, the knowing and claiming of traumatic experience could only be retold from the far side of a temporal and intersubjective space, as if from a narrative perspective outside the experience (if not outside the consciousness) of the subject who lived the trauma. Implied in this necessary
distancing is a necessary structuring of such experience as a form of narrative, which is told as a story so the one narrating it might begin the journey toward claiming the story as her own. This means becoming able to bear giving one’s attention to and, ultimately, attributing meaning to the difficult encounters that are retold.

Accordingly, Constance’s account suggests that the effort to resist speech seen here may reflect resistance to the enactment of premature tellings (i.e., premature constitutional activity) relative to experiences that have not yet been comprehended or claimed. They are not claimed because the one who would claim them cannot yet grasp them from a narrative, meaning-making perspective. Such resistance may thus serve to guard pre-reflective awareness against those who would impose narrative meanings from outside the sensate consciousness of the one who encounters trauma. It may, in other words, serve to defend consciousness against those who presume to “understand,” while having no comprehension of the unique horizons, embodied perceptions, or “immediacy of felt experience” that are everywhere alive and active in the constitutional process—whether of an individual or an intersubjectively engaged group.

In this sense, the term “getting it” designates one who recognizes the value of protecting and preserving boundaries of experience and language that are not yet comprehended or claimed. One who “gets it” respects, and if necessary, defends a “safe space” in the words of Yvonne—a space within which another may undertake resistance as well as movement toward memory and affect—free from presumptive expectations about their willingness or capacity to do so. By contrast, those who do not “get it” move in on another’s experience, using speech (and calling for a response) that is premature and presumptive. Assuming that their own horizons and currents of awareness are held in common with others, those who don’t get it do not inquire to test their assumptions. Their ways of interacting are thus felt as damaging—as a violation, even as an assault—evoking a self-protective, distancing response. An otherwise trusted colleague, friend, or
loved one may unexpectedly evoke such a reaction when the one who labors to cope with an overwhelming trauma feels as yet unprepared to engage mentally, emotionally, or verbally with felt events. This situation may thus evoke the abrupt response, “Don’t talk to me.”

**The language of traumatic suffering.** The manner in which Constance gave language to her traumatic exposure was indeed primarily narrative in structure. She rarely sought conceptual terms by which to label her experience. Instead, she narrated graphic stories of her own and other people’s actions and interactions, describing physical details of sensation, bodily injury, and the emotional impact of events, which for Constance possessed a physical force. Thus, her language of secondary traumatic suffering comprised a taut, dramatic storyline that was far removed from the constitution of symbolically abstracted concepts or terminology.

Such languaging and enactment of narratives appeared to support Constance’s constitutional activity, much as Britzman (2013) suggests, assisting her to survive her work psychically and return to face new challenges another day. In particular, situated and embodied conversations in familiar environments helped her to cope with tremendous pain and loss. Her descriptions, for example, of meeting other nurses at a local restaurant after leaving work from “the worst of the worst” trauma, then talking and crying on the phone with Penny as she lay on her couch at home, evidenced the crucial role of informal languaging of her ED encounters as a means toward constituting claimed experience from traumatic events.

**Learning in response to traumatic suffering.** I have sought to demonstrate that narrative languaging like this is one tool used by consciousness in the mental, emotional, and embodied constitution of experience, and that this activity can be understood as a kind of learning. Yet for a new nurse like Constance, it was not enough. Constance had no doubt that she was in dire need of far more opportunities for varied forms of psychological support. (This is
explored further in chapter seven.) In different words, she was seeking opportunities for learning that affirms “education as an emotional situation” (Britzman, 2013, p. 95).

For despite the camaraderie among the ED nurses of which Constance spoke regularly, there also was evident a considerable distance of thought and emotion among the nurses, as seen in the almost complete lack of interest or concern shown by her fellow nurses on the day she returned from bringing a three-year-old gunshot victim to the PICU—when one nurse was “the only one who said” something to her and expressed concern for her needs in that moment. Indeed, the whole of Constance’s account indicates that the emotional isolation she felt that day was representative of one dimension of the ED nursing staff culture. It is demonstrated more explicitly in her account of staff interactions following the train accident that had precipitated Constance’s care of “the worst of the worst” trauma patients—the deceased mother and the unborn baby who died after a post-mortem delivery in the ED. Constance explained that, following her many hours of labor on behalf of both victims and the bereaved father:

there were a couple nurses that had [worked in the ED] for a long time [who] were like...‘What’s the problem?’ And it was chalked up to me being a newer nurse, and struggling with it. Do you know what I mean? And I was almost, like, made to feel bad.

And there was an accusation made that there’s those of us that like to be involved with it—and like to draw out the emotional side of it. And I’m like—I don’t like it. I don’t seek it. But if it happens to me, I don’t— Now, maybe it is because I’ve only been doing [ED nursing] two years and I’m not jaded. But sometimes, some of the nurses can make you feel like that. Some of them can make you feel like, ‘It happened. It’s over. Move on. Next thing.’ So there’s different—people deal with it differently. There are some nurses that….

PI: They don’t want to hear about it, they don’t want—

C: They’re like, ‘Get over it.’ So it depends. But I wonder if [psychological care] was done from the beginning, like, if it’s always there, and they don’t know any different…. You know? And I wonder, how many, what percentage of nursing staff like this do become addicted to drugs, or drinking, or ... do you know what I mean? I do wonder that. Because I can see how easily it could happen. It could, very easily. (C:II:31)
This shaming response that was communicated by some nurses is characteristic of interpersonal acts that operate to enforce a culture of repression, as outlined by Fromm (1951, 1955), by Miller (1981, 1983), by Britzman (1998, 2013), and alluded to by Forester (1999). It is an oppressive extension of the emotional distancing expressed by those who say, “Don’t talk to me,” for it goes farther—sending a repressive message to others, “Don’t talk about this, period.” By any psychological measure, attitudes such as, “It happened. It’s over. Move on. Next thing,” and “Get over it,” in response to events like those Constance faced on the day of the train accident, are beyond stoic: They are alienated and alienating—depersonalized and mechanistic responses to tragedy. They belong to a hegemonic world of social oppression, enforced by mutual conspiracies of unthinking and unfeeling silence. Similar to Shem’s “Laws of the House of God” that reflected a cruel hidden curriculum in physician training, the ED where Constance found herself also operated by unspoken commandments, among them: “If the patient dies, there is nothing to talk about.” This reflects a title by Miller (1984) that captures a more universal commandment of psychic repression, Thou Shalt Not Be Aware—the hegemonic strategy for dealing with intense suffering by pretending that nothing happened and emotions do not exist.

By applying a critically informed psychodynamic framework of analysis, however, it becomes possible to illuminate the psychic forces that operate in response to such extreme emotional pain, and bring explanatory power to bear on dismissive, shaming actions like those Constance experienced. In this context, the actions of some fellow nurses can be seen as an urgent strategy to maintain collective silence about events that are perceived or experienced as unapproachable and unbearable. Enforcing repression is a means of dealing definitively with the destabilizing effects of traumatic material in consciousness by silencing those who threaten to disrupt repression. It is, further, an imperative strategy for psychic survival among those who are not prepared to “bother” themselves with the mental and emotional labor of confronting “inside-
outside” conflicts and “random paradoxes and contradictions … and uncanny slips into sudden awareness of difficult truths” (Fenwick, 2000, p. 251). Such truths include the desperately painful knowledge that traumatic horrors may visit anyone at any time, without warning and without reason, and seemingly without justice or mercy.

Constance does not name the lack she felt as a lack of learning, but as a lack of support. Yet the lack of emotional support that characterized the ED at ASMC indeed generated learning according to a hidden curriculum. Considered within this analytic perspective, Constance can be recognized as undertaking immense informal learning with respect to navigating complex emotional and social demands and constraints in her ED nursing work. Her accounts of experience, and the analysis of those accounts, affirm that such learning comprised a powerful emotional situation that shaped her practice. Moreover, even apart from the obvious trauma cases that came through the ED’s doors, it is evident that all of Constance’s learning was characterized by a degree of “ordinary but ubiquitous trauma” (Britzman, 2013, p. 770).

Like Yvonne, Constance’s most important resources for learning to cope with such intense traumatic exposure occurred through her own initiation—by seeking out disparate sources of reflective thought and critique that could help her reconstitute her experience and reimagine new ways of dealing with her work. Aside from her strong connection to Penny, her informal mentor, another such source was Constance’s Reiki practitioner, to whom she had turned for help with the physical chest pain she experienced after a series of trauma cases in her first year in the ED. For example, recalling the uncle who was charged in the death of his nephew (who had not been secured in a child car restraint), Constance described to her practitioner her action of taking his hand to calm and reassure him. Constance then recounted her practitioner’s critique and described her own application of this perspective with regard to other patients experiencing overwhelming physical and psychical pain:
My Reiki practitioner said I took in that—when I grabbed the hand—she [said], ‘You’re taking in that—’ She [said], ‘You need to learn to—put—put yourself out, and give from around you, not take it in.’ So what [this] has taught me … is that energy is everywhere, and I take that in [from the larger environment] and I give that. So [a different] guy was just, he was just screaming [in pain from an injury], and I just … I will, like, yell at somebody, and I say, ‘Look at me in the eyes! … We’re going to breathe!’ And I’ll squeeze their hand really hard…. You know, because I’ve learned…. (C:II:16)

Here Constance articulated a different structure of meaning for conceiving her relationship to patients undergoing extreme suffering. Rather than imagining herself linked directly to her patient by empathic concern, she undertook a new mental structure for caregiving that specifically encompassed the wider physical environment in which traumatic events took place—the “energy” that is “everywhere.” Referencing quantum physics, Constance sought to conceptualize herself and her patient as operating together in a lifeworld environment that was not just empty space or air, but physical energy that is alive with motion and potential. In this way, she could conceive a mediating instrument that operated between herself and her patient. Further, this instrument also served as a boundary, creating a functionally protective distance between her own and her patients’ subjectivities while preserving her intersubjective empathic concern.

Constance’s learning in regard to STS was thus entirely independent of any resource offered by the hospital system. It was further independent of any organized type of instruction. It was informal and psychodynamically grounded, yet potent. It engaged and was responsive to her inside-outside conflicts of experience and the difficulties posed by learning not only as a cognitive activity, but an emotional one too. Constance concluded our meeting by reflecting:

I think it’s a shame there’s not more things to help nurses to deal with the violence and trauma…. My—and this is just my point of view, if I was going to have [better support], it would have to be [with] another nurse. It would have to be peer-to-peer. You know, the chaplain doesn’t understand. She doesn’t get it…. [And] I don’t want managers because you’re always guarded. You can’t freely say—‘Well, why weren’t there more nurses?’ (C:II:32)
In the next chapter, I demonstrate ways that Constance did engage with peer-to-peer support and informal, psychodynamic learning during the focus group session with Yvonne.

**Static Meaning Structures for Constance: [C]**

*The structure of secondary suffering and traumatic stress.* For [C], a critical care nurse’s experience of bearing witness to profound suffering is ultimately inseparable from the material demands of the nursing work. This includes stunning, disturbing disparities perceived in acts of “caregiving” that may be violent, loud, and pain-inducing, and which may potentially cause harm as well as alleviate it. The work further involves sustained conflicts between one’s own physical needs, empathic concerns, emotional capacities, and critical thinking requirements—all under the crush of a rushing life-and-death train of events.

The experience begins as a sense of exhilaration and power in the capacity to help another—to “keep them alive.” This soon is overlaid by a terrifying sense of anxiety with respect to the responsibility, complexity, and exhausting demands of the work. There is little sense of control over what “comes through the door” and what is “coming at you.” Overwhelming emotional, even physical, pain may be felt with the mere act of walking onto the unit. Former scenes of suffering—the sounds, smells, words, and images—live on in consciousness, even as one is faced with new urgencies and feels compelled to “run in and help.”

Meanwhile, despite the most expert treatment efforts, there is a recurrence of loss—“the worst of the worst” forms of pain, morbidity, death, and mourning that prove to be inescapable. There develops a disturbing mix of awe and horror toward one’s own experiences and actions as a nurse, as well as toward the patients whose suffering demands such care. One feels “hammered emotionally,” then feels guilt for objecting to the inevitable, endless, harsh demands.
This triggers a drive to distance oneself emotionally from many aspects of the work. One may begin to avoid connecting humanly with patients to protect against their circumstances suddenly “becoming personal.” A sense of dislocation and depersonalization develops: of being in “a separate world” or “being in Vegas.” One feels cut-off from the mundane lifeworld and from one’s former naïve, innocent perceptions of it—perceptions that are still taken for granted by friends and family who are not exposed to this work.

Group identity, with its shared meanings, comes to replace more private nuanced feelings. A fierce pride overshadows ambivalence and reflective self-awareness. There is a sense of “being in the trenches,” “in a war zone,” as the need for mental and emotional survival competes alongside the physical survival of patients. An “us” versus “them” worldview arises, in which “they” are the ones who don’t “get it,” “don’t understand,” and “have no idea.”

A further quality of experience may arise that has much in common with addiction: a numb, obsessional attachment to suffering concurrent with a drive to end it—a sometimes self-destructive, torturous marriage of constructed meanings and chosen acts. This evolves into a “love-hate” relationship with the work and those who do it. A nurse may “want to quit” and yet “can’t quit,” may want to speak and yet can’t speak. A nurse may long to share her experience, but recoils from invitations to do so by issuing sharp warnings like “Don’t talk to me.” In time, she may not know what to do—what else is even possible. An awful place to be.

**The structure of language for understanding traumatic suffering.** For [C], a vocabulary for secondary suffering consists in a series of narratives where emotional conflict and acute suffering are central. There are few conceptual formations, but rather storied sensations and embodied reactions that are shared informally, primarily outside of work. In the face of “the worst of the worst” pain and suffering, however, there are no words at all. There is screaming in one’s head; there is crying on the phone; there is laying restlessly on the couch or falling into a dead
sleep at night; and there is wordless crying in the arms of a trusted loved one. But when traumatic exposure crests and overwhelms a nurse, there are few words. Only later, the stories come, in episodes. This telling may or may not ease the pain. Language is a two-edged sword: it can harm or heal. When in doubt, no words are best: “Don’t talk to me.”

The structure of learning in response to traumatic suffering. For [C], learning to cope with the experience of bearing witness centers on learning to decode unspoken intersubjective commandments of psychic survival that operate in an environment where “the worst of the worst” trauma and tragedy may roll through the doors at any moment, and there seems no way to protect or defend oneself from its personal impact. In this setting, learning is all about survival: professional, emotional, and physical survival too. A nurse must learn to decode her own exhaustion, her pride, her pain, her anger, and her shame—then arrive the next day ready to face new emergencies. The learning of treatment protocols and techniques all bear a complex relationship to the task of coping with mental and emotional impacts from seeing others suffer serious harm while realizing there is sometimes very little a nurse can do to help.

In this context, formal “debriefings” are experienced as shallow and irrelevant—token administrative gestures that are too little too late. A single poorly led debriefing can teach a nurse never to trust such a venue, while rumors of overpowering anger or grief spilling out in a session may inhibit other nurses from even trying to attend one. Debriefings may also be harmful—traumatizing in themselves—when they fail to create a confidential safe space in which both words and silence are honored and the nurses in attendance are shown respect and concern.

Informal gatherings with trusted peers are a preferred way of gleaning guidance and developing support where informal ways of learning can evolve. These arise spontaneously, often outside work hours, among friends and colleagues who have built shared understandings based on a common history. There, a nurse can better give voice to her experience and find companionship
and caring. Yet in the workplace, attitudinal structures are slow to respond. With few exceptions, the critical care culture of trauma nursing resists giving voice to suffering. On the rushing train of emergency care, there is no time or space for the work of mourning.

Analysis of Holly’s Meaning-Making

Holly began her career in a very large urban PICU as a new graduate nurse (GN) because she “really liked the critical thinking and all the pathophys and ... lots of science—like, there was more than just that human piece that I liked” (H:II:3). She explained that, upon marrying, she moved to the semi-rural region surrounding ASMC and joined the PICU staff there. She and her husband soon began a family and within a few years, they had three children. This transformation, she said, profoundly shaped her work with families of sick children, making it far more difficult for her to maintain a separate sense of identity as a mother, apart from the PICU mothers whose experiences she witnessed.

During the interview, Holly spoke thoughtfully and, at times, with deep emotion. She gave no indication that she was hesitant to describe her experience and she could readily access her subjective impressions and constituted memories. Phenomenologically speaking, Holly remained present and attentive to our dialogue, and she was able to describe her perceptions and express her feelings and thoughts fluidly and in detail. She was articulate even when she cried and did not become confused or forgetful, nor did she trail off into phrases like, “I don’t know...” or fail to finish sentences. Moreover, similar to Constance and Yvonne, Holly expressed a strong interest and desire to help advance the study’s aim of better understanding nurse trauma exposure and to raise awareness within the profession, for the benefit of future nurses.

The experience of secondary suffering and traumatic stress. Holly said that she began her PICU career with:
this completely erroneous, unfounded idea that ... every kid that was critically sick was
gonna have a devastating outcome. That, like, the fact that you were intubated and laying
in an ICU and had tubes attached where I didn’t think tubes belonged, meant ... your
outcome had to be terrible—like, nobody could go home and be normal after this. ... 
The knowledge deficit, obviously. (H:II:14-15)

Thus, during her first two years in the large PICU with more than one hundred nurses on staff, she
initially perceived life support equipment and all the “big machinery that make a room look really
scary” not as signals of hope for recovery, but as “terminal things,” signals of death. Slowly,
however, she acquired a realization that critical illness is not always equivalent to terminal illness,
and some kids do get better:

Holly:  ...and we got to help them get better—like, I remember the first time I bagged a
patient, how I was, afterwards, it was this complete shock that—I was just their lungs!!
Like, they’re alive ’cause I was just their lungs! That was a big thing for me….  I
remember feeling very...the gravity of what we do became very serious at that point.

PI:  They had oxygen in their brain the whole time because...

H:  —because I knew, when I walked in, that’s what I had to do. (H:II:15)

By contrast, Holly recalled a more stressful example of her early experiences in the PICU, the
task of opening emergency medication dispensers during a resuscitation or “code”:

H:  I remember not being able to open bristojets because I was shaking so much,
[laughing] like, as a newer nurse— [imitating herself] ‘Oh my God, I’ve gotta draw up
the Epi and I don’t even know how to open the—where does this yellow—?!’ You know?
[laughs quickly] And now it just—you just do it. It’s just like—time to make a cake. Time
to code a kid….  Not because it’s lost its criticalness, its value, its scariness, it’s just that...

PI:  Your body knows what to do—

H:  [spoken together] Your body knows how to do it—and that you can do it. (H:II:14)

These passages, in which I began a thought and Holly finished it (and the reverse), arose regularly
during our interview and implicates a phenomenon that merits further discussion.

*Intersubjectivity in the analysis of STS.* Aside from suggesting a degree of spontaneous
intersubjective alignment in meaning-making between Holly and myself, the recurring moments
in which we anticipated or completed each other’s thoughts suggested that there may have existed more significant streams of constitutional processes—even established structures of meaning—that were mutually asserting themselves within the spontaneous intersubjective flow of our dialogue. Given our backgrounds, this is not surprising and, indeed, was evident to an extent in each of the three interviews—for as critical care nurses, we all had encountered a number of similar experiences that made common meaning structures more likely to emerge.

As I have suggested in previous chapters, however, an appreciation of the power of intersubjectivity in consciousness complicates qualitative data collection and analysis, for it compels recognition that there can be no clean, clear demarcation between the constitutional activities of the participant and those of the researcher. Phenomenological research praxis, as I have presented it, is somewhat unique among qualitative methodologies in its capacity to efface the nature and effects of intersubjective activity within the flow of mental work applied to data collection and analysis. This is so because the phenomenological reduction, when undertaken as an emergent praxis rather than as a more singular act of “bracketing,” has potential to engender within the researcher’s consciousness both iterative self-awareness and reflective self-critique, which may result in far more complex, nuanced, and comprehensive analytic insights than mere bracketing. This holds tremendous value when, as in my engagement with Holly’s account, the perceived force of intersubjectivity does not end with the interview. In my case, it reasserted itself repeatedly in my consciousness during the months of data analysis that followed, compelling me to undertake ever more penetrating self-analysis and self-critique—i.e., phenomenological praxis.

As a result of that praxis, I found that a failure to attend systematically to these intersubjective currents in my consciousness yielded relatively shallow, convoluted, and obscured findings based on Holly’s account. Whereas the reduction had equipped me to work in a manner that was searching and quite free with respect to Yvonne’s and Constance’s accounts, I concluded
that the psychic currents asserting themselves in my work with Holly’s data hindered my efforts and necessitated a more complex presentation of my analytic process with regard to her descriptions—specifically encompassing fuller revelation of my intersubjective world of experience and praxis with her data. Given the fundamentally intersubjective nature of all secondary traumatic experience, this challenge comprises an important matter for recognition and discussion in this type of research. It also presents an important outcome of the methodological insight that it is the consciousness of the researcher, not of the participant, which is the final constituting agent in qualitative analysis, understood from the perspective of Husserl’s work applied to empirical scientific inquiry (Giorgi, 2009).

Hence, when a persistent disturbance of intuitive perception or free imaginative variation is detected by an investigator within her constitutional work of data analysis, it is imperative to the quality of the resulting research that this disturbance not only be explored, but that it be effaced as fully as possible. Under these conditions, I do not find it sufficient to undertake this praxis in private analytic memos beyond the reach of scholarly observation, for transparency in the constitutional process is key to establishing trustworthiness in qualitative research. Further, it is not sufficient to present this praxis in isolation from the data and the very moments in its analysis that elicit the disturbance—for just as intraphenomenal relationships among meanings (see Chapter 4) can be missed by segregating moments in the data (e.g., when establishing themes), so intraphenomenal relationships that shape research findings may likewise be overlooked by segregating complex intersubjective currents of meaning-making during the investigator’s practice of data analysis.

Consequently, the evidentiary discussion that follows presents a twin stream of insights. It focuses primarily on those derived from Holly’s descriptions, but encompasses in tandem some from my own phenomenological praxis. I highlight a number of significant moments within
Holly’s account as exemplars of her constitutional activity, while scrutinizing certain meanings within my own consciousness at critical points in the analytic process. In this way, I undertake to demonstrate essential meaning structures in Holly’s account using intersubjectivity as a tool to yield more trustworthy static findings. As this chapter remains focused on static structures rather than genetic ones, I do not pursue structurally intersubjective meaning-making activity in relation to STS, but reserve this form of analysis for the next chapter.

“That feeling everybody has [of] trying not to cry, and crying anyway.” When Holly made the geographic move and began working in ASMC’s smaller PICU, she soon grew into a leadership role that involved not only her critical care knowledge and skill, but even more so, her capacity to provide sensitive end-of-life care to children and their families. She acknowledged that she worked with experienced PICU nurses who told her they routinely “get really shaky” on their way in to work—because “you just don’t know what you’re walking into” (H:II:16) Indeed, this was my experience in my 20s throughout my critical care tenure. Yet Holly explained, “I’m definitely not the person who gets anxiety ’cause she’s worried about going to work…. It’s what I do, and we’ll figure it out as we go” (H:II:5).

At the same time, however, she affirmed that “you have to have a healthy fear to do what we do well” because “there’s never a ‘nothing’ patient … even if they’re looking okay right now” (H:II:16). Yet the unpredictability of events in the PICU and the intensity of care required by her patients were not what Holly found most traumatic in her work life. Here, she alludes to the emotional and relational dimensions that she found far more challenging:

H:  I’m usually fine when I’m caring for the patient. It’s when we’re ready to bring the family in that I definitely feel, like … my neck gets, I don’t know, either tense or cold, or like, I feel uncomfortable. And … I almost always … at least tear up, if not … cry a little when a mom first sees—like, I talk to them at first … but then as they, like, start losing it, or are laying on the bed, or whatever it is they’re gonna do … or let out that wail [inaudible] that their kid’s gonna die … I cry with them.
So there’s, like, that feeling that everybody has when they’re trying not to cry [laughs] and they’re crying anyway. …But if we’re actually, legitimately, coding-coding [a kid], the typical adrenaline reaction—in check—you know what I mean? …You’re doing what you need to do and acting calm, but...inside you’re not.

PI: And when that’s the case, is it...how would you describe that…?

H: [pause] Like, kind of out-of-body, like, you’re just...[doing] what needs to happen to get the job done. Like, you can’t think about the fact that you’re doing [chest] compressions and making a heartbeat while you’re doing it. You have to think about that later. You know? So, I think it’s kind of out-of-body…. Your body just takes over and does what it’s gotta do, and there’s no emotion piece….

This moment in Holly’s account, when she described there being “no emotion piece,” echoed her previous comment: “It’s just like—time to make a cake. Time to code a kid….” It appeared to reflect her clinical expertise and growing level of assurance in her ability to “figure it out” in conjunction with her fellow nurses—one patient at a time as clinical emergencies arose. Nevertheless, it was rare that Holly characterized her work in this way, as procedural or instrumental. Indeed her description in the initial paragraphs above only hint at the depth of sensitivity and insight she appeared able to provide when interacting with families. This was evidenced in numerous descriptions, for example, when she commented:

I’ve had lots of younger nurses come and say, ‘I don’t know how you work with families like that. I don’t know how you talk with families like that. That’s really hard for me….’ [And] you can tell, from what they tell me, it’s helpful for them to have that modeled for them, if they’re not at that point in their … where they can do that. (H:II:8)

Holly did not valorize her capacities in this regard, but spoke with a confessional quality that sometimes touched on embarrassment, for example, when she remarked with a timid laugh, “I just really like palliative care. I don’t know why…” (H:II:8). Moments earlier, she had elaborated:

I don’t want to say I enjoy, but I guess I do ... modeling how [end-of-life family care] gets done. ...[I]t’s because I work well with families like this—even though I have to always be the one doing it—it’s not fair to the family to not get what they need in an emotional and a supportive way. So, if I’m the kid’s neighbor [working in the next room] and I see a nurse really struggling to have that kind of interaction the family’s looking for—I get it, I’ve been there. It’s hard enough to manage what’s going on with the patient, and then add
the six family members at the bedside and—it’s really hard, especially when you’re trying to make sense of the medical piece going on. So, I usually make sure that I go do the family piece, and ... [the newer nurse] can figure out the medical piece, and [Holly drops her voice momentarily] ... usually they don’t realize it, but the medical piece is so irrelevant by that point ... nothing we’re gonna do is fixing it, you know? (H:II:7-8)

Similar to Yvonne, Holly noted that her skill in working with families meant that she must “always be the one doing” family caregiving in end-of-life situations. Further, by her own initiative, it also meant she was not just doing it, but she was also “modeling” this level of care in the presence of newer PICU nurses who “struggled” to interact sensitively with the families of dying children. Several structures of meaning are suggested in this passage, which presents something of a baseline expression for recurring and evolving perspectives in her account—including: (1) her interest in mentoring other nurses through “modeling” for them how complex emotional care is offered, (2) her altruistic concern for and commitment to responding to others’ needs, and (3) her frankness about the grueling mental demands of PICU work with its interwoven physiological and emotional dimensions of care.

It is notable that when describing her emotional labor above, Holly’s description moved rapidly from speaking of her own capacities and the resulting pressure “to always be the one doing it,” to expressing (in a mid-sentence shift) what she believed is “fair” for her patients’ families, and then to describing what is “really hard” for newer nurses in the very next sentence. Here and elsewhere in the interview, Holly presented a similar constellation of emotional needs and emotional suffering involving family members as well as other nurses, and she often described taking steps to involve herself in such scenes to provide synergistic support to multiple people involved with each child. Taken together, these patterns presented a structure of meaning in which Holly recognized a triad of agentive groups, each with distinct emotional needs relative to dying children: (1) the families of her patients, (2) her fellow PICU nurses, and (3) herself as a
senior nurse. As she gradually articulated this structure, however, Holly persistently ranked her own needs and concerns last among the three, while simultaneously describing a strong sense of fulfillment that she gained through her actions as a supportive agent in relation to the other two groups. Such altruism was persistent throughout her account, yet she often expressed a poignant sense of mourning as well—sometimes almost despite herself, as when she dropped her voice in the passage above to add, as if in an aside, “they don’t realize it, but the medical piece is so irrelevant by that point … nothing we’re gonna do is fixing it, you know?”

“When you see a death went better … that was something you could help them do.” At this point in my work of data analysis, I found it imperative to enact a more searching practice of the reduction—for here is where the force of intersubjectivity arising between Holly and myself touched a nerve in my own history. I became increasingly aware within myself of unsettling emotional identifications with Holly and her story—for like her, I had graduated from a BSN program as a young adult, then immediately began work in critical care nursing. Like her, I was initially overwhelmed, but persisted in slowly developing my capacities, my confidence, and a sense of camaraderie. Also like Holly, I had a deep passion for compassionate end-of-life care and trying to help make “a death go better” for the sake of both patients and families.

Unlike Holly, however, I gradually found less and less support within the lifeworld of my work, and so I became less and less able to cope with the emotional and relational challenges there, or the profound mourning it elicited within me. I lacked Miller’s enlightened witnesses and, apart from Shem’s novel, had insufficient words or conceptual frameworks (i.e., hooks’s theories) for understanding my experiences or imagining ways I could respond to restructure my thoughts and my world. Thus, unlike Holly, I left critical care nursing, then left nursing practice altogether—feeling angry at the profession, disappointed in myself, as well as confused and sad.
This sense of alignment, complicated by a marked sense of disparity—and a perception of defeat in my view of myself as a nurse—created significant mental interference as I worked to explore Holly’s constitution of her experiences in the present, as distinct from my constitution of my own experiences in the past. This is known as countertransference in psychoanalytic theory, and the mental conflict deriving from it ensued for months. Ultimately, I can claim neither that I resolved it to my full satisfaction, nor that the analysis below is as clear and incisive as I might wish. I can, however, reveal my practice of the reduction and I can claim that my work of data analysis became gradually freer and more searching (though still painful in new ways) as I allowed myself intentional mental space and time to mourn my history and my losses—not unlike the ways in which I encouraged Holly and then witnessed her mourning her experiences and feelings of loss gradually over the course of the interview.

Holly did not do so easily, however. On the contrary, the pattern sketched above in which she foregrounded other people’s needs and suffering, particularly those of the families of her patients, while placing her own needs and pain in the background became more and more evident as she spoke. At the same time, however, her descriptions of traumatic scenes gradually demonstrated that her approach to suffering revolved around decisions to cultivate emotionally intimate relationships, particularly with families, as a way of coping with the sadness she faced:

Families want us to be humans. And it’s a lot more meaningful for a family to see that you care, even if that means you cry with them, even if that means you look as defeated as they feel during your shift. Like … that can be way more meaningful to them than anything you do to an IV pump … any lab value you call and report to the doctor, like … that’s important, but it is not what it’s about. So, being able to balance both and let yourself [be open emotionally], it’s the harder part to do.

…and I think that once you allow yourself to do that, you can—it can just be more gratifying to be the patient’s nurse, even when the outcome is what the medical world feels as defeat, it doesn’t have to feel like a defeat. It can feel like … accomplishing … the end of a life, even though it was too short, in a way that was most meaningful and helpful to the family. (H:II:24)
Yet the forces of consciousness that motivated Holly to consistently offer such support were complex. In particular, she described a pair of related yet distinct currents—a sense of responsibility and a sense of fulfillment—that moved her toward giving of herself in this way. The sense of responsibility derived from a structure of meaning Holly voiced that she had been given “a gift” (see next page) of being able to support families in the way she did. The sense of fulfillment derived from gratification she described experiencing (as above) in the practice of emotional vulnerability and intimacy with patients and their families. Thus, Holly characterized her work essentially, not in procedural terms (i.e., as treatments), but in terms of relationship building that possessed lasting value for her, as it did for families, because the quality of interactions was profoundly meaningful, memorable, and mutually comforting:

When you can see that, you know, a death went better, or a really awful experience went better for a family. That was something you were able to help them do. Or the hour you sat and asked them to share their memories, and looked at their cell phone pictures and their videos of their daughter, or whatever that was that they needed to do. …You can’t take [the pain] away, but working through the initial, like, this is all my fault, or…. [sighs] Like, you—you leave knowing that somebody needed to do that tonight. These people couldn’t have done that alone. (H:II:23)

These reflections echo an experience that Yvonne presented, when she described “really being able to get in with those families, and get them talking and get them expressing, is one of the best therapies for me, as opposed to running out of the room, and not being able to deal with the families” (Y:II:14). Holly, too, went on to say: “I’ve watched nurses not let themselves go there, and feel things with families, and I think it makes … it hard on them” (H:II:23).

In its surface, data such as this might be tempting to categorize under the often-used construct of compassion satisfaction (e.g., the ProQoL-V). Indeed, only moments prior to relating the description above, Holly had said:

It helps me to realize that, this is hard for me, but it pales in comparison to what these people are going through, and God gave you a gift to help them through this time, and
you’ve gotta use it. Because you can. So you find some kind of strength, somewhere, which is a lot, for me, faith-based, and you meet that need. Which involves putting your [own needs] away. That’s what helps me … or that’s what keeps you coming back, or allows you to continue to do it, or put yourself away for them is … the fulfillment of meeting that need. (H:II:23)

Yet as with Yvonne’s data, the structure of meaning-making here is complex and TCA offers limited tools with which to unfurl the cross-currents of feelings as well as thoughts that conflict as well as cohere, even as they underlie and motivate such mental activity. In particular, the passage above conveys not just fulfillment or satisfaction, but also a sense of responsibility that borders on obligation, even duress, in statements like, “you’ve gotta use it. Because you can.” Indeed, the nonverbal quality of Holly’s account—her facial expressions, posture, and tone of voice—did not often communicate satisfaction and fulfillment, but rather grieving and pain. Often her voice became strained and thin as she spoke of children’s deaths and parents’ mourning. Often, too, she spoke swiftly, as if the possibility of lingering on her descriptions was barely tolerable. These tensions in the verbal and nonverbal content of Holly’s account suggest that her ways of coping with trauma exposure were not simply reducible to a construct such as compassion satisfaction.

“They couldn’t do anything…. You can’t either…. I just can’t go there.” Many of the passages above, however, provide another kind of evidence, which suggests more complex structures of meaning-making at work in Holly’s consciousness. This evidence involves the structure of the language itself that Holly employed throughout her descriptions, which may reflect psychical conundrums she was actively engaged in trying to manage, as regards the interconnectedness of her lifeworld with that of other nurses and patients’ families in the PICU. The clues to such a structure go beyond Holly’s pattern of privileging others’ needs above her own, and encompass the utility as well as the difficulty involved in embracing intersubjectivity with those whose lives she was intimately involved.
To examine this structure in Holly’s language, I will revisit several passages in the preceding pages. First, considering the quotes presented on page 198 (and following) more closely, Holly often spoke in first person singular (“…the first time I bagged a patient…. That was a big thing for me…”) or “I was shaking so much…” as well as in first-person plural (“we got to help them…” or “when we’re ready to bring the family…”). However, she also used a second-person narrative voice here (“You just do it…”). Elsewhere, Holly moved fluidly between first-person singular and plural: “It’s what I do and we’ll figure it out as we go.” Yet the next passage (on p. 201) evidenced a shift that took place gradually as Holly began to discuss the painful experience of bearing witness to PICU families’ suffering. She opened this description by speaking primarily in first-person singular: “I’m usually fine…”; “I feel uncomfortable…”; “I talk with them…”; “I cry with them….” At this point, however, after she spoke of “that feeling everybody has when they’re trying not to cry,” Holly’s use of second-person voice appeared and quickly dominated:

You’re doing what you need to do and acting calm, but … inside you’re not. …Like, you can’t think about the fact that you’re doing [chest] compressions and making a heartbeat…. Your body just takes over and does what it’s gotta do, and there’s no emotion piece….(H:II:13)

Second-person voice did not emerge only when Holly spoke of emergency treatments like resuscitations, however. Although early in our interview, Holly more readily sustained her use of first-person singular (“I usually make sure that I go do the family piece…” (H:II:8)), she relied increasingly on a second-person structure of speech to express herself as the interview progressed. For example (see p. 206 above): “When you can see that…a death went better…. That was something you were able to help them do…. Like, you—you leave knowing that somebody needed to do that tonight” (H:II:23). And, “families want us to be humans. And it’s a lot more meaningful for a family to see that you care, even if that means you cry with them, even if that
means you look as defeated as they feel…” (H:II:24). That is, Holly’s use of a second person voice most often appeared as she engaged in offering extended descriptions of the painful realities of bearing witness to other people’s suffering—in particular, the suffering of families.

The use of second-person voice is often understood as a distancing tactic of consciousness and such an interpretation would certainly make sense here—a tool by which Holly could remove herself at key moments from her own narrative, making it about “you” rather than “me.” Yet the structure of her use of the second person suggests other possibilities as well. Specifically, it appeared to be linked to her concern for the pain of others. At times, the “you” invoked the pain of one whom Holly seemed to address (e.g., “I get it, I’ve been there. It’s hard enough… especially when you’re trying to make sense of the medical piece going on”). At other times, the “you” invoked the secondary suffering of a hypothetical third person to whom she likened herself (e.g., “you find some kind of strength, somewhere” and “you leave knowing that somebody needed to do that tonight”).

Yet Holly’s use of second person was not only aligned with her descriptions of concern for fellow nurses and families. At times, it seemed to reflect—even to invoke—her awareness of a broader human context, a sense of collectivity and intersubjectivity in the nature of her work with others. With respect to families, for example, Holly linked her work to the larger context of her faith community when she said, “you find some kind of strength, somewhere, which is a lot, for me, faith-based, and you meet that need” (H:II:23). Elsewhere, her use of “you” was more subtle, implicitly evoking a sense of the presence of another, for example: “the hour you sat and asked them to share their memories, and looked at their cell phone pictures…. You can’t take [the pain] away, but … you—you leave knowing that somebody needed to do that tonight. These people couldn’t have done that alone” (H:II:23). With respect to her fellow nurses, Holly’s consciousness of collectivity, even of community is further supported by her frequent, and fluid, use of the first
person plural, “we,” interwoven with her use of both first and second person singular. For example, her statement: “This is what I do and we’ll figure it out as we go.” Or, “if we’re actually, legitimately, coding-coding [a kid]…you’re doing what you need to do….” And her statement (see Appendix E), “you’re not randomly working with different people…you become each other’s family every weekend. We fight like brothers and sisters by Sunday…you know, like, that’s part of what we do.” Linguistically, each of these statements tacitly invoked a sense of solidarity in relation to the nurses with whom she worked so closely.

From the perspective of the eidetic reduction, I found these linguistic shifts in Holly’s descriptions to be familiar and congruent with some of my own ways of speaking and thinking about traumatic experience. I identified with her use of a second-person voice and recognized it (or imagined it, eidetically speaking) as a tool or device that had many times served not so much to distance or estrange me from painful perceptions and memories, but on the contrary, to help me approach such mental content by calling on the psychical presence of others. Those “others” were not abstract and theoretical. They were palpably imagined as well as recalled—individuals who became active in my consciousness through my manner of speech—who were not “them,” but “you”—who were not there, but here. People I conceived had once suffered similarly as I did, and so with whom I shared a human connection. In other words, in my own experience, thinking and speaking in such a manner had operated to make traumatic exposure less lonely, more bearable, and more psychically approachable as well.

Thus, partly on the basis of such intersubjective analysis, it seems plausible to me that Holly’s frequent use of “you” in her descriptions served not just to create a degree of psychical space between her emotional awareness and her verbal accounts. It also invoked for her a conceptual frame within which she could intertwine traumatic exposure with her experience of meaningful relationships, of mutuality, of solidarity in a community. In other words, I find that a
consciousness of intersubjectivity through the enactment of significant relationships is a central structure in Holly’s constitution of the experience of bearing witness to suffering. It functions adaptively to undergird her capacity to remain present even to very painful perceptions, while strengthening her ability to claim and constitute those perceptions gradually into relational meanings over time. That is to say, it was through heavily intersubjective constitutional processes, which yielded particular meaning structures that affirmed human solidarity and community, from which the stable practices of Holly’s clinical empathy and technical skill could emerge and become expressed as compassion and dedication to fellow nurses, patients, and families.

There is one additional and very poignant example of the communal implications of Holly’s use of the second person that is important to examine, for it was the only time during our interview when she did not contain (in her words, “put away”) her pain, but showed acute emotional distress and cried openly with me. It occurred in response to my query as to whether there are things she avoids: either physical places, or topics of thought or discussion. Holly paused for a moment, then she said:

Holly: I think the hardest ones for me … that I try to just not let myself go there, is these teenagers with mental health things that … they’ve attempted suicide or…. And it’s really hard to watch a kid that comes from a family that looks perfect on the outside, and realize that…they couldn’t do anything about it. You can’t either. …And like, I, like. I [stutters] I just can’t go there [she starts to cry] ’cause, I’d go crazy. [openly crying now] ’Cause it’s really scary…

PI: Yeah….

H: …to think about.

PI: Yeah…. You mentioned a child recently who had been hanging….

H: Um-hmm. [inaudible] … because I was feeling like, how do I not be this mom in 10 years? Like, how do you make this not your story? You don’t. So you just try not to think about it, but that was very hard for me…. [inaudible; still crying openly, wiping tears from her face] [That] definitely, throws me over the edge to think about. (H:II:17-18)
Here, Holly demonstrated a profound openness and willingness to expose one of her most closely held fears, a moment that was unlike any other in our meeting. Her speech moved fluidly between first and second person and I perceived in her use of “you” not only that she was addressing me, nor merely that she was finding a tool that gave her a degree of distance from pain. Even more, I was impressed that Holly’s words sounded a type of call: “How do you make this not your story?”

The meaning that presented itself to my consciousness, particularly on reflection, was an invocation (however brief) of a community of mothers who sometimes fear for their children—an invocation that provided respite (however brief) from the isolating effects of fear, and a powerfully (though fleetingly) imagined perception of companionship in sorrow.

As it had elsewhere, Holly’s manner of speaking here also invoked a mental structure of parallel experiences shared by herself and others—reflecting Husserl’s phrase, “a multiplicity of conscious subjects communicating with one another” (as quoted by Zahavi, 2012, p. 185). Among these imagined and invoked subjects, she moved fluidly from “they couldn’t…” to “you can’t…,” then back to the first person, “How do I not…?”—thereby including herself amongst the subjects she implicated, and so claiming this pain as her own: “How do I not…? How do you make…? You don’t. … [That] definitely throws me over the edge.” Holly’s words, together with the depth of emotion she expressed, thus presented to my awareness an experience of a mother calling out to find others who might listen and bear witness to her experience of secondary trauma and mourning. The significance of this description resided as much in her willingness—or perhaps in a sense of necessity she experienced in this moment—to foreground her own suffering rather than to marginalize or rationalize it as she had done at certain other moments of the interview. Her doing so here was consistent with her descriptions of acknowledging her suffering frankly with the close group of her fellow nurses on weekend-night shifts.
“We take care of each other ... you’re not in there doing it alone.” On the basis of this analysis regarding Holly’s use of language and my proposal that her keen awareness of relational intersubjectivity functioned as a core meaning structure and as a tool that stabilized and sustained her, Holly’s use of language throughout the interview acquires growing significance. Indeed, almost all of her descriptions of the PICU nurses, their activities, and the culture of their relationships involved the use of intersubjective, inclusive pronouns: most often first-person plural, but also second-person voice. In this way, she expressed both explicitly and implicitly the many ways in which she and fellow nurses worked together as an open yet integrated system, a mentally and emotionally synergistic group.

For example, Holly described the communication of privileged health information among the nurses in this way:

Our unit, as a culture, has very free flowing communication about all the patients. Like, we treat the [whole] unit as our patient. So, we start with a group report that reviews what’s going on with every patient for 10 minutes. So nothing’s a secret—it’s very much a culture of ... they’re all our patients and we all take care of them. (H:II:22)

Holly’s description immediately established a very different focus than my question suggested regarding legal structures and constraints upon information flow. Instead, her very first words projected an intersubjective lens: “Our unit, as a culture….” She then refined this broad view to declare an explicitly collective stance that was practiced among the PICU nurses: “they’re all our patients and we all take care of them.”

Similarly, when I inquired about the language she and her fellow nurses used to describe the emotional dimension of their work, Holly answered, “we call it trauma … like, it’s our trauma too” (see Appendix E for further contextual content). Noticeably, though my question asked about words she or her “friends” used, Holly did not answer in an individualized manner—almost as if to do so would be incongruent with the question. Rather, her response conveyed an
intersubjective quality of experience that she seemed virtually to have embodied: “… and we’re happy to tell people that it sucks. [lets out a sardonic laugh] We tell each other, you know, that it sucks.” She then proceeded to articulate in detail the powerful culture of caring and support that the regular weekend-night staff of nurses had developed, informally and communally, over the years they had worked together:

We are very good at taking care of each other. Like, we recognize that what we do isn’t easy. And I think that, as a unit, as a whole, because we’re small enough to all know each other, and know each other well, and especially working weekends means our core weekend staff all work together all the time, so…you’re not randomly working with different people all the time…. You become each other’s family every weekend. We fight like brothers and sisters by Sunday, we all joke around that—“It’s Sunday night, everybody’s catty like their sister.” [laughs] You know, like, that’s part of what we do. So, I think that…we’ve learned to take care of each other and be completely frank about how much things suck, or how hard they are.

PI: Uh-hmm. Yeah, so that’s where the debriefing really happens, it sounds like.

H: It totally does. Totally. (H:II:6)

This is not merely a way of speaking about trauma. I find that Holly’s description evidences something far more substantive and revealing. Recalling Forester (1999), Holly’s account suggests an embodied, structural way of psychically re-presenting the experience of trauma (rather than repressing or reproducing it) as a communal experience in her consciousness. There is, indeed, a ritual quality to the social life that Holly portrayed among the weekend-night nurses. Her account suggests that it is precisely this shared and participatory, ritual culture of frank relationships that made the traumatic exposure she faced at work bearable for her. It further suggests that Holly’s leadership in cultivating a caring and honest staff culture helped to make trauma exposure more bearable for her fellow nurses as well.

This proposal of a fundamentally intersubjective structure of meaning is further illustrated, even more graphically, in Holly’s description of how the nurses took care of each other through the tragedy of a child’s death. When she was in charge, Holly explained:
...[and] it’s time to do postmortem care, I tell [the assigned nurse] to go do their charting and I find somebody else, and we go in and we do it, because the worst thing in the world is to code a kid all night, and then be the one who zips the bag up. ... Most of us have that [view]: ‘You don’t do this part. I’ve got this part.’ ... We have a lot of younger nurses...and so many GNs.... [It’s] hard for us, so obviously if you’ve never done this before, this is awful. You know?

Like, somebody the other day was, like, ‘This is torture! Every shift, somebody’s dying!’ Yeah, that’s a good way to put it—it is [torture]. So...in that sense, we take care of each other...you’re not in there doing it alone, you’re not—if your patient dies at 4 o’clock [in the morning] we’ve been very good about breaking the union rules—we’re not gonna send somebody else home with more seniority so you can take their assignment. You’re gonna go home. Like, your work here tonight is done. (H:II:27)

Her phrase, “you’re not in there doing it alone,” expresses well the essence of Holly’s constitution of intersubjective awareness as she faces the ongoing trauma of PICU work. Yet her relationships with fellow nurses do not appear to be the only source of communal support she had developed. Her close, caring relationship with her mother was also an evident source of grounding in her constitution of an internalized awareness of compassionate presence.

“I call my mom on the way home.” Whereas Holly’s husband was unable to listen or engage with her experiences at work, her mother served as an ongoing witness to her suffering. Holly explained that her husband “doesn’t want this to affect me emotionally, even though he knows it does, he doesn’t want to watch that cause my pain.” So, she said, he tells her, “I’m glad you can do [that work], but I don’t want to talk about it with you” (H:II:11). By contrast, Holly felt free to approach her mother to talk at length when she needed to do so:

On a really rough night, I call my mom on the way home, and if I’m going to cry, that’s when I’m gonna cry. And it’s always going to be with her. And it’s never going to be with my husband.... And it’s okay, I get it. ...

So I always tell my mom: she doesn’t have a choice; she’s the mom, she has to listen. [laughs, a different laugh, lighter and higher pitched, almost a giggle] Like—[louder, as if she’s actually speaking to her Mom and crying] ‘Mom, I know this sucks, and I know I’ve done this every day now, every shift I work, for like seven shifts in a row, but can I do it one more time?’ [Holly’s voice combines talking, crying, and laughing here]
And she—she listens. ... And she’s probably learned more about medicine than she ever wanted to know [still crying and laughing, her voice cracking] or just pretends to know—[imitating herself, in a high pitched, stressed voice] ‘...and we couldn’t get a line in, and she’s not gonna get better—’ you know... [her voice returns to its previous quality] ...she just totally pretends she knows what I’m saying. That’s probably my greatest ... source of—get it all out, to Mom. (H:II:11)

This moment in Holly’s account was the only other point in the interview when she allowed the rawness of her emotions to break through fully into expression. Her description also suggested that, given the series of deaths preceding the interview, she had made many such calls to her mother in recent days. Her account indicated no other person with whom she could speak so graphically and honestly outside the PICU, yet this single, deep and strong outside relationship seemed to make a significant difference in her capacity to cope—and perhaps, too, in her ability to accept her husband’s limitations in this regard.

Holly further indicated that her children provided a type of “therapy” for her (see APPENDIX E) stemming from a reassurance she found in her active and enjoyable family life at home with them. This comfort, however, could cut both ways:

And ... then there’s the shifts where there’s like the survivor’s guilt of like ... just as easily as that was her kid and she never expected it to be, that could’ve been my kid last night too. Or that could be my kid in 10 years—that you think you’re doing everything you can, and then he hangs himself and you open your garage door and there he is— And ... so that’s usually part of the ride home too. (H:II:11)

As was the case here, Holly would often, spontaneously recount traumatic scenes with patients or families in the context of describing her relationships with significant people in her own life. This suggested to me that, at the time of our interview, her ability to separate the lived experiences of her patients’ families from those of her own family was particularly fragile:

You can tell when I’ve had a rough night, because if my four-year-old wants to play six more games of Candy Land, we’re gonna play! [laughing] Because you live with this, like— [spoken softly] what if today is the last time? What if this is the last time I play Candy Land with you?
And [louder again] that’s an awful way to live, and you try not to do it, but there are times when you just can’t help but do it. And you just sat with a dad who laid there and said, [her voice transitions to deep emotion, as if she were the Dad she describes] ‘I’m sorry I didn’t let you sleep in my bed last night, baby, I’m so sorry’...as you withdrew [life] support on his nine-year-old [Holly is nearly crying].... And you can’t not go home and ... at least a little bit. ... I don’t want to regret anything. (H:II:12)

Thus, although Holly’s own family offered her a warm and intimate sense of community, they also presented a constant reflection of how fragile “family life” can be. Yet the relationship with her mother seemed to function differently—providing her with an experience of a strong and stable witness, an enlightened witness in Miller’s (1990) terms, who could bear to embrace the loss, sadness, and sustained mourning induced by Holly’s lifeworld in the PICU.

“I don’t know what my manager could offer me.” Holly made clear that she did not take the culture of caring among the weekend-night shift nurses for granted. She explained that in her former PICU, no such camaraderie or support was readily accessible during work hours because of the unit’s larger size and different patterns of scheduling: “You could work three nights in a row and not know anyone working near you in the hallway.”

Yet even as Holly’s current group of nursing peers forged ways to care for each other, nurse managers like those who spoke to Holly in the hallway on the morning of the interview evidenced little understanding of how such support developed or could best be sustained in nurses’ lives. Holly related this gulf in comprehension within the context of describing the debriefing-like sessions the nurses undertook spontaneously, almost nightly, in which they critiqued the wider organizational culture and provided each other with mutual affirmation:

PI: The formal offer of, what can we do to help, and so forth, it seems almost in another world from what you have actually … just kind of seized on as the opportunity arose to provide that for yourself along the way. Is that…?

H: Yeah. Absolutely.

PI: Do you think … the managers you work with have an awareness of the kinds of resources you’re drawing on, and the way you’re sustaining yourself?
H: Uhn-uhn. No. I think … they’re too removed, like, I think they’re aware of somebody going through … multiple traumatic experiences, but I don’t think they’re aware of where that support comes from….

They think that their debriefings with cookies, or the pizza they buy in the middle of the night because it’s been a rough week, like [she laughs quietly] we always call it the death pizza. “Oh, all the kids died. Here’s a pizza, that’ll be better, right?” No. It’s really not, but thanks.

But we were talking about this last night, and everybody was saying, what we do goes above a piece of pizza, or the “perk” which is a little, you know, sticker that you can trade in for some, I don’t know, cafeteria gift card or something … it’s almost demeaning. It’s like…do you get it at all? Like, A: This is my job. I don’t need a gold star to do it. B: Even if it wasn’t my job, we’d do it because we love it and we care about these people. I don’t know, it’s just…it’s almost condescending. (H:II:10)

Similar to Yvonne’s use of the phrase “a little,” Holly’s repetition here of the word “almost” minimizes her likely anger, as well as her insight that the PICU nurse managers’ gestures of “support” not only failed, but backfired badly by sending a message that the PICU staff were viewed like children who could be distracted or cajoled into persevering through difficulties through the use of food or other token rewards.

Moreover, important qualitative differences became evident between Holly’s description of caring for families throughout the excerpts examined above and her description of helping families when she spoke with the two nursing supervisors in a hallway on the morning of our interview (see APPENDIX E for the full excerpt surrounding this passage):

We just talked it out a little, about what I’ve gone through, and how it makes you appreciate your kids more when you go home [talking very fast] and gives you a different perspective in life, and that…these families need somebody at their greatest hour of need, and you’re thankful you can be there, even if it’s hard for you, it’s not – what you’re going through isn’t anything [compared to] what those people are going through. And you just do it. And, that doesn’t make it easy, um – and then – yeah, they just asked if there was any support they could offer… And there really isn’t. I don’t, I don’t know what my manager could offer me that would make going through what we’ve gone through with these families [inaudible] – like, it stinks. And it’s sad. (H:II:1-2)
In this description, while having the conversation with her managers still fresh in her mind, Holly recounts emphasizing her altruism and the primacy of families’ needs over her own. Unlike previous transcript quotations (e.g., see p. 207), she does not allude to the patience or tenderness she demonstrates in her relation to families, or the intimate moments of listening and witnessing that she invites. Nor does she find it possible to convey the comfort she receives from being present with families in this way and sharing in their loss and grief. Rather, in response to her supervisors’ expressions of concern, Holly spoke of “these families” who “need somebody.” She proceeded to speak in sweeping, almost theoretical terms, then explicitly denied the depth of her own suffering: “what you’re going through isn’t anything….” Further, she resisted making space for her own emotional needs, stating “you just do it,” and telling her managers “there really isn’t” any kind of help they could offer. In an added explanatory comment, as if for my benefit, Holly said, “I don’t know what my manager could offer me….”

Doubtless, Holly’s characterization of her experience when speaking with her nurse managers was shaped significantly by existing meaning structures she held regarding their expectations and their capacity to help. As she made clear above, she found her them “too removed” from the life of the PICU to grasp her emotional needs or to respond in helpful ways to her own or other PICU nurses suffering. Yet the very fact that her managers stopped her in an open hallway at the end of a grueling stretch of three 12-hour night shifts to make their offers of sympathy and help, just as she was preparing to leave and go home, itself raises questions—at a minimum about their insight, but also about the depth of their interest or concern for her wellbeing. Holly found a response that was politically expedient: She showed respect while enacting the role of the selfless nurse who appreciated the concern they displayed—yet, she simultaneously veiled the complexity of her feelings and needs. In this way, she maintained
diplomatic relations with her administrative bosses and also managed to leave work and put the weekend behind her in a timely manner.

On further reflection, however, what may be discerned in this hallway conversation is a fairly heart-wrenching failure of communication, support, and understanding. As if a quiet echo of Constance’s experience in the failed debriefing or Yvonne’s experience when “nobody recognized” her exhaustion until she was “called in” for “a little meeting,” Holly in fact found no help in her managers’ brief and superficial displays of concern, nor could she imagine anything they were capable of doing that would ease her experience of trauma. Consequently, she and her managers found themselves enacting a public show of warmth, altruism, and support that actually affirmed a very different structure of meaning—specifically, that there really is nothing anyone can do, and therefore nothing anyone is responsible to do, to ease the present suffering among the PICU nursing staff. The implicit message underlying this meaning structure is a more disturbing directive—we all just have to live with this. Most unsettling, perhaps, as she described the conversation to me at the start of the interview, Holly appeared to agree with this assessment.

Yet she reached quite different conclusions apart from her supervisors. Further, she and her fellow nurses clearly were already enacting fruitful practices support and mutual aid in the relative seclusion of weekend-night shifts. A number of qualities are noticeably missing in the actions Holly described were taken by her nurse managers—among them, the provision of privacy, attentiveness, and the cultivation of a “safe space” for emotional labor. I will examine this further below, under learning.

**The language of traumatic suffering.** When I inquired about the language that Holly and her fellow nurses used to describe the emotional dimension of their work and their exposure to so much suffering, Holly answered, “We call it trauma … and we’re happy to tell people that it sucks” (also see Appendix E). She continued:
Holly: …we all recognize that this is traumatic to walk through these times in people’s lives with them.

PI: For you all.

H: Yeah, like, it’s our trauma too. I think we all recognize that, and talk about that … and we’re happy to tell people that it sucks. [sardonic laugh] We tell each other, you know, that it sucks. (H:II:6)

Though Holly did not state this explicitly, her descriptions evidence that she was among the more senior nurses who helped to cultivate such a climate in the PICU, at least among the weekend-night staff. It was a climate that not only allowed, but encouraged stark honesty—that it “stinks” and it “sucks.” No other terms used in the published literature arose in Holly’s account: only trauma. Yet Holly made clear that at night, the nurses spoke privately and freely about how they felt and what they thought with no inclination to euphemism or political correctness. “Somebody the other day was, like, ‘This is torture! Every shift, somebody’s dying!’ Yeah, that’s a good way to put it—it is. So ... in that sense, we take care of each other...” (H:II:7). Their ability to critique the broader nursing culture of the PICU, including actions by supervisors such as those presented above, also appeared to be an integral part of their work to bring substantive language to bear on the climate of suffering in which they worked.

Holly acknowledged that the pace of night shift allowed the nursing staff more time and space for confidential speech and reflection to arise within the flow of their work. By contrast, on day shift, Holly suspected that the nurses miss out on the directness and depth of interaction that she so appreciated. “It’s just the nature of the beast…. There’s more time for that on night shift and … specifically, weekend night shift is just … close. So I don’t know that that exists as well [during the day]” (H:II:10).

**Learning in response to traumatic suffering.** Like Yvonne, Holly had pursued a variety of educational programs to support her learning with respect to traumatic exposure and, also like
Yvonne, her descriptions evidenced it was ultimately the relationships she developed in these contexts that were most instrumental in supporting her capacity to cope with STS. Holly’s account also made evident that she was herself an important mentor, particularly for newer nurses in the PICU, with regard to coping with secondary trauma while sustaining empathy and engagement with patients and families. She stated explicitly that she accomplished this guidance with newer nurses primarily through the “modelling” of actions.

Holly described having come into this capacity gradually, starting with her first year of work in the larger PICU where she was able to focus primarily on the “medical part” while learning the “family part” of care more slowly. Once at ASMC, however, Holly worked steadily to develop her capacity to provide emotional and relational dimensions of care and, with this, to become an intentional model to other nurses for how this care is given. Yet she never minimized the difficulty of working with families of dying children:

Holly: No one can meet the family’s needs. Like, the family’s needs at that time are far greater than anything any of us can do, right? …Let’s do the best we can. So, I feel like, not only are we doing the best we can for the family, but hopefully we’re helping another nurse eventually be able to do the best they can for the family too. So, that’s….

PI: Where did you learn this?

H: I just really like palliative care. [she lets out a soft, almost embarrassed laugh] I don’t know why, I….

PI: Do you feel that this is something you figured out as you went, or do you…?

H: I do—I’ve gone to classes, I mean, I seek out opportunities to learn more. Um … I’ve developed really great relationships with families who have lost children, and been fortunate enough to be able to talk to them a year later or two years later and say, ‘What was helpful to you? What did you not want to hear? What did you not want someone to say or do?’ (H:II:8)

Thus, Holly had herself learned by being mentored—less by other nurses, perhaps, than by the families of former patients with whom she had developed significant, trusting relationships, then sought out as teachers. Her vulnerability and tenacity to initiate and pursue such intimate forms of
learning are striking, yet consistent with the relatively autonomous learning that both Yvonne and Constance undertook. And Holly’s learning, like theirs, was often informal.

Aside from her treasured relationships with other weekend-night nurses and with parents of former patients, Holly also cultivated valuable relationships that had begun in the context of formal educational programs, such as a medical residency training program on end-of-life care and conversation where she served as a mentor:

Holly: Our…residency program got a grant [for interdisciplinary] simulation experiences for end-of-life conversations. So we take [a medical] resident and … [there is] a paid actor in a clinical situation, which is usually related to … [an] end-of-the-road [diagnosis, and a] withdrawal of [life] support, making the best decision for the child…. [The resident has to have] this conversation with the paid actor [playing the role of a parent]. And we watch it as a multidisciplinary team … from another room … [we’re] really a cohesive group.

And we make comments as we go, our team talks, [and then] we bring in the resident, and we talk to them about what went well, what [they] could’ve done differently, what we’ve seen work with families, what we struggle with. So they really like, utilize—and our one attending [staff physician] that I’m very close with sought me out to be the nurse that represents nursing…. I think that has helped me learn a ton because, as a team we talk about it, so you’re getting that feedback about stuff’ [suddenly whispering] you really don’t talk about a lot….

PI: Stuff you…?

H: [louder again] —you really don’t talk about when you’re on the floor. Like, nobody walks away from a death and says, you know, ‘Dr. Bob, I really liked how you had that conversation with the family.’ Or, ‘You know what I heard?’ Or, ‘Do you know what that mom heard? What you said and what she heard weren’t the same thing.’ And, ‘Do you know they’re getting a mixed message?’ So, talking about that outside the unit is really helpful…. (H:II:9)

Here, Holly suggests that her own learning grew from intersubjective meaning-making activities that were embedded in vulnerable dialogues held among professional peers—and then further in conversations with medical residents. Initially, even the opportunity for her learning here was grounded in her relationship to the attending physician with whom she was “very close … [who] sought me out to be the nurse…” on the multidisciplinary team. That team, in turn, became very “cohesive,” taking risks in their conversations with medical residents and each other as they
sought to deepen their collective insights about how to guide conversations with parents regarding their loss of a child. These cross-disciplinary activities created rich soil (recalling Berry’s (1990) metaphor) and a culture of relationships that was sufficient to support learning like this, so that difficult but crucial knowledge could take root even in the context of sorrow.

Moreover, the confidential and cohesive relational dynamics that Holly outlined in the simulation training program suggest parallels with the structure of relationships and dialogue she experienced with the weekend-night nurses. Specifically, both settings were relatively cloistered and protected in terms of privacy and confidentiality, and both featured a structure of dedicated time and proximity that encouraged significant and sustained dialogue. Moreover, like the PICU at night, the simulation program seemed to offer a peer-to-peer quality of encounter among the various professional representatives involved. Further, both settings presented a culture and climate that tolerated uncertainty and valued emotional life. Finally, while Holly does not describe this explicitly, in both settings interactions surely took place that were unexpected, uncomfortable, even conflictual, but were tolerable within those contexts of cohesive support and so initiated processes of developmental change in the consciousness of those involved.

Holly’s account thus presents, in essence, a structure of useful learning in response to STS that is comprised of intersubjective meaning-making through the relational activities of mutually bearing witness and embracing mourning as a shared, even ritual practice among caring peers.

**Static Meaning Structures for Holly: [H]**

**The structure of secondary suffering and traumatic stress.** For [H], a critical care nurse’s experience of bearing witness to profound suffering comes down to coping with frequent traumatization—her own as well as her patients’ and that of their families. As she progresses beyond shock and anxiety in the face of frightening machinery and sudden emergencies, the
realization grows that it is sometimes possible to help patients get better, and one’s skill at helping
does grow. Raw fear gives way to a “healthy fear” and a sense of vigilance, given the realistic
understanding that anything can happen with any patient at any time.

But while inward confidence grows, “confident” is never fitting in the outward
environment. There is fulfillment in easing a traumatic situation or seeing a patient get better,
though it remains a grim form of satisfaction—helping families “in their greatest hour of need” as
a child is allowed to die or is sent home with little hope of recovery. It’s not just that “it’s sad”
and “stinks” and “sucks”—it can be “torture.” For helping requires “going in” to others’ painful
experiences; at the same time that a nurse must “stay out” for her own wellbeing—empathizing
without over-identifying—a balance that is extremely hard to sustain. Such empathic practice
makes it impossible to avoid the disturbing realization that tragedies touching patients and
families might also touch one’s own life and family—the terrible knowledge that “it could be me”
or “mine.” Thus, psychological over-identification and “survivor’s guilt” can “scare you to death”
and send a nurse “over the edge.”

Yet an empathic connection is what patients and families need most and what has the
potential to render even the most tragic scenarios less painful, more meaningful, and less
traumatic for everyone involved, including the nurse. Thus, a critical care nurse lives with the
embodied experience of her physical and relational attempts to help, to heal, to protect, all the
while accepting the lived constraints that she often can do none of these to the extent she would
wish. From “odd, unexpected, shouldn’t happen” kinds of deaths on the one hand, to intractable
incurable physical states of suffering on the other, bearing witness to the experiences of
chronically and terminally ill patients means living with the knowledge that there are often no
good solutions and little one can do to make things “right.” A nurse must learn to accept doing
“the best we can” and derive implicit fulfillment from acts of empathic relationship. Supporting
fellow nurses and receiving their support is a crucial counterbalance to the practice of empathy toward patients and families.

The structure of language for understanding traumatic suffering. For [H], having a language for secondary suffering means straight-out calling it trauma—voicing that the experience of watching children die is extremely traumatic for nurses, though in a different way than for patients and families. It is crucially important that nurses feel free to say what they really think—somewhere, sometime, with someone—and trusted fellow nurses who share similar experiences are often the best confidants.

Cultivating such stark honesty among nurses who work together regularly can be accomplished at a high level of intimacy in the quiet and seclusion of night shifts—relative to the frantic pace and burgeoning interdisciplinary staff activity of the days and evenings. The pace and routines of night shift permit greater perceptual space for confidential speech and reflection to arise within the flow of work. In this context, a familiar group of nurses can find themselves giving voice to spontaneous as well as reflective impressions of pain and trauma—telling each other that the work “stinks” and “sucks,” is “torture” and is “sad,” yet implicitly serving as witnesses for each other. A perception of psychological safety develops, further cultivating openness and trust. Nurses can then find themselves able to build meaning cooperatively, as they voice their own pain and respond to each other’s.

Such language makes it possible for them to understand one another, to take risks, and to give and receive demonstrations of caring and support.

The structure of learning in response to traumatic suffering. For [H], learning to cope with the experience of bearing witness to suffering is a journey into an embrace with mourning. It requires an ongoing succession of practice in the arts of witnessing, empathizing, reflecting on lifeworld encounters and embodied responses, receiving compassion as well as offering it,
speaking frankly as well as listening carefully, and drawing hope from the recognition that relationships can be an abiding source of comfort—if a nurse can bear to be open and vulnerable.

Learning through watching and, more profoundly, through empathic witnessing builds a psychic foundation for cultivating such capacities, so long as it is combined with the experience of being regularly cared for and supported by more senior colleagues. The freedom to give honest voice to one’s own pain, in relationship to colleagues as well as with family or friends, is a crucial element in sustaining one’s learning endeavor to survive psychically without becoming emotionally callous and closed.

Being a mentor to others is a further source of learning, by way of synthesizing one’s experience while testing and integrating it in relation to the experience of others. Finally, the capacity to give open, honest voice to suffering depends on a culture of acceptance and respect among colleagues at work. Such an environment not only better sustains seasoned nurses; it cultivates empathic growth and higher levels of caregiving expertise in newer nurses as well.

**Findings II: Generalized Static Meaning Structures**

**Synthetic Structure of Secondary Suffering and Traumatic Stress**

For a critical care nurse, bearing witness to profound suffering is an experience of ongoing labor to survive an internal crash of extreme, opposing sensations, actions, emotions, and ideals. It is the crash of helping and hurting, of hypervigilance and exhaustion, of imposing control and feeling helpless, of obsessional attachment and a need to escape, of wanting to scream or cry yet feeling unable to listen or speak. This experience is physically debilitating, mentally numbing, and emotionally crippling. It may subsume a nurse into a state of wordless shock, vicious anger, cold indifference, and even, potentially, into a pattern of hollow and mechanistic practice. On the other hand, when tempered by empathic witnesses with whom a nurse can voice her pain and
mourn many kinds of losses, the experience of secondary suffering and traumatic stress may become a crucible for learning, a catalyst to action, and a developmental foundation from which a nurse may forge a previously unimagined path for her professional practice and personal life.

**Synthetic Structure of Language for Understanding Traumatic Suffering**

A language by which to name and understand secondary suffering is not an object to be attained and mastered. It is spectral and ephemeral. Words matter—they help to objectify and make visible the most elusive experiences—but they are not altogether determinate and discrete. Rather, they reflect moving facets in a holographic lifeworld of experience that is encountered and defined intersubjectively. A nurse’s words for secondary suffering are forged in the heat and chill of 3 a.m. full codes and in the stillness of a room where a body awaits transport to the morgue. The language of secondary suffering thus envelops a horizon stretching from breathless narratives to wordless, empty pain, yet becomes manifest only in relationships, in the witnessing of one person’s experience by another. For this reason, the language of secondary suffering is dangerous—it evokes the process it describes—calling into presence and intersubjective vulnerability the one who would listen. It is an unseen phantom that both frightens and frees. For this reason, in the lifeworld of critical care nursing, acts of speech and acts of listening are radical and courageous achievements that bear seeds of change: the potential to transform relationships, workplaces, and the history of a profession.

**Synthetic Structure of Learning in Response to Traumatic Suffering**

For a critical care nurse, learning to cope with experiences of traumatic suffering involves an evolutionary development of two forms of insight: insight about the culture within which a nurse practices, and insight about her own perceptions, needs, feelings, and priorities.
Learning to decode unspoken intersubjective expectations and informal commandments within a particular critical care setting is a crucial prerequisite to learning how to survive psychically within that environment. Formal venues within the clinical setting, such as critical incident stress debriefings (CISDs), often vary from being helpful, to tedious, to being traumatizing in and of themselves. For this reason, informal venues are valuable and often preferable for nurses: They arise spontaneously between colleagues or with a nurse’s close family or friends, wherever trust has been established through a common history, through consistent demonstrations of respect and consideration, and by the slow forging of shared understandings.

In the context of such relationships, learning can flourish through modelling, mentoring, and giving genuine voice to one’s mourning in the company of witnesses who can bear to listen and show concern. A nurse learns by finding such witnesses, as well as by becoming such a witness to others. Yet the act of bearing witness to others’ open and honest accounts of suffering may itself be a precarious act—evoking the traumatic experiences to which it attends.

For this reason, learning to cope with traumatic exposure further requires a nurse to develop insight about herself—her needs and her limits, emotionally as well as cognitively and physically. This learning involves cultivating a capacity to frankly acknowledge to oneself periodic internal crashes of perception, cognition, and emotion, to step back and reflect on what is happening both inside and outside of oneself, then to make decisions and take actions to adjust oneself and one’s level of workplace trauma exposure.

The latter enactment of learning may include a nurse developing more numerous and varied forms of self-care, more support in close relationships, more intentional self-compassion, as well as limiting the depth and intensity of her work with “the worst,” most traumatized patients for a period of time. Actions resulting from such learning may also include a nurse’s decision to leave a setting without self-reproach, when she concludes it is “not a good fit” for her any longer.
CHAPTER SEVEN
RECLAIMING EXPERIENCE:
FROM VOICE AND MOURNING TO LEARNING AND PRAXIS

...[T]he Runt blasted off again, shouting... “YOU KILLED POTTS! You drove him nuts about the Yellow Man, and you didn’t help him when he was crying for help. If an intern sees a shrink, you...think he’s nuts. Potts was scared that if he saw Dr. Frank it would damage his career. You bastards, you eat up good guys like Potts who happen to be too gentle to ‘tough it out’."

“You can’t say that about me,” said the Leggo sincerely, looking crushed. “I would have done anything to save Potts, to save my boy.”

“You can’t save us,” I said, “you can’t stop the process. That’s why [we’re leaving]...we’re trying to save ourselves.”

“From what?”

“FROM BEING JERKS WHO’D LOOK UP TO SOMEONE LIKE YOU!” screamed the Runt.

“What?” asked the Leggo shakily, “what are you saying?” ...
“What we’re saying is that the real problem this year [has]...been that we didn’t have anyone to look up to.”

“No one? No one in the whole House of God? ... You can’t mean that, no.”

“What we mean, man,” said Chuck forcefully, “is this: how can we care for patients if’n nobody cares for us?”


Findings III: Genetic Data Analysis and the Structure of Learning

“I love what I do, but because I don’t have support, I’m going to leave. And I know that... I’m exactly where I want to be, but things like that ... is why people leave. And I find that so sad.”
—Constance (FG1:36)

How can nurses, or doctors or other helping professionals, care for others if nobody cares for them? Further, without such care and support, how can nurses or others who engage with powerful traumas experienced by those for whom they care, remain present to their work in any sense of the word? It is not hard to anticipate or understand that, on many levels and in many
forms, those who are consistently so exposed will leave. They will leave in the body—changing jobs or changing professions. And before that, they will leave in mind and heart by divorcing themselves intellectually and emotionally from the embodied experiences they encounter. They will become depersonalized technicians, expert machines, indifferent to the pain of others.

This chapter presents a dynamic interpretive meaning structure that I characterize as genetic. That is, it is enhanced by an approach to the data that examines two emergent axes of experience within the study: the passage of time and the development of relationships among the nurses. The structure presented here is generated through analysis of data from the focus group stage of the study. As discussed in chapter five, the focus group was held one month after one-to-one interviews and involved two of the three nurses: Yvonne and Constance. Through their rich interactions, I investigate the impact of time passage (since the individual interviews) and of intersubjectivity on the two nurses’ constitutional processes. In particular, I seek to discern developmental changes in critical psychodynamic forms of meaning-making—outcomes that I have argued comprise instances of informal learning. In contrast to chapter six, however, separate structures are not generated in response to each of the three research questions. Rather, the focus here is upon learning. Thus, a single, more complex structure is presented that incorporates attention to all three major research questions.

In addition, the analysis presented here is somewhat freer in terms of the imaginative dimension of eidetic analysis. I explore the nurse’s interactions liberally in relation to the adult education and psychoanalytic literature I have reviewed. I also draw on the intersubjective relations between the two nurses and myself by examining periodically my own responses to them and considering how their meaning-making may even be reflected in my feelings, thoughts, and responses. This use of an intersubjective lens that includes consideration of my experience of
the nurses as part of the data relevant to phenomenological analysis of their experience is supported by the psychoanalytic principle of transference and counter-transference.

According to this theory, painful internal meaning structures that are not readily verbalized (for example, due to an experienced need for psychic repression), may instead be enacted in various other ways, by the back door, in the context of significant relationships. Meanings of these kinds, as they are excluded from front door movement through consciousness, must engage other means of expression than rational verbal accounts. Typically, they employ nonverbal, yet nonetheless intersubjective “showing” rather than “telling” of difficult knowledge from the consciousness of one person to another. During genetic data analysis, I have sought to open my awareness to the possibility that nonlinear, possibly non-rational forms of expression might have operated at the focus group stage through my own relations with the nurses.

Based on these approaches to data analysis, the present chapter concludes with a genetic structure of learning in the context of secondary trauma and peer relationships. It is my intent that this concluding structural essence will provide not merely a cross-sectional snapshot of the experience of learning, but a relatively dynamic portrayal that reveals the spectral nature of trauma and the iterability of human responses to it, as expressed in the trauma literature.

Secondary Suffering: Learning over Time and in Relationships

The first focus group began with my invitation for Yvonne and Constance to speak of their experience with the research process thus far, along with developments in their work since our last meeting. They both expressed that work had been “better”—fewer deaths in succession and less stressful schedules and types of caregiving. They also described surprise at the sheer volume of memories and details they each had related in the individual sessions (both had reviewed their own transcript). Both further expressed a sense of relief and comfort derived from the opportunity
to share their stories, in the words of Constance, with “somebody that understands—that I could talk to, and describe a situation, and not have to edit myself” (FG1:8).

These responses immediately elicited further stories. Constance recounted an event that had occurred since our individual interview, in which she witnessed STS in a senior ED nurse. A young disabled woman was brought to the ED by her family for treatment of complications from a shooting sustained several years earlier in a mass trauma event. Constance’s senior nurse had been a primary caregiver for the patient on the day of the mass trauma, and when she realized the young woman arriving in the ED was her patient from years earlier, she became tearful and distressed. Constance explained:

And she’s like, she’s like—‘you don’t understand – I don’t even work on [the anniversary of the shooting]. I don’t work on that day.’ She said, ‘I was her nurse. I received her in the trauma bay when she came in.’ And she said, ‘I took her up to the ICU, and after I was done turning her over, I fell to the floor and cried.’ [Constance is herself crying.] And she’s like—‘because you don’t understand, my husband has to—my husband doesn’t even know what to do with me on that day.’ And she goes, ‘I’ve tried to [do things to help] ... and I just can’t...’” (FG1:7)

Constance related this story for several reasons. First, this account represented an entry point to discussing the multiple ripple effects of secondary trauma: for though Constance “wasn’t even a nurse then,” the original event was impacting her years later as she witnessed her senior nurse’s distress and realized that nurse still suffers posttraumatic effects from her caregiving work on a day years ago. This echo-like effect comprises a tertiary degree of trauma impact on nurses.

Second, Constance relayed this story in preface to describing a significant interaction with her own husband. For the young woman’s current ED visit, Constance was the primary nurse and she was deeply moved by the love and commitment shown by the family, who clearly had provided her with outstanding ongoing care for years since the event. When Constance got home
and attempted to share her sense of inspiration with her husband, she had to explain the prior context of the shooting, and he responded in a way she did not expect:

He’s like—‘Stop! Stop talking to me!’ And [he] just started sobbing. He’s like, ‘I can’t hear that.’ And I thought—and I said—but I didn’t get to the good part yet. ... I felt awful that I did that to my husband ... you know, I wanted to say to him, look how they took care of her, look [how they love her] ... [but] once I said the gunshot went into her head, he just—lost it. And I still don’t know why that affected him so much. ... [But] that night really affected me, cuz I felt really bad that I made my husband so upset. ... And I realize that I can’t talk to my husband anymore.... I really hurt him, and ... the only thing he said is, ‘I don’t understand why people can be the way they are.’ (FG1:7-8)

At this point, Yvonne offered her perspective that Constance would need to “have this conversation” with her husband to rebuild understanding with him and perhaps find a better resolution. Yet she agreed with Constance that it was possible she would no longer be able to turn to him for this kind of support.

It is important to note that this is precisely what Sheppard (2015) heard from 16 nurse participants in the qualitative field study phase of her investigation regarding the suitability of the ProQoL-V for assessing STS in nurses. She wrote: “All participants described wanting to talk to a partner, friend, or family member after work. In every case, the attempt to talk actually caused the nurse more distress,” which resulted, she explained, from the nature of the other person’s response—either their distress, or their “asking too many questions” or trying “to fix it instead of just listen” (p. 58). Eventually, the nurses Sheppard interviewed indicated they “began to push away from the potential source of support” (p. 58). Yet because the ProQoL-V poses no queries regarding this type of experience, Sheppard concluded it is not capable of detecting this evidently common effect of STS in nurses.

In the case of Constance, she was faced with the necessity of pulling away from her husband in order to protect him, more so than herself. She listened and responded openly as Yvonne shared her thoughts, then she asked Yvonne a question:
Constance: Have you had that before? Have you had a time where you’re just talking to somebody close to you, and then you realized that…. 

Yvonne: Yeah. It happens a lot. Yeah. Yeah. (FG1:8)

Constance’s manner of interacting shifted in this moment. She paused from narrating the seeming freight train of stressful, traumatic events that raced so unrelentingly through her perceptual world in the ED. Instead, she asked a vulnerable question of someone she was quickly growing to trust and respect, so as to glean a wider context and some assurance about the nature of her own experience. The interaction that followed presented parallels with the kinds of interactions Constance described between herself and her informal mentor in the ED, Penny. It suggests that Constance indeed sought and was receptive to supportive mentoring—when she could find it. For Constance and Yvonne, this shift continued to deepen over the 90 minutes that ensued, gradually manifesting an intersubjective, structural pattern of vulnerability, openness, kindness, and mutual support.

What became apparent in this conversation and the intersubjective activity that evolved through the balance of the meeting is the very formulation that Forester (1999) invoked when he wrote about the crucial place of “voice and mourning, mutual learning and action that recognize and respond to [people’s] needs and interests” (p. 220). The evolving dialogue also exemplifies Britzman’s (2013) conception of learning “as an emotional situation” (p. 95). Constance’s individual account evidenced that she found very few senior nurses in the ED who were capable of recognizing and responding to another nurse’s emotional need to give voice and to mourn tragic encounters with patients. For Constance, there was only Penny, and in one brief instance, the nurse who led the SIDS baby debriefing and “was the only one who said” how sorry she was the day Constance returned from taking the three-year-old gunshot victim to the PICU. In the focus group meeting, however, it appears she began to identify such a companion in Yvonne.
For Yvonne’s part, her interest and concern with supporting newer nurses was well matched to the needs and interests presented by Constance. Moreover, they found they had a number of shared perspectives from which to explore their experiences with STS. For example:

Constance: …some of the newer nurses ... I sit there and I think to myself—these girls are 23 years old.

Yvonne: Um-hnn.

C: They’re so young, and they don’t know how to process emotions ... you know, they haven’t had life—on top of—it’s not just nursing experience, it’s *life experience*, and learning how to put your feelings, and what to do with it—they don’t have that yet.

Y: Right.

C: And it makes me sad for them sometimes. You know, there was a pediatric—a SIDS—that they tried to resuscitate and—they couldn’t. And my one friend, she’s young, and I found her in the soiled utility room just—crying. And she didn’t want anybody to know. She was afraid the other nurses would know.

And that’s just so sad for me. They ended up having a debriefing shortly after, but she was like—and she said, ‘I don’t know why this is bothering me so much.’ And I looked at her and—[quick sardonic laugh]—‘Of course it’s bothering you!! It was a baby!’ I mean, ‘It bothers you because you want a baby, and because, you know, you just saw the parents…!’

Y: Right…. (FG1:13)

Here, Constance was beginning to constitute a meaning structure that explained features of another nurse’s suffering, such as the symbolization that links another’s trauma with one’s own desires or sorrows and the importance of self-acceptance toward one’s unique rendering of traumatic content. Further, she was drawing on the depth and breadth of Yvonne’s pediatric critical care experience and self-understanding in order to test her constitutional process:

Constance: Now I can say that to her [laughs]—no problem! But I—for yourself, to work yourself through that is hard. But the more experience I’m getting, the more I don’t care if somebody sees me upset.

Yvonne: Uhm-hmm! [agreeing]

C: You know, the more secure I am, and it’s like, ‘No…!’
Y: Uhm-hmm. [supporting Constance]

C: [to Yvonne] And I’m sure you experience that – the more you go along, the more you’re like—‘Yes, I’m upset—this bothers me.’

Y: [interwoven speech] Uhm-hmm…. It’s a process.

C: Yeah.

Y: ’Cause at some point you figure it out, it truly does bother everybody…. (FG1:13-14)

The possibility of observing learning as I have defined it, rather than gathering descriptive accounts only, was realized in such interactions as this. Here, Constance is learning by working through contested interpretations of experience—inside-outside conflicts of meaning and significance (Fenwick, 2000). She is also learning by giving voice to her mourning (Forester, 1999) and claiming the emotional situation in which she practices nursing, rather than allowing it to become silenced and lost within her (Britzman, 1998, 2013).

Yvonne, too, shared stories of past experiences. When I asked both nurses to recall an incident when their psychological needs were not met and describe what that pain was like, Yvonne recounted a time in which she provided support to the mother of a 15-year-old boy who sustained brain damage, just short of clinical brain death, after a sudden cardiac arrest during a soccer game. The multi-generational family involved was of traditional Eastern European cultural orientation, and the male decision-makers sought every form of life-sustaining treatment in the hope this eldest son would recover. Short of that, it was presumed that “Mama will take care of him.” Yvonne sought a private conversation with the mother, in which she learned that “she knew [her son] would not want to live this way…. She was happy to care for him … but it was so heartbreaking to know that she had such strong feelings … [and] knew he truly would have wanted to die” (FG1:21). Yet despite the insight Yvonne gained from this interaction, she realized
that there was no way she could advocate for either mother or son, given the strongly established paternalistic structure of the family. Yvonne tried to express how this affected her:

Yvonne: …knowing how she felt, and just being completely helpless to change [the fact that she] was not allowed to even say [what she thought] to anyone in her family. So, I think it was the frustration—wanting to help her, in a way to make it better for her, but there was no way. There was not going to be a way to make it better.

PI: How did you take care of you in the weeks that followed? [Did you] already know things that you could do to help yourself …

Y: Not so much—

PI: ...or was it early on, when you….

Y: No, no...um...wow...I don’t know that I remember so much. I really don’t, um ....

PI: Was that a time when you really didn’t have a lot of ways of…?

Y: I didn’t. No, I didn’t. I remember thinking about it. Um, but I don’t remember what I did to make it better. And if I did, it was totally without consciousness. I had no idea that I was, like—‘Okay, today, I need to go for a run.’ ‘Cause that was really awful, which I know now, but then I didn’t.


Y: Yes. Yep. Yeah, because there were very, very few people who knew that conversation between mom and I even took place…. (FG1:22)

Bearing witness alone turned out to be almost unbearable for Yvonne at a time, early in her career, when she had limited knowledge and few established practices by which to care for herself and make her way through the felt helplessness and grief she experienced.

Yvonne, moreover, had not spoken of such a feeling in our individual interview—i.e., of a time when her psychological and communicative efficacy was entirely blocked by the caregiving situation she faced. It is significant that she could not recall what she did to get through this painful time—a clue, perhaps, that she was not at ease, still, with her way of doing so. During the group discussion, we joked that I asked “hard questions,” but Yvonne was willing to embrace the difficulty and uncertainty of trying to answer here. In our individual interview, on the other hand,
although she was indeed unclear about chronology and linkages at times in her account, it was not common that she stated directly: “I don’t know” or “I don’t remember.” Her willingness to do so here may have signaled a progressive change in her openness to revisiting experiences that were relatively opaque in her consciousness, and very likely still painful.

From the perspective of a psychodynamic theory of learning, then, Yvonne was working with the forces of interference and resistance in order to integrate lost and found facets of her awareness. Her loss of memory about her own ways of coping suggests a lost subject, and so a strand of unclaimed experience, which may be traced to the deeply painful events with which this strand of experience was associated. On the other hand, Yvonne recalled the mother and the son quite vividly, as well as her conversation with the mom and her own sense of isolation and defeat. Had Yvonne found more support, or had available more tools for psychic self-care, would she have remembered her actions and their outcome, as she remembered the “awesome perspective” she gained after walking out of the “little meeting” with her supervisors and traveling across the ocean with a close friend for nearly three weeks?

**The Language of Suffering: Learning by Voicing Experience**

Constance concurred with Yvonne during the focus group that the term CF was a preferable alternative to the more common term, burnout. Neither felt, as Sheppard (2015) found with many of the nurses she interviewed, that CF implied a loss of compassion:

Yvonne: …when I was having—I had a little bit of trouble with, as we call it here, “burnout,” but we used to call it “compassion fatigue” were I lived …

Constance: Huhn…I like “compassion fatigue.” [laughs] It makes me … it makes it –

Y: …not feel so hippie-ish, huh?

C: [laughing] No, it’s not that. It’s just makes it feel … not so final. ’Cause when you say “burnout,” you—
Y: You’re done. Uhm-hmm.

C: [echoing]—that’s it, you’re done. But compassion fatigue means maybe you can come back from it.  (FG1:29)

No other terms were raised by the nurses in the first or second focus groups. Their work to render trauma exposure into language operated less in terms of finding labels by which to designate experience than finding intersubjective validation of the quality of particular experiences. This may reflect the exploratory nature of these meetings, in which the nurses were getting to know each other, though in the case of Constance, it surely also reflects the fresh, raw quality of her experiences in the ED. Consistent with a phenomenological formulation of the work of consciousness, such immediacy tends toward wider ranging constitutional processes—i.e., preliminary generation of broad mental structures capable of comprehending unfamiliar objects and events. This work precedes more abstract, symbolic constitution of morphological essences, where succinct terms can suffice to represent entire categories of experience.

In particular, employing language to name experience functioned significantly in terms of designating particular facets of the emotional response to trauma. Again, for the most part, the nurses showed little interest in highly abstracted terms to designate their experience, such as STS versus VT or CF, but rather focused on the value of naming more particular elements of internal experience, such as difficult emotions like anger:

Yvonne: Where I worked before, we had this young nurse, and there was a baby that died of an infection. And we had a debriefing after. And, um, she actually had to run out of the room—our docs were awesome ... so one of the doctors went out with her. Actually, I went out, and one of the docs came out. And she was so upset and angry at the parents for not bringing the baby in sooner. But it was so important for her to say that …

Constance: Yeah.

Y: …and get it out.

C: Uhn-huhn.
Y: And she was just crying, and she was just, like ... but for her to be able to validate her feelings, and not [feel] wrong feeling them, was really important.

C: Do you have debriefings upstairs the same way that you did at your other facility?

Y: We have them, but I’m not quite sure what goes on in them. I haven’t been to one yet. And I know that they have some that are purely the science of what happened. But I don’t know if they have any that are just, like, free-for-all, talk, express your feelings—and we, we did [at the previous hospital], and we had—our docs came, and, actually, talked about how they felt about things. Ah, but I’ve not been to one here. I’ve either been not available or just—I just haven’t gotten to one.

C: Hmm…. We’re struggling with our debriefings, and…. Y: What are you struggling with...?

C: They’re struggling with creating a proper debriefing.

Y: Uhm-hmm, very important. (FG1:14)

I will return to the notion of a “proper debriefing” below.

For both Constance and Yvonne, forming deep connections with one or more trusted friend represented a crucial tool in their ability to bring language to bear on their experiences with trauma exposure at work. It appeared that such friendships made it possible for these two nurses to explore their own constitutional processes aloud with a witness, yet without judgment, for the invariable element was an ability to speak freely and spontaneously, without the interference of being questioned, criticized, or even comforted:

Constance: I can be with [my friend] Sandy and I don’t have to censor myself at all. I can say anything to her, she won’t be offended—

Yvonne: Yeah.

C: She won’t judge me, she won’t—nothing. If I start crying on her shoulder though, she’s not going to hug me. She’s not that person.

Y: Yep.

PI: But she’s also not going to go—‘I can’t listen to this!’

C: ...that’s why I go to her. I can go and talk about things and not be judged....
Y: Sounds like my [one] girlfriend. She’s the same.
C: Yeah.
Y: One of those non-judgmental, talk-about-anything kind of people.
C: It’s nice to have one of those.
Y: Yeah…. No matter what, you can say it. (FG1:19-20)

**Critical Praxis in Community: Learning by Contesting Experience**

As potent as the entire meeting between Yvonne and Constance proved to be, by far the most powerful moments were those involving Constance’s revisited descriptions of “the worst of the worst” day in her ED career, that of the train accident. (Please see the excerpt of this portion of the focus group in sample data analysis, APPENDIX F.) These portions of the conversation opened profound breaches between the descriptive content Constance offered in our initial interview and the descriptions she offered in the temporally and intersubjectively extended context of the focus group session. Specifically, Constance revealed several elements in her experience that she had omitted completely or alluded to only vaguely during our interview.

The first of these breaches involved Constance’s feelings in connection with the bereaved father that day. During our one-to-one meeting, she had stated, “I never wanted to see the husband … and I ended up having to. And that really bothered me. I never wanted to see him….,” She did not explain this, but moved on in her account. Yet when she spoke with Yvonne, Constance volunteered the reason why it “really bothered” her. She described her immense effort, along with two NICU nurses, to prepare the body of his newborn so the father could “hold his baby—like, clean, and wrapped in a little blue bundle” (FG1:24). Then she continued:

Constance: And it … it devastated me … something inside me will never be the same after that.
Yvonne: Uhmm-hmm…
C: And then...they came back and gave me the box with [the photos and handprints] in it, and the two [NICU] nurses and I went to present it to him. He was holding his son, and...I went to give it to him and he was almost at that moment...annoyed with us. ...I sat the box on the table. I said, “Do you want to see anything?” He said, “No.” And I left, and for some reason, I was angry that he does not know what we went through...

Y: Uhm-hmmm...

C: ...for him. Like, I mean, the sacrifices [we] made—and I still have that pain in my chest, that...anger, and hurt that nurses do that for somebody and you can just dismiss them. ...That was really, really hard for me...for when he had the chance to look right at us...he’ll never see us again. And I thought—God, how awful of me to feel that way. (FG1:24)

Constance went on to reproach herself for her anger toward the father, as presented in the data excerpt and analysis (please refer to APPENDIX E). This, in turn, led to an extended emotional and critically reflective interaction between Constance and Yvonne, in which I sought to maintain my role in the background as a compassionate witness. Intersubjectively, Constance and Yvonne undertook Forester’s (1999) tetrahedron of transformative activity: voice, mourning, learning, and action. Upon Constance’s decision to give voice to her anger and hurt in the presence of Yvonne and myself, she entered into an opportunity to mourn with the supportive presence of witnesses who could comprehend the nature of her pain. This mourning opened a space in which she revisited her experience and reflected on it—not repressing or rigidly reproducing a particular construction of lived events, as Forester (1999) warned can be a risk of engaging publicly with traumatic history—but instead re-presenting them more fluidly and fully through an attentive intersubjective exchange.

I find this to be precisely the kind of relational activity suggested by Miller (1990) when she described the potential of enlightened witnesses to help catalyze pivotal change in a person’s perspectives and life trajectory. During this dialogue between the two nurses, facets of consciousness that had been silenced and all but lost to Constance—banished in shame—were given voice. As she was given a safe space to mourn these embodied facets of her awareness, she...
then became more receptive to the reflections of her witness, Yvonne. A tentative, then more robust discourse of intersubjective reappraisal and reconstitution of meanings ensued. All these activities comprise learning.

As intense as this interaction was, it did not come to an “end,” with the nurses moving on to other descriptions of a casual or more superficial quality. On the contrary, these moments in the session became a reference point and a portal through which a succession of related events and concerns were expressed more and more freely by both nurses. I will represent this by presenting just one follow-up revelation and then an extended excerpt of a discussion about debriefings. In both of these excerpts, the fourth point of Forester’s transformational tetrahedron becomes increasingly evident: that of action.

In our initial interview, Constance had described the following moment early in her account of the train accident trauma:

…when I was in there, I was okay. I was doing the moves, I was doing something…. I couldn’t fix [the baby], couldn’t fix [the mother], but I could take care of the dad. And [that’s when] they came in and they told me [that the mother] was on her way to my daughter’s college, and I … lost it. And I don’t – I guess at that moment … it became personal… (C:II:10)

During the interview, Constance did not elaborate further on this moment, but when on to describe her day as the trauma progressed. Yet in the focus group, having discussed the lack of adequate support that day, Yvonne’s reflections prompted a further revelation from Constance:

Yvonne: …it’s unfortunate that you didn’t have a senior nurse there, who at least acknowledged, and could give you some support. I think that’s important in an environment like that …

Constance: Our senior nurse came in to tell me that [the mother] was on her way to [my daughter’s college]—and that’s when I collapsed in the corner on the chair. Because then it made it personal….

Y: Uhn-hnn…
C: …And then she said [recounting the senior nurse’s words using a dismissive, subtly disparaging tone]: ‘Yeah, Constance is sitting here crying, so maybe you’d better have somebody come in.’ And it made me feel—[momentary pause as Constance sees both Yvonne’s and the PI’s eyes widen in response; Constance laughs quickly]

Y: That was 100% not okay—!

C: —feel like, ‘Oh, I’m sorry—!’

Y: —just so you know, that is 100% not okay. They should have never done that. And I’m sorry you were put in that position.

C: [tearfully] I think, someday, it’ll be easier to do those things…. I just wish we had more support.

Y: I wish you did too.  (FG1:28)

At this point, my intersubjectivity as the researcher conducting data analysis, bears discussion. Within my consciousness as Constance related this event, I found two opposing perspectives were contending for dominance. One conception was that this statement posed an unkind and unhelpful response from a senior nurse to a relatively new nurse. The competing thought was that I had myself witnessed and experienced this type of casual disparagement so many times in so many situations over my nursing career that I barely paused internally to consider it further. This was an example of the value of Husserl’s phenomenological reduction in the practice of the research. My initial reflex to dismiss the inappropriateness of this comment by the senior nurse reflected a pre-existing structure of meaning within my own consciousness, which had its origins in experiences more than 35 years in the past. Concurrently, however, I had since developed some understanding of elements in consciousness that could give rise to such a comment, so that I could locate myself imaginatively (to some extent) in the position of either Constance or her senior nurse.

I cannot claim that it was my practice of the reduction that helped me to step back and reconsider my response to Constance’s account in that moment. Yvonne’s prompt, passionate,
and articulate reply preempted such practice and presented me with challenge: if a veteran critical care nurse instantly found this comment so entirely unacceptable, why was I almost willing to accept it as “the way things go”? Yvonne’s intersubjective presence and voice contested my more passive strand of awareness and confirmed Constance’s tentative presentation of feeling unjustly denigrated and dismissed. Absent that intersubjectivity, I am not certain what would have emerged from my own praxis. I suspect, however, that the strand of awareness in Constance that contested her treatment would have been silenced again, perhaps repressed into the passive, unclaimed realms where her shame about her anger with the father had been residing. Instead, she was presented with another opportunity to mourn, to learn by reshaping meanings, and then consider what actions might protect her and support her growth as a nurse. The dialogue continued in that direction:

Constance: [tearfully] I think, someday, it’ll be easier to do those things…. I just wish we had more support.

Yvonne: I wish you did too. Um, I’m gonna liken it to the IV skills [Constance laughs] that you’re looking [to develop further] … because I think dealing with these sorts of things… takes a lot of…practice…

C: Uhn-hnn…

Y: …skill, and knowledge … and without all of that, it’s impossible to cope. And I think that the more you know about these things and the more you experience, the better you get at it.

C: Yeah….

Y: But, unfortunately, maybe some people don’t … maybe they have the experience, but not the education, and that’s how they can go—‘Oh, well, Constance’s here … you’d better get in here.’ As opposed to recognizing the distress you’re in, and doing something to help you…

C: Uhm-hmm…

Y: …so, I would say, educate yourself on that aspect. I’ve just been going—I don’t know if you’ve been to the palliative care course that All Saints offers?

C: No, not yet—I saw it –
Y: Please go in the spring.
C: Okay.  (FG1:28-29)

Yvonne’s comment merits exploration: “Maybe some people have the experience, but not the education, and that’s how they can go—‘Oh, well, Constance’s here ... you’d better get in here.’” What is the distinction Yvonne is highlighting between “experience” and “education”? I would suggest it is represented well in the constitutional process Husserl so painstakingly described, tested, revised, and in some respects, moved toward beginning to deconstruct and reimagine over the course of his lifetime. Yvonne’s distinction between experience and education, in other words, may be conceived as a difference between automatic reliance on naïve, passive, pre-reflective, and possibly repressed structures of meaning in consciousness, on the one hand, or alternatively, an engagement with dynamic, emergent meaning structures that are iteratively constituted and reconstituted through mental action that is critically reflective, substantively grounded, imaginative, and resilient—mental action capable of engaging rigorously with traumatic, embodied, situated, and intersubjective crashes of awareness that are encountered in the lifeworld.

The definition and operations of learning that I articulate and strive to demonstrate in the preceding pages are consistent with such a conception of education. Moreover, critical psychoanalytic theory enhances a phenomenological framework like this for conceptualizing learning in this way. It expands possible ways of conceiving the emotional axis of mental life and enriches a consideration of what it means for consciousness to restructure existing meanings. As Yvonne suggests, it can help to account for the wide breach between two very different responses to secondary traumatic stress: on the one hand, “You better get in here—Constance is losing it,” and on the other hand, “Constance is hurting—please get someone in here so I can help her.”
Near the end of the session, Constance began to voice paths of action that she apparently already had begun to formulate as the necessary consequence of her stress, isolation, and unacknowledged mourning in relation to her work as an ED nurse. After discussing yet another harmful repercussion of the poorly facilitated debriefing session she attended on the day of the train accident, Constance concluded:

Constance: That is how dysfunctional, in my mind, this whole environment is…. I never wanted to work anywhere else but [the ED], but there are times that it—because of this—I love what I do, but because I don’t have support, I’m going to leave. And I know that. I’m, you know, I’m…going to end up leaving my job that I love, where I sacrificed four years of my life and school and time with my daughter to get to—I’m exactly where I want to be, but … things like that are gonna—is why people leave. And I find that so sad.

[Constance starts to cry again softly.]

Yvonne: I’m sorry. I’m sooo…. Oh—my—goodness. I am so sad … that there was not a better team that can handle these situations. Oh—I kind of was feeling—I have to go to [a debriefing] now. And, oh my goodness, I’m probably going to get in trouble…. [she laughs softly, with a hint of mischievous delight, while Constance listens, holding her in a sustained gaze] (FG1:36)

I find it profoundly moving that two nurses, who had never met before this day, could have such an encounter within the temporal space of less than two hours. Further, that Yvonne would feel so moved as to apologize to Constance, as if on behalf of an entire profession that had betrayed her, is startling. Yet it is also consistent with the ideals that Yvonne described having developed over her career—which is to say that, within the structure of this investigation, Yvonne actualized with Constance the learning and transformations of consciousness that she claimed to have experienced during her career. Her quiet chuckling laugh as she said, “And, oh my goodness, I’m probably going to get in trouble,” voiced her determination, strength, confidence, and even pleasure at the prospect of taking further action in a new environment to demonstrate her professional alignment with her hard-won learning.
One final extended excerpt from the data holds value for suggesting directions in the development of theory and practice to better support the cognitive and emotional learning needs of critical care workers exposed to trauma. I asked the nurses explicitly about critical incident stress debriefings (CISDs):

PI: …If we term it the right instruments or tools, does anything come to mind about what makes it a better debriefing, more helpful or effective…?

Constance: I’ve never been to one yet. Except with you [indicating PI], I haven’t …

Yvonne: …A safe environment. …Um, I think it’s helpful when you have people who were involved in the same … event or group of events, I think you can have a shared discussion. I think it’s important to not … have technical aspects. If you want to have a technical … um, critiquing, that has to be separate. Because if you start doing technical, then people start feeling they did something wrong, and what could we do better. And with that just—[Constance makes sounds restlessly—wanting to speak]—intimates something wasn’t done well enough.

C: Yeah, I don’t like that.

Y: So that does not need to be in a debriefing at all. It totally needs to be about sharing feelings in a safe environment. Nothing technical. Noth—if we want to see what went wrong in this code, it needs to be completely separate. Um, but—sharing—and having all disciplines there.

PI: Uhmmm…

Y: Cuz I think when you see your doctors … and they will try to be very stoic and dad-like, but when you actually see them and how they feel, it’s … awesome. Very helpful. But even your co-workers, ah … but just having the safety to talk about how you’re feeling is important, without having to disguise things.

PI: [to Yvonne] And you’ve…been part of quite a number of debriefings….

Y: Unfortunately, yes….

C: …The way it’s set-up, is— ‘Okay, let’s pray, let’s do—’ And—no—that’s…

Y: No, no, no …

C: …not me.

Y: No.

C: And that’s really hard, cuz that’s what’s offered to us….
Unfortunately, from what I was hearing, that was like a ... chaplain [in training] that really had no idea what he was doing. And that’s one of the most important things that needed to happen [tapping the table firmly with her finger] for those folks who were there—and they were given someone that had no experience to handle the situation.

C: Uhm-hmm.... Yeah, cuz—

Y: That was unfortunate. That should have never happened without [tapping the table again, distinctly] a senior chaplain being there, to help redirect.

C: Yeah—

Y: It should have never happened that way.

C: —and the sad part about it was, it was my first debriefing, as it was for the other [NICU] nurses. That’s the only one I’ve ever been to, cuz nobody’s ever—you don’t get debriefed in the ER very often. I mean they...you just don’t—

Y: So you’ll never do that again…

C: Uhn-nnn.

Y: ...or want to, unless somehow you happen to stumble upon a really good one.

C: Uhn-nnn.

Y: It’s like putting a first-year resident in charge of a pediatric code.

C: Yeah.

Y: No, it should never have happened. And I’m sorry that happened to you. (FG2:34-35)

Yvonne’s likening of a CISD (a debriefing) to a pediatric code is telling. It reveals the seriousness with which she regarded mental and emotional care in a “proper” debriefing, and highlights the profound discrepancy between her view and prevailing attitudes and practices in critical care settings like ASMC’s ED. Whereas it goes without saying among critical care professionals that a pediatric emergency resuscitation requires the leadership of at least one expert pediatric emergency clinician, it is not at all obvious to senior staff in many critical care settings that a CISD requires the leadership of at least one expert mental health clinician.
Consistent with a variety of other statements Yvonne had made throughout our research meetings, this excerpt brings together elements of effective CISDs that she described having identified during more than a decade of involvement in such sessions. Drawn from Yvonne’s experience, these essential components include:

- well-trained and experienced leadership,
- staff participants who have been involved in the same event or a related group of events,
- support and encouragement for the sharing of feelings,
- a safe environment—both confidential and nonjudgmental,
- nothing technical being discussed—technical critique is kept entirely separate,
- having all disciplines present (particularly physicians and nurses),
- participation of senior staff as well as newer staff,
- no imposition of religious assertions by debriefing leaders or senior staff upon other participants,
- support for expressing one’s own feelings and perspectives without having to disguise, censor, or apologize for one’s thoughts.

It is significant that a number of these components are suggestive of elements in the conception of learning that I have developed in this research. In particular:

- inclusion of and value placed on emotional contents of consciousness,
- a structure of support (“a safe environment”) for exploring thoughts, feelings, conflicts, and breaches that bely implicit meaning structures and catalyze renewed, more explicit meaning-making,
• affirmation for re-presenting rather than repressing a range of mental content, in support of consciously finding and claiming as well as contesting experience,

• emphasis and value placed on intersubjectivity in the work of re-structuring meanings and claiming / contesting experience, and

• affirmation of the work of mourning as an essential element in surviving and possibly transcending traumatic exposure.

While it may seem overreaching to speak of transcending traumatic experience, Yvonne’s actions over the course of this study demonstrated to me that it is possible to do so. Moreover, the significance of these correspondences lies precisely in appreciating the power of learning for addressing traumatic exposure in such a way that includes overcoming or transcending the crippling impact of trauma. Although such learning certainly does not take the place of mental work done with support from clinicians trained in the psychotherapeutic disciplines, learning like this does complement such work. Further, it does not appear to be overreaching to assert that such learning is tacitly if not explicitly active in all forms of psychotherapeutic healing work.

A Genetic Structure for Adult Learning in the Context of Secondary Traumatic Stress

Learning to cope in response to STS involves a herculean effort to grasp what resists comprehension and to feel disturbing depths of pain. It is everywhere present within the experience of STS—manifesting in maladaptive and adaptive forms, producing a wide range of learning outcomes that can manifest in statements like, “Don’t talk to me” and “Get over it”—or can manifest in leaving a clinical setting, a job, or the profession as a whole. Sometimes, however, this learning manifests in decisions and actions to bother oneself to notice what’s happening: to step back, figure things out, and make adjustments that involve witnessing, mourning, and better caring for oneself and other nurses too. Such learning may be understood,
essentially, as intersubjective work over time that strives to claim, constitute, deconstruct, and reconstitute structures of meaning derived from the wounding shrapnel of traumatic exposures and encounters in clinical practice.

This learning thereby comprises an embedded, relational, and emotional as well as cognitive activity that is traceable within, but not separable from nurses’ moment-to-moment lived experiences of pain and suffering. It is socially situated and temporally enacted. It is driven through forces of repression, interference, and resistance. It is a difficult—a precarious—practice. Most essential, fruitful learning in the context of traumatic suffering cannot be accomplished alone. To become adaptive and emancipatory, this learning requires an intersubjective community of engaged, caring witnesses—“enlightened witnesses” in Miller’s (1984) sense of the word—people with whom the work of meaning-making can be undertaken without judgment or reprisal. Whether fellow nurses, key family and friends, or trustworthy senior colleagues, these relationships must be stable, respectful, and honest in the sense that they embrace increasingly open and uncensored reflection, speech, and action.

In the context of such a relational community, a nurse may find it possible to claim and embrace her experience of traumatic exposure by giving voice to her own suffering and that of others too. She may find it within her to undertake the heavy labor of mourning and restructuring myriad symbolized meanings that are embedded within her pain across the horizon of her history and present life. Through such work, she may find it possible to claim and integrate her emotions as well as her thoughts, her bodily sensations as well as her memories. Through such learning, she may become better prepared to enact her nursing practice as an integrated expression of knowledge and emotion, of bodily skill and hard-won insight, for the welfare of her most vulnerable and traumatized patients, their families, and also for the welfare of her professional colleagues and nursing peers.
CHAPTER EIGHT
IMPLICATIONS AND FUTURE DIRECTIONS

Law IV of the House of God: The patient is the one with the disease.

_I struggle to rest and cannot. Like a missile my mind homes to my hospital, the House of God, and I think of how I and the other[s] ... had been sad and sick and cynical and sick, for [all our doings] had been done without love, for all of us had become deaf to the murmurs of love._


Significance

This study contributes a detailed qualitative investigation of the nature of secondary traumatic stress (STS) among nurses: It is one of few in the literature and the first major qualitative study to be advanced in over a decade. Moreover, it is the first study to examine nurses’ experiences of STS from an adult learning perspective.

Like several earlier qualitative studies on the topic, the present work relies on a phenomenological methodology, yet one that is quite distinct from previous such studies in that it employs a different approach to phenomenological praxis. The approach I have adapted, that of the Duquesne School of phenomenological research and, more specifically, the work of Giorgi (1970, 1985, 2009), has long garnered the respect of qualitative researchers—despite the contested nature of phenomenological research perspectives and practices and the lack of a broad methodological consensus in the field. Thus, in addition to the substantive findings of this investigation, the study contributes one example of an adaptation of Giorgi’s modified Husserlian method. It also models a more complex theoretical framework and analytical process than other qualitative studies of nurse STS have attempted.
As the findings of this research were aimed at neither determining the prevalence of STS in nurses nor testing particular so-called “interventions” that would ameliorate its effects, the study also advances an exemplar of a different variety of research aim. Here, a method of inquiry was crafted to permit an intimate exploration of interior psychic experience in order to yield a richly nuanced, multi-dimensional presentation not only of STS, but of the nature of learning responses that are embedded within its lived experience.

The contribution made here toward concept advancement and differentiation among the terms burnout, compassion fatigue, occupational stress, secondary traumatic stress, and vicarious traumatization is modest in relation to the profound effort that is needed in this field. Most significant, perhaps, this study calls into question continued scholarly use of the term compassion fatigue, as it severely euphemizes the lived quality of secondary traumatic experience and confuses it with other facets of occupational stress and burnout. In so doing, this research further supports work by Sheppard (2015), Watts and Robertson (2015), and others that question continued use of the Professional Quality of Life scale (ProQoL-V) to advance an understanding of traumatic stress effects, especially among nurses. Collectively, these findings build toward a call for renewed conceptualization of the ProQoL—one that does not attempt to reduce measures of either traumatic stress or burnout to mere subscale indicators of the poorly defined and misleadingly termed CF construct.

Finally, through a searching investigation of STS in three particular nurses, this study makes a contribution to the exploration of adult learning under conditions of intense suffering and loss. The study adopted a theoretical framework that understands learning as an embedded, relational, and emotional activity that is traceable within, but not separable from moment-to-moment lived experience in the world. As such, these findings help to illuminate a dimension of learning that is rarely given more than passing acknowledgement in the adult education literature:
namely, non-rational and even irrational forms of learning, driven by pain and suffering, through forces of repression, interference, and resistance, and enacted through mourning, intimacy, imagination, and critically reflective action. I will discuss implications for adult educators in more detail below.

**Implications for Trauma Research**

Two aspects of this study raise implications for scholars of trauma studies. First, this research contributes an adaptable framework for better understanding complex, powerful, and often conflictual learning practices that people enact in response to traumatic experience. These have little to do with cognitive activities typically considered to be learning per se, even though they may include practices like reading, attending a class, or discussing substantive content with colleagues or friends. Learning activities identified in this research include reflective discourse and emotional discharge that are physically potent and not always rational: expressing anger in workplace confrontations, feeling nothing and wondering why, venting with coworkers in the middle of the night, lying on a couch too exhausted to move, wrestling thoughts winding up in one’s head, or sobbing in a trusted person’s arms, for example.

Although such activities are sometimes subsumed under the broad concept of psychodynamic work by practicing psychotherapists, these types of learning activities are not limited to psychotherapeutic contexts, and the assumption that they are reflects an impoverished notion of what learning is or can be. On the contrary, these activities may be fruitfully approached as examples of a potent, informal, and materially transformational expression of learning, for which human consciousness is well equipped and capable of enacting wherever social and cultural conditions do not undermine or obstruct its practice. Freeing this dimension of the work
of consciousness from the realm of “seeing a therapist” and supporting it in other contexts is a crucial step toward building sustainable human culture in a world riddled with violence and pain.

Second, on the basis of this research, I would underscore recommendations made by other trauma scholars and investigators regarding the human dimension of the research process dealing with such content as trauma studies require (e.g., Taylor & Bradbury-Jones, 2011; Valent, 2012b). In particular, trauma scholarship is not best conducted by solo investigators who are working primarily alone. Genetic phenomenological insights suggest that intersubjective elaboration of qualitative data analysis enriches the research process and strengthens its findings. Further, among the essential structures of meaning derived from this research is an appreciation of the crucial role of intersubjectivity in the eidetic process of meaning-making in response to trauma exposure—the act of claiming of traumatic experiences as meaningful, useful, and integral to one’s life in particular ways.

Mental constitution may thus be understood to require the presence and engagement of witnesses and companions throughout the vulnerable work of constitutional activity—and this applies no less to trauma researchers than to primary sufferers of traumatic events. In my observation, this necessity of having peer witnesses, as well as being a witness for others when conducting trauma research, calls for a type of scholarly community life that exceeds what is often enacted among contemporary academic professionals. Without a richer community to provide thoughtful intersubjective support, the researcher will suffer and so will the research. Moreover, advancing the field of study while attracting empathic future scholars makes the need for structures of intersubjectivity and supportive witnessing imperative.
Implications for Nursing

This study has taken an in-depth qualitative approach to illuminating the nature of STS in critical care nurses and identifying concomitant experiences, including ways of learning, which may either intensify or help relieve traumatic stress effects. Critical care nurses were selected to ensure a sample with abundant traumatic exposure, not to imply that only critical care nurses suffer the experience of secondary traumatic stress. Indeed, the findings here suggest that perceptions of traumatic exposure are highly individualized, such that nurses in any professional context, no matter how apparently routine, may find themselves undergoing this experience. In addition, organizational forces that appear to aggravate nurses’ vulnerability to traumatic stress may operate powerfully in otherwise routine nursing care settings, making such nurses more sensitive and placing them at higher risk. Hence, the present research has broad applicability for the nursing profession, both in terms of concept advancement and the contribution of a theoretical framework for adult learning praxis.

The construct of STS has long been in need of a more robust evidentiary basis, particularly outside the psychotherapeutic disciplines. With growing dissemination of the construct in the years after 1995, STS suffered from its close linkages to the less clearly conceptualized compassion fatigue (CF) and the still-contested constructs of burnout and vicarious traumatization. The present study suggests ways in which research into the specific nature of STS can be advanced to help clarify the conceptual basis of future work. This is a necessary complement to quantitative research, which unfortunately has become increasingly reliant on the ProQoL-V and ever more focused on establishing incidence rates and identifying variables associated with CF, all the while assuming that the fundamental concepts and their interrelations are sound. As evidence mounts, however, that these are neither entirely sound nor necessarily valid within the field of nursing, the quality of nursing research into STS is
increasingly at risk of suffering from eroding validity and dissolving relevance. This study provides needed rigorous qualitative evidence about the nature of traumatic exposure and the experience of secondary traumatic suffering, specifically among nurses. Only through such work can the profession find a more reliable and valid fit between the construct of STS and tools for investigating it within the unique demands of nursing work.

Finally, this research presents unsettling findings that are contrary to widely held assumptions and ideals for educational practice within the healthcare field, as reflected in the scholarly nursing literature. Here, I have departed from a disease model of diagnosis and treatment regarding the effects of acute trauma exposure by presenting a learning model instead. Yet simultaneously, I have argued that the effects of trauma exposure among healthcare providers like nurses cannot be prevented through education in the way that the spread of infectious disease can be prevented through inoculation and the restriction of known transmission routes. On the contrary, traumatization is implicit within and an expression of the human capacity for intersubjectivity—for empathy—a highly valued capacity in nurses on which compassionate healing work relies. Moreover, perceptions and manifestations of trauma exposure do not often follow logical, predictable avenues for mapping out prevention. Thus, programmatic instruction and instrumental learning are poorly matched to the psychical demands created by STS.

For these reasons, professional calls for educational activities that would immunize, prevent, or intervene in STS are not only misguided—under some conditions, they may be harmful to nurses. This may be the case even when programs are well planned and ethically sound. This is so simply because programmatic education, by its nature as a didactic method having more in common with Freire’s banking education than with his problem-posing approach to reflective adult learning, is not responsive to the pain and suffering induced by traumatic
exposure. This insight raises important implications for theory and practice in the field of adult education, which should be studied by health educators seeking to address STS.

**Implications for Adult Teaching and Learning**

For the field of adult education, this research aims to expand the discourse on psychoanalytic readings of adult learning praxis, as well as to pique the interest and attention of adult education scholars with respect to the psychoanalytic dimension of critical theory. These are not intellectual concerns only, but substantive and emotional ones. In phenomenological terms, I have made a case here that learning is enacted in the context of trauma by bringing the intentionality of consciousness to bear on lifeworld encounters, attending to currents of psychic interference and embodied response that ensue, then working to explore, create, and restructure meanings so as to claim traumatic experience as one’s own within a renewed matrix of embodied and relational understandings and actions. In other language, learning in the context of trauma is well described by Forester’s (1999) tetrahedron of voice, mourning, learning, and action.

Such conceptualizations of learning in response to trauma, combined with the findings of this study, suggest that educational programs and so-called interventions under consideration by educators in the healthcare sector, however well-intended they may be, require thoughtful reexamination. Specifically, where such programs aim to protect, prevent, inoculate against, counteract, or in any sense dissolve secondary suffering among healthcare providers or students (or anyone exposed to major traumatic suffering in others), I find their purposes to be misguided and their results potentially harmful. This research suggests that nurses’ responses to traumatic exposure cannot simply be managed along the lines of hospital “infection control,” “risk management,” or “human resource management” programs. Such workforce education models conform to Freire’s (2005) banking education where knowledge becomes a commodity to be
exchanged for material (often economic) ends. Yet as Fenwick (2000) warned: “In a time when an understanding of managed experiential learning is ascending as a primary animator of lifelong learning, the need to disrupt and resist reductionist, binary, individualized notions [of learning] … and pose alternate conceptions becomes urgent” (p. 244).

Historically, work by both Freire and Fromm pose alternatives that are far better matched to the needs of nurses like those who participated in this study. The learning needs of such nurses who cope with STS align well with Freire’s (2005) problem-posing model of education, and they also reflect Brookfield’s (2002) description of learning, recalling Fromm (1976), in which “the conversation ceases to be an exchange of commodities (information, knowledge, status) and becomes a dialogue in which it does not matter anymore who is right” (p.110). Although instrumental knowledge (information about STS and coping strategies) does provide tools and a kind of support to nurses, it does not suffice as a full or adequate response to the levels of psychic pain demonstrated in the nurses studied here. Indeed, this research indicates that the most helpful outcome of formal trainings (e.g., programs on end-of-life care attended by two of this study’s participants) is the resultant access to a network of supportive peer relationships with healthcare providers sharing similar concerns. This study further indicates that it is precisely through the cultivation of such relationships that nurses can best find support, and so undertake the sustained emotional labor involved in bothering themselves to “notice the breaches between acts, thoughts, dreams, waking, wishes, and responsibility” in the context of trauma, and so “learn by working through the conflicts of all these psychic events” (Fenwick, 2000, p. 251).

Consequently, a central conclusion of this research is that the structure of learning required in response to traumatic suffering involves—in a phrase—a voluntary and communal embrace with mourning. Such an act implies an organizational commitment to the emotional life of nurses. It further implies a determination to foster workplace cultures that do not merely
tolerate, but that support and nurture the emotional life of nurses and recognize a range of needs among them. This requires structural provisions within day-to-day nursing practice that make possible intentional acts of witnessing—both among nursing peers and between nurses and other helpful witnesses they may find. It further depends on an open, non-judgmental climate for honest communication, along with venues that are structurally safe. Such safety includes not just physical privacy, but accountable commitments to confidentiality among participants.

Based on the findings of this study, it is only through such structures and practices, within such intentionally cultivated relational climates, that traumatic exposure and secondary traumatic experiences can possibly be claimed and gradually, adaptively integrated into the matrices of a nurse’s consciousness. It must be noted, however, that such learning required by nurses is also applicable to adults facing other forms of primary and secondary trauma exposure in a variety of other contexts. The field of adult learning is in need of more emotionally nuanced conceptions of learning that can be responsive to people’s needs in such settings. Such theories must account for evidence, such as presented here, that consciousness is neither monolithic nor fully accessible to logical awareness and intellectual reason, but is rather internally divided and ever in search of its own “lost subjects.” I suggest that not only the work of Freire, Fromm, Forester, and Britzman, but also that of Freud, Husserl, and later philosophers in the phenomenological tradition, all offer promising sources for developing more adequate theories of adult learning in the face of trauma.

**Limitations of the Research**

Several factors limit the application of this research and call for further inquiry that builds on that which is advanced here. The very small sample size, three participants whose accounts were analyzed in depth, calls for additional investigations of other nurse triads and small groups
in order to expand the core data available using this research methodology and conceptual framework. Expanding the sociocultural variability of future samples is also needed.

As a project of doctoral research, this study was also limited by the necessity that I conduct it as a sole investigator, from design to execution, for purposes of individual evaluation. While my dissertation committee and a number of other mentors were very helpful to me, and my dissertation adviser and chair was exceptionally skilled and tremendously supportive, I nonetheless complete this project with a painful awareness that the study of trauma—particularly in-depth phenomenological analysis of detailed qualitative accounts of traumatic experience—is not readily amenable to solo data analysis or reporting. As Valent (2012b) expressed so well, trauma “swamps us” and “haunts us,” and “is the fracture that stops us from running as we would wish” (p. xxvii). I experienced this fracturing effect in my consciousness, increasingly, throughout data collection and analysis. Fractures require structural support and so do trauma researchers. I drew on the support of a number of enlightened witnesses, but I must consider that this work could be further enriched and strengthened through collaborative work with a small but dedicated research team. Moreover, even though I was able to persevere through this project, I do wonder how much trauma research never comes to fruition because the investigator finds inadequate structural, relational, and “enlightened” forms of support.

Finally, this study did not attempt to replicate or expand knowledge about the incidence of STS among nurses, nor are the particular accounts given by the nurses in this study generalizable to larger populations of nurses. Rather, it is only this study’s conclusions about the nature of the three nurses’ activities of consciousness—their meaning-making and the constraints they experienced in relation to that activity—that is transferrable, and may be cautiously generalizable upon further scholarly investigation and confirmation.
Future Directions

The limitations above make evident the need for further research. In particular, the present research design and analytic approaches would benefit from application to nurses practicing in a wider variety of clinical settings, and reflecting a wider variety of sociocultural backgrounds. An assumption is sometimes implied in secondary trauma research that those nurses who face the most dramatic or explicit trauma exposures are also those who suffer the most serious secondary traumatic effects. This study, however, suggests that the complex nature of constitutional forces within consciousness, such as the psychoanalytic notion of deferred action, make the experience of trauma and secondary trauma highly personalized and quite unpredictable. On this basis, more careful study is also needed of secondary traumatization among nurses who are not so obviously or dramatically exposed as are emergency department and ICU nurses.

Demographic limitations of this project also call for similarly close study of the experience of nurses having more varied cultural backgrounds: e.g., those who are not Caucasian, who work in urban settings, who are not United States citizens or whose families are recent immigrants, and whose faith traditions lie outside the Judeo-Christian trajectory. In addition, study is needed among nurses who are male. Aside from the new perspectives that such participants would bring to rich qualitative investigations of STS in nurses, the application of critical feminist and critical race theory to a similarly careful analysis of such nurses’ accounts would be a tremendously valuable contribution to this field of research.
AFTERWORD

...Give me hope
Help me cope with this heavy load
Trying to touch and reach you with
Heart and soul...


I have found this work to be deeply sad and painful. My determination to reach for an occasional thread of art and weave it into the narrative of this work has been foremost to help myself survive the undertaking. At the same time, it is my hope that the resulting tapestry has helped my readers better survive bearing witness to the accounts presented here.

On a very personal level, the most remarkable outcome of this study has been the rebirth of my own capacity to return to clinical nursing practice. This was not something I expected or sought and, as best as I can determine by reflecting on my own constitutional processes, it occurred as a direct result of my sustained and searching interactions with the nurses in my study. These interactions allowed me to witness very intimate accounts of other nurses’ experience and discover that my profound sensitivity in my early 20s, and my deep sense of mourning, were neither strange nor unusual. My analytic work with the three nurses’ accounts further required me to revisit my own history and search my awareness—and thereby inevitably to constitute new meanings from my long-held experience. And like the constitutional process I claim to have witnessed between Constance and Yvonne, my own were likewise mediated both intersubjectively and temporally over the course of the project.

Equally important, it seems to me, my interactions with my nurse participants offered me a caring relational context in which to confess my own inability to transcend the mourning I faced as a young nurse. Although within the context of the research, my confessions were brief and
limited in scope by my objective of staying focused on them, and so sharing only enough information to enhance openness, trust, and rapport among us, I found that the acceptance and respect they afforded my reflections to be, quite frankly, transformational.

Upon my return to clinical nursing practice, I encountered more nurses, some nearer to my own age, who had experienced many forms of traumatic exposure through the years and had develop numerous ways of coping with their disappointment, anger, disillusionment, and pain—without leaving the profession. A remarkable sense of humor characterized many of these nurses, along with blunt honesty about their perspectives and a steady determination to take each day as it came—even as they embraced their inner worlds of experience with a minimum of self-judgment. My evolving relationships to these nurses, as to my nurse-participants, did not engage my consciousness just as rational mental activity, but as embodied and emotionally impassioned encounters that were situated in particular geographic and cultural locations and encompassed physical acts of caring that had consequences in the lives of people.

As I have navigated through these experiences and claimed them as my own while striving to complete the work of this dissertation, I have found comfort in the artistry of certain musicians, poets, and philosophers. Among the philosophers, I find myself drawn to the work of Husserl because it seems to me that he respected and engaged with experiences of suffering, even if he never found an adequate way to articulate such experience philosophically. He lost a son in World War I and his philosophy is considered by some to have deepened considerably in the years that followed. It seems to me, too, that Derrida was a philosopher who embraced the shattering effects of trauma, loss, and grief. Derrida was an artist—a poet—in almost equal measure as he was a breakthrough philosopher of Husserl’s stature. His obsession with ghosts or spectres, traces of presence that are never quite present, evidences his capacity and commitment to wrestle with angels of death and mourning. That is to say, like Levine (2009), I find in Derrida a fourth-
generation phenomenological philosopher worthy of serious exploration by those who care about the experiences of ill, injured, and dying people—and who care about the experience of those who attempt to help them under the worst mental and emotional conditions. Derrida, more than any other philosopher I have read, seems capable of bringing heart and hope and light to dark places. His immense and varied work holds depths of promise for helping nurses, doctors, and other trauma workers cope and stay safe as they unwind traumatic memories that haunt them.

Despite the pain I have experienced in this effort toward scholarship, I hope this is a beginning and not an ending. The most important lesson I have learned is that trauma workers, including trauma researchers, require sustained and intentional intersubjective support by a community of people committed to relationships with them, if they are to accomplish their goals. Such a practice is not merely a comfort in the work of trauma studies—it is an essential element of effectiveness in this realm. To the extent that my own research in this field will be sustainable and useful in the years ahead, it will occur only in that context.
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APPENDIX A

REVIEW OF NURSING-SPECIFIC LITERATURE ON STS AND RELATED SYNDROMES (CF, Burnout, VT)

Total articles or chapters surveyed: n=113 ➔ organized into 3 broad categories:

71 empirical investigations (quantitative, qualitative and mixed methods);
32 conceptual investigations (brief case presentation, concept analysis and advancement, editorial, policy development, review of literature, theory development); and
10 educational praxis / “intervention” reports

Nineteen-year span: 1997 to 2016 (4 months only of 2016)

Five continents represented: Africa, Asia, Australia, Europe, North America.

Thirty (30) countries of researcher origin: Austria, Australia, Belgium, Canada, China, Czech Republic, Ethiopia, Finland, France, Greece, Hong Kong, India, Ireland, Israel, Japan, Korea, Latvia, Lebanon, Netherlands, New Zealand, Norway, Portugal, Singapore, South Africa, Spain, Sweden, Turkey, Uganda, UK, US.

Eleven (11) areas of specialty nursing practice investigated: community health, cardiovascular, emergency, hospice, intensive care, labor & delivery / midwifery, maternal / infant, oncology, pediatrics, psychiatric / mental health, and acute trauma.

Publication Trends (frequency and geography (empirical & conceptual categories only):

1997 to 2004: 0 or 1 articles published annually \ \ 75% by North American authors
2005 to 2008: 1 to 3 articles published annually || ➔ 75% by North American authors
2009 to 2011: 6 articles published annually //
2012: 8 articles ➔ 25% by North American authors
2013: 4 articles ➔ 50% by North American authors
2014: 10 articles ➔ 40% by North American authors
2015: 14 articles ➔ 21% by North American authors
2016: 4 articles (first 15 weeks only) ➔ none (0%) by North American authors
APPENDIX B

INFORMED CONSENT

Informed Consent Form for Social Science Research
The Pennsylvania State University

Title of Project: Bearing Witness: Nurses’ Experiences of Caring for Patients in Crisis

Principal Investigator: Patricia Webb, BSN, RN, MA, Doctoral Student
Adult Education Program, 314 Keller Building
University Park, PA 16802
724-321-6098 phw120@psu.edu

Advisor: Dr. Fred Schied, Associate Professor
Adult Education Program, 305E Keller Building
University Park, PA 16802
814-683-3499 fms3@psu.edu

1. **Purpose of the Study:** The purpose of this research is to understand more fully the experiences of registered nurses who care for patients suffering with severe health crises or other life traumas. This aspect of nurses’ work has not been systematically studied in depth. The research will explore with a small group of nurses how it is that they respond to various types of suffering and trauma, which they observe among their patients as well as their patients’ close family and friends. The research will also explore how these nurses learn to work with and manage their own responses over time.

2. **Procedures to be followed:** You will meet with the researcher either two or three times. Each meeting will take between one and two hours of your time, and will be held in a comfortable, private room that is located conveniently for you. If agreeable to you, the researcher may visit the clinical setting where you provide care to patients; however, this is optional and you may elect or decline a visit to your clinical setting while still participating in the research project.

   The first meeting is a one-to-one interview with the researcher that will last approximately 60-90 minutes. The remaining meeting(s) are “focus group” sessions that include you and approximately two other nurses with the researcher. The focus group sessions will last approximately 90-120 minutes.

   During the second meeting (the first focus group), you and the other nurses in your group will be offered the opportunity to try practicing a brief daily “reflective exercise,” individually, for about ten (10) days. If you and the other nurses in your group decide to try practicing the exercise, your group will meet with the researcher one additional time following the ten days of practice. You and the nurses in your group may also choose not to
practice the reflective exercise, and not to meet an additional time. Your group will reach a
decision about this together during the first focus group session.

Interviews and focus group sessions with the researcher will be audio and video recorded.
These recordings will be stored and archived on a password-protected drive in a secured
location known only to the researcher for use in future research. Only the researcher will have
access to archived recordings.

Following the first interview, a brief typed summary of your comments will be provided to
you by the researcher for review and reflection. Similarly, following the first focus group
session, a summary of the group’s comments will be provided to each member of the group
for review and reflection. You will have the opportunity to contact the researcher directly with
comments about this summary. Also, at each follow-on focus group meeting, you will have
the opportunity to comment on the researcher’s summary from the prior meeting.

3. **Discomforts and Risks:** There are no risks in participating in this research beyond those
experienced in everyday life. Some of the researcher’s questions may be personal and could
cause some discomfort. You will be asked to think about and talk about your experiences of
witnessing suffering among your patients, and this carries a natural risk that you will re-
experience some of the responses you had at the time of the events you are recalling and
describing. In the focus group(s), you will be asked to participate as these kinds of
experiences are recalled and discussed among a small group of nurses, and this carries a
similar risk of re-experiencing past feelings and responses.

4. **Benefits:** The benefits for you of participating in this research include the comfort and
camaraderie of sharing your thoughts and feelings with other people who have had similar
experiences and are able to relate to you, empathize and support you. You may find that you
achieve greater understanding of your own experiences by talking about them with others.
There is also a potential benefit in practicing the brief daily reflective exercise, if you and
your group choose to do so.

The benefits of this research for society include the development of a deeper, richer, more
powerful understanding of nurses’ experiences of caring for patients who are suffering with
severe health crises or other life traumas. An improved understanding of this aspect of nursing
care can be used to support nurses in managing these experiences more successfully on their
own, and in their relationships with other nurses. It can also be used to advocate for the needs
of nurses and for the types of resources that can be made available to support the wellbeing of
nurses who provide care of this kind to patients.

5. **Duration/Time:** This research will be conducted over a period of two (2) to four (4) weeks,
beginning with your initial interview with the researcher. A typical interview schedule
follows, as an example:

- **Week 1:** One-to-one interview with the researcher (60-90 minutes)
- **Week 2:** First focus group session with the researcher (90-120 minutes)
- **Week 2-3 (optional):** Daily practice of a reflective exercise (5-10 minutes daily for
  10 days)
- **Week 4 (optional):** Second focus group session with researcher (90-120 minutes)
6. **Statement of Confidentiality:** Your participation in this research is confidential. The information gathered will be stored digitally and secured on a computer hard drive in a password-protected file. All transcripts of digital recordings will be stored in a locked file. Your name or other personal information will not be used to label or identify any files. Instead, codes and pseudonyms will be used to identify participants, and no one other than the researcher and her necessary research assistants (faculty advisor and a transcriptionist) will have access to the recorded or transcribed information. The Pennsylvania State University’s Office for Research Protections, the Institutional Review Board and the Office for Human Research Protections in the Department of Health and Human Services may review records related to this research study to ensure research integrity. In all future publications or presentations resulting from the research, pseudonyms will be used, unique personal circumstances will be altered, and no personal information will be shared so as to protect the privacy of participants.

7. **Right to Ask Questions:** You have the right to ask questions about this research. You can ask the researcher to provide you with clarifications and/or additional information at any time during the study. The researcher can be reached 24-hours/day, 7-days/week at 724-321-6098 or at phw120@psu.edu. In addition, you can contact the researcher’s faculty advisor, Dr. Fred Schied, at 814-863-3499 with any questions or concerns you may have about this research. You can also call this number if you feel this study has harmed you. If you have any questions, concerns, or problems about your rights as a research participant or would like to offer input, please contact The Pennsylvania State University’s Office for Research Protections (ORP) at (814) 865-1775. However, the ORP cannot answer questions about research procedures; those questions can be answered by the researcher.

8. **Voluntary Participation:** Your decision to participate in this research is voluntary, and you can end your participation at any time. You do not have to answer any questions you do not want to answer. Your decision not to take part in this study, or your decision to withdraw from this study at any time, will involve no penalty or loss of benefits that you would otherwise be entitled to receive.

You must be 18 years of age or older to consent to take part in this research study.

If you understand and agree with the information outlined above, and you consent to take part in this research study, please print your name, sign your name, and indicate the date below.

_____________________________________________  _____________________
PRINTED Name of Participant      Date

________________________________________
SIGNATURE of Participant

Please indicate by signing your initials below, if you consent to the secure archiving of recordings of your participation in this project for the purpose of future research on nurses’ experiences of
“bearing witness.” Alternatively, you may request that recordings of your participation be destroyed within five years from the date of this consent by signing your initials next to that option.

INITIALS I agree to the archiving of recordings of my participation for purposes of future research.

INITIALS I request that recordings of my participation be destroyed within five years of the date of this consent.

_____________________________________________
PRINTED Name of Person Obtaining Consent

_____________________________________________
SIGNATURE of Person Obtaining Consent Date

Thank you. You will be given a copy of this consent form for your records.
BEARING WITNESS:

Nurses’ Experiences of Caring for Patients in Crisis

An Invitation to Participate

Your patients’ suffering takes many forms.

Being in crisis is one thing, but witnessing crisis in others, whether it’s your patients or their families, is another thing altogether.

It takes a toll on you.

My name is Patty Webb.
I’m a registered nurse and a graduate student in adult learning.
I’m studying how nurses learn to manage experiences of bearing witness to serious crisis and suffering among their patients and their patients’ families.

I’ll be meeting with nurses in this area over the next few weeks. We’ll explore what it’s like to bear witness, and we’ll hold focus groups sessions where nurses can talk confidentially with me and a few other nurses who share similar types of caregiving experiences.

If you’re interested in being one of those nurses, I hope you will contact me at your first opportunity. I look forward to hearing from you!

Patricia Holland Webb, RN, MA
Doctoral Candidate in Adult Education, Pennsylvania State University

724-321-6098
phw120@psu.edu
APPENDIX D

INTERVIEW GUIDE

Bearing Witness: Nurses’ Experiences of Caring for Patients in Crisis
A research study conducted by Patricia Holland Webb, BSN, RN, MA
Doctoral Candidate in Adult Education, Pennsylvania State University

Interview Guide – Individual Session
I’m interested in learning about your experiences with caring for patients in crisis - ones who are dealing with serious pain, illness, injury, trauma or a near-death experiences. Let’s start by talking about a “typical day”:
• What happens when you first arrive at work? [Brief initial exploration of key points in a work day: staff, patients, assignments procedures, activities, interactions, etc.]

• What is it like for you when the day [shift] ends and you leave?
  o Is there anything you typically do when you leave work?
  o What do you typically do when you first get home?

• When you’re not at work, and you think about your patients and the work you do with them, what’s the first thing that comes to mind?

• When you’re not at work, how do you feel when you think of going into work after a couple days off?

• Do you ever have dreams about your patients, the unit, or the people you work with?

• Now, I’d like you to think about times when you are at work.
  o When you talk with other nurses, what kinds of things tend to come up?
  o Do the nurses you work with ever talk about how their work is affecting them – such as their health or things going on in their life?

• I’m assuming that you protect your patient’s private health information. So, given the limits this creates, how are you and other nurses able to talk about your own feelings toward your patients or their families – about things they’re going through?

• Is there a word that comes to mind, to describe how you feel your work affects you?

I’m also interested in learning how some of your experiences may have changed over the months [years] you’ve worked with patients in crisis. To start out, I’d like you to think about the very first day of work, or the first patient you had, involving crisis care.

• When you think of that time in your life, what stands out?

• Are there pictures that came immediately to mind? Can you describe them to me?

• Are there sensations in your body that you notice as you and I talk about this?
• Are there any other impressions that come to you – maybe the memory of a smell or a sound, maybe a texture or a type of movement?

• When you recall that early time in your work life, is there anything that occurs to you that you find yourself trying *not* to think about?

• What words might describe how it feels to talk about this?

This is very helpful. I imagine there have been many times over the months [years] when these types of memories have come up.

• When that happens, what do you tend to do?

• Are there things you tend *not* to do – things you avoid, perhaps – as a way to deal with these thoughts or memories?

Now, I’d like you to compare that first few days or weeks of your work life taking care of patients in crises, with the way you experience you work life now.

• What differences do you see?

• Are there things you notice you *do* differently now, compared with the early days?

• What else has changed over this time?

• Are there changes in how you “see” your work – how you make sense of it?

• When you think about changes inside you, how do you think those have happened?

• Are there other things you’d still like to change, if you could?

Thank you for all you’ve shared with me. There’s one more thing I’d like to ask you. Can you tell me a little about your goals related to work and your patients?

• Are there things you’d like to learn, regarding the kinds of patients you see most?

• Are there goals you’d like to accomplish where you work, or where you live?

• Are there any other hopes or aspirations you’d like to mention?

Thank you for your time today.

**Interview Guide – First Focus Group Session**  
*(Short Form)*

**Part 1**

*Introductions … “ice breaker”*

• What is this like for you – being here to talk – together?

• As we progress today, consider whether you’d like to meet once more….
Part 2

Negotiated agreements – “ground rules”: confidentiality of content; freedom to decline responding to a question; “what happens here, stays here”

- *Since our interview*: what thoughts, memories, dreams, reflections have come up?

- What surprised you about that interview or your responses?
  - Did we miss anything important…?

- What was your general response to looking through your interview transcript?

- How is this discussion unfolding for you?
  - Comparison to what you had expected…?
  - Comparison to other conversations you’ve had with RNs…?

- Have you heard any new words used in the discussion that you don’t often use yourself, or don’t hear others use when talking about these things?

- What do the terms “vicarious trauma” & “secondary traumatic stress” mean to you?

- I’ve been asking a lot of questions. Are there questions that occur to you about this experience of “bearing witness,” which you’ve never happened to ask anyone?

Part 3

Deliberation about the option of daily reflective praxis and meeting once more. Then, proceed either with closure or with presenting reflective exercise options and answering questions.

Resource List with websites

Thank you for your time and for all you’ve shared with me today.
APPENDIX E

INTERVIEW ANALYTIC SAMPLES

The following pages provide an example of the analytic process followed with individual interview data.
Yvonne: I never thought about it back then, I never thought of compassion fatigue or anything back then, because that was just not in my vocabulary. I was too young of a nurse, um….

But working in the PICU, we had an incredible amount of drownings, and one thing I did actively do to help myself was to do drowning prevention days in the community. And I know that was helpful and I would recommend to the other girls in my unit: Come do them, they’re really helpful. They’re so helpful to you, to go out and be able to do something other than CPR when the kids get here, talk to the families, go provide education. I even did education for lifeguards.

But to me, that was very helpful, because I had a point when we had so many drownings one year, I remember walking into the unit and there was another one, and I just went into my director’s office, burst into tears, and said, ‘We need to have a – I can’t do this, I cannot believe we have another

Yvonne thinks now that she never thought about how she was coping back then. She never thought of compassion fatigue or anything like it then, because it was just not in her vocabulary. She was too young of a nurse.

But they had such an incredible number of drownings come into the PICU, and one thing Yvonne did do actively to help herself was to teach drowning prevention days in the community. And she knew that was helpful to her, and she would recommend to the other nurses in her unit: Come do them – they’re really helpful, to you, to go out and be able to do something other than CPR when the kids get here. Go talk to the families. Go provide education. Yvonne even did education for lifeguards.

But to her, that was very helpful because she had a point when they had so many drownings in one year, she remembers walking into the unit, and there was another one, and she just went into her director’s office, burst into tears,

Yvonne was too young to think about something like compassion fatigue early in her career.

It was just not in her vocabulary.

But she did figure out that taking action proactively with regard to preventive education helped her a lot. She began teaching regular drowning prevention days in the community, and she encouraged fellow nurses to do the same.

One year, there were so many pediatric drowning cases coming into the PICU that Yvonne burst into tears one morning when she arrived at work and found ‘there was another one.’ She felt she couldn’t face providing this type of care once again, and went to her unit director to ask for a critical stress debriefing. At the time, her director complied. This was when Yvonne began seeing what was happening to her – she began to recognize the depth of her own suffering and realized she was

Yvonne had no vocabulary or conceptual framework for noticing or responding to ‘compassion fatigue’ (CF) in herself or others early in her career.

She came by this awareness only through difficult experience.

Yet she did realized early-on that preventive public education activities made it possible for her to counteract the helplessness and hopelessness she experienced in relation to the devastating pediatric injuries she saw at work.

Still, she eventually found this was not enough to sustain her.

At her former hospital, interdisciplinary debriefings (i.e., ‘critical incident stress debriefings’ or CISDs) had also once provided Yvonne with a safe environment where expressing emotional pain was professionally acceptable, and mutual support was offered between physicians and nurses.
And she’s like, ‘Okay!’ And picked up the phone. But it was like, I was so … fatigued about all that. And then I said, okay – I’ve got to get my – and by then I’d been a nurse for quite a while, and recognized the symptoms in myself.

But I was a little sad that, other than my director calling, my other supervisors didn’t recognize signs. Um, I was a little short with another mom, like, a few weeks later. And I was actually a little short with a mom who brought – who was there because her little one had a submergent injury. And she was like, well, this alarm – and I was like – and I was a little short with her. I was a little short with some of my other staff, I was not as patient with newer nurses. Um…. I didn’t have that ability to focus as well. And I guess, afterwards, I figured it out.

But I actually even got called in about something that happened with one of our newer nurses, and it was – and nobody recognized at all that I was like – wow – you know. I’d been a nurse for like eight or nine years in this particular unit, maybe eight, and had seen a lot, and I was in charge a lot, and going to have to figure out ways to better care for herself.

In retrospect, however, she was sad to realize that – other than her director’s willingness to schedule a debriefing – none of her other supervisors showed much insight about how her work with children and families was affecting her.

Slowly, she figured out that the quality of her nursing practice had started changing around this time, too. She was ‘a little short’ with families and fellow nurses – her responses to others became more judgmental or dismissive, and she had more trouble organizing and focusing on the details of her work. She couldn’t see these changes in herself at the time, however.

It reached a crisis when Yvonne was ‘called in’ for disciplinary action by one of her supervisors over an incident involving a newer nurse in the PICU [described in more detail later in the interview].

When this confrontation with her supervisors took place, Yvonne felt devalued and also felt she was being placed in a double-bind as a senior PICU nurse. On the one hand, her end-of-life care with families was consistently praised, yet she was rewarded by ‘getting

Yvonne could not perceive what was happening with her at the time, but in retrospect, she can recognize that the quality of her clinical work and her professional interactions were deteriorating.

Yet even this form of support became inadequate at a point in her PICU career, when she found her nurse supervisors were unable to understand what was happening with her or to intervene effectively.
was responsible for a lot, and I’d seen – I’d always get the worst of the worst kids. And I’d always [hear] – you’re doing fabulous end-of-life care – so I got all the end-of-life kids.

PI: And you were charge nurse, frequently….

Y: Um-hmm. So, I guess, after – in retrospect, I was a little: ‘Hmm…,’ that nobody recognized that. They were just like, well, something must be going on at home with her. You know, as opposed to, ‘Okay, let’s see what’s going on.’ And I did, I was able to adjust myself, I actually … took a good couple week vacation. Actually, a good girlfriend and I went overseas. But then, it took me some contemplation that, you know, I just have to take the time to … go for a bike ride, to contemplate, to talk to other people when these things are really on my brain.

PI: So you figured that out gradually.

Y: Yeah.

PI: It had to be you figuring it out.

Y: I figured it out and I adjusted it. Which is why, I guess, I’m so newer nurses – but nobody recognized at all the condition that Yvonne was in, personally. Looking back, she thinks, ‘Wow.’ She’d been a nurse for about eight years on that unit and had seen a lot, was in charge a lot, responsible for a lot, and she would frequently get the worst of the worst kids. She’d hear: ‘You’re doing fabulous end-of-life care,’ and so she tended to get all the end-of-life kids.

So, in retrospect, she has felt disturbed that nobody recognized she wasn’t doing well under these demands. Other nurses and her managers seemed to think, ‘Well, something must be going on at home with her.’ As opposed to thinking, ‘Hmm … okay, let’s see what’s going on.’

Despite this, Yvonne was able to adjust herself. She actually took a good couple weeks of vacation. She and a close girlfriend went overseas together for a couple of weeks, but it took her some contemplation to realize that she had to start making sure that she took time for herself, to go for a bike ride, contemplate, or talk to other people when things were really on her brain.

So she figured it out mostly on the worst of the worst children to care for. On the other hand, she was expected to handle this clinical load along with her all other senior nurse responsibilities – being in charge, providing leadership to staff, orienting newer nurses – all without commensurate support within the structure of nursing.

When she demonstrated noticeable signs of impaired interpersonal functioning at work, Yvonne did not perceive that her nurse supervisors reflected on or demonstrated any awareness of the possible role of CF or STS in shaping her actions on the unit. They and her own coworkers seemed to assume the changes they saw flowed from personal problems ‘going on at home.’ Eventually, this resulted in a punitive response when a major conflict arose, rather than a form of assistance or intervention.

In the end, Yvonne had to acquire insight about her situation on her own, with the help of a few trusted friends outside the PICU. This began with a journey across the ocean with a close friend, during which Yvonne was able to contemplate and start gaining perspective. She then began to develop strategies to help herself – to adjust herself and her life in ways that would make continued PICU nursing a healthful option.

She realized that making time for herself – to think or ride a bike or talk to a friend – were crucial for sustaining herself.
sensitive, with watching other nurses, and seeing what I can do to help them, because I can see – you know, we’ve had a lot of bad cases in our unit – we’ve had eight deaths in three weeks.

PI: Wow….

Y: And, you know, there’s a couple of the nurses who keep getting these kids. And they just come into the break room and they are just, like, wiped out – completely wiped out. And there is like – you know, we’ve got to take care of those girls ’cause they are a mess – they are not doing well right now either. You know? Um … so, I think it’s important for nursing to recognize this in their coworkers, especially in positions in ICUs and trauma units and things.

PI: Do you hear it talked about much?

Y: You know what, we actually did have three debriefing meetings scheduled this week. Unfortunately, I couldn’t go to any of them, ’cause I would’ve liked to have gone to give input.

Then, having recognized her past anger and insensitivity toward the needs of newer nurses, Yvonne began to define herself partly by her determination to pay close attention to the needs of newer nurses, and respond proactively with compassion and education.

Yvonne sees that numerous ASMC PICU nurses are suffering deeply, and she’s not yet sure whether they have access to adequate support from their peers or from nurse supervisors and leaders.

Nor does Yvonne now assume that, because three debriefings were just held in the PICU, nurses are receiving the support they need.

Rather, she implies (and states later in the interview) that she has questions about the nature and quality of the debriefings being offered – whether they are designed or led in such a way as to be helpful to nurses.

She intends to find out and offer input in her new clinical setting.
Constance texted her daughter a little later and said, ‘This is THE worst of the worst,’ and told her, ‘I just need you to…’ not ask any questions when they talked next.

The staff did have a debriefing that day, and then they just had to go back to work. As she related this, Constance laughed sardonically. As she had commented earlier, you can’t put a sign up, ‘Closed for the afternoon.’ So she had to go back to caring for other patients after trying to resuscitate that baby and everything else they did.

Constance really struggled with all of this. It was very upsetting, and it’s still very difficult, even to think about. It makes her heart ache.

Again, she paused. Her voice broke as she spoke next, and she suppressed tears. She thinks it’s so important for nurses to have help with these traumatic types of situations.

Constance had a fellow ED nurse named Penny who is just amazing and has helped Constance in the most difficult situations.

Constance voiced the phrase, ‘THE worst of the worst,’ a number of times like a kind of shorthand, or a symbolized representation of an event that is beyond speech.

Because the accident was in the news, Constance asked her daughter not to inquire about it when they next spoke. Aside from patient privacy, Constance knew the events would be far too upsetting for her to talk about.

Trying to resuscitate the newborn baby whose mother had died on arrival—and then losing the baby and going through the postmortem care that was required—all these acts and outcomes were entirely new and excruciatingly painful for Constance. Even after many, many months, it was still almost too overwhelming to talk about.

Constance’s speech presented frequent ‘breaches’ in which she stops, redirects her thought, breaks off, then redirects again. She then describes her coworker, Penny.

Constance quickly mentions ‘a debriefing,’ but moves on quickly to emphasize the felt pressure to get back to work. Her quick laugh conveys a grim awareness that ED staff are constantly caught in an impossible bind—between the relentless train of emergencies coming through their doors, and the urgency of their own mental, emotional, and physical needs and limits—a recurrent conflict presented by her account.

She again mentioned a debriefing, then returned to the necessity of going back to work as usual, even an event like this one, ‘THE worst of the worst.’ Constance made it clear that, many months later, she had not been able to recover from the psychic trauma of this day.

She has found the lingering pain inescapable—it remains with her not only as psychological anguish. She alludes to physical pain with a quality of ‘heartache’ as well.
She was an ER travel nurse for 18 years. And she did lots of L & D [labor and delivery nursing], and she knows babies, and she’s, she’s just one of those people that the second something happens to me, I go to her.

PI: Yeah.

Cnsc: And I look at her, and I’m like—and she’s like—[animated voice] ‘Okay! Here’s what we’re gonna do!’ And … she came in [the day of the train accident]—she started at 11, and [the accident] was, like at 9 in the morning, or 10 o’clock that it happened. She ended up coming to me, and she knew that—just a couple weeks before, I had helped a woman who lost her baby, who delivered a 15-week-old, and she’d helped me with that. It was the first time I’d ever experienced that. And she says, ‘You had that to prepare you.’ Because I knew then what to do with this, but she … knew. She’s just so great at this, but she—but they ended up calling it [calling an end to the resuscitation effort, and pronouncing the baby dead]—you know, they did everything.

Our nurse manager ended up coming in from out of town, and Penny was an ER travel nurse for 18 years, and she did lots of labor and delivery nursing, too. She is the person Constance would go to the moment anything happened.

When they’re working the same shift, Constance will just look at Penny, and Penny will say in an energetic voice, ‘Okay! Here’s what we’re gonna do—!’ Constance appreciates her positive attitude, her knowledge and experience.

Penny was scheduled to work the day of the train accident, and she ended up in the same room, working on the mother while Constance worked on the baby with the two NICU nurses. A couple weeks before, Penny had helped Constance through helping a woman who lost her baby at 15 weeks. When they talked the day of the train accident, Penny said, ‘You had that to prepare you,’ because Constance had learned what to do for a newborn from the prior experience. Somehow Penny just understood. But they still lost the baby that day, even though they did everything they could.

Their nurse manager had come in from out of town that day, and then the father got there. But they didn’t get any notice when he

Penny was a veteran ED nurse with a steady demeanor and an evident affection for Constance: they seem to have informally adopted each other as mentor/mentee. Constance felt she could not have gotten through many of her experiences in the ED without Penny’s guidance and support.

Penny’s capacity to maintain her composure and an upbeat focus in emergency situations is very reassuring to Constance, who seems to draw on an internalized sense of Penny’s stabilizing influence even as she recounts this ‘worst of the worst’ trauma.

Penny’s assertion that ‘You had that to prepare you,’ regarding a previous newborn trauma case helped to assure Constance that she would find within herself a capacity to provide the care needed in this emergency.

Nevertheless, just as Constance’s last newborn emergency had ended, this resuscitation effort ended with losing the baby, despite all the team’s efforts. [Constance described elsewhere that she and two NICU nurses spent nearly two hours on the baby’s postmortem care before his father arrived.]

Speaking about her relationship with Penny appears to provide Constance with a pathway in to recounting the events of this day.

It is also evident that Constance wants very much to talk about these events, despite the difficulty involved in doing so, for she has spoken steadily without hesitating, evading, or deflecting my queries.

Constance has symbolized her experience of her relationship with Penny into a structure of meaning that involves embodied memories of comfort and reassurance, which come through intersubjectively on a visceral level of perception in this portion of the account.

The emotional dimension of this symbolized structure was powerful enough to stabilize Constance in the face of a trauma that was worse than anything she had ever imagined. The structure extended as well beyond assumed temporal limits of knowledge, as Constance affirmed the thought that Penny ‘knew’ that a prior trauma was “to prepare” Constance for this one.
the father ended up coming in and, you know, he … after I had done all that with the baby, he came in—and we didn’t have warning that he was there—we thought it was gonna take longer. But what ended up happening is, one of the [students on the train] had called him that they were in an accident, so he was en route already. So we thought we had more time and [voice drops, speaking very quietly] when he got there, [his wife’s] body wasn’t ready to be seen yet. …And because … [inaudible] … she had been hit pretty bad, and so [the wound] was open. So we needed to clean her up for him to see her. So it turned into something that took—after we got hours with the baby—it was running down the hallway with this patient, with a sheet over her, getting into the room, taking her off and just—she was still on the backboard. And we had to take her—and the hospital, literally, we—and, here, me and my nurse manager are just—after doing something that took so much time [i.e., preparing the body of the baby for its father]—my nurse manager … [inaudible, as her voice drops in volume] and now we’re doing this, and we were rubbing her legs, just so fast and hard, and it was so … arrived. They thought it would take him longer to drive across the state. But later they found out that when the accident happened, one of the kids on the train called to tell him what happened. So he’d gotten right in the car, and was en route before patients even started arriving in the ER. At this point, Constance’s voice again dropped to a hush momentarily. When the dad got to the ER, his wife’s body wasn’t ready to be seen. Constance remembers lifting the wife’s arm, and there was nothing, no structure—she had been hit pretty badly and the wounds were all open. So they had to clean her up for him to see her, and it turned into something—after Constance had spent all that time preparing the body of the baby—this was a situation where she was running down the hallway with the mother on a gurney with a sheet over her, getting her body into another room and taking her off the backboard from the scene of the accident. She and her nurse manager were rubbing mother’s legs, just so fast and hard, and bandaging her and it actually felt violent. One of the things Constance had to do was take the wedding ring off the mother’s hand. She will never forget that.

Constance then redirected her narrative to describing the arrival of her nurse manager, and then the baby’s father’s—much sooner than anyone had expected him.

Therefore, an anxious rush ensued in which Constance was called upon to assist her nurse manager in preparing the wife’s/mother’s body, which had been badly injured in the accident, for her husband to see before her body was taken to the morgue.

Thus, after spending close to two hours preparing the body of a dead baby for the father, she was now required to help prepare the body of a dead wife for the husband.

But unlike the almost sacred quality with which Constance and the two NICU nurses had been able to perform postmortem care on the baby and memorialize its birth for the father and family, preparing the wife’s body to be seen was rushed and impersonal and violent.

Perhaps most disturbing for Constance was having to remove the wife’s wedding ring from her hand. Constance shuddered as she expressed how vividly she still remembers doing this.

Constance’s account conveys no sense of familiar relationship with her nurse manager who arrived. In fact, the quality of this relationship comes through in stark contrast to those with Penny and the two NICU nurses with whom she had worked so closely that day.

Constance relates her distress over the succeeding events to the sudden arrival of the father, so much sooner than expected. Yet in the background of this portion of her account is the presence of her nurse manager, with whom she seems to have had little rapport. The intersubjective dimension of Constance’s experience of the events involving the mother’s body was thus distinctly different than those involving the baby.

A structure of meaning becomes perceptible in which Constance’s experience of the physical violence used to prepare the mother’s body for her husband functions as a material reflection of the mental and emotional violence she herself felt throughout the day’s events. The embodied actions Constance was responsible to perform, such as the removal of the mother’s wedding ring, were thereby constituted as haunting symbols.
violent. And then one of the things I had to do was, I had to take her wedding ring off her hand. And I will never forget that. You know, and that—

And then, I wanted to be done with it. I never wanted to see the husband. I never wanted to—and I ended up having to [see him]. And that really bothered me. I never wanted to see him—I’m like, okay, I did this…. But … the photos, the blankets and everything, they ended up upstairs, getting them printed out in the computer, and then they brought them down and asked me to take them to the father. So Constance presented everything to him—they’d put the pictures and the hand prints and everything in a little box. Constance gave it to him and said, ‘Here are the pictures. There’s a disk in here…. That was just so hard—it made it so personal. Constance will never forget the father’s face, holding his baby, ever. Ever. Ever. You know.

So it ended up … you know, we needed debriefing. And I was just working and I’m just like, ‘Nobody talk to me—just let me alone, let me do my—I don’t want to talk about it.’ And this was, like, afternoon at this point. And we went into the debriefing room,

Afterward, she just wanted to be done with it all. She never wanted to see the husband. She never wanted to meet him and have to face all that—but she ended up being the one who had to do it. That really disturbed her. It happened that way because the photos and other things they had done—all of that was sent upstairs, and the pictures were printed on the computer, and when they brought it all back down, someone asked Constance and the two NICU nurses to take them to give to the father. So Constance presented everything to him—they’d put the pictures and the hand prints and everything in a little box. Constance gave it to him and said, ‘Here are the pictures. There’s a disk in here…. That was just so hard—it made it so personal. Constance will never forget the father’s face, holding his baby, ever. Ever. Ever. You know.

After all that, they really needed a debriefing. She had gone back to staffing the ED and she was saying, ‘Nobody talk to me—just let me alone. Let me do my work—I don’t want to talk about it.’ It was afternoon at this point.

After coping with the rushed, rough, even violent quality of postmortem care, preparing the body of the wife, Constance felt ‘done.’ She did not feel that she had it within her to face the husband/father.

Constance did not specify who ‘they’ were, who brought down the photos, blankets and “everything,” then asked her to take them in to the father with the other nurses. Nor did she describe any discussion or negotiation regarding this request. Rather, she implied that, as in other aspects of her work, when she was asked to provide a type of care, she complied and somehow found within her to do it.

Constance indicates that it was the personal, face-to-face quality of her encounter with the baby’s father that so haunted her.

Constance knew that she and the other nurses “needed debriefing,” yet she was wary of talking to anyone or disengaging herself from getting “back to work.” Possibly, her ED duties provided temporary distraction and relief from her anguish and anger.

of the psychic violence she herself experienced, and that she perhaps believed she had inflicted too.

Constance’s work involving the mother’s body, and the necessity of performing them alongside a senior nurse she barely knew could not therefore trust, exhausted the limits of Constance’s emotional capacity. When these events were over, she felt that she was “done.”

Constance’s lack of voice and agency in decision-making here, along with the general disregard for her psychic needs and limits at such a moment, is both striking and saddening. As traumatic as the entire day was for her, it was the brief encounter with the father that appears to have “finished” her in terms of secondary traumatization. This does not become fully evident, however, until later FG session data revealed what Constance found most disturbing in this encounter.

Pushing away potential support, as Constance did at this point, was noted by Sheppard (2015) to be a common outcome of STS among nurses where prior instances of “support” were not experienced as helpful, but rather were found to be upsetting, even re-traumatizing.
and it was—I came in late, ’cause I was working … the other two NICU nurses were sitting in there already, and Penny was in there, and the chaplain was in there. And I remember just sitting there. Like, I couldn’t even … speak, like I can’t—I lose my voice when I get really upset like that. I completely, it goes—I kind of scream in my head, but I can’t … voice. And I just remember thinking, this is just—and the chaplain was talking, and talking and talking and talking and talking, and finally Penny looked at him and said, ‘You need to let Constance talk for a moment.’ You know…?

PI: [Penny] looked at the chaplain and said that?

Cnsc: Yeah, Penny said to the chaplain, ‘You need to, you need to stop speaking and’—you know what I mean? Because….

PI: Yeah.

Cnsc: And that’s when I realized that, well, this isn’t going anywhere. This isn’t going to help. So what ended up happening was, the next two days, I was lucky that I was off, and I didn’t get off my

When the debriefing started, Constance came in late because she was busy elsewhere in the ED. But the other two NICU nurses were already there, and Penny was there too, along with the hospital chaplain. Constance remembers just sitting there. She couldn’t even speak. She loses her voice when she gets really upset like that. It just completely goes—she kind of screams in her head, but she can’t voice her thoughts. And she remembers thinking that the chaplain was talking—and talking and talking and talking. And finally she remembers Penny looking at the chaplain and saying, ‘You need to let Constance talk for a moment.’ Penny actually looked at the chaplain and said, ‘You need to stop speaking….’ And that was when Constance realized, ‘This isn’t going anywhere. This isn’t going to help.’ Because the chaplain seemed more upset than anyone else and wouldn’t stop talking.

But what did happen was that Constance was lucky enough to be off work for the next two days, and she barely got off her couch. She would call Penny and cry, and they would talk. But Constance couldn’t talk to anybody else. It was just

Constance attended the debriefing nonetheless. She indicates that she possessed an awareness of being in need of some form of debriefing. Further, her professional pattern of conducting herself is clearly to do what is asked of her, and the debriefing was held out as mandatory in the sense that some effort went into to organizing it, and Penny as well as the NICU nurses were all present.

Constance recalled very little detail from the session itself except the incessant talking by the chaplain, the “screaming” in her own head, and Penny’s statement to the chaplain that he needed to allow Constance to speak.

What she did recall viscerally was her own “screaming” psychic pain and the total ineffectiveness of anything said or done during the session to help her with that.

Penny’s redirection of the chaplain appears to have been the only moment in the debriefing when Constance felt her experience was comprehended or “witnessed.” The mental, emotional, and embodied history of relationship between the two nurses was foundational in creating this aligned awareness.

The debriefing presents through Constance’s account as having comparable traumatic potency as her encounter with the father.

It thus became a part of the many contradictions and traumas of the day, rather than offering tools or a safe space for coping with them.

Further, like the necessity of Constance working alongside her nurse manager in preparing the mother’s body, the debriefing also presented a situation of necessary engagement with a staff member (in this case, the chaplain) with whom she had minimal relationship and limited shared experience.

Constance’s perception of a literal loss of voice—an incapacity to speak—provides a striking physical reflection of the voicelessness, i.e., lack of agency, that she had experienced throughout the day, in the necessity that: 1) she help prepare not only the body of the deceased baby, but also of the deceased mother for the husband; 2) she lead the group of nurses who presented the father with the box of photos and handprints; and 3) she attend a debriefing she had no confidence would help her that was led be someone with whom she
couch for two days. And I would call Penny and cry, and we would talk, and—now that I remember it, she—she, she actually got there during the trauma, because she worked on the mom, when they delivered [the baby]. . . . Yeah . . . but, she—it . . . I couldn’t talk to... anybody else. It was just her and I.

And then, what we did was, her and I and there was, one of—we came here [the restaurant Constance chose for the interview], um, it was a couple days later, we were back at work—we came, ate and ate—I lie!—that day I came here with them, and had ice cream. We filled up the table with junk food. We did. Because my husband was not home, and I didn’t want to go home—I knew there was no possible way I could go home alone that day. It was just—I didn’t want to go home. So me and another nurse that had been in the trauma, we came here, and we sat and we ate and we talked.

Finally, she went home and crawled into bed and cried for hours. When her husband did get home, she was still crying—he couldn’t even ask her what happened—she still couldn’t talk at that point. She just cried. She couldn’t talk to him or anyone else, but she could talk to Penny. And she could talk with the nurse at the restaurant after the shift. There was a feeling, and she thinks it’s very common, that she had no significant relationship or foundation of trust through shared experience and understanding.

There is no evidence in Constance’s account that any nurse who had worked in the ED that day, other than Penny, was able to provide Constance with comfort and support in the succeeding days.

Constance vaguely indicates that there was at least one other nurse who came to the restaurant following their shift. Yet she offered no other details about the nurses or the conversation. What Constance foregrounds are details of the restaurant (an ice cream shop that represented evident comfort, given she chose it for our interview), the food they ate, and the passage of time while her husband was away. While it is unclear what this means in terms of Constance’s experience of her interactions with the other nurses, it suggests that the time at the restaurant functioned as a temporal placeholder for a pre-reflective state of mind. That is, the nurses’ company, the food, and the mundane lifeworld surroundings helped to hold outside Constance’s awareness the powerful responses at work in her consciousness.

The two days off work allowed Constance some time to attend to her varied sensations, embodied memories and emotions, while gradually beginning to reflect on the day’s events. Penny was the only nurse in the ED to whom Constance felt she could talk in those two days. Spending both days on her couch evidenced the degree of physical exhaustion that accompanied her emotional and mental exhaustion.

Constance’s temporary confusion about the chronology of events, when she went to the restaurant and who else came, cleared as she described the emotional aftermath of the day. The absence of her husband at home until late that evening appeared to be an anchor point in her memory—a relational structure around which her recollection of the hours after her shift were organized.

When she did go home, it appeared to be with the expectation that her husband would arrive imminently. She was able to cry alone with the knowledge that he would be with her sooner than later, and when he did arrive, she couldn’t talk. She could only cry with him.
had happened. And I just cried. And then the next day—but I couldn’t talk to him, but I could talk to [Penny]. There’s that feeling of—I couldn’t talk to the chaplain, and that’s very common, you can’t….

PI: Could not talk to the chaplain?

Cnsc: Yeah. Even though he wasn’t letting me at first—I don’t think I could’ve anyways. Because she doesn’t understand….

PI: Could not talk to the chaplain?

Cnsc: Yeah. Even though he wasn’t letting me at first—I don’t think I could’ve anyways. Because she doesn’t understand….

Crying with someone appears as a distinct activity for Constance, with different prerequisites for trust, as opposed to crying and talking.

Even though Constance trusted her husband deeply, and felt assured that he cared deeply about her, she still could not talk to him about the events of that day. She felt certain that no one other than another trauma nurse would comprehend the quality of her experience.

When she arrived home, she was able to allow these responses “front door” intentional entry into her awareness and she cried and cried—with the concurrent anticipated awareness that her husband would soon be home and she would not be alone.
HOLLY

Holly: Yeah. We’ve had like … I’ve personally been there for six deaths in three weeks, which is a lot in a pediatric ICU.

PI: Yeah….

H: So, to be the one providing the actual hands-on care. And some of that – they were, they were my patients or, I’m in charge a lot, in the room the whole time, so either way, providing the sole support for the family, or almost the sole support for the family through – and none of them – like, our unit’s had 10 [deaths], total, in 3 ½ weeks. And I’ve been in six of them, so they’re all happening in six of them, so they’re all happening weekend night shifts [quick laugh], to the point that, like, [nursing] management came to me this morning to give me a hug and say: You’ve had the brunt of it and I don’t know why, and we’re really, really sorry, and we hope you’re okay, and is there anything we can do….

PI: Management being…?

H: My manager, my clinical head.

PI: Would that be, like … a head nurse? Or more like the supervisor for the…?

The unit as a whole has had 10 deaths in 3 ½ weeks. Holly has been personally involved with six of those deaths in just three weeks’ time. That is a lot in a pediatric ICU – to be directly involved in caring for that many dying children in such a short period. Some were Holly’s own patients, but she’s also been in charge on the unit a lot, which means she’s closely involved with end-of-life situations even when the patient is not assigned to her care. So either way, she’s been providing primary support for numerous families during their children’s deaths. It also means the deaths have mostly been happening on weekend night shifts, which is when Holly works – three out of four weekends each month, three consecutive 12-hour shifts from 7pm to 7am on Friday, Saturday, and Sunday.

We met on a Monday morning when she had just completed one of these three-night, 36-hour stretches of work.

It’s reached the point where management came to her that very morning before she left to go as the nurse who’s most often in charge, Holly was directly involved in providing care and support with all six of those cases.

Holly’s clinical head nurse & the ICU supervisor approached her at the end of her shift – early morning on the day of our interview. They offered recognition and sympathy, gave her a hug, and asked if there was anything they could do to help.

For Holly and her fellow weekend night (W/N) PICU nurses, work has been absolutely brutal in recent weeks, psychologically as well as clinically, because of a sustained series of very tragic deaths that have been deeply unsettling.

Holly is offered sympathy by two nurse managers at the end of her three-night 36-hour work stretch, early on a Monday morning. She described their demonstration of caring, but does not communicate any sense of personal relationship or rapport with either of them.
H: Both, like the ICU supervisor & our head nurse, our clinical head nurse, came to me this morning.

PI: And what was your response, in terms of the question, is there anything we can do?

H: I think I’m okay [weak laugh], and … we just talked it out a little, about what I’ve gone through, and how it makes you appreciate your kids more when you go home, [talking very fast] and gives you a different perspective in life, and that … these families need somebody at their greatest hour of need, and you’re thankful you can be there, even if it’s hard for you, it’s not – what you’re going through isn’t anything [compared to] what those people are going through. And you just do it. And, that doesn’t make it easy, um – and then – yeah, they just asked if there was any support they could offer…. And there really isn’t. I don’t, I don’t know what my manager could offer me that would make going through what we’ve gone through with these families [inaudible] – like, it stinks. And it’s sad. [voice cracking]

PI: It stinks; it’s sad….
H: And they’ve all been deaths that are completely unexpected. There’s not, like, the [inaudible] patient, where you’ve developed that relationship, and you’re so sorry, but you know this is…

PI: Where you know…

H: … [where] it’s time, and it’s a relief. And everybody’s prepared, and palliative care was involved. These are all like … MVAs, ruptured AVM … a hanging, an overdose, like – the whole gamut, the congenital – undiagnosed congenital heart defect born at home – I mean, just odd, shouldn’t happen. And a few of those, that’s fine, but this many of those is not fun [continues speaking very fast; voice high, soft, and thin]. So, it’s just been … it’s just rough.

PI: Did you sit down in a room with your – with these managers for a little while?

H: This was like, in the hall this morning, on my way out … so….

Yeah.

PI: Yeah….

H: And they – and they offer some, like, some debriefings and stuff, but they’re during the – with the chaplain & the counselor on the unit, and whatever … [pause]

She said she doesn’t know what her managers could offer her that would make this any easier – going through what she & the unit are experiencing. Holly said it just stinks. And it’s sad.

She added that all the recent deaths have been the kind that are completely unexpected. They haven’t been patients where the nurses develop a close relationship & provide support, where palliative care is involved & everyone is pretty well prepared, where you’re so sorry, but you know the death is coming & you can work your way through it. These have all been just odd unexpected, shouldn’t happen kinds of things. Car accidents, a ruptured arteriovenous malformation, a hanging, an overdose, an undiagnosed congenital heart defect – the whole gamut. Having a few of those over a month is not uncommon. But this many in such a short time has been very rough.

Management offers some debriefings & things like that, but they’re usually during the week with the chaplain & the counselor on the unit. That’s helpful to some people, but Holly usually doesn’t

Worse, the recent deaths have all been sudden ‘odd, shouldn’t happen’ kinds of things, affording little time to prepare oneself psychologically. Ten such deaths in 3½ weeks is about 3 per week, or a death almost every other day. Yet most have occurred on W/N shifts, so it’s been continuous for the nurses working that schedule.

At this point, Holly’s speech, which is already very fast, has become high-pitched, and thin in tenor – belying her profound sense of stress as she recounts these events. Her words, taken alone, however, might not convey this.

Holly did not mention where the conversation with her managers took place until she was asked; she answered the question casually, as if it were a small detail. I perceived no indication that she was down-playing an awareness of the likely impact of this setting upon her interaction with her managers – it seems the possibility of another setting had not occurred to her.

Holly’s account jumps from the hallway meeting to the ‘debriefings and stuff’ that are typically offered on the unit during times like these.

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Holly’s account jumps from the hallway meeting to the ‘debriefings and stuff’ that are typically offered on the unit during times like these.

More briefly, the message is: We all just have to live with this.

Holly affirms this to be so.
um, and that’s helpful to some people. I usually don’t find that overwhelmingly helpful, um, and they’re always offered, like, during the week or … at a time that I’m not driving in there to talk about why work makes me sad, you know? [laughs] Like – my kids have that therapy for me, and, we have it at home and, that’s fine. Yeah…

PI: Okay … alright … right.

* * *

PI: Do you have words, or do you and your friends on the unit have words you use to describe what it’s like, in terms of what you deal with emotionally, interpersonally … in the course of this work?

H: Well, I definitely think we call it trauma. Like, we all recognize that this is traumatic to walk through these times in people’s lives with them.

PI: Traumatic for you all.

H: Yeah, like it’s our trauma too. I think we all recognize that, and talk about that … and we’re happy to tell people that it sucks. [lets out a sardonic laugh]

When Holly and her fellow weekend night PICU nurses talk about what this work is like for them, about what they deal with emotionally and interpersonally in the course of their work, they simply call it trauma. They all recognize that it’s traumatic to walk through these times in people’s lives with them. They consider it traumatic for them as nurses, not just for their patients – it’s their own trauma, too.

PI: Management offers debriefings for the nurses, but Holly does not find them ‘overwhelmingly helpful.’ Further, they’re typically offered when W/N shift nurses are gone, during the week, which would require them to make an extra trip to the hospital to participate. Holly is not about to leave her family and drive in ‘to talk about why work makes me sad.’ She finds comfort & support with her family, and that has been enough.

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Holly states that all the nurses recognize this and talk about it, and they don’t hesitate to tell people that it sucks.

Management offers debriefings for the nurses, but Holly does not find them ‘overwhelmingly helpful.’ Further, they’re typically offered when W/N shift nurses are gone, during the week, which would require them to make an extra trip to the hospital to participate. Holly is not about to leave her family and drive in ‘to talk about why work makes me sad.’ She finds comfort & support with her family, and that has been enough.

* * *

With regard to the topic of STS, Holly does not speak about herself individually, but rather speaks collectively of the group of nurses with whom she has worked so closely for five years.

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PI: Traumatic for you all.

H: Yeah, like it’s our trauma too. I think we all recognize that, and talk about that … and we’re happy to tell people that it sucks. [lets out a sardonic laugh]
PI: Uh-huhn.

H: We tell each other, you know, that it sucks. Uh … [pause] … so, I think – I mean, we are very good at taking care of each other. Like, we recognize that what we do isn’t easy. And I think that as a unit, as a whole, because we’re small enough to all know each other and know each other well, and especially working weekends means our core weekend staff all work together all the time, so you’re … you are a team. Like, you’re not randomly working with different people all the time, you’re…you become each other’s family every weekend. We fight like brothers and sisters by Sunday, we all joke that – ‘it’s Sunday night, and everybody’s catty like their sister.’ [laughs] You know, like, that’s part of what we do. So, I think … yeah, we’ve learned to take care of each other and be really frank about how much things suck, or how hard they are. … As for specific words, I don’t know.

PI: It sounds like this is where the ‘debriefing’ really happens.

H: It totally does. Totally.
APPENDIX F

FOCUS GROUP ANALYTIC SAMPLE

The following pages provide a working example of the analytic process followed with focus group data.
C: And I thought – God, how awful of me to feel that way. How awful [she laughs nervously] … of me to be … upset that nobody acknowledged what we did. I, like – that’s so selfish of us, because – here this man lost his wife and his baby, you know … but – you feel bad for having those feelings. You feel – you know, it’s this – awful place to be in, and … to get through – that really bothered me for a really long time. It’s like, I’m a really selfish person, and I would beat myself up over it, being selfish, and being … egotistical … but I don’t feel like that’s what that is – I don’t truly feel that that’s what that emotion is. But I don’t know, but I ended up, I told you [PI], going to Reiki and … um, you know, doing a lot of meditation and stuff to help with the pain, but … I’ve never completely processed that. Like what to do with that – cuz every time I bring it up, I get that … [gesturing with hands around her neck, her voice taking on a higher, thinner quality] … feeling in my throat.

FIRST ANALYTIC STEP – 3rd PERSON VOICE – close paraphrase:

Constance thought, ‘God, how awful of me to feel that way.’ She thought it was awful of her to be upset that no one acknowledged what she and the NICU nurses had done – that it was selfish of her, because this man had lost his wife and baby. So she felt badly for having these feelings and said it’s an awful place to be and to try and get through. It has really bothered her for a really long time – feeling that she’s a really selfish person. She would beat herself up over it psychologically – for being selfish and egotistical. But when she has reflected on it, she doesn’t truly think the emotions she’s had are about selfishness. But she doesn’t know, and she ended up dealing with all this by going to some Reiki sessions and doing a lot of meditation to help with the pain she was experiencing. But she knows she’s never really processed the events, or figured out what to do with the experience internally – because every time she thinks about it, she gets an awful choking feeling in the area of her neck.

SECOND ANALYTIC STEP – EARLY EIDETIC TRANSFORMATION – sensitive to the literature on STS and responsive to the study’s purpose & research questions:

Constance felt very critical of herself about her anger, resulting from the lack of any recognition as to the emotional commitment she and the NICU nurses had made to helping the father. Intellectually, she understood he had just sustained an almost unbearable loss and her suffering seemed small compared to his. Yet, she still felt hurt that her altruism and grief were unacknowledged. She also felt trapped in this clash of conflicting thoughts & feelings: an ‘awful place to be.’

Because she had never experienced something like this before, she had no sense of whether her feelings were understandable, or were selfish and egotistical.

Even though she sought help, and had found help from Penny, she knew she had resolved the psychological pain of the events that day, and her pain was still manifesting itself physically.

THIRD ANALYTIC STEP – FURTHER EIDETIC TRANSFORMATION – employing more extensive ‘free imaginative variation’ to constitute genetic meaning structures:

In our individual interview, Constance had not mentioned the anger she felt, initially toward the father. Nor had she spoken of her anger with herself for her feelings. She had only said she never wanted to have to speak to the father.

Constance’s conflict of thoughts and emotions led to an internal psychological crash that haunted her for months. She felt trapped with these internal forces and found that she could not free herself at will from their impacts inside her.

These internal forces soon manifested for Constance as very severe physical pain.
PI: Yeah, your chest and throat? That whole area …

C: Agh! It’s awful! Yeah, yeah, it’s awful. But, you know … is that a normal feeling? I don’t know. Is that, you know – what does that mean – what does that say about your character as a person, that you feel like that…?

PI: And, have you had a place to ask those questions, other than when it’s come up…

C: Un-nnn. [shaking her head, no] That’s the first time I’ve ever said that to anybody. [pause of a few seconds] You don’t want … [suddenly, Constance stops, and for the first time during this account of the mother’s and baby’s deaths, she begins to cry … there is another significant pause; then Constance speaks though choking sobs] You already judge yourself enough. You don’t want to be judged by somebody else.

PI: [very softly] Yeah …

[Constance cries quietly as Yvonne & PI sit quietly & attentively]  
[pause]

and upper chest. It’s really awful, and she doesn’t know if this is a normal feeling to have. But she does wonder what it says about her character as a person, that she would have feelings like she did in response to the events.

She hasn’t had any place or any person with whom to ask these questions until now – and this is the first time she’s ever told anyone about these feelings that she’s had since the events.

Constance began to cry when she acknowledged that she’s never expressed this to anyone, including during our initial interview, when she recounted most of the same events – but not her distressed feelings about her actions not having been acknowledged at the time, nor her guilt and self-reproach about those feelings in the months that followed.

Constance said the reason she’d never told anyone of her feelings was she didn’t want to be judged by someone else – she was already judging herself harshly enough.

She cries for several minutes.

Constance, as a relatively new critical care nurse, had no normative sense of whether the thoughts, recurring memories, emotions, and physical sensations she had been experiencing were ‘normal’ for trauma nurses.

She feared that her feelings testified poorly to her character as a person and a nurse.

Consequently, she had kept these thoughts and feelings almost entirely to herself. In fact, she had never before told anyone what she shared in the preceding moments of the focus group.

Acknowledging all this to the PI and to Yvonne, a fellow critical care nurse who demonstrated empathy, triggered an emotional release in Constance: she began to cry openly and confessed that she had feared others’ judgment – which would have been added to the burden of her own self-judgment.

Constance’s physical pain was a reflection of her psychical pain. It gave voice to her mourning and her guilt, as well as to her anger about being placed in such a painful position: for as she said in the individual interview, “I never wanted to see the husband… and I ended up having to…."

Also, as she had said in the ii, “I lose my voice when I get really upset like that. …I kind of scream in my head, but I can’t—voice.” Though Constance had voiced her profound grief to Penny, she had never voiced to anyone her anger, her guilt, or her shame and fear that her feelings meant she was a bad person and a bad nurse.

Describing all this to Yvonne and the PI gave her a greater sense of voice, and helped her to convey significant emotions.

The apparent structure of meaning Constance had constituted from her encounter with the father was that all her efforts had not helped him, but rather, her offering (of the photos, etc.) was an intrusion. This structure precipitated her loss of hope that she could help him, and became further linked to a notion that she must be a bad nurse and a bad person for feeling such things.
Yv: I think when you give so much of yourself … that you, um … [Constance has audibly shaky breathing as she listens to Yvonne] … it sounds like you gave an awful lot of yourself that day.

C: [crying more quietly] Yeah …

Yv: You weren’t just going through tasks; you were going through a lot of emotion.

C: [through soft choked sobs] Uhn-hnn.

Yv: And that was probably the first time you’d ever bathed a dead baby…?

C: [slight groan] Yeah.

Yv: So, that was quite a monumental day for you also…. And, of course, you did it so he would …

C: I couldn’t fix it, but I could –

Yv: … to take away some of the pain –

C: – for him. Like I could do something. You know, there’s that feeling like you can’t do anything? You get so frustrated, like you said, when you can’t do anything. It’s so hard – and this is something tangible that I could do. I couldn’t

Yvonne’s calm recognition of how deeply Constance had given of herself physically, mentally, and emotionally that day appeared to calm and reassure Constance. She released more than one deep, shaky breath, and was able to continue crying, but more quietly, and could also to listen and make eye contact with Yvonne and the PI.

Yvonne voiced recognition that Constance had made a profound emotional commitment to this family: she had undertaken nursing care that she had never before imagined, let alone performed, and had carried it out with compassion and concern for a family’s loss, not merely as tasks to be completed.

Yvonne demonstrated an understanding of Constance’s deep desire to help the single person who was still alive to be helped – the father – and she showed understanding of the frustration and pain that results when there is so little one can do to help another.

Yvonne also continued listening, without pressing her perspective, when Constance voiced more of her own frustration and pain.

Constance had so hoped she could help the father through her acts of

In voicing her hurt, anger, fear, guilt, and shame with Yvonne and the PI, Constance took the risk of testing her constituted meaning structure intersubjectively: would Yvonne and the PI condemn her as she had condemned herself?

In the quiet witnessing of her pain, and the gentle affirmation of her actions reflected in Yvonne’s verbal and nonverbal response, and the PI’s nonverbal response, Constance found that she was not judged, but was cared for and respected.

In this situation, Yvonne (primarily) and the PI (secondarily) functioned as Miller’s enlightened witnesses. Yvonne, in particular, had personally accomplished a depth of self-awareness and self-understanding that she did not have a psychic need to hijack (so to speak) Constance’s experience in order to work on reconstituting meanings from past experiences of her own. Rather, she was able to remain calmly focused on and sensitive to Constance’s meaning-making throughout the dialogue.
fix her; I couldn’t fix the baby; but I could do something for Dad.

Yv: To maybe make this not so awful.

C: Yeah.

Yv: So … but giving … this being your first experience in that, I’m sure your emotions were just an awful mess.

C: Uhn-hnn.

Yv: And you probably just wanted someone to just take care of you at that moment in time.

C: [softly] Uhn-hnn.

Yv: And to hand that stuff to Dad and have him not have any idea, or knowledge of … or – didn’t even want to know at that moment – what your day was like, was hurtful.

C: You don’t want him to know –

Yv: Of course you don’t …

C: … but you want him to be – like, it’s such a sacrifice, like you said, we gave so much of ourselves, and then the realization that he will never know, but then, we did that so he wouldn’t know. It’s such an –

done. Constance said that the feeling of not being able to do anything is very frustrating for her, but she had tried to stay focused on something tangible that she could do to help.

Yvonne affirmed how very hard all this is emotionally, especially since Constance had never provided such care under such tragic conditions before. And she added that Constance would have an understandable need for someone to take care of her at time like that. Constance agreed. Yvonne then expressed an understanding of how hurtful it could feel not to have any of her efforts – both physically and emotionally – be acknowledged by the person for whom she’d done it.

Constance said that she really didn’t want the dad to have to know all that she and the NICU nurses had gone through in order to provide him with his beautiful swaddled baby to hold, and pictures and handprints and other tangible things by which to remember his baby.

Yvonne acknowledged that you don’t want a parent to know in detail, but Constance added that, at the same time, she did want preparing the bodies of his lost wife and child. Her pain resulted partly from her disappointment that these acts could help him more.

Because Yvonne was the only nurse with whom Constance had risked this much disclosure of her constituted experience, this conversation was the first in which Constance could access another critical care nurse’s appraisal of the situation, and how difficult it was—for any nurse, even an experienced one, but especially for a relatively new nurse.

Yvonne systematically reflected back to Constance the various feelings and needs that Yvonne perceived intersubjectively through Constance’s description of her experience. Constance’s responses indicated that Yvonne’s reflections were largely accurate, though Constance freely refined the new meanings Yvonne expressed.

Yvonne began to voice tentative engagement with the possible revision of her meaning structure that Yvonne articulated, in contrast to the one she had thus far claimed. This revision included greater recognition of Constance’s selfless and courageous intention to do everything she could to help the father, her ability to find inner strength to carry out that intention over many hours of physical labor, and her willingness to engage in the emotional labor necessary to complete her nursing tasks with deep compassion rather than emotional distance & guardedness.

Constance’s meaning structure (i.e., her constituted belief) that the father “will never know” and so never be able to appreciate what she and the two NICU nurses did in an attempt to help him that day was a key morphological essence she had constituted from the day.

Through their dialogue, the two nurses gradually rewrote aspects of the narrative (meaning) structure of Constance’s motivations, needs, feelings, and desires.

Intersubjectively, Constance began to take tentative engagement with the possible revision of her meaning structure that Yvonne articulated, in contrast to the one she had thus far claimed. This revision included greater recognition of Constance’s selfless and courageous intention to do everything she could to help the father, her ability to find inner strength to carry out that intention over many hours of physical labor, and her willingness to engage in the emotional labor necessary to complete her nursing tasks with deep compassion rather than emotional distance & guardedness.

Constance’s meaning structure (i.e., her constituted belief) that the father “will never know” and so never be able to appreciate what she and the two NICU nurses did in an attempt to help him that day was a key morphological essence she had constituted from the day.

This essential meaning structure organized a great many related feelings and memories.
Yv: I don’t agree … that he’ll never know. Was he going to know at that moment? Un-nnn. He was too full.

C: Uh-hnn …

Yv: Did he ever look back and think, ‘Oh my goodness.’ Did people say, ‘Oh my goodness, they took the time to take those pictures – I had a baby die and nobody did…’ you know – I … I don’t believe that he never knew or never acknowledged … I don’t believe that at all. I just think at that moment …

C: Uhn-hnn …

Yv: … he was too full …

C: Uhn-hnn.

Yv: … and could not possibly, even … you could have probably told him he just got a billion-dollar check, and he wouldn’t have cared.

C: And then I felt awful for being upset by that, I do. [her voice still slightly shakey with crying] I feel awful, because he was having that moment with his son, and it was just like, I can’t –

Yv: I’m sure you do.

Yvonne did not hesitate to disagree, gently but clearly and directly, with Constance’s belief that the father would never know what she gave of herself that day.

Yvonne said she disagreed that the father would never know. She said that he just couldn’t know it in that moment – he was ‘too full’ of other thoughts and feelings at that time.

Constance stated that she still felt awful for being upset by the father’s dismissive response, because she understood he was having his only moments to hold his baby son right then, and she can’t get over feeling this guilt.

Yvonne did not hesitate to disagree, gently but clearly and directly, with Constance’s belief that the father would never know what she gave of herself that day.

The possibility that the father might look back later with a different understanding apparently had not occurred to Constance before, or if it had, she had dismissed the thought.

Now, however, having access to the perspective of a veteran pediatric critical care nurse who could grasp her experience, Constance appeared to find this alternative possibility plausible and comforting, to an extent.

Yet, she continued to feel guilt for her hurt and disappointment that there was no space in the events of that day for her own pain. Further, this point in Constance’s account evidences that she also felt pain and guilt that her only contact with the father seemed to disrupt his “having that moment with his son,” thereby causing him further pain, rather than comforting him.

Yvonne affirmed that such pain in Constance is understandable.

Whether or not Yvonne recognized this belief as an essential structure in Constance’s consciousness, Yvonne tactfully, but directly challenged the belief.

In the theoretical language of CS/CF research, Constance was not able to derive satisfaction from her practice of compassionate care through her encounter with the father, and for this reason CF eclipsed CS. Yet such an analysis reduces very complex perceptual and intersubjective experiences to a single axis of significance.

The individual interview evidenced that Constance was neither prepared nor assisted by more senior staff to undertake this profound moment with the father, which she was asked to carry-out.

Yvonne’s suggestion that the father was “too full” provided Constance with another lens by which she could approach constituting meaning from her encounter.

Even as she suggested alternative “readings” or interpretive meanings for the father’s actions, Yvonne did not minimize or dismiss Constance’s meaning-making.
C: You know …

Yv: I’m sure you do. I would never discount that you do. But that probably is part of your process of being a more seasoned nurse …

C: Uhn-hnn …

Yv: … is … acknowledging and going, Oh my goodness – but I just feel you had a very overwhelming day, yourself, and you just needed someone to give you a hug and say, Oh my goodness, what you did was wonderful.

C: Yeah, because we went back to work after that …

Yv: … and nobody … and nobody did.

C: Uhn-uhnn…. No, and I asked –

Yv: And you’re like, ‘Really?!’

C: Yeah!

Yv: ‘This is the most amazing thing I have ever done in my life, and not one person has acknowledged it.’

C: Uhn-hnn.

and feelings like these are all part of the process of growing into a more seasoned nurse. She said this growth involves acknowledging these responses in oneself, but also recognizing that it was an overwhelming day, and that Constance herself had a legitimate need to be cared for too – such as someone to give her a hug and say, ‘Oh my goodness, what you did was wonderful.’

Constance stated that, far from it, when all these events were over, the nurses all just went back to their work with other patients.

Yvonne probed with a statement, as to whether anyone had shown recognition of the quality and commitment demonstrated in Constance’s work that day, and Constance confirmed that no one had expressed this to her. Yvonne then responded, as if she were Constance: ‘Really?!’ Constance agreed that this is how she felt. Yvonne continued, as if she were in Constance’s place, ‘This is the most amazing thing I have ever done in my life, and not one person has acknowledged it!’

Constance agreed.

Yvonne did not minimize Constance’s perception that the presentation of photos, etc, was not carried out in an effective manner so to comfort or help the father cope in that moment, but she also implied by suggestion that Constance was not a seasoned, senior nurse who could have been expected to manage such a moment without support and guidance.

Further, Yvonne affirmed that Constance had legitimate and very overwhelming needs of her own, which were not being recognized or met that day.

Constance’s return to her refrain that “we went back to work…,” which she voiced immediately as she began her first description of this day in the individual interview, suggests that this is another key morphological essence in her constituted experience—i.e., the injustice and, indeed, violence, entailed in being sent back to work immediately following many hours of embodied human engagement with a complex trauma of such tragic magnitude.

Yvonne found a way to craft language that recognized the newness of Constance’s immersion in critical care nursing work, while simultaneously affirming her impressions, experienced feelings, and interpretive meaning-making.

Yvonne also shifted the focus of their dialogue from what happened between Constance and the baby’s father to what happened between Constance and the more senior nurses in the ED that day. This opened an intersubjective conceptual space for new possibilities of reflection, interpretation, and also mourning, and further supported mutual learning between them.

Yvonne modelled for Constance what Yvonne considered a fully legitimate perspective toward Constance’s work that day—that Constance was “amazing” and she deserved to be acknowledged and respected for the series of actions she undertook that day.

Yvonne thus implicates the ED senior nursing staff as culpable in their repeated failure to provide such recognition or support.
APPENDIX G

GLOSSARY OF MEDICAL TERMS

**ALS:** Advanced life support; sometimes known as ACLS, advanced cardiac life support

**ADN:** Associate Degree in Nursing

**Attending:** short for attending physician, a hospital staff physician who is responsible for the medical treatment of patients on a particular unit or group of units; in an academic medical center, the attending also oversees the work of medical students, interns, and residents

**Bristojet:** a medication dispenser for emergency intravenous drug administration; typically, bristojets are used to administer concentrated doses of epinephrine, atropine, or similar medications in a full code situation

**BSN:** Bachelor of Science in Nursing

**CISD:** Critical incident stress debriefing, sometimes referred to simply as a debriefing

**Code:** an emergency resuscitation; sometimes known as a “code blue”; a full code involves aggressive cardiopulmonary life support and resuscitation efforts as well as life support interventions for other major organ systems and the prevention or treatment of shock

**ED:** Emergency department; also known as an ER, emergency room, or an EU, emergency unit

**GN:** Graduate Nurse, an RN candidate who has received a degree or diploma, but has not yet passed the state board of nursing examination

**Gomer:** an acronym, GOMER, “Get out of my emergency room”; the term came into use among medical interns in the 1970s; it typically refers to an aging adult who suffers from some form of advanced dementia superimposed on a constellation of other chronic diseases that are difficult to treat medically

**ICPs:** intracranial pressure readings

**ICU:** intensive care unit

**LPN:** Licensed Practical Nurse

**MICU:** medical intensive care unit
NICU: neonatal intensive care unit; an ICU for newborn and premature infants

PICU: pediatric intensive care unit

SICU: surgical intensive care unit

RN: Registered Nurse

Palliative care: comfort care measures; a specialized form of medical and nursing care designed to minimize physical and psychological suffering during protracted periods of illness, including but not limited to end-of-life situations

Vasoactive drip: a slow, sustained intravenous infusion of a medication that directly affects the cardiovascular system, particularly, for the emergency treatment of extremely low blood pressure; the rate of these infusions are titrated in dynamic relation to blood pressure changes
VITA

PATRICIA HOLLAND WEBB

Education

  Major: Adult and Community Education
  Supporting Areas: Transformative Learning, Narrative Learning Theory

BA, with Honors, University of Pittsburgh, College of Arts & Sciences, Pittsburgh, PA, 1988.
  Major: English, The Writing Program, Supporting Areas: Literary Fine Arts, Classical Studies

BSN, with Honors, Ohio State University, College of Nursing, Columbus, OH, 1979.
  Major: Nursing Practice

Selected Professional Background

Registered Nurse, State Correctional Institute at Benner, Pennsylvania Department of Corrections (PADOC). (June 2016 - present). One of a 19-nurse team providing direct inpatient and outpatient medical and psychiatric care to a 2,100-inmate population. Bellefonte, PA, USA.

Founder & Principal, The Learning Shire, LLC. (July 2006 - Present). Health education consultancy focused on individual and group learning for patients, families, and healthcare professionals. Offering informational seminars, animal-assisted learning, and counseling sessions on disease management, critical thinking, reflective learning, team-building, mind-body integration, and psychological resilience. State College, PA, USA.

Instructor, Indiana University of Pennsylvania. (January 2015 - June 2015). Graduate instructor for capstone research course for the Master’s degree program in adult and community education. Indiana, PA, USA.

Registered Nurse, Mental Health Management Services (MHMS). (May 2014 - June 2016). Direct psychiatric nursing care as a contract provider in a forensic mental health unit at the State Correctional Institute at Rockview, PADOC. Bellefonte, PA, USA.


Primary Acute Care Registered Nurse, Ohio State University Hospitals. (1979 - 1981). Cardiovascular intensive & intermediate care and medical intensive care units. Hospital service as Professional Liaison Committee member. Columbus, OH, USA.

Awards and Honors

Nicholson Fellowship, Penn State University, Adult Education Program. University Park, PA, USA. (August 2009 - June 2010).

Margaret Mahler Award for Outstanding Graduate Student Research, Indiana University of Pennsylvania. Indiana, PA, USA. (May 2008).