A Master's Thesis:
A Narrative Inquiry into the Experiences of Trauma-Informed Care with
Nurses Working in Rural Acute Care Settings

by

Stephanie Wright
B.Sc., University of Ottawa, 2006

A thesis submitted in partial fulfillment of the Requirements for the Degree of

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We acknowledge and respect the lək̓ʷəŋən (Songhees and Esquimalt) Peoples on whose territory the university stands, and the lək̓ʷəŋən and W̱SÁNEĆ Peoples whose historical relationships with the land continue to this day.

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## Abstract

Principles of trauma-informed care are strongly aligned with nursing ethics, professional standards, and human rights and provide a framework for safe, compassionate, person-centred care. Additionally, trauma-informed care promotes emotional safety, patient engagement and empowerment, and treatment adherence, leading to improved health outcomes. Trauma-informed care also draws attention to recognizing vicarious trauma. Research suggests that rural nurses' limited knowledge and education challenge incorporating trauma-informed care into practice in rural healthcare settings. In this narrative inquiry I explore the experiences of nurses in relation to trauma in rural acute care settings. Narrative inquiry helps to better understand how nurses' personal, practical, social, and institutional stories impact care delivery related to trauma-informed care, including vicarious trauma. I engaged with two nurses, Veronica and Barb, in three to four 1-hour conversations across 2 to 3 months. The conversations were recorded and transcribed verbatim. Transcriptions and field notes, including personal observations and reflections, formed the narrative accounts and were analyzed for resonant threads. Two threads were made visible: a) Learning to name trauma: the absence of language, turning to metaphor, and attending to embodiment, and b) Disrupting dominant stories of trauma-informed care: balancing personal and professional boundaries, and exploring the complexities of rural environments. This study has the potential to inform organizational policies, resources, and educational efforts to address trauma. It could enhance nurse retention and create innovative ways to support quality in patient-centred care, improve patient outcomes, and empower nurses and patients working with trauma.



*Keywords:* Trauma-informed care, narrative inquiry, vicarious trauma, rural nursing

## Table of Contents

Supervisory Committee ..... ii
Abstract ..... iii
Table of Contents ..... iv
List of Abbreviations ..... vi
Acknowledgements ..... vii
Dedication ..... viii
Chapter 1: Narrative Beginnings ..... 1
Chapter 2: What is Known? ..... 6
  Trauma-Informed Care in Rural Nursing ..... 6
    What is Trauma? ..... 7
    Trauma-Informed Care ..... 9
    Vicarious Trauma ..... 11
    Understanding Trauma: Nurses' Knowledge, Attitudes, and Competency ..... 13
    The Way Forward ..... 14
Chapter 3: Methodology and Methods ..... 17
  Methodology ..... 17
    What is Narrative Inquiry? Why Narrative Inquiry? ..... 18
    Ontological and Epistemological Underpinnings ..... 19
    World Travelling ..... 20
    Participants ..... 21
    Field Texts ..... 22
    From Field Texts to Final Research Texts ..... 23
  Ethical Considerations ..... 24
    Relational Ethics ..... 25
  Coming to the Field ..... 26
Chapter 4: Narrative Account for Veronica ..... 28
  Coming to Understand TIC ..... 28
  Turning to the Context of Rural Nursing ..... 34
  Recognizing Trauma in Yourself ..... 41
Chapter 5: Narrative Account for Barb ..... 49
  Coming to Understand Trauma-Informed Care ..... 49
  Turning to the Context of Rural Nursing ..... 56
  Recognizing Trauma in Yourself ..... 63
Chapter 6: Publication (to be submitted to the Canadian Journal of Nursing Research) ..... 73
Abstract ..... 74
Disrupting Dominant Stories of Trauma: A Narrative Inquiry into the Experiences of Nurses Working in a Rural Setting in Western Canada ..... 75
  Trauma-Informed Care in Rural Nursing ..... 76
    Trauma-Informed Care ..... 77
    Vicarious Trauma ..... 77
    Understanding Trauma: Nurses' Knowledge, Attitudes, and Competency ..... 78
  Methodology, Methods, and Procedures ..... 79
    Setting and Sample ..... 80
    Data Collection and Analysis ..... 81

Narrative Accounts: Meeting Veronica and Barb ........ 82
Coming to Know Veronica ........ 82
Coming to Know Barb ........ 84
Resonant Threads ........ 87
Resonant Thread: Learning to Name Trauma ........ 87
The Absence of Language ........ 88
Turning to Metaphors ........ 89
Attending to Embodiment ........ 91
Resonant Thread: Disrupting Dominant Stories ........ 93
Balancing Personal and Professional Relationships ........ 93
Exploring the Complexities of Rural Environments ........ 95
Lack of Resources. ........ 95
Safety and Security. ........ 96
Discussion: Implications for Rural Contexts ........ 97
Limitations ........ 99
Conclusion ........ 99
References ........ 101
Chapter 7: Contemplating the Significance ........ 104
Taking a Reflective Turn ........ 104
Attending in New Ways ........ 107
Conclusion ........ 110
References ........ 112
Appendix A Research Poster ........ 117
Appendix B HSD Graduate Student Research Award 2023 Proposed Budget ........ 118
Appendix C Guiding Questions ........ 119
Appendix D Ethics Approval ........ 120
Appendix E Information Letter and Consent Form ........ 121
Appendix F Wellness Support Card ........ 124

## List of Abbreviations

| Abbreviation | Unabbreviated |
|---|---|
| CCOT | Critical Care Outreach Team |
| CNA | Canadian Nurses Association |
| HSD | Human and Social Development |
| ICU | Intensive Care Unit |
| IV | Intravenous |
| RT | Respiratory Therapist |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| TIC | Trauma-Informed Care |
| UBC | University of British Columbia |
| VCH | Vancouver Coastal Health |

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## Dedication

To nurses. The vital role you play every day is inspiring. Your strength, courage, and compassion are truly remarkable. Most importantly, your experience matters. I see you, I hear you, and I value your contributions immensely.

# Chapter 1: Narrative Beginnings

As a nurse, I have witnessed trauma in its physical, emotional, and psychological forms regularly. Trauma is a part of the job. It is something that affects almost every one of the patients I have cared for in one way, shape, or form. For a long time, it was easy for me to keep these patient experiences at a distance as part of their diagnosis and to care for them with empathy and skill, separate from my own life. Nevertheless, trauma does not discriminate. I learned that it has a way of showing up when I was least prepared and in ways I least expected. I also learned that trauma leaves a lasting mark and can change the way one experiences the world.

I began to recognize trauma affecting me differently when I moved away from the city, adding a lengthy commute to my long 12-hour shifts as a critical care nurse in the Intensive Care Unit (ICU). Instead of the 10-minute walk to my apartment a few blocks from the hospital, where I would pour a glass of wine and turn on the television to turn off the day, I now had long periods of quiet time. Time for the events of the shift to be played, replayed, and analyzed in my mind. During these drives, I would sometimes think about what I could have done differently or what I would make sure to address the next day. Sometimes, I felt satisfied for having made some slight difference that might have mattered to someone. Over time, I noticed that I started to become troubled by the traumatic events or situations I witnessed each shift as the days replayed in my mind during the commute. I no longer had a quick exit or distraction from my thoughts, but a quiet place to sit in the discomfort that came from reliving experiences most people will never have to encounter. I was jolted into this reality as I drove home along the long, winding highway after a shift in the ICU and reflected on a day I do not think I will ever forget.

On this day, I was the critical care outreach team (CCOT) nurse, a role in which I held great pride. The CCOT is an on-call rapid response and early intervention team providing

support to staff and patients on general wards within the hospital in the event of patient deterioration. Typically, the ward nurses call when concerned about their patients, need help with an unfamiliar skill, or require assistance caring for a deteriorating patient. I was called by a nurse in the acute medical ward for a patient whose blood pressure was dangerously low and presenting with a presumed upper gastrointestinal bleed. It was apparent that this patient needed to be seen immediately, so I grabbed my bag of supplies, exited the doors of the ICU, and headed up the elevator to the ninth floor of the hospital. When I stepped onto the ward, I was led to the patient's room by the nurse who had called me. I found a cachectic, 26-year-old, Indigenous patient vomiting copious amounts of blood into a small paper tray. Presumably, the bleeding was caused by ruptured esophageal varices related to his end-stage liver failure. He was alone, frightened, and dying before my eyes. I quickly introduced myself to the patient and told him I was there to help, as I unclamped the intravenous (IV) tubing and squeezed the bag of saline solution hanging from a pole bedside his bed to force the fluids into his depleted veins. I reached for the IV supplies to insert a second line into his black, blue, and jaundiced arm. I instructed the bedside nurse to call for more blood products and to notify the ICU team immediately. The ICU team arrived within moments, and it was not long before he was transferred to the ICU for acute and critical management of his life-threatening bleeding. I handed over all I knew about the patient to the ICU nurse taking over his care and apologized for the mess as if it were my fault. I excused myself to change out of my blood-stained scrubs and into a clean set to carry on with the rest of my shift.

Moments later, standing in my fresh scrubs and ready to take a quick break to reset, my pager beeped again. There was time enough for a sip of water and a nod to the charge nurse, indicating the patient from upstairs was getting settled, and that I was off again. This time, the

call took me to the psychiatric ward. I rushed down the long hallways of the underground tunnel system and arrived at the mental health services building. I was greeted by panicked staff who ushered me down the corridor. I immediately caught the familiar, metallic scent of blood. The nurse guided me right, and then left, and into a room with blood-streaked floors and walls. The report I received upon entering the room was that a 19-year-old patient had taken a razor blade into the bathroom and cut herself. As she watched the blood pour from her wrist, she became light-headed. She stepped back and slipped on the blood that had dripped onto the floor, hitting her head on the sink, and sustaining a sizable laceration on her forehead. I helped another nurse and care aide get the patient safely into her bed where we could better assess her injuries. Fortunately, her injuries were not life-threatening. As I bandaged her wrist and the open wound on her forehead, I awkwardly asked about her day and what had led to turning to hurt herself. She was sad, and life just felt like too much. I had no words of encouragement for her, still overwhelmed by the situation myself but knowing this was the hardest day for her, I nodded and held her hand. The psychiatrist would soon be in to assess her. I thanked the nurses on the ward, completed my paperwork, and returned to the main hospital to take my lunch break.

On my return to the ICU, I updated the charge nurse, who then notified me that a patient with severe burns would be admitted in the next hour. It was a good time to make sure I got a break in before I would have to help with their admission. I secretly hoped my shift would end before the patient arrived, knowing I would have to be ready either way.

Fueled by a constant stream of adrenaline throughout the day, it was not until my drive home that the events of that day began to sink in. I thought about how traumatizing those experiences must have been for the patients. I wondered if I did enough to help them in those moments. Did I care enough? Did I make them feel safe? Could I have done more? The

adrenaline in my body continued to swirl and spin my thoughts. I could not contain my grief and exhaustion as I entered the doors of my house. I unleashed the flood of tears I had held back as I replayed the day in my mind. Unable to explain what was wrong to my partner through uncontrollable sobs and in words he would understand, he stood firm and held me, feeling helpless.

Reflecting on these experiences, I now see how I was driven not only to fulfill the patient's immediate needs but also to uphold the system requirements—to respond to the next call, to facilitate a critical transfer, and to be ready for whatever came next. Though hard to admit, I did not stop to consider how this hospital experience may be traumatizing for the patients involved at that moment—the stigmas of mental health, the historical traumas of the Indigenous peoples, or the potential for personal triggers and other intersectional considerations. I did not stop to consider how it was affecting me. I think about this now as I have stepped into roles that are further away from the bedside and have provided me with the perspective one gains with distance. This was but one day in my life as a nurse. Many similar stories from years of point-of-care nursing practice live on the shelves of my mind. They sometimes resurface in conversations with friends and colleagues, cloaked in the dark humour we know so well as healthcare practitioners: a seasoned, unconscious effort to make light of a "day at the office." Sometimes, I am triggered unexpectedly by events or people that intersect with my practice or home life. I have, at times, become withdrawn, numb, and distant to patients; protecting what little reserve I have left to keep myself from crumbling under the pressures of life, in and out of work. I have been irritable with family and friends who needed too much of my limited compassion stores. I have spent time distracting myself by overdoing healthy and not-so-healthy activities to avoid facing the fact that the profession I chose has become the thing that is wearing

me down most. I recognize these now as trauma responses from years of exposure to direct and indirect trauma that I have experienced in the workplace. These experiences are a part of who I am now. I cannot unsee the things I have seen; they affect how I see the world. They sometimes affect how I interact with it.

Trauma is inescapable in healthcare. With a commitment to person-centred care and respectful, therapeutic relationships, a nurse's work is caring and relational. We cannot separate the trauma of patients and the trauma of nurses. Trauma-informed care is highlighted in so much of the work in healthcare, and I wonder how well this approach is applied in fast-paced, intense, and diverse environments. Thinking of my own experiences has led me to ask many questions about how trauma-informed approaches live in nursing practice. How could a conscious awareness and understanding of trauma-informed care have affected my patient interactions and their healthcare experiences? How do nurses recognize trauma in their practice? How do they cope with trauma? How does their understanding of trauma relate to nurses' relationships with their patients? How does trauma affect nursing retention? How does trauma-informed care play out in practice? These are some of the questions that form my research puzzle. As I explore the application of trauma-informed practice, I will engage in narrative inquiry to stay within the nurses' experience through story, over time, and in the context of their environments.

## Chapter 2: What is Known?

In this research study I inquire narratively into nurses' experiences as they practice trauma-informed care in rural acute care settings. Narrative inquiry explores experiences through relational storytelling with attention to the dimensions of time, personal and social interactions, and place to understand context and meaning (Clandinin, 2013; Clandinin & Connelly, 2000). This research will allow us to understand better how nurses' personal, practical, social, and institutional stories impact care delivery related to trauma, including vicarious trauma (Caine et al., 2022).

### Trauma-Informed Care in Rural Nursing

Trauma-informed care has become a widely used term in healthcare. The Substance Abuse and Mental Health Services Administration (SAMHSA) (2014) has characterized trauma-informed care as understanding the prevalence of trauma, distinguishing the signs and symptoms of traumatic stress, and responding with combined knowledge and skills to prevent re-traumatization or reliving of previous trauma. The principles of trauma-informed care strongly align with nursing ethics, professional standards, and human rights, guiding nurses to provide safe, compassionate, unbiased, person-centred care. By incorporating the principles of trauma-informed care into policy and practice, safe environments foster patient engagement, increase treatment adherence, and promote health equity that will ultimately improve health outcomes for communities (Dowdell & Speck, 2022; Fleishman et al., 2019; Zordan et al., 2022). Knowledge and access to trauma-informed care resources are not equally distributed; Ervin et al. (2021) found that 70% of healthcare staff in rural healthcare settings reported needing more knowledge and education related to trauma-informed care. This statistic is concerning considering rural

communities' unique challenges, such as limited access to healthcare resources, cultural diversity, and geographical isolation.

In the past year, I had the opportunity to participate in a knowledge translation pilot project for nurses related to trauma-informed care at the rural practice site where I work. The education was provided in a workshop format outside of the hospital grounds. Throughout this workshop and the group discussions, I learned that nurses were familiar with the term 'trauma-informed care' but needed to learn about the core values and the ethical importance of integrating this practice into care. I noticed that they seemed unaware of how the traumatic experiences of others can lead to moral residue, trigger symptoms of traumatic stress, and affect their well-being and ability to provide quality nursing care. While nurses have ample opportunity to put trauma-informed approaches into practice, there is a gap in education and training that could effectively help rural nurses engage in knowledge mobilization for trauma-informed care.

***What is Trauma?***

Trauma is a universal experience not confined to geographical boundaries and does not discriminate based on race, ethnicity, socioeconomic status, career, age, gender or sexual orientation (SAMHSA, 2014). Trauma responses manifest in unique and various ways depending on the individual, environment, and situation (Marks et al., 2022). It is estimated that approximately 70% of the world's population has experienced a traumatic event on at least one occasion (SAMHSA, 2014). While the definition of trauma varies in the literature, SAMHSA (2023) offers a comprehensive explanation based on the *Three E's* of trauma: Event, Experiences, and Effects. They explain that "trauma results from an event, series of events, or a set of circumstances that an individual experiences as physically or emotionally harmful or life-threatening and that may have lasting adverse effects on the individual's functioning and mental,

physical, social, emotional, or spiritual well-being" (SAMHSA, 2023, p. 2).Trauma triggers the brain to release high levels of cortisol and norepinephrine to switch into survival mode, functioning to serve fight, flight or freeze responses instead of preserving the executive functions that regulate experiences and can create disturbances in memory, planning, focusing, decision-making, and learning (Clark, 2023; Dowdell & Speck, 2022; Fleishman et al., 2019; Marks et al., 2022). Van der Kolk (2014) claimed the essence of trauma is dissociation, in which the physical, emotional, and sensory experience of the trauma is separated from reality and stored in memory as fragments of the event(s) to be relived in unpredictable and uncontrollable ways if left unresolved. Unresolved trauma causes continuous circulation of the body's protective stress hormones that can cause the replaying of defensive and emotional responses (van der Kolk, 2014). As the elements of trauma are replayed, the stress hormones act to engrave traumatic memories deeper into the mind (van der Kolk, 2014). The trauma response affects the neurobiology of the amygdala, hippocampus, and pre-frontal cortex, resulting in lasting changes to memory and brain function (Dowdell & Speck, 2022; van der Kolk, 2014). Victims of trauma may be subject to nightmares, flashbacks, mood disturbances, and hypervigilance or reactivity, and in the absence of adequate coping, can lead to substance use, depression, anxiety, and withdrawal (Clark, 2023; Lewis et al., 2019).

While traumatic experiences are not limited to specific populations, those most vulnerable to long-lasting effects have often experienced traumatic stressors such as homelessness and violence or are structurally marginalized due to race, ethnicity, sexual or gender diversity, and face inequities in access to the social determinants of health (Browne et al., 2012; Zordan et al., 2022). This vulnerability can increase someone's risk for re-traumatization, in which interaction, experience, or environmental cues trigger memories, thoughts, or emotions

related to a traumatic experience, causing traumatic stress symptoms to resurface (Schippert et al., 2021). Risks for the re-traumatization of individuals accessing health services are exacerbated by fear associated with the environment, discomfort with medical procedures, use of restraints, previous negative interactions, and experiences of judgment or invalidation, all of which can be reminders of previous trauma (Dowdell & Speck, 2022; Schimmels & Cunningham, 2021; Schippert et al., 2021; Zordan et al., 2022). For these reasons, nurses must be aware of the potential for re-traumatization and understand the signs and symptoms of trauma to avoid triggering patient responses through their words, silences, or actions. There is a need to understand the intersectional ways trauma affects nurse-patient interactions and health outcomes and how using trauma-informed approaches can foster safe, ethical, and compassionate care.

### ***Trauma-Informed Care***

A trauma-informed approach to patient care encompasses respect for human rights and patient dignity. It is connected to the foundations of nursing ethics to provide safe and compassionate care, free of judgment (Dowdell & Speck, 2022). Trauma-informed care is a concept that assists nurses in acknowledging the importance of a patient's lived experiences. It provides a framework for care delivery that encompasses knowledge and understanding of how trauma can impact a patient's mental, physical, and emotional well-being, identifies signs and symptoms of traumatic stress, and guides practice for a safe, empathetic, and respectful approach that resists re-traumatization (Dowdell & Speck, 2022; Ervin et al., 2021). While the initial focus of trauma-informed care is recognizing trauma, the basis of the practice is grounded in building connections to acknowledge the brain and body's response to trauma and working toward supportive healing (Schimmels & Cunningham, 2021).

SAMHSA (2014) explained the concept of a trauma-informed approach as grounded in four assumptions and six fundamental principles. Guiding with four assumptions: realization, recognition, response, and resisting re-traumatization, SAMHSA (2014) posits:

> [a] program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to resist re-traumatization actively. (p. 9)

The six key principles for a trauma-informed approach are as follows:

Safety: Ensures the patient's physical and psychological safety is respected. Respect for safety involves creating safe and supportive environments that reduce re-traumatization risk.

Trustworthiness and transparency: Establishing trusting relationships and being transparent about the process, decisions, and expectations limits feelings of powerlessness.

Peer support: Engagement with others who have experienced trauma can be healing, minimize feelings of isolation, and promote collaboration toward recovery.

Collaboration and mutuality: Meaningful relationships that level the power dynamic and create a partnership between nurse and patient that respects each person's role in the trauma-informed approach.

Empowerment, voice, and choice: Encouraging patients to advocate for themselves and recognize the importance of the individual guiding their care, focusing on strengths-based approach.

Cultural, historical, and gender issues: Understanding how culture, history, and individual backgrounds shape their experience of trauma and how this provides the opportunity to tailor care and supportive interventions.

These principles align with the ethics of care and professional nursing practice standards. They are used to assist in guiding safe, compassionate, and ethical care to minimize the adverse effects of trauma and re-traumatization.

***Vicarious Trauma***

Nurses are vulnerable to the impacts of trauma. Over time, the effects of repeated empathetic engagement with traumatized patients and indirect exposure to trauma can negatively influence a nurse's psychological wellness (Isobel & Thomas, 2022). These experiences can leave nurses with lingering emotional effects from situations that have been morally distressing and have left lasting impressions on thoughts and feelings that are carried on over time (Canadian Nurses Association [CNA], 2017). More severely, these feelings can manifest and, over time, develop into a type of traumatic stress called vicarious trauma (Isobel & Thomas, 2022; Tabor, 2011). A term initially identified in trauma therapists by McCann and Pearlman (1990), vicarious trauma refers to the experience of developing traumatic responses as a result of exposure to the trauma experienced by others (Isobel & Thomas, 2022).

Rural nurses are vulnerable to experiencing vicarious trauma due to the high frequency of repeated exposure to stories of trauma and abuse, lack of resources, geographical isolation, community cultural diversity, limited debriefing opportunities, and limited onsite psychological support (Jahner et al., 2022). Patients are also members of the community that nurses are a part of in their ordinary lives. Patients and nurses' shop at the same grocery store or find their mail at the same post office; they have children who go to the same schools and play in the same

playgrounds. So, when traumatic events arise in a rural community hospital, there is potential for a more intimate impact on the nurses than in urban centers.

The CNA *Code of Ethics* (2017) outlines a nurse's ethical responsibility to maintain accountability for their practice, including maintaining fitness to practice. Nurses are accountable for their awareness of their physical, emotional, and mental capacity to provide safe and competent care and must withdraw themselves if unable to do so (CNA, 2017). The cumulative exposure to caring for those who have survived traumatic events can affect job performance, morale, behaviour, personal and professional relationships, and communication, and symptoms have been shown to parallel those of post-traumatic stress disorder, causing shifts in world views and beliefs, altering self-esteem, and emotional and psychological health (Tabor, 2011). Jahner et al. (2022) suggested that vicarious trauma is an occupational health and safety risk to the mental health of rural nurses and that this phenomenon creates negative repercussions and risks for patient safety. Without recognition and understanding of this phenomenon, both nurse and patient suffer. Fleishman et al. (2019) stated, "implementation of TIC [trauma-informed care] is much like putting on an oxygen mask in an airplane. You must first put on your mask before assisting others. If nurses do not care for themselves, they will not be able to properly care for patients" (p. 9). A critical part of trauma-informed care is to practice self-reflection and reflexivity to understand how personal history and trauma can potentially influence the quality of patient care. Recognizing vicarious trauma is an essential component of trauma-informed care that requires awareness, acknowledgment, and support to promote both nurse and patient well-being.

### *Understanding Trauma: Nurses' Knowledge, Attitudes, and Competency*

Nurses are at the forefront of healthcare and perfectly positioned to influence healthcare experiences with a trauma-informed approach to promote health equity, quality patient care, and positive work environments. As nursing moves toward technology-driven, standardized care models and quantifiable patient results, it is becoming more difficult for nurses to engage in therapeutic and trusting relationships that exemplify principles of trauma-informed care (Schimmels & Cunningham, 2021; Stokes et al., 2017). Schimmels and Cunningham (2021) claimed that education and support for trauma-informed care are essential to provoke a cultural shift from task-focused care to care based on trust and avoidance of re-traumatization of both patients and staff. Unfortunately, practical education, awareness, and effective training for trauma-informed care are lacking based on my experience. In their study exploring nurses understanding and experiences of trauma-informed care, Stokes et al. (2017) found that most nurses still need formal education for trauma-informed care as part of their nursing education. Additionally, Bruce et al. (2018) listed time constraints, lack of training, unclear information, and concern for re-traumatizing patients as barriers to providing trauma-informed care in the clinical setting, further highlighting a need for education, training, and organizational changes.

There is limited research related to trauma and trauma-informed care specific to rural nursing practice in Canada. A systematic review completed by Jahner et al. (2019) confirmed a paucity of research on trauma and rural nursing practice in all of North America, stating that most research originates in Australia and Tasmania. However, within the limited research there are valuable insights that indicate opportunity for further investigation into rural nursing and trauma-informed care. A study by Ervin et al. (2021) examined the knowledge, attitudes, awareness, practice, confidence and competence of staff related to trauma in three rural health

clinics in Australia. While the study included clinical and non-clinical participants, about 60% were nurses. Most participants (70%) reported that they needed to become more familiar with the principles of trauma-informed care and did not have experience applying principles to practice; a large proportion of participants in the study reported an interest in receiving more trauma-informed care training.

As previously stated, my experience in rural practice has highlighted a knowledge gap around trauma-informed care related to the lack of training and organizational support to effectively provide nurses with the foundational knowledge and skills to provide a trauma-informed approach. The unpreparedness of rural nurses to provide trauma-informed care puts patients in rural communities at risk for poor health outcomes as patients may avoid accessing services that may exacerbate or reignite previous trauma. Furthermore, recognizing the risk and supporting vicarious trauma is essential to protect the well-being of rural nurses to enable them to provide quality patient care.

***The Way Forward***

For trauma-informed care to be fully embedded into rural healthcare practices, all levels of the organization will have to play a part in shifting the culture toward ensuring rural healthcare policies and practices support nursing practice grounded in the principles of trauma-informed care. As I embarked on this journey of narrative inquiry, reflecting on the literature findings and my own experiences, I wondered if some of these recommendations would come forward as I inquired into nurses' experiences.

Nurses as individuals can positively influence a patient's healthcare experience by applying principles of trauma-informed care into their everyday practice. Small gestures and acts of kindness can make a big difference in creating a safe space to accept care and prevent re-

traumatization. Applying trauma-informed care practices as a universal precaution can limit the risk of re-traumatizing someone who carries trauma with them (Ervin et al., 2021). Beyond knowing how to recognize signs and symptoms of traumatic stress, simply asking for permission to assess and follow a patient-centred plan, adjusting body language or tone of voice to minimize the inherent power dynamic, being honest and transparent about the treatment plan, and avoiding the use of mechanical or chemical restraints are some ways nurses can make micro level changes to ensure compassionate and ethical care.

Education is essential for nurses to become competent in providing a trauma-informed approach. My experience at a trauma-informed practice workshop highlighted the need for effective clinical education initiatives around trauma-informed practice for rural nurses. Without this vital education, nurses and their patients suffer. From an organizational level, advanced practice nurses, educators and leaders can work collaboratively to apply frameworks for trauma-informed approaches to address the specific needs in rural acute care settings. Frameworks will guide the integration of research, practice knowledge, interventions, and lessons from the lived experiences of trauma survivors and help nurses create and implement education strategies, policies, and resources from a trauma-informed lens (SAMHSA, 2014). Organizations also need to recognize the unique qualities that contribute to vicarious trauma for rural nurses and provide appropriate opportunities for support. Such supports could include formal and informal debriefing, providing strategies for healthy coping, peer support services, and attention to maintaining healthy work environments.

Ethical practices in healthcare systems need to be implemented within all levels of organizations to create systems of safety, equity, justice, and accessibility that incorporate each site's unique needs within health authorities. Significant systemic change can be promoted

through advocacy for evidence-based, ethically informed, and collaboratively created policies. These policies should move the system toward a trauma-informed culture and a belief system that promises health equity and fair resource allocation to serve populations in all corners of the province.

# Chapter 3: Methodology and Methods

Trauma-informed care is vital to ethical nursing care in rural communities. Implementing trauma-informed care principles in rural nursing practice can improve patient outcomes, enhance nurse-patient relationships, and create a more compassionate and supportive healthcare environment. Trauma-informed approaches positively impact the lives of patients who have experienced trauma and contribute to resilience and healthier rural communities. Additionally, by addressing vicarious trauma and prioritizing the well-being of rural nurses, healthcare organizations can create a supportive, resilient workforce that is better equipped to provide quality care to patients. Recognizing that trauma-informed care can be promoted in all areas of healthcare and tightly linked to ethical care, I have outlined a knowledge gap related to my experiences and the existing literature. My research puzzle highlights the need to inquire into nurses' experiences to understand better how to provide education, collaboration, organizational shifts, and sensitivity to the unique challenges of rural settings for nurses' engaging in trauma-informed care.

## Methodology

Nursing requires an interplay of dynamic relationships between patients, environment, and context to maintain person-centred care and foster therapeutic relationships. A trauma-informed approach contributes to quality patient care, yet nurses must be more familiar with and understand the principles of trauma-informed care and its translation to practice (Stokes et al., 2017). This narrative inquiry provides a rich and in-depth study into how trauma is understood and applied in practice over time within the unique context of rural acute care settings; it provides opportunities for education initiatives and mobilization of knowledge relevant to everyday nursing care within rural settings. Rural settings are complex environments where

multilayered contexts, diverse patient populations, and community integration play critical roles in how trauma-informed healthcare is delivered and taken up.

***What is Narrative Inquiry? Why Narrative Inquiry?***

Narrative inquiry is a relational approach that explores and understands the stories participants tell and live to gain insight into their experiences, perspectives, and meanings attributed to those experiences within social, cultural and institutional contexts (Clandinin & Rosiek, 2007). According to Clandinin and Rosiek (2007), narrative inquiry "is a way of honouring lived experience as a source of important knowledge and understanding" (p. 42). The researcher and participant work collaboratively to inquire into experiences within a three-dimensional framework of temporality, sociality, and place (Clandinin, 2013; Clandinin & Caine, 2013; Clandinin & Rosiek, 2007). With attention to the past, present, and future, social interactions, and location, experience is understood with rich, contextual meaning (Clandinin & Connelly, 2000).

Narrative inquiry upholds justification for the study in three ways: personally, practically, and socially (Caine et al., 2022). These justifications will answer the "so what?" and "who cares?" questions at the start of the inquiry, as well as throughout the inquiry, and consider this in the composition of interim and final research texts (Clandinin & Caine, 2013). Personal justification positions the researcher within the phenomenon of interest (Clandinin & Caine, 2013). My narrative beginnings make visible my experiences and positionality in relation to the participants and the phenomena under study. Practical justification considers how nurses' experiences providing trauma-informed care in rural settings inform insights into social, institutional, and community contexts that shape patient care delivery. Finally, social/theoretical justification shows that rural nurses' valuable knowledge and experiences can contribute to

policy development, social justice, and equity (Clandinin & Caine, 2013). By understanding rural nurses' experiences and the contexts in which they work, the necessary education, support, and organizational change can be made to advance the practice of trauma-informed care.

Clandinin and Caine (2013) outlined 12 key touchstones for a narrative inquiry; these include relational responsibility, being in the midst, negotiation of relationships, narrative beginnings, negotiating entry to the field, moving from field to field text, moving from field texts to interim and final research texts, representing narratives of experience in ways that show temporality, sociality, and place, relational response community, justifications—personal, practical, and social, attentive to audience, and a commitment to understanding lives in motion. While each touchstone is significant, I will discuss some in greater depth.

### ***Ontological and Epistemological Underpinnings***

As I embark on this journey to explore the experiences of trauma and trauma-informed care, I understand that each experience of trauma is unique and contextual. As experience is central to narrative inquiry, the methodology is in keeping with Dewey's pragmatist philosophy (1938), accentuating the importance of continuity and the dynamic relationship between the individual and their environment (Clandinin & Rosiek, 2007). Experience is viewed as transactional and ever-changing, with each experience providing context for the next (Clandinin & Rosiek, 2007). Building on Dewey's conception of experience as continuous and interactional, the ontology of narrative inquiry embraces this as the criteria forming the basis for the three-dimensional narrative inquiry space: temporality, sociality, and place. It holds that experience will be explored with attention to how the past, present, and future, social interactions, and location provide richness, context, and meaning (Clandinin & Connelly, 2000). This approach

values the richness of individual stories and offers the opportunity to reveal the diverse ways nurses make sense of their lives at work.

Narrative inquiry highlights a commitment to understanding subjective experiences, the socially constructed nature of reality, and the importance of context and relationships in knowledge creation. This approach values the richness of individual stories and seeks to uncover the diverse ways nurses make sense of their lives at work. As I think of experience in these ways and as transactional and ever-changing, I continue to wonder how repeated exposure to trauma shapes nurses' knowledge, perceptions, and interactions with the world around them.

### ***World Travelling***

Nursing often feels like a small world with unique dynamics and connections characterized by strong bonds, shared experiences, and a sense of community. As a fellow nurse, I am aware that while I may have some shared understanding of the nature of the work with participants, we come from different worlds moulded by our own personal and professional experiences accumulated throughout our lives. Lugones (1987) proposed that by "travelling to someone's 'world,' we can understand what it is to be them and what it is to be ourselves in their eyes" (p. 17). Positioned as a researcher, I entered the participant's worlds with ease as a *fluent speaker* (Lugones, 1987) of nursing language and connected by similar professional awareness, but I cannot assume knowing of the nurses' experience without travelling to their worlds to enable my understanding of their experiences integrating trauma-informed care within their rural practice settings. As I engaged in narrative inquiry, I wove multiple worlds together to shape new understandings, knowledge, and relationships as we travelled together with loving perception that allowed for openness, curiosity, and freedom from judgment (Lugones, 1987).

### *Participants*

The participants for this study were employed nurses with a minimum of 1 years' experience in rural nursing. For this inquiry, the participants required a minimum of 1 year of experience working in rural acute care to ensure experiential knowledge and clinical experience in the practice setting. Participants were not required to have knowledge or training in trauma-informed care as this study aims to explore their current understanding of the concept and experiences with trauma.

Two nurses were recruited for this study from a 20-bed rural acute care facility. This is a typical sample size for a narrative inquiry study (Clandinin, 2013), as the goal of this qualitative study is not to generalize the findings but to uncover meaning and expose various realities related to trauma-informed care within the context of rural nursing practices (Polit & Beck, 2021). Therefore, this small sample allowed for a deep understanding of the experiences through narratives that were told over time in a series of meetings. A complex and dynamic relationship between researcher and participant is essential for narrative inquiry. Time and commitment were required to foster trust and develop rapport with each participant, making engaging with a small number of people necessary.

Nurse leaders at the site distributed emails including information about the study, its purpose, and request for participants. Posters were placed in highly visible locations (see Appendix A). I also spent time at the hospital socializing the study for recruitment purposes. Socializing the research in this way, promoted awareness and cultivated relationship and connection. Interested nurses were given my contact information or agreed to have their contact information given to me. A total of five nurses inquired to participate. All those who were interested met the inclusion criteria. For the purposes of this study and limited time constraints, I

chose to confirm two participants and selected them on a first-come, first-serve basis. Participants were contacted before the conversations to discuss the study and process in depth prior to signing consent. Conversations were audio recorded and transcribed verbatim, and the information collected in the conversations remains confidential. Participants were provided with refreshments and received a small honorarium of $25 for their time taken to participate in the study to cover potential costs, including parking, childcare, or incidental fees that may have been incurred throughout the research process. I was awarded the HSD Graduate Student Research Award which assisted in supporting these costs (see Appendix B).

***Field Texts***

Narrative inquiry requires an understanding that the research begins in the midst of both participant and researcher lives, recognizing that "their lives are shaped by attending to past, present, and unfolding social, cultural, institutional, linguistic, and familial narratives" (Clandinin & Caine, 2013, p. 170). The setting for narrative inquiry is a relational space often referred to as the *field* and negotiated between researcher and participant (Clandinin & Caine, 2013). As a researcher, it was important for me to meet participants in an environment chosen by the participants to foster psychological safety and comfort for them to share their experiences. The initial conversation with my first participant took place at a local coffee shop and we soon realized that this was not an ideal place to share our stories due to the noise and lack of privacy. I offered a selection of other options for places we could meet, including my own house, which both participants quickly agreed to. The remaining series of conversations took place in my living room.

Field texts were composed over four 1-hour in-person conversations with each participant. The prolonged engagement with participants supported the credibility of the study as

it provided the opportunity to build trust and rapport with participants, ask clarifying questions, and encouraged elaboration to gain an in-depth understanding of the experience (Polit & Beck, 2021). Participants led the conversations and were guided by open-ended questions to clarify my interpretation or to help provide a deeper understanding of their experiences around trauma (see Appendix C). Some examples of these questions were: How would you describe your understanding of trauma-informed practice? How have you experienced trauma in your work? How do you understand and recognize vicarious trauma? How would you describe the support and education available for trauma-informed care?

I recognized that speaking about trauma may be triggering or uncomfortable for participants as they re-told and re-lived their stories. I invited them to develop field texts to share through journaling, art, or poetry, as this may provide a safer way to express their experiences. I encouraged participants to share artifacts, such as art or photographs, to help contextualize experiences or shape their stories. Neither participant chose to share field texts in ways other than conversations, though they were grateful for the option.

I kept field notes to document contextual information during participant conversations (Clandinin & Caine, 2013; Polit & Beck, 2021). The field notes contained my observations and interpretations, as well as my reflections and experiences in relation to the narratives. These notes were used in the data analysis as texts were negotiated with participants.

***From Field Texts to Final Research Texts***

In active collaboration, I negotiated field texts and interim texts alongside participants, also called narrative accounts. The active engagement of participants ensured that narrative interpretations represent the experiences discussed and make visible the relationships the participants and I hold. To convey the depth of our discussions, I chose to write the narrative

accounts as a series of letters. Each letter focused on a distinct aspect of the experience of trauma-informed care related to the study. This approach enabled me to express my understanding of the participants experiences in relation to my own, intertwining our narratives as we walked alongside one another. Once the letters were composed, they were shared with the participants, providing an opportunity to for them to read the letters at their own pace, reflect, and respond. Negotiating in this way ensured accurate interpretation and representation of their experiences and attention to anonymity. Throughout this iterative process, I continued to live in the relational three-dimensional narrative inquiry space with the participants as field texts were composed and co-composed (Clandinin & Caine, 2013). Once narrative accounts were negotiated, I worked with my supervisory committee to lay the accounts metaphorically side by side and explored resonant threads across the accounts (Clandinin & Connelly, 2000). These resonant threads formed the central elements of the final research texts. As the final research texts took shape toward understanding the research puzzle, I continued to attend to the personal, practical, and social justifications of the researcher/participant collaboration.

**Ethical Considerations**

Harmonized ethics approval for this study was obtained through the University of British Columbia (UBC) Research Ethics Board and the University of Victoria Human Research Ethics Board (#H23-04049) (see Appendix D). Operational approval for recruitment was granted through the Vancouver Coastal Health Authority (VCH). This study adheres to self-determination, and written consent was obtained before engaging in conversations. An information letter and consent form (see Appendix E) was provided describing full disclosure of the intention behind the study, conversation process, participant expectations and expected time commitment, compensation, and criteria for participation selection (Clandinin, 2013). To respect

confidentiality, each participant selected a pseudonym. Narrative accounts were negotiated and confirmed with participants to ensure they are comfortable making their experiences public. All paper data and consent forms are kept in a locked filing cabinet at the University of Victoria campus, and electronic documents are stored in a password-protected file to be kept for 5 years after the study is completed.

I recognized that re-living experiences throughout the study held the potential to trigger trauma responses or psychological distress due to the intense nature of the care they provide in these challenging environments. The participants were permitted to withdraw from the study without question or reason. Resources were provided to support psychological wellness for all participants (see Appendix F). Most importantly, this work adhered to key features of relational ethics.

***Relational Ethics***

Relational ethics is foundational to narrative inquiry as it requires a deep connection between researcher and participant. Throughout the inquiry, I worked alongside participants and collaborated from a place of equity, not hierarchy, understanding that the relationships are reciprocal and require mutual vulnerability and care (Clandinin & Caine, 2013). Ethical responsibilities within this inquiry were upheld by adhering to the key features of relational ethics in narrative inquiry outlined by Clandinin et al. (2018) as wide-awakefulness and ongoingness of experience; moving slowly; engaging with imagination, improvisation, playfulness/world-travelling; uncertainty and not knowing; and lived embodiments.

Attending to this inquiry with wakefulness to the ongoingness calls us to be engaged, curious, and attentive to the living and sense-making of the experiences of both participants and me while understanding that experience is ongoing, continuous, and a process that is always in

the making. Speaking about trauma was difficult and required building relationships of trust and rapport between myself and the participants. Entering these relationships slowly honoured the participants and allowed space for the stories to be shared safely through verbal and non-verbal communication. Engaging with imagination, improvisation, and playfulness/world-travelling was necessary throughout the inquiry. I negotiated relational spaces with participants, co-composed the field, interim and research texts, and navigated narratives with flexibility and curiosity about where the stories took us. I was aware of my uncertainty about where this inquiry would lead, conscious of my assumptions based on my own experiences, and mindful of entering participant relationships with vulnerability, respect, and openness to the unknown. Finally, the knowledge we carry from our experiences is embodied. As stories of trauma were brought forward, it was necessary to handle them with care and offer silence and contemplation.

Continuing with a commitment and responsibility to relational ethics, I was mindful that my personal, professional, and social positioning would also impact my relationship with the study and the participants as we engaged in the inquiry. As I came to understand the narratives, I maintained a sense of wonder, open-mindedness, appreciation, and imagination. I hoped to create space for nurses to voice their experiences with trauma and minimize the isolation some might feel in their work environments that are limiting them from providing trauma-informed care. Keeping in mind the reciprocal nature of relational ethics, I recognized that by endeavouring in this narrative inquiry, I am forever part of the participant's story, as they have become part of mine.

**Coming to the Field**

Trauma is part of the job. Reflecting on the experiences shared in my narrative beginnings, I consider the differences between nursing in urban and rural healthcare settings.

While trauma-informed care in both settings is essential, the urban ICU setting is well-resourced with staff, services, and technology; it also tends to provide anonymity in the nurse/patient relationship. In rural settings, contextual differences such as location, healthcare infrastructure, population diversity, and community connections create different challenges, contributing to the difficulty of accessing support for trauma-informed practice while also highlighting its importance. I wondered how these challenges affect rural nurses' ability to incorporate the complex concepts of trauma-informed care into practice.

The benefits of trauma-informed care are well documented. Trauma-informed care principles aim to improve health equity, inclusivity, and person-centred care while also calling to attention the potential for vicarious trauma in healthcare workers (Schimmels & Cunningham, 2021). The principles support acknowledgment of trauma in a way that fosters wellness and connection, shifting the lens of care from "What's wrong with you?" to "What happened to you?" (Schimmels & Cunningham, 2021, p. 406). If the limited available research suggests that rural nurses feel unprepared, uneducated, and unsupported to approach their work with a trauma-informed lens, understanding trauma from their perspectives and within their experiences will help to create sustainable ways to integrate trauma-informed care and trauma awareness to benefit communities, nurses, healthcare teams, and systems.

In chapter 4 and 5, I share the narrative accounts of Veronica and Barb. Chapter 6 is a manuscript that will be submitted to the Canadian Journal of Nursing Research. And chapter 7 returns to questions of the personal, practical, and social significance of this work.

## Chapter 4: Narrative Account for Veronica

Veronica initially approached me in the hospital hallway after reading the recruitment poster she had received via email. She was interested in both trauma-informed care and the research process itself. When she first approached me, I had reached the maximum number of participants in a short amount of time, but she agreed to stay on standby. As it happened, she was needed and thankfully when I reached out to her a couple of weeks later, she was still willing to participate. Our first meeting took place at a local café. We caught up over coffee, I learned about what brought her to nursing and how she ended up in a rural town. We found it too crowded and noisy at the café for the meaningful conversations we wanted to have and so we negotiated a different location for future meetings. I offered my home, which she accepted, and we continued our conversations in my living room. A quiet space where we could comfortably share our experiences with more privacy and confidentiality. Our discussions were fruitful, yielding numerous insights and even more questions. I chose to represent these narrative accounts through letter writing. I composed a series of three letters discussing her coming to understand trauma-informed care, addressing the context of rural nursing, and recognizing personal trauma. These letters served to articulate my understanding of her experiences in relation to my own—interweaving our stories as we walked alongside one another.

### Coming to Understand TIC

Dear Veronica,

When you recall the start of your 8-year nursing career, your reason for choosing this path was simple. You wanted to help people. You wanted to help people heal. It seems like such a worthy and clear focus, yet as I think about my own life as a nurse, this can be so hard to achieve. There are so many distractions in the care system now that often undermine our deep

desires to help and heal. As I listen to you tell your stories over the course of our conversations, it is clear to me that you continue to find meaning in your work with that reason still alive and at the core of your day-to-day practice. I could hear in your voice how much this still matters to you. At the beginning of these conversations, I found myself wondering if you recognize that helping people also includes helping yourself—but I am sure we will come back to that later. As a nurse, I wonder how much we attend with the same care to each other, and I also wonder if it is possible to call on each other when we struggle. Can we see these struggles in our colleagues? Or do we wait until things have gotten too hard, when hearts are broken or when people resign and leave the profession? I am so glad we get to talk.

As we took our initial turn toward exploring trauma-informed care, I was curious about how you came to understand this concept and what it means to you in your practice. I was interested to learn that you found that formal education in undergraduate programs seem to gloss over or completely neglect this topic. My experience was similar. For both of us, coming to understand trauma-informed care came through self-directed learning and has been influenced by different people in our practice over time. I wonder if this will ever change. It also makes me wonder if trauma-informed care is only about knowledge? How do we learn to attend to the emotional and social contexts of our work and our well-being as nurses? How do we learn this? How did you learn this?

Initially inspired by a clinical instructor whose teachings emphasized the importance of listening closely to patients and comforting them, you came to understand trauma-informed care early in your career as embracing a "caring aspect." It was interesting for me to hear how you sensed that this instructor had experienced something traumatic in her life. There was something in the way she stressed the significance of really listening to the patient that stayed with you.

Something that continues to impact the way you interact with patients to this day. I can hear this in the stories you share with me in our conversations. I wonder what it was that influenced her teaching in such a way. It is interesting to me that you suspected her approach was not only about the patients, but that it was something personal for her. You suspected “something big happened, but she didn’t ever delve into it.” So early in your career you were able to recognize that trauma has the potential to shape our lives and the way we interact with the world. Perhaps this is what we carry in our heart and our body. There is a way we embody care that matters and that seems to have spoken to you in your interactions with your instructor. I wonder if many of us are lucky enough to have instructors who share their own vulnerabilities with us. It makes me wonder about the idea of listening. What does listening mean? Listening is connected to attending to, it is about being heard and perhaps, it is also about being touched.

I think about some of my experiences—both in nursing and my personal life, that have stayed with me and shifted the way I think or act or teach. Resuscitating a patient while their family members stood in shock at the end of the bed reminds me of the importance of transparency and accountability in my practice. It too is about listening—listening to what is happening to them, listening even when they are silent. How does the work we carry out in that moment live in their bodies? In the stories they will carry forward. I know that how I listen is visible in my body, in the ways my eyes meet theirs. I wonder what happens to you in these moments. The squeeze of a patient’s hand when they are scared and struggling to breathe keeps me humble, compassionate, and aware of how vulnerable patients are in my care. The look in my mom’s eyes when she finally accepted that the chemo wasn’t working tells me grief shows up for people in a myriad of ways and doesn’t disappear just as easy as it arrived. These stories are embodied in the way I interact with others. They shape how I see the world. As think about how

trauma impacts me as a nurse and how it is visible in your life, I wonder if we attend as carefully to this as we do with patients.

Furthering your education has helped you come to understand that a person's experiences continue to live within them—whether they realize it or not, and that it can change how they respond to situations. As we talk about recognizing trauma, it was so interesting for me that you recalled your childhood experience. The memory of past hospital visits come back to haunt you when a pediatric patient was under your care with similar needs. As I write this letter to you, I keep thinking about this. There is something about our early experiences that stay with us. I wish we would have talked more about this, but I wasn't sure how much of this story you wanted to share with me. You leaned back in your seat as you described the visceral reaction and strong aversion to having to perform an invasive intervention on this child, as though pushing yourself away from the table would distance you from this event again. In this moment, it was clear to me that this was a time that had a lasting impact on you. But you weren't aware of the healthcare associated trauma you still carried until you began to talk about it again. The momentary silence between us after sharing this seemed as though you were beginning to recognize the significance. I wonder if this has added a new lens to the way you understand trauma-informed care. Shedding a new light on healthcare associated trauma. Coming to understand the impacts of the residual effects from another time. Making sense of the fear and anxiety in patients who might not realize they are experiencing the re-emergence of their past experiences. And what happens when your experiences meet theirs? Does it call forth a different act of listening?

Recognizing symptoms of trauma is different depending on the individual and situation. You have found that people can be really 'amped up' or hyperactive, demanding, and visibly upset. Other times they are more withdrawn and don't want to engage with you at all. Attention

to each individual presentation is vital. I wonder how you have learned to read these very diverse reactions to trauma. In my experience, this is no easy feat. I've witnessed, and perhaps been guilty of, the mishandling of symptoms resulting in an exacerbation of trauma responses and subsequent re-traumatization. It makes me wonder what role guilt plays in our trauma. Does guilt signal a failure of duty? There is no absolute, one size fits all steps to follow. Trauma-informed care requires patience and flexibility. You are quick to recall your interactions with a patient who has become well known to you. Her visits to the hospital are many and it seems as though "she is always in some sort of crisis." Other times she presents with seemingly benign requests but becomes overdramatic and disruptive to others around her if her requests are not met or she doesn't get what she wants. This is frustrating for the staff and for the patients in the department. Only when you learned her history did you begin to understand what might be going on for her and I see heart break in your face as you disclose—"it was really, really bad." Looking down at your hands, you re-call the pieces starting to fit together as you realize all that she had been through makes life extremely hard for her. You now notice how her disruptive behaviour escalates when she feels like no one is listening and think how this could remind her of her own voicelessness in a previous time. I listen as you reflect on how this patient's experiences of trauma come to the surface in the hospital when she feels unheard or unseen. My mind goes to times where I have been misunderstood. Where I didn't have the words to articulate what I needed. There is a sense of isolation that comes with this. I think about how lonely and frustrating it must be for her each time she seeks healthcare. As we continue to talk about what might be going on for this patient, a new sense of understanding develops about her attention-seeking behaviour and dramatic tendencies. There is no doubt the behaviour is distracting and draining—especially over the course of a 12-hour shift, but you can now see that the being in the

hospital can be re-traumatizing for her. And while you recognize that knowing someone's history of trauma isn't necessary for you to care for them, knowing what she had been through changed your perspective. I wondered if knowing changed how you interacted with her. If this shift in perspective has allowed you the capacity to find extra compassion in hard-to-find spaces. And by shifting your perspective, could you also see yourself as changed in relation to her? I inquire about this not with judgment or blame. I asked because I re-call times where I hastened care with impatience, not stopping to consider what has happened to the patient. A one-track mind to getting the work done. The outbursts distracting, demands impossible, and time evaporating. It's not something I like to admit, but it's the truth. These are perhaps the moments where I did neither listen nor hear. Aren't nurses always supposed to be patient, tolerant, and impartial? I noticed you contemplate how to come to terms with what this knowing meant for you. I wonder if self-judgement creeps in for you as it has for me, when you tell me that yes, in fact, it probably did change the way you interacted with her.

The subdued. The reserved. The disconnected. It's often apparent to you that their demeanor stems from past trauma, caring for these individuals can present a different set of challenges. Finding the necessary time to establish trust and create a safe space for them to open up to you can seem like an impossible task. Listening, building rapport, and gaining even a small insight into how best to support them requires patience and dedication. As I listen to you, I am reminded of the busy days; the ones where there was never enough time. Reflecting on these moments brings to mind the hectic days filled with constant demands, where time always feels scarce. Balancing the intricate narratives of patients, bustling departments, and conflicting priorities remains a constant struggle. Your dedication to being present when a patient needs you is evident, yet the perpetual battle between the time you have and the time you need persists.

Sometimes, you point out, all you can offer is a simple gesture—a sandwich, a cup of tea, a warm blanket—hoping it conveys the care and concern you feel. I nod knowingly as you share this, remembering the calming effect and profound gratitude that handing over a saran wrapped sandwich of white bread and processed cheese could have. These are the things people remember. You know that while they might not remember your name or what you did to treat their medical concerns, they will remember how you made them feel. If all you can spare is a brief moment to offer a small gesture, it matters. I'm pretty sure nothing feels better than being wrapped up in a warm blanket with a full belly on a bad day. I wonder if during the hard days, and the days that didn't feel you could anchor in the ways you had always imagined, if someone came and wrapped a blanket around you or offered you a cup of tea? Would this have mattered? Is this part of attending to the trauma, you and I and other nurses carry?

As I walk alongside you in the re-telling and re-living of your stories, I notice how you naturally weave principles of trauma-informed care into your practice. I notice your attention to person-centered care in the way you describe what trauma-informed care means to you—making the patient feel safe and heard and cared for. That you must accommodate your approach to work with the patient in a way that serves them and their experiences. That even though there is never enough time, small acts of kindness can leave lasting impressions.

With compassion,

Stephanie

## Turning to the Context of Rural Nursing

Dear Veronica,

I am so glad I get to write to you again. Our conversations are important to me, and they help me gain new insights about trauma-informed care. And most importantly, it is such a gift to

learn from you. When I think about the connection between place and experience, I see how one shapes the other, both personally and practically. I know I can't fully understand someone's experience without coming to know the context in which the experience occurs and the people who are involved. Because setting provides such valuable context to experience, I was keen to hear how working in a rural acute care environment shapes your care, experience, and approach to trauma-informed care. So many of my own experiences are drawn from working in resource laden urban centers and I wondered how or if experiences around trauma in healthcare differ in rural areas. I also wondered if rural settings call forth different trauma for nurses, or if the trauma they experience is attended to differently. I wondered if the small community of nurses who work in rural settings, allows perhaps for a different way to attend to and listen to each other. Knowing that you had practiced in both urban and rural settings, I was also curious to hear how your experiences differed for you, from place to place. Specifically, how traumatic situations are perceived and managed while living and working in these spaces. I think about the years I have spent working in large, tertiary centers and the seemingly abundant resources at my disposal. Even still, this didn't mean I was protected from traumatic experiences or that the patients I cared for didn't have the resources they needed to help manage their trauma in ways that were meaningful to them. It just meant that there were more people around, more specialists, more beds, more options. Looking back, I see the illusion of protection from trauma because of these things. In my experience, having these things doesn't prevent re-traumatization. Place can't be separated from trauma-informed care. Place is part of the story. I see that is still a part of my trauma.

First, I wanted to understand how you perceived the contrast between rural and urban nursing. Without hesitation, you exclaimed that in rural, "The nurses are it!" We both let out a

laugh, knowing that this feels true for most nurses, no matter where they work. I think about the clinical responsibilities, organizing, collaborating, and managing that I have taken on as a nurse—it often feels like you're doing it all. I ask you to elaborate a bit more. What does that look like in your rural acute care site? A stream of different roles pours out of you—you are the respiratory therapist (RT), the ECG tech, the intravenous team (IV) team, and depending on the time of the day, you fill in the gaps for the allied health team members such as physiotherapy or social work. None of these are what you were trained to do, and yet, embodying the jack of all trades is necessary to ensure the patients get the care they need when certain services aren't available. All of this while still carrying out your nursing responsibilities. I notice as you list these different roles encompassed in your job, you are matter-of fact in the way you speak. You highlight the multidimensional aspects of rural nursing and the importance of being flexible. I think of what a heavy load that can be, day after day. I wonder how you're able to carry all of that and still manage to care for a department full of patients that continuously come through the revolving door. You shrug and say, "you just do," like it was obvious. Like there was no choice. This resonates for me. Sometimes there is no other option. You just do what you have to do, with what you have, for the patients. I am left with a sense of awe at the ways in which you step up and do what needs to be done at a moment's notice. The level of problem-solving, overseeing, and collaborating that is required in the span of an ever-evolving 12-hour shift will never cease to amaze me.

You can't possibly be an expert in all areas so knowing who to call for help is vital. You recall many times you wished there was an RT available to help with a patient requiring oxygen support. When patients need specialized equipment to manage their respiratory failure and you weren't comfortable operating it. How stressful that must be! I think about how many times I

have relied on an RT to set up a ventilator or to help manage oxygen levels so that I could focus on the other tasks like medication infusions, monitoring vital signs, comforting family, and keeping a patient alive. But here, there are no RT's. You have to draw on the skills you have acquired over time and rely on the nursing team you're working with. You recall a time when you were still picking up shifts in the city—straddling the worlds of rural and urban. Noticing how you might be able to leverage the resources in one place in a way that would help you care for patients in another, you ask the RT to practice setting up a high flow oxygen device. They tell you with certainty, "you don't need to know how to do that." At this urban site, it's true, you don't. There are RT's scheduled around the clock. I immediately sense the frustration in your voice as you bring me back to that interaction. In a rural site, you do need to know. As you say this, I reflect on my previous misperceptions of what rural sites had access to and ignorant assumptions that there is equity in resource allocation within our systems. I see how annoyed you must have been as you describe how you turned to them and said, "Oh, but I do." Because in a rural hospital, you are it. But they don't always understand. It's hard to explain the nuances of rural healthcare when you have never experienced it. If you do need an RT, there is an emergency phone number to reach someone at the urban site for help. The emergency contact is readily available at all hours. While this is can be reassuring, you note with genuine transparency that in the heat of the moment, you can't call. You don't have time to find the phone and wait for instructions when a patient needs your immediate attention. I can see how there can be a lot weighing on you in those moments. Tentative and uncertain in performing skills you haven't been trained to do—especially when a patient's life is depending on it. I wonder how this stays with you.

There are times when the required resources aren't available by phone. When the services are not available, patients need to be transferred to the city for care. When I reflect on this, it's the stories of your experiences with patients who struggle with mental health in your rural community that stay with me. There is sadness and compassion in your voice as you recount the times you have encountered patients who have resisted coming to hospital until they are in crisis. They know that coming to the hospital may mean they will need to be transferred from their community to the city for assessment and treatment. I sense the moral distress this causes for you. The acute mental health services they require are only offered at the urban centers but leaving their community in a vulnerable circumstance causes immense distress for the patient. The distress lingers with you. You feel what they feel. You remember a time you helped a patient on a conditional discharge who had thought they missed their community appointment. They came to the hospital panicked. They were filled with fear thinking they would be sent back to the psychiatric ward in the city. I hear your care and compassion as you take steps to ensure the patient's doctor knows that they were there and that they are safe. As you reflect on this situation, I see how you grapple with the knowledge that transferring them will provide the best care, yet it weighs heavily on you to realize they are unwilling to leave due to fear and mistrust. I notice your growing conflict as you describe the situation where certain patients are left to arrange and finance their own journey home after being discharged. They may not have the means to pay for the hefty taxi rides or access to other transportation. They may have no one to call, no one to go with them—they are alone. In these conversations, I feel your frustration with the broken system and sense sadness and helplessness in your voice. This is the way it is. In your stories, I am reminded of another way trauma-informed approaches are missing within our systems.

There are times when you have felt alone at work. When you have felt unsafe and vulnerable. With stories of violence toward healthcare workers on the rise, I have found this to be a topic of much concern in nursing conversations. Sadly, I can think of many times where I have been afraid of a patient or afraid for others. My personal safety endangered as a patient uttered violent threats toward me through their teeth. Dodging punches and kicks to avoid injury when trying to help a patient to be repositioned in bed. Finding drugs and weapons while sifting through a patient's belongings to find their identification. These are still vivid memories for me. They have made me weary of the people with unpredictable behaviour or violent histories. They sometimes just make me weary of people walking down the street. But in my experience with violence at work, I had found comfort in knowing that I was not alone. That with the push of a button or overhead call, a team of trained security officials respond—along with a variety of other healthcare professionals to attend to the situation. Another difference between urban and rural healthcare settings.

A couple of stories come to you as we discuss the safety and security you feel working in rural areas. Where there is not a large "code white" response when the safety of staff or patients is threatened. One security officer for the entire site and a skeleton crew of healthcare staff, especially in the nighttime hours. Yet another example of how it can feel like "you're it" in rural nursing. In these situations, you're calling the police to help—hoping they aren't tied up in the community somewhere. Sometimes having to convince them to come quickly. Frustratingly stressing over the phone, "I'm really alone." You recall a time at 2 o'clock in the morning a person was banging aggressively at the doors, appearing frantic and unwell. Or the time you had to help barricade a person acting aggressively between two sliding doors to prevent them from eloping while waiting for the police to arrive, what seemed a very long, twenty minutes later.

These experiences sound frightening. There is a quickening of your voice as you recount these times. I wonder how they stay with you over time. I wonder how you can turn to principles of providing trauma-informed care in these moments. How you can use a trauma-informed approach to patients when you feel unsafe to be near them. When you are overwhelmed by the need to protect your own safety. When the place where you work is also a place that can be unsafe.

When I think of the interconnections between place and experience, I think about how the community in which you live might influence trauma-informed care. Throughout our conversations, I come to understand how attention to community keeps you grounded in ethical and trauma-informed care. You share with me that you have a knack for recognizing people's faces. There was a time you recall when you saw someone who you recognized at the gym. It took you a moment before you could place where you had known her from. Your face lights up at the memory of this connection—you had triaged her only a few days before! Seconds later, the awkwardness sets in. The link of nurse/patient relationship vanishes, and you are two people out for some exercise at your local gym. I see how encountering people in town after providing treatment for them at the hospital might feel uncomfortable. You've known them in a vulnerable moment, a different context. As awkward as it can be, it also brings awareness to how you treat people. You wonder how they remember you. In the city, there seemed to be a veil of anonymity. So many people concentrated in one place, I knew it was very unlikely that I would bump into one of my patients on the street—let alone recognize them. You nod, and I see that you can relate to this. Only now am I wondering if that had influenced my practice and my patient care. Thoughtfully, you admit that your trauma-informed approach is probably better in your rural setting. Knowing that you may run into patients while out on your regular errands keeps you

accountable to caring for your patients in a way that leaves them with a positive impression. You want them to remember you in ways that speak of the care and healing you provided, the reasons you became a nurse in the first place. I can see how the connection to community creates more awareness about how you're treating people. It may be a bit easier to approach situations more trauma-informed and less rushed because of the likelihood that you'll see people out and about around town. This resonates with me as I become settled into rural living and the frequency of seeing familiar faces when I leave my house becomes more common as the years pass. I can't help but feel that there can sometimes be a sense of obligation to uphold an image of professionalism, of care and compassion, when people know that you are a nurse—even, as you say, when you're going out to the pub with your friends. You're hoping that a patient you cared for the other day doesn't recognize you. I wonder if these are also moments where you struggled with who you are and are becoming as a nurse. Are these moments where trauma has shaped your identity and who you are? Sometimes there is no off switch to being a nurse.

Warmly,

Stephanie

**Recognizing Trauma in Yourself**

Dear Veronica,

Our conversations continue to be impactful to me as I learn how trauma-informed care lives in your experiences. I continue to be grateful for your time as I write these letters to you, reflecting on our discussions. It has been taken a long time for me to come to recognize that the work I do may have a lasting impact on me. That it has shifted my views of the world, ate away at my patience, and affected my health and well-being. It's hard to turn inward when my instinct as a nurse has always been to make sure those around me are cared for first. But I am human.

When tragic things happen to people, I feel sad and powerless. I feel the anguish of loss as I witness families holding on tightly to the hands of their dying loved ones. I feel frightened and helpless when I'm doing everything I can to bring a patient back from the brink of death and nothing is working. So many times, I have had to keep it together for the sake of the patients. Stifle my own emotions to protect theirs. When I think of the feelings I still carry as they are attached to these memories, I worry that we haven't done a good enough job of creating spaces for nurses to come to terms with how they might be affected by trauma in their work. Even more, how to recognize it as trauma in the first place. To call out the trauma nurses carry from vicarious experiences. There seems to be an understanding that seeing bad things and hearing sad stories is just part of the job. But how do we make sense of it? I was so curious to know if you have noticed similar experiences.

As our conversations turned toward exploring the potential trauma that you carry from your work, I am filled with trepidation as I become aware of my inexperience and discomfort in having to ask about your experiences in this way. The experiences that may highlight your vulnerability and open doors you may have made a point of keeping closed. I worry that my positionality in a leadership role as an educator makes it difficult for you to share your experiences openly with me. Have I created a safe space for you to share your stories? I also worry that it might only be me who has recognized the toll that the repeated exposure to distressing events has taken. I hoped that by sharing how I came to recognize vicarious trauma in myself on car rides home after long shifts, that you might be open to exploring your own experiences alongside me. As we sit in my living room drinking coffee and eating homemade cookies, I notice you appear relaxed and take this as a good sign.

You shared this story with me, acknowledging that you wouldn't have been able to discuss it a week or 2 ago. The event was too recent. The effects too raw. I notice your surprise as you realized this at the end of our conversation. I wonder if you had taken the time to consider yourself in this story. I'm not sure what shifted for you, but I felt a profound sense of gratitude that you were willing to be vulnerable, to re-tell this story, and re-live this experience with me. I know this was hard to do—maybe the cookies helped provide some comfort.

When you began to share your experience, I could sense your apprehension when you shifted in your seat, as if trying to figure out where to start. Perhaps it was because you were unsure of where this story would lead or what it would reveal. I noticed the occasional shake in your voice as you spoke. The wringing of your hands. In these small gestures, I could tell that this was something that had had a big impact on you. Something that still lives in you as you recount the story. I wonder if you are aware of these signals, suggesting to me that the trauma from this situation is still just below the surface. We have talked about recognizing trauma in others, but I wonder if you are able to separate yourself from the patient to acknowledge how you have embodied trauma. I wonder if you are still working out how to make sense of it all.

As an experienced emergency nurse, you have come to know that reckoning the unknown is what you do. The unknown is part of your everyday work. Patients come through the doors with a chief complaint, and you put the wheels in motion to help uncover a diagnosis and develop a plan of action to provide best patient care. The unknown becomes differentiated and managed through process and strategy. Triage according to acuity scores, collecting blood work, facilitating diagnostic tests, keeping track of time, following algorithms, and accessing resources appropriately. I can see that you thrive in this environment. The emergency department is

unpredictable, but you are confident in most situations because you draw on your clinical knowledge and experience to know how to put the pieces together to find a solution.

But you recall a time when you didn't know what to do. You thought you had figured out the puzzle but as you watched the blood swirl, you realized the situation had taken an unexpected turn. You described those initial moments, frozen in fear, searching your knowledge and previous experience to figure out what to do. I see that you were trying your best to hide your own shock as the events unfolded because you knew that the outcome was bleak, your mind racing to find a solution, and you didn't want to worry the patient. But this was something no one had encountered before. The situation complicated by miscommunication, staffing shortages, and limited resources at your disposal. And even though your team rallied together, it's interesting to me that you still felt alone. As you recall trying to come to terms with what was happening, you were met with an acute awareness of the alone-ness of being at a rural site. No specialty teams would show up at the push of a button to assist the situation. So far from a place where the patient could have the immediate care they needed. I wonder how this memory will come back to you in years to come. Will you think about the coming together of your team or will you think about how alone you felt? Maybe both.

And then there is the patient looking up at you weakly, with pale skin and pain in her eyes and I feel as though I am there with you. I recall that look in the eyes of the patients I have cared for. The type of look that is searching for answers—truth, hope, or maybe just a little bit of strength. Willing you to help them. I'm reminded of times I have felt the heavy weight of responsibility in those moments. Moments where the boundaries in the nurse/patient relationship evaporate and the sadness, fear, or courage binds you instead, in human connection. It's this connection that makes me wonder if vicarious trauma is inevitable for nurses. That we too, can

be affected by the traumatic circumstances of others. That you and I don't carry armor to protect us from experiencing another human's emotion, pain, or suffering when we're on the job. But I wonder if we have learned to disregard our own trauma over time because society calls us hero's and tells us we're resilient. Because we become so good at hiding our own emotions behind brave faces for the sake of our patients and their families that we have become unable to acknowledge the trauma we carry. I wonder if when you told the patient you would stay with her and that everything was going to be ok, despite knowing the outcome would be grim—the words you spoke to her were also helping to soothe you.

Self-doubt, uncertainty, and helplessness are some of the residual feelings you're left to make sense of. You have had trouble sleeping with continuous thoughts of what had happened—thinking about what you missed or could have done differently. Did you do enough? I can see that you are still asking yourself these questions. Unable to go back to work for a couple of days, filled with apprehension as you think of having to sit across from where it all started. I wonder what this distance means for you. What does it do to help you process this trauma, knowing you'll have to go back eventually? How does time change your response? I remember feeling like there was a physical barrier preventing me from going back to work—to face the place that had left me wounded. I took time too. But when I do go back, it's still there—the emotional response perhaps more subtle, but not forgotten. I think about how you have not only been affected by what happened to the patient but also how the environment now carries something different for you. I'm reminded again, of the relationship between place and experience as this becomes evident to me in this part of your story. The place was too hard to go back to because it would amplify the memory of experience, bringing it back to the surface again. How do we put ourselves back into a place that holds such traumatizing memories, time after time, without

becoming affected in some way? I think about how with a trauma-informed approach, we adjust the environment to minimize trauma and resist re-traumatization for patients—but what about for us? How are healthcare systems attending to the trauma of staff who are working in these environments day after day? As you replay the events in your mind, trying to make sure you didn't miss anything, I hope you can give yourself some grace. Sometimes despite our greatest efforts, the outcomes are not what you or I hope for.

Where do you go from here? What happens after days like these? The days where you are left feeling insecure, doubtful, alone, scared, worried, and hopeful—sometimes all at the same time. When the things you see at work so often come with sadness or trauma. We work toward mitigating trauma for our patients, but what about us?

Something that helps you, is to use these experiences as lessons you can learn from. A way to process events and evaluate what went well and what could be done better next time. And I guess that this is the sticking point for me—there will be a next time. Taking lessons from these experiences to use them as opportunities to learn might help us come to terms with the trauma, to explain it, to think about how we can improve our practice if we're met with a similar experience, but it doesn't allow us to forget. I wonder how we can really move past something when we have placed it somewhere to be called forward time after time as a basis for comparison. Eventhough you say to yourself, "I'll never do that again," I wonder too, if there is trauma in the anticipation of having to use this knowledge again? As it is recalled, are we not at risk of re-living the trauma? Does calling on this previous knowledge not reignite the embodied trauma we hold and trigger the memories of who was there, what happened, and what it felt like? Times we may never want to repeat but will never truly be forgotten means that they stay with us, who knows for how long.

I am curious if you find comfort in talking to your partner when you come home from a hard day. With a short laugh you assure me, no, he can't handle what your worst day would be like—he's too sensitive. The comment stays with me for a moment as I think about the sensitive nature of nursing. The sensitivity of nurses. A profession that requires us to be perceptive and empathetic to others but somehow seem to disregard sensitivity for ourselves. How is it that nurses are expected to handle traumatic experiences but those outside of the profession are unable to? I can't recall a time when someone assumed I was too sensitive to hear a sad story or support someone's bad day. Does anyone say nurses are too sensitive? Is there an assumption that we are built with something different—an invisible layer of protection? It was interesting to me when you shared a time when you asked what his worst day at work would be like. His response was sustaining a traumatic injury, like cutting off his hand. I nod, seeing where this is going. You explain to him that on his worst day, he would come to your work, and it would just be another average day for you. I consider how that is true for so many non-healthcare people hearing stories from my 'day at the office' and the response is almost always—"I don't know how you do what you do." Sometimes I don't know either. I see the pieces of our conversations coming together as you point out that what they don't realize is that you just start to think it's normal. It's just what we do. But what we do is not normal.

So, you turn to those who understand the 'not normal.' You find comfort in turning to your nursing friends. I hear how trust in the words of your colleagues who helped you make sense of this time and assured you that you did everything you could have. I think of how many times I have turned to my nursing friends to debrief a shift or cry about a patient. It's easier to seek solace in camaraderie. There is no need to provide an explanation. It is a place to turn for mutual understanding and support. But when I think of our conversations and recognize the

difficulty in acknowledging our own trauma as nurses, I wonder how we learn to trust our colleagues. Are we bonded by traumatic experiences and mutual understanding? If so, I wonder if this creates potential for a false sense of security. Does it confirm our biases or minimize the trauma by normalizing the experience? Is there potential for us to validate each other's experiences because we're all a little wounded and need to feel less alone? Just a couple of things that come to me as I think about how we hold vicarious trauma for ourselves, and for others.

Take good care,

Stephanie

As our conversations came to a close, I find myself even more perplexed about the many layers and considerations that are necessary for nurses in rural areas to apply trauma-informed approaches. I was so grateful to have had the opportunity to hear Veronica's stories, to learn from her experiences, and walk alongside her as we explored trauma-informed care in her nursing practice and her life. We have left the door open to come back to these conversations should anything come up—parting ways, knowing our paths will continue to cross. My hope is that these conversations have provided some insight to how trauma presents in her work and how it has shaped her both personally and professionally.

# Chapter 5: Narrative Account for Barb

After reading the recruitment poster and having a casual conversation to ask some clarifying questions, Barb volunteered to participate in this narrative inquiry. We came together over coffee, and I shared my reasons for embarking on this research journey about trauma-informed care. I told her about how I came to realize the trauma I had experienced in my career and that I was curious to know if others felt the same. Knowing that she came with a diverse clinical background and experience in various rural areas, I was so interested to know more about how she experienced trauma-informed care. I know Barb as a charismatic, fun-loving person who loves the rush of the emergency department and has always taken opportunities to challenge herself to grow in her nursing career. Never one to sit still, she has gained a wealth of experience over the years, and I was so grateful that she volunteered to talk to me in this way. To capture the richness of our conversations, I chose to compose these narrative accounts through a series of letters. Each letter highlighting a different component of how trauma-informed care is experienced. This method allowed me to articulate my comprehension of her experiences in connection with my own, our narratives intertwined as we journeyed together.

## Coming to Understand Trauma-Informed Care

Dear Barb,

As we settle in on the couches in my living room with hot tea and snacks, I am eager to get to know you in a different way. To have conversations we haven't taken the opportunity to have before. In your 12 years of nursing, you have worked all over the province, in other provinces, and overseas. You come to these conversations with a wealth of experience in different clinical areas—from critical care, to emergency, to obstetrical nursing—you explain this as the "trifecta" for rural nurses. Your perspectives will be so interesting for me to learn

from. I have come to know you as adventurous and free spirited, making it easy for me to see why you have accumulated such a diverse clinical background throughout your career. Your laugh is infectious and it's so easy for you to find humour in situations as I recognize the hints of sarcasm and dark wit I have come to know well as a characteristic of so many nurses. I am so interested to talk to you about how your experiences have shaped your understanding and approach to trauma-informed care.

When I think of trauma-informed care, I think it's important first, to understand how you recognize trauma in people. How you know that someone has experienced trauma and that this may influence the way you interact with them. It was interesting to me how quick you were to make clear that we were talking about the patient's trauma, firmly stating that "trauma-informed care literally means nothing pertaining to myself." It is "all about patients who have trauma." I take this as a sign you may not have considered how your own trauma or experiences might be a part of a trauma-informed approach. Perhaps it's something you don't want to talk about. I would not be surprised by this. My experience leading up to our conversations has shown me that, as nurses, we aren't encouraged or well prepared to acknowledge our trauma. Your comment has piqued my curiosity as to where these conversations will take us. I'm so interested to know how you might come to think in different ways over the course of our time together.

To recognize trauma, you tell me, "you need to be able to read people." You consider yourself a people person and reading people is something that goes hand in hand with that. Knowing a bit of their background and why they have come to hospital this time also helps to give you some context in preparation for assessing symptoms related to trauma. You sound confident as you describe how you begin to assess someone within the first few moments of bringing them into a room. To get a sense of how to approach them. Patients may be "warm and

open to you" you interpret this as "a green light." Giving you permission to proceed with your care without having to think too much about being sensitive to specific triggers. Other times, when they're avoiding eye contact, not really giving you a lot of answers, or seem a bit more guarded, and "not giving you much" you recognize the potential that "something's going on here." Understanding that something may have happened to them. In these cases, you take your time and really explain what you are doing. You recall a time where you didn't read the signals the right way. You "learned your lesson" as you moved to lift the patient's shirt to assess their abdomen, the patient pulled away, and questioned what you were doing. A momentary breach of trust. I think of how fragile a patient's trust can be when they come into the hospital. The uncertainty, fear, and vulnerability of the unknown. When you explain this time, remembering that you got caught up in doing what needed to be done, the patient's dignity slipped your mind, and you acknowledge shyly, "we just forget they are people sometimes." I understand this feeling as I think about the times when routine and tasks were all I was able to focus on as the demands of the day were piling up—forgetting there was a person at the other end of my stethoscope. In a hurry to get through to the next patient, or the next shift. Not always my fully present self. But I wonder then, how can we trust in our ability to read people to assess for trauma when the context is more complicated? What if we read it the wrong way and it leads us to make assumptions and take actions that could be detrimental to patient outcomes? Detrimental to us, if misreading the situation leads to a negative reaction? If we can't appropriately and accurately recognize a trauma response, how can we provide trauma-informed care? I am curious to know how you learned to recognize trauma. Where did you learn to read people?

Aside from Indigenous Cultural Safety training, you don't recall a time where you have specifically learned about trauma-informed care or formal training to recognize trauma in

someone. Mostly, this comes from what you have learned over years of practice. Of watching and learning from other nurses you have worked with who seem to have a way of attending to patients in an effective way. Of reflecting on situations that didn't go as planned and considering what you could do differently—as in your experience attempting the abdominal assessment before receiving permission from the patient. You also recognize your confidence and approach to patients has changed as you have aged—accumulating both professional and personal life experience to support your practice. You have learned to ask questions in different ways as you developed more assurance in your knowledge and understanding of disease and system processes, changing how you interact and work in relation to patients. I think about how we bring experiences forward again and again, from all aspects of our lives, to help navigate and make sense of current situations. And how we will call on those current situations in the future. What does this mean for new nurses? Nurses who have not yet had the opportunity to learn from mentors or accumulated experience. Those who have so much to learn about the real world of nursing outside of what is learned from textbooks. Those who have a lot to learn about the world in general. I think about how hard this must be in today's healthcare climate where staffing shortages, retention, and attrition are very real concerns.

We turn to what trauma-informed care looks like for you in your practice. How do you incorporate a trauma-informed approach? As you take a moment to think about this question, I see you working through what this would look like in a regular day. When you recognize that a patient might have been through something difficult, addressing them from the perspective that something has happened to them, not what's wrong with them. You see it as an opportunity to make their experience better. Simple things like dimming the lights or bringing them a warm blanket is sometimes all it takes. You describe this as bringing it "back to basics." I think about

how sometimes the most unassuming things can bring the most comfort—the simple necessities that symbolize safety and warmth. I wonder if these things have also brought you comfort in challenging times.

Sometimes people are able to tell you what they need—they know what works and what doesn't. You can get them something for their anxiety, something for pain, or just answer their questions, but it's not always so easy. Sometimes it's harder to tell. When patients are withdrawn or quiet, and don't make eye contact with you, it takes a little bit more work. When you suggest you might ask them what is triggering for them, I hear uncertainty in your voice. I wonder if you were asking me if this is the right thing to do. I have wondered that myself. If they could just tell us, we could avoid retraumatizing them. But I think about asking someone what their triggers might be as they are exposed and vulnerable in a hospital bed. I think about how the word 'trigger' might be triggering. Would they know how to tell you? Would they be able to articulate what trauma is for them? Would they be aware or recognize it as a trauma response themselves? It might not be obvious to them, just as it isn't to us. I wonder if there is some hesitancy about what the rules are when we label care as trauma informed. I think about how a significant portion of nurses work integrates a trauma-informed approach, yet hasn't been learned from formal nursing curriculum. As I walk alongside you in these conversations, I'm learning that so much of your knowledge has come from what you have learned in your years of experience, through observation and mentorship, and trusting in your "nursing spidey senses" or intuition. For something so sensitive and with great potential for harm, is that enough?

Time constraints often come up as a challenge when we talk about trauma-informed care. We talk about slowing down. About how there never seems like enough time to provide the care some patients really need. To really be able to sit with a patient, to be attentive what they're

telling you, or perhaps even more important, what they're not telling you. To read their body language and gauge how they will respond to you or to the situation they are in. Memories of busy days come flooding back to me. Days where I felt as though I was being pulled in a million different directions. Trying to convince myself that it was enough if everyone was alive at the end of my shift—but knowing that it wasn't. That patients deserved more. You tell me about a time when you were in a busy diner watching the only two staff members buzz around making breakfast and taking orders. It felt like everything was moving so fast. But when one of them turns to take your order, he slows right down. He is calm. He smiles. He pauses to ask how you are and politely thanks you for your order. This stays with you as you think about how in nursing, it's not that different—"you can be really busy but most of the time you can take a few more minutes to make the patient's experience a little bit nicer." Take time to hear them and help them. I know you're right, but I think about how hard it is to do this sometimes. Overcapacity and understaffed departments, bounding from one task to the next, patient to patient, fueled by adrenaline and caffeine. There are many limitations within the system preventing us from slowing down. I wonder how patients interpret the revved up nervous systems and fast-paced environments. How does this impact their experience of trauma? I wonder what it does to nurses over time.

Trauma-informed care often requires you to hold space for those who have had previous negative experiences in life, and with healthcare. While you understand this comes with the work, I begin to see how this can be challenging for you at times. When you're a patient's first point of contact with the healthcare system, on what feels like their worst day, you can be met with a lot of anticipation, residual anxiety, and sometimes hostility. You recall a time where a patient came in, untrusting of nurses, his guard up, questioning everything you were doing.

Nothing you were doing was right. He had a negative experience at another hospital and was making you pay the price. I can see this was hard for you as you shared how you were trying everything you could think of to make his experience better. The trauma from his previous hospital experience wasn't your fault but you felt the repercussions. I think of how being the face of healthcare puts you at risk of also being the point of care punching bag. Sometimes people can't see that it was not your fault, they just need someone to blame. Sometimes the warm blanket doesn't work. I wonder what this does to nurses over time. How does that wear on you when you are doing your part, but having to deflect or carry the negative perspectives people have of the entire system? How do you keep caring?

In a setting where you consistently encounter people on their toughest days, regardless of what is happening in your own life, maintaining composure is imperative, you explain. Even though you might witness these difficult moments numerous times a day, you recognize the importance of striking a balance: acknowledging their struggles without allowing them to overwhelm you. But how do you maintain the balance? How do you preserve the boundaries of the nurse-patient relationship and while also meeting people with human connection and compassion? And why do you have to? A part of this is maintaining professionalism within your nurse-patient relationship. You tell me, "There's definitely a professional Barb … it's me, but with a shade of professionalism." A veil that keeps you on one side of the thin divide. You treat people as equals, take time to summarize their concerns, and understand their needs—making sure the basics are covered. If that separation didn't exist, you recognize that "we would be so exhausted and need so much time off of work if we were to take on all this emotional load… in some situations, if you actually cared so much, you'd never get any work done." I think about how it can be so draining, showing endless amounts of compassion. Always having to be 'on'

and “when you do this day in and day out, it just becomes monotonous.” As you say this, I hear how difficult it can be when you’re triaging so many patients in a day. It becomes almost automatic and perhaps, less caring. It becomes more difficult to show up in a good way. The routine of it. You’ve seen this before, they’ll be fine—or they won’t. I remember days where I could feel my compassion dissipate as I became disillusioned by the demands of the shift. When patients come in time and again, it can sometimes be difficult to find compassion or reserve judgement. Do you triage your compassion based on the seriousness of a patient’s condition, or does everyone get the same amount? I start to think of compassion as a currency. I wonder if there is a certain amount we can afford to spend before we’re in the red. How does compassion get replenished? Is it limited by what is affecting us outside of work? What happens when we run out and there’s nothing more to give?

With empathy,

Stephanie

**Turning to the Context of Rural Nursing**

Dear Barb,

Our conversations have been so insightful for me. I am grateful to learn from your perspectives and walk alongside you as you share your stories with me. As I come to understand trauma-informed care through your experiences, it is important to acknowledge the context in which these experiences occur. The places where your stories have lived. I think about how recounting our experiences is so tightly woven into the places they happen. About the interconnectedness of place and experience in shaping how we re-live and re-tell stories. Of how characteristics of physical locations can conjure memories, emotions, and sensations that can influence the way we perceive and recount our experiences. Turning to the context of rural

nursing, I wondered if rural settings invoke different trauma for nurses, or if the trauma they experience is attended to differently. With your diverse nursing experience, I was curious to hear how the places you've worked have contributed to your perception and understanding of trauma, and practice of trauma-informed care.

Your nursing career has taken many turns in relation to the locations you have worked, but perhaps most drastically when you traded urban center critical care nursing for small town mountain life on the other side of the world. It was a stark contrast, going from places where you got to "work with all the machines and all the doctors and suddenly there was nothing." Not absolutely nothing, though, just a lot less than you had become accustomed to until this point in your career. You point out that they had a CT scanner. I notice as you share your stories of working in different rural sites, having a CT scanner becomes a defining feature for just how rural a site is and how it also seems to provide you some security. You explain that most places you worked weren't remote, "but it was rural—everywhere I worked, most sites had a CT scanner, so I felt comfortable." I wonder what it is about this big machine that alleviates stress for you. A creature comfort for diagnosis and treatment from your years in urban sites? There were other things that were unsettling for you that contrasted what you were used to in the cities—specialty units overseen by general practitioners, high volumes in small spaces, inadequate staffing levels, unsafe patient ratios. One of the sites you describe as "the wild west"—it was so busy all the time and you weren't staffed properly to meet the high demands. As you tell me these stories, I think about the inequities in healthcare and resource allocation for rural sites. I wonder how these inequities affect patient care—not only access to care but also quality of care. Without appropriate resources, how are nurses supposed to provide quality care? I think about emotional toll that nurses may experience due to moral distress, burnout, and

inadequate support. Continually striving to fulfill basic requirements with limited resources, are they feeling like they're swimming against the current?

You recall a time where a patient was in cardiac arrest, and you remember being "really alone." In the middle of the night, a skeleton crew of staff, and nowhere for the patient to go but there—you had to jump into action and work with what you had. Even the unit clerk was pulled in to do chest compressions. I think about the difference from urban places where you often have an abundance of people or a designated team to respond to emergency situations with expertise and specialty training. It was interesting to me how highly you spoke of this experience, while I imagined it to be quite stressful. It was a time so early in your rural nursing career and what has stayed with you is the value of teamwork and the importance of working together—even if that meant people were working outside of scope. You recall the calm energy in the room, the dim lights, following algorithms, everyone working together to do what they could to save the patient's life, amid a life-threatening situation. I could see that you were proud of the work you had done, and even though the patient didn't survive, you sounded quite confident that they likely wouldn't have survived at a larger center either. I wonder if your confidence in this realization helped you see the other sides of this experience. There was only so much you could do with what you had. It comes up a couple of times in our conversations—that you can only do what you can do. I wonder if other rural nurses are able to come to terms with distressing situations in this way. I wonder how that stays with you. I wonder if working together in rural, out-of-the-way places changes how you respond to trauma—to each other's and to your own. I also wonder if your experience in critical care has influenced how you perceive caring for sick patients in rural areas—perhaps the exposure to poor outcomes, even with a full complement of resources, has helped you to understand that you do the best you can with what you've got, and

that death is part of life. Drawing on previous experience and knowledge. I wonder if it's always this simple for you.

Working in rural settings requires you to be resourceful, not only for patients being treated at the site, but also to ensure patients get to where they need to go for the treatment they need. Many rural sites don't have the capacity to care for critically ill or specialized patients and often need to transfer them to the larger, urban sites for care. Arranging a patient transfer isn't always straightforward. Rural sites are isolated, and transfer can get disrupted by unpredictable weather conditions, availability of emergency transportation services, human resources, and the instability of the patients themselves. Again, I hear the importance of teamwork as you recall a time you had to coordinate a transfer for a patient with a bad head injury. They needed to be flown to the city, but the fog was too thick, and it wasn't safe to fly. Knowing this patient's outcome was dependent on treatment that could only be provided in the city, you had no choice but to find another way. When you tell me, "You have to put your heads together and figure out a plan because help isn't coming," I sense the urgency of the situation come back to you as you re-tell this story. Your voice quickens as you explain how you tracked the weather to find a place nearby where there was no fog. You arranged ground transport to a neighbouring town and then a flight to the city from there. You reflect on what resources would be available at an urban site to assist this type of situation—social work, patient care coordinator, or discharge planner—but "when you work in these northern sites, it's all your problem." Nurses always wearing different hats, taking on different roles. While this isn't unique to rural nursing in my experience, I can see the necessity to move between roles or out of scope is exacerbated in places that are underserved. I think about how stressful it might be to carry the weight of that responsibility. What if the

patient doesn't get there in time? How will they get back? What about their family? I wonder how that stays with you.

Being in a rural area also makes it difficult to be able to offer the types of care patients need within their own communities. To keep them at home where they are comfortable, with family, community, or cultural support. You recall the many times you have cared for those struggling with substance use and think about how you "wish there were more detox beds." Limited space in town for specialized care means they have to travel to urban areas, to unfamiliar places with unfamiliar faces at a time where they need to feel safe and secure. You've seen this become a barrier to their health and well-being as they come into the emergency department time and again for short term solutions. I can see that this is frustrating to you as you tell me of these limitations. I wonder how this impacts you over time—knowing that people have options for treatment but because inequities within the system, they aren't accessible. You recall some places where there is no medical imaging. Patients have to travel off island or out of town to receive diagnostic imaging or testing. For the patient, this often comes with burdens they aren't willing to take on. You tell me, "It's not because they are refusing care, but because it's so challenging to get there and back that they don't want to bother or can't for financial or logistical reasons—or maybe because of previous negative experiences with the system." I think about how helpless this would make me feel. You want to help but your hands are tied.

Working in both urban and rural settings, you notice a prevalent stigma surrounding rural patients. This stigma implies that these individuals either declined care or should have sought treatment sooner to avoid reaching a point where treatment becomes challenging. This judgment lacks consideration for the unique circumstances these patients face. You recall admitting a patient from a rural center when you were working in the city and other nurses questioning why

they didn't do this or that. I remember thinking this many times before I was exposed to rural nursing. I can hear your compassion and understanding for rural nurses as you defend them to your urban colleagues, "they're just trying to stay afloat." They don't know that the blood work wasn't done because lab doesn't work on the weekend, or there's only one nurse and one doctor on, or maybe they just didn't have time. You're an advocate for rural nurses and patients when you're working in the city—I see you carry a sense of pride as you say, "I'm like a rep for the small guys." This makes me smile. We need more representation for the small guys. I think of how you call forward your experiences to help others understand. And about how these experiences have also shaped your identity as a nurse—a shift in relation to the places you have worked. I wonder if you carry trauma with you from the aloneness, the pressure to problem-solve, the getting by with what's available. I wonder if your experience in rural settings changed your perceptions of healthcare or maybe, your perspectives on life.

Something that stands out for me in our conversations, quite significantly, is violence in the workplace. You share a few different times where violence has threatened your safety at work, beginning with a time very early in your career. You recall a patient throwing a chair at you. You tell me this nonchalantly, like it wasn't a big deal. I am surprised by your indifference, but you assure me that things like that don't really affect you anymore—over time you have learned that it sometimes comes with the job. It's interesting to me that you have come to normalize this. I think about a time where a patient told me he was going to kill me. Looking me straight in the eyes as he said it with such conviction in his voice, I was sure he meant it. It makes me shudder and I can still see the bed space and surrounding equipment clearly in my mind. I recall several times where patients have tried to hurt me by grabbing my arm or throwing a punch or a kick. Dodging the blows while trying to give them medication that will keep them

alive. Because if I don't, is that considered abandonment? Where is the line of ethical duty? I wonder how those early experiences as a nurse, a time where you are both vulnerable and impressionable in your career, have influenced how you perceive violence at work now.

As we continue to talk about violence and security, I notice there are still times where you feel unsafe and fearful. You have experienced varying levels of security response depending on where you work. In the city, if someone became violent or aggressive the point of harm you would have six security guards responding and you would "literally do nothing." Aside from administering medication, you have other people who are trained to step in and take over. They have also implemented Relational Security Officers, whose job it is to de-escalate patients to avoid using physical interventions. But that role doesn't exist in many rural places. It's another job nurses in rural areas have to do. In contrast to urban centers, rural sites have minimal security on site, or sometimes, none at all. In times like these, you tell me, "everyone jumps in" to help. You recall a time where everyone, including the unit clerk (a different one this time), helped you hold an aggressive patient down so you could sedate them, "because what else are you going to do? You're gonna call the RCMP and maybe they're there in 10 minutes, but 10 minutes in that situation feels like 6 hours"—so you do what you have to do because other patients and staff are at risk of being harmed. I think about the rise of violence in healthcare and wonder who is looking after the nurses?

You realize that this scenario mirrors many of the situations you've encountered while working in rural areas. You recall times where you have been working alone in a clinic, thinking there are "people that may look harmless and then they pull a knife on you." I'm not sure if this has really happened to you. I didn't ask you in the moment. I don't think to ask you because I know it's not impossible. I recall finding various weapons on patients several times—

unfortunately, it's not uncommon. "And that Code Silver thing—what a joke, right?! Run, hide, fight,"—a terrifying thought as you reflect on the newest HEMBC response code meant to indicate threat of a person with a weapon, an active shooter, or a hostage situation. Even if this level of violence hasn't happened directly to you, I think about the trauma in the anticipation of possibility. Thinking about a possibility that could easily be reality. As we seem to be facing more uncertainty and violence and emergency services are stretched thin, safety is a real concern. You recall the fear and anxiety come up for you when you are assigned to be first call or knowing you'll be the only one present, not knowing what might be coming through the door. Having to wait for the RCMP, however long it might take them to respond. The only defence you have in this moment is relying on your communication skills and hoping you will be able to de-escalate the situation. What happens when de-escalation techniques don't work? Or you think you have a grasp on the situation only to realize you have aggravated the patient to the point of aggression and you have to wait for help to arrive? How do you incorporate a trauma-informed approach when you're scared for your life? How do you manage your own trauma generated from the place you work—a place that evokes feelings of fear and anxiety?

With kindness,

Stephanie

### Recognizing Trauma in Yourself

Dear Barb,

When we first began to talk about how you understand trauma-informed care you were quick to recognize that it was something you do to make a patient's experience better. You assured me that "trauma-informed care literally means nothing pertaining to myself." You had never heard of the term vicarious trauma. This was not surprising to me. It took me some time to

come to understand this term, recognize it in my practice, and how it has affected me over time. I see you start to put the pieces of this term together and as we continued to work through some of your experience's I notice how your understanding begins to shift. How you being to see how your experiences have influenced you over time. You started to ask me questions—you began to challenge your own thoughts. I see something shift in your understanding and how you are beginning to link your experiences together and look at them in different ways. You are becoming attentive to past experiences in different ways as we move forward in our conversations. This makes me excited that we have been able to come to this place alongside one another. But I'm also nervous. I'm nervous that I have opened some cracks in your thinking. That these conversations have helped you come to understand your experiences but also that we have begun to link previously unknown traumas to your ways of thinking, coping, and processing your work.

As we delve into our discussions, I notice how you contrast your perspectives from the past to the present. Comparing your viewpoint as a novice nurse with your seasoned outlook now, after 12 years. While it has been challenging for you to pinpoint exactly how your work has left you with residual trauma, I notice that you are reminded as you re-tell times from your past. When you were new to nursing, lacking confidence, unorganized, and scared of making mistakes, you would sometimes leave work crying because patients or their families had been unkind to you or yelled at you. You would take it personally, letting their words go straight to your heart, shattering what little confidence you had. You hated it. I can hear in your voice that this was something that really upset you, though you assure me, you took it so much worse than you do now. I'm not sure I'm convinced and find myself curious to learn more about how you've come to this place. Patients are still mean, but you are firm in your statement that it doesn't affect

you as much anymore. You can’t remember the last time someone made you cry at work—it’s been 5 or 6 years, as far as you can recall.

I think about the times I have been yelled at by patients or family members. Usually because of long wait times or their dissatisfaction with the doctors’ recommendations. Things that were out of my control. I recall a time where a family member was so mean to me, yelling and harassing me incessantly throughout my shift. The experience was so upsetting that one of the doctors and many of the nurses working that same day reached out to me for many days afterward to see if I was ok. I remember thanking them and shaking it off—of course I was fine. It’s happened before, and I was sure it would happen again. I am surprised that this memory comes back so vividly for as I share it with you. I can still see the woman’s face glaring at me disapprovingly if I close my eyes. There was nothing I could do to make her see I had no control. I wonder, as you recall those early days, how you move past the hurt from the verbal abuse. And does it ever really go away? Or have you just started to measure the severity of the impact based on the number of tears shed? We talk about how time, experience, and mentorship help to create a foundation for managing these harsh interactions. To de-escalate and approach with confidence. I wonder if as we get more confident in responding to this behaviour, have we also learned to develop a thicker skin to protect ourselves from the blows the next time? Because sadly, there is always a next time. I wonder what it means to have to adapt to this trauma so we can continue to do the work. Is this repeated abuse what hardens us as nurses? We build up our walls so that a person’s words don’t cut as deep, and we slowly become covered in scar tissue. Is this what contributes to the darkening of our hearts? How do we know when it’s happening? What does this do to us over time? I wonder how this affects our interactions with our colleagues, communities, and loved ones.

We may have found ways to manage, but we don't forget those early years. I notice this as you re-tell your stories. Going back and forth from what it was like in the beginning of your career to what it's like now. Bringing these experiences back to the front of your mind to compare one time to another. These experiences stay with you—they live in a place where you can call on them to help make sense of your work, your memories, your emotional turmoil.

You have come to understand vicarious trauma as "things happen to us, but we just shove it into our subconscious. And then it reappears, gets recycled, and reappears." We talk about how there are little things, events or a series of events, that happen over time and can sometimes show up in ways you're not expecting. Things you thought you had long since forgotten, and as if something suddenly clicked into place, I watched you sit up a little straighter and say, "All of a sudden, you're in a conversation and you're anxious. You don't know why… Something or someone triggers it. And you're like, why am I turning beet red right now?" I wonder if this has happened to you. It seems to me that you are familiar with being triggered by something from your past. I think of a time when a friend called to see if I had any N95 masks because there was black mold in the bathroom they were renovating. For a split second I was back in the hot zone during the pandemic sweating in my PPE with my respirator strapped tightly to my face, heart racing. I get the impression you don't want to elaborate on this as you take the conversation on a quick turn to acknowledge that you are generally unaffected because you don't have an emotional relationship to the patients you see. You don't know them personally. You say this as a though to place a clear boundary between you and the patient. I wonder how you do this. How do you so clearly disconnect? From the patients or from sharing their worst days with them. Your answer seems simple to you as you tell me matter-of-factly, "you see it all the time and you

just get used to it." Do you? If you're caught off guard by something in casual conversation that triggers symptoms of an anxiety attack?

I think about this emotional disconnection as a survival mechanism in a highly emotional profession. A way to protect boundaries and keep distanced so it doesn't affect us as much. But I wonder if we are really able to fully disconnect from those who we have shared such intimate moments with—so often, life altering moments. You mentioned the word dissociate—"How do you dissociate from the things you see every day?" Should you? I think a bit more about that word—dissociate. Disconnect, separate, detach, isolate. And from what? From social context, from environment, from patients, from each other—to me, it's all so interconnected in nursing. Dissociating from distressing situations can serve as a coping mechanism, allowing us space to manage our emotions and continue providing care effectively. But what if this dissociation becomes a habitual response? What if it gets confused as resilience? I worry this will lead to emotional detachment and potentially compromise the quality of patient care. I worry it might lead to alienation from the human connection central to nursing. I worry that if it gets confused as resilience, it might perpetuate an inability to recognize and respond to our own trauma.

What happens when someone is kind and we let them inside the protective barriers we've worked so hard to put in place as professionals? What if there is a patient who points a mirror at you and suddenly you see similarities in your loved ones, or maybe in yourself? There was a patient who touched you in this way. Someone who was living a life that you could see for your future self. They had a terminal prognosis with only weeks left to live when you first met. I hear the sadness in your voice as you remember your interaction with her and share your connection to her through mutual interests and goals. It was this patient, or patients like these, that put a little bit of humanity back into your work when you've allowed your walls to be built high over time.

As I listen to how you remember this patient, I see how you care. Your compassion resonates and while the story brings sadness, you also recognize this as a "nice little wake-up call" that you need sometimes. A reminder that your "heart's not that black—it's a shade of grey." I think of how important these reminders are to me. Allowing space for connection so that we can show up with compassion and authenticity. Closing ourselves off to the normal emotional responses to distressing situations can't be healthy over time. I think of the "black heart" metaphor so often used in nursing. I've used it many times, in conversations with friends and colleagues—passed off as a joke, but it's not a joke. It's sad to think that to survive in this caring profession we have to paint our hearts black, protect it with armour, to minimize the trauma. An expression of sarcasm, suppressing the real emotion to create an illusion that you aren't affected by the hardships of the world. Aren't our hearts are supposed to be filled with colour?

So how do we create boundaries that allow us to be present in our profession but also protective of our well-being? It's hard to imagine how there could be a complete separation between work life and home life. How do we know if letting them in is too much for us to carry emotionally? What do we do when it is? You tell me that "you shouldn't take so much of it home that it affects our personal life and relationships outside of work. You should be able to function normally outside of work—that's how much you should be able to take home. As soon as it starts affecting you outside of work, then you've got an issue." I wonder though, how do we know when too much is too much? I was curious how you are able to recognize if you've started to allow your work to interrupt your life outside of work. I think about your ICU experience and how it challenged your ethics at times. There was a time where your partner had to remind you how much you hated it and of times you would come home crying because of the moral distress you experienced. So interesting to me that you recall him having to remind you of this. I wonder

how far you had buried those feelings. I wonder if you'll want to come back to them. I can tell you remember as you slowly allow yourself to go back there. You remember the anguish you felt knowing the treatment you were providing was futile—care you had to continue to provide, and you shared with me that you were often left thinking about how animals are treated better. A dark thought in a helping profession. I think about trauma that comes from morally distressing and ethically complicated circumstances. I recall my years in the ICU. The internal struggle I felt as decisions being made outside of my control involved contemplating the value of a life worth saving. No real control over the decisions being made but being the one who comforts the family either way. Feeling like you're doing more harm than good with your hands tied. Coming to terms with the clash of your own values and the work you do. Helpless. It was when you started to notice your attitude toward this type of work started to shift that you knew it was time for something different. You recall becoming disenchanted, feeling annoyed, and thinking "this is stupid." You think about how you weren't as on top of things as you should be, and I can see how doing a good job is important to you. It's interesting for me as I listen to how your feelings shifted over time as you worked in the ICU—about how you became unable to function normally at work, with a "bad attitude" and "eye-rolling." I wonder if you notice that sometimes the emotional burden can be too heavy to carry at work.

There are turning points in our conversations where I can see that you are starting to become more curious about what happens as we collect these cumulative experiences and contemplate what that does to us over time. I see that you are moving back and forth between coming to terms with the recognition of your own trauma but sometimes deflecting your connection to it. I wonder how you recognize symptoms of trauma in yourself. How you process the hard things you see at work, day in and day out. How the events of the past show up for you

in your life. You think on this for a moment. A silent moment where I can see that you're scanning the file folders of your mind to recollect a defining experience. You can't recall having experienced any severe traumatic events but, in our conversations, I can see that there are moments that stay with you and think that this is perhaps more impactful. Maybe it's not the big life altering situations that leave the lasting marks. I wonder if you notice this. I hope it's ok that I'm sharing this with you. I can see that you continue to think about what it means to 'just get used to it' and come to terms as you take a moment to think about some of my questions. "It's not something that nurses talk about very much, all these little micro traumas," you tell me. It's not something you have thought a lot about. When you start to turn questions over to me, I see that have found a new way of thinking. You start to consider how to make sense of these experiences. I hear you say a little more quietly, "seeing all this stuff, and you're just meant to move on from it," and I wonder if you're speaking to me or to yourself. And when you ask me, "over time, what does that amount to? How do you not bring anything home?" I wish I had the answers. In many ways, I'm still trying to figure that out too.

In a job where it is impossible to avoid trauma, I wonder how you cope with the experiences that have caused distress or confusion. How do you make sense of them in order to move forward and move on to the next patient? I hear that it is important for you to talk to your colleagues or nursing friends. To discuss the things that went well and the things you could have done better or differently with those who can truly understand and empathize. I need to do this too—to reflect on traumatic experiences in a way that leaves us with some sort of lesson or opportunity for change. What stays with me though, is the importance of hearing someone tell you that you've done a good job. To receive acknowledgement and validation from those around you helps come to terms with stressful situations. You are sure to tell others they've done a good

job because you know you'd want to hear the same. It was so interesting for me as we talked about where this desire comes from that you take me back to your childhood. To a place where you felt like you were always trying to measure up. Trying to prove yourself to make people proud. Searching for affirmation to build your confidence, yet perpetually falling short of validation you sought. Coming to understand this relationship to your adult life you say, "my childhood trauma's seep into my career" and I think about how trauma lives in places we don't always know and it shows up at times we least expect. I wonder if time and experience has really changed how you attend to your trauma. I also think about your decision to choose nursing as a career. For some, it's seen as a profession with little acknowledgment and appreciation—a chance to chase validation endlessly. Yet, others regard it as a deeply respected vocation—a chance to be valued in a way your upbringing never allowed.

I wonder how your childhood experiences could be related to your early years as a nurse as you recalled your insecurity and sense of self-doubt leaving you vulnerable to the negative interactions you still remember. Searching for someone to tell you had done a good job. I hear frustration in your voice as you tell me of a time where you knew something was wrong with a patient and no one was listening to you. No one was supporting you. The senior nurse didn't help you. You had done the best you could but when you handed over to the day shift, being blamed for things you couldn't control, holding back the flood tears that were accumulating over the night, you "felt like she was just throwing [you] to the wolves and it felt icky." You had tried your best and it wasn't enough. I notice you look down at your hands as you finish this story and see that you must have felt so helpless and alone. I think about the long-standing culture of having to prove yourself in nursing. The saying "nurses eat their young" rings true in my experience. Having to prove yourself in the beginning. Having to earn respect. Trying to keep

your head above water. A sense of fear instilled in the early years of nursing practice. I'm hopeful this culture is shifting. You look up slowly after telling me that story and say, "I don't know why that just popped into my head." I think about how it is all connected. Different traumas from different parts of our lives, sometimes embedded deep within our subconscious. Showing up in unexpected ways. Always embodied.

With heartfelt care,

Stephanie

My conversations with Barb have left me both intrigued and validated, as I reflect on our journey together. The twists and turns of our discussions took us down paths untravelled and left some rocks unsettled. We closed with some unanswered questions, some things to think about in the quiet of the forest, knowing we can come together again to continue to explore this topic. I am so grateful for this. I hope these conversations have shed some light on how trauma manifests in her work and how it has influenced her both personally and professionally.

**Chapter 6: Publication**

**(to be submitted to the Canadian Journal of Nursing Research)**

Disrupting Dominant Stories of Trauma: A Narrative Inquiry into the Experiences of Nurses Working in a Rural Setting in Western Canada

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**Abstract**

Principles of trauma-informed care are strongly aligned with nursing ethics, professional standards, and human rights and provide a framework for safe, compassionate, person-centred care. Additionally, trauma-informed care promotes emotional safety, patient engagement and empowerment, and treatment adherence, leading to improved health outcomes. Trauma-informed care also draws attention to recognizing vicarious trauma. Research suggests that rural nurses' limited knowledge and education challenge incorporating trauma-informed care into practice in rural healthcare settings. In this narrative inquiry I explore the experiences of nurses in relation to trauma in rural acute care settings. Narrative inquiry helps to understand better how nurses' personal, practical, social, and institutional stories impact care delivery related to trauma-informed care, including vicarious trauma. I engaged with two nurses, Veronica and Barb, in three to four 1-hour conversations across 2 to 3 months. The conversations were recorded and transcribed verbatim. Transcriptions and field notes, including personal observations and reflections, formed the narrative accounts and were analyzed for resonant threads. Two threads were made visible: a) Learning to name trauma: the absence of language, turning to metaphor, and attending to embodiment, and b) Disrupting dominant stories of trauma-informed care: balancing personal and professional boundaries, and exploring the complexities of rural environments. This study has the potential to inform organizational policies, resources, and educational efforts to address trauma. It could enhance nurse retention and create innovative ways to support quality in patient-centred care, improve patient outcomes, and empower nurses and patients working with trauma.

*Keywords:* Trauma-informed care, narrative inquiry, vicarious trauma, rural nursing

## Disrupting Dominant Stories of Trauma: A Narrative Inquiry into the Experiences of Nurses Working in a Rural Setting in Western Canada

*Fueled by a constant stream of adrenaline throughout the day, it was not until my drive home that the events of that day began to sink in. I thought about how traumatizing those experiences must have been for the patients. [...] The adrenaline in my body continued to swirl and spin my thoughts. I could not contain my grief and exhaustion as I entered the doors of my house. I unleashed the flood of tears I had held back as I replayed the day in my mind. Unable to explain what was wrong to my partner through uncontrollable sobs and in words he would understand, he stood firm and held me. Reflecting on these experiences, I now see how I was driven not only to fulfill the patient's immediate needs but also to uphold the system requirements—to respond to the next call, to facilitate a critical transfer, and to be ready for whatever came next. [...]. I did not stop to consider how it was affecting me. I think about this now as I have stepped into roles that are further away from the bedside and have provided me with the perspective one gains with distance. Thinking of my own experiences has led me to ask many questions about how trauma-informed approaches live in nursing practice. How do nurses recognize trauma in their practice? How do they cope with trauma? How does their understanding of trauma relate to nurses' relationships with their patients? How does trauma affect nursing retention? How does trauma-informed care play out in practice for nurses?*

My narrative beginnings shaped this narrative inquiry into the experiences of rural nurses in relation to trauma. In addition to working as a registered nurse in critical care and clinical education, I have had the opportunity to participate in a knowledge translation pilot project for nurses related to trauma-informed care at a rural practice site. Through this work, I learned that

nurses were familiar with the term *trauma-informed care* but needed to learn about the core values and the ethical importance of integrating this practice into care. I noticed that nurses seemed unaware of how the traumatic experiences of others can lead to moral residue, trigger symptoms of traumatic stress, and affect their well-being and ability to provide quality nursing care. While nurses are encouraged to practice trauma-informed care, there is a gap in education and training that could effectively help rural nurses engage in knowledge mobilization for trauma-informed care.

**Trauma-Informed Care in Rural Nursing**

Trauma-informed care has become a widely used term in healthcare. The Substance Abuse and Mental Health Services Administration (SAMHSA) (2014) has characterized trauma-informed care as understanding the prevalence of trauma, distinguishing the signs and symptoms of traumatic stress, and responding with combined knowledge and skills to prevent re-traumatization or reliving of previous trauma. The principles of trauma-informed care strongly align with nursing ethics, professional standards, and human rights, guiding nurses to provide safe, compassionate, unbiased, person-centred care. By incorporating the principles of trauma-informed care into policy and practice, safe environments foster patient engagement, increase treatment adherence, and promote health equity that will ultimately improve health outcomes for communities (Dowdell & Speck, 2022; Fleishman et al., 2019; Zordan et al., 2022). Knowledge and access to trauma-informed care resources are not equally distributed; Ervin et al. (2021) found that 70% of healthcare staff in rural healthcare settings reported needing more knowledge and education related to trauma-informed care. This statistic is concerning, considering rural communities' unique challenges, such as limited access to healthcare resources, cultural diversity, and geographical isolation. Rural settings are complex environments where

multilayered contexts, diverse patient populations, and community integration play critical roles in how trauma-informed healthcare is delivered and taken up.

### *Trauma-Informed Care*

A trauma-informed approach to patient care encompasses respect for human rights and patient dignity. It is connected to the foundations of nursing ethics to provide safe and compassionate care, free of judgment (Dowdell & Speck, 2022). Trauma-informed care is a concept that assists nurses in acknowledging the importance of a patient's lived experiences. It provides a framework for care delivery that encompasses knowledge and understanding of how trauma can impact a patient's mental, physical, and emotional well-being, identifies signs and symptoms of traumatic stress, and guides practice for a safe, empathetic, and respectful approach that resists re-traumatization (Dowdell & Speck, 2022; Ervin et al., 2021). While the initial focus of trauma-informed care is recognizing trauma, the basis of the practice is grounded in building connections to acknowledge the brain and body's response to trauma and working toward supportive healing (Schimmels & Cunningham, 2021).

### *Vicarious Trauma*

Nurses are vulnerable to the impacts of trauma. Over time, the effects of empathetic engagement with traumatized patients and indirect exposure to trauma can negatively affect a nurse's psychological wellness (Isobel & Thomas, 2022). This repeated exposure can develop into a type of traumatic stress called vicarious trauma (Isobel & Thomas, 2022; Tabor, 2011). A term initially identified in trauma therapists by McCann and Pearlman (1990), vicarious trauma refers to the experience of developing traumatic responses as a result of exposure to the trauma experienced by others (Isobel & Thomas, 2022).

Rural nurses are vulnerable to experiencing vicarious trauma due to the high frequency of repeated exposure to stories of trauma and abuse, lack of resources, geographical isolation, community cultural diversity, limited debriefing opportunities, and limited onsite psychological support (Jahner et al., 2022). Patients are also members of the community that nurses are a part of in their ordinary lives. Patients and nurses' shop at the same grocery store or find their mail at the same post office; they have children who go to the same schools and play in the same playgrounds. So, when traumatic events arise in a rural community hospital, there is potential for a stronger relational impact on nurses than in urban centers.

The cumulative exposure to caring for those who have survived traumatic events can affect job performance, morale, behaviour, personal and professional relationships, and communication; symptoms have been shown to parallel those of post-traumatic stress disorder, causing shifts in world views and beliefs, altering self-esteem, and emotional and psychological health (Tabor, 2011). Jahner et al. (2022) suggested that vicarious trauma is an occupational health and safety risk to the mental health of rural nurses and that this phenomenon creates negative repercussions and risks for patient safety. Without recognition and understanding of this phenomenon, both nurse and patient suffer. Recognizing vicarious trauma is an essential component of trauma-informed care that requires awareness, acknowledgment, and support to promote both nurse and patient well-being.

***Understanding Trauma: Nurses' Knowledge, Attitudes, and Competency***

As nursing moves toward technology-driven, standardized care models and quantifiable patient results, it is becoming more difficult for nurses to engage in therapeutic and trusting relationships that exemplify principles of trauma-informed care (Schimmels & Cunningham, 2021; Stokes et al., 2017). Schimmels and Cunningham (2021) claimed that education and

support for trauma-informed care are essential to provoke a cultural shift from task-focused care to care based on trust and avoidance of re-traumatization of both patients and staff. There is limited research related to trauma and trauma-informed care to support trauma-informed rural nursing practice in Canada. A systematic review completed by Jahner et al. (2019) confirmed a paucity of research on trauma and rural nursing practice in all of North America, stating that most research originates in Australia.

**Methodology, Methods, and Procedures**

This narrative inquiry provides a rich and in-depth study into how trauma-informed care is understood and applied in practice over time within the context of rural acute care settings; it provides opportunities for education initiatives and mobilization of knowledge for nursing care within rural settings. Narrative inquiry is a relational qualitative research methodology where the researcher inquires into the stories participants tell and live to gain insight into their experiences, perspectives, and meanings attributed to those experiences within social, cultural, and institutional contexts (Clandinin & Rosiek, 2007). According to Clandinin and Rosiek (2007), narrative inquiry "is a way of honouring lived experience as a source of important knowledge and understanding" (p. 42). The researcher and participant work collaboratively to inquire into experiences within a three-dimensional framework of temporality, sociality, and place (Clandinin, 2013; Clandinin & Caine, 2013; Clandinin & Rosiek, 2007)). With attention to the past, present, and future, social interactions, and location, experience is understood with rich, contextual meaning (Clandinin & Connelly, 2000).

As experience is central to narrative inquiry, the methodology is in keeping with Dewey's pragmatist philosophy (1938), accentuating the importance of continuity and the dynamic relationship between the individual and their environment (Clandinin & Rosiek, 2007).

Experience is viewed as transactional and ever-changing, with each experience providing context for the next (Clandinin & Rosiek, 2007). This approach values the richness of individual stories and offers the opportunity to reveal the diverse ways nurses make sense of their lives at work.

### *Setting and Sample*

Participants were employed nurses with a minimum of 1 year's experience in rural nursing. Two nurses from a 20-bed rural acute care facility in Western Canada were recruited to participate in this study. This is a typical sample size for a narrative inquiry study (Clandinin, 2013), as the goal of this qualitative study is not to generalize but to uncover meaning and expose various realities related to trauma-informed care within the context of rural nursing practices (Polit & Beck, 2021). Narratives were told over time in a series of conversational meetings. Participants were not required to have knowledge or training in trauma-informed care.

Nurse leaders at the site distributed emails including information about the study, its purpose, and requests for participants. Posters were placed in highly visible locations. Interested nurses were provided with the necessary contact information or agreed to have their contact information shared with me. Initial conversations with the participants described the study in detail, and written consent was obtained. Conversations were audio recorded and transcribed verbatim. Participants were provided with refreshments and received a small honorarium of $25 for their time. Ethics approval was obtained through the British Columbia Harmonized Ethics Board, and operational approval for recruitment was through the Vancouver Coastal Health Authority (VCH). To establish confidentiality, all names and identifying information have been replaced.

***Data Collection and Analysis***

Narrative inquiry requires an understanding that the research begins in the midst of both participant and researcher lives, recognizing that "lives are shaped by attending to past, present, and unfolding social, cultural, institutional, linguistic, and familial narratives" (Clandinin & Caine, 2013, p. 170). The setting for narrative inquiry is a relational space often referred to as the *field* and negotiated between researcher and participant (Clandinin & Caine, 2013). It was important for me to meet participants in an environment they chose to foster psychological safety and comfort so they could share their experiences. Field texts were composed over four 1-hour in-person conversations with each participant. Participants led the conversations and were guided by open-ended questions to clarify my interpretation or to help provide a deeper understanding of their experiences around trauma-informed care. I recognized that speaking about trauma may be triggering or uncomfortable for participants as they retold and relived their stories. I invited them to develop field texts to share through journaling, art, or poetry, as this may provide a safer way to express their experiences. I also encouraged participants to share artifacts, such as art or photographs, to help contextualize experiences or shape their stories. Neither participant chose to share field texts in ways other than conversations, but they were grateful for the option.

I kept field notes to document contextual information during participant conversations (Polit & Beck, 2021). These notes were used in the data analysis as texts were negotiated with participants. I collaboratively negotiated field texts and interim research texts alongside participants, called narrative accounts. The active engagement of participants ensured that narrative interpretations represented the experiences discussed and made visible the relationships the participants and I held. Once the narrative accounts were composed, they were shared with participants, providing an opportunity for them to read at their own pace, reflect, and respond.

Once narrative accounts were negotiated, I laid the accounts metaphorically side by side and explored resonant threads across the accounts (Clandinin & Connelly, 2000). These resonant threads form the central elements of the final research texts.

## Narrative Accounts: Meeting Veronica and Barb

To convey the depth of our discussions, I chose to write the narrative accounts as a series of letters. Each letter focused on a distinct aspect of the experience of trauma-informed care. This approach enabled me to express my understanding of the participants' experiences in relation to my own, intertwining our narratives as we walked alongside one another.

### *Coming to Know Veronica*

With an interest in trauma-informed care and research, Veronica sought me out as I walked down the hospital hallway to inquire about this study. Continuing her own education had sparked a research interest. Veronica and I had worked together for a short time, and while our interactions were always friendly, it wasn't until we engaged in this narrative inquiry that we came to know more about each other's lives.  Below is a composite of a series of letters I wrote to Veronica as a relational way to represent the stories she retold and relived alongside me.

> *Dear Veronica, your reason for choosing nursing was simple. You wanted to help people. You wanted to help people heal. You came to understand trauma-informed care early in your career as embracing a 'caring aspect,' and it was the significance of really listening to the patient that stayed with you. Learning about trauma helped you come to understand that a person's experiences continue to live within them—whether they realize it or not and that it can change how they respond to situations. Only when you learned of a patient's history did you begin to understand what might be going on for them, and I see heartbreak in your face as you remember some of the people you cared*

*with. As we continued to talk about what might be going on for a particular patient, a new sense of understanding developed. Knowing what they had been through changed your perspective; it probably changed the way you interacted with them. Time to establish trust and create a safe space for patients to open up to you can seem like an impossible task. A sandwich, a cup of tea, a warm blanket—hoping it conveys the care and concern you feel.*

*You anticipate that they will remember how you made them feel, to remember you in ways that speak of the care and healing you provided and the reasons you became a nurse in the first place. You have a knack for recognizing people's faces. Knowing that you may run into patients while out on your regular errands keeps you accountable. It's hard to explain the nuances of rural healthcare when you have never experienced it. You just do what you have to do, with what you have, for the patients. Patients having to leave their community for care in the city causes immense distress. The distress lingers with you, as you are not sure about the care they will be able to access in the city.*

*You have felt alone at work, unsafe and vulnerable. There have been times where you waited for the police to arrive, what seemed a very long, twenty minutes later. I feel your frustration with the broken system and sense sadness and helplessness in your voice. You are confident in most situations because you draw on your clinical knowledge and experience to know how to put the pieces together to find a solution, but it was the occasional shake in your voice as you spoke. The wringing of your hands. These small gestures told me something that had had a big impact on you, where you didn't know what to do, where you were frozen in fear. Trying your best to hide your own shock, your mind racing to find a solution, and you didn't want to worry the patient, who was looking*

*up at you weakly, with pale skin and pain in her eyes. An acute awareness of the aloneness of being at a rural site.*

*Unable to go back to work for a couple of days, and trouble sleeping with continuous thoughts of what had happened—thinking about what you missed or could have done differently. Self-doubt, uncertainty, and helplessness are some of the residual feelings you're left to make sense of. You find comfort in turning to your nursing friends. Non-healthcare workers can be too sensitive to the stories, and what they don't realize is that you just start to think it's normal. It's just what we do. But what we do is not normal. You weren't aware of the healthcare-associated trauma you still carried until you began to talk about it again.*

*With care, Stephanie.*

***Coming to Know Barb***

Barb is a charismatic, fun-loving person with an infectious laugh. Barb reminds me of the hints of sarcasm and dark wit I have come to know as characteristic of so many nurses. She is adventurous and free-spirited and has accumulated a wealth of experience in her personal and professional life. With a diverse clinical background and experiences across various rural sites, I was thrilled when Barb volunteered to participate in this study. We have known each other for many years, a friendship forged through nursing connections and intersecting professional lives. Coming together as a researcher and participant was a shift to an unfamiliar place that soon settled as curiosity unfolded, going back and forth in time and coming to make sense of experiences. The conversations we shared were so different from those in our past as we ventured into this inquiry alongside one another. The following is a synthesis of the letters written to Barb representing the narrative accounts of our conversations.

*Dear Barb, I remember when you told me that "Trauma-informed care literally means nothing pertaining to myself." It is "all about patients who have trauma," and to recognize it, "you need to be able to read people." You consider yourself a people person, and reading people is something that goes hand in hand with that. If someone is "warm and open to you," it's "a green light," but if they're "not giving you much," you understand something may have happened to them. You have an opportunity to make their experience better by dimming the lights or bringing them a warm blanket; you go "back to basics." You might ask them what is triggering for them, uncertainty in your voice, as you wonder: Is this the right thing to do?*

*You have learned about trauma-informed care over years of practice, observation and mentorship, and trusting in your "nursing spidey senses." Confidence and your approach to patients changed as you aged. Moving from urban critical care to small-town mountain life was like going from places where you got to "work with all the machines and all the doctors, and suddenly there was nothing." A patient was in cardiac arrest, and you remember being "really alone." You had to jump into action and work with what you had. You had to coordinate a transfer for a patient with a bad head injury; the fog was too thick, and it wasn't safe to fly. I can still hear you say: "You have to put your heads together and figure out a plan because help isn't coming, [...] when you work in these northern sites, it's all your problem." You have compassion and understanding for rural nurses as you defend them to your urban colleagues; calling forward your experiences to help others understand. You've been met with a lot of anticipation, residual anxiety, and sometimes hostility. Nothing you were doing was right.*

*Regardless of what is happening in your own life, maintaining composure is imperative. "There's definitely a professional Barb." If that personal and professional separation didn't exist, you recognize that "we would be so exhausted and need so much time off of work. If you actually cared so much, you'd never get any work done."*

*You recall a patient throwing a chair at you—times where you feel unsafe and fearful. You call the RCMP, and "maybe they're there in 10 minutes, but 10 minutes in that situation feels like 6 hours,"—so you do what you have to do because other patients and staff are at risk of being harmed. Things like that don't really affect you anymore—over time, you have learned that it sometimes comes with the job. Knowing you'll be the only one present, not knowing what might be coming through the door. Trauma in the anticipation of possibility.*

*You had never heard of the term vicarious trauma. Moving back and forth between coming to terms with the recognition of your own traumas and deflecting your connection to them, unaffected because you don't have an emotional relationship to the patients you see. You mentioned, "You see it all the time, and you just get used to it." At the same time, you said that when you meet someone you can see yourself in, you also recognize this as a "nice little wake-up call." A reminder that your "heart's not that black." You remember the anguish you felt knowing the treatment you were providing was futile… dark thoughts in a helping profession. There are moments that stay with you: "It's not something that nurses talk about very much." Acknowledgement and validation from those around you helps you come to terms with stressful situations. And there is a moment where you shared with me that you recognize that your "childhood traumas seep into [your]career" as you try to prove yourself to make people proud. Suddenly, you*

*recall a time where no one was supporting you, blamed for things you couldn't control, holding back the flood of tears that were accumulating over the night. You look up slowly and say, "I don't know why that just popped into my head." I think about how it is all connected and how your tears speak to the embodiment of trauma.*

*With affection, Stephanie.*

**Resonant Threads**

Laying the narrative accounts of Veronica, Barb, and also my experiences metaphorically alongside each other, I am beginning to name threads that resonate across our experiences (Clandinin, 2013). Resonant threads can also be described as the "echoes that reverberated across" the participants' stories (Clandinin, 2013, p. 132). It is important to acknowledge that, in laying participants' narrative accounts side by side, I am not looking for universal or generalizable stories; instead, the "richness of the narratives of experience" is most important (Clandinin & Connelly, 2000, p. 142). While there are multiple threads that resonate across our experiences, in this paper, I will explore two threads in particular, which are called *Learning to Name Trauma* and *Disrupting Dominant Stories of Trauma.* These two threads held significant practice implications. They highlighted for me the complexities inherent in the experiences of the participants.

**Resonant Thread: Learning to Name Trauma**

The first resonant thread became visible in the early conversations with Veronica and Barb. Along with limited knowledge of vicarious trauma and its relation to trauma-informed care, I noticed Veronica and Barb's hesitancy in acknowledging and describing their own trauma but detected their emotional or somatic responses threaded throughout our conversations. It was easy to see trauma in others. Still, there was difficulty in turning inward to recognize and

acknowledge their own trauma as a response to their work or in relation to patients or the environment. I was reminded of van der Kolk (2014), who stated, “Language evolved primarily to share ‘things out there,’ not to communicate our inner feeling [...]. Most of us are better at describing someone else than we are at describing ourselves” (p. 239). In this narrative thread, I could see that language, metaphor, and embodiment are part of the ways in which participants began to name trauma.

***The Absence of Language***

When it came to exploring the effects of trauma alongside the participants, I noticed my own apprehension. I recognize that I, too, am still learning to name trauma. I was trying to recall how I had been taught how to talk about the trauma I experienced. Veronica described a time so distressing that it left her unable to go back to work for several days and suffering sleepless nights with recurring thoughts of different outcomes. Yet, she did not label this as trauma. She described the trauma as something inherent to her work. In doing so, she minimized the psychological and physical burdens she carried from the experience. In her retelling and reliving of the experience, it was the patient’s trauma that was re-told, turning to find ways to attend to their experience, to comfort them. It was also difficult for Veronica to convey her experiences to colleagues who were situated in urban centers. She said, *It’s hard to explain the nuances of rural healthcare when you have never experienced it.* I wonder if, within this rural vernacular where trauma is too hard to explain with words—the tensions experienced around trauma are further perpetuated. Sometimes, when people cannot find the words for things that have happened to them, or when there simply are no words that capture what has happened, a different kind of language takes over communication about the experience.

As I listened to Barb, I noticed her *Moving back and forth between coming to terms with the recognition of [her] own trauma but sometimes deflecting [her] connection to it.* She doesn't recall any severe traumatic events that have happened to her, but as our conversations evolved, she started to wonder about how different moments have stayed with her. She recognized that *it's not something that nurses talk about very much, all these little micro traumas.* Never having heard of vicarious trauma before our conversations, it takes some time to see that her early experiences as a nurse continue to stay with her. She has normalized them over time, adapting to her experiences and believing that this is just part of the job. In this way, trauma appears normalized and serves as a way to cope.

Baes et al. (2023) claimed the growing trend toward identifying less intense events as trauma risks reducing the severity of trauma experienced by an individual. The threshold for what is considered traumatic is reduced. Thinking of the word 'trauma' and its liberal use in an increasing number of contexts, I wonder if the trauma nurses regularly witness at work plays a role in changing the threshold for accepting an experience as traumatic. I wonder how this might influence the experiences of trauma. If nurses cannot name trauma in a meaningful way, if they are unable to talk about it in a way that is recognized by administrators, will they find less support? In this inquiry, participants' experiences show how language to recognize and describe traumatic experiences can be replaced by silence, isolation, and moral distress, which diminish the well-being of nurses and the quality of care they provide.

### ***Turning to Metaphors***

Without words, we turn to other ways to make sense of and describe experiences. Metaphor is a powerful tool often used in nursing, adding richness to context, emotion, and nuance within our narratives. Fitzpatrick and Farquhar (2019) stated, "It is through these

interpretive acts that people give meaning to their experiences of the world and develop their relationships within the world" (p. 3). Perhaps nurses turn to metaphors because it is hard to locate the right words to describe their experiences in professional practice in ways others will understand. The interplay of metaphors across the conversations became a point of interest within this thread. Metaphors came forward most clearly in my conversations with Barb. She describes elements of her nursing practice, such as trusting her *nursing spidey sense,* as her way of knowing, which has developed over time. Approaching patients who have given her *a green light* with their openness to care signifies a patient who is not at risk for re-traumatization. I wondered if she noticed how her stories were laden with metaphors and how this helped her describe her work.

Descriptions of what it looks and feels like for nurses to protect themselves from the emotional impacts of the job became visible through the use of metaphors. As Barb described an experience that carried powerful emotion, connecting her to a patient, she considered the nurse/patient boundary and stated that her *heart's not that black—it's a shade of grey.* Metaphors, like the black heart, were also used when speaking about the nursing profession. We discussed how sad it is *that to survive in this caring profession, we have to paint our hearts black, protect it with armour, to minimize the trauma … expression[s] of sarcasm, suppressing the real emotion to create an illusion that you aren't affected by the hardships of the world.* This was particularly troubling; when no one supported her as a new nurse, she *felt like she was just [being thrown] to the wolves*. Metaphors were also used to speak to the rural context in which participants worked. Working in rural places that were understaffed and overcapacity, it was like *the Wild West*; a vision of ruleless chaos came to mind, and I could imagine the various types of trauma that might exist in a landscape such as that.

As primary tools for comprehension, metaphors play a pivotal role in shaping meaning, masking certain aspects of reality while illuminating others (Fitzpatrick & Farquhar, 2019). Metaphors serve to make the strange familiar and knowable and, conversely, to make the familiar strange. In this way, they help us to explore possibilities for understanding experiences and phenomena (Lakoff & Johnson, 2008). It is essential to embrace metaphors as a communication tool as nurses learn to name trauma "when 'ordinary' language is not 'enough'" (Busch & McNamara, 2020, p. 331). Metaphors allow space for imagery to convey the meaning, tone, or feeling necessary to bring experiences to life—to creatively describe trauma in a way that makes sense for us and others.

***Attending to Embodiment***

Perhaps what was most notable within this thread of learning to name trauma was not the words spoken by participants but the silences, subtle gestures, and tones of voice as stories were relived and retold. This called attention to embodied trauma, a reminder that stories are stored and live in our bodies. Veronica and Barb spoke about how they overcame traumatic experiences by talking to colleagues or people who could relate to them and helped them see lessons for improvement in their experiences. Yet, in our conversations, I could also see how they were only beginning to realize how trauma had manifested in their bodies. It was learning to see that trauma is an important part of "embodied knowledge [, which] is the intuitive, subjective knowledge that [we] refer to in order to make sense of [our] practice" (Maniago, 2018, p. 4). It is integrated into our actions, behaviours, and physical experiences.

I noticed signs of embodied trauma throughout our conversations. Veronica was unaware that she carried healthcare-associated trauma until a childhood experience came back to her in response to a doctor's order in the emergency department. During our conversation, she

described that she had become frozen in past memories and could not bring herself up to the task of following the doctor's orders. At other points, I noted *the occasional shake in [her] voice as [she] spoke. The wringing of [her] hands* in the re-telling of a time that left her with residual feelings of *self-doubt, uncertainty, and helplessness.* I suspect she was still making sense of her experiences as she shared this time with me. The sleepless nights and flashbacks add to the signs of the trauma she carries but was unable to name.

Van der Kolk (2014) maintains that "[t]raumatic memories of arousing events that are not necessarily available to conscious memory may return, often suddenly and unexpectedly, as flashbacks, overwhelming emotions, or 'speechless horror'" (p. 43). This claim resonates in my conversations with Barb as we explored vicarious trauma, and she recollected a moment in time she had long forgotten. *All of a sudden, you're in a conversation, and you're anxious. You don't know why […] Something or someone triggers it. And you're like, why am I turning beet red right now?* This remark was quickly followed up with comments such as *those things don't affect me anymore,* and I wonder if she was quickly discounting what her body was telling her or that she felt a need driven by some kind of external/social/internalized cue to downplay or minimize the way the experiences affected her.

Some stories did not have words or metaphors and instead were embodied as fear, anxiety, dissociation, sadness, anger, uncertainty, shock, helplessness, empathy, and compassion. It is in the shaky voices, quickened breathing, grief-stricken looks, memories of tears, or anticipation of violence that trauma becomes visible. As the conversations with Veronica and Barb evolved, I noticed a new acknowledgment of how they recognized the experiences that continue to live in them—coming to understand that "it is embodied knowledge that contributes to the overall perception and understanding of the situation and is an integral part of experiential

learning that nurses identified as the main component of the process of change" (Maniago, 2018, p. 5). In this way, perhaps trauma moves away from being incomprehensible and unspeakable.

## Resonant Thread: Disrupting Dominant Stories

Trauma-informed care aims to create environments that promote healing and recovery, reduce re-traumatization, and support individuals in rebuilding a sense of control and empowerment in their lives. Thinking with Veronica and Barb's experiences called attention to the complexity of competing, overlapping situations and relationships rural nurses must balance within the sphere of trauma-informed care. At present, the dominant stories of trauma-informed care fail to capture some of the social, environmental, and institutional nuances experienced by rural nurses. Disrupting dominant stories of trauma-informed care calls forward counterstories outlining aspects not previously emphasized in the literature. Counterstories are stories that contribute "to the moral self-definition of its teller by undermining a dominant story, undoing it and retelling it in such a way as to invite new interpretations and conclusions'' (Lindemann Nelson, 1995, p. 23). Counterstories broaden perspectives, challenge assumptions, and provide a contextual understanding of trauma-informed care within nurses' experience.

### *Balancing Personal and Professional Relationships*

Nurses are not immune to trauma, and trauma is part of the human experience. Conversations with Veronica and Barb called attention to how nurses are positioned within their personal histories, experiences, and traumas, while they also come to know patients who are living with their own trauma. It was interesting to learn how they attempted to separate themselves, to define personal and professional boundaries, and to notice the tensions that arose in doing so. Over time, Barb learned to draw a line between her professional and personal selves. *There's a professional Barb,* who is a lot like Barb but *with a shade of professionalism.* She

mentioned that if this separation didn't exist, it would be too easy to take things home. The emotional toll would be too great, and according to Barb, *you would never get any work done.* The invisible divide between witnessing patient trauma and whatever trauma comes forward for her would be too much to carry. Yet, in listening to Barb, it is evident that when the job involves helping those through their worst days, time after time, the experiences of trauma are cumulative. Although Barb held her two personas separately, I noted the tension in the boundary still present for her as she asked, *How do you dissociate from the things you see every day?* To dissociate means to isolate, separate, and detach. Dissociation is a concept that seems foreign when thinking of nursing, as nursing is deeply rooted in relational care with patients. I wonder when Barb used the word dissociate, if she was asking for a way to protect herself from her work. Perhaps emotional disconnections become a way to survive, a way to protect oneself from carrying too much trauma.

Veronica and Barb brought forward experiences from their personal childhoods that have shaped their professional identities. Veronica recalls her own healthcare-related trauma triggered unintentionally by a patient. Being unprepared for her strong response changed her approach to care. Balancing personal and professional relationships for rural nurses is further complicated by their connection to and visibility within the community. Veronica recalls seeing past patients at the gym or the pub—finding it awkward at times due to the vulnerability and confidentiality of the relationship; *it also brings awareness to how [she treats] people… Knowing that [she] may run into patients while out on [her] regular errands keeps [her] accountable to caring for [her] patients in a way that leaves them with a positive impression.* This calls attention to the interconnectedness of the rural nurses' work, their ordinary lives, and the pressure to uphold societal expectations. McCallum et al. (2023) report nurses face particular challenges in

upholding patient confidentiality and nursing professionalism in rural settings, where community members frequently have familiar relationships. Patients are friends, family members, colleagues, or acquaintances from the community. These connections hold the potential to increase the possibility that trauma will deeply affect those involved on a personal level. In many ways the pursuit of or reliance upon boundaries (or at least conventional ones) may be a futile endeavour that perhaps even adds to the complications of trauma/vicarious trauma.

***Exploring the Complexities of Rural Environments***

The dominant stories in healthcare are often informed by healthcare providers working in urban environments. These stories cover up and even diminish the complexity of nursing practice in rural environments (McCallum et al., 2023). Trauma-informed policies written for urban centers do not account for the unique relationships, geography, and challenges nurses experience in rural healthcare settings. The narrative accounts of Veronica and Barb made visible the contextual understanding of trauma and how the environment can trigger trauma. If education and support for trauma-informed care are essential to move from task-focused care to incorporating principles of trauma-informed care (Schimmels & Cunningham, 2021), then attending to the tensions between location and trauma-informed care experienced within a rural context is critical.

**Lack of Resources.** Veronica was quick to exclaim, *In rural, the nurses are it!* This was followed by a long list of responsibilities she fills when support and allied health staff are unavailable in her rural setting. This aligns with the findings of McCallum et al. (2023), who identified rural nursing "as a complex subspecialty of nursing that requires a generalist knowledge and skill set" (p. 4). There is pressure that comes with that responsibility, as nurses need to be ready for whatever comes through the door, regardless of whether they have had the

right training or resources to support the required care. I noticed tensions arising for Veronica and Barb as they were unable to meet the prescribed standards of care, as well as the standards they set for themselves, given the location and limited resource accessibility. These tensions are connected to trauma for patients and nurses, as Veronica and Barb indicated.

One of the hardest things about resource availability in rural communities is that patients are sent to urban centers for specialty assessments, diagnostics, or treatments. Veronica recalls the unsettling feelings she has, knowing patients resist coming into the hospital until it is too late or leave before they are seen because they know they will likely be sent to the city, a place that can exacerbate their trauma. Barb shares that *it's not because they are refusing care but because it's so challenging to get there and back that they don't want to bother or can't for financial or logistical reasons—or maybe because of previous negative experiences with the system.* The conflict between patient needs and patient desires creates distress for Veronica and Barb as they struggle to provide care due to a resource-limited context.

A significant source of stress can come from caring for the critically ill in rural settings and working within the limits of the available resources. Teamwork is essential, especially if the team is small. Barb remembers a time with a patient who had sustained a severe head injury and needed to be flown to a higher level of care for life support. A dense fog had grounded emergency crews, and Barb recalls having to *put [their] heads together and figure out a plan because help [wasn't] coming.* Taking matters into her own hands, she mapped out a route by ground that wasn't affected by fog and organized a flight from there—exemplifying the scope of responsibility rural nurses hold and the potential for trauma that is part of the ordinary work.

**Safety and Security.** Unfortunately, experiencing violence and aggression is not uncommon in healthcare. Rural nurses face a much different risk to their personal safety than

those in urban settings. For example, Veronica and Barb's accounts outlined contrasts in rural and urban security responses. In urban settings, if de-escalation techniques have proven ineffective and people are at risk of injury, robust security teams are available to assist with physical restraint, and the nurses are responsible for administering medication and monitoring patients' responses. Their experiences in rural environments, under similar circumstances, were contrasting. No specialty teams come at the push of a button or call overhead. Instead, Barb mentions, *You're gonna call the RCMP, and maybe they're there in 10 minutes, but 10 minutes in that situation feels like 6 hours.* Veronica recalls having to trap an aggressive person between sliding doors with the help of a patient's family member until the RCMP arrived.

There is also trauma in the anticipation of possibility. Barb recalls times when she was working overnight alone, thinking there are *people that may look harmless, and then they pull a knife on you.* She thinks of possibilities that could easily be realities. There is anxiety that comes with not knowing what might be coming through the doors and hoping that therapeutic communication and de-escalation techniques are enough to temper a violent situation is part of the daily work. The trauma that lives in Veronica and Barb's experiences—anticipated or not, highlights tensions in providing trauma-informed care while attending to personal safety or the safety of others.

**Discussion: Implications for Rural Contexts**

This narrative inquiry provided a rich and contextual understanding of how trauma-informed care is understood and practiced in rural acute care nursing. The resonant threads pulled forward highlight aspects of how nurses recognize and experience trauma in their work. While both threads are explored separately, it is important to pay attention to their close relationship and interconnection. In the absence of language and recognition, participants

normalized their experiences and minimized the trauma within them. The challenge to find language and have the ability to recognize and name trauma is critical for nurses to challenge dominant stories of trauma and to advocate for systemic changes.

My narrative beginnings, which began this article, make visible my experiences and positionality in relation to the participants and the phenomena under study. Practical justification considers how nurses' experience providing trauma-informed care in rural settings inform insights into social, institutional, and community contexts that shape patient care delivery. Exploration of these experiences through narrative inquiry can inform education initiatives, targeted support requirements, and organizational changes to advance the practice of trauma-informed care. This study provided significant insight into the complexity of nursing practice in rural environments. Throughout the inquiry, it was evident that community, personal/professional boundaries, resource allocation, and workload within the rural context had an impact on shaping nurses' experiences in relation to trauma and trauma-informed care. There is a detrimental aspect to geographical location related to how trauma is experienced and attended to.

This study emphasized the importance of acknowledging and engaging with nurses' experiences to enhance our understanding of how to offer education, foster collaboration, and implement organizational changes. There is an urgent need to cultivate sensitivity to the distinct challenges faced in rural settings that embrace trauma-informed care. By prioritizing the needs of urban healthcare, administrators disregard the rural landscape and "the particulars that do not fit its dominant patterns" (Lindemann Nelson, 1995, p. 28). This study has offered insights suggesting that overarching organizational policies built on urban models and resources are not transferable to address the unique and nuanced needs and challenges in rural contexts. Shifting

the focus of trauma-informed care to include the values and realities of rural nurses and their communities has implications for improving nursing retention, recruitment, and overall nurse well-being.

**Limitations**

It is important to recognize that a narrative inquiry begins:

> with a respect for ordinary lived experience, the focus of narrative inquiry is not only a valorizing of individuals' experience but also an exploration of the social, cultural, and institutional narratives within which individuals' experiences were constituted, shaped, expressed, and enacted—but in a way that begins and ends that inquiry in the storied lives of the people involved (Clandinin & Rosiek, 2007, p. 9).

Therefore, the intent of the study is not to generalize findings to all nurses who work in rural settings but rather to raise new questions and insights that show the complexities of the experience of trauma. Given the attention to the depth of the experience of participants, two participants were invited to engage in the study.

**Conclusion**

With increased attention to trauma over recent years, nurses working in rural settings have not received adequate investigation. It is important to understand the unique geographic challenges that impact their experience of trauma and trauma-informed care. It is critical to recognize that the impact of trauma should be evaluated individually, taking into account its potential harm to each person (Meretoja, 2020). The experiences of Veronica and Barb raise significant questions about the adequacy of language to name trauma and to disrupt dominant stories of trauma-informed care. It is essential that nurses' experiences are central in shaping

both practice and policy responses to trauma, ensuring that specific needs are given the attention they require.

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# Chapter 7: Contemplating the Significance

In this final chapter, I return to the personal, practical, and social significance of this work. It is here that I answer the questions of: So what? And Who cares? Over the course of the study, I realized that these questions matter deeply. I have seen how trauma affects the personal and professional lives of nurses. It is important to address its impact in ways that acknowledge that change is possible.

## Taking a Reflective Turn

The idea for this study was initially born from my experiences as a nurse and further developed as I wondered how nurses attend to patients with trauma while attending to their own. Looking back, I also see that I was looking for a way to make sense of my own experiences, as I wondered if others had also felt the effects of vicarious trauma. Much like I did in the narrative accounts, I turn once more to writing a letter to the participants.

Dear Veronica and Barb,

As I continue to engage in this narrative inquiry, I am writing this letter to share what I have learned from you and how our conversations have changed me. Our time together was filled with intriguing stories, emotional realizations, and new understandings. When I came to this study, the intention was to better understand how trauma-informed care is practiced by nurses in rural acute care settings, but what I learned was so much more.

Approaching this study, I brought my perspective as a nurse, a nurse educator, and a member of a rural community. Each of these characteristics contributing to the formation of this research puzzle as we came together in this relational space. I also came to this study as a novice researcher, acutely aware of my inexperience and discomfort with the art of engaging in research conversations. I appreciated your patience and grace as I found my footing as we walked

alongside one another. As a researcher, I am committed to sharing new knowledge while also making sure that you experience no harm as part of your participation and while you shared many details of your experiences. As an educator, I want to share your lessons and help others learn from you. As a nurse, I feel protective of them.

Reflecting on the narrative threads that resonated in this study, I am protective of your stories because I have learned how hard they are to tell. As we learned to name trauma—contemplating our use of metaphor and becoming aware of embodied trauma, I noticed the challenge in acknowledging our own trauma—the challenge to look inward to acknowledge how the work we do affects us. To make sense of the sleepless nights, the tears shed after a shift, or the crippling anxiety that pops up out of nowhere. We have not been taught how to respond to this. My awareness was drawn to the discomfort I felt when inquiring about your trauma, as if I might be intruding or overstepping in some way. I wonder if, as we learn to name trauma, it will also help us talk to one another about our experiences in therapeutic and supportive ways. We have also not been taught to talk to each other about our trauma. As I listened to you both open up over time, the conversations became more at ease. I noticed that by sharing my own vulnerability, fostering secure relationships, and facilitating a safe environment, experiences were shared more openly. We need compassionate and understanding places to land if we are to address our trauma to help others address theirs. I wonder how much of our trauma is shared as we experience it.

It became clear that trauma-informed care is greatly influenced by the environments in which we practice. Our conversations made visible the complexities of rural nursing in relation to personal and professional relationships, access to resources, and community, disrupting dominant stories of trauma that are reflective of urban ideals. Rural nurses are just *doing the best*

*they can with what they have*. Until recently, my clinical experience was derived from hospitals in big cities. My practice was deeply embedded with urban privilege and a misperception of rural healthcare. Engaging in our conversations reminded me of times I may have judged or underestimated the skills and finesse required for nursing in rural areas. I expected more without appreciating rural nurses are working with so much less. It is a different world, and the same rules can't always apply. While exploring your experiences, I was drawn to the dedication and connection to the community I heard in your stories. The ways you brought your limited resources together to make sure the patients had what they needed or got to where they needed to go. I was struck by the powerful teamwork as you came together, whether to resuscitate a patient or stand together for safety, and the juxtaposition of aloneness that spoke loudly within these experiences. It reminded me that while we may appear strong and resilient, trauma is always present for nurses, and the rural context significantly contributes to how trauma is experienced and manifested in individual ways.

Perhaps the most interesting thing for me was noticing how our conversations emphasized Dewey's (1938) conceptualization of experience as interactive and continuous. They exemplified experience as "a changing stream that is characterized by continuous interaction of human thought with our personal, social, and material environment" (Clandinin & Rosiek, 2007, p. 6). Veronica, I noticed this in how you explained your coping strategies and the lessons you learned from colleagues during challenging times as you dealt with limited resources. I saw this in how you integrated that knowledge to inform your future experiences and decision-making—pulling on past experiences to make sense of new ones. Barb, in the way you consider how your practice and interactions have shifted and how you build on previous experiences. Your perceptions of certain experiences have changed over time as you gained knowledge and moved

from novice to experienced nurse. These are just a few examples. I also noticed that as previous experiences were pulled forward in our conversations and experiences were retold and relived, the trauma came and was present. I think back to my narrative beginnings, about my tearful entrance to my house after that awful day, and I know now that it was not just that one day that I was crying for. It was the accumulated trauma from years of hard days, culminating in a few moments where my body could no longer hold it inside.

I hope to continue having conversations with you both. I am still thinking of our last conversation, Barb. You told me you needed to think more about some of the things that came up around trauma-informed care, specifically about how trauma affects you. You had never really thought about it before. *How do you have empathy but not take it home? ... Should you forget everything before you leave the hospital? ... Is there a healthy amount that you can take home? ... How do you know when it's too much?* You circle back to these questions, speaking out loud, as you collect your things to go home. I don't have the answers yet, but I can assure you I wonder the same things. Hearing your questions reminds me why this narrative inquiry was important. I feel inspired to see that you have started to think about trauma in different ways.

With deepest gratitude,

Stephanie

**Attending in New Ways**

While Veronica and Barb's experiences do not offer generalizations about all rural nurses, their stories have pointed to some of the "complexities, contradictions, and inconsistencies often inherent to policies and their implementation" (Clandinin & Caine, 2013, p. 175). Attending to the social significance of this research study, I recognized the importance of

understanding experience to affirm, challenge, or negotiate social norms, values, and identities within the rural landscape of nursing and trauma.

MacLeod et al. (2004) reported that the complexity of nursing practice in rural and remote settings is greatly undervalued. Organizations have an opportunity to integrate rural nurses' experiential knowledge for policy improvement with consideration for the distinctive challenges rural nurses encounter related to trauma and trauma-informed care. Urban-centric language and mentality embedded with policy risks isolating rural nurses further and perpetuating a system of inequity for staff and patients. Veronica and Barb outlined several key experiences that exacerbated trauma in their work related to their environment, such as violence, safety, and emergency transfers. These experiences required that they work outside the scope of practice outlined by organizational policies derived from urban-resourced environments. Repositioning the organizational policies and initiatives to include rural contexts in relation to trauma ensures diverse and equitable support, site-specific education, and resource accessibility for rural nurses to engage with trauma-informed care at the forefront of their practice.

Coming to know Veronica and Barb through our conversations has made visible an opportunity to enhance disciplinary knowledge around trauma and perhaps change the narrative. Trauma will always be a part of a nurse's job, as exposure to distressing events is inevitable. Jahner et al. (2020) described this as an "unavoidable occupational hazard" (p. 480). So much of the work Veronica and Barb described related to patient care was inherently trauma-informed despite the absence of extensive formal training. The missing piece related to vicarious trauma and a recognition of the trauma they experienced both personally and professionally because of their exposure. As they learned to name trauma, I wondered how nurses integrate their experiences and how they work with trauma. Are we doomed to carry our trauma and the trauma

of others as a dark cloak that only gets heavier as the years pass? What does that mean for nursing retention or the quality of care we provide our patients? If trauma is unavoidable, is there potential to shift the narrative of trauma as something inevitable and difficult to an opportunity for personal growth?

In their exploratory study of therapists working with trauma survivors, Arnold et al. (2005) explained how the participant's work had changed their lives in positive ways, referring to this change as vicarious posttraumatic growth, suggestive of the potential benefits of trauma work. They outline three main posttraumatic growth categories: positive self-perception changes, interpersonal relationships, and philosophy of life. In this positive light, therapists reported gains in sensitivity, compassion, insight, tolerance, and empathy, demonstrating an improved ability to understand, accept, and connect with others (Arnold et al., 2005). Some found a deeper appreciation for the strength of the human spirit in their trauma work, reinforcing or reigniting optimism in the future (Arnold et al., 2005). I am reminded of when Veronica learned the history of her difficult patient and how it changed her perception of the situation and allowed for more compassion. I recall the palliative patient Barb saw herself reflected in and how her interaction reminded her to live life to the fullest. Or how they both took their experiences in traumatic situations as opportunities to learn so they might improve their practice in the future. This positivity and self-development exemplify posttraumatic growth, as Arnold et al. (2005) described.

The principles of trauma-informed care embed a strengths-based approach that encourages empowerment, choice, collaboration, and peer support within its framework to support patients with trauma. Suppose we applied these same principles to care for nurses and attend to posttraumatic growth. In that case, I wonder if we might disrupt a dominant story of

trauma that shifts the inevitable negative impact to something more positive and sustaining. If we intentionally apply a strengths-based, growth mindset approach to educate and support trauma in nursing, we might learn to work with trauma. If we learn to work with trauma, I wonder if we might enhance the sustainability of nurses in the profession. In doing so, we might sustain their dreams of making a difference and helping others.

**Conclusion**

With increased attention to trauma over recent years, nurses working in rural settings have not received adequate consideration. This narrative inquiry set out to explore the experiences of rural nurses providing trauma-informed care. Engagement with two nurses, Veronica and Barb, required holding space for conversation that attended to the vulnerable and sensitive nature of trauma work. It was essential to foster a safe and relational setting to connect for meaningful understanding of their experiences. Once this was established, it became clear that their experiences raised significant questions about the adequacy of language to name trauma and to disrupt dominant stories of trauma-informed care.

In learning to name trauma, their experiences highlighted the ways both verbal and nonverbal expression affect how nurses attend to and discuss trauma. The use of metaphors spoke to the creative ways nurses convey their experiences. Attending to embodied trauma disclosed the trauma that lives within us long after the experience. The use of metaphors and embodied knowledge became a reference point for intuitive, subjective, and experiential knowledge, which was often unknowingly, through actions, behaviours, and emotions expressed in practice.

Veronica and Barb's experiences offered counterstories that disrupted dominant stories of trauma-informed care, which is most often situated in urban-centred policies. They made visible

the social, environmental, and institutional nuances experienced by rural nurses. The interconnectedness of personal, professional, and community boundaries in rural nursing, in addition to the challenges of resource accessibility and safety are unique to rural settings and impact trauma work.

While the results of this study are not generalizable, rural nurses' experiences must be central to shaping both practice and policy responses to trauma in relation to settings. Trauma is an inevitable part of nurses' work. Considering the current critical nursing shortage, there is an opportunity to support nurses to work with trauma. To shift the narrative from trauma as exclusively negative to something that has the potential to enhance a positive, strengths-based growth mindset. This study holds implications for future research to investigate how nursing education and supportive strategies could be implemented so that nurses will continue to do the important work they do.

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## Appendix A

## Research Poster

## Appendix B

## HSD Graduate Student Research Award 2023 Proposed Budget

| **Item** | **Justification** | **Time of Expenditures** | **Cost** |
|---|---|---|---|
| Honoraria | Compensation for participant's time, childcare, and/or transportation.<br>3 participants x 6 meetings each at $25/meeting | March 2024 - April 2024 | $450 |
| Refreshments | Coffee/tea and small snack.<br>3 participants x 6 meetings $15/meeting | March 2024 - April 2024 | $270 |
| Transcription | Professional services at $35/hour; 1 hour of tape = 2 hours of transcriptions.<br>$70 per transcript at 3 participants x6 meetings | May 2024 | $1,260 |
| **Total** | | | **$1,980** |

## Appendix C

## Guiding Questions

1. How would you describe your understanding of trauma-informed care?
    a. What has shaped your understanding?
    b. Has your understanding changed over time?
    c. Are there particular places where you have learned about trauma?
    d. Did you learn about trauma in your education? (both initial education or professional development)

2. Have you experienced trauma in your work?
    a. Could you share some of the events and how these impacted you.
    b. Looking backwards, what could have been done differently.

3. How do you understand and recognize vicarious trauma?
    a. Can you share some examples?
    b. When and where did you first learn about vicarious trauma?
    c. What has helped you deal with vicarious trauma? What has made it difficult to address?
    d. What are some ways in which you look after yourself? Are any of these supported by your workplace?

4. How would you describe the support and education available for trauma-informed care?
    a. Are there things you wish there were in place to better address trauma?
    b. Could you offer any recommendations?

## Appendix D

## Ethics Approval

University of Victoria

**Certificate of Ethical Approval for Harmonized Minimal Risk Behavioural Study**

University of Victoria
Human Research Ethics Board
Michael Williams Building, R. B202 PO Box 1700 STN CSC
Victoria, BC V8W 2Y2
Tel: 250-472-4545

**Also reviewed and approved by:**

- **UBC Behavioural Research Ethics Board**

| Principal Investigator: | Primary Appointment: | Board of Record REB Number: BC23-0625 | UBC REB Number: |
|---|---|---|---|
| Vera Caine | University of Victoria | Board of Record: University of Victoria | H23-04049 |

**Study Title:**
A Narrative Inquiry into the Experiences of Trauma-Informed Care for Nurses Working in Rural Acute Care Settings

**Study Approved: February 9, 2024** **Expiry Date: February 9, 2025**

**Research Team Members:** Stephanie Wright, Principal Applicant, University of Victoria; Andrew Estefan, Co-supervisor

**Sponsoring Agencies:** - University of Victoria

**Documents included in this approval:**

| Document Name | Version | Date |
|---|---|---|
| **Protocol:** | | |
| Research Proposal | N/A | December 11, 2023 |
| **Consent Forms:** | | |
| Information Letter and Consent Form | Version 2 | February 6, 2024 |
| **Advertisements:** | | |
| Recruitment Poster | Version 2 | January 30, 2024 |
| **Questionnaire, Questionnaire Cover Letter, Tests:** | | |
| Guiding Questions | N/A | December 11, 2023 |
| **Letter of Initial Contact:** | | |
| Letter of Initial Contact | N/A | December 11, 2023 |
| **Other Documents:** | | |
| Wellness Support Card | N/A | February 6, 2024 |

This ethics approval applies to research ethics issues only and does not include provision for any administrative approvals required from individual institutions before research activities can commence.

The Board of Record (as noted above) has reviewed and approved this study in accordance with the most recent requirements of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2).

The "Board of Record" is the Research Ethics Board delegated by the participating REBs involved in a harmonized study to facilitate the ethics review and approval process.

The application for ethical review and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

**This study has been approved either by the Board of Record's full REB or by an authorized delegated reviewer.**

REBC

## Appendix E

## Information Letter and Consent Form

# Information Letter and Consent Form

Ethics Study Number: BC23-0625

**Study Title:**
A Narrative Inquiry into the Experiences of Trauma-Informed Care for Nurses Working in Rural Acute Care Settings

**Research Investigator:**
Stephanie Wright
3800 Finnerty Rd.
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University of Victoria
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**Supervisor**:
Dr. Vera Caine
3800 Finnerty Rd.
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**Background**

You are being invited to participate in a research study entitled *A Narrative Inquiry into the Experiences of Trauma-Informed Care for Nurses Working in Rural Acute Care Settings.* This study is conducted by Stephanie Wright and supervised by Dr. Vera Caine from the School of Nursing at the University of Victoria. The results of this study will be used in support of my master's research.

**Purpose**

This study aims to explore nurses' experiences as they practice trauma-informed care in rural acute care settings. I am interested in understanding how nurses' personal, practical, social, and institutional stories impact their ability to incorporate the complex concepts of trauma-informed care into practice.

**Study Procedures**

If you choose to participate in this study, you will be asked to have audio-recorded conversations with me over a 3 to 5-month period. Each conversation is estimated to take about one hour. We will meet in public places, such as restaurants and cafes, or in places that work best for you. Virtual meetings are also an option. I hope to meet you once every one to two weeks for a total of five to six conversations. The conditions for meeting will be negotiated between us.

As a participant, you are welcome to talk freely about your past and current life experiences. All the conversations will be audio-recorded and transcribed. I will invite you to share your experiences through writing, art, photographs, or any artifacts that may help me better understand your experiences. All items shared will be returned to you during the conversations.

You are eligible to participate in the study if you:

1. Are an acute care nurse (RN/LPN).
2. Have worked in a rural acute care environment for a minimum of 1 year.
3. Are English speaking.

**Benefits**

You will be given an opportunity to tell your life stories within a safe relationship with the researcher. You might gain insights into how trauma presents in your work and how this has shaped you. By telling your stories, you may become more aware of your life history, identity, belief/value, and strengths. You may also obtain a clearer understanding of how your life experiences are shaped by various familial, cultural, social, and political backgrounds. However, it is important to note that there might be no direct benefit to you.

**Payment or Renumeration**

Participation for this study is voluntary; however, I will provide refreshments and you will receive a $25 honorarium at each conversation.

**Risk**

As you tell your experiences, you may encounter memories and feelings which could be distressing or discouraging to you. Also, you may perceive frustrations and limitations which could be stressful to you. It is acceptable to express negative emotions during the conversations, but if it is difficult for you, you are not obliged to tell me everything. If unidentified issues surface during our conversations, I can direct and connect you to appropriate supports or resources without disclosing any of your information. In addition, you may choose at any time during any conversation to skip questions that may make you uncomfortable.

**Voluntary Participation**

Participation in this study is voluntary. Should you choose to participate in this study, note that you are under no obligations. Additionally, if you volunteer to be in this study, you may withdraw at any time up to the point before you give consent to the final narrative account. You may also refuse to answer any questions or talk about particular experiences. You can request to stop the audio-recording at any time. It is important to note that you will not be able to withdraw from this study once you review your narrative account.

**Confidentiality & Anonymity**

The information obtained in this study will be used in the writing of my master's thesis. It will also include various presentations or research papers. To avoid any personal identification the use of any particular names or places will be modified and you will be given a pseudonym. I will encourage you to choose your own pseudonym. Before information is disseminated, I will share the narrative account, which reflects your story, with you.

Please note that for a minimum of 5 years after the completion of the study, all the data will be stored securely in a locked cabinet or in electronic devices that is password protected and encrypted. My supervisors and I are the only ones who will have access to the original data. You can ask for a copy of reports or publications on research findings at any time.

**Further Information**

If you have any further questions regarding this study, please do not hesitate to contact Stephanie Wright at stephaniewright@uvic.ca.

The plan for this study has been reviewed for its adherence to ethical guidelines by the Research Ethics Board. If you have any concerns or questions regarding your right as a research participant, you may contact the Human Research Ethics Board at 250-472-4545 or ethics@uvic.ca.

Thank you for considering being a part of this research. I very much look forward to working with you.

*Consent Statement*

I have read this form and the research study has been explained to me. I have been given the opportunity to ask questions and my questions have been answered. If I have additional questions, I have been told whom to contact. I agree to participate in the research study described above and will receive a copy of this consent form. I will receive a copy of this consent form after I sign it.

________________________________________ _________

Participant's Name (printed) and Signature Date

________________________________________ __________

Name (printed) and Signature of Person Obtaining Consent Date

## Appendix F

## Wellness Support Card