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Revisiting the Fork in the Road: Exploring the Meaning of Critical Incident Stress Among Intensive Care Unit Nurses

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Revisiting the Fork in the Road: Exploring the Meaning of Critical Incident Stress Among Intensive Care Unit Nurses

by

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Abstract

The nature of registered nurses' (RNs') work in the intensive care unit (ICU) places them at risk for encountering work-related critical incident stress. Critical incident stress is a term used to describe the broad and diverse range of responses that occur following a sudden and unexpected event known as a critical incident. Critical incident stress in the context of ICU nurses has been understudied. The purpose of this inquiry was to expand understanding of the meanings of work-related critical incident stress for RNs working with adults in the ICU. This research study was conducted using an interpretive approach based on Gadamer's philosophical hermeneutics.

Nine ICU RNs were interviewed to gain insight and further understanding of this topic. The interpretations from this work suggested that nurses attempted to cope with critical incident stress by functioning in "autopilot," altering their ability to critically think and conceal emotions. Critical incident stress was influenced by the perception of judgment from co-workers and by the organizational culture. Participants emphasized the importance of timely crisis interventions tailored and individualized to support those in need of assistance. The concept of co-worker support underpinned by an authentic way of being with another through relating and connecting with team members was one element of crisis intervention considered beneficial. This study highlighted that critical incident stress was transformative in how ICU nurses' practiced and in their view of nursing. For some participants, transformation took place in the form of an altered professional self-identity. Understanding the experience of critical incident stress in the context of ICU RNs has implications for nurses, the discipline, and the health care system.

Preface

This thesis is original, unpublished, independent work by the author, G. Harvey. The descriptive findings reported in Chapters 4-8 were covered by REB16-1433, issued by the University of Calgary Conjoint Health Ethics Board for the project "Revisiting the Fork in the Road: Exploring the Meaning of Critical Incident Stress Among Intensive Care Unit Nurses" on February 9, 2017.

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To my sweet Sera, my world, my-everything, you motivate and inspire all that I do. I hope that I have role-modeled to you that anything is possible with hard work and perseverance.

To Adrian, my husband, I continue to admire your adventurous spirit in your willingness to take risks to better yourself personally and professionally. You encouraged me to take this risk and motivated me to begin this work – I am thankful to you!

And to my "Nonna Rosa," my guardian angel, although you are not here in person I know you are always with me as I continue trekking along my destined path.

Dedication

To my intensive care unit nursing colleagues who remain dedicated and committed despite the risks that challenge the work that you do, your courage does not go unnoticed.

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Chapter One: The Tap on My Shoulder-Being Addressed by the Topic

The Road Not Taken (1916)

Two roads diverged in a yellow wood,
And sorry I could not travel both
And be one traveler, long I stood
And looked down one as far as I could
To where it bent in the undergrowth;

Then took the other, as just as fair,
And having perhaps the better claim,
Because it was grassy and wanted wear;
Though as for that the passing there
Had worn them really about the same,

And both that morning equally lay
In leaves no step had trodden black.
Oh, I kept the first for another day!
Yet knowing how way leads on to way,
I doubted if I should ever come back.

I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood, and I –
I took the one less traveled by,
And that has made all the difference.

Robert Frost (1874-1963)

This poem written by Robert Frost resonates with me as I vividly recall a monumental experience as an intensive care unit (ICU) registered nurse (RN) that led me to a fork in a road. "Be one traveler, long I stood" (Frost, 1969, p. 105) carefully and methodically examining each path, recognizing the need to make a decision that I would not regret. I pondered over and over whether or not to take the path that led to continuing my career as a nurse, or to take the other route and leave the profession. I proceeded cautiously and with uncertainty, "knowing that I could not travel both" (Frost, 1969, p. 105). Slowly placing one foot in front of the other I questioned the possibilities, the

"what if?" and the "what could be?" I "then took the other, as just as fair, and having perhaps the better claim" (Frost, 1969, p. 105), the path that had me continue as a RN. It was the potential for personal and professional growth that made one road more desirable over the other. Moving forward, "knowing how way leads on to way, I doubted if I should ever come back" (Frost, 1969, p. 105). However, deep into my travels I was presented with an opportunity to come back, to rigorously explore and attend to my curiosity of how I once arrived at the place that presented two diverging roads. As a doctoral student in nursing I revisited this fork in the road to better understand it.

The Event Leading to the Fork in the Road

"Understanding begins when something addresses us" (Gadamer, 1960/2013, p. 320). Being addressed personally by something is like a firm tap on the shoulder, it is becoming acquainted with something so powerful that it lures us in and once captivated, it transforms us. The experience of being addressed puts us in a place where we feel perturbed, agitated and uncomfortable, yet keen, curious, and open to its possibilities. As a novice nurse working with adult patients in the ICU I was confronted with, and later addressed by, the topic of critical incident stress. The following reflections are from a journal excerpt that I wrote to describe my first encounter with critical incident stress, the event that led me to the fork in the road.

It was four in the morning and my last of four shifts in the ICU. My "stable" patient who was waiting to be transferred to a surgical unit was sound asleep. Quietly doing the checking and monitoring at his bedside, I looked at him sleeping peacefully and recall feeling envious of how calm and serene he appeared. The charge nurse informed me of an admission I was about to receive; this was a second patient to be added to my

assignment. My new patient was a 20-year old woman who had been in a motor vehicle accident and sustained multiple traumatic injuries. Even after a year working in the ICU I was still nervous admitting a new patient. The nervousness stemmed from the unpredictability and complexity of patients who had experienced traumatic injuries. I primed intravenous lines, prepared "big bertha" (the rapid infuser used to replace large amounts of intravenous fluids after excessive blood loss) and grabbed the cart that contained arterial and central venous catheters in preparation for the admission.

Within 10 minutes of being informed of the admission, my patient arrived on a stretcher with multiple emergency room (ER) nurses and a respiratory therapist. The ICU medical resident and several of my nursing co-workers rushed to the bedside to assist. I received report from the ER RN who indicated that "Jane" (a fictitious name) had multiple fractures, a facial laceration and large hematoma to her abdomen, a closed head injury, and bilateral pulmonary contusions. I briefly glanced at Jane and noted the fresh blood and swelling made her face unrecognizable. The parts of her face that were visible appeared pale and bruised. With her dark hair and petite bone structure I was struck by how she looked a lot like my sister. As Jane was wheeled in, the scent in the room suddenly shifted from stale cleaning products to fresh blood. The noise from multiple ICU staff members speaking at the same time made it difficult to grasp Jane's immediate needs and plan of care. As I was gathering and prioritizing my thoughts, the charge nurse escorted Jane's mother into the room. She stood at the end of Jane's bed sobbing uncontrollably; the grief of a mother filled the room and was unbearable to watch.

In spite of all the activity around me, my body position was fixed. My physical stance had not changed since the ER RN provided me with the verbal report. My feet felt like they were cemented to the ground; I started to sweat and the nausea was impossible to control. The movement of others in the room was robotic, attending to the tasks they had selected. Jane, lying unconscious in the bed with a barely palpable pulse, did not appear to bother them. When I looked at Jane I saw my sister. I was angry, sad, and frustrated that no one else in the room was visibly impacted by Jane's ordeal. One of the ICU RNs yelled "her blood pressure and pulse are dropping" and suddenly what seemed like a motion picture was now in "fast forward" mode. What was I supposed to do now? My feet were still stuck to the floor and I was paralyzed physically and mentally. I couldn't think, I didn't know what to do next and I was overwhelmed. I couldn't imagine what the others around me were thinking as they looked at my inability to move or do something to help. What was wrong with me? Why was Jane making me feel like this? I couldn't think logically or clearly and felt unsafe to provide patient care. What am I doing here? Maybe I shouldn't have become an ICU RN? Maybe I shouldn't have become a RN? This had never happened to me before, why now?

I asked the charge nurse to re-assign the care of Jane to another colleague. Without hesitation, the charge nurse asked a senior colleague to take care of the young woman. I tried to leave the room discreetly and all I really wanted to do was scream and cry at the same time. I found myself absorbed in a world that had suddenly become foreign and unfamiliar. I knew that I still had one patient to care for, but I couldn't bear to go back to my assigned station. Was I the only RN who had ever felt like this while caring for a patient? How could I feel so alone in a room full of people? Why did I feel so

isolated for weeks after this event? Very sadly, Jane died several hours after her admission to the ICU.

Several days after Jane died I suffered from lack of sleep, little appetite and frustration from my inability to rationalize the experience I had encountered. Eventually my lack of sleep subsided and I regained my appetite, however I remained haunted by the numerous unanswered questions. One question in particular became an obsession as I desperately attempted to seek a response to –what did I experience? This incident in the ICU took place concurrent with the beginning of my studies in the Master of Nursing program. At that time, I shared these challenges with my faculty supervisor who encouraged me to engage in reflective writing. It was through ongoing journaling, a review of the literature, and self-understanding that led to naming the experience "critical incident stress." It was at this point that I had been addressed by the topic. This address arrived with an invitation to respond to the tap on the shoulder, to confront what had unexpectedly greeted me face-to-face. Critical incident stress in the context of ICU nursing became my area of focus in my masters and doctoral studies. My return to the fork in the road was not a coincidence or accidental, it was deliberate and influenced by my ongoing relationship, the bond and deep personal connection I have with the topic.

Why Revisit the Fork in the Road? The Significance of the Topic

The personal experience I shared is an example of a work-related critical incident. A critical incident is an unexpected event considered traumatic because of its ability to overwhelm commonly used coping abilities that result in distress (Everly & Mitchell, 1999, 2008). The nature of nurses' work in the ICU places them at risk for encountering a

critical incident. Hay and Oken (1972) offered a vivid description of ICU nursing and the potential for distress associated with challenging situations.

> In addition to mechanical stimuli, one can discern moaning, crying, screaming, and last gasps of life. Sights of blood, vomitus and excreta, exposed genitalia, mutilated wasted bodies and unconscious and helpless people assault the sensibilities. Unceasingly, the ICU nurse must face these affect-laden stimuli with all the distress and conflict that they engender. (p. 382)

Exposure of ICU nurses to work-related critical incidents leads to critical incident stress (de Boer, van Rikxoort, Bakker, & Smit, 2013; Mealer, Shelton, Berg, Rothbaum, & Moss, 2007). Critical incident stress includes the psychological, physical, and existential responses that may be exhibited by those that have experienced an extraordinary work-related trauma (Everly & Mitchell, 1999, 2008; Mitchell, 2010, 2012). When ICU nurses become emotionally distressed as a result of a critical incident, their thinking may become disorganized and unclear (Mitchell, 2012). This means that ICU nurses may experience cognitive impairment evidenced by poor concentration, memory lapses, and confusion (Caine & Ter-Bagdasarian, 2003). In a clinical practice area that requires quick decision-making and high concentration, this cognitive impairment may compromise patient safety. Research suggests that critical incidents are correlated with a loss of confidence in clinical knowledge and abilities, as well as medical errors that potentially lead to adverse events (Arndt, 1994; LeBlanc, MacDonald, McArthur, King, & Lepine, 2005; Seys et al., 2013; Wolf, Serembus, Smetzer, Cohen, & Cohen, 2000). All of those who are exposed to a critical incident will experience some degree of distress, and 9% - 45% of those individuals may develop significant dysfunction (Everly & Mitchell, 2008).

The impact from a work-related critical incident may extend beyond patient care, influencing nurses' health and the health care system (Caine & Ter-Bagdasarian, 2003). Researchers have demonstrated that ICU nurses are at increased risk of post-traumatic stress disorder (PTSD), depression, and anxiety (Mealer, Jones, & Moss, 2012; Mealer et al., 2007). Nurses' health is important to consider given they are known to have one of the highest levels of absenteeism (Dabboussy & Uppal, 2011). One of the primary reasons for high absenteeism rated among nurses is psychosocial factors such as work related fatigue and stress (Shamian et al., 2003). There is a stigma attached to showing vulnerability following a critical incident that makes this experience challenging to endure and difficult to expose (Avraham, Goldblatt, & Yafe, 2014; Halpern, Gurevich, Schwartz, & Brazeau, 2009). The need to respond to the firm tap on my shoulder was influenced by obligation and responsibility to ICU RNs, to the health care system, and to critically ill patients.

Responding to the Tap on my Shoulder

The critical incident stress I experienced led me to two diverging roads, where I experienced uncertainty in selecting what I hoped would be the right path. The route I chose many years ago has led me to a place of further exploration, an opportunity to dig more deeply into the topic, all the while challenging my personal assumptions and beliefs. I have come to see the critical incident stress I experienced as more than a response to a work-related event; it was a personal tap on *my* shoulder that summoned *me,* and I have responded. The research question that guided my inquiry of the topic was: how might we understand the meanings of work-related critical incident stress for RNs working with adults in the ICU? This inquiry addressed the experiences of nurses

licensed only as RNs hence, moving forward the term “nurse” will be used interchangeably with RN. The next chapter will address the traditions and prior understandings that have situated this topic, and influenced my pre-suppositions.

Chapter Two: Traditions and Prior Understandings that Situate the Topic

"To study psychological trauma is to come face-to-face with human vulnerability in the natural world…" (Herman, 1992, p. 7)

"To understand anything at all requires having an angle on it, a perspective, an interpretive slant, in the absence of which we would just not understand, period" (Caputo, 2018, p. 5). My angle, my perspective, my slant on this topic has been informed by my personal experience, as well as an ongoing review of the relevant anecdotal, research, and seminal literature. Anecdotal is a term I have selected to describe sources that are not formal research studies, but which are written by those with expertise in the area of interest. I see these resources as the housing of traditions and prior understandings that situate the topic, and ultimately the research question. In this chapter I will provide an overview of the particular traditions and prior understandings that have been beneficial in the conduct of my inquiry, and influential in my ongoing interpretations of the topic. I will begin with a broad overview of critical incident stress, and then narrow my discussion by exploring this type of stress in the context of nursing, followed by ICU nursing.

The Ever-Present Vista of Critical Incident Stress

The word "critical incident" originated from the field of organizational behavior, and was initially used by John Flanagan (1954) as a method of analysis for determining successful and unsuccessful job outcomes (Everly & Mitchell, 2008, p. 4; Flanagan, 1954, p. 1). Flanagan (1954) referred to a critical incident as a technique for gathering data that involved direct observations of human behavior to solve practical problems. Today, the term critical incident is primarily used in a different realm. More specifically,

a critical incident is frequently referred to as a traumatic event that is perceived as threatening and distressing (Everly & Mitchell, 1999, 2008; Mitchell, 2012; Mitchell & Everly, 1997). An individual may experience a critical incident directly (primary trauma) or indirectly (secondary traumatic stress) by witnessing or empathizing with the suffering of others (Figley, 1995; Mitchell, 2012). Authors agree that experiencing a sense of helplessness over a situation and a personal connection are common characteristics of a critical incident (Beavan & Stephens, 1999; Burns & Harm, 1993; Cottrill-Walker, 2000; Gates & Gillespie, 2012). A critical incident is subjective and individualized; thus no two individuals will likely experience a critical incident in the same way (Appleton, 1994).

What is Critical Incident Stress?

Critical incidents may produce a spectrum of physiological and psychological responses (Mitchell, 2012; Mitchell & Everly, 1997). Some of these responses may occur as a result of stress hormones such as cortisol and adrenalin that are responsible for preparing the body to fight the threat, or flight and run away (van der Kolk, 2014). A freeze response generated by the parasympathetic nervous system may also occur, and is characterized by immobility and a numbing of emotions (van der Kolk, 2014). The "fight or flight" and "freeze" responses may be reflected in the experience of critical incident stress. The term critical incident stress refers to the reactions from a critical incident and is characterized by a range of cognitive (e.g. confusion, reduced concentration), emotional (e.g. anger, grief), physical (e.g. increased heart rate, headaches), behavioral (e.g. changes in eating and sleeping), and spiritual responses (e.g. loss of faith, cessation of religious practice) (Mitchell, 2012; Mitchell & Everly, 1997). Various authors use the term traumatic stress interchangeably with critical incident stress. In the context of work-

related incidents, the term critical incident stress appears to be more commonly used by the military and health sciences professions (Mitchell, 2012). Critical incident stress may be detrimental to an individual's well-being, causing acute stress disorder (ASD) and PTSD.

The Possibilities from Critical Incident Stress: PTSD and PTG

PTSD is a trauma and stress related disorder that results from directly experiencing or witnessing a traumatic event, learning that an event occurred to a family member or friend, or experiencing repeated exposure to details of an event (American Psychiatric Association (APA), 2013). In 1980, the American Psychiatric Association recognized PTSD as a diagnosis by publishing it in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM-III) (Cougle, Kilpatrik, & Resnick, 2012; Everly & Mitchell, 1999, 2008; Figley, 2012). A history of exposure to a traumatic event that meets specific stipulations is integral to the diagnosis of PTSD (APA, 2013). Unlike critical incident stress, PTSD has particular diagnostic criteria that must be present for more than one month (APA, 2013). The criteria consist of four diagnostic clusters and are described as re-experiencing, avoidance, negative cognitions and mood, and arousal (APA, 2013). The suffering endured with PTSD may be considered delayed when the full diagnostic criteria are met at least six months after the incident (APA, 2013). While critical incident stress has been associated with PTSD, the potential for psychological growth does exist (Everly & Mitchell, 1999; Mitchell, 2012). Post-traumatic growth (PTG) is used to describe the positive and personal changes that some individuals report, as a result of their attempts to cope with the outcome of a traumatic event or highly stressful experience (Joseph & Linley, 2006; Linley & Joseph, 2004; Park, 2010;

Tedeschi, 2012; Tedeschi & Calhoun, 1996, 2004). A variety of other terms have been used in the literature to denote positive outcomes as a result of traumatic experiences including: adversarial growth, stress-related growth, benefit finding, and perceived benefits (Tedeschi, 2012; Tedeschi & Calhoun, 1996, 2004).

Social Support and Resilience

There are various factors that influence the diversity and potential outcome of the critical incident stress experienced (Carlson & Dalenberb, 2000). An individual's developmental stage, the severity of the incident, social support, and a genetic predisposition to vulnerability or resilience to trauma are examples of such factors (Carlson & Dalenberg, 2000). The concepts of social support and resilience have been widely discussed and researched in the area of trauma. Social support is broadly defined as the availability of helping relationships (Leavy, 1983). Social support has the potential to facilitate a "buffer-effect" between a traumatic stressor and stress reactions (Barrera, Sandler, & Ramsay, 1981; Gabert-Quillen et al., 2012; Leavy, 1983; Michael & Jenkins, 2001; Mitchell, Evans, Rees, & Hardy, 2014; Ozer, Best, Lipsey, & Weiss, 2008; Viswesvaran, Sanchez, & Fisher, 1999). Studies have shown that low levels of social support may produce negative health outcomes (Cohen & Wills, 1985; Galea et al. 2003). More specifically, those with more social support are less likely to develop PTSD and depression after a traumatic event (DeLong, 2013; Dinenberg, McCaslin, Bates, & Cohen; 2014; Galea et al., 2003; Yuan et al., 2011). The protective effect of social support, particularly co-worker or peer support as a helping relationship, underpins various interventions used to mitigate the impact of a critical incident (Arndt, 1994; de Boer, et al., 2013; Haplern et al., 2009; Seys et al., 2013; van Pelt, 2008). There is

increasing evidence that validates social support as part of an intervention known as Critical Incident Stress Debriefing (CISD), or as a stand-alone approach offered from co-workers, can be beneficial to the traumatized individual (Adriaenssens, de Gught, & Maes, 2012; Arndt, 1994; de Boer et al., 2013; Laposa & Allen, 2003; Michael & Jenkins, 2001; Seys et al., 2013; van Pelt, 2008). "Recovery can take place only within the context of relationships; it cannot occur in isolation" (Herman, 1992, p. 133).

Resilience is a complex concept and there is no one agreed upon definition (Southwick, Pietrzak, Tsai, & Krystal, 2015). According to the American Psychological Association (2018), resilience is "the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress" (para. 4). Research has found that resilient individuals may experience some degree of impact from critical incident stress without significantly compromising their ability to continue functioning (Bisconti, Bergeman & Boker, 2006; Ong, Bergeman, Bisconti, & Wallace, 2006). There are psychosocial factors that have been associated with resilience and correlated with reduced symptoms of traumatic stress (Southwick et al., 2015). Primary factors that have been shown to protect against and assist in the recovery from traumatic stress include: active coping or problem-solving, exercise, a positive outlook or optimism, following a moral compass, social support, developing self-awareness, and cognitive flexibility or being open in one's approach to problem-solving (American Psychological Association, 2018; Haglund, Cooper, Southwick, & Charney, 2007; Jackson, Firtko, & Edenborough, 2007). Enhancing resilience has shown promise to reduce PTSD symptoms in high-risk groups such as paramedics and nurses (Connor, Davidson, & Lee, 2003; Mealer et al., 2012; Streb, Haller, & Michael, 2013). Resilience is a concept that can be learned and

developed by individuals; this is the premise behind the treatment of PTSD and various crisis interventions (American Psychological Association, 2018; Bonanno, 2008). Crisis intervention is the delivery of emotional assistance by stabilizing and reducing distressing symptoms while facilitating an adaptive level of functioning (Everly & Mitchell, 1999, 2008).

Crisis Intervention: The Past, The Present

Thomas Salmon (1919), a British military physician, was one of the first to explore and identify the beneficial effects of crisis intervention with combat troops during World War I (Salmon, 1919). In the era of World War II the principles of immediacy, proximity, and expectancy were defining features of crisis intervention derived and adapted from military psychiatry (Everly & Mitchell, 2008). In addition to Salmon, Lindemann (1944) and Caplan (1964) have also been credited with advancing the field of crisis intervention from the perspective of disaster response and community mental health (Everly & Mitchell, 1999). Lindemann's research on crisis intervention was influenced by the death of 492 individuals who were part of the Cocoanut Grove nightclub fire in Boston (November 28, 1942) (Lindemann, 1944). Lindemann interviewed 101 patients who were impacted by the disastrous fire, to uncover the complexities of grief associated with the experience of a crisis. Caplan later joined Lindemann in the development of a community mental health program located in Boston that offered crisis intervention (Everly & Mitchell, 1999). Caplan was known for his work in delineating three tiers of preventative psychiatry referred to as primary, secondary, and tertiary prevention (Everly & Mitchell, 1999). These three tiers have been instrumental in developing the current models of crisis intervention. Today, the most commonly described early crisis

intervention models in the context of health care organizations are critical incident stress management (CISM) (Everly & Mitchell, 1999, 2008) and psychological first aid (Forbes et al., 2011; Hobfoll et al., 2007).

Critical incident stress management (CISM). CISM was developed by Jeffrey Mitchell as an approach to support those distressed from an encounter with a critical incident (Everly & Mitchell, 1999). The core components of Mitchell's CISM interventions are consistent with the underpinnings of Caplan's (1964) work and include: pre-crisis preparation (education), individual crisis intervention, demobilization, defusing, CISD, family CISM, and follow-up or referral (Everly & Mitchell, 1999). Authors have noted that the success of this model is that it is a gestalt relying on a comprehensive approach, rather than stand-alone interventions (Everly, Flannery, & Eyler, 2002; Everly, Flannery, & Mitchell, 2000; Mitchell & Everly, 2000). Building resilience underpins CISM techniques such as pre-crisis preparation, as well as CISD and defusing (Everly & Mitchell, 1999, 2008). CISD and defusing are two small group interventions within the CISM model that emphasize the inclusion of co-worker support (Mitchell, 2010). The efficacy of CISD alone has been heavily scrutinized, as researchers have found it to be ineffective in reducing long-term levels of PTSD symptoms (Bisson, Jenkins, Alexander, & Bannister, 1997; Regehr & Hill, 2000; Rose, Brewin, Andrews, & Kirk, 1999). Given the inconsistency in evidence supporting CISD (Devilly, Gist, & Cotton, 2006; Hobfoll et al., 2007), there is strong international consensus that psychological first aid (PFA) is the intervention of choice to assist those exposed to events considered traumatic (Forbes et al., 2011).

Psychological first aid (PFA). Influenced by Beverly Raphael's (1986) seminal work, various organizations (e.g. The National Child Traumatic Stress Network and the National Centre for PTSD (2006), World Health Organization, (2011)) have adopted PFA approaches for those impacted by trauma and disaster (Lewis, Varker, Phelps, Gavel, & Forbes, 2014; McCabe et al., 2014). Hobfoll et al. (2007) used a panel of experts to identify five empirically supported principles to guide crisis intervention. These principles are consistent with the core tenets of PFA and include promoting a sense of safety, a calming presence, a sense of self-efficacy, connectedness, and hope (Hobfoll et al., 2007). These five principles enhance resilience at the individual, group and community levels (Hobfoll et al., 2017; Southwick et al., 2015). For example, to promote a sense of calming Hobfoll et al. (2017) suggested stress inoculation and breathing retraining, and to promote self-efficacy offering relevant resources and education to set realistic goals were recommended. Implementing PFA requires action techniques such as: look (e.g. ensuring safety), listen (e.g. communicating effectively), and link (e.g. linking to resources), as well as recognizing limitations (World Health Organization, 2013). Although initially discussed in the context of natural disasters, Forbes et al. (2011) suggested that these principles could be applied to organizational settings, such as hospitals, where staff are placed at risk of exposure to traumatic experiences. Various authors have highlighted that PFA lacks robust research of the principles (Forbes et al., 2011; Fox et al., 2012; Hobfoll et al., 2007) and thus at this point in time, it is considered evidence-informed rather than an evidence-based approach.

Leaning in for a Closer Look: Critical Incident Stress in Nursing

The unpredictable and complex nature of nurses' work increases their risk of experiencing work-related critical incidents (Caine & Ter-Bagdasarian, 2003; Cottrill-Walker, 2000; Wright & Casier, 1996). Various research studies have recognized commonalities and differences in the types of experiences that nurses from unique practice settings consider as critical incidents. For example, nurses employed in medical and surgical areas of practice found that moral distress, a lack of responsiveness by a health care professional, violence toward a nurse, emergency situations, patient death (particularly young patients), and coming in contact with infectious body fluids were perceived as critical incidents (Appleton, 1994). The death of a child and the sexual abuse of a child were also found to be traumatic experiences by nurses in these settings (O'Connor & Jeavons, 2003).

Nurses in the emergency department (ED) were found to confront traumatic events more frequently than those in medical and surgical settings (Adriaenssens et al., 2012). Similar to other studies, nurses from the ED were also significantly impacted by the death or abuse of a child (Adriaenssens et al., 2012; Burns & Harm, 1993). However, unlike medical and surgical departments, ED nurses considered the death of a co-worker, mutilation of victims from injury, and providing care to a critically ill patient who was a relative or close friend as traumatic (Adriaenssens et al., 2012; Burns & Harm, 1993). Beavan and Stephens (1999) used a qualitative method to categorize the characteristics of traumatic events experienced by ED nurses (n = 9). Distressing experiences involved personal issues associated with empathy and self-doubt, contextual issues related to a nurse's role, control issues or feeling helpless, and organizational concerns linked to a

lack of resources and conflict with co-workers (Beavan & Stephens, 1999). To summarize these studies, irrespective of the setting, the reviewed research showed nurses in clinical practice are susceptible to critical incident stress as a result of various work experiences. Thus, it is not surprising that numerous authors agreed timely and effective crisis intervention (Antai-Otong, 2001; Oster & Doyle, 2000; Swanson, 2002) was essential to nurses and their patients (Priebe & Thomas-Olson, 2013).

Crisis Intervention in Health Care

CISM in health care. CISM is currently the favored and most frequently cited intervention for managing critical incident stress in nursing. The International Critical Incident Stress Foundation (2018) website provides a current list of CISM teams that exist world-wide. While the majority of the CISM teams correspond to police, emergency medical response, and firefighter groups, there are health care centers included. Approximately 16 CISM teams are located in Canada, and four are situated in the province of Alberta. Multiple nurse authors have anecdotally validated the benefits of adopting the CISM model in an acute care facility (Blacklock, 2012; Cudmore, 1998; Jefferson & Northway, 1996; Kalain, 1999; Oster & Doyle, 2000; Sacks, Clements, & Fay-Hillier, 2001; Smith, Wasilowsky, & Valeriano, 2012; Wright & Casier, 1996). Unfortunately to date, other than these anecdotal accounts, there are only a few research studies that have attempted to explore CISM within the acute care context. For example, Priebe and Thomas-Olson (2013) examined the impact on the timeliness of CISM relative to a stress reaction. The diverse sample consisted of health care staff such as nurses, respiratory therapists, physicians, medical imaging personnel, and educators (n = 63). The subjects within the study were placed into different groups; one group was deemed

the early group and CISM intervention occurred within 24 hours of the incident (n = 24), while the late group participated in the intervention later than 24 hours (n = 39). The results of this study validated the need for early intervention, as it enhanced the healthcare professionals ability to cope with the incident.

Flannery, Fulton, Tausch, and DeLoffi (1991) implemented and evaluated an intervention called the Assaulted Staff Action Program, modeled after CISM, to support staff victims of patient assaults. Qualitative feedback from this program suggested most staff regained a sense of control and felt supported, while they began to make meaning of the incident. Muller-Leonhardt, Mitchell, Vogt, and Schurmann (2014) used questionnaires (n = 78) and structured interviews to understand the implementation of CISM in hospital settings. They proposed the success of a CISM program was dependent on the attentiveness of the work culture and organizational structure. More specifically, open communication within the organization and trust were imperative factors in offering support to distressed co-workers.

CISD in health care and nursing. Despite the continuous debate among researchers CISD, a component of CISM, continues to be a primary focus of crisis intervention in the nursing literature. Numerous nurse authors have recommended the implementation of CISD as a means of supporting staff that have experienced a work-related critical incident (Antai-Otong, 2001; Appleton, Nelson, & Wedlund, 2018; Burns & Harm, 1993; Dietz, 2009; Hammerle, Devendorf, Murray, & McGhee, 2017; Hanna & Romana, 2007; Hollister, 1996; Iacono, 2002; O'Connor & Jeavons, 2003; Sacks et al., 2001; Spizer & Burke, 1993). Currently, there are several inquiries that have explored the effectiveness of debriefing for hospital nurses (Burns & Harm, 1993; O'Connor &

Jeavons, 2003; Robinson & Mitchell, 1993). Among the studies that I have reviewed, most nurses perceived the need for CISD (Healy & Tyrrell, 2013) and considered it beneficial after a critical incident (Burns & Harm, 1993; O'Connor & Jeavons, 2003; Robinson & Mitchell, 1993; Theophilors, Magyar, & Babl, 2009). A descriptive study conducted by Burns and Harm (1993) found that 32% (n = 682) of nurses that were surveyed had participated in CISD and that of those, 88% (n = 682) found the intervention beneficial in reducing symptoms related to a critical incident. Nurses reported that the benefit of CISD was underpinned by the ability to engage in dialogue about the incident to others who could empathize (Burns & Harm, 1993; O'Connor & Jeavons, 2003; Robinson & Mitchell, 1993). Interestingly, there were nurses that participated in a study completed by O'Connor and Jeavons (2003) who resented the time CISD took from their personal lives, and who felt uncomfortable discussing their critical incident in a group. Anecdotally, nurse authors have advocated for other strategies such as: stress education, group discussions, reflective practice, and enhanced social support (Marshall & Zolnierek, 2012; Swanson, 2002; Theophilos et al., 2009). There is increasing evidence that validates immediate support from nurse co-workers after a critical incident may be beneficial to the traumatized individual (Arndt, 1994; Muller-Leonhardt et al., 2014; Seys et al., 2013; van Pelt, 2008).

There were various limitations to the nursing research studies I reviewed that focused on CISD. The lack of standardization, the level of facilitator expertise, the use of CISD as a stand-alone intervention rather than a component of CISM, and the timing for implementation, were common concerns noted and made explicit by various researchers (Burns & Harm, 1993; Laposa & Allen, 2003; O'Connor & Jeavons, 2003). Perhaps most

concerning was the lack of information provided on the model or framework that underpinned the CISD approach implemented, and on the training or background of the facilitators. Moreover, the time frame that had lapsed between the critical incident and the implementation of CISD sessions were not made explicit by most researchers. Given the variations stated by nurse authors, it is difficult to know the appropriate time frame for implementing CISD following a critical incident. This stems from the inconsistency of the timing noted in Mitchell's work, as in various sources he suggested that the technique be used between 24-72 hours after a critical incident (Mitchell, 1983, 2010; Mitchell & Everly, 1997), while in another he proposed within one to ten days (Everly & Mitchell, 1999). Perhaps this speaks to the larger issue in terms of what is meant by offering "early" and "timely" intervention after a critical incident.

PFA in health care. The process of implementing and evaluating the principles of PFA in a health care context is in its infancy (Lewis et al., 2014). Various authors have recommended the use of PFA as a model to be employed within organizational settings, such as hospitals, where there is a likely risk of exposure to trauma (Everly & Flynn, 2006; Forbes et al., 2011; Lewis et al., 2014; Schultz & Forbes, 2014). Anecdotal accounts of PFA programs implemented in hospital settings have only recently emerged in the literature (Connors & Wu, 2017; Gispen & Wu, 2018). However, formal research associated with PFA used in acute care environments was lacking in my review of written sources. Regardless, there have been suggestions in moving forward with such an endeavor. Forbes et al. (2011) wrote a position paper that argued for the implementation and evaluation of PFA to begin with organizational settings considered at high risk for exposure to traumatic incidents. The authors suggested that implementation include the

development of organizational policies and procedures, training of staff, adherence to the principles, and follow-up. PFA is facilitated by lay-people rather than mental health providers, thus after being trained, nurses and other members of the health care team may support those in distress (Shultz & Forbes, 2014). A study completed by Lewis, Varker, Phelps, Gavel, and Forbes (2014) reinforced the importance of training managers and staff to implement PFA. Their results suggested effective training enhanced manager and staff knowledge of potential traumatic events and PFA, and improved their perceived ability to implement this approach when needed. Everly, McCabe, Semon, Thompson and Links (2014) echoed the significance of providing training for non-mental health workers employing the principles of PFA. Their research concluded that effective training approaches (RAPID-PFA) enhanced participants' knowledge of crisis intervention, increased their self-efficacy in the application of the principles, while elevating confidence in personal resilience. PFA is based on principles rather than a structured and rigid technique, hence the benefit of this approach is its ability to be tailored to meet individual needs (Bisson, Brayne, Ochberg, & Everly, 2007).

The Possibilities from Critical Incident Stress Experienced by Nurses

After a critical incident, it is common for nurses to experience a stress response, and some may even develop anxiety, depression, and PTSD (Adriaenssens et al., 2012; Czaja, Moss, & Mealer, 2012; de Boer et al., 2011). Mealer, Burnham, Goode, Rothbaum, and Moss (2009) found nurses who met the criteria for PTSD also exhibited symptoms of burnout syndrome. The co-existence of PTSD and burnout syndrome impacted the manner in which nurses in this study functioned at work and at home. PTSD

has the ability to alter the care that nurses provide to their patients, and to disrupt their social relationships (Mealer & Jones, 2013).

Critical Incident Stress in ICU Nursing

Specialized nursing care that developed to meet the needs of adult critically ill patients began in ICU settings located in the United States in the early 1950s, while Canadian ICUs opened later in the mid-1950s (Vanderspank-Wright, Bourbonnais, Toman, & McPherson, 2015). The ICU emerged to address needs of an acutely ill patient population that required frequent monitoring and the advancement of technological treatments (Fairman, 1992; Vanderspank-Wright et al., 2015). The physical layout of the first ICUs consisted of sectioned off areas of general nursing wards, with patient beds divided by curtains. This layout presented challenges as ICU nurses were confronted with occupational stressors such as a lack of privacy for patients, little natural light, and the challenges of new knowledge and clinical skills required. The ICU was referred to as challenging because of its complicated machinery and its intense patient focus (Hay & Oken, 1972; Strauss, 1968).

The unique and intricate nuances of the ICU began to be identified and described by authors in the 1960s (Kornfeld, Maxwell, & Momrow, 1968; Koumans, 1965; Strauss, 1968). “It is hard to imagine any other situation that involves such intimacy with the frightening, repulsive, and forbidden. Stimuli are present to mobilize literally every conflictual area at every psychological developmental level” (Hay & Oken, 1972, p. 383). This quotation by Hay and Oken (1972) alluded to the unpredictability and potential for psychological distress aligned within this dynamic practice setting. The first published report on ICUs by the British Medical Association (1967) reinforced that this

environment placed extraordinary psychological burdens on nurses (Crickmore, 1987). The technological complexity and the precariousness of patient outcomes put nurses in this high need setting at increased risk of experiencing critical incident stress (Cottrill-Walker, 2000; Wright & Casier, 1996).

Over the years authors have shifted their focus from the impact of daily occupational stressors experienced by ICU nurses to the potential for encountering a critical incident (Caine & Ter-Bagdasarian, 2003; Cotterill-Walker, 2000; Cudmore, 1998; de Boer et al., 2013; Laws, 2001). Unlike occupational stressors, critical incident stress differs in its intensity, sudden onset, and the occurrence of a traumatic experience (Mitchell, 2012). There are few research studies (de Boer et al., 2013; Keriasiotis & Motta, 2004; Laws, 2001; Mealer et al., 2007; Mealer et al., 2012; Smith et al., 2012) and anecdotal sources (Alexy & Hutchins, 2006; Caine & Ter-Bagdasarian, 2003; Cotterill-Walker, 2000; Wright & Casier, 1996) that speak to critical incident stress in the context of nurses in the adult ICU setting. The anecdotal sources used case studies or personal accounts to describe critical incident stress and advocated for the implementation of CISD. The research primarily focused on exploring the events ICU nurses defined as critical, the implementation of interventions, and elements associated with PTSD. There are currently a small number of research studies that speak to related components of critical incident stress in the context of ICU nursing. Most of these studies are quantitative, with a few from the qualitative paradigm. Given the small number of inquiries conducted, I will summarize each as a way of offering a more in-depth and current perspective on the topic.

The most recent study conducted by de Boer, van Rikxoort, Bakker, and Smit (2013) sought to gain insight into various elements of the topic. Specifically, the researchers aimed to identify the clinical events that ICU nurses perceived as critical incidents, the reactions and coping strategies, and the need for support. In this qualitative exploratory study of ICU nurses (n = 12) a thematic analysis revealed events such as high emotional involvement, avoidable incidents, substandard patient care, as well as intimidation by family or friends were considered to be most traumatic. Participants experienced both physical and emotional reactions, and primarily coped using active and problem-focused approaches, as well as co-worker support.

Nurses in the ICU commonly assist with the cardiac and respiratory resuscitation of the critically ill. Laws (2001) examined whether nurses in critical care experienced an emotional response indicative of critical incident stress when they performed cardiopulmonary resuscitation (CPR) (n = 31). This descriptive research uncovered that 83% of the nurses demonstrated clinical manifestations of critical incident stress in response to performing CPR. Interestingly, 50% of the critical care nurses indicated that sights, sounds, and smells elicited an emotional response to previous CPR incidents.

Mealer, Shelton, Berg, Rothbaum, and Moss (2007) proposed that ICU nurses were repeatedly exposed to critical incidents, and were thus at increased risk for PTSD. Their descriptive research study revealed that ICU nurses (n = 230) had an increased prevalence of PTSD symptoms when compared to general nurses (n = 121). Approximately 20% of ICU nurses had symptoms consistent with potential anxiety disorders and almost 30% had symptoms of depression. Mealer, Jones, and Moss (2012) sought to expand on this research by identifying the characteristics and mechanisms

employed by highly resilient ICU nurses to develop a protective "buffer" in developing PTSD. Using a thematic approach their qualitative research found highly resilient ICU nurses (n = 27) used positive coping skills such as social support, optimism, spirituality and cognitive flexibility in managing within a demanding work environment. The researchers suggested health care organizations consider strategies that foster nurses' resilience, such as resilience training and the encouragement of teamwork. Similarly, completing a national survey of randomly selected ICU nurses (n = 3500), Mealer et al. (2012) found the presence of high resilience was associated with lower prevalence of PTSD, symptoms of anxiety, depression, and burnout.

Smith, Valeriano, and Wasilowsky (2012) described the evaluation of a debriefing program developed for neuroscience ICU nurses in the management of critical incident stress. Staff attended a crisis intervention course and became part of a debriefing team to support their co-workers following a critical incident. The numerical and qualitative feedback from staff demonstrated improvement in various indicators such as job satisfaction and morale. Remarkably, the authors noted that over a three-year period there was a decline in the number of debriefing sessions conducted. They attributed this to earlier recognition of critical incident stress and faster informal support offered by co-workers. In a descriptive study, Keriasiotis and Motta (2004) reinforced that social support was beneficial in managing work-related traumatic events for nurses (n = 125), including those from the ICU (n = 51).

In summary, the limited number of research studies suggests that critical incident stress experienced by nurses in the ICU is an understudied topic. How do I define understudied? The etymology of the word under is derived from the Latin word *infra*

which means “below,” and was used in Old English as a preposition meaning “between, among” (*Online Etymology Dictionary*, 2018). This understudied topic means there is, and *always* will be, more to uncover beneath the surface. To know more requires a closer look at the gaps, and what lurks in-between the predominant areas addressed in the existing literature. The research studies that are most aligned with understanding critical incident stress endured by ICU nurses focused on the types of incidents experienced as critical, the effectiveness of interventions, and the prevalence of potential outcomes. In close proximity to the topic, one of the objectives from the qualitative study conducted by de Boer et al. (2013) was to describe ICU nurses’ reactions from a critical incident by thematically categorizing common or repetitive participant responses. While this thematic approach offered valuable information, it was unable to penetrate beyond the descriptions and venture into the potential richness of interpretive approaches. Hence, an obvious gap lies in understanding the meanings of work-related critical incident stress as experienced by nurses from the ICU. This is the gap, the in-between or among, that I propose to address in the conduct of this research study.

Reflective Thoughts

To enter into the crevices requires a research approach that offers an experiential and expansive understanding of the topic, as it is encountered on its own terms. It calls for a methodology that does not isolate or detach segments of the topic rather, situates the topic amidst its history and tradition so it may be understood holistically and contextually. Critical incident stress is complex and messy because of its nuanced intricacies, and thus the voices of those that have been greeted by its affliction are paramount to enhancing understanding. Gadamer’s philosophical hermeneutics is a

suitable match to explore these complexities through an “interpretive slant” (Caputo, 2018, p. 5). Hermeneutics offers access into the nooks and crannies revealing how critical incidents are lived, endured, and experienced by ICU nurses. “Hermeneutics describes the experiential world that is running all the time, beneath the radar of rules, algorithms and objectifying knowledge” (Caputo, 2018, p. 223). To the best of my knowledge, this is the first hermeneutic inquiry conducted on this topic. In the next chapter I will describe my use of Gadamer’s philosophical hermeneutics to “come face-to-face with human vulnerability” (Herman, 1992, p. 7) as it has always already existed in the world of ICU nursing.

Chapter Three: Gadamer's Philosophical Hermeneutics

"For this reason, dialectic proceeds by way of question and answer or, rather, the path of all knowledge leads through the question." (Gadamer, 1960/2013, p. 371)

Hans-Georg Gadamer (1960/2013) began his magnum opus titled *Truth and Method* with a poem by Maria Rainer Rilke. This poem immediately captured my attention, and reinforced the suitable use of a hermeneutic stance to guide my inquiry.

> Catch only what you've thrown yourself, all is mere skill and little gain; but when you're suddenly the catcher of the ball thrown by an eternal partner with accurate and measured swing towards you, to your center, in an arch from the great bridgebuilding of God: why catching then becomes the power-not yours, a world's. (Gadamer, 1960/2013, p. vii)

Reflecting on these words I realized that being guided by Gadamer's philosophical hermeneutics to better understand the topic meant that I had entered into a game that was already at play. Understanding is an event (Gadamer, 1960/2013), like a game, and I had been captured, summoned, and struck by this topic. While the game progressed, the to and fro of the ball in play facilitated a disruption of the topic allowing me to see it, expose it, and understanding it differently, at least for now. In the midst of this match the power I had inherited was not for me to control or manipulate, but rather belonged to the world that I encountered and experienced (Grondin, 2003).

> To understand is not to control, but is a little like breathing or loving: we do not know what sustains us, nor where the wind which gives us life comes from, but we know that everything depends on it and that we do not control anything. (Grondin, 2003, p. 20)

My inability to have power over the game offered possibilities of what could be, rendering it unpredictable and in flux. I recognized that this game was unique, as it required me to engage with integrity into an ongoing dialogue with the topic, with the text, and with myself. "There is a dialogue, a being-together, a game in which we are involved" (Grondin, 2003, p. 18). As a player I experienced a re-interpretation of the self, as with each decision I pondered, considered, and eventually reconciled with, was always relative to myself. Gadamer (1960/2013) began with this poem because it spoke to the dialectical game of understanding within a context and tradition, as it is played and lived - this is hermeneutics.

What is Hermeneutics?

> In this situation hermeneutics is focused on something that is *not understandable* (life). Indeed, this is somehow always the case for hermeneutics. Challenged by something not understood or not understandable, hermeneutics is brought onto the path of questioning and is required to understand. In this process one never has some advance lordship over all meaningfulness. Instead, one is answering an always self-renewing challenge to take something not understood, something surprisingly other, strange, dark-and perhaps deep-that we need to understand. (Gadamer, 1995, p. 363)

Gadamer (1977) referred to hermeneutics as a "practice" and "an art" involved in explaining and understanding the meaning of something vague and ambiguous (p. 44). The word hermeneutics is derived from the Greek verb *hermeneuein*, which means to interpret, to give utterance to (*Online Etymology Dictionary*, 2018). Etymologically, the origin of hermeneutics was associated with the mythological Greek God Hermes, the son

of Zeus (*Online Etymology Dictionary*, 2018). Hermes was a mischievous and cunning character who translated and delivered messages of the gods to mortals (Caputo, 2018; Moules, 2002; Moules, McCaffrey, Field, & Laing, 2015). These messages were often playful and obtuse, "enticing interpretation" (Moules et al., 2015, p.2). Hermes travelled between two worlds, engaging in the interplay between language and interpretation. According to Gadamer (1977) hermeneutics is "this bringing of something out of one world and into another, out of the world of the gods and into that of humans, or out of the world of a foreign language into the world of one's own language" (p. 44). The tradition of hermeneutics is a philosophy and a practice of interpretation (Moules, 2002) that mediates the in-between, and navigates the complexities and ambiguities that exist within one's world.

Hermeneutics was initially applied to the interpretation of Biblical scripture or texts (Grondin, 1994). The practice of hermeneutics dates back to Augustine (354-430) who was known for his universal claim of hermeneutics, and his deliberations on the limitations or forgetfulness of language (Grondin, 1994). Hermeneutics has been influenced by other historical figures such as Friedrich Schleiermacher (1768-1834), Wilhelm Dilthey (1833-1911), and Edmund Husserl (1859-1938) (Grondin, 1994). Martin Heidegger (1889-1976), a student of Husserl, extended Husserl's phenomenological philosophy by examining the ontological stance of understanding, through the mode of being in the world *(Dasein)* (Annells, 1996; Laverty, 2003). Gadamer (1900-2002), who was influenced by the work of Husserl and his teacher Heidegger, expanded on Heidegger's hermeneutics emphasizing that understanding is always occurring and is bound to interpretation (Annells, 1996; Laverty 2003). Gadamer

(1960/2013) proposed that hermeneutics is a mode of understanding that occurs within the context of history and tradition, dialogue and language. He was primarily interested in the question: "how is understanding possible?" (Gadamer, 1960/2013, p. xxvii). Gadamer's philosophical hermeneutics has been shaped by history and traditions that have been bestowed to us by others (Moules, 2002; Moules et al., 2015).

Gadamer's Hermeneutics as a Philosophy

Hermeneutics is a philosophy that can be applied, practiced, and lived. To grasp the application of Gadamer's hermeneutics for research purposes requires understanding substantial concepts that have bearing on its practical capability. Hence, I will now offer a brief description of the philosophical tenets that underpin Gadamer's hermeneutics, and influenced the manner in which my research study was conducted.

History, Tradition, and Prejudices

Distinct to hermeneutics are the notions of historicality and tradition that make understanding possible (Davey, 2006). According to Gadamer (1960/2013) "understanding is, essentially, a historically-effected event" (p. 310). To understand means to situate oneself and what is being understood within a historical context or landscape. Gadamer (1960/2013) argued for historical awareness or historically-effected consciousness that shapes how we view the topic, the world, and ourselves. According to Gadamer (1960/2013) we are historical beings that are always already tethered to our past and its traditions. "In fact history does not belong to us; we belong to it" (Gadamer, 1960/2013, p. 289). Historically-effected consciousness means we continuously participate in the world as historical beings thus, understanding is partial and never complete. To have a historical awareness means to recognize that we are always

embedded within traditions (Gadamer, 1960/2013). “We are fooling ourselves if we think we can simply discard tradition and start from a blank slate” (Moules et al., 2015, p. 38). The traditions in which we stand establish an essential condition for understanding, a concept Heidegger called forestructures, and Gadamer referred to as prejudices (Moules et al., 2015).

Gadamer (1977) acknowledged that his concept of prejudice was restored from the negative connotation implied by the French and English Enlightenment. He (1960/2013) defined prejudice as “a judgment that is rendered before all the elements that determine a situation have been finally examined” (p. 283). Gadamer referred to prejudice as our prior understanding that functions like a portal to gain access to the topic (Grondin, 2003). Prejudices offer the “initial directedness of our whole ability to experience,” and create an opportunity to question, ponder, reflect, and be open to the new and different (Gadamer, 1977, p. 82). Prejudices mean we arrive to a situation inadequate, without enough understanding and yearning to know more, recognizing that the situation exceeds us. Unlike Husserl’s phenomenology that argued for bracketing past assumptions and beliefs, Gadamer proposed it was impossible to remove ourselves from prior understanding (Grondin, 1994, 2003; Laverty, 2003). Our understanding of the world is influenced by prejudices we know exist and can be articulated. However, we must also submit to the idea that there are prejudices of which we are not aware, and that remain inaccessible to us (Moules, 2002). To engage in the event of understanding means to surrender and wager what we consider true. “In fact our own prejudice is properly brought into play by being put at risk” (Gadamer, 1960/2013, p. 310). To understand

requires an ability to remain curious and open to the endless nature of interpretation, driven by an ongoing conversation.

Language as the Medium for Understanding

The notion of language in the context of tradition dates back to Augustine (Grondin, 1994). Heidegger and Gadamer continued to view language as fundamental to hermeneutic understanding (Holroyd, 2007). According to Gadamer (1960/2013) "language is the universal medium in which understanding occurs. Understanding occurs in interpreting" (Gadamer, 1960/2013, p. 407). Understanding and interpretation are synonymous; they are "indissolubly bound together" (Gadamer, 1960/2013, p. 417). It is through language that we relate to the world, it is how we experience the world, and how the world presents itself to us. Gadamer used a term by Augustine, *verbum interius* or the inner word, to expose the limitations that exist alongside the use of language (Grondin, 1994, 1995). By *verbum interius* Gadamer meant "that spoken discourse always lags behind what one wants or has to say, the inner word, and that one can understand what is said only when one derives it from the inner speech lurking behind it" (Grondin, 1994, p. xiv). Words carry with them an element of the unsaid, as we cannot completely exhaust the meaning behind their expression and intention thus, understanding is always incomplete (Grondin, 1994, 1995).

Understanding through conversation. The emphasis on emergence of understanding through conversation was what made Gadamer different from Heidegger and Husserl (Binding & Tapp, 2008). According to Gadamer (1960/2013) "conversation is the process of coming to understanding" (p. 403). It is possible for a conversation to occur between the reader and text, as well as between two people (Fleming, Gaidys, &

Robb, 2003; Geanellos, 1998). Conversation with a person or text requires a commitment to engage in the back and forth of question and answer. In hermeneutics a question posed during a conversation is like a key used to unlock a door and free the imprisoned or unspoken that has remained restrained, dormant, or forgotten. Gadamer (1960/2013) said "the essence of a question is to open up possibilities and keep them open" (p. 310). A conversation in hermeneutics is carried out with intent and purpose, as the goal is a fusion of horizons that reflects new understanding has been created (Moules et al., 2015; Walsh, 1996). "Rather, understanding is always the fusion of these horizons supposedly existing by themselves" (Gadamer, 1960/2013, p. 317).

Seeing beyond our horizon. When we enter into an already existing conversation with a person or text, we are influenced by what Gadamer (1960/2013) referred to as our horizon. "The horizon is the range of vision that includes everything that can be seen from a particular vantage point" (Gadamer, 1960/2013, p. 313). Horizons are developed by our personal values, assumptions, and beliefs that influence how we see the world (Moules et al., 2015). Horizons are not fixed or permanent; they arise from historical beings that are always in flux, emerging and shifting (Gadamer, 1960/2013). "The horizon of the past, out of which all human life lives and which exists in the form of tradition, is always in motion" (Gadamer, 1960/2013, p. 315). The way we engage with others, including the text, is molded by our historical horizon (Moules et al., 2015). Gadamer suggested that the concept of horizon extended beyond acknowledging our perspective, to accepting the responsibility of enlarging and enhancing our "breadth of vision" (p. 316). "To acquire a horizon means that one learns to look beyond what is close at hand-not in order to look away from it but to see it better, within a larger whole

and in truer proportion" (Gadamer, 1960/2013, p. 316). To look beyond what is close at hand requires a commitment to engage in the movement of understanding generated from the hermeneutic circle, a concept that originated from Schleiermacher.

The Ripple Effect of the Hermeneutic Circle

To appreciate the interplay mediated by question and answer, reflecting and understanding, attending to past and present, is to invoke the hermeneutic circle. The hermeneutic circle is one way of letting understanding unfold with continuous renewal of questioning, reflecting, and understanding (M. Mayers, personal communication, February, 13, 2018). The hermeneutic circle is a metaphor that invites understanding the whole of something, relative to its parts and the context of those parts (Grondin, 2003). "Fundamentally, understanding is always a movement in this kind of circle, which is why the repeated return from the whole to the parts, and vice versa, is essential" (Gadamer, 1990/2013, p. 196). There is an uneasiness associated with the image of a single circle as similar to a wheel, it is suggestive of the same beginning and end point (M. Mayers, personal communication, February, 13, 2018), driven by monotonous cycling and repetition. Grondin (2003) suggested that if one wanted to avoid the idea of the circle they might consider "a constellation of understanding, which brings about its luminosity" (p. 82). I see the hermeneutic circle like the ripple effect made by throwing a pebble in a body of water, creating a far-reaching effect that widens on and on and on. Being addressed by something initiates movement, it has the ability to disrupt, connect, and expand into something larger. The hermeneutic circle extends beyond contextualizing parts relative to their larger structure. Like Heidegger, Gadamer saw the ontological significance of the hermeneutic circle (Moules et al., 2015). This significance points to

the idea that we are situated with our pre-suppositions and experiences amidst the circle, constellation, or ripple, prepared to bear the risk of our own understandings. This metaphor for understanding beckons us to engage in the endless reciprocity between experiencing, reflecting, and interpreting, propelling understanding in new directions.

Hermeneutic truth in *aletheia*. Gadamer saw understanding as achieving a form of "truth" that was unlike the traditional discovery of "truth," that uses objective and scientific claims. Hermeneutic truth lies in what Heidegger referred to as *aletheia*, the Greek word for truth or disclosure (Grondin, 2003). "Truth as disclosedness and as being toward discovered beings-a being that itself discovers-has become truth as the agreement between innerworldly things objectively present" (Heidegger, 1953/2010, p. 216). Etymologically, *aletheia* is derived from "lethe," a mythical river in Hades whose water when consumed caused forgetfulness (*Online Etymology Dictionary*, 2018). Gadamer (1995) spoke of *aletheia* as the event of "both concealment and unconcealment" (p. 365). Hermeneutic practice involves revealing what was once hidden or forgotten, exposing it, renewing it, and enlivening what has been taken-for granted (Moules, 2002). *Aletheia* is similar to entering a clearing in the forest (T. George, personal communication, June 7, 2018), moving away from the dark path and making visible what truly exists, the natural beauty. While traversing this path the clearing is not infinite, and thus what has been temporarily illuminated fails to remain permanently in view. There will always be something of the truth that remains hidden (Grondin, 2003). Truth in hermeneutics is in the power of "discovery which does not forget that it cannot discover everything," and its ability to go beyond the infinite limits of objectifying knowledge (Grondin, 2003, p. 22).

Gadamer's Hermeneutics as a Research Practice

> I did not intend to produce a manual for guiding understanding in the manner of the earlier hermeneutics. I did not wish to elaborate a system of rules to describe, let alone, direct, the methodical procedure of the human sciences. (Gadamer, 1960/2013, p, xxv)

Hermeneutics or interpretive inquiry does not provide an algorithm or a pre-ordained procedure similar to other methods for conducting research. Instead, hermeneutics is a methodology or a "process by which insights about the world and the human condition are generated, interpreted and communicated" (Koch, 1996, p. 174). As an interpretive methodology it is directed by its philosophical groundings, from which knowledge is derived through dialogue and unpredictable discoveries that become rediscovered. Researchers are situated and engaged amidst this dialogue rather than distanced or removed from it. In the remainder of this chapter I will bring into play Gadamer's philosophy to elaborate on the research design I used in my hermeneutic study.

My Position as Researcher

According to Gadamer (1960/2013) understanding is a mode of being, "a being of the work of art" (p. 110) that resides as being "in-between" (p. 306). To understand the topic I was distinctively situated in a place of in-between, a space that invited a dialogical encounter between what was known and unknown, mediated by my past and present horizons (Davey, 2006). "The true locus of hermeneutics is this in-between" (Gadamer, 1960/2013, p. 306). Davey (2006) called this space a generative space that allowed me to create and reflect on the differences that existed in the topic and in the life I had been

living. “It is the generative space of the in-between, the space of the hermeneutical encounter, which discloses the reality of alternative possibilities not presently my own but which might yet become my own” (Davey, 2006, p. 15). Within this space, Gadamer’s (1960/2013) notion of play reinforced my active rather than passive engagement with the topic in a way that made interpretation relational. “The player participates; the observer merely looks at” (Caputo, 2018, p. 94). The more I entered into conversation with the data and the topic, the more the data spoke to me, became apart of me, and transformed me. Caputo (2018) argued that understanding in the hermeneutic sense does not occur if we are unchanged. I experienced a continuous formation of the self in a way that cultivated and shaped me, an experience Gadamer (1960/2013) referred to as *“bildung”* (p. 9). Perhaps this revelation was not surprising given Gadamer (1960/2013) claimed that “all such understanding is ultimately self-understanding” (p. 261). It was this subjectivity, the impossibility of alienating myself from understanding that made hermeneutics an inherent fit for this inquiry. Subjectivity in hermeneutics is not a barrier to “greater objectivity, but rather a gateway to it” (Davey, 2006, p. 19). The experiences and prejudices I brought to this work were not kept in abeyance, rather were a “valuable resource” that influenced my decisions and enhanced my interpretations (Moules et al., 2015, p. 121). I remained open to the displacement of my prejudices so that I could encounter the topic, as it exists.

The Research Question

“Questioning always brings out the undetermined possibilities of a thing” (Gadamer, 1960/2013, p. 383). To be congruent with Gadamer’s philosophy of hermeneutics, the research question I developed attended to enhancing meaning and

understanding (Fleming et al., 2003; Moules, Field, McCaffrey, & Laing, 2014). As mentioned in Chapter One, the question I explored was: how might we understand the meanings of work-related critical incident stress for RNs working with adults in the ICU? The word "we" refers to those who have been influenced by or may be associated with work-related critical incident stress (e.g. nurses, managers, health care administrators, nurse educators). Gadamer (1960/2013) argued that there is a close relation between a question and understanding. Hence, as this work progressed I consistently returned to my research question as a way of staying close to the topic, amidst my emerging interpretations.

Gathering ICU RNs who Informed the Topic

Hermeneutic researchers seek the participants that can best inform the topic (Moules, 2002). The RN participants for this study were recruited from one of the four ICU settings within Calgary (Alberta) that provided care to adult patients in acute care hospitals. The eligibility requirements that guided participant selection are listed in Appendix A. Imperative to this study was the requirement that nurses had experienced a work-related critical incident in the ICU setting, and demonstrated a willingness to discuss the topic. Recruitment of participants was initiated by seeking permission and support from each of the ICU managers. During face-to-face meetings I fully apprised the managers of the proposed study, as well as discussed my plan for recruitment. I asked the managers to forward an email message to their RN staff, and added inserts or a smaller version of the recruitment poster into staff mailboxes. See Appendix B for a copy of the letter that was forwarded to RNs. Posters were displayed in the staff-rooms and areas regularly accessed by nurses during a work shift. See Appendix C for the template that

was used for the inserts and posters. The nurses who initiated contact and agreed to volunteer their time, met the eligibility requirements, and could best enlighten the topic, were invited to participate in the study. It was difficult to define in advance an adequate number of participants required for this study, given the focus was gathering "richly textured" descriptions, rather than a specific sample size (Moules et al., 2015, p. 90; Sandelowski, 1986, 1995).

Bonnie, Abbey, Charlene, Hanna, Ken, Mandy, Natalie, Olive and Stella (pseudonyms) were the nine ICU RNs who met the eligibility criteria and contributed to a fusion of horizons (Gadamer, 1960/2013). I considered myself extremely privileged to have met and conversed with each participant as they eagerly and courageously shared their experiences. There was diversity among participants' ages and years of experience as a nurse in the ICU. Participants ranged from 34 to 58 years of age, and had between 2 to 18.5 years of experience working as a nurse in the ICU. Two of the nine nurses were currently on a one-year temporary leave of absence from the ICU, and were working in different areas of clinical practice.

Generating Data: Traveling Unknown Terrain Alongside Participants

Acquiring knowledge or understanding took place through conversations with participants. Unstructured interviews with several guided questions that addressed areas of curiosity were used to sustain conversation while keeping the topic in view (Cohn, Kahn, & Steeves, 2000; Moules et al., 2015). Unstructured interviewing does not imply that I wandered with (Brinkmann & Kvale, 2015) participants in a loose, aimless, or unproductive manner. It meant that I engaged in an open, yet purposeful conversation that proceeded with "delicacy and tact" (Moules et al., 2015, p. 98). First staged-

interactive interviews were sufficient and second or follow-up conversations were not necessary. This decision was based on my ability to seek clarity around ambiguous concepts that emerged from past interviews in subsequent conversations with other participants. My approach with each interview reflected the metaphor of a traveler described by Brinkmann and Kvale (2015):

> In the traveler metaphor the interviewer is a traveler on a journey to a distant country that leads to a tale to be told upon returning home. The interviewer-traveler wanders through the landscape and enters into conversations with the people he or she encounters. The traveler explores the many domains of the country, as unknown terrain or with maps, roaming freely around the territory. (p. 57)

Prior to our travels, a mutually agreed upon time and location was discussed with participants. In finalizing the setting for the interviews, it was reinforced that considerations included the significance of privacy in order to protect personal integrity, as well as the need to minimize background noise (Moules et al., 2015). I recognized the sensitivity of the topic and took the time before the formal interview began to develop rapport with participants (Schmied & Wilkes, 2011). This consisted of personal introductions in which I spoke to my background as an ICU nurse who had experienced a critical incident, the purpose of the research and interview, and the importance of asking for breaks as needed (Brinkmann & Kvale, 2015; Schmied & Wilkes, 2011). Each interview was audio recorded (a second audio recorder was used for potential technological issues) which allowed for the transcription and ongoing analysis of the data (Cohn et al., 2000).

Questions and possibilities. I began the interview with open-ended questions that were used to more fully explore participants' experiences (Moules et al., 2015, p. 95). "Could you tell me about your experience with critical incident stress?" is an example of an open-ended question that provoked dialogue and invited the sharing of their experiences. The questions I asked were used as a compass, to direct the flow of the conversation and ensured the topic remained the focal point (Holroyd, 2007; Vandermause & Fleming, 2011). I offered participants as much time as they needed to ponder and respond thoroughly to the questions posed (Schmeid & Wilkes, 2011). Asking questions that created a context for new understandings to emerge in the dialogue required the use of my judgment in knowing the appropriate moments to remain silent and actively listen (Binding & Tapp, 2008; Geanellos, 1999; Vandermause & Fleming, 2011). Active listening became an essential component to the interviews, as it created an opportunity for me to reflect on the messages conveyed, engage in further questioning, and navigate where to go next (Moules et al., 2015).

The need for "some" structure. The dialogue with each participant required that I had some structure to minimize the emotional and cognitive recall of the critical incident (Nunkoosing, 2005). The efficacy of emotional and cognitive ability to recall details of a critical incident is questioned (Devilly & Cotton, 2003; Devilly et al., 2006). Devilly, Gist, and Cotton (2006) suggested that the process of revivification may compromise those who normally have gone on to process the information successfully and "runs the risk of sensitizing such persons to the stimuli involved at a time when desensitization is vital to resolution" (p. 329). Transparency of this risk was detailed in the consent form and verbally reinforced prior to beginning each interview. During the

first two interviews I deliberately avoided questions and opportunities that invited a step-by-step re-telling of these participants' critical incidents. By completely avoiding the incident in these interviews, I subsequently realized that I lacked the context and thus my understanding of the topic remained superficial. In consultation with my committee members, I decided to begin the remaining interviews by inviting participants to briefly (in one minute or less) summarize the critical incident they experienced. This time limit minimized and added solid boundaries to participants' recall of their critical incidents, while offering me sufficient details to navigate my exploration more effectively. Consistent with all participants, I attempted to externalize the critical incident so it became objectified in a way that they could separate themselves from the problem (White & Epston, 1990). To do this, I referred to their critical incident as "the event" or "the incident." A brief overview of "the event" created an opportunity for me to generate more effective questions that led to further questions, deeper insights, and thicker descriptions.

Data Analysis or Interpretation: The Disruptive, Eruptive Nature of Understanding

Moving beyond the dialectic of the question and answer involved the generation of interpretations. "In hermeneutics, analysis becomes synonymous with interpretation" (Moules, 2002, p. 14). It is important to note that analyzing data was not where my interpretations were initiated; rather, interpretation began when I was addressed by the topic. Brief notations made during the interviews, transcribed verbatim texts, tone of voice, periods of silence, physical expressions, and gestures were all examples of data (Crist & Tanner, 2003; Fleming et al., 2003; Moules et al., 2015). There was an iterative and dialectical approach to working with this data as I consistently read and re-read, interpreted and re-interpreted the texts, listened to audio recordings, while questioning

and contemplating (Crist & Tanner, 2003; Moules et al., 2015). Like a ripple effect, questions led to more questions, followed by reading, writing, dialogue and reflecting, expanding and enlarging my understanding.

Hermeneutic work does not systematically use themes to categorize descriptions, rather involves diligently taking notice of what agitates, disrupts and erupts within us (Moules et al., 2015). I focused on elements of the text that struck me and kept me awake at night, attempting to discern the relationship to the topic and to the research question. Gadamer (1960/2013) claimed that "when we understand a text, what is meaningful in it captivates us just as the beautiful captivates us" (p. 506). After each interview I listened to the audio recording and concurrently read the transcript, highlighting and briefly noting elements of resonance and difference, newness and uncertainty (Moules, 2002; Moules et al., 2015). These brief notations became initial interpretive memos in which I elaborated on my beginning thoughts, descriptive elements, and beginning conjectures. In the bi-weekly meetings with my faculty supervisor we reviewed the transcript and my corresponding interpretive memos. The dialogue with my faculty supervisor was beneficial as it sparked further insights and questions that compelled me to write additional memos, and influenced interviews that followed. Typically two to three successive memos that ranged between 10 and 13 pages in length were written for each interview. Transcripts and interpretive memos were read side-by-side as I listened to the texts speak; this widened my existing horizon. After the nine interviews and corresponding memos were completed, I was drawn to write three additional memos that reflected a conversation across, within, and between all of the data. It was from each of the memos that the interpretive writing for the upcoming chapters took shape.

Offering my written interpretations. Hermeneutic scholars recognize that there are innumerable approaches of working with and presenting the data (Crowther, Ironside, Spence, & Smythe, 2017; Moules et al., 2015). Presenting written interpretations derived from hermeneutic research is often unique and has its own flair (Moules et al., 2015). The experiences shared by participants as stories were valuable contributions that needed to be heard, read, and presented in a way that exposed new understandings of the topic within its context (Crowther et al., 2017). Smythe, Ironside, Sims, Swenson, and Spence (2008) argued that to separate a story from its contextual background jeopardized the potential for meaning and understanding to occur. To preserve the integrity of the story while illuminating the topic, the verbatim transcripts that were integrated throughout my written interpretations were carefully crafted into comprehensible narratives (Crowther et al., 2017). In the crafting of these stories the actual words of participants were used, but shared in a more concise and legible format (Crowther et al., 2017). Story crafting from verbatim transcripts was done by: removing extraneous details while keeping the data as "story," adding context for clarity, re-ordering sentences for coherence, and polishing grammar. According to Crowther, Ironside, Spence, and Smythe (2017) working with crafted stories is an approach to engaging with the data in a hermeneutic way, while acknowledging the researcher's pre-understandings. The reliable nature of this approach is rooted in the story's truthfulness or unconcealedness, that reveals itself through resonance and probable meaning (Crowther et al., 2017).

There were particular participant stories that boldly spoke to my emerging interpretations, and thus stood out as paradigm exemplars (Benner, 1984; Benner & Wrubel, 1982). Paradigm exemplars are those that leave an impression and a permanent

imprint so they can be re-told and re-read, offering new learning and clarity (Benner & Wrubel, 1982). The crafted stories I have selected to present in the form of paradigm exemplars allowed the topic to emerge in ways that displaced the existing conversation. My use of paradigm exemplars does not suggest other narratives did not contribute to a fusion of horizons. The voices from all participants were germane to this work, and thus have been threaded throughout my written interpretations. A successful interpretation was a written account that convinced me, captivated me, was one that I could follow (Grondin, 2003), and ultimately revealed new possibilities for understanding.

"Rigor" in Hermeneutic Research: Trustworthiness and Believability

Rigor is defined as a state of exact, strict, and careful adherence (*Merriam-Webster,* 2018). The focus on exact and strict measurements is a goal quantitative researchers attempt to achieve in ensuring rigor or trustworthiness of their studies. The study of human experience in the qualitative paradigm cannot be measured with exact precision, but must remain focused on the careful consideration of integrity and authenticity (Koch, 1996; Sandelowski, 1986). "Rigor in hermeneutics is the careful attention to the treatment of topics such that the work engenders trustworthiness and believability" (Moules et al., 2015, p. 172). To appraise the trustworthiness and believability of interpretive nursing research, de Witt and Ploeg (2006) offered criteria for consideration: balanced integration, openness, concreteness, resonance, and actualization. I used de Witt and Ploeg's (2006) considerations to guide my hermeneutic inquiry.

Balanced integration referred to my responsibility of ensuring that there was congruence between the philosophy, the research, and the topic (de Witt & Ploeg, 2006). Legitimizing knowledge by ensuring there was coherence between the hermeneutic

philosophy and the research was echoed by various authors (Fleming et al., 2003; Morse, Barrett, Mayan, Olson, & Spiers, 2002). Adopting and maintaining an *openness* and transparency that exposed the study to scrutiny was evidenced through the numerous discussions that occurred with my supervisor and supervisory committee (de Witt & Ploeg, 2006). "Trustworthiness becomes a matter of persuasion whereby the scientist is viewed as having made practices visible" (Sandelowski, 1993, p. 2). The idea of integrity found in *concreteness* spoke to the recognizability of the topic within a landscape of the human experience (de Witt & Ploeg, 2006). Credibility is established when "faithful descriptions or interpretations of a human experience that the people having that experience would immediately recognize it from those descriptions or interpretations as their own" (Sandelowski, 1986, p. 30). In attending to the idea of concreteness, I was cognizant of the topic's historical and cultural contexts as well as its potential implications for nursing practice (de Witt & Ploeg, 2006). The goal of this proposed hermeneutic inquiry was to reflect a rich, true-to-life, and meaningful account of the topic; this reflects *resonance* (de Witt & Ploeg, 2006). *Actualization* or the potential for future possibilities speaks to my recognition that interpretations are ongoing and will never be final (de Witt & Ploeg, 2006). This inquiry was not only intended to enhance understanding of the topic, but to also be compelling, raise more questions, and strive for re-interpretation over and over again.

Hermeneutic research emphasizes the need for researchers to engage in self-awareness through the reflection on pre-suppositions and prejudices (Koch, 1998). Journal writing and conversations with my faculty supervisor as well as supervisory committee were methods of reflexivity that I employed throughout the research process

(Dowling, 2006; Koch, 1996, 1998). Another approach that I employed to initiate my reflective thoughts was the completion of an inquiry audit. I used an inquiry audit to note the decisions I made, the prejudices that were challenged, and the new insights that I acquired (Koch, 1994/2006; Rodgers & Cowles, 1993). In my journal entries I would often elaborate on the struggles I first noted within the inquiry audit. These brief and initial notations served as an immediate way of recognizing the sensible use of my known prejudices (Moules, 2002). "The important thing is to be aware of one's own bias, so that the text can present itself in all its otherness and thus assert its own truth against one's own fore-meanings" (Gadamer, 1960/2013, p. 282). Hermeneutics as an approach to inquiry requires researchers to engage in continuous self-critique, thus enhancing self-awareness (Dowling, 2006; Koch, 1998).

Ethical Considerations: Proceeding with Integrity

Informed consent. Before proceeding with the proposed research I received approval from the University of Calgary Conjoint Health Research Ethics Board. The appropriate senior critical care administration were informed of this proposed study by the Provincial Research Administration Team that was part of Alberta Health Services (AHS) (Alberta Health Service (AHS), 2016). This team had been established to streamline operational processes for conducting research within AHS (AHS, 2016). A copy of the consent form was provided to participants at least one week prior to the interview for reading, reflection, and an opportunity to consider potential questions about the research. See Appendix D for a copy of the consent form. Upon arrival to the interview I reviewed the consent form with each participant and responded to questions that emerged. I reinforced to nurses that their participation was voluntary, confidential,

and that they were able to withdraw from the study at any time without penalty (Streubert & Carpenter, 2011). Following this, an opportunity to sign the document was provided. Participants were given a copy of their signed consent form for future reference.

Adherence to privacy and confidentiality. By signing the consent form participants agreed to be audio recorded during the interview, have their texts transcribed, and the research findings published and presented. Pseudonyms were used rather than the names of participants in the transcripts and in this dissertation. These pseudonyms will continue to be used in all written, published, and presented materials (Cohn et al., 2000). A password-protected computer was used to safeguard electronic data, and hard copy transcripts will continue to be stored in a secure office for five years (University of Calgary, 2011). Although every effort was and will be made to preserve confidentiality, participants in this study were informed that complete anonymity could not be guaranteed (Streubert & Carpenter, 2011).

Potential risks and benefits. Asking participants to speak about their experiences with critical incident stress required sensitivity. Understanding this topic required participants and I to walk along a path of uncertainty and unfamiliarity with potential risk. Trekking with participants required that I proceeded cautiously with a sense of moral integrity and discernment. "There is an ethical dimension to making decisions at all points in the research process so that they must be constantly negotiated with awareness and sensitivity" (Moules et al., 2015, p. 177). Given the sensitive nature of critical incident stress, there was a risk that participants could have experienced emotional distress. Recognizing this risk, my role as a researcher rather than clinician was made explicit with each participant (Cowles, 1988; McSherry, 1995). I provided contact

information for two potential resources that would not incur a cost to all participants: a health care employee assistance program and a community walk-in counseling service. The employer program could be accessed by telephone or through a website online, 24 hours a day and 7 days of the week. The community resource offered immediate walk-in services and during an emergency could be accessed by telephone, text or email. In their review of the literature, Corbin and Morse (2003) found no documentation that qualitative research interviews had caused participants long-term harm or required referral for follow-up intervention. In fact, "anecdotal evidence suggests that interviews are more beneficial than harmful" (Corbin & Morse, 2003, p. 346). There was the possibility for participants to feel empowered, gain a sense of self-awareness, catharsis, and experience healing (East, Jackson, O'Brien, & Peters, 2010; Schmied & Wilkes, 2011).

Reflective Thoughts

Hermeneutics was one way of entering into the already existing sparse conversation of the topic offering robust insights, while simultaneously revealing more questions, more unknowns, and more gaps or in-between. This approach was well-suited for the topic because of its capacity to understand more holistically and contextually, exposing how it had been "lived-in" and "lived-through" ICU nurses (Crowther et al., 2017, p. 827). "Hermeneutics is about context and the recognition that phenomena cannot exist uncontextualized" (Moules et al., 2015, p. 91). In addition to expanding understanding, hermeneutics served as a launching point from which additional unfinished conversations could continue to renew and regenerate the topic, potentially changing and enhancing ICU nursing practice. Philosophical hermeneutics "proposes that

understanding does not merely interpret the world but changes it" (Davey, 2006, p. xiv). My understanding of hermeneutics has morphed since the first time I read Gadamer's (1960/2013) *Truth and Method.* I have come to see hermeneutics as more than a philosophy and artful practice; it is a way of being and living- my way of being and living. Hermeneutic understanding has been inherent in the way I relate to others, and engage in my practice as a nurse and educator.

I eagerly accepted my invitation into the game or event of understanding with a sense of openness to the discoveries, the mysteries inherent from all that was in-play and being played. "It is we who take and catch the ball, it is we who are in the game and are capable of being part of the world" (Grondin, 2003, p. 18). The next five chapters, presented as five paradigm exemplars, move into my current interpretations that reflect the meanings of critical incident stress as experienced by ICU nurses. The intent of this interpretive work is not for it to be read and understood accurately, correctly, or as I had intended. Rather, it is intended to speak to readers with resonance and attunement, so that it may provoke further questions and re-interpretation, keeping this game continuously in play.

Chapter Four: "I Desecrated His Body for the Sake of a Job"

From the moment that Ken and I began our conversation, it was as if everything tangible and within our midst faded. The table, the chairs, the clock were no longer objects of existence, and the topic immediately dominated and became the focus. We had been drawn in by the topic, absorbed into the to and fro of question and dialogue, purpose and intent (Gadamer, 1960/2013). I finally understood and encountered what Gadamer (1960/2013) meant by "play fulfills its purpose only if the player loses himself in play" (p. 107). There was something definitely at play. Amidst the movement of play, I was captivated by Ken's compelling account of what it meant to experience critical incident stress as an ICU nurse, and his willingness to show vulnerability and raw emotion. There were numerous aspects of Ken's experience that spoke to me and provoked further thinking. However, during our dialogue there was one phrase in particular that did more than speak to me, it shouted at me. *"I desecrated his body for the sake of a job."* My interpretations for this chapter were influenced by these words that Ken spoke in a deliberate, yet passionate and assertive tone of voice. In this chapter I will bring to light the use of aggressive measures to sustain life as the essence of Ken's experience with critical incident stress. Ken referred to this critical incident as a "*game changer*" that left him wounded, scarred, and different. A brief description of the game changer is required to offer context, clarity, and a common ground for learning something new, something different.

The Game Changer

Ken smirked when I began the interview by asking him to briefly highlight details of a critical incident he had experienced as an ICU nurse. I am convinced that his smirk

served as a warning, that once his story was spoken aloud it could never be unheard. The echoes of his words would touch me, teach me, and move me. With a sense of urgency Ken took initiative in the dialogue and began describing his role in the context of the critical incident. The critical incident took place during a night shift when Ken was a "*66 nurse,*" which meant he was assigned to the ICU outreach team. At the time, this team was also comprised of a physician and a respiratory therapist that responded to calls from staff members within the hospital who had concerns about deteriorating patients. While Ken attended to a patient that had been transferred from the ICU to a less acute unit, he heard his pager alarm followed by an overhead announcement *"code blue to the ICU patio."*

> *I run to the left of the door where we go out on the patio and I see someone lying on the ground, and all I hear is "he fell or jumped." We all recognized this individual as one of our patients that had just gone up to a less acute unit, maybe a day or two prior. We were all attempting CPR* [cardiopulmonary resuscitation]*, and trying to get the crash cart outdoors. I remember it was slippery because of the flooring that we had, and so trying to maintain physical balance was a challenge. I immediately saw one of my colleagues who was really good at his job, struggling to start CPR. So I pulled him off and I started CPR but noticed there was no chest recoil. It was only when I got down on my knees and started doing the CPR that someone patted me on the shoulder and said watch where you're stepping. I didn't really understand until I looked down at my surroundings and around the patient's head was his brain matter. I have responded to a lot of code blues being in the ICU, but this one felt like it took*

hours and not minutes.

The depth, the visuals, the frustration and the helplessness that radiated from Ken's tone of voice were piercing. Ken was keen to tell his story and did not shy away from verbalizing the horrific and unimaginable images that stuck with him. At one point during this description, I wondered if Ken had taken a breath between sentences, as he did not pause nor hesitate in offering the details. Ken was focused, made direct eye contact, and appeared somewhat relieved that I was listening and attentive to his experience. Initially I assumed that the disturbing visual images associated with this incident were likely the reason he considered it traumatic. I also pondered whether there was a deeper connection with the patient as Ken had immediately recognized his face from the ICU. A personal connection to a situation is a common feature of a critical incident (Beavan & Stephens, 1999; Burns & Harm, 1993; Cottrill-Walker, 2000; Gates & Gillespie, 2012). Despite these initial assumptions I sensed there was more to be told, more lurking beneath the particulars. Getting a closer look at the topic required digging deeper into the layers of Ken's complicated experience. It required an exploration into why Ken defined this specific experience as a critical incident. Although Ken briefly mentioned the visual images associated with the patient, the impact from this trauma extended beyond what could be seen and heard. Unlike the initial description of the incident where Ken appeared stoic, confident, and methodical, the tone and cadence of his voice suddenly shifted.

Why did this bother me so much? I asked the resident physician to quit, I almost begged him to stop; everyone wanted him to stop. Why is he not calling it? Why is he not stopping this? Why are you making us do this? I don't want to do this

anymore because the patient is so clearly dead. In my career as an ICU nurse I have learned that I want to respect you in life and in death.

Ken began to speak louder and the anger as well as frustration was palpable as he elaborated on his emotional plea to stop the resuscitation. Ken labeled this incident as critical because he unwillingly engaged in the implementation of aggressive measures on a patient that was "*so clearly dead."* Ken grudgingly became an accomplice to a patient death that he perceived to be disrespectful and inhuman. After what *"felt like hours"* of repetitive CPR the patient was pronounced dead by the ICU resident physician. Ken and his colleagues returned to the ICU, and as they entered the unit there was a sudden realization of what had occurred and what felt like a nightmare became a reality. "*The code blue team really broke; they were crying and struggling to maintain composure and a sense of control. I became tasky trying to keep busy and cope with the moment."* Ken was traumatized as he pondered his actions that conflicted with his personal values of nursing care and his knowledge of death.

ICU Nurses "Know" Death

Experienced ICU nurses know death, they frequently encounter it, they often recognize death's approach, and can predict its arrival. As I listened to Ken's narrative I was drawn to the various ways of knowing that he used to immediately grasp the larger picture and recognize that there was something different, something disturbing about attempting to bring this patient back to life. Ken used his theoretical, practical, and intuitive knowledge to assess the situation, make inferences, and anticipate the possibilities. Intensive care nursing is an interpretive practice that relies on various ways of knowing to grasp the mysteries, the unexplainable, and validate the hunches (Harvey,

Tapp, & Moules, 2016). As Ken arrived to what he referred to as the "*crime scene,"* he astutely zeroed in on the objective, the theoretical indicators that the death of this patient was imminent. "*There's no possible outcome that this gentleman is going to survive, his brain matter is outside of his head and his chest is caved in."* Ken used his experiential knowledge to validate that this patient resuscitation was unlike the numerous others he had encountered as an ICU nurse.

> *I've done lots of codes as an ICU nurse, I've done blood, I've done all the bodily fluids. I had one gentleman that was barfing up fecal matter and bleeding out his other end so I had a knee in each. This was different; it's the most highly charged code I have been a part of.*

As an experienced ICU nurse it became apparent that Ken had developed an intuitive sense that nudged him to question what felt wrong and immoral. He used this sense to verbalize his uncertainty to the team "*why are we doing this?"* "*You can't explain it, its almost a palpable feeling, everyone wants to stop, I want to stop."* Ken spoke about these ways of coming to know as if it had been taken-for-granted and minimized in this situation. "*The patient is very clearly dead; he's very clearly not going to be coming back. But as a nurse I'm not allowed to know what death looks like, I have to ask permission from a physician to know what death looks like."* Ken was equipped with the knowledge to influence patient care but felt helpless when he could not use this knowledge to advocate for a respectful death. Ken knew death; he knew it well enough to recognize that this patient's death was different because he had "*desecrated*" the patient's body for the sake of his job.

The Desecration of a Body

"I desecrated his body for the sake of a job." These words caught me off guard; they agitated me, taunted me, and addressed me. I believe the intent behind this phrase is central to the distress Ken experienced from the critical incident. Hence, I will attempt to unravel its meaning in the context of how it was experienced. The word desecrate summons images of violence and destruction. As a verb, desecrate means to damage or disrespect something or someone that is considered sacred (*Merriam-Webster*, 2018). Etymologically, the origins of the word desecrate come from the old French word *defile,* to make foul or dirty (*Online Etymology Dictionary*, 2018). Throughout its etymological history, it was associated with compromising what was considered holy (*Online Etymology Dictionary*, 2018). The essence of nursing practice is to protect and preserve the wholeness, the integrity of the being, the soul, the flesh. In the eyes of a nurse, the personhood of the other is considered sacred as it signifies more than flesh and blood; it is the housing of a kindred spirit that lives, loves, laughs, and at times suffers. Ken perceived the aggressive measures used to resuscitate this patient as a tampering of the sacred, exposing it, devaluing it; making it vulnerable and undignified. The body became an object that was detached and reduced to broken parts that required immediate and intensive mending. The typical heroic measures used to keep patients alive in the ICU were now considered a weapon that destroyed, violated, and desecrated the human body. While Ken used the word desecrate, other participants in this study used similar terminology such as "*full-force care*," "*flogging*" or "*torturing*." Participants used these violent undertones to describe their role in complicated and questionable aggressive

treatments, used as a last resort in attempts to recover basic functioning of the human body.

Ken continually reinforced and emphasized his responsibility in ensuring the facilitation of a peaceful death. This emphasis was likely deliberate to validate how vastly different his nursing care was for this patient. "*If you're going to die I want to help you die in peace and if there is no intervention that's going to help you, then why can't we just let you go. I don't understand the need to push the boundaries at end-of-life."* Ken spoke about death in the ICU as if it was dichotomous, patients do not just die they either die a good death or a bad death. The ICU offers highly technical and advanced interventions that may influence the type of death that patients experience. These interventions may be used in a way that "*push the boundaries*" leading to a death that is perceived as torturing, flogging or desecrating the body. Ken strongly believed that as a nurse in the ICU he was expected to advocate and facilitate a good death, one that remained within the limits of ethical practice. Similarly other participants spoke about death as if it were two distinct entities, good or bad, dignified or undignified, and there was nothing in-between. However, I believe there is a tension that exists in-between the polarity, it is a space saturated with questions, conflict, and moral distress.

"Left in Limbo"

The critical incident positioned Ken amidst the in-between, *"left in limbo,"* and it was within this place that he experienced moral distress. Uncertainty, conflict, and numerous questions accompanied this moral distress and also resided within this space.

> *Questioning why I did something on someone, and for the sake of what? I need to feel comfortable with the interventions that I'm doing and that they match up with*

> *what the person wants. That's where the conundrum arises, because I talk about respecting them and respect comes from what the patient wants. So if that patient wants me to beat the shit out of them with CPR, even if there's no chance of survival, hell fine. My conscience is clear because this is what you want. If the patient says don't touch me, I'm going to be the one that will throw people off them and yell stop we're done, let them go, this is what they wanted*.

For Ken, this experience was labeled a critical incident because it conflicted with what he valued most, respecting his patients. "*I want to respect my patients in life and in death and I've done a lot of both."* Ken's definition of respect went beyond facilitating a good death, one that was peaceful, as it extended to fulfilling patient's wishes. The voices of the critically ill are typically silent and their wishes lay dormant, as they are unconscious and tethered to mechanical ventilators. For Ken this experience became increasingly difficult and distressing given at that point in time, the patient was unable to communicate their wishes.

Moral distress implies choice between what is considered right and wrong, and the need to make a decision among options presented. Ken used his ways of knowing and personal values to justify a decision he desperately wanted to see enacted. Unfortunately he was not permitted to pursue this decision, as there was an element of external control that hovered over him. *"I'm not allowed to be the one to stop and say that what we are doing is wrong, morally wrong."* Ken continued with what was expected of him and adhered to the resident physician's orders. *"Unfortunately the resident physician was so stunned by the whole incident, he wasn't thinking clearly. He was the one with the least experience in critical care and we were reliant on him."* Ken recognized that there were

variables and factors that influenced the decisions made for the patient. The institution's policies, the level of experience and hierarchy among team members, and the organizational culture inherent in the ICU that focuses on saving lives, were rooted within the actions taken on behalf of the patient. Ken validated that there were circumstances within this setting that required the use of aggressive interventions to support patients through critical illness.

> *When we have exhausted all options I have no shame asking why we are continuing to flog? I respect the interventions and I appreciate the process, I never disagree with the process. But if we have done our due diligence why do we have such a hard time saying goodbye and letting go? We're not going to save this person and all we are doing is torturing them at this point.*

Determining whether or not to use intense and forceful interventions is often deliberated in the ICU, influencing the tension that resides in the midst of the in-between.

Traumatic Wounds "A Scar on the Psyche"

Following the critical incident Ken spent the remainder of the shift attending to the needs of others, he unintentionally neglected his own injuries. *"I ended up taking over the duties of the charge nurse, contacting the family, the attending physician, and the manager."* I deliberately used the word "injuries" as it matched the tone Ken used to describe the impact from his traumatic experience. Ken referred to himself as being *"wounded"* and *"scarred"* as a result of the critical incident. There are some wounds that can be seen, felt, and accepted as the flesh is torn by insult. Other wounds remain hidden and unnoticed for a period of time, despite their severity. The extent of the injuries initially went undetected as Ken refused to acknowledge his wounds at work; he kept

them concealed until he went home. *"I refuse to be broken at work. I can be broken at home but I'm paid to do a job and I'm the professional. So I refused to let it break me then and there."* When Ken arrived home he realized the penetrating impact the open sores had on his ability to meet his own basic human needs.

> *When I got home I didn't sleep for days and was woken up by nightmares. Every time I closed my eyes I couldn't blink without seeing his body, specifically the shoulder region and upwards. I was not eating, not drinking, and nauseated to the point that I thought I was going to throw up 24 hours a day. I was exhausted and barely coherent going through this mental, physical, and emotional turmoil. You are affected on every level, to your core.*

Ken attempted to cover his wounds by maintaining a sense of normalcy, but unfortunately he could not find reprieve, he was trapped. *"My body was wrecked, my mind was wrecked, and it was a very vicious cycle that you aren't allowed to get out of by your own brain. I really felt stuck."*

Ken returned to the ICU approximately five days after the critical incident with his wounds diligently disguised. However, he knew that beneath the dressing his tissue remained open, angry, and oozing. *"The nightmares aren't going to stop, the feeling like shit isn't going to stop, so I can try and put one foot in front of the other and keep going."* It took a year for Ken to acknowledge the incident as traumatic and validate the *"mental torture"* he endured. Unfortunately, Ken experienced re-injury several years later with a similar incident.

> *I remember getting off the elevator going to get coffee and all I heard was "holy shit, we need to call ICU," and I thought I am from the ICU, and I happen to be*

> *on the code team. I walked past the commotion to find a gentleman had just jumped and was lying on the cafeteria floor with blood starting to pool. It was unbelievable because the same charge nurse and the same attending physician were working that shift. In the first 30 seconds this volcano of emotion erupted and I started to see everything from the first incident. And it's weird how your brain plays tricks on you because I saw his face on this guy. I'm looking down at this guy and I remember having to close my eyes and just breathe, and then opened my eyes again and do what needed to be done. The patient ended up somehow surviving and remained fully neurologically intact. I found this experience easier; I was just tasky and I took the emotion out of it. I don't really feel all that affected by this one.*

Ken described himself as more prepared and used the previous incident to support his co-workers, anticipating they would likely suffer a similar stress response. *"I was able to use my prior experience to support my colleagues by being honest with what to expect after, and normalizing their reactions to the situation."* Ken's initial critical incident suddenly exposed him to a hidden risk that had always already existed in this setting. The hidden risk was the potential for critical incident stress. Recognizing this risk made Ken more attuned to the possibility of re-injury from future traumatic events, and became beneficial for navigating a similar incident.

Ken spoke about his experience with critical incident stress as if it were permanent and cyclical; other participants held similar sentiments. Participants described occasions where critical incident stress revealed itself months or years after the traumatic event with the same intensity, and other times it remained distanced. A common trigger

among participants was the physical space where their incident had occurred, as it served as a reminder of their trauma. Ken requested he be assigned to patients whose rooms were located farthest from the patio. *"I would like to not be in beds 8, 9, 10, 11, 12 or 13 because that was the back half of the unit where all of this happened and you look in the rooms and there's windows out on to the patio."* Despite avoiding the physical space, Ken admitted to never being completely healed from the critical incident and that he would always be left with an "*open wound,"* a permanent scar. Open wounds heal from the inside out, and the edges eventually close causing the skin to look different as a result of scar tissue formation. Ken was transformed; he would never be the same, his scars looked different because he was different. "Scars are the mark left on the flesh to be seen and told, touched and read" (Kearney, 2016, p. 3). *"This experience will always be an open wound and I think it will be a scar on the psyche forever. It's that one learning opportunity that you don't ever want, but you respect the hell out of it after it happens because it has changed me forever."*

Connecting the Dots to Ken's Experience with Critical Incident Stress

"The game itself is a risk for the player. One can play only with serious possibilities."

(Gadamer, 1960/2013, p. 110)

Ken's description of the game changer reinforced the risks inherent in the day-to-day work of ICU nurses. One of the risks or serious possibilities is the critical incident stress associated with the implementation of aggressive measures to sustain life. Implementing aggressive interventions is not atypical as an ICU nurse, given that the inherent commitment of the organizational setting is to prevent death at significant costs (Benner, Hooper-Kyriakidis, & Stannard, 1999). These interventions become

questionable when they are perceived as a weapon used to desecrate the already clearly dead human body. Ken's experience spoke to his deep and authentic concern for how this patient died, more specifically this patient's experience of death. I believe it is the nature of this experience that influences whether or not an ICU nurse considers the death of a patient a critical incident. Crucial to my interpretation is the acknowledgment that the proliferation of advanced and highly technical machinery in the ICU has led to inadvertently overlooking the organic nature of death (Benner et al., 1999). Gadamer (1996) extended this acknowledgement by explicitly noting the potential implication for the "dazzling" achievements of science has served to depersonalize the experience of death (p. 61). One of the predominant reasons Ken perceived this resuscitation as traumatic was the depersonalized nature inherent in the patient's experience of death. *"I desecrated his body for the sake of a job"* validated Ken's perception of this depersonalization.

The Co-Experience of Death

Depersonalizing the patient's experience of death took place in the form of cruel and violent aggressive measures that were implemented on what Ken described as a corpse. The patient's body was objectified while their personhood diminished and was eventually neglected. It was evident from Ken's narrative that the patient's experience of death was significant to him as an ICU nurse. I propose that this significance to ICU nurses exists because death is co-experienced in some way by both the patient and the ICU nurse providing care. I recognize that this co-experience of death is obviously understood and encountered differently by both the patient and the ICU nurse. For Ken, the co-experience reflected an element of self that was implicated in the care he provided

to the dying patient. Gadamer (1996) suggested "the prolongation of life finally becomes a prolongation of death and a fading away of the experience of the self" (p. 62). In this quotation Gadamer (1996) referred to the self as the person or patient experiencing the mysteries of death. However, I offer the self may also be extended to the ICU nurse, to Ken, whose sense of naivety about the concept of death crumbled as a result of this critical incident. Ken increasingly perceived death as complex, messy and ugly rather than a simplified linear process. The fading away of self emerged as Ken questioned the existential dimension of death, the meaning, the value, the sacredness cocooning the patient's experience relative to Ken's personal values and beliefs.

Phronesis as Moral Knowledge

Ken was a seasoned ICU nurse whose experiential knowledge about death was undermined and diminished by members of the health care team. Ken felt helpless that despite his knowledge of death he felt that he was not allowed to know what death looked like. Ken's multiple ways of knowing death was faded and minimized during the course of treating this patient. This left Ken feeling helpless as he attempted to use his knowledge to ensure that the patient's experience of death was marked with dignity and respect. Ken's knowledge of death was rooted in the theoretical and practical or experiential domains of clinical practice (Benner, 1984). Through years of experience Ken developed intuitive knowledge that influenced his decision-making (Acebedo-Urdiales, Medine-Noya, & Ferre-Grau, 2014; Benner & Tanner, 1987). I propose there was an additional way of knowing death, moral knowledge (Carper, 1978; Gadamer, 1960/2013), that was less explicit but valued and inherent in Ken's description. Gadamer (1960/2013) used an Aristotelian term, *"phronesis"* or prudence translated as practical

knowledge and moral knowledge, to describe judgment and response within a situation (p. 330). *Phronesis* requires an engagement through discerning and taking action (Gadamer, 1960/2013). The work of *phronesis* cultivated Ken's ability to see, hear, and discern, what had confronted him. It was clear that Ken was able to judge and discern that this patient's resuscitation was unusual and different from the numerous others he encountered. However, I suspect Ken's struggle with responding to the situation in a way that aligned with his personal values and beliefs compromised this moral knowledge, and contributed to his critical incident stress.

Moral Distress: The Tension In-Between

The game changer positioned Ken in-between his dichotomously perceived good and bad death. It was within this space that Ken was left in limbo to encounter moral distress. Gadamer (1960/2013) spoke about the "in-between" as a mode of being in which understanding occurs when situated as a being in-between the familiar and strange. Davey (2006) described the ontology of the in-between as a tension amongst what is known and what is yet to be discovered. I see the being in-between as a space sustained by the existing tension between power and powerlessness amidst moral distress. Similar to a game of tug-of-war the tension varies and is dependent on which side exerts the most force or power. Jameton (1984) argued that the discipline of nursing is representative of the "strong tensions between power and powerlessness" (p. 10). There were various power struggles evident in Ken's description of the critical incident that facilitated his moral distress. I would like to expand on the most obvious struggles Ken endured within the space, to offer a better understanding of the moral distress that underpinned the critical incident.

Moral distress may occur when a nurse makes a moral judgment but cannot act on that judgment (Jameton, 1993). Ken brought to light an interesting power dynamic in the value judgment he placed on a perceived good and bad experience of death. I recognize that Ken's judgment in this context was derived from his personal values and beliefs (Wilkinson, 1987/1988). Ken judged this patient's experience of death as having desecrated his body because it conflicted with what he deemed important, which was respecting the personhood of the patient. Ken had some element of power in this particular situation, as his judgment over what he conceived as a good and bad death likely influenced the actions he desired and fulfilled. One action Ken was able to enact was to question the futility of the interventions among members of the team engaged during the resuscitation. However, his voice went unheard and he continued to participate in an action he considered immoral. During morally distressing situations, even if a nurse speaks out, their voices may be silenced and their actions diminished (Jameton, 1993; Varceo, Pauly, Webster, & Storch, 2012). As a being in-between the tension between power and powerlessness became evident when Ken was unable to use his moral judgment to enact his desired action, to let the patient die peacefully. Jameton (1984), a philosopher, was credited with coining the term moral distress in the context of nursing practice (Corley, 2002). In his seminal work, Jameton (1984) described moral distress as "arising when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p. 6). This definition implies that nurses discern and judge between a right and wrong course of action in a given situation. There is often more than one right thing to do, however acting on one may preclude acting on others (Corley, 2002). While nurses may judge the patient's experience of death, this

judgment may extend to the responses they select to pursue and those they are unable to pursue because of existing obstacles (Wilkinson, 1987/1988).

Ken's preferred right course of action was to cease the patient resuscitation and offer the patient a dignified, respectful, and peaceful death. Consistent with Jameton's (1984) definition of moral distress, Ken's morally appropriate action became difficult to fulfill because of the external constraints that served as a barrier. One of the most obvious constraints was the varied medical and nursing perspectives of death. Perhaps the in-between space was the tension amid Ken's mandate to respect the patient's experience of death, and the medical mandate to prevent it. The right course of action looked different for both Ken and the resident physician. For Ken, doing the right thing was to advocate for the patient receiving burdensome treatments that he considered to be futile. For the resident physician, the right course of action was to aggressively treat the patient despite the futility. Ken felt powerless when he was expected to abide by the resident physician's orders, and to continue with actions that conflicted with his judgment of a good death and professional mandate. The exercise of medical power has been recognized as an institutional obstacle that exists for nurses attempting to pursue their right course of action (Corley, 2002). The unique professional mandates, and the power struggle inherent within those abiding by these mandates, influenced the tension Ken experienced within the place of in-between.

Various research studies have explored moral distress experienced by ICU nurses (Atashzadeh Shoorideh, Ashktorab, Yaghmaei, & Alavi Majd, 2015; Choe, Kang, & Park, 2015; Henrich et al., 2017; Mealer et al., 2007; Meltzer & Huckabay, 2004). A fair number of research studies have associated moral distress with the aggressive treatment

used only to prolong death (Elpern, Covert, & Kleinpell, 2005; Meltzer & Huckabay, 2004; Whitehead, Herbertson, Hamric, Epstein, & Fisher, 2014; Wilkinson, 1987/1988). These studies give credence to the complex, typically blurred decisions made by ICU nurses that provoke moral distress. In the broader nursing literature moral distress has been associated with concepts that occur over time such as burnout (Juthberg, Eriksson, Norberg, & Sundin, 2010), job dissatisfaction (de Veer, Francke, Struijs, & Willems, 2013; Ulrich et al., 2007), and attrition rates (Elpern et al., 2005; Varcoe, Pauly, Storch, Newton, & Makaroff, 2012; Whitehead et al., 2014; Wilkinson, 1987/1988). While the research to date has offered insights into nurses' experiences of moral distress, to my knowledge there is little known about ICU nurses experiences of moral distress in the context of critical incident stress. Moral distress was initially an unassuming component to the critical incident experienced by Ken and various other participants. Perhaps this is related to the easily concealed nature of moral distress as it quietly slithers through, around, and in-between the work of ICU nurses. It is because of this discreet and unobtrusive element to moral distress that I believe it requires serious and deliberate consideration when ICU nurses experience critical incident stress.

Fluctuating Amidst Walking Wounded and Wounded Healer

Ken was left with an open wound and a *"scar on the psyche forever"* as a result of the critical incident. As I reflect on Ken's experience, I have become particularly attuned to his persistence in continuing to work despite his penetrating and painful open wounds. This brought to mind the term "walking wounded" as I envisioned Ken struggling with his own injuries inflicted by the critical incident, while continuing to provide patient care. The notion of walking wounded has been described and defined

with slight variations by different authors (Conti-O'Hare, 2002; Groesbeck, 1975; Jackson, 2001; Zerubavel & Wright, 2012). In the context of nurses who have experienced trauma, Conti-O'Hare (2002) referred to the walking wounded as nurses who recognize that they have been wounded from trauma, but are unable to understand the impact of their injuries on themselves. At the time of the incident, Ken refused to acknowledge his injuries at work, *"I refused to be broken at work,"* and thus they remained concealed for a period of time. I wondered whether Ken *"refused to be broken at work"* because of the risk for stigma. Zerubavel and Wright (2012) argued that the perception of an individual's woundedness is dependent on the characteristic of their wound and the scar or imprint that remained. The characteristic of the wound may be influenced by the potential for stigma (Zerubavel & Wright, 2012). The walking wounded face the possibility of feeling stigmatized if the origin of the wound is exposed, and if judgment by co-workers involves questioning of competence (Avraham et al., 2014; Halpern et al., 2009; Zerubavel & Wright, 2012). The risk of stigma may create a sense of isolation for nurses who have encountered a work-related trauma and silently suffer (Conti-O'Hare, 2002; Zerubavel & Wright, 2012). The risk of walking wounded extends beyond stigma, as neglecting open sores may lead to PTSD (Mealer et al., 2012; Mealer et al., 2007). According to van der Kolk, McFarlane, and van der Hart (2007) PTSD indicates "a failure of time to heal all wounds" (p. 7).

Ken confessed that it took him one year after the critical incident to acknowledge it as traumatic, and to validate his woundedness. I questioned whether this acknowledgment and validation suggested a form of mending or healing had taken place. This led me to seek further understanding of the transition from Ken's open wounds to

the scar on the psyche that remained. There are various authors that have suggested the existence of a transition from walking wounded to a wounded healer (Christie & Jones, 2014; Conti-O'Hare, 2002; Zerubavel & Wright, 2012). Conti-O'Hare (2002) proposed that definitive distinctions between walking wounded and wounded healer were not clear-cut. Moving forward with this discussion I make the assumption that Ken has progressed along this trajectory, and despite the obscurity, I see Ken as a courageous wounded healer. A wounded healer creates possibilities that serve to benefit the ICU nurse and the discipline of nursing as a whole (Conti-O'Hare, 2002).

The archetypal image of the wounded healer has been associated with Shamanism and Greek mythology, specifically the myth of the centaur Chiron (Groesbeck, 1975; Jackson, 2001). Chiron, an immortal born half-man and half-horse was known as wise, compassionate, and knowledgeable in the area of herbal medicine (Groesbeck, 1975; Jackson, 2001). Hercules accidently struck Chiron in the lower half of his body with a poisoned arrow causing him to seek refuge in a cave, while tending to his own incurable wounds (Jackson, 2001). Chiron was known for using his own wounded presence in a self-sacrificing manner to heal the suffering of others (Groesbeck, 1975; Jackson, 2001). It was through the healing of others that Chiron transformed his own woundedness, exemplifying his portrayal of a wounded healer (Groesbeck, 1975; Jackson, 2001). The legend of Chiron reinforced for me the significance of ICU nurses recognizing that healing the critically ill can only happen through healing of the wounded self (Conti-O'Hare, 2002). According to Conti-O'Hare (2002) a nurse's transition from walking wounded to wounded healer requires engaging in reflection, transformation, and transcendence of the critical incident experienced.

A number of the literature sources used to inform my interpretations have described the terms walking wounded and wounded healer as if they involve a unidirectional transition. While Ken spoke about his experience as a walking wounded ICU nurse, I initially envisioned a unilateral transition from open wounds to transformation. However, as Ken began to share details of the second similar critical incident that took place one year later, I began to consider the potential for re-injury. Reflecting on Ken's experience I have come to realize that the transition from walking wounded to wounded healer does not occur in one direction rather, it is potentially cyclical and fluctuates. Zerubavel and Wright (2012) propose four trajectories that may occur after the experience of a wound: post-traumatic growth, recovery, chronic dysfunction and relapse. They depict this trajectory as a process evolving over a period of time (Zerubavel & Wright, 2012). I see this trajectory containing movement, swinging from one direction and back again similar to a pendulum shifting back and forth. This fluctuation of to and fro creates the ongoing opportunity to mediate past and present experiences. Transformation requires understanding of wounds from the past in order to move forward as a wounded healer (Zerubavel & Wright, 2012). Perhaps this is what Gadamer (1960/2013) implied in acknowledging that understanding is engaging in tradition, "a process of transmission in which the past and present are constantly mediated" (p. 302). Ken spoke to feeling better prepared for the second critical incident as a result of his first encounter. Hence, the ICU nurse who transitions to wounded healer may use their enhanced self-awareness and insights to inform their unexpected return to walking wounded. Like Chiron, Ken used his own wounded presence in a self-sacrificing manner to heal the suffering of his wounded colleagues (Groesbeck, 1975; Jackson,

2001). Despite the formation of scar tissue on previously open wounds, there is the possibility for new wounds to acutely puncture the skin or re-injure the original scar (Zerubavel & Wright, 2012).

Returning to the Research Question

Ken offered various insights that contributed to the meaning of work-related critical incident stress. In this chapter I suggested that the patient's experience of death is co-experienced by both the ICU nurse and the patient. Albeit they are experienced differently, a death that desecrates, tortures, or flogs the sacred, a patient's personhood, may be perceived by an ICU nurse as traumatic and lead to critical incident stress. The tension between power and powerlessness that influences the degree of moral distress experienced needs to be considered in this stress response. Finally, ICU nurses who experience critical incident stress are situated between the to and fro of walking wounded and wounded healer. Critical incident stress wounds, scars, and permanently transforms ICU nurses (Herman, 1992; van der Kolk, 2014). Ken used the term game changer as if he was a player in a game, willing to accept the risks. I recently watched the first episode of a television series called "Greys Anatomy," depicting the experiences of surgical intern (student) physicians. The opening phrase spoke to me as I was in the process of writing this chapter. "Each of you comes here hopeful, wanting in on the game. You will be pushed to your breaking point. This is your starting line. This is your arena. How well you play, that's up to you." Critical care nurses like Ken arrive to the ICU hopeful to make a difference, wanting in on the game filled with excitement, challenges, and learning opportunities. There are risks in this game, risks such as critical incident stress that will push ICU nurses to their breaking point. How well the game is played, that

moves beyond the individual ICU nurse to the context, the playing field, the work-culture of the ICU setting.

Chapter Five: The Unspoken "Unwritten Rules" of the ICU

There are a lot of unwritten rules about who you are when you're an ICU nurse. One of those rules is that you don't show emotion, that includes personal emotion. You show empathy and caring towards families who are dealing with tragedy. You show empathy and caring towards your colleagues. But there is this silent, unsaid idea within this work culture that it's not OK to be emotional or break down at the patient's bedside.

With an intense gaze and a composed demeanor Natalie confidently uttered these powerful words aloud. I was immediately compelled by this statement, perhaps even slightly uncomfortable with Natalie's revelation. I attributed this uneasiness to Natalie's transparent and direct approach used to expose the *"silent"* and *"unsaid,"* yet pervasive *"unwritten rules"* within the ICU. The significance of the work or organizational culture relative to critical incident stress began to emerge during Natalie's description of the event she considered traumatic. In the latter part of this description, Natalie's tone of voice shifted from calm and subdued to defensive and slightly angered, as she elaborated on the sideway glances she received by ICU team members following her display of overwhelming emotion. The sideway glances reinforced the existence of the unwritten rules and their impact on Natalie's response to trauma. In this chapter, Natalie's experience will address the influence of the ICU organizational culture on critical incident stress. I will begin by offering a brief description of Natalie's critical incident that led to the sideway glances of disapproval and influenced my interpretation of the unspoken unwritten rules of the ICU.

The "Sideway Glances" of Disapproval

Natalie removed her sweater and rolled up the sleeves of her long-sleeved shirt, as if to imply she was prepared and eager to assist me with the ongoing task of understanding. Natalie confidently began the interview by offering the background to her stress response, more specifically, the details of the incident that she defined as critical.

> *I had just arrived for a day shift and I was assigned the same patient as the day before. The patient was scheduled for a diagnostic procedure that required him to lie flat for an extended period of time. From the time I arrived I noticed the patient was delirious, and as I looked over I noticed he was attempting to climb out of bed and take his gown off. Knowing that I needed to get things moving along, I asked my nurse colleague who had taken care of him over night if she had maximized all of the PRN medications for his current agitation. She replied with a firm nod and then verbalized to me "yes, I've tapped it out." So I looked up and yelled across the nursing station to the resident physician: "Can I give him Diazepam?" He looked at me and said "sure" and so I began to prepare the medications. I double-checked the electronic medication administration record, and then made sure that the patient could also have a narcotic for pain. My safety checks were fine according to the orders and so I loaded the syringe with 1.5 mg of Hydromorphone and 10 mg of Diazepam. I settled the patient back into bed and then accessed his intravenous site; I proceeded to push the medications. I briefly turned my back to look at something on the counter, and suddenly the patient's monitor alarms began to beep. I looked up and realized that he didn't have his oxygen on, and then the nursing attendant next to me commented: "he's*

looking kind of bad." I was convinced that he looked bad because he didn't have his oxygen on, so I put his oxygen saturation probe on his finger. With the probe on his finger the monitor alarms suddenly started to triple beep. The patient had arrested. Even though the patient survived, in the moment, I felt like I killed him.

Natalie paused for approximately 30 seconds at this point in the narrative, and appeared uncertain of how to proceed. During this period of silence, I wondered if Natalie considered this experience a critical incident because of her perceived harm to the patient. She saw her actions as more than causing harm, administering the medications paralleled the extreme, the worst-case scenario -*"I felt like I killed him."* However, similar to Ken's experience, there was something more concealed beneath the obvious. As Natalie proceeded with the details she abruptly changed the topic of the conversation. Natalie shifted the emphasis of the dialogue from feeling like she *"killed a patient"* to her overwhelming *"emotional upheaval"* that followed the critical incident. With this transition of topics there were nuances that suddenly emerged from beneath the obvious, highlighting Natalie's perception of the expectations inherent within the ICU.

In that moment I was plagued by a flood of thoughts and emotions. As help from my colleagues arrived I realized that I needed to step aside, I was too emotional and not fit to practice. At this point there were members of the team that walked into the ICU as this was taking place. I felt ashamed in that moment because of the sideway glances, the obvious disapproval of me having a moment of emotional outbreak.

There was meaning behind the *"sideway glances"* and a silent, yet deliberate message was conveyed to Natalie, who responded by feeling ashamed. Natalie believed

the message was intended to communicate team members' disapproval of her *"emotional outbreak."* It was at this point that I immediately realized Natalie's critical incident stress went beyond potentially harming a patient, and was increasingly more complex than anticipated. The sideway glances of disapproval were germane to Natalie's experience as this shed light on the contextual or workplace cultural influences associated with her response to the critical incident. Natalie's feeling of shame was derived from the optics that she could not cope with the incident. *"I was ashamed because I wasn't handling it; it is difficult when there are a lot of unwritten rules as an ICU nurse."* Natalie inadvertently broke the unwritten rules by showing emotion at the bedside and now there were consequences, a price to pay for her actions.

Breaking the Rules: The Harm in Showing Emotion

Rules may be perceived as absolute and rigid as they can either be followed or broken. Rules may also be less clear-cut as suggested in the phrase "bending the rules," when they are deliberately ignored or altered. There are consequences to knowingly or unknowingly breaking or bending the rules and thus, the goal is to avoid violating the expectations that have been imposed. Rules can be plural or singular, implied or explicit; regardless of their structure they are considered powerful as they dictate the way things should be. Throughout the interview Natalie spoke about the unwritten rules as if they were absolute and in the plural form. Hence, I assumed she would describe more than one definitive or rigid expectation inherent within the ICU. Despite speaking about these unwritten rules as if there were multiple, Natalie's description remained consistently focused on emotion, more specifically, avoiding a display of emotion during patient care. *"These unwritten rules are about emotionality, about whether you can cut it or not, it's*

part of the ICU culture." The unwritten rules were implicit, and could never be located as a hard copy document similar to other clinical expectations that were central and easy to access. These rules were concealed and became increasingly evident when they were violated or broken.

Natalie addressed the unwritten rules as if they remained on the tongue never to be spoken aloud, similar to a hidden secret. *"These unwritten rules remain quiet, under the radar, and are never discussed out loud."* The idea of secrets is interesting as it conjures various meanings and interpretations. Secrets may be referred to as mysteries that cannot be fully explained, like the deep dark mysteries of the universe. There are good secrets, the kind that you keep when you are planning a surprise birthday party. There are also closely held secrets to protect others against the possibility of being hurt or harmed. Perhaps the unwritten rules in the ICU remained unsaid or secret because to utter them aloud was to expose their potential for harm. This form of injury was different than Natalie's initial perceived harm to her patient. Harm in this context took place in the form of being judged as incompetent, unreliable, and unfit to be an ICU nurse.

> *When ICU nurses are emotional or breakdown at the bedside they are judged to be someone who doesn't belong, they're not effective, they can't cut it, and they're not good enough to be on the team because they can't be relied upon. You do what it takes to follow the unwritten rules, if you can't do what it takes you need to go. It's just not the place for you.*

According to Natalie, breaking the unwritten rules jeopardized the trajectory of a nurse's career in the ICU. The consequence of breaking the rules was significant, potentially life altering, and thus *"you do what it takes to follow the unwritten rules."* Unfortunately, the

critical incident Natalie experienced evoked overwhelming and uncontrollable emotion. *"I realized that I don't have control and there is something in the universe other than us humans that is in play."* As a result, she inadvertently violated the unwritten rules by exposing her identity as a human being rather than primarily as a trained professional.

"The Reality is, I am Just a Human Being"

The topic of conversation associated with the workplace expectations became increasingly personal for Natalie. She elaborated on the impact of the unwritten rules that challenged her identity as an ICU nurse.

> *I was distressed, I was upset, trying to be professional and hold it together but I couldn't help the overwhelming feelings. I am supposed to be a professional; I am trained to manage difficult situations. Being a trained professional means to set everything aside, to not allow your emotions to cloud your ability to do your job. That is really hard when something like this happens. But the reality is, I am just a human being.*

Natalie's description suggested the existence of two distinct identities, the *"human being"* and the *"trained professional."* Natalie appeared disheartened when she uttered the phrase: *"But the reality is, I am **just** a human being."* Natalie spoke of "*just"* a human being as if this identity were inferior and undesirable as compared to the ideal trained professional. Natalie associated being human with a display of *"overwhelming feelings"* and *"a flood of emotions"* that were considered difficult to control and less desirable. I wondered if this less-preferred identity likely stemmed from a work environment that thrives on the use of technology and advanced skills to manipulate and control life and death. Regardless, it was evident from Natalie's tone of voice that she

was irritated by her human identity, as not only was it associated with uncontrolled emotions, it was also easily identifiable. To be seen by co-workers as an emotional ICU nurse was problematic in the face of adversity, as she believed that it was considered unacceptable and violated the unwritten rules. *"I shouldn't be feeling emotions because I'm not allowed, I'm an ICU nurse."* Another participant echoed Natalie's sentiment, but also spoke to concealing these emotions. This participant shared the metaphor of a *"metal heart"* used as a shield to protect and contain their display of emotions from other co-workers during difficult situations. Natalie was unable to hide her emotions, but aspired to remain a trained professional; this was an expectation she believed coincided with ICU nursing.

In the ICU it was expected that the human being be placed aside while the trained professional dominated. *"In the ICU your humanness has to be put aside to do the job you do because you are expected, if you're a trained professional then you do it."* Natalie used the word "professional" twelve times throughout the interview, which I believe was symbolic of its relevance to this setting. Natalie defined a professional by a nurse's ability to manage challenging situations by keeping emotions detached and at a distance. This separation was important as Natalie suggested emotions had the potential to compromise the delivery of patient care. Natalie appeared to objectify emotions, as if they were a tangible item that could be manipulated, easily separated, temporarily stored, and then returned when needed. On numerous occasions Natalie supplemented the word "trained*"* to her description of a professional nurse. As a verb, the word train means to give or receive instruction, to discipline or drill over a period of time (*Merriam-Webster*, 2018). This definition implies that over time ICU nurses have been disciplined or drilled

to behave in a certain way. There is an element of control that underpins the act of discipline. Hence, if an ICU nurse is a trained professional they are consistently expected to maintain control, including restricting their emotions. When Natalie was unable to remain a trained professional, she succumbed to her altered identity - just a human-being. It was important for Natalie to revive her professional identity, as she had something to prove to her co-workers and to herself. Natalie needed to redeem herself after the critical incident by finding the courage to continue with the care of her patient.

Still in the Game: The Risk and the Courage to Continue

Natalie did not hesitate in pondering whether or not to return to patient care, she *"had to go back." "While I stepped away my other colleagues administered medications to reverse the drugs I had given and the patient survived. After I released my initial distress by crying and getting support from a colleague, I had to go back."* Natalie initially coped with her overwhelming distress by receiving support from another ICU nurse. Natalie then returned to patient care because she felt obligated; she had knowledge of the patient's history and knew him best. *"I returned to the room because as a bedside nurse I had received report. I knew the patient best because I had looked after him before."* I propose that Natalie's intention of returning to the bedside extended beyond her obligation to patient care, as it represented her recovered professional identity. It reinforced to her co-workers that she could be relied upon and in the future would continue to be an effective member of the team. *"To step away, cry on that nurse's shoulder, pull it together, go back in and appear professional again validated that I was still in the game."* Similar to Ken, Natalie's use of the word game implied that there was something at play. A game is challenging, competitive, and as described in the previous

chapter, involves an element of risk. One of those risks is the possibility of losing what was placed at stake before the game began. As a player, Natalie's decision to return was influenced by the perception of her co-workers. Natalie needed to prove that she had not lost the game, rather that she was still in the game, willing and ready to accept the associated threats of remaining in play.

Returning to the playing field involved an element of uncertainty, as it was unclear how Natalie's co-workers would respond to her *"stepping aside"* to manage her emotions. Hence, I suggest Natalie's return to patient care was courageous; she was willing to accept the possibility of additional sideway glances from team members. Courage is the mental strength to choose and the willingness to confront difficulty (*Merriam-Webster*, 2018). Natalie made a choice to confront difficulty inherent in the possibility of rejection, ridicule, and appearing incompetent. However, Natalie was confident that her years of experience as an ICU nurse, and her reputation would take precedence over the judgments held by co-workers. *"Given my experience I was viewed as credible, I was viewed as a smart and decent nurse. So, I knew that this incident would not cause me to be shutout from the culture."* Natalie was certain that despite critical incident stress she had earned credibility and competence that would ensure her acceptance. This suggested that years of experience would make it easier for ICU nurses to gain acceptance, belonging, and fit within the culture. Natalie acknowledged that novice ICU nurses could be disadvantaged in this setting as they may lack awareness of the inherent workplace expectations.

> *We disservice new nurses by not telling them about the cultural expectations, the unwritten rules. It's one of those things that new nurses have to experience and*

figure out for themselves, unfortunately it's one of those things you learn on the job.

As a seasoned ICU nurse Natalie earned her re-acceptance into the culture and remained in the game. While in play, Natalie gained valuable insight and renewed understanding of ICU nursing, and the existing culture that influenced her critical incident stress.

Coming to Understand Organizational Culture: A Wish List for ICU Nurses

As the interview came to an end Natalie became progressively more silent and appeared rather contemplative. Looking at me with a serious face and thoughtful eyes, Natalie began to reflect on her experience of critical incident stress, with continued emphasis on the organizational culture.

I am very thankful that I still allow myself to be emotional and that I can teach others by the way they observe how I handle things. The culture that exists may not be the only way to exist in the ICU environment, you can still survive and thrive.

It became increasingly clearer that Natalie's critical incident impacted her current and future nursing practice. Natalie's thoughts reflected an adjustment in her prioritizing the importance of the expectations inherent within the ICU. Despite the influence of the culture on nurses' work, she was convinced that it was possible to co-exist independently along-side these expectations.

Natalie gained pearls of wisdom from her experience with critical incident stress and was eager to offer key learning for ICU nurses.

I wish someone would have told me upfront that you will encounter a traumatic event and you may or may not have caused it. What I would want is what I don't

think can happen, and that would be, to be told that you will never be harmed by the event. That you would never be punished and it would not change the way people think of you. You're going to be a part of them, that doesn't change who you are or what you are.

In this wish list Natalie illustrated the importance of transparency and honesty by informing ICU nurses of the potential for critical incident stress in this setting. Based on her experience with the sideway glances of disapproval, Natalie reinforced the possibility of harm in the form of judgment from co-workers following a critical incident. This type of harm paralleled a sense of punishment for breaking the unwritten rules. Perhaps most importantly, Natalie acknowledged that despite the influence of the unspoken unwritten rules of the ICU, they remained powerless over *"who you are or what you are."*

Connecting the Dots to Natalie's Experience with Critical Incident Stress

Silence

There is a silence where hath been no sound,
There is a silence where no sound may be,
In the cold grave-under the deep deep sea,
Or in the wide desert where no life is found,
Which hath been mute, and still must sleep profound;
No voice is hush'd-no life treads silently,
But clouds and cloudy shadows wander free.
That never spoke, over the idle ground:
But in green ruins, in the desolate walls
Of antique palaces, where Man hath been,
Though the dun fox, or wild hyena, calls,
And owls, that flit continually between,
Shriek to the echo, and the low winds moan,-
There the true Silence is, self-conscious and alone.

Thomas Hood (1799-1845)

There is a silence where no sound may be, that roams within the ICU; this form of silence speaks, it shouts, and it lingers. According to Natalie *"there is this silent*

unsaid idea within this work culture that it's not OK to be emotional." This idea of silence was scattered throughout Natalie's experience and predominant in her descriptions of the sideway glances and the unwritten rules. The absence of sound in the sideway glances reached Natalie in a way that conveyed a message of disapproval. This message became significant and meaningful to Natalie's experience of critical incident stress. In her description of this experience Natalie put into words what I had overlooked and taken-for granted as a practicing ICU nurse. Natalie verbalized and exposed one of the values and hidden assumptions that wander within the confines of the ICU, and contribute to the organizational culture (Schein, 1984). Before I offer my interpretation, it is important that I land on a definition of organizational culture. There is variability and inconsistency in the definition and description of these two words (Schein, 1984; Scott-Findlay & Estabrooks, 2006). Labels such as "work or organizational climate," "job context and job environment," are among the more common terms used interchangeably with organizational culture (Sleutel, 2000). I have elected to adopt the term organizational culture as defined by Edgar H. Schein (1984), to expand on my interpretation of critical incident stress.

> Organizational culture is the pattern of basic assumptions that a given group has invented, discovered, or developed in learning to cope with its problems of external adaptation and internal integration, and that have worked well enough to be considered valid, and therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems. (p. 3)

I will now use this definition to approach my interpretations of the silence that accompanied the sideway glances of disapproval.

Beneath the Silence of the Glances

A glance may suggest that one is briefly watched and potentially scrutinized. The glance may extend beyond mere observation and contain hidden meaning or intent. For Natalie, the sideway glances served as a mode of interaction that unknowingly transmitted assumptions to her about the situation being observed. Foucault (1963) spoke to the idea of "the glance" as striking at one point rather than "a gaze," that "scans a field" and is "endlessly modulated" (p. 149). The glance may be deliberate as it "instantly distinguishes the essential; it therefore goes beyond what it sees" (Foucault, 1963, p. 149). Natalie perceived the sideway glances as going beyond a quick glimpse, the glances were deliberately piercing with judgment, as the meaning behind the eyes was striking and immobilizing. In Greek mythology Medusa, known as a Gorgon, used her eyes as a weapon by turning gazers into stone (*Wikipedia*, 2018). The glances, in essence, immobilized Natalie and heightened the critical incident stress that suddenly dominated. "The glance is of the non-verbal order of contact, a purely ideal contact perhaps, but in fact a more striking contact, since it traverses more easily, and goes further beneath things" (Foucault, 1963, p. 150). The sideway glances were more than observation, they represented what lay further beneath, and traversed into the influence of the unspoken, unwritten rules inherent within the ICU's organizational culture.

A Glimpse into Tradition

Culture is embedded in a group of people that have a shared history in which perceptions, thoughts, and feelings have been passed on to new members with conviction (Schein, 1984). Based on Schein's (1984) definition of organizational culture novice ICU nurses are informed by more experienced nurses to "perceive, think, and feel" a certain

way (p. 3). Schein's (1984) thoughts suggested there was either a verbal or non-verbal transmission of information passed to new members. I surmise that the unspoken, unwritten rules of the ICU have been handed down from the past, from the tradition and historical landscape of ICU nursing. ICU nursing has always been part of a tradition as "we are always situated within traditions" (Gadamer, 1960/2013, p. 294). Natalie's perception of the sideway glances reflected values, beliefs, and assumptions inherited from the tradition of ICU nursing.

The ICU setting contributes to a culture in which nurses have unique social patterns unlike other nursing practice settings (Scholtz, Nel, Poggenpoel, & Myburgh, 2016). Since the inception of the first ICU, authors acknowledged this area of clinical practice as different because of the remarkable psychological demands placed on nurses (Crickmore, 1987; Kornfeld et al., 1968; Koumans, 1965; Strauss, 1968). At that time, hospitals selected their expert nurses to care for the critically ill that were triaged to the intensive setting (Fairman & Lynaugh, 1998). This selection process suggested to other nurses that the hand-picked were different and more superior to those who remained behind. "Although most nurses in the special care areas did not admit to difficulties with other nurses, one gets the sense that most considered themselves to have been performing at a higher level" (Fairman & Lynaugh, 1998, p. 87). Newly selected ICU nurses needed to justify they had authority, expertise, and capability of enduring the extraordinary burdens encountered. Perhaps the intent to prove and conceal their difficulties planted the seed, the expectation to consistently portray the trained professional that required a control of emotion. Over time the values, beliefs, and assumptions derived from the past developed into the currently accepted norms by ICU nurses, including Natalie. In order to

better understand the connection between culture and critical incident stress, it is important that I unravel the thread from a complicated situation that parallels a messy ball of yarn. This thread begins with further exploration of the ICU's organizational culture that influenced Natalie's experience of critical incident stress.

Unraveling the Thread

In his seminal work Schein (1984; 1992/2017) proposed a three-tiered iterative framework to analyze the structure of organizational culture. According to Schein (1984; 1992/2017) culture can be manifested or made visible at several different levels: artifacts, espoused values and beliefs, and basic assumptions. These levels vary from the most tangible to the taken-for-granted underlying assumptions referred to as the essence, or DNA of culture (Schein, 1992/2017). I will use this framework as way of organizing my interpretations and new understandings of the cultural elements that underpinned Natalie's experience of critical incident stress.

Artifacts and panopticism. Artifacts represent the observable architecture of the physical environment such as the language, technology, rituals and routines (Schein, 1984; 1992/2017). This level allows for understanding how Natalie constructed her environment, and to identify what behavior patterns were discernible (Schein, 1984). I believe the ICU's physical space lends itself to the observation of others and being observed by others. It was easy for Natalie to notice the silent sideway glances from co-workers because of the structural layout of the ICU. The physical layout of most ICUs consists of a nursing station that allows for continuous observation of patients whose beds are typically divided by a glass wall or curtain (Fairman & Lynaugh, 1998). It a space that invites a watchful vigilance of the critically ill by ICU nurses. Along with the

opportunity for glancing and gazing, there is a form of constraint and control inherent in the physical layout (Henderson, 1994) that accompanies the intent for taking notice or noticing others.

Foucault (1977) used the metaphor of the panopticon, conceptualized by Jeremy Bentham, as a vehicle for theorizing the disciplinary techniques that permeate existing societal structures, including health care. The panopticon is relevant to ICU nursing because of its similar architectural structure, and the inherent social practices that occur because of this special arrangement (Henderson, 1994). The panopticon was a circular prison in which all the prisoners' cells faced forward toward the center of the circle (Cheek & Rudge, 1994; Foucault, 1977). In the center was a guard tower from which prisoners were constantly monitored and scrutinized, both by guards and other inmates (Cheek & Rudge, 1994; Foucault, 1977). This resulted in the development of disciplinary measures designed to control, to ensure conformity to a new normal (Cheek & Porter, 1997; Cheek & Rudge, 1994). Natalie's experience reinforced to me that ICU nursing is situated within a surveillance apparatus that lends itself to the ongoing invisible monitoring of both the patient and the nurse. This results in the development and control of compliant behaviors by ICU nurses that align with the cultural values and beliefs that perfuse the setting, and become the new normal (Henderson, 1994). For Natalie, the compliant behavior that aligned with the cultural expectation was to portray the trained professional by avoiding a display of emotion, despite the traumatic incident. The sideway glances conveyed to Natalie that she had violated this norm. Foucault (1977) claimed that the disciplinary technique involving surveillance produced a "docile body" (p. 135). Perhaps ICU nurses are representative of the docile bodies, molded, shaped, and

controlled to conform to culturally driven expectations. Critical incident stress challenges the structure of the docile body, as its' overwhelming nature (Antai-Otong, 2001; Caine & Ter-Bagdasarian, 2003; Everly & Mitchell, 1999, 2008) is difficult to conceal within the open spaces of the ICU, particularly under the watchful vigilance of other team members.

The trained professional as an espoused value and belief. To understand why Natalie responded the way she did, it is important to address the values that guided her behavior (Schein, 1984). It was evident from the emphasis Natalie placed on the trained professional that professionalism, associated with maintaining a sense of control, emerged as a deeply held value. The expectation to maintain professionalism at all times was the belief derived from this value. Natalie defined a trained professional by an ICU nurse's ability to objectify and control his or her emotions, to *"put their humanness aside."* Espoused values and beliefs suggest "what ought to be" and serves as the normative behavior in managing situations (Schein, 1984; 1992/2017). Based on Natalie's description, the trained professional was perceived as a normative behavior in all circumstances, including critical incident stress. Values are gradually transformed into underlying assumptions about "how things really are," and become increasingly taken-for-granted so that their existence eventually fades yet remain in operation (Schein, 1984). I believe the unwritten rules were derived from the value and belief associated with the trained professional, and were then transformed into an underlying assumption.

The underlying assumption embedded within the unwritten rules. Culture as a set of basic assumptions defines for an ICU nurse what is significant in a situation, and how to emotionally respond to that situation (Schein, 1992/2017). Natalie seemed to

evaluate her response to the critical incident by using the unwritten rules as criteria. The criteria from these rules determined how she perceived, processed, and felt about the critical incident. The unwritten rules remained unspoken, yet pervasive, because they were and remain a taken-for-granted underlying assumption. It is this taken-for-granted quality that contributes to the unspeakable, un-discussable nature of these unwritten rules (Schein, 1984). The unwritten rules challenged Natalie's identity as an ICU nurse as she struggled with the tension between the trained professional and just a human being. Conceivably this tension was culturally driven and anticipated, given that underlying assumptions contribute to an individual's sense of identity (Schein, 1992/2017). "Cultures tell their members who they are, how to behave toward each other, and how to feel good about themselves" (Schein, 1992/2017, p. 23). The ICU's organizational culture inadvertently challenged Natalie to question her identity and behavior in response to the critical incident.

The Power of Culture

Schein (1992/2017) suggested there is a power of culture that exists, as hidden assumptions permeate and are mutually reinforced. Based on Natalie's experience, I found myself questioning the power of culture in the context of critical incident stress. According to Foucault (1982) "power exists only when it is put into action" (p. 788). The power of culture was put into action when Natalie stepped aside and courageously returned to the game, avoiding the possibility of being *"shutout from the culture."* There was power of culture in the shame Natalie experienced from the sideway glances and the struggle with her nursing identity. The power of culture was enacted when Natalie questioned her career as an ICU nurse following the critical incident. Natalie recognized

that the power of culture would be difficult for novice ICU nurses to navigate in a setting they considered foreign and unfamiliar. Schein (1968; 1992/2017) validated the existence of unwritten rules that function like "the ropes" for novice members to gain acceptance into the new and strange setting. This becomes problematic when novice ICU nurses lack awareness and insight of potential risks such as critical incident stress. Perhaps this speaks to the broader question of whether the unwritten rules can be altered to accommodate critical incident stress. I believe we begin by simply acknowledging there is something more lurking silently behind the term "culture" in the context of critical incident stress. That something more is powerful, and has the ability to transform a nurse's identity and career.

Returning to the Research Question

I believe there are many aspects of critical incident stress that have silent and unspoken distinctions; organizational culture is one of those components. As I ponder this belief I think of a term I introduced in Chapter Three used by Augustine, *verbum interius*, or an inner speech that "strives to be externalized in spoken language" (Grondin, 1994, p. xv). The notion of *verbum interius* reinforces that to understand we must look beneath what is said, recognizing and attending to the inner speech peering from behind (Grondin, 1994). Natalie's experience reinforced for me that there is always more prowling behind the word culture, in the context of critical incident stress. Perhaps this reminds me of the endless nature of language (Gadamer, 1960/2013), and the ongoing understanding of this topic. I propose that beneath the unspoken silence lies the potent influence of the organizational culture on an ICU nurse's experience of critical incident stress. The power of culture (Schein, 1992/2017) requires serious consideration in an ICU

nurse's response to a work-related trauma. I recognize that my interpretations cannot wholly capture the essence of this topic. Circulating amidst the unspoken silence there is an abyss of knowledge waiting to be glanced, gazed upon, and explored. Amidst the unspoken silence is my obligation to venture into this abyss, to consider the concept of coping in a labile, unpredictable and risky playing field known as the ICU.

Chapter Six: Getting Back on the Horse

The moment I shook Olive's hand to introduce myself I was intrigued by her witty demeanor and dry sense of humor. Olive was funny and occasionally sarcastic, while at the same time forthright and determined to share her experience with critical incident stress. As the interview steadily progressed I realized that Olive's use of humor and sarcasm was increasingly more evident in the descriptions that exposed her vulnerability. Midway through the interview I was struck by one of these descriptions in which Olive attempted to make light of the struggle she endured following a critical incident. *"I have to get back on the horse, but I don't want to get back on the horse because this is not going to be a fun horse ride."* Olive used this metaphor to elaborate on her experience of coping with critical incident stress, and the challenge of returning to patient care following a work-related trauma.

While listening to Olive recall her encounter with critical incident stress, I became more and more curious about how ICU nurses got back on the horse. Olive went into detail on how she used various mechanisms to combat her critical incident stress. Some of these approaches inadvertently impacted her connection with patients. Olive recognized that getting back on the horse would not be an easy feat, and it was this challenge that sparked my interest to know more, to know better, to know differently. In this chapter Olive's experience will illustrate the strategies she used to cope with critical incident stress. In order to further understand the connection between critical incident stress and coping it is important to address the incident that led to the fall from the horse. Hence, I will begin with an overview of Olive's critical incident, a recoverable error that she vividly recalled from her early years as a novice ICU nurse.

The Recoverable Error

Recoverable error is a term I will use in this chapter to describe Olive's experience with inadvertently causing harm, but not death, during patient care. Although the error was recovered or reversed, for Olive the impact of being responsible for a patient's deteriorating health status was similar to committing a *"cardinal sin,"* and left her feeling *"mortified."* As she prepared to summarize the critical incident there was an awkward, but brief, period of silence as Olive initially appeared to be at a loss for words. Within seconds Olive began to speak and maintained momentum as she briefly summarized the critical incident.

> *I was helping several team members in the ICU with the cardiac resuscitation of a patient who developed symptomatic ventricular tachycardia. This was not my assigned patient, and thus on that particular day I was assisting with his care. This patient had a cardiac rhythm but he wasn't doing well enough, so we needed to intervene by doing a cardioversion. I felt like I was being rushed, like I needed to get things done in a hurry and everybody was shouting the words "go, go, go." As the team prepared for the intervention one of my peers yelled out "oh no, he's gone into atrial fibrillation." I knew that despite the change in cardiac rhythm the patient still needed to be cardioverted. I was the nurse in charge of the crash cart so in the process I forgot that I needed to synchronize. The physician ordered the number of joules and I pressed the shock button. As soon as I hit the shock button I realized that I didn't synchronize the machine, and as a result the patient suddenly went into ventricular fibrillation. I knew how to use the defibrillator and I knew the steps that I should have taken, but the fact that I didn't use that*

> *knowledge in front of people I held in high regard, stuck with me. I was absolutely mortified because I felt like I should have known better, I let the team down. I immediately burst into tears and thought "oh my God I don't believe this is happening." It felt like I had committed some cardinal sin, where literally a slip of a button had changed this patient's cardiac rhythm.*

After the initial awkward silence Olive's recollection of her experience easily slipped off the tongue as if no time had passed. Olive saw this recoverable error as a *"cardinal sin,"* an action that was considered unacceptable and deadly. "*In the ICU it is about making things* (pause) *I don't want to say perfect, but that's the only word that stands out right now. We have to do things just right, and we are always looking for the best."* She saw herself as an imperfect and flawed ICU nurse, and the very act of making a mistake was potentially detrimental to the patient and harmful to Olive. *"I was nauseated, my heart leaped into my throat, and there was incredible disbelief that I did that. I wanted to crawl under the linoleum, run away and hide."* The critical incident stress Olive experienced went beyond the physical symptoms, as she was left questioning the perception of her colleagues. "*Knowing that colleagues still saw you as a good nurse even if I made a mistake was a difficult part of the experience."* Olive's actions left her in disbelief as she realized that she was capable of causing harm with interventions that were aimed and intended to do good. *"Bad things happen in the ICU, but when it's you who causes it, it's a whole different kettle of fish."* It was amidst the day-to-day taken-for-granted responsibilities as an ICU nurse, that Olive began to perceive differently the risk of inflicting injury and harm to those in her care.

Automatically Functioning in Autopilot

Constricted by the physical environment, Olive remained in the room attending to the patient who was now in ventricular fibrillation, a lethal cardiac rhythm. The furniture and her co-workers in the patient's room became an obstacle, and barricaded Olive's body against the bed. *"I couldn't get out of the room because I was wedged up against the bed and staff were behind me, so I couldn't physically leave the room until the dust settled."* With a rattled self-confidence, Olive remained responsible for managing the crash cart required to rectify the error and attend to the patient's immediate life threatening needs. She stood near the crash cart feeling *"panicky"* and fearful of causing further injury to the patient and her colleagues. *"I was terrified of making another mistake and initially I tried to be as meticulous as I could, making sure no one touched the bed while I shocked the patient with energy."* Olive *"tried"* to become increasingly more aware of the buttons she pressed on the defibrillator, and the safety of others around her. However, this heightened attentiveness was difficult to sustain given her cognitive abilities had suddenly been altered from the critical incident.

> *I was physically standing there, but I was shut off from everybody and everything. If somebody had given me orders, chances are I wouldn't have heard or processed them, and they would have had to tap me on the shoulder to get my attention.*

Olive experienced an imbalance between her body and mind as they were now disconnected from one another. In that moment Olive was standing in the room assisting her co-workers, however, she was *"shut off"* from the world that surrounded her. In

response to this disharmony between body and mind, Olive temporarily entered into a mode she labeled as *"autopilot."*

> *I was suddenly in autopilot where I just listened to what the physician was saying, and took the thinking out of it. I needed to do this because otherwise if I thought too much about it, I would start to overthink and then make another mistake.*

In autopilot it was difficult for Olive to remain *"meticulous"* and attentive with her nursing care, given the thinking component had been removed. Another participant referred to autopilot in a similar context, and used the term to reflect the dulled cognitive awareness and minimal effort they exerted with patient care. This participant explained: *"To cope with the critical incident I went into autopilot where I didn't go above and beyond what was expected."* Autopilot altered Olive's existing ICU nursing practice to the point where it was different and potentially unrecognizable.

Prior to the critical incident Olive questioned and anticipated relevant components of patient care, demonstrating clinical reasoning and judgment. Olive involuntarily entered into autopilot, and this altered her use of *"higher thinking." "Rather than thinking ahead, like critically thinking, I just needed to get through this, I needed to get the patient through this. So I automatically began to function in autopilot."* Autopilot briefly hindered Olive from moving beyond the obvious, and searching for insightful clues to uncover the mysteries that accompany caring for the critically ill. It influenced her capacity to anticipate possibilities associated with patient outcomes. *"Being in autopilot I shifted from being very rigid with nursing care to more of an automatic kind of function."* Olive perceived autopilot as an attempt to cope with the immediate impact from critical incident stress, while continuing with the expectation of providing ongoing

safe patient care. *"I desperately needed to cope so I could get this job done without further errors."* While Olive was in autopilot, the patient's lethal cardiac rhythm converted back to normal and she was left stumbling from the overwhelming ordeal.

From Inside a Glass Box to Closing the Cupboard Door

When the error had successfully been reversed Olive walked out of the patient's room and was struck with the intensity of what had occurred. Olive was left to endure the response of the critical incident, while the world around her continued to move forward unchanged, undisturbed. Olive acknowledged that moving forward would be challenging as it was *"not going to be a fun horse ride,"* but that she had to return to the responsibilities for her assigned patient. Throughout the interview Olive used several metaphors to describe her response to the incident and her attempt to move forward, and *"get back on the horse."*

"The Glass Box Kind of Feeling"

There was something striking about one metaphor in particular, a glass box, which Olive used to describe her initial response from the critical incident.

> *Once the patient had regained his rhythm, my colleagues started to leave the room and I became shell-shocked, almost like inside a glass box kind of feeling. Everyone else was carrying on outside the room and I was trying to put the crash cart back together again, really trying to dissociate from what had happened.*

I was most enthralled by Olive's attempt to objectify the *"kind of feeling"* she was unable to put into words. A glass box is fragile and delicate making its structure vulnerable and susceptible to being broken or shattered. The recoverable error put Olive in a closed space where she felt fragile, breakable, and vulnerable. For Olive

vulnerability was associated with the potential of being perceived by her co-workers as an incompetent ICU nurse. At the time of the critical incident the perception of Olive's co-workers was important to her, as she had recently moved from another country.

> *It was incredibly important at that point in time for me to feel like people saw me as a competent nurse. I had just come from New Zealand where it was a totally different nursing system. Everything was different, Tylenol was not Tylenol, Gravol was not Gravol, and so I felt like my learning curve was hideously steeper than others. My learning extended beyond just the ICU, I had to learn the North American Canadian way of thinking in nursing. And so I felt like I was trying to prove that I was just as good as my co-workers. I nursed in a different place and my background was different, but I was just as good.*

Olive had expectations of herself as an ICU nurse as she was trying to *"prove"* to her co-workers that she was credible, competent, and *"just as good."* Olive was now vulnerable as the recoverable error jeopardized her intent to prove, and compromised how she was perceived. The transparent nature of a glass box offers full exposure to what is encased within its delicate structure. Unfortunately, feeling fragile, Olive's imperfections and flaws were now transparent and exposed from every angle and in plain sight for all of her co-workers to see. Feeling defenseless from this exposure, Olive found herself defeated with discouraging self-talk that she desperately attempted to close behind a cupboard door.

"Into the Cupboard and Close the Door"

Olive shifted the focus of the conversation from the glass box to a cupboard, as a way of describing the need to contain her initial negative thoughts and emotions.

> *I know I need to spend time on this but I can't right now so I am going to put the incident over here and close the cupboard door. I have to put the negative self-talk thoughts and emotions associated with the incident into the cupboard and close the door so that I can focus on what I am doing. Then, I will open the door and look at this thing to figure it out because this is not the right time or place.*

Olive spoke about compartmentalizing the negative thoughts and emotions behind a cupboard door. Unlike a transparent and fragile glass box, the solid and protective nature of a cupboard door would conceal and contain the negativity. Olive rolled her eyes and threw her head back with a laugh, as she elaborated on the meaning she assigned to the *"negative self-talk thoughts and emotions." "I can't believe I did that, now people are going to think that I'm stupid. These thoughts were the negative sort of things that started to bubble up into my mind."* Olive recognized that there were implications associated with critical incident stress. More specifically, that this form of stress had the potential to compromise patient care and thus, she was adamant in that moment that anything associated needed to be briefly concealed. *"I have to close the door because I have a job that I need to do, that job needs to be done."* Olive was aware that closing the cupboard door was a temporary solution. When she felt the time was right, Olive would open the door and deepen her understanding of the critical incident.

"They Can't Get Any More Dead"

Olive eventually got back on the horse; it was a pivotal moment that continued to influence her current nursing practice. This monumental experience was when Olive

received support from a nurse clinician that influenced her return to patient care. The support from this co-worker arrived in the form of acknowledgement and reassurance.

> *The patient wasn't mine so after he was treated I had to return to the care of my assigned patient. Before I returned to my patient I burst into tears and ran to the clean utility room to collect myself. The nurse clinician at the time stopped me to make sure that I was OK and then said something that stuck with me. He said something like "I've gone through it and you will get through this. You will never forget the sync button again." And then he said: "They can't get any more dead. Anything you do will make them better, you are not going to make it any worse."*

The nurse clinician that stopped Olive on the way to the clean utility room initiated a form of assistance and support. This co-worker recognized and acknowledged that Olive was impacted by the experience. This interaction went beyond a simple acknowledgement of the critical incident. The clinician then validated the risk of error associated with ICU nursing, and that this risk was not uncommon given he had experienced it in the past. *"At that moment I realized that's part of being a human nurse in an ICU, you will make oopsies."* However, in addition to the acknowledgement and validation, germane to Olive's response to critical incident stress were the words *"they can't get any more dead."*

Olive's sarcastic grin returned as she uttered the phrase "they can't get any more dead," while simultaneously shrugging both shoulders. Olive appeared to have developed a new understanding of the critical incident as it suddenly appeared less like a cardinal sin, and more like an error that could be reversed and altered. The clinician reinforced to Olive that *"anything you do will make them better, you are not going to make it any*

worse." This quotation implied that no further harm was possible and thus, additional interventions could only enhance the health status of the pulseless patient. Olive immediately experienced a sense of redemption as she had received absolution from the cardinal sin.

> *The nurse clinician's words put the event into perspective. Even though I had made a literal slip of a button, we had taken the patient into a rhythm that wasn't great, but we also put him into something that was totally flexible and fixable.*

Olive gained perspective and insight into the actions and outcome of the error that was now perceived as recoverable, *"flexible and fixable."*

The phrase "you can't get any more dead" was not only effective for Olive immediately after the critical incident, but also served as a career altering learning opportunity. "*I will never forget the sync button and they're only dead once, because they don't get any more dead. These are the two things that have stuck with me."* Olive used the learning she gained to support novice ICU nurses who experienced their first patient resuscitation. She offered reassurance by sharing the phrase that assisted her with altering her perspective of the critical incident.

> *For new nurses going on their codes* (resuscitation of a patient) *for the first time I just tell them their patient does not get any more dead than dead. Yes, this is scary, but anything you do is going make them better. You are not going to make it any worse.*

For Olive, restructuring the perception of the critical incident was an effective coping strategy and inadvertently offered her the assistance she needed to get back on the horse. Olive opened the cupboard door and reflected on learning she gained from her experience

with a recoverable error. *"I learned a great deal from that experience and now as a senior nurse, I try to use it and lead by example. I've given up on trying to be perfect and learned that making a mistake means you can teach others from your mistake."* Olive's experience with critical incident stress validated that returning to patient care was not fun or easy. Olive's experience also validated that coping with a critical incident was possible and transformative.

Connecting the Dots to Olive's Experience with Critical Incident Stress

"I learned there are troubles of more than one kind. Some come from ahead, others come from behind. But I've bought a big bat. I'm all ready, you see. Now my troubles are going to have trouble with me."

Dr. Seuss (1965)

This quotation by Dr. Seuss resonated with me as I pondered Olive's experience with critical incident stress. There are troubles of more than one kind experienced by ICU nurses. Some come from ahead, others come from behind, and one or more may come from the blindside. It was Olive's various approaches to coping with her unanticipated troubles that caught my eye. Perhaps this message by Dr. Seuss spoke to me because I perceive effective coping mechanisms similar to a big bat, a way of defending oneself from vulnerability, from trouble. To more fully understand critical incident stress it is important that I connect the dots between Olive's experience with the incident and coping. Although critical incident stress and coping are very distinct concepts, similar to two pieces of a puzzle, putting them together adds clarity to the larger picture. Critical incident stress occurs because it overwhelms an ICU nurse's natural ability to cope (Antai-Otong, 2001; Caine & Ter-Bagdasarian, 2003; Everly & Mitchell, 1999, 2008).

Without critical incident stress there would be no need for an ICU nurse to adapt and cope (Everly & Mitchell, 1999, 2008). Using the seminal work of Lazarus and Folkman (1984) I will define coping as "constantly changing cognitive and behavioral efforts to manage specific external and or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 141). Before I elaborate on coping in the context of critical incident stress, it is important to provide further insight into the vulnerability that underpinned Olive's unexpected trouble, the critical incident I referred to as the recoverable error.

The Vulnerability in Recoverable Error

Early literature alluded to the potential for inevitable error at the hands of an ICU nurse as an occupational stressor (Hay & Oken, 1972; Kornfeld et al., 1968; Strauss, 1968). More recently, errors caused by nurses have been referred to as more than an occupational stressor, and described as potentially traumatic (Cabilan & Kynoch, 2017; Jones & Treiber, 2012; Rassin, Kanti, & Silner, 2005; Seys et al., 2013). In the broader literature, the term "second victim" coined by Wu (2000) has been used to describe health care providers, including nurses, who become traumatized by their involvement in an unanticipated adverse event, a medical error or patient related injury (Scott et al., 2009). Researchers have suggested that nurses traumatized from unanticipated error experience a variety of emotional responses such as shame, guilt, frustration, anger, anxiety and fear (Cabilan & Kynoch, 2017; Chan, Khong, & Wang, 2016; Jones & Triever, 2012; Laurent et al., 2014), potentially leading to PTSD (Rassin et al., 2005). I propose that alongside this list of emotional responses is the vulnerability, such as the glass box kind of feeling in this instance, that requires serious consideration.

The word vulnerable means capable of being wounded or open to attack (*Merriam-Webster,* 2018). Etymologically the origin of the word vulnerable was derived from the Latin noun *vulnus* or wound*,* associated with being physically wounded or having the power to wound (*Online Etymology Dictionary*, 2018). To inadvertently cause harm from an error wounds ICU nurses by stripping them of their confidence and upsetting their emotional equilibrium (Jones & Treiber, 2012; Laurent et al., 2014), and by altering their professional identity (Cabilan & Kynoch, 2017; Schelbred & Nord, 2007; Seys et al., 2013) leaving them open to further injury. The recoverable error threatened Olive's identity as an ICU nurse as she became exposed to her own imperfections, and struggled to reconcile being human and prone to error (Cabilan & Kynoch, 2017; Schelbred & Nord, 2007). There were risks associated with this vulnerability, as Olive was now open to further insult in the form of blame, judgment, or scrutiny by other co-workers (Schelbred & Nord, 2007). Olive was particularly concerned about the perception of her co-workers at that point in time, given her attempt to prove she belonged in the setting. Vulnerability has the potential to unravel human connections by impeding the ability to empathize, belong, and love (Brown, 2012). I believe Olive's sense of vulnerability derived from the recoverable error tampered with the human connections she strived to sustain with those in her care, and in her relationships with co-workers.

Tampering With the Human Connection

Exposed, open and vulnerable, Olive had to get back on the horse. To do this, Olive described various initial coping mechanisms she used to manage the demands of the overwhelming critical incident. Lazarus and Folkman (1984) proposed two forms of

coping responses used by individuals: emotion-focused and problem-focused. Emotion-focused forms of coping are used to regulate feelings associated with the situation, without altering the actual situation. Problem-focused coping involves strategies used to analyze and manage or alter the distressing situation experienced. Both forms of coping are not separate entities, rather are related as they can facilitate and impede each other in the coping process (Lazarus & Folkman, 1984). Olive described an altered mode of being in autopilot, and closing the cupboard door as initial strategies for coping with the traumatizing error. Based on Lazarus and Folkman's (1984) description, I consider autopilot and the cupboard emotion-focused forms of coping.

Both autopilot and the cupboard door contained elements of detachment. Autopilot temporarily altered Olive's ICU nursing practice, as it involved the removal of higher thinking. Olive became increasingly task focused with the continued resuscitation of the patient that altered her critical thinking. Along with eliminating higher thinking, Olive diligently stored her negative thoughts and emotions into the cupboard. Autopilot and closing the cupboard door allowed Olive to briefly disconnect from the recoverable error and the associated emotions, seeking immediate solace and reprieve. Some researchers have found nurses' use of emotion-focused coping, such as distancing or detaching, temporarily effective (Harrison et al., 2015), while others deemed it ineffective (Lewis, Baernholdt, Yan, & Guterbock, 2015; McMeekin, Hickman, Douglas, & Kelley, 2017). Benner and Wrubel (1989) argued that emotions are essential for nurses with advanced levels of expertise to effectively grasp a situation. "Emotions are no longer always considered entities to be coped with, although one's responses to feelings may create the need for coping with the emotion so that one can attend effectively to the

situation" (Benner & Wrubel, 1989, p. 97). Regardless of these inconsistencies among authors, my intention is not to determine whether autopilot or closing the cupboard door was effective or ineffective for Olive. Rather, I am most interested in the implication of emotional detachment as a result of critical incident stress, for ICU nurses and the discipline as a whole.

"Traumatic events call into question basic human relationships" and connections with others (Herman, 1992, p. 51). Human connections underpin an ICU nurse's use of their theoretical, practical, and intuitive senses to care for their patients (Benner & Wrubel, 1989). Placing emotions, even briefly, behind the cupboard door alienated Olive from those in her care, and tampered with this human connection. More specifically, detached emotions hindered Olive from gaining access to the larger clinical picture (Benner, Tanner, & Chesla, 2009; Benner & Wrubel, 1989). It cut her off from being engaged in patient care in a thorough and complete way. Emotions are like a compass that guide an ICU nurse with higher levels of expertise to follow their intuitive hunches, and then attend to those hunches (Benner et al., 1999; Benner & Wrubel, 1989). A proficient and expert nurse's intuitive sense requires a grasp of the whole situation hence, making emotion imperative (Benner & Tanner, 1987; Benner et al., 2009). According to Benner and Wrubel (1989) emotions "are essential to the highest level of functioning" and should not be blocked or ignored (p. 61). It is important to reinforce there are circumstances that may require an ICU RN to diminish or modify emotions for optimal functioning (Benner & Wrubel, 1989). For example, novice nurses who are inherently focused on the completion of step-by-step tasks benefit from diminished anxiety and fear (Benner et al., 1999; Benner et al., 2009). However, I believe it is significant for ICU

nurses to recognize that the ongoing storage of emotions behind a cupboard door may jeopardize the human connection in the care of the critically ill.

Expanding ICU Nurses Horizon through Reframing

Autopilot and the cupboard became a temporary form of protection from the scathing impact of the critical incident stress experienced by Olive. Lazarus and Folkman's (1984) definition of coping suggested constant movement and adjustment used by an individual to meet the demands of overwhelming trouble. This movement was evident in Olive's narrative, as she spoke about an additional approach commonly used by ICU nurses known as "reframing" the critical incident (Burgess, Irvine, & Wallymahmed, 2010, p. 137). The phrase "they can't get any more dead" was significant for Olive, as it inadvertently reframed the recoverable error. The incident appeared less like a cardinal sin and more like an opportunity to mend what was perceived as lifeless. Reframing is a coping strategy that widens an individual's perspective of a difficult situation (Seaward, 2006, as cited in, Hughes, Gourley, Madson, & Le Blanc, 2011). I selected this description of reframing because the notion of a widened point-of-view paralleled Gadamer's (1960/2013) idea of a horizon or range of vision. To widen or expand one's horizon, it is important to look beyond what is directly in front so it may be viewed from a broader and perhaps unique outlook. Reframing the critical incident created the possibility for Olive to look beyond what was close at hand. This did not alter Olive's experience of the recoverable error; rather, it expanded her horizon gaining a broader perspective, a different perspective. "They can't get any more dead" reinforced for Olive that error was an inevitable component of ICU nursing, and part of being a *"human nurse."*

Olive was animated with the non-verbal gestures she used to role-play her co-worker uttering the phrase “they can’t get any more dead.” I believe the manner in which Olive mimicked her co-worker suggested the phrase was spoken with an undertone of dark humor. Dean and Major (2008) suggested humor was an effective approach for critical care nurses to reframe challenging situations such as critical incidents. Their research found that by reframing the situation, critical care nurses regained a sense of perspective on the incident, and their associated negative emotions faded over time. Olive’s sarcastic nature throughout the interview led me to believe she was likely familiar with the use of dark humor as a coping strategy. My hunch was validated when “they can’t get any more dead” was an expression Olive now used to support novice nurses that encountered work-related trouble.

Returning to the Research Question

Several authors (Benner & Wrubel, 1989; Hay & Oken, 1972; Laurent et al., 2014) suggest that there is a fear of making mistakes that lingers amidst ICU nurses who work in a setting that lends itself to a minimal margin for error. Patient errors caused by ICU nurses are inevitable, yet despite this, perfection remains an inherent expectation (Jones & Treiber, 2012; Laurent et al., 2014). A recoverable error may be perceived as a critical incident for ICU nurses, leaving them vulnerable from their woundedness, and open to attack. Olive’s experience spoke to the various strategies of tending to these wounds; a band-aid to initially control the penetrating injury. Autopilot, closing the cupboard door, and reframing the recoverable error were examples of protective strategies Olive used to continue with patient care. I recognize that the coping strategies used by ICU nurses to get back on the horse may vary from Olive’s description (Lazarus

& Folkman, 1984). This variability is not my main concern, but I am most concerned with the implication of coping strategies, such as emotional detachment, that may alter an ICU nurse's ability to remain connected to those in their care. Emotions are one way of coming to know the patient and their broader clinical picture (Benner et al., 2009; Benner & Wrubel, 1989). Emotions are the nutrients that sustain human connections (Benner & Wrubel, 1989), the core and the essence of ICU nursing. Achieving emotional equilibrium compromised by critical incident stress is imperative to ICU nurses and to the discipline of nursing. To do this one must widen their horizon and be open to the possibility of receiving support through crisis intervention.

Chapter Seven: "Just Something Simple, Somebody Right There"

Charlene smiled as she sat in the chair next to me and in a quiet tone, perhaps even a whisper, stated *"OK I am ready."* Charlene had a calming presence and I found myself drawn to her confident, yet laid-back, relaxed way of being. Initially Charlene appeared at ease leaning back into the chair with her legs crossed. *"The critical incident I experienced took place in January, it's now the end of April and I still can't talk about it and not cry."* Charlene, who considered herself a senior nurse, began by acknowledging having experienced multiple critical incidents as an ICU nurse. The critical incident Charlene was prepared to share was evocative and vivid *"it feels like it just happened."* As Charlene began to elaborate on the preliminary details associated with the critical incident, she seemed increasingly anxious as she abruptly leaned forward into the chair. *"There's one incident that happened just recently that really affected me, probably the most out of anything in my career."* Charlene was candid in the details she shared about this critical incident, and her ongoing struggle for ways to make meaning of the experience. *"I think it's still an ongoing process that I'm still trying to process."* Charlene spoke at length about several crisis interventions she used to reduce her ongoing distress experienced from the trauma. In her description of crisis intervention Charlene uttered one phrase in particular that I considered poignant, and influenced my interpretations for this chapter. *"If it was just something simple, somebody right there."* The intent of this chapter is to explore Charlene's experience, underpinned by this phrase, to further understand the influence of crisis intervention on critical incident stress. I will begin by offering an overview of *"the devastation of the moment,"* the critical incident that precipitated Charlene's use of crisis intervention.

"The Devastation of the Moment"

Minutes into the brief description of the *"messy"* and *"devastating to see"* critical incident, Charlene made an effort to hold back her tears. As I handed Charlene a small box of tissue, she looked down at the ground and paused to wipe the tears in her eyes that had not yet seeped onto her face. She clenched her tissue tight with one hand, took a deep breath, made direct eye contact with me, and then began sharing the details.

> *It was a night shift and we admitted a woman who was a retired nurse that had suffered approximately 65 percent burns to her body. She was not my assigned patient, but I assisted with her admission to the ICU. I have dealt with many burn patients before but this one just absolutely devastated me. I remember the patient looking at us as she was wheeled on the stretcher through the doors of the ICU to her assigned room. The patient's burns were so severe that we couldn't get a blood pressure on her and so the resident physician did not want us to sedate her. Knowing that this patient could not be sedated, and that she was in an incredible amount of pain was horrible. I have tried over and over to think about why this particular woman devastated me the most. The only thing I can think of is because she was not at fault for this horrible accident. Being in a wheelchair reduced the patient's mobility, she was just cooking and then caught on fire. She didn't do anything wrong to deserve this suffering. Before we did the initial dressing change my colleagues and I took off the blankets. Seeing this frail contractured lady with her limbs and trunk severely burned, and with fasciotomies everywhere was horrific. I honestly wanted to throw up and I was just trying not to cry. Then her eyes wide open looked at me; that was extremely memorable and really*

> *difficult. I questioned what I was doing in the ICU and if I was really helping people by extending their suffering. I have ongoing moral and ethical issues about what we do, but it really hit home for me with this patient. It was awful, the devastation of the moment, I was just so deeply saddened and burdened by what she had gone through.*

I was immediately attracted to the phrase *"devastation of the moment"* and I quickly scribbled each word on a scrap piece of paper beside me. These words were compelling, powerful, and I believe effectively summarized Charlene's critical incident. As a verb, the word devastate means to ruin by violent action, to reduce to chaos, or helplessness (*Merriam-Webster*, 2018). There was devastation in the visual images associated with exposing the patient's frail body for the initial dressing change. Witnessing the severity of the burns and fasciotomies that violently ruined and disfigured the patient's body remained imprinted in Charlene's memory. Prior to complex wound care Charlene was accustomed to ensuring comfort and compassion, by alleviating a patient's pain and suffering. This experience became more complex and devastating because of the lingering moral distress underpinned by feeling helpless, and unable to comfort the patient. *"We were torturing this patient."* The distress was heightened with Charlene's increased empathy, as she identified differently with this critically ill individual. Charlene saw the already vulnerable patient as undeserving and blameless of the injuries inflicted. The devastation was reduced to further chaos and disorder the moment the patient looked directly at Charlene. While Charlene described this part of her experience, I thought about the popular metaphor: the eyes are the window of the soul. Charlene witnessed the soul, the essence of the person behind their charred body. There

was a deeply human and personal connection that took place when the patient made direct eye contact. Charlene's reaction to this devastation was immediate, and alongside the stress response she experienced were the unanswered questions that remained.

> *Immediately I was in shock about the devastation of what I was seeing. As I assisted the primary nurse with the initial dressing change I wanted to throw up, I was so nauseated. And then I started to question a lot of things, like moral issues. What are we doing to people? What is the ultimate outcome? I cried all the way home and then I tried to sleep for a few hours. I woke up, cried the entire day, and my husband held me for hours. I've cried for a lot of patients in my career, but I've never cried for anybody like I did for her.* Charlene grasped for more tissue as tears now spilled down both sides of her porcelain-like face. *The patient eventually died and I felt a lot of relief but it's still with me. I feel more at peace because she is not suffering anymore.*

It was evident that Charlene was nearing the end of her brief description of the critical incident, as she slowed down her breathing and re-adjusted her position. I interpreted this gesture to suggest she could now settle in and continue with the rest of the interview. Charlene threw her tissue in the garbage and did not take another one. When the interview topic changed to crisis intervention, Charlene went from somber and serious to irritated and perhaps even bothered. I took note of this change and wondered whether this was related to her experience with crisis intervention. Having offered the context, I will now attend to Charlene's experience with crisis intervention, while considering the phrase *"just something simple, somebody right there."*

Co-Worker Support: "They Get What I Go Through"

Charlene's first source of crisis intervention came from other ICU nurses. *"I immediately left the patient's room after I assisted with the initial dressing change and started to talk with other nurses about how I felt. This form of support was ongoing as the patient remained in the ICU for sometime."* I suspected Charlene sought support from other nurses first because they were easily accessible to her at that point in time. *"I am open with my co-workers, I get the support and validation I need when I feel pretty crummy."* Charlene considered these individuals more than peers or co-workers, as they were also her friends outside of the ICU setting. *"Most of my friends are from the ICU, they get what I go through."* The cohesive relationship that existed between Charlene and her ICU nursing friends developed from being part of a team that consistently worked the same schedule. The connectedness and *"respect"* between Charlene and other nurses from this team was palpable and evident from her description.

"My Team Rescued Me"

There were other participants that contributed unique insights into the value of being part of a team within the ICU setting. These participants elaborated on the support they received from their own team members, specifically other ICU nurses. For these participants, support was given in the form of reassurance that the team would not leave their member to suffer in isolation. Support paralleled a form of salvation, as the team would *"rescue"* their member in times of crisis. One participant stated:

> *The reason why many of us go into ICU nursing is because we know we are a team, and that people will rescue you when something goes down. The fact that my team rescued me validated to me that I was a valuable member of the team.*

This quotation suggested that supportive teams were comprised of individuals who were willing to put themselves at risk for another co-worker. There was an element of trust required between team members knowing that despite the risk, someone would rescue the co-worker in need of assistance. Rescuing a distressed co-worker implied that someone would first see or take notice. Charlene validated this thought as she reflected on her co-workers who took notice of another colleague in need of rescuing. "*We are all really good at seeing other colleagues struggling and supporting each other through those difficult times."* After this comment, I questioned whether ICU nurses preferred to be noticed given the risk of stigma (described in Chapter Four) associated with critical incident stress (Avraham et al., 2014; Halpern et al., 2009). I believe that being noticed in the context of crisis intervention was an important part of Charlene's experience, and thus further exploration is required.

The word notice means to become aware of, to observe, and to discern (*Merriam-Webster*, 2018). Etymologically, the origin of the word notice comes from the Latin word *notitia* associated with being known and to point out (*Online Etymology Dictionary*, 2018). The action of pointing out something implies someone is watching another, or perhaps watching over another. According to Charlene there was benefit to being noticed or watched over by co-workers, and other participants echoed this perspective. One participant described: *"My colleague noticed before I did, that I wasn't OK, I was in distress and very upset. This colleague looked at me and asked "are you OK?" and then said "it's OK we've got this."* In this description being noticed went beyond pointing out a co-worker in distress, and included discerning the need for assistance. The act of noticing offered this participant a sense of relief that someone had recognized and

validated the distress, as well as determined that the appropriate next step was to intervene and rescue. Several participants extended these thoughts to address the significance of managers who would notice struggling team members after a critical incident. One participant stated: *"I want management to notice that what we do is really hard, to be available, and to genuinely take interest when critical incidents occur."* Being noticed after a critical incident was something simple and effective for Charlene and other participants.

"Been There, Done That"

Charlene was adamant that the somebody offering crisis intervention needed to be familiar with critical incident stress in the context of ICU nursing. *"That somebody needs to have been there, and done that."* Charlene reinforced the benefit of conversing with other ICU nurses who also cared for the same critically ill patient. *"Connecting with others who were also having a hard time and struggling with the care of this patient, made it easier. You don't really understand someone's experience unless you have been through it."* According to Charlene, individuals who had *"been there, and done that"* were equipped with the pre-requisite for genuine understanding of her experience. Several other participants shared Charlene's perspective and also described the benefit of knowing that another co-worker was familiar with, or experienced the same critical incident. One participant shared: *"I found it helpful knowing the people that were in the puddle with you, were there, and knew what happened."* Charlene and other participants considered sharing the *"puddle"* therapeutic because those in the puddle knew the incident; they had lived it, endured it, and perhaps even suffered from it. I propose that the expression been there, and done that does not imply that the critical incident was

necessarily experienced in the same way. Rather, that the incident had addressed those that encountered it in a way that made it impactful and memorable. In addition to the support received from ICU nurses, Charlene also accessed several formal approaches to crisis intervention. Charlene appeared eager and ready to share her experience with one approach in particular, she referred to it as *"debriefing."*

Debriefing: Somebody There, But from the Outside

Over a period of time Charlene, who was frequently in the charge nurse role, realized that other ICU nurses experienced difficulty caring for this patient.

> *A lot of other nurses were having a hard time taking care of this patient as well. They would take care of the patient for one day, and then would say that they couldn't come back the next day. Some nurses would leave half way through the day because they couldn't continue with providing care.*

Charlene decided to inform the unit managers of the impact this patient was having on the ICU nurses responsible for care. In her discussion with these individuals, Charlene advocated for the implementation of a formal debriefing session. *"We had two debriefing days that were voluntary and multi-disciplinary, so we could talk with other people and hear everybody's view."* The advantages and disadvantages of debriefing became evident through Charlene's experience as a participant in this group-based intervention.

"Other People Struggled and I Wasn't Alone"

Charlene was visibly aggravated when she admitted the attendance by ICU nurses was poor for the debriefing session. *"I went to one of the debriefing days and I was disappointed because not many nurses showed up."* Nevertheless despite this, Charlene experienced several benefits from attending the single session. Charlene spoke in detail

about the benefit of verbalizing her thoughts and the challenges she experienced assisting with the patient's care. She also commented on the effectiveness of listening to the unique perspectives offered from different members of the health care team.

> *It was good that I could share my thoughts and then listen to others. We had physicians, social workers, and others that also attended the debriefing and it was helpful to hear their perspective on things. Sometimes we get caught up in what we're doing at the bedside, and we don't always see the whole picture.*

Interestingly, Charlene's thoughts were vastly different from another participant who found varying perspectives from other health care professionals compromised the effectiveness of the debriefing. This participant highlighted the importance of recognizing each member of the inter-professional team arrived at the debriefing with a unique *"lens."*

> *Other members of the team have a totally different lens, so they're not going to appreciate the emotion that nurses bring to the debriefing. There has to be some understanding from other disciplines that this is the lens I look through.*

In addition to the benefit of listening to diverse perspectives, debriefing offered Charlene a space to feel less alienated in her experience with critical incident stress. *"I found debriefing helpful because it was good to hear that other people struggled, and that I wasn't alone."* Existing within this space was *"somebody…there,"* the presence of other co-workers that had also been impacted by the patient and their complex situation. Despite these benefits, Charlene grappled with the challenges she encountered as a participant in the debriefing.

"An Outsider Looking into the ICU"

As the debriefing session progressed Charlene experienced an emerging sense of abnormality. She saw herself as unusual or atypical because unlike her co-workers, she was not in control of her emotions.

> *In the session I remember bawling the entire time and nobody else was crying. I thought to myself "what is wrong with me?" Why can't I get control of my emotions? I wondered why everyone in this session looked like they were benefiting, and I was still impacted.*

Charlene associated the lack of emotion from her co-workers as evidence that they were advantaged and benefiting more from the debriefing. Charlene's sense of abnormality heightened when she recognized the difference between her obvious ongoing distress, and her co-workers that appeared to be on the mend. For Charlene, this session opened up questions about normalcy as she compared her stress reaction to others within the group.

Charlene rolled her eyes to express her annoyance with having waited a month for the debriefing to take place, this didn't allow for *"somebody **right** there." "We had the debriefing one month after I cared for the patient, I would have liked it sooner."* Charlene argued that if someone had noticed the struggles nurses endured sooner, interventions could have been implemented in a timely manner. *"If someone had just noticed that nurses were struggling from the outset instead of waiting a month, something could have been done earlier."* Other participants shared similar sentiments related to the challenge of organizing a timely debriefing session, and the ineffectiveness of a delay. Charlene extended her frustration to the facilitation of the debriefing conducted by an *"outsider."*

The individual who led Charlene's debriefing session was from a different health care specialty area. Charlene saw the facilitator as an individual positioned as an outsider peering into the ICU; this stance influenced her perspective on the effectiveness of the session.

> *A staff member from the spiritual care department led the debriefing session. I don't think that this person really understood what happens in the ICU. The facilitator was trying to help us work through the challenges with the patient, but it wasn't helpful because they were an outsider looking into the ICU. You truly don't know what it's like until you have worked there.*

Charlene perceived the facilitator as credible in terms of their theoretical perspective associated with critical incident stress. However, as an *"outsider"* they were unable to empathize with the experience of having cared for the patient as an ICU nurse. Although there was somebody present that facilitated the debriefing, that somebody needed to *"know what it was like."* Despite attending the debriefing session, Charlene's symptoms were relentless, as she remained emotional when she thought about the patient. Around this period of time, Charlene also took note of her altered approach to patient care.

> *I was becoming more distant from the patients in my care. Last night I had a patient that was going to die and I thought: "whatever they're going to die." I know this is terrible of me, it's not like me, and I prayed this didn't come across to the patient's family.*

It was at this point Charlene decided to persist with her continued recovery from the devastation, and to find a way to set things right, to set things back to a new normal.

Navigating the Existing System: "All This in Order to Talk to Somebody"

Charlene appeared deeply connected and profoundly invested in her work as an ICU nurse. *"I have so much pride in being a critical care nurse."* This pride served as her motivation to address the tension she experienced with the tormenting symptoms. Like candles extinguishing one by one, Charlene's possibilities were now limited. She pursued another option for assistance known as the Employee and Family Assistance Program (EFAP).

> *It was several months after the critical incident and I just couldn't get the patient out of my mind. I couldn't stop crying, and I started to see how this was affecting my patient care and how I saw my job as a nurse. I questioned whether I needed to seek out another job. So I contacted another resource, the EFAP and I saw a counselor a few times to try and work through things, and maybe change the way I thought about the situation.*

Charlene was constrained by what had become her new normal, persistent emotional turmoil and a tumultuous relationship with her work. The disappointment was obvious in Charlene's tone of voice, as she pondered the possibility of seeking new employment. Prior to this critical incident, Charlene admitted to having left her position in the ICU for one year to pursue a different area of nursing practice. *"There were ongoing moral and ethical issues and I needed to step away from the ICU."* The EFAP was one of the limited possibilities that remained for Charlene to salvage her career as an ICU nurse. Unfortunately, Charlene was bombarded with logistical issues that made this resource difficult to navigate.

> *I appreciate the EFAP but I feel like it is difficult to access. Even though it is*

> *easy, by the time you phone and talk to someone else and then go downtown, its not easy. I don't go downtown very often, so finding a parking spot and paying $25 to see the counselor for an hour is exhausting. I don't even have any way of getting a hold of the counselor, now I have to call the main people and try to get a hold of this person. I have to do all of this in order to talk to somebody.*

Amidst the muddled, challenging, and complicated facets of accessing this resource, Charlene wanted something simple *"to talk to somebody."* These facets were overwhelming enough that they threatened Charlene's continued use of the intervention. *"I have seen the counselor a couple of times and then I didn't make any further appointments."* Charlene confessed that her recovery from the devastation of the moment was in progress, and the healing was ongoing. *"Today I am doing better overall, but I am still healing. This critical incident will stick with me for a long time."* Suddenly Charlene's request for an intervention that consisted of just something simple, somebody right there, was abundantly clearer to me. I became aware of the extent to which existing methods of crisis intervention could enhance or hinder an ICU nurse's experience with critical incident stress.

Connecting the Dots to Charlene's Experience with Critical Incident Stress

The Abyss

Terrorized by truth
Startling reality
Seeing the unfathomable
Imagining the could-be.
Abandoned by humanity
Tormenting darkness
Spinning with uncertainty
Powering the will-be.
Acknowledging animosity
Alarming brutality

Shielding from envy
Languaging the ought-to-be.
Searching for community
Permeating aloneness
Longing for accomplishment
Valuing a hope-to-be.

Sandra Schmidt Bunkers (2002)

The moment I read this poem by Bunkers (2002), I immediately envisioned Charlene's experience of critical incident stress. Charlene's devastation of the moment brought to bear the startling reality of critical incident stress. Critical incident stress plagued Charlene leaving her spinning with uncertainty, animosity, and aloneness. The critical incident responsible for her distress was underpinned by having experienced the unfathomable suffering of an already vulnerable patient. Slithering amidst this suffering was the moral distress of torturing the patient with aggressive treatment. During the vivid details, I was compelled by Charlene's use of various crisis interventions to alleviate her own suffering; seeking to re-gain a sense of accomplishment and the ought-to-be. Embedded within her descriptions of crisis intervention was the value of team, of community, and of connectedness. Charlene's request for crisis intervention was concrete and straightforward, just something simple, somebody right there. This phrase offered me insight into the significance of noticing, discerning, and the mere presence of the right somebody to alleviate distress.

"The Face of Suffering" (Caputo, 1987, p. 273)

The suffering of the patient marked Charlene the moment they made eye contact- *"her eyes wide open looked at me."* This moment was meaningful as it spoke to relating and the moral responsibility of responding to another human being. John Caputo (1987) wrote: "The eyes of the other lure us into mystery and confusion, shadows and dark

recesses; they are not windows of the soul but a house of mirrors" (p. 274). The patient's eyes drew Charlene into the "mystery and confusion," the "shadows and dark recesses," of their vulnerability and pain (Caputo, 1987, p. 274). The patient's eyes reflected a face-to-face (Levinas, 1969) encounter that addressed Charlene, and beckoned her to respond to the suffering being endured. I believe the call to respond extended beyond her professional obligation, as Charlene was not assigned to the patient and could have disengaged from the encounter. Charlene's experience of critical incident stress was influenced by a decision she made to remain present, a decision derived from a more personal moral responsibility.

Emmanuel Levinas (1969) wrote about the ethics of the face as enacting one's moral responsibility that takes place from an encounter with the other. The face is relational as it represents human connectedness with the other (Levinas, 1969). "The Other looks at me, I am responsible for him, without even having taken on responsibilities in his regard; his responsibility is incumbent on me" (Levinas, 1985, p. 96). Similar to Ken's experience, despite the moral distress associated with futility, Charlene had been lured in, now connected, committed, and responsible for the patient. There was a concealed risk that corresponded with this commitment to assist with the patient's care. "Turning towards the other means to encounter utter vulnerability, suffering, and one's own finitude" (Naef, 2006, p. 148). The patient's eyes wide open became "a house of mirrors" (Caputo, 1987, p. 274), exposing Charlene to her own vulnerability and suffering in the form of critical incident stress. Based on her display of emotions during the interview, I propose Charlene experienced some degree of suffering from the devastation of the moment. Suffering is defined as the emotional response to the

incident that was endured (Morse & Carter, 1996). Charlene's emotions that manifested from her suffering were at the core of the critical incident she described, and were significant to the crisis interventions she experienced. Emotions saturated Charlene's experience of critical incident stress.

Crisis Intervention: Relating, Connecting, and Emotional Equilibrium

Charlene's experience with critical incident stress altered one of my existing pre-suppositions related to crisis intervention. I anticipated that most participants would consider commonly used crisis interventions, such as peer support or co-worker support and debriefing to be effective. I have been humbled by the task of understanding and gained increased familiarity with the need to remain open to possibilities. At the Heidelberg Colloquium on July 9, 1989 Gadamer contended: "the possibility that the other person may be right is the soul of hermeneutics" (Grondin, 1994, p. 124). The insights I gained from Charlene's experience enabled me to re-examine my understanding, and to consider that the other might be right. My understanding of crisis intervention evolved, as I no longer consider that one approach could be conducive to the majority of ICU nurses. The variability and inconsistency of crisis intervention descriptions from participants suggested that one size does not fit all. Charlene's phrase "just something simple, somebody right there" was an appropriate place to begin my ever-expanding appreciation of nuances of crisis intervention. The meaning behind these words alluded to the importance of relating, connecting, and attempting to regain emotional equilibrium that was disrupted by critical incident stress. Relating through genuine understanding was derived from members of Charlene's team who had been

there, done that. Throughout this chapter I have used the term "genuine" because I envision this form of understanding as authentic, sincere, and common.

***Sensus communis* as relating and connecting.** Charlene spoke at length about the importance of team in the context of ICU nursing. Consistently working with the same members of the team created a sense of cohesion, support, and reassurance that *"people will rescue you"* in a crisis. Researchers have suggested that nurses found debriefing (Burns & Harm, 1993; O'Connor & Jeavons, 2003; Robinson & Mitchell, 1993; Theophilos et al., 2009) and co-worker support (Adrianssens et al., 2012; de Boer, et al., 2013; Muller-Leonhardt et al., 2014) effective after a critical incident because they could verbalize their experiences to empathetic co-workers. However, I propose that the benefit stems from more than venting initial thoughts and emotions to an empathetic ear. Charlene's experience with effective components of crisis intervention highlighted an element of relating with co-workers grounded in a shared bond or connectedness. During the interview I quickly scribbled the word "community" on a piece of paper, as Charlene eagerly elaborated on the benefits she received from team members. The relevance of this scribbled word did not emerge until I began writing this chapter. Parse (1999) defined community as "a oneness of human connectedness that is configured with unique values and beliefs" (p. 119). This definition implies a sense of unity, cohesion, or connectedness derived from relating with others that shared common experiences.

Gadamer (1960/2013) used the term *sensus communis* to describe the "common sense" found within a team or community, such as ICU nurses (p. 19). "The main thing for our purpose is that here *sensus communis* obviously does not mean only that general faculty in all men but the sense that founds community" (Gadamer, 1960/2013, p. 19).

Moules, McCaffrey, Field, and Laing (2015) shared an example of an interpretation of texts written by Laing (2013) about the *sensus communis* fostered by children's cancer camps. Laing referred to the common connection inherent within families; a sense of belonging only acquired by those who shared the experience of a child with cancer (Moules et al., 2015). Similarly, knowing that people were in the same puddle was comforting because it meant there was a common understanding. Those in the puddle were ICU nurses who experienced a kinship with each other and the critical incident that was encountered. Relating to another through understanding surges from "common experiences, common language, and common images" (Cody, 2001a, p. 291). The individual who facilitated the debriefing session Charlene attended was viewed as an outsider because they did not share this common understanding. According to Gadamer (1960/2013), *sensus communis* also reflected a way of knowing through the common sense used in the judgments of what was considered right and wrong. This way of knowing appeared to be evident in co-workers who noticed distressed ICU participants and discerned the need to offer them support.

Bearing witness through personal presence. One form of support that emerged from Charlene and other participants' experiences included the simple act of being noticed or watched over by co-workers. This form of assistance moved beyond mere observation. Being noticed or watched over meant bearing witness to the distress experienced from critical incidents. Cody (2001a) defined the term bearing witness as "the telling, the attesting through one's personal presence to the veracity or authenticity of what was witnessed" (p. 289). Bearing witness is underpinned by an authentic "human-to-human relating," derived from a commitment to connect with another (Cody,

2001a, p. 289). Based on participants' descriptions, bearing witness primarily took place in the form of "face-to-face discussions," or engaging in dialogue with others (Parse, 1998, p. 72). This form of assistance offered participants a true presence (Parse, 1998), a way of honoring and acknowledging their suffering (Cody, 2001a, 2001b; Naef, 2006). This special way of being with another requires attentiveness to remaining non-judgmental and respectful, standing in solidarity and in community with the distressed ICU nurse (Bunkers, 2001; Cody, 2001b; Naef, 2006).

Co-workers who dared to bear witness took risks in selecting between fleeing in the moment or walking along side another (Mitchell & Bunkers, 2003). Gadamer's (1960/2013) notion of *sensus communis* is brought back into play here, as an element of judgment or "common sense" is required in making this decision (Campbell & Davis 2011). In addition to judgment, a nurse's intuitive sense and self-awareness are often used in selecting whether or not to engage (Campbell & Davis, 2011). Choosing to flee may stem from the fear associated with the unknowns and uncertainty of heeding to the call of another (Mitchell & Bunkers, 2003). Amidst these risks Mitchell and Bunkers (2003) urged nurses to consider the opportunity for growth and transformation. I believe that to willingly walk side-by-side in "the active stillness" (Parse, 1998, p. 71) of a distressed ICU nurse is an intervention that considers the notion of just something simple, somebody right there. Bearing witness is more than a potential intervention, it is a moral responsibility and way of being (Naef, 2006) that pays tribute to the challenging work and presence of ICU nurses.

Restoring emotional harmony and balance. The impact of Charlene's critical incident was evident during the interview, as she continued to show emotions such as

frustration, anger, sadness, and uncertainty. Although I recognize emotion is one component of critical incident stress, I believe it is a significant element. Critical incident stress has been characterized as an intense state of emotional crisis followed by distressing signs and symptoms (Mitchell, 2010, 2012; Mitchell & Everly, 1997). One goal of crisis intervention, such as co-worker support and debriefing used by Charlene, is to mitigate and attend to these emotions (Everly & Mitchell, 1999, 2008; Mitchell 2010; Mitchell & Everly, 1997). Too much, too little, or no emotion derived from critical incident stress may signal a sort of imbalance, and require intervention (van der Kolk, 2014; van der Kolk, McFarlane, & Weisaeth, 2007). Gadamer (1996) referred to the possibility of imbalance in the context of mental health. Mental health includes emotional well-being hence, I believe his argument is also relevant to emotional health. "Like all loss of equilibrium, mental disturbance too is dialectical, capable of being restored but also capable of leading finally to complete destruction through total loss of personality if the restoration of equilibrium cannot permanently be maintained" (Gadamer, 1996, p. 60). Based on Gadamer's (1960/2013) thoughts, emotional health is capable of being restored, but also capable of complete destruction. Charlene attempted to use various forms of crisis intervention to restore her emotional equilibrium. Unfortunately, the lack of emotion displayed from co-workers during the debriefing session left Charlene feeling abnormal, and thus isolated from the rest of her community-*"what is wrong with me?"* She became suspicious of her emotional health status and the effectiveness of this intervention. Gadamer (1996) suggested that ongoing imbalance was capable of a "total loss of personality" (p. 60). I believe that ongoing emotional imbalance may broaden, to include the potential for complete destruction through a total loss of self. This loss of self

became visible as Charlene reflected on her altered way of being with those in her care, *"becoming more distant from the patients."* Charlene questioned her career as an ICU nurse and pondered the need to step away. Supporting ICU nurses suffering from critical incident stress requires attentiveness to emotion, and timely crisis interventions that effectively facilitate balance and harmony of those emotions.

Returning to the Research Question

To broaden understanding of critical incident stress, our understanding of crisis intervention must be considered. The paradoxes between Charlene's experience of crisis intervention and other participants' descriptions reinforced the challenges of finding the single, most effective approach to support ICU nurses. For example, Charlene's experience of critical incident stress suggested the benefit of team in the context of crisis intervention. Other participants were at odds with the idea of team because of the unwritten rules that may over-emphasize conformity in team culture. The benefit of being noticed or watched over by co-workers may be perceived as a sideway glance, looming with judgment. Charlene sought a crisis intervention to alleviate her emotional turmoil, while other participants discretely attempted to contain and store their emotions. These contradicting examples reinforce the complicated nature of crisis intervention. ICU nurses' responses to trauma are unique and varied and thus, one intervention will not be effective for all nurses. I have developed a better appreciation for Charlene's suggestion of just something simple, somebody right there.

Integral to Charlene's experience with various forms of crisis intervention were relating and connecting. A true presence (Parse, 1998) coupled with a common understanding may offer initial reprieve from the emotional imbalance caused by critical

incident stress. There are risks to being fully present with another; Mitchell and Bunkers (2003) used the term “abyss” to more fully explore the lived experience of these risks. The poem I shared earlier in this chapter “The Abyss” (p. 126), was a creative approach used by Mitchell and Bunkers (2003) to disseminate their reflections. This poem resonated most with my ever-expanding understanding of critical incident stress. Through my eyes the abyss has the potential to terrorize and torment ICU nurses, as they attempt to find a glimmer of hope-to-be from their devastating experiences. Through my eyes the abyss unveiled the potential for transformation in how ICU RNs practice the art of nursing, and their perception of the discipline.

Chapter Eight: The Change in "How I Nursed"

Mandy took a seat in one of the upholstered chairs that surrounded the large conference room table. Mandy was articulate, soft-spoken, and initially appeared cautious and uncertain as she waited for me to begin the interview. She quietly muttered: *"I hope the critical incident I experienced will help with your research."* I glanced away from reviewing the completed consent form, and reassured Mandy that her experience would contribute to my ongoing understanding of the topic. This seemed to immediately put Mandy at ease as she raised her eyebrows and confidently uttered: *"This critical incident took place around Christmas, the circumstances of it were awful."* I was drawn to Mandy's narrative as she exposed an aspect of the topic that I initially acknowledged, but had not considered in depth. Mandy offered me insight and perspective on transformation and its relationship to critical incident stress.

I was moved, captivated, and marked the moment Mandy revealed the change she experienced to her nursing practice following the work-related trauma. *"The critical incident I experienced didn't necessarily change my view of nursing, but how I nursed."* This phrase gave me goose bumps on my arms as I was struck with an immediate sense of revelation. Beyond the classic signs and symptoms of critical incident stress was the potential for it to seep into the crevice of something more personal and intimate, an ICU nurse's identity. In this chapter I will move beyond my superficial assumptions and delve into the notion of transformation, bringing into focus Mandy's experience of the change in *"how I nursed."* Mandy's initial uncertainty and hesitation resolved, as she persuasively expanded on the reason she defined this critical incident as *"the straw that broke the camel's back."*

"The Straw that Broke the Camel's Back"

Mandy began the interview by acknowledging that she had temporarily left her position in the ICU to work in a different area of nursing practice. Although she experienced previous critical incidents as an ICU nurse, the complex situation she was prepared to describe influenced her decision to briefly leave the ICU. *"It was this incident, although there have been other incidents too, that was the straw that broke the camel's back."* This particular experience was memorable and most impactful as it evoked intense *"anger"* and *"frustration,"* that left Mandy with a sense of *"dread going to work."*

> *I was taking care of a pregnant young woman who looked like she was in her 20s. This young woman and her toddler-aged child, who was unrestrained, were in a motor vehicle accident. Her boyfriend, who had been drinking alcohol, was the individual driving the vehicle when the accident occurred. The woman was ejected from the car and sustained multiple injuries, including a severe spinal injury. I think I was most bothered by the boyfriend who was at her bedside complaining about his back-pain, rather than showing concern for his injured girlfriend. The boyfriend stayed with his girlfriend the whole night and showed no remorse. He seemed to be looking for attention by being focused on his own needs and his back pain. This made me angry and frustrated knowing that he had walked away without a scratch. I have looked after other people who have been in car accidents. I have never had the person who caused the accident in the room at the same time; this was one of the most difficult parts of the incident.*

After this brief initial description of the critical incident, as with other participants, I sensed there were additional elements yet to be revealed.

Moving Closer to the Inconspicuous Thread: Revealing the Nuances

Critical incidents are similar to a tapestry woven from threads of varying colors, patterns, and textures. Upon initial glance each delicate strand goes unnoticed as the eye visualizes what is most obvious. Moving closer each thread is intricately connected and intertwined, contributing to the work of art. The inconspicuous thread woven in, through, and across this particular trauma was the profound personal connection with the incident. More specifically, this connection was Mandy's critical appraisal of herself and her nursing practice. The inherent personal connection with Mandy's experience of critical incident stress called into question her identity as an ICU nurse.

> *I failed the patient in that I didn't want to give this woman my usual level of care because her boyfriend was in the room. Knowing he was in the room made me hesitant to start my assessments of his girlfriend. Then I just did what I needed to do and didn't go beyond that. I normally have a very high standard of care and I always think to myself, if this were my family member in the bed what would I want for them? This patient didn't receive neglectful care, but I just don't feel like I was meeting my own standard of care.*

Mandy immediately noticed a change to the way she practiced and identified as an ICU nurse. Mandy was distressed as she began to realize that the high standard of care she was accustomed to providing had been compromised. Mandy's typical nursing care went beyond attending to the patient's needs, as she was equally diligent with supporting the

family. Knowing that care of the family is central to ICU nursing, Mandy grappled with her inability to maintain this core value, leading to a sense of moral conflict.

> *Families are important to the ICU. I normally have great rapport with families and people, families are important to me and to my practice. Instead of getting to know this family, I had no interest in talking to the boyfriend and getting to know him. I was so quick to dismiss him, that's the part that bugged me, that instantly there was such negative feelings. I just wanted to avoid the room altogether, I just avoided it.*

To be situated in the same room as the individual who caused her patient's injury, accelerated Mandy's existing anger. This anger influenced the relationships she had with her co-workers in the ICU. "*I started going to work angry and the relationships with my co-workers were strained, they were not the same. I started to think of one hundred other places I would rather be and I dreaded going to work."* These strained work relationships contributed to Mandy's emerging self-doubt and potentially her sense of self-worth. Mandy questioned her competence, standard of care, relationships with patients and families, her career choice, and her future as an ICU nurse.

With self-doubt, Mandy courageously continued with the care of her assigned patient, *"it's something I had to do."* However, beneath Mandy's sense of obligation was the fear associated with the risk of stigma from mental health.

> *The climate, the expectation in the unit is not welcoming of a) being sick, and b) being sick from mental health. The culture in our unit is not supportive of mental health. I feared the stigma around needing to take days for personal health and the potential repercussions from calling in sick. So, I went back to look after the*

patient and her boyfriend for my scheduled three consecutive night shifts.

Mandy contemplated taking days off after the first night shift, however the fear of stigma was a barrier to prioritizing her own mental health needs. With bitterness in her voice, Mandy elaborated on the anguish she endured continuing to care for the patient and her boyfriend.

I was physically nauseated and sick. I was sad and just dreaded going in to work. When I was with my family I didn't feel like myself. It was awful because I don't feel like I was present with my own family during our Christmas meal.

Similar to Olive, Mandy used a temporary self-protective approach she referred to as *"autopilot"* to cope with her immediate distress. However, unique to Mandy's experience was her continued use of autopilot that extended beyond an initial coping strategy. For Mandy, autopilot became a more definitive alteration to how she provided care in the ICU.

"All of My I's were Dotted, My T's were Crossed"

Mandy spoke about autopilot with uneasiness and discomfort, as if it were an unwelcome stranger. I smiled when Mandy first uttered the word autopilot as it was a familiar term that resonated from the interview I completed with Olive.

I continued with the three night shifts by going into autopilot so that I didn't have to be in that situation, so I could minimize it. In autopilot you know the steps, you know you can do them, but whether or not you are putting 100% into them is totally a different thing. I could go into autopilot and still make sure that all of my I's were dotted, my T's were crossed, and that my patient would be maintained over night. I did not go beyond what needed to be done which was different for

me, because in the past I had such a high standard for myself.

In *"autopilot"* the high standards Mandy once provided were reduced to the minimal effort she now put forth into patient care. Mandy justified autopilot by offering reassurance that the safety of her patient was not compromised, *"my patient would be maintained."* However, once the *"I's were dotted"* and *"T's were crossed,"* she did not go beyond the necessary patient care responsibilities. Perhaps what riveted me most about Mandy's description of autopilot was that unlike Olive, she referred to this new way of being, how she nursed in the ICU, as potentially ongoing in this setting.

In a more despairing tone of voice Mandy explained that autopilot had gotten worse after the incident, and that it was likely definitive if she continued to work in the ICU.

> *Knowing I was leaving for a new job 5 weeks after the critical incident helped me. The new job was only temporary for one year. If I had stayed past the 5 weeks I would still have the same issues with "autopilot." I knew when I left the ICU for another area of nursing practice I was past the point of autopilot in my nursing care. Before autopilot I used to look at the monitor and wonder what's going on there, and why is this different? I was now not probing, not looking or questioning what was happening to the patient.*

Misty-eyed, Mandy reminisced about her ongoing experience with autopilot, as if she was grieving a loss. Mandy mourned her former identity as an ICU nurse in response to the loss of her expert nursing edge. Mandy was a seasoned ICU nurse whose years of clinical practice were evidenced by descriptions that reflected an intuitive sense, and an innate ability to rapidly grasp a widened perspective of the patient's situation. *"Before I*

used to think, for example, if I had a patient with 50 mL of urine output and then dropped to 10 mL I would be questioning the cause. I would be trying to figure out what was going on with the patient." Mandy's continued practice in autopilot compromised her astute observation skills and the questioning for expert early intervention. Autopilot reflected that Mandy was less committed or involved, and her personal ethic of caring was jeopardized and at risk. Interestingly, what appeared like grief in her description of an altered identity briefly subsided. Mandy grinned and clapped her hands together when she acknowledged that autopilot disappeared during her leave of absence from the ICU. "*There is no more autopilot in the new area of nursing. I was learning something every day, there was no opportunity for autopilot because I didn't know enough."* Similar to Mandy, other participants described an ongoing altered identity following a work-related trauma.

I vividly recall one participant's depiction of *"robo-nurse,"* a label they used to elaborate on how their existing ICU nursing practice had changed. This participant stated:

> *I can now disconnect at a very different level that I thought possible. I can turn into robo-nurse where there are no feelings and I am just very task-oriented, I can still go through the motions. Work becomes work and I am not here to be your friend, I am not here to be your companion. I am here to save your life. I am still more on the cooler side, and I don't like getting close to my patients because of the risk.*

This participant described the term robo-nurse as a *"safe zone"* that created an emotional disconnection from patient care. Throughout the interview the participant used *"robo"* as an abbreviation for the word robot. A robot may be programmed to resemble a human

being, however behaves in a mechanical or unemotional manner (*Merriam-Webster*, 2018). Robo-nurse and autopilot were described as artificial identities that emerged as a way to detach. Detachment was possible as a mechanical or unemotional ICU nurse by objectifying and depersonalizing others to the tasks required for sustaining life. Detachment may be considered an effective emotion-focused coping strategy for some nurses (Cecil & Glass, 2015; Harrison et al., 2015). However, a connection and concern for patients are considered conditions of caring (Benner & Wrubel, 1989). These conditions are necessary, as they nudge an ICU nurse to take note of subtle signs of improvement or deterioration in the patient. Participants, including Mandy, demonstrated concern for their patients, however it became clearer that there was a disconnect that potentially compromised caring. Autopilot was difficult to sustain as Mandy began to see the implication of this strange and unusual way of being in her personal and professional relationships.

> *I'm not providing the best care to my patients. It is impacting me, it is impacting my relationship with my boyfriend, it is impacting the time I spend with my family. Even the relationships with my co-workers weren't the same quality that they were before.*

As the interview progressed I sensed Mandy's resentment toward the critical incident. She resented the fact that critical incident stress had robbed her of existing relationships with others, and the connection she once had with her work.

Noticing "More Bad than Good:" An Altered View of ICU Nursing

"The critical incident I experienced didn't necessarily change my view of nursing, but how I nursed." Mandy claimed that the critical incident did not

"necessarily" change her view of nursing. I have deliberately returned to this quotation because I propose that Mandy's critical incident changed both how she nursed **and** her view of nursing.

> *I started to notice all the bad things and all the little things. I noticed the ways we failed as nurses, as a health care system, and I just felt like we were not doing anything good. I was finding so many things wrong with the place, like more bad than good.*

My daughter marvels at her toy eyeglasses that change the color, perception, and intensity of her surroundings, without changing the landscape and structures in view. In this description Mandy reflected on her altered view of ICU nursing as if she had put on those toy eyeglasses. With this newly tainted lens, Mandy *"started to notice"* what already existed in a way that was transformed and different. Mandy's tone of voice at this point in the interview was marked with skepticism, as if the toy eyeglasses had unveiled what was previously masked or hidden. She was discouraged by what had been brought to light, that the work of ICU nurses was potentially in vain and futile. Mandy perceived ICU nursing and the health care system as having failed, making them deficient and ineffective to those who require their services. Mandy's new onset of cynicism where she noted *"more bad than good,"* was likely derived from her emerging judgments. *"I began to not see the best in people and making judgments about my co-workers, my patients and their families. These judgments didn't go away after the incident, they continued and remained with me."* It is important to note that these toy glasses are not used to enhance clarity and thus, it is easy to lose perspective on what

really exists. Mandy was hopeful that a new position outside of the critical care setting would adjust her lens of ICU nursing and the health care system.

"I Don't Understand Myself and I Don't Like it"

Distance and time away from the ICU provided Mandy with a chance to reflect on her nursing practice. *"I knew I needed a change because I realized I don't understand myself and I don't like it."* This space from critical care was like a breath of fresh air, an opportunity to gain insight into the transformative influence of critical incident stress. This included the positive impact from the critical incident she most recently experienced and willingly shared.

> *I became more aware of my personal biases that I had not considered in the past. Those biases that I had and that I didn't think I had before. It might have just been really easy for me to say "that alcoholic" or "that drug addict" as judgments. But I don't think I was as aware of my judgments and biases until that incident.*

Mandy elaborated on how her nursing practice had changed, with an optimistic tone. There was a glimmer of gratification as Mandy reinforced an enhanced awareness of personal biases and judgments. Mandy acknowledged that prior to this experience she was unaware of these biases and judgments. One participant explored how their practice changed using a more tangible, tactile, and practical strategy that arose from their work-related trauma. This participant stated:

> *After the critical incident I gained a new respect for working in the ICU. I now realize that I needed to make adjustments to my clinical practice so that I wouldn't experience a similar critical incident. So, I created a sheet that has a*

> *systems assessment and all the things I need to check for my patients. On this sheet I have a column just for lab values and trends, central venous pressures, and other items such as wounds and skin care, for example. On the other side of the sheet I have a stick man that I can circle if there are intravenous or central lines. With medications, I now attach a wide piece of tape to my work-station that I can check off each hour. These new strategies help me stay organized and in control of my day.*

The development of documents to enhance identified gaps in clinical practice as a result of critical incident stress was beneficial for this participant. By *"mentally processing"* and *"breaking down"* the critical incident, this participant both acknowledged and took action to improve their nursing practice.

Participants who contributed to my understanding of the benefits to critical incident stress began their descriptions with the word "I." Mandy used the phrase *"I became aware of..."* While other participants used similar connotations: *"I am now reminded of...," "I have learned that...," "I am now focused on..."* Based on the language used by participants, there was an element of self-knowledge derived from critical incident stress. To gain self-knowledge Mandy commented on the importance of *"processing"* the critical incident. Some of the participants used words such as *"reflecting"* and *"deconstructing"* their experiences, so they could make sense of them. Transformation of the self, as a person and as a nurse, took place as a result of processing, reflecting, and deconstructing what had occurred. One participant eloquently summarized this connection between transformation and self-knowledge:

> *There was self-knowledge that came from dealing with many different critical*

incidents and the way I processed those to understand them better. Having experienced multiple critical incidents I have learned along the way, the things that work well for me and those things that don't work so well. The incident I shared today was a reflection of my past experiences. It is a reflection of those pearls I learned from each one that brought me to the place that I am today, the place that I can say "I managed fairly well."

The *"straw that broke the camel's back"* was memorable because it altered and transformed Mandy's way of being as an ICU nurse, how she provided care to the critically ill. Conversely, this critical incident also provided Mandy with the opportunity to benefit from making meaning of her clinical practice. It was evident from Mandy's narrative that she experienced some form of personal and professional transformation. As the interview came to an end Mandy's sense of caution and uncertainty that was obvious in the beginning, returned. Mandy confessed that she was unsure if she would return to ICU nursing after her temporary leave was completed. However, with enthusiasm and confidence, Mandy asserted she was certain of one thing, that *"with time my wounds will heal."*

Connecting the Dots to Mandy's Experience with Critical Incident Stress

"It's no use going back to yesterday, because I was a different person then."

Lewis Carroll, Alice in Wonderland

This quotation from Lewis Carroll's *Alice in Wonderland* (1865/1999) stands out as I ponder the notion of transformation in the context of critical incident stress. While in Wonderland, Alice encountered emotional upheaval that led her to question and doubt her identity. After passing through the looking-glass Alice underwent a transformation of

self, and embarked on a quest to regain understanding and meaning of "who in the world am I?" (Carroll, 1865/1999 p. 28). Mandy's experience of critical incident stress led to a transformation of self that inflicted uncertainty and doubt from the loss of her former identity. Similar to Alice in Wonderland, Mandy struggled to understand "who in the world am I?" Mandy's transformation of self and identity was evident in her descriptions that suggested a change to how she nursed and her view of nursing. Alice's transformation in the whimsical Wonderland was depicted as a journey that contained a logical beginning, middle, and an end point. My initial thoughts of transformation paralleled this depiction as a continuum with finality. Although I now see transformation as a journey, I consider it messy, arduous, and infinite. I acknowledge that transformation is a broad term and thus has the potential to be interpreted differently. Hence, I now offer my interpretation of the word transformation and its relevance to critical incident stress.

The word transformation means the act of being changed in structure or appearance (*Merriam-Webster*, 2018). In an etymological association the origin of the word transformation comes from the old Church Latin *transformationem*, a change of shape or to metamorphose (*Online Etymology Dictionary*, 2018). Reflecting on the concept of transformation I find myself drawn to the classic parallel of a butterfly's metamorphosis. This conversion from one form to another exemplifies a distinct unidirectional transition into something unrecognizably different. Mandy's transformation signaled a change, from one way of being to another, leaving her with an unfamiliar grasp of self-identity. Gadamer (1960/2013) contended:

> Transformation means that something is suddenly and as whole something else, that this other transformed thing that it has become is its true being, in

> comparison with which its earlier being is nil. When we find someone transformed we mean precisely this, that he has become another person, as it were…Thus transformation into structure means that what existed previously exists no longer. (Gadamer, 1960/2013, p. 115)

Gadamer's (1960/2013) conception of transformation implied an irreversible change to one's way of being, as they become another person with a new identity. Mandy and other participants experienced damage to the self as their identity formed prior to the trauma was "irrevocably destroyed" (Herman, 1992, p. 56). There is disruption that exists along the continuum to transformation, as the overwhelmed individual struggles to integrate and adapt to changes (Jaffe, 1985; Janoff-Bulman, 1992). It is amidst this contention from trauma that some may find meaning and growth, and others experience ongoing negative effects (Tedeschi, 2012; Tedeschi & Calhoun, 1995, 1996, 2004; Triplett, Tedeschi, Cann, Calhoun, & Reeve, 2011). For the purpose of this chapter, I will consider transformation in the context of critical incident stress as an irreversible and ongoing change to the self. Mandy's transformation was propelled by the critical incident that "shattered" (Janoff-Bulman, 1989; 1992, p. 51) her personal assumptions.

"Shattered" Assumptions (Janoff-Bulman, 1989; 1992, p. 51)

Early in the interview Mandy admitted to having experienced multiple critical incidents prior to the one described. I saw Mandy as a resilient individual who continued with providing care to the critically ill despite these multiple traumatic events and the risk of stigma from mental health inherent in her workplace. Resilience, as described in Chapter Two, is frequently referred to as bouncing back and adapting to adversity (American Psychological Association, 2018; Southwick et al., 2015). Mandy's resilience

was an asset given its correlation with reduced symptoms from traumatic stress in nurses (Mealer et al., 2012). Despite the past critical incidents she experienced, it was the most recent that was the straw that broke the camel's back. Perhaps this was the most impactful to Mandy because it implicated personal assumptions she held about herself and the world around her.

I believe Mandy defined this experience as traumatic because it disrupted her personal assumptions of ICU nursing, the health-care system, and her sense of self, (Janoff-Bulman, 1989). The seminal work of Janoff-Bulman (1989; 1992) suggested that traumatic events "shatter" an individual's core assumptive knowledge or schema. According to Janoff-Bulman (1989, 1992) people typically hold three fundamental assumptions about the world: the world is benevolent, the world is meaningful, and the self is worthy. Brewin and Holmes (2003) suggested these assumptions be expanded to include the world is predictable and thus invulnerable. Based on the original three assumptions by Janoff-Bulman (1989; 1992) I pondered whether Mandy's belief about the virtue of the world was compromised with the boyfriend's desire to meet his own selfish needs over those of the patient and her child. I wondered if Mandy's anger and frustration was driven from her altered view of a meaningful world, by questioning unjust injuries to an undeserving patient and child. However, I believe Mandy was most influenced by the final fundamental assumption that challenged her perceived self-worth as a nurse, and as a human being. Mandy was distraught with the perception of having failed the patient because of her inability to provide her typical high standard of care. Mandy began to see more bad than good, noting the gaps and flaws in her nursing practice that extended to her critical perception of others. The incident became known as

the straw that broke the camel's back because it violated and compromised Mandy's assumptions related to her competence, standard of care, relationships with patients and families, and career choice. Mandy's transformation in how she nursed and her view of nursing took place as a result of these "shattered" personal assumptions (Janoff-Bulman, 1992, p. 51).

Who am I? The Transformation of Expert ICU Nursing Practice

Mandy's self-identity was seized, enslaved, and overpowered by the critical incident she described. Mandy's transformation in how she nursed was distinctly described as autopilot, while another participant used the term robo-nurse. Autopilot and robo-nurse extended beyond emotional detachment, as it compromised the practice of these expert nurses. I considered Mandy to be an expert ICU nurse based on the descriptions and examples she shared from her clinical practice. An expert nurse uses mature practical reasoning, coupled with intuitive knowledge to gain understanding of an existing situation, while remaining open to the possibilities of what could be (Benner, 1984; Benner et al., 2009). Their astute observations and decisions are made based on the intense connecting, relating and knowing those in their care. Expert ICU nurses become particularly skilled with "following the body's lead," in critically ill patients who are unable to voice their concerns (Benner, 2002, p. 480). Expert nurses seamlessly use their past and present ways of knowing to anticipate likely future events, extending their field of view to the larger clinical picture (Benner et al., 2009). Mandy's transformation to autopilot jeopardized her expert nursing practice. Mandy became disengaged, objectifying and depersonalizing patients in her task focused approach to care. Rather than probing, looking, and questioning situations, Mandy simply ensured the I's were

dotted and T's were crossed. As a disengaged ICU nurse, Mandy saw those in her care as a problem to be solved rather than allowing her understanding to be shaped by a "watchful reading" of the patient (Benner et al., 2009, p. 138). Gadamer (1996) suggested that objectifying patients to complex medical data puts them at risk for a loss of their personhood. I believe it was this risk for a loss of her patient's personhood that was now enacted and distressing for Mandy.

Reflecting on Mandy's transformation, I found myself considering the broader implications to autopilot and robo-nurse. I wondered about the risk of doing nothing to assist ICU nurses with their unwanted altered identities. Mandy proposed that autopilot was no longer her way of being in the temporary position she held outside the ICU suggesting that she developed a new nursing identity that replaced autopilot. Perhaps the context requires consideration for ICU nurses seeking relief from an unwanted identity that emerges from critical incident stress. Robo-nurse remained an identity for another participant who continued to work in the ICU after the critical incident. It is possible that other ICU nurses continue to provide care to patients in their altered identities of autopilot and robo-nurse. These altered identities have the potential to jeopardize expert nursing practice and tarnish the pride of ICU nursing, as willingly conveyed by various participants. There was a ripple effect from Mandy's experience with autopilot that seeped into her relationships with others. Tampering with the expert clinical practice of an ICU nurse has the potential to negatively impact the nurse, the critically ill, and the discipline of nursing. Mandy's tone of voice revealed a commitment to making sense of her transformation by processing the critical incident. Traumatic events that challenge an

individual's assumptions tend to initiate cognitive processing by which there is an attempt to rebuild core beliefs (Cann et al., 2011).

Lego Blocks to Rebuild: The Potential for Positive Transformation

Janoff-Bulman and Frantz (1997) declared that those who have experienced trauma "see the world as it really is, stripped of the meaning and order we all too readily assume to exist" (p. 95). Mandy's experience illuminated the notion of being stripped of the meaning that once existed relative to the self, and to the world of ICU nursing. This interpretation evolved from Mandy's declaration that *"I don't understand myself and I don't like it."* Mandy and other participants used words such as processing, reflecting, and deconstructing the critical incident as a way of articulating their need to rebuild what had been destroyed. Although these words suggested a breaking down of sorts, I see making meaning like pieces of Lego blocks being adjusted and configured to build a structure of something coherent and rational. Park and George (2013) suggested meaning occurs on two interrelated levels: global and situational meaning. Global meaning reflects an individual's goals, beliefs about the world and themselves, and their sense of meaning or purpose in life. Situational meaning is associated with the context of the stressful situation, more specifically how that situation is understood. Participants described their attempts to gain renewed global and situational meaning that were violated by the critical incident (Park & Folkman, 1997; Park & George, 2013). Piecing together by reconciling the global and situational meaning to gain access to a comprehensible structure of the incident, and of the self, occurred in the form of deliberate reflection. Triplett, Tedeschi, Cann, Calhoun, and Reeve (2011) found that voluntarily engaging in reflective or deliberate rumination was associated with meaning making. One participant explained

that to make meaning *"it's all about self-reflection, as nurses we do it all the time, it is how we advance our practice and how we try and do better the next time."* Reflection as a strategy to make meaning requires nurses to connect their actions with the outcome of a situation (Tanner, 2006). While some participants reflected to make meaning of the critical incident, they inadvertently gained self-knowledge or self-understanding. I see self-knowledge and self-understanding as synonymous terms.

Mandy became increasingly more aware of her biases that she had not considered in the past. Other participants described sudden revelations they gained about themselves personally and professionally. Perhaps transformation involving self-understanding should not be surprising as Gadamer (1960/2013) proposed: "it is true in every case that a person who understands, understands himself *(sichversteht),* projecting himself upon his possibilities" (p. 261). ICU nurses, like all human beings, are consistently engaged in understanding their world around them and thus develop ongoing self-understanding (Gadamer, 1960/2013). The ongoing development of self-understanding suggests that an ICU nurse's self-identity is in flux. Based on this premise, transformation of self is infinite and never ending given self-identity is always already evolving.

Changes in perception of self may lead to a positive transformation that reflects self-renewal, and an opportunity to thrive and grow (Calhoun & Tedeschi, 1998; Tedeschi, 2012; Tedeschi & Calhoun, 1995, 1996, 2004). As described in Chapter Two, post-traumatic growth (PTG) is a concept that speaks to the possibility of perceived benefits from processing and restructuring a traumatic event (Calhoun & Tedeschi, 1998; Joseph & Linley, 2006; Linley & Joseph, 2004; Park, 2010; Tedeschi, 2012; Tedeschi & Blevins, 2015; Tedeschi & Calhoun, 1995, 1996, 2004). I am uncertain whether

participants, including Mandy, experienced PTG from the critical incidents they encountered. This uncertainty is appropriate given positive transformation is not common to all individuals who have experienced trauma (Tedeschi & Blevins, 2015). However, I am confident in proposing that each participant was in some way, shape, or form changed as a result of critical incident stress.

Returning to the Research Question

I'm afraid I can't explain myself, sir.

Because I am not myself, you see?

Lewis Carroll, Alice in Wonderland

Critical incident stress led Mandy to the question of "who am I?" as a person, and as an ICU nurse. Questioning her identity as an ICU nurse was derived from inadvertently veering from her typical high standard of patient care. Mandy found her clinical practice strange and unfamiliar, as she was no longer the same ICU nurse. I propose that critical incident stress is transformative in how ICU nurses practice and in their view of nursing. Mandy's experience of autopilot called to question the implications of transformation associated with the creation of a different self-identity. I believe that continuing to provide patient care in autopilot and robo-nurse endangers the existence of expert ICU nursing practice, and thus the discipline as a whole. This speaks to the importance of acknowledging the potential for an altered self-identity from critical incident stress, as well as the need for effective methods of support to address the corresponding implications from transformation. Alice in Wonderland's transformative journey came to an end, thus implying a final destination and a return to her former reality. Unlike this non-fictional character, the reality of an ICU nurse's transformation

from critical incident stress is irreversible and thus ongoing. “Transformation is a journey without a final destination” (Wade, 1998, p. 716). It is impossible for ICU nurses who have been transformed by critical incident stress to go back to yesterday, because they were a different person then.

Chapter Nine: From Hermeneutics to Nursing Practice

"In the course of our reflections we have come to see that understanding always involves something like applying the text to be understood to the interpreter's present situation."

(Gadamer, 1960/2013, p. 318)

Hermeneutic work demands more than the interpretation of texts, it requires us to bring our understandings into the world so they may be adapted and lived – "it is a work of application" (Gadamer, 1960/2013, p. 338). Application in hermeneutics is bringing the salient and newly derived from interpretation into our present situation, our self-understanding. Gadamer (1960/2013) claimed that "to understand a text always means to apply it to ourselves" (p. 416). The application of this research inquiry must bring my interpretations into the present clinical context so that it might inform, alter, and enhance ICU nursing practice. In this chapter I will discuss the application of new understandings and the implications for those that may benefit from this doctoral work. I will also reflect on the possibilities for further inquiry to stimulate evolving conversations associated with the topic.

The Application of New Understandings

The interpretations I offered in previous chapters have concrete utility for ICU RNs and potentially for nurses from other practice settings, the unit managers, and nurse educators working with undergraduate students. I propose that this work has implications that extend beyond individual responsibilities to include suggestions for health care organizations. I will now elaborate on the interpretive findings from this inquiry by offering practical strategies that may be used to navigate some of the complexities associated with work-related critical incident stress experienced by critical care nurses.

Insights for ICU Nurses to Ponder

Amidst their commitment to supporting the critically ill, there is the possibility for ICU nurses, particularly those that are novice, to enter into this practice setting naïve or innocent to its capability for wounding, scarring, and permanently injuring. Unfortunately the risk of critical incident stress and naming it accordingly may be exposed only after it has occurred. Nurses arrive to the ICU setting eager to engage in the challenges associated with caring for the critically ill, yet are seemingly unprepared for an encounter with one or more critical incidents. To more fully comprehend the risk of critical incident stress requires recognition of the circumstances or stimuli that may initiate this response. Recoverable errors and morally distressing situations involving aggressive futile measures to sustain life featured strongly as examples that participants in this inquiry perceived as critical incidents. I suggest ICU nurses should be aware of the potential effects of these situations, and to prioritize the importance of self-care by engaging in activities that offer enhanced immunity or inoculation from critical incident stress. Activities may include participating in stress education sessions that focus on critical incidents and critical incident stress, actively seeking opportunities to enhance resilience, and reflecting on effective personal coping mechanisms.

Participants suggested that critical incident stress has the potential to impact critical or higher thinking, and the emotional connection that nurses develop with patients and their families. One approach ICU nurses may use to temporarily cope with critical incident stress is to emotionally detach themselves from patient care. There is the potential for this disconnection to morph into a more permanent transformation by altering their professional self-identity, and subsequently compromise expert nursing

practice. Emotional detachment can lead to depersonalized care by objectifying the patient and limiting interactions to the minimally necessary tasks required to sustain life. To isolate emotions as separate entities may constrain an experienced nurse's capacity to take notice, grasp, navigate, and respond to clinical indicators (Benner et al., 2009; Benner & Wrubel, 1989). More specifically, emotions enhance attuned expert observation and intuitive responsiveness to subtle patient cues (Benner et al., 2009). Prolonged emotional detachment may impede nurses from advancing to a higher level of expertise (Benner et al., 2009; Benner & Wrubel, 1989). Nurses with advanced expertise not only provide care to the critically ill, but also mentor both novice and experienced nurses. Neglecting or minimizing emotional detachment as a potential consequence of critical incident stress not only threatens expert nursing practice, but also endangers the discipline. I believe nurses should be attuned to the consequences of emotional detachment from patient care and if required, seek assistance or support to regain their connection with others.

Insights for Managers to Ponder

The power of organizational culture (Schein, 1992/2017) became evident as participants described the impact of the silent, yet pervasive unwritten rules that may dictate the unacceptable display of emotion in the ICU. The nurses influenced by these rules may attempt to muzzle their emotions from critical incident stress to minimize the vulnerability associated with ridicule, judgment, and stigma. The potential for being glanced upon and scrutinized is inherent in the typically open physical structure of the ICU, making it difficult for nurses to conceal their overwhelming emotions following a critical incident. It is important that managers consider the influence of the organizational

culture in an ICU nurse's response to a critical incident. As they consider a range of options for post-incident supportive intervention, managers might seek further understanding of the culture inherent in their unit. The culture of an organization is best exposed through interaction (Schein, 1992/2017). This would suggest that engaging with staff members by listening to their experiences and displaying an open curiosity about the effects of intense clinical events, may help managers to gain insight into the reciprocity between the unit culture and responses to critical incidents. Facilitating team-building activities that encourage open and transparent communication, with a focus on accepting a display of emotion, may enhance the organizational climate to one of cooperation and support (Benner et al., 2009). Understanding the team's values, beliefs and assumptions may inform managers' suggestions for crisis intervention and follow-up care. Team intervention might be considered when there is a lack of connectedness or community inherent between members, and to enhance psychological safety.

The metaphor "any one-size-fits-all" is inappropriate when striving to support nurses' transitions from walking wounded to wounded healers. Management might consider approaching crisis intervention from a more individualized perspective rather than a strict formulaic standardized approach. This may preclude the need to activate a range of supportive responses dependent on those requiring assistance and the nature of the critical incident. Prior to activating an intervention it would be beneficial for managers to connect with those who were involved in the critical incident, to acknowledge their distress and gain understanding of their specific needs. Connecting with the right individual, as defined by the traumatized nurses, may generate a sense of safety and offer a calming presence (Hobfoll et al., 2007). The benefit of co-worker

support cannot be negated nor minimized, as the presence of a team or community member who can bear witness by a genuinely empathetic response may be invaluable. Bearing witness to a co-worker's distress requires an intimate relationship of trust, hence I offer that this form of support likely lends itself best to an organizational culture that facilitates an acceptance of exposing raw emotion and respects the human possibility of failure. Bearing witness to a co-worker's distress should be implemented with tools and skills that include basic psychological first aid techniques such as look, listen, link, and recognize limitations (Creamer et al., 2012; World Health Organization, 2013). Managers might consider offering frequent co-worker support training delivered by a mental health professional for existing nurses, and in orientation sessions for those entering the setting. These sessions should offer the necessary tools and skills to support co-workers seeking assistance, and integrate fundamental elements of critical incident stress education.

Insights for the Health Care Administrators to Ponder

The insights I have offered for ICU nurses and unit managers may be challenging to enact without the support of the larger health care organization. I believe that the health care administrators should accept some responsibility for promoting the overall health and well-being of their staff. Accepting this responsibility requires a commitment to establishing a culture of health for individuals, teams, and the health care community (Goetzel et al., 2007; Kent, Goetzel, Roemer, Prasad, & Freundlich, 2016; Payne, Cluf, Lang, Matson-Koffman, & Morgan-Lopez, 2018). According to Kent, Goetzel, Roemer, Prasad, and Freundlich (2016) a culture of health may be described as a "workplace that places value on and is conducive to employee health and well-being" (p. 117). This

means moving beyond the development of policies and procedures and creating opportunities to enact what is expected within these documents.

Health care administrators might consider the implementation of an easily accessible onsite resource for health care professionals. This suggestion stems from an existing service implemented by Providence Health Care (2012) in Vancouver (British Columbia, Canada) known as the Centre for Practitioner Renewal (CPR). CPR consists of inter-professional health care providers that offer services, facilitate educational opportunities, and conduct research to support the well-being of individuals and groups. Similar to this resource, services may be adapted to meet the tailored needs of a health care team or community. Offering *ongoing* onsite professional development opportunities that address a spectrum of health related topics such as developing resilience, enhanced self-awareness, emotional health management, and providing the skills required for co-worker support could be tailored to specific teams and settings. A focus on research would reinforce the implementation and evaluation of current evidence-based interventions used to support health care professionals. Critical incident stress is situational and a relational experience shaped by the context and reactions or responses of other co-workers. The focus on teams as well as enhanced relationships and connections with the self, others, and with how one derives meaning underpins the approaches used by CPR. Implementing a resource that addresses the continuum of critical incident stress (e.g. before and at various points after the incident) would place value on the health and well-being of staff, as well as demonstrate commitment to supporting those who have experienced work-related critical incident stress.

Insights for Nurse Educators to Ponder

Familiarity with the term critical incident stress should not take place after the occurrence of a critical incident. I believe all nurses, including undergraduate nursing students, should recognize the potential for critical incident stress and be provided with the opportunity to prepare themselves for one or more incidents during their nursing career. Nurse educators might consider opportunities to integrate stress management concepts into various aspects of the undergraduate curriculum such as in simulated learning experiences, the classroom, and clinical setting. The meanings gained from this inquiry have informed my practice as a nurse educator. For example, I have altered my approach as a debriefing facilitator for student nurses who engage in potentially distressing simulated clinical experiences. Following these learning experiences, I have come to recognize the significance of asking students to ponder and elaborate on strategies and resources that may be employed to manage overwhelming clinical situations.

Simulated learning exercises that contain objectives related to self-care may be developed to provide students with an opportunity to reflect on personal strategies. Discussion following the simulation activity might include guidance in navigating university support systems, and consideration of health care institution services available to them upon graduation. The theoretical underpinnings associated with the concepts of stress, trauma, resilience, emotional awareness, and coping might be integrated into the classroom setting. Clinical instructors should be attentive to nursing students who have encountered potentially traumatic situations in the practice setting, and support them accordingly. This would require clinical instructors to have the necessary skills for

facilitating discussions with students in the post-conference learning environment. Offering trauma related professional development opportunities for all nursing faculty, including clinical instructors, would inform strategies used to support students and the integration of stress related concepts throughout the curriculum.

The Adventure and Danger of Hermeneutic Work

According to Gadamer (2007), understanding is an adventure and is dangerous, "all understanding, like action, always involves a risk" (p. 243). The adventurous nature of hermeneutic work lies in the potential to re-create and re-awaken a topic that has been taken-for-granted in the day-to-day shuffle of living. Although there are inherent strengths in using hermeneutics as a research practice and a way of seeing the world, Jardine (2016) offered a warning of the dangers in conducting this type of work. Hermeneutic work is "inevitably haunted by the ghosts of doubt, affliction, exhaustion, fear, and failing" (Jardine, 2016, p. 1). Reflecting on Jardine's warning I found myself contemplating the frustration I experienced in my pursuit of richer understandings of the topic. There were times of uncertainty as I navigated my way through the unfamiliar, the messy, the unknown, and the unstable. Hermeneutics asked something of me, a sacrifice in a sense, to give up the idea of a method or fixed foundation to reach a final conclusion or end point. Gadamer (1960/2013) said "the discovery of the true meaning of a text or a work of art is never finished; it is in fact an infinite process (p. 309). The endless nature of understanding limits the offering of final conclusions; this may be perceived as both a strength and limitation of hermeneutic work (Moules et al., 2015). The fusion of horizons I achieved in my interpretations is not fixed or fused as implied, rather will be de-fused, enticing re-interpretation. One of my prejudices was challenged as I initially assumed that

understanding with a hermeneutic lens would be a neat and tidy pursuit of knowledge. Engaging in the event of understanding is messy, windy, tumultuous, and turbulent. "Understanding is always restless, unquiet understanding" (Davey, 2006, p. 100). I have come to appreciate the complexity of hermeneutic work, the strengths and limitations, the beauty and the demons (Jardine, 2016).

Questions and Possibilities that Await Beyond the Fusion of Horizons

The meanings derived from this hermeneutic inquiry reflected a fusion of horizons. A fusion of horizons does not infer that I now fully understand this topic, as this would suggest finality. "It is enough to say we understand in a different way, if we understand at all" (Gadamer, 1960/2013, p. 307). Rather, in the midst of engaging in the event of understanding, the world presented itself in a way that generated deeper understanding of critical incident stress. The fusion of horizons or expanded insights derived from this inquiry creates possibilities for avenues of future research.

This study highlighted the importance of considering moral distress associated with aggressive measures in the ICU as a potential critical incident. In Chapter Four I articulated that moral distress encountered by ICU nurses had received considerable attention by researchers (Atashzadeh Shoorideh et al., 2015; Choe et al., 2015; Elpern et al., 2005; Henrich et al., 2017; Meltzer & Huckabay, 2004). More aligned with the topic, researchers have briefly noted moral distress as one of many examples perceived by nurses as a critical incident (Appleton, 1994; O'Connor & Jeavons, 2003). Among the research that has been reviewed, exploration into ICU nurses' experiences of critical incident stress as a result of morally distressing situations is lacking. The critical care setting is conducive to ethically challenging situations (Atashzadeh et al., 2015; Choe et

al., 2015; Henrich et al., 2017; Mealer et al., 2007; Meltzer & Huckabay, 2004) hence, additional research might specifically explore the meanings of ICU nurses' experiences of critical incident stress resulting from work-related moral distress.

I have proposed that the organizational and unit culture may influence an ICU nurse's response to a critical incident. Scholtz, Nel, Poggengpoel, and Myburgh (2016) conducted an ethnographic study to explore and describe the culture of critical care nurses (n = 13). This study validated unique social patterns of behaviors and interactions indicative of the existence of a distinct ICU nursing culture. Described in Chapter Two, Muller-Leonhardt et al. (2014) argued that the effectiveness of implementing a Critical Incident Stress Management (CISM) program in acute care settings was dependent on this organizational culture. More specifically, a culture that facilitated open communication and trust was found to be an important consideration in offering support to traumatized co-workers (Muller-Leonhardt et al., 2014). I propose further exploration into how the organizational culture influences ICU nurses' experience with critical incident stress may inform the strategies selected to support the staff in this setting.

Among the lengthy non-exhaustive list of potential signs and symptoms of work-related critical incident stress (Mitchell, 2012; Mitchell & Everly, 1997), a loss of role-identity has not been explicitly noted in the scholarly literature. This work has highlighted that an altered professional identity or loss of role identity may emerge as a temporary coping strategy, and for some nurses, may develop into a more permanent transformation with indeterminate effects. Understanding this temporary and more permanent transformation in the context of critical incident stress merits further consideration. Various participants from this inquiry experienced positive

transformations from critical incident stress. While nurses may be at risk for negative responses to critical incident stress, they may experience post-traumatic growth. The notion of post-traumatic growth in the context of nurses is understudied (Itzhaki et al., 2015). The few studies that have been conducted among nurses revealed that those working in areas commonly exposed to traumatic events such as patient death, experienced personal growth and increased meaning in life (Itzhaki et al., 2015; Lev-Wiesel, Goldblatt, Eisikovits, & Admi, 2009; Michael & Jenkins, 2001; Taubman-Ben-Ari & Weintroub, 2008). Future research that more fully explores the possibility of post-traumatic growth experienced by ICU nurses from a work-related critical incident would offer a more comprehensive understanding of the topic.

This hermeneutic work has validated the complex challenges of attempting to select the single most effective approach to receiving crisis intervention. The phrase "something simple, somebody right there" reinforced the importance of the right presence willing to bear witness to the suffering of another. A significant portion of the anecdotal and research based nursing literature continues to advocate for the implementation of CISM (Blacklock, 2012; Cudmore, 1998; Flannery et al., 1991; Jefferson & Northway, 1996; Kalain, 1999; Muller-Leonhardt et al., 2014; Oster & Doyle, 2000; Priebe & Thomas-Olson, 2013; Sacks et al., 2001; Smith et al., 2012; Wright & Casier, 1996) and Critical Incident Stress Debriefing (CISD) (Antai-Otong, 2001; Appleton et al., 2018; Burns & Harm, 1993; Dietz, 2009; Hammerle et al., 2017; Hanna & Romana, 2007; Hollister, 1996; Iacono, 2002; O'Connor & Jeavons, 2003; Sacks et al., 2001; Smith et al., 2012; Spizer & Burke, 1993). Exploring and evaluating the effectiveness of additional approaches, such as the principles of psychological first aid (PFA), that attend to

individualizing ICU nurses' needs is a gap at this point in time. How do we best support ICU nurses who have experienced critical incident stress? An inquiry that attends to this question may offer insight into the ambiguity that exists in defining effective and timely crisis interventions.

Moving Beyond the Fork in the Road

Two roads diverged in a wood, and I-

I took the one less traveled by,

And that has made all the difference.

Robert Frost (1874-1963)

Moules et al. (2015) proposed that "understanding is the ultimate hermeneutic wager: that understanding matters and will make a difference" (p. 196). Based on this proposal, I am hopeful that my returning to the fork in the road has enhanced understanding of critical incident stress in the context of ICU nursing and will make a difference. The interpretations that I have offered in this dissertation will resonate differently with those who engage in nursing work in the ICU setting. However, the beauty of hermeneutics is underpinned by its potential use of these varying perspectives to influence, inform, and unveil what has been out of sight. Gadamer stated that, "even if it must always be understood in different ways, it is still the same text presenting itself to us in these different ways" (Gadamer, 1960/2013, p. 416). Consistent with the notion of *aletheia* I am reminded that when something is opened, something else is inadvertently closed or hidden. The revealing of new understandings arrived with awareness of the limitations to hermeneutics. Understanding critical incident stress in the context of ICU nursing will remain vast and open to new possibilities. Despite this inquiry having

offered new horizons of understanding, there will always be aspects that remain obscured. “Certainly waking life is bright and open for everything-but then suddenly everything is covered over and hidden. Thus, we come again and again to the limit of all openness, a limit which always retreats once again” (Gadamer, 1995, p. 364).

My return to the fork in the road has created an opportunity for me to understand critical incident stress as it has been experienced by other ICU nurses. I realized that this return was different than my initial encounter because I was different. I had arrived with my historical being and prejudices that influenced my new and emerging understandings of the topic. I have come to see critical incident stress as more than a list of signs and symptoms that occurs in response to a critical incident. Critical incident stress as experienced by ICU nurses is deeply personal and intimate, nuanced and complex, fades with time and yet never completely goes away. I now move beyond the fork in the road and onto a path with new opportunities, new possibilities, new landscapes, expanding my horizon and self-understanding. Moving beyond the fork in the road means attending to my emerging curiosity of how to best support and prepare undergraduate students for the realities of clinical practice. This would include exploring the potential to better understand undergraduate nursing students’ experiences of critical incident stress encountered in the clinical setting. “When we are on this path we have the feeling that we are now headed in the right direction. The path under our feet becomes a way” (Gadamer, 1994, p. 114).

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Appendix A: Eligibility Requirements for Recruiting Participants

For RNs to be involved in this study, participants must:

- Be fluent in English;
- Be employed full time, part-time, or casual in one of the adult ICUs within Calgary;
- Have experienced a work-related critical incident defined as: sudden (Caine & Ter-Bagdasarian, 2003) traumatic event(s) that have the potential to overwhelm one's coping mechanisms resulting in distress and impairment of adaptive functioning (Everly & Mitchell, 2008);
- Have directly experienced or indirectly witnessed (seeing and/or hearing) a critical incident as an RN in an adult ICU setting;
- RNs who have untreated and/or unmanaged symptoms for Acute Stress Disorder and/or Post-Traumatic Stress Disorder will be ineligible to participate.

Appendix B: Recruitment Letter for ICU Participants

Dear Intensive Care Unit Registered Nurses,

We would like to invite you to participate in a research project. Giuliana Harvey, a doctoral student at the Faculty of Nursing, University of Calgary is examining work-related critical incident stress experienced by intensive care unit (ICU) registered nurses (RNs). A critical incident is a sudden (Caine & Ter-Bagdasarian, 2003) traumatic event that has the potential to overwhelm one's coping mechanisms resulting in distress and impairment of adaptive functioning (Everly & Mitchell, 2008). We are seeking RNs who have experienced a work-related critical incident in the ICU and are willing to voluntarily participate in an interview about their experiences. The results of this study have potential to more fully explain the impact of this type of stress encountered by ICU RNs, validate the significance of the topic to nurses' health and patients' well being, and create new possibilities for timely crisis interventions.

If you choose to participate in this study and meet the criteria for eligibility, Giuliana Harvey will arrange a time and location at your convenience to conduct the interview(s). At no time will your identity be disclosed and pseudonyms will be used to replace your name at all times. Please contact Giuliana Harvey or Dr. Dianne Tapp if you would be interested in participating in this study or if you would like further information.

Sincerely,

Giuliana Harvey RN, Doctoral Student, University of Calgary
Email:
Phone:

Dianne Tapp RN PhD
Professor, Faculty of Nursing, University of Calgary
Email:
Phone:

UNIVERSITY OF CALGARY

Appendix C: Inserts and Posters for Recruitment of Participants

TAKING A CLOSER LOOK AT CRITICAL INCIDENT STRESS EXPERIENCED BY ICU RNs

1. **Are you an RN who has experienced a work-related critical incident in the ICU?**

Critical incidents are sudden (Caine & Ter-Bagdasarian, 2003) traumatic events that have the potential to overwhelm one's coping mechanisms resulting in distress and impairment of adaptive functioning (Everly & Mitchell, 2008).

2. **Would you be willing to contribute to understanding critical incident stress experienced by ICU RNs?**

3. **Would you be willing to share your experiences with critical incident stress?**

If you have answered YES to these three questions **you may be eligible to participate in a research study being conducted by a University of Calgary Nursing Doctoral Student.**

Contact: Giuliana Harvey RN, Doctoral Student
Faculty of Nursing, University of Calgary
Email:

Ethics ID: REB16-1433
The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

UNIVERSITY OF CALGARY

Appendix D: Consent Form

TITLE: Understanding the Meaning of Critical Incident Stress Experienced by ICU RNs

INVESTIGATORS:

Dr. Dianne Tapp (Principle Investigator)
Phone:
Giuliana Harvey (Doctoral Student)
Phone:

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

BACKGROUND

Critical incident stress in the context of intensive care unit (ICU) registered nurses (RNs) is an area of focus that has been understudied. While the potential for critical incident stress exists in the ICU environment, how RNs in the ICU interpret these experiences and the meaning they derive from them is not well understood. A qualitative research inquiry will explore and develop further understanding of ICU RNs' experiences with critical incident stress. The results from this research have potential to more fully explain the impact of this type of stress encountered by ICU RNs, validate the significance of the topic to nurses' health and patients' well being, and create new possibilities for timely crisis interventions.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to explore what your experiences of critical incident stress within the ICU setting have been, and to understand more fully the meaning of these experiences.

WHAT WOULD I HAVE TO DO?

Your participation in this research will involve:

Attendance at one or two audiotaped interviews with the doctoral student. This interview will last from one to one and a half hours and will involve you and the interviewer. The doctoral student will arrange an interview time and location that is mutually agreed upon,

such as in your home or at the Faculty of Nursing, University of Calgary. You can stop this interview at any time, take a break and resume. Alternatively, you can stop the interview and withdraw from the research. In any event, there will be no penalty to you should you choose to withdrawal from this study.

WHAT ARE THE RISKS?

The purpose of this research is to more fully understand the meaning that ICU RNs derive from their experiences with critical incident stress. In our conversations, we expect to talk primarily about the experience of critical incident stress. However, we may also talk about related aspects of the topic such as support and crisis interventions, if you feel they are relevant.

There is a risk that these conversations may leave you feeling worse than before you participated. Although an attempt will be made to avoid you recalling explicit details of the critical incident, there is the possibility of being re-sensitized to the experience.

In the event that you feel you require support to overcome these feelings, you will be provided information to access a professional from the: Employee and Family Assistance Program or Eastside Family Centre. These services are free for you to access should you feel it is necessary.

WILL I BENEFIT IF I TAKE PART?

This study is not expected to have any direct benefit for you, however other people who have participated in this kind of research have said that talking about their experiences has been helpful and rewarding.

The information we get from this study may help us to understand more fully how ICU RNs understand and interpret their experiences. This is useful information for other ICU RNs, health care professionals, and the critical care organization as a whole in order to inform current crisis interventions.

DO I HAVE TO PARTICIPATE?

You are under no obligation to participate in this study.

Voluntariness and Withdrawal of consent

Your participation in this study is voluntary. You may withdraw from this study at any time without jeopardizing your relationship with Alberta Health Services and the University of Calgary. You may withdraw from the study in a number of ways:

- By contacting the principle investigator or doctoral student with your decision to withdraw;

- By not attending, or canceling, your interview appointment;
- By stopping an interview and advising the researcher that you cannot stay, wish to leave, and/or withdraw from the study.

In the event that you withdraw from the study, information from the interview will be destroyed and will not be used in the study.

WHAT ELSE DOES MY PARTICIPATION INVOLVE?

Data from the interviews and conversation transcripts will be used to describe possible understandings of critical incident stress for ICU RNs. The results of this study will first appear in the doctoral student's dissertation, with a strong likelihood that individual manuscripts will follow in relevant journals and/or presented at conferences afterwards. Pseudonyms will be used to protect your anonymity.

There are no additional obligations or responsibilities accompanying participation in this study.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

You will not be paid for participating in this study, nor will you incur any cost associated with your participation. Should interviews take place at the Faculty of Nursing, University of Calgary, you will be compensated for any parking costs.

WILL MY RECORDS BE KEPT PRIVATE?

Access to records about you will be restricted to: the principal investigator, the doctoral student, and the University of Calgary Conjoint Research Ethics Board. All personal information and contact details will be securely kept on a password protected computer dedicated specifically to this study.

The interviews recorded on audiotapes will later be transcribed into written text. At no time will your identity be disclosed and a pseudonym will be assigned to replace your name at all times. All research data will be stored in a locked filing cabinet in the secure office of the principal investigator at the University of Calgary. Although every effort will be made to preserve confidentiality, complete anonymity cannot be guaranteed.

IF I SUFFER A RESEARCH-RELATED INJURY, WILL I BE COMPENSATED?

In the event that you suffer injury as a result of participating in this research, no compensation will be provided to you by the University of Calgary, Alberta Health Services or the Researchers. You still have all your legal rights. Nothing said in this consent form alters your right to seek damages.

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a participant. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. If you have further questions concerning matters related to this research, please contact:

Dr. Dianne Tapp
or
Giuliana Harvey

If you have any questions concerning your rights as a possible participant in this research, please contact the Chair, Conjoint Health Research Ethics Board, University of Calgary at 403-220-7990.

Participant's Name	Signature and Date
Investigator/Delegate's Name	Signature and Date
Witness' Name	Signature and Date

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

A signed copy of this consent form has been given to you to keep for your records and reference.