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Application of the Nurse as the Wounded Healer Theory to Traumatized Professionals

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PERMISSION

Title   Application of the Nurse as the Wounded Healer Theory to Traumatized

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Abstract

Nurses care for children who have been abused and can experience subsequent emotional trauma that has profound personal and professional impact. The purpose of this independent study was to examine current evidence related to emotional trauma of nurses caring for abused children and provide recommendations for healing. A comprehensive literature search of Medline/PubMed, EBSCOhost CINAHL, Science Direct Journals (Elsevier), Scopus (Elsevier), Sage Journals, PubMed Central, Wiley Online Library, and PsycARTICLES data bases yielded 18 articles that met the inclusion criteria of English, peer reviewed sources published prior to 2000. The Theory of The Nurse as the Wounded Healer framed the evidence-based recommendations for wounded nurses to overcome, to transform, and transcend the experience and trauma of caring for victimized children. The theory provided a good fit with the project because it explained the phases through which nurses proceed to become wounded healers after experiencing trauma from caring for abused children.

Application of the Nurse as the Wounded Healer Theory to Traumatized Professionals

Nursing is an extremely rewarding profession in which displaying empathy for suffering is taught, however, there is little known about the nurse's own responses to the suffering they witness (Rowe, 2003). Nurses and other health professionals commonly care for children whom are victims of abuse or neglect. Society views children as innocent, powerless, and incapable of protecting themselves, which makes caring for victimized children especially challenging for nurses (Pistorius, Feinauer, Harper, Stahmann, & Miller, 2008). Sometimes the specifics of the abuse or neglect are so alarmingly traumatic that it causes emotional pain and suffering in the nurse caring for the child, which in turn can have negative effects on nursing practice and future patient care (Conti-O'Hare, 2018). Traumatized nurses even neglect to care for themselves. Failure to recognize symptoms of trauma stress from the job can further compromise the nurse's ability to provide quality patient care (Beck, 2011).

It is important to examine how caring for abused or neglected children impacts the nurse's practice and how the nurse might transition into a "wounded healer" through the stages of recognition, transformation, and transcending or remain a "walking wounded" as described in Conti-O'Hare's Theory of The Nurse as the Wounded Healer. This project is aimed to identify current evidence related to emotional trauma associated with nurses caring for abused and/or neglected children and to determine the utility of The Nurse as the Wounded Healer Theory as a framework to develop strategies to overcome the emotional consequences, which may impact future nursing practice and patient care.

Purpose

The overall goal of this project was to develop evidence informed recommendations for healing of nurses traumatized by caring for children who have been abused. A literature review

was conducted to determine the relationship between nurses working with victimized children and the trauma experienced by the nurses themselves during these patient assignments, as well as the effect this experience has on the individual's nursing practice.

Analysis of the evidence from the review of the literature was important to illuminate the often unseen and forgotten emotional pain nurses experience after caring for a child who has been traumatized. The Nurse as the Wounded Healer Theory provided the framework for the project and subsequent recommendations for nurses to overcome emotional struggles faced when caring for traumatized children.

Significance

Current research has made it clear that caring for abused children is stressful (Barrett, Denieffe, Bergin, & Gooney, 2017). Recurrent exposures to suffering and traumatic experiences are common among nurses, especially those working with children, and chronic exposure can lead to physical and psychological destress of the healthcare provider (Maloney, 2012). Both compassion fatigue and secondary trauma stress are potential consequences (Maloney, 2012). Previously, secondary trauma stress was often recognized in non-nursing disciplines like social work but is now beginning to come to the surface in nursing practice (Maloney, 2012). Such traumatic events can have deep and lasting impacts on nurses and if nurses are unable to process the experience, both professional and personal consequences can result (Maloney, 2012).

Nurses caring for abused children use words to describe their negative emotions such as shock, upset, and anger (Barrett et al., 2017). Often nurses think about these cases outside of work and for long periods of time afterwards (Barret et al., 2017). Unresolved emotional stress experienced by nurses can ultimately negatively impact patient outcomes because the emotional impact of traumatic events can overwhelm a person's usual coping response, thus creating

significant distress in the nurse (Maloney, 2012). Nurses may exhibit cognitive symptoms such as confusion and poor concentration, physical effects like fatigue, insomnia, gastrointestinal problems, and muscle tension, emotional effects such as anxiety, depression, guilt, anger, and denial, and behavioral manifestations like social withdrawal, substance abuse, and aggression (Maloney, 2012).

Successfully transcending through this emotional pain to a point where the experience is integrated into their personal self requires deep reflection and effort to become aware of pain, fear, brokenness, and humanity. This reflective journey transforms the experience in a way that the nurse can use self as a powerful tool to tend to the pain and suffering of others (Corso, 2012). The transformation of becoming a wounded healer is a goal many traumatized nurses strive to achieve and the willingness to reflect inward may be the most effective path to helping the patient heal (Corso, 2012).

Process

A comprehensive literature search of the University of North Dakota Harley French Library was conducted, utilizing the Medline/PubMed, EBSCOhost CINAHL, Science Direct Journals (Elsevier), Scopus (Elsevier), Sage Journals, PubMed Central, Wiley Online Library, and PsycARTICLES data bases with the key terms "*conti-o'hare*", "*caring for abused children*", "*effects of caring for abused children*", "*pediatric nurses and child abuse*", "*effects of nurse caring for abused children*", "*trauma of the healthcare professional and child abuse*", "*emotional trauma in nurses and pediatrics*", "*nurse as wounded healer and child abuse*", "*nurses working with abused children*", "*secondary trauma from caring for child of abuse*", "*posttraumatic stress and nursing*", "*vicarious trauma and nurses AND child abuse*", "*nurse as wounded healer*", "*wounded healer*", and lastly "*nurses and child abuse*". The focus of this

process was to identify and analyze the current evidence that defines the problem and to make

evidence-based recommendations for nurses who care for children who have been victimized.

Inclusion criteria for retained literature was peer reviewed and written in English language.

Exclusion criteria included all sources published prior to year 2000.

The initial search of the combined databases with keywords "*conti-o'hare*" resulted in 13

articles. They were sorted by relevance, and all were reviewed. One article was chosen that

demonstrated the effects of stress on nurses and the relationship of the Nurse as Wounded Healer

theory to health professionals.

The next search of the combined databases with exclusion criteria applied included the

keywords "*caring for abused children*". This resulted in 4,590 articles for review. Due to the

substantial number of articles presented, the data was further limited to the years 2010 through

2018. This resulted in 2,477 articles. Articles were sorted by relevance and the first 100 article

titles and abstracts were examined for significance to the project. One article of the 100 was

chosen that specifically discussed the views of pediatric nurses caring for abused children.

The keywords "*wounded healer*" was searched in the combined databases with exclusion

criteria applied. This resulted in 905 articles. Data was sorted by relevance and the first 200

article titles and abstracts were examined for application to the project. Of those examined, two

articles were determined to be relevant with description of the Nurse as the Wounded Healer

Theory and its application to trauma in healthcare. This search was further narrowed to the

keywords "*nurse as wounded healer and child abuse*". This search provided 17 results. All

articles were reviewed, and one was chosen for the project.

Keywords "*emotional trauma in nurses and pediatrics*" was searched in the combined

databases with exclusion criteria applied. A total of 1,417 articles resulted. They were sorted by

relevance and the first 100 article titles and abstracts were reviewed. One article was chosen

from this search due to its detailed descriptions of the emotional impact of traumatized nurses.

Next, keywords "*nurses working with abused children*" was searched in the combined

databases with exclusion criteria applied. This resulted in 2,123 articles. They were sorted by

relevance and the first 200 article titles and abstracts were examined. Two studies regarding

encounters with abused children and their parents and working with sexually abused children

were chosen from this search.

Due to the number of articles that discussed the specific types of trauma experienced by

health professionals caring for abused children, I decided to search the specific trauma terms to

determine if more applicable articles would be found. All were searched within the combined

databases and with exclusion criteria applied. The first included keywords "*secondary trauma*

from caring for child of abuse". This displayed 1,849 articles for review. They were sorted by

relevance and the first 150 articles were examined. Of the examined articles, three were chosen

for the project due to their in-depth discussions of secondary trauma stress and compassion

fatigue. The second search was of keywords "*posttraumatic stress and nursing*". This resulted in

an alarming number of 4,159 articles. Results were sorted by relevance and the first 100

reviewed. One article was chosen from this search. The third search of specific trauma terms

included keywords "vicarious trauma and nurses" AND "child abuse". The two were combined

with the Boolean connector "AND". Results included 169 articles. They were sorted by

relevance and all article titles and abstracts were reviewed for appropriateness. Four articles were

utilized from this search due to the higher level of detail regarding trauma in nurses and the

newer publications dates of the articles.

The last search of combined databases with exclusion criteria applied included keywords "*effects of caring for abused children*". The results were 3,023 articles. The data was sorted by using the relevance filter to the search terms and again the first 100 articles were examined. No articles were chosen from this search as the results were limited in new data related to the effect of caring for abused children on nurses. Additional searches of the combined databases with exclusion criteria were of keywords "*pediatric nurses and child abuse*", "*nurse as wounded healer*", "*effects of nurse caring for abused children*", and "*trauma of the healthcare professional and child abuse*". With all the identified keyword searches, the results were sorted by using the relevance filter to the search terms and the first 100 articles reviewed. After review of the first 100 articles using these keyword searches it was determined the searches were not relevant to be used due to the production of limited new data regarding traumatic effects to nurses caring for abused children.

Additionally, a search was conducted to specifically target an article noted in the bibliography of a chosen article. The article was located and retained for the project. The text The Nurse as Wounded Healer by Conti-O'Hare (2002) was also utilized to inform application of the conceptual framework as well as Conti-O'Hare's Nurse as the Wounded Healer Theory online website.

The strength of the evidence summarized in Appendix B was analyzed using Melnyk's pyramid. A total number of 18 articles were retained for the project representing evidence from various levels of the Melnyk's pyramid (see table 1),

Table 1

Level of Evidence	Research design	No. of each
I	Systematic reviews or/ and meta-analysis of RCTs	0
II	One or more randomized controlled trials	2
III	Non-randomized, quasi-experimental study	0
IV	Case control study or Cohort study	0
V	Systematic review of descriptive & qualitative studies	9
VI	Descriptive study or Qualitative study	6
VII	Expert opinion	1

Theoretical Framework

The theory of The Nurse as the Wounded Healer by Conti-O'Hare was incorporated for recommendations for wounded nurses to overcome the emotional consequences of caring for abused or neglected children. The theory provides a theoretical view to strengthen the understanding of experiences shared by nurses in stressful situations and gives a path for nurses from being a walking wounded to becoming a wounded healer (Christie & Jones, 2013; Mealer & Jones, 2013). The theory recognizes that nurses have the capacity to heal trauma by transforming and transcending the experience, allowing them to therapeutically help others (Mealer & Jones, 2013).

The walking wounded are those, who have experienced a personal exposure to trauma and have ineffective coping with the impact of the trauma, which results in unresolved pain (Christie & Jones, 2013). These nurses are bound to past trauma and remain physically, emotionally, and spiritually affected (Mealer & Jones, 2013). Often the walking wounded

experience problems in social, intimate, or working relationships and project their woundedness on both patients and colleagues (Christie & Jones, 2013). The wounding is reflected in the individual's nursing practice in many ways (Conti-O'Hare, 2018).

On the other hand, if trauma is dealt with effectively, and pain is recognized, transformation and transcendence to healing results and the nurse is led to become a wounded healer (Christie & Jones, 2013). The individual's suffering is recognized as a part of human growth and development (Conti-O'Hare, 2002). The trauma or wounds have been understood and will not interfere with patient care activities allowing the nurse to provide the service of healing (Christie & Jones, 2013). Conti-O'Hare's theory explores the nurse's ability to transcend personal trauma to build better therapeutic relationships with others (Christie & Jones, 2013). Therefore, the "therapeutic use of self is dependent on the degree to which the trauma is transcended; only after this transcendence can personal experience of healing be used to help others" (Christie & Jones, 2013). Furthermore, Dunning (2006) presented characteristics often found in effective healers which included:

- a high level of technical expertise and competence;

- empathy with their clients and colleagues derived from their own experiences;

- the ability to actively channel healing energy and healing intent;

- the capacity to think positively;

- compassion for their clients and colleagues reflected in their actions and ability to listen;

- the humility to recognize they are only one part of the healing process;

- the ability to recognize healing is an ever-evolving process that involves letting go of factors that inhibit healing; and

- a commitment to their own health and wellbeing (p. 255)

These assumptions led to four key propositions integrated into Conti-O'Hare's theoretical framework. These include:

- in the search of wholeness, traumatized individuals may pass from the stage of walking wounded to wounded healer;

- nurses and other health professionals become wounded healers after recognizing, transforming, and transcending the pain of trauma in their lives;

- wounded healers become able to use themselves therapeutically to help others; and

- transformation will have a positive impact on the healthcare system, society, and the nursing profession as a whole (Christie & Jones, 2013).

Transformation and transcendence are complex. It is important to understand their meaning. Transformation is a dynamic force that expands consciousness to allow the nurse to become aware of existing and newer self-perceptions (Mealer & Jones, 2013; Conti-O'Hare, 2002). It promotes acceptance of feelings and experiencing the consequences of feelings to reconnect through self-transcendence (Mealer & Jones, 2013). Transcendence comprises the emotional growth and ability to find meaning in one's own suffering (Mealer & Jones, 2013).

Conti O'Hare has included the use of the Q.U.E.S.T Model for self-transcendence within her theory as a means to help guide nurses and other health professionals in the evaluation of themselves in terms of dealing with the trauma and in healing to become wounded healers (Conti-O'Hare, 2018). The model provides five steps of reflection which guides the healing process. The theory explains that recovering and transcending from a wound require insight and reflection to understand the experience and use the experience to help others (Dunning, 2006). "Wounded healers are able to transform their wound into a positive experience by being open to the possibility, recognizing, questioning, and eventually, consciously using the experience" (Dunning, 2006, p. 254). The goal of the Q.U.E.S.T. model is to aide nurses and other health professionals in healing themselves and their profession (Conti-O'Hare, 2002).

Several assumptions have been identified within the Q.U.E.S.T model. These include:

- growth and transcendence are an unending process;

- trauma patterns may appear more commonly than realized within all types of relationships;

- recovery begins only when nurses and other caregivers remain open to the possibility of trauma occurring in their lives;

- transformation and transcendence become possible through understanding the pain caused by trauma; and

- therapeutic use of self can be facilitated when practitioners consciously and deliberately apply their knowledge of trauma to foster mutual growth between themselves and their patients (Conti-O'Hare, 2002, p.145).

The five steps within the Q.U.E.S.T. model include: question, uncover, experience, search for meaning, transform, and transcend (Conti-O'Hare, 2002). The first step, questioning, is a form of self-examination and exploring the impact of trauma (Conti-O'Hare, 2002; Conti-O'Hare, 2018). Uncovering the trauma pattern is the next step and often includes detail that is difficult to remember and could involve potential consequences of recalling painful memories (Conti-O'Hare, 2002). The next step is also difficult as the wounded may not be able to accept the trauma and could block certain incidences (Conti-O'Hare, 2002). In the experience step, one must examine their own feelings about the event and acquire a new perspective on it (Conti-O'Hare, 2002; Conti-O'Hare, 2018). Searching for meaning is sometimes viewed as the most critical step in the Q.U.E.S.T process (Conti-O'Hare, 2002). "Searching for and understanding the meaning behind the suffering becomes a necessary aim toward attaining a higher level of consciousness and transcendence" (Conti-O'Hare, 2002, p. 150). Transformation and transcendence are the final step. The wounded begin to develop the ability to examine past traumatic events with renewed awareness and begin to forgive one's self as well as others (Conti-O'Hare, 2002).

Caring for abused children can have profound emotional and traumatic impacts on nurses. If nurses are ineffective at coping with this trauma, their woundedness may be projected on their patients leading to a decreased quality of care (Christie & Jones, 2013). The Nurse as the Wounded Healer model is particularly suited for this project because it provides an explanatory method for the nurse to draw on his/her traumatic experiences and transcend on the woundedness in order to establish better therapeutic and caring relationships with patients (Christie & Jones, 2013). The method will help establish an understanding of the phases nurses must proceed through to become a wounded healer after experiencing trauma from caring for abused children. The knowledge of this process can help act as a guide for traumatized nurses and the care of themselves necessary to heal and promote better practice.

Literature Review

Recent research confirms that nurses caring for children of abuse suffer negative emotional consequences. Additionally, there is sufficient evidence to support that trauma can have profound impacts on the nurse's personal and professional life. Working with victims of violence can be emotionally taxing to healthcare professionals but caring for children who have been victims of abuse can be even more challenging for them (Coles, Dartnall, & Astbury, 2013). There are many reasons why working with children of abuse is more challenging for nurses. Some of these factors include:

- conflict with parents or care givers;

- being witness to child abuse incidences;

- hostile working environments;

- lack of or failure of services for child victim assistance;

- direct healthcare provider threats and concerns of safety; and

- the possibility of litigation (Coles et al., 2013, para. 8).

These issues further complicate working with children of abuse and can lead to strong

emotional reactions by the healthcare provider (Coles et al., 2013). The strong reactions disturb

the emotional balance of the healthcare professional and can cause caregivers to suffer

overwhelming negative feelings (Kanno, 2010). This section is organized in sub-sections. The

first sub-section describes evidence that emerged from the literature review related to the types

of trauma experienced by nurses caring for abused children, the reasons for trauma experienced

in those working with children, and the effects of the trauma on the nurse and subsequently on

patient care. The second sub-section provides current evidence of strategies for improving the

personal health of nurses who have been traumatized by experiences in practice, including caring

for victimized children.

Associated Trauma

The literature also described the unique characteristics of types of trauma. It is important

to fully understand trauma definitions and implications to nursing practice when faced with

painful and devastating situations. Lindsay, & Heliker (2018), defined trauma as the "exposure to

experiencing, witnessing, or being confronted with events involving actual or threatened serious

injury or death or threats to individual's physical integrity" (p. 64). Associated types of traumas

further defined and differentiated in the literature review were compassion fatigue, primary

and/or secondary traumatization, and vicarious trauma.

The first type of associated trauma identified was compassion fatigue. Compassion

fatigue refers to the effects of everyday work with survivors of traumatic life events, or

perpetrators (Geoffrion, Morselli, & Guay, 2016). Geoffrion et al.'s article (2016), posited the

impact of compassion fatigue was found to be associated to cognitive, emotional, and behavioral

effects. The article uncovered numerous consequences nurses face after development of compassion fatigue. Consequences included:

- preoccupation with traumatic events;

- avoidance and numbing;

- lowered frustration and tolerance;

- dread of working with certain clients;

- a decrease in the feeling of safety;

- a diminished sense of purpose; and

- a decreased level of functioning (Geoffrion et al., 2016).

Maloney (2012) contended that long-term compassion fatigue could also lead to post-traumatic stress disorder. Cognitive effects like lowered concentration, decrease self-esteem, cause negativity, confusion, memory lapses, and thoughts of harm to self or others can be caused by compassion fatigue (Geoffrion et al., 2016; Maloney, 2012).

Researchers found that nurses also experience a full range of emotional responses triggered by compassion fatigue. For example, nurses may feel powerless, be consumed by rage, survivor guilt, denial, and depression (Geoffrion et al., 2016; Maloney, 2012). Additional behavioral implications of compassion fatigue might include irritation, impatience, aggressive behavior, sleep disorders, nightmares, and hypervigilance (Geoffrion et al., 2016; Maloney, 2012). But it also created personal suffering for the nurses, and included physical ailments like fatigue, insomnia, gastrointestinal problems, and muscle tension (Maloney, 2012).

Primary traumatization was another type of associated trauma that was described in the literature. Primary traumatization refers to a direct experience of the trauma (Geoffrion et al., 2016). Research found that nurses may experience primary traumatization when the event such

as working with children who have been physically abused is traumatizing for the professional (Meadors & Lamson, 2008). This effect could also result from emotional identification when a nurse is caring for a victimized child associates the child with his or her own child. This was identified as a particular danger when the patient was of similar age, gender, or temperament to the nurse's child. Similarly, when the circumstances surrounding the trauma were similar to the nurse's personal experiences or memories, he or she had the potential to develop tangential fears (Meadors & Lamson, 2008; Pistorius, Feinauer, Harper, Stahmann & Miller, 2008). Symptoms of primary traumatization were similarly described to the effects experienced by nurses suffering compassion fatigue with decreased appetite, irritability, social withdrawal, increased anxiety, and increased sadness added to the previous description (Meadors & Lamson, 2008).

Secondary trauma is a third form of associated trauma. Researchers found that secondary trauma occurred when the provider was personally affected by the primary traumatization of his/her patient or in other words was described as the "stress resulting from helping or wanting to help a traumatized or suffering person" (Meadors & Lamson, 2008; Beck, 2011, p.3). Research found that symptoms of posttraumatic stress and other symptoms were similar to those from primary traumatization (Maloney 2012, Meadors & Lamson, 2008; Beck, 2011).

Kellogg et al. (2018) conducted a cross-sectional study using a predictive correlational design to expand knowledge of personal influences of secondary trauma stress in pediatric nurses. Statistical relationships between secondary trauma stress, the age of the nurse, years of nursing experience, and coping mechanisms were explored. The researchers concluded that neither age nor years of service were predictors of secondary trauma stress. However, more than half of the participants in this study were experiencing signs of secondary trauma stress and were not effectively coping with their stress (Kellogg et al., 2018). According to Kellogg et al. (2018),

dysfunctional coping processes of denial and behavioral disengagement were predictors of secondary trauma stress in pediatric nurses.

Vicarious trauma was the final associated trauma identified in the literature. It was found to occur after an individual witnessed another person's stories and details about the trauma experienced (Geoffrion et al., 2016). Researchers observed that vicarious trauma can have strong effects on individuals and caused exhaustion, extreme sadness, dissociation, or isolation and was as debilitating as a primary trauma (Coles et al., 2013; Pistorius et al., 2008).

The search for literature also populated an article discussing the concept of posttraumatic stress disorder (PTSD) in nursing that described the concept within the context of the Nurse as the Wounded Healer Theory. The conceptual analysis by Mealer and Jones (2013) described that PTSD symptoms are common among pediatric nurses due to repeated exposure to traumatic experiences. Consequences of PTSD in nurses is an alteration in the nurse's worldview that includes self-blame, hopelessness, and preoccupation with fear (Mealer & Jones, 2013). Manifestations present in response to this alteration and often perpetuate PTSD symptoms as well as predict future PTSD severity in nurses (Mealer & Jones, 2013). When the Nurse as the Wounded Healer Theory is applied to PTSD, it is thought that PTSD manifestations are based on the individual nurse's exposure to traumatic events and their ability to self-heal, and the ability to transform and transcend the experience (Mealer & Jones, 2013).

Trauma experienced from caring for abused children was found to have long lasting effects on the nurse. Research indicated that traumatic reactions of nurses relate to the proximity, intensity, and duration of exposure (Meadors & Lamson, 2008; Coles et al., 2013). The next sub-section will present evidence uncovered related to nurse trauma.

Nurse Trauma

Numerous studies were located that examined the causes of trauma experienced by healthcare providers. Craig and Sprang (2010) recognized variables associated with the development of compassion fatigue in their correlational design study that investigated the impact of using evidence-based practices on compassion fatigue, burnout, and compassion satisfaction in a random, national sample of self-identified trauma specialists. The variables identified as precessors for development of compassion fatigue included work on the frontlines, female gender, younger age, increased exposure to trauma clients, longer length of time providing treatment post sexual abuse, occupational stress, and the clinician's own maltreatment history (Craig & Sprang, 2010). Other studies found that nurses working in higher stress specialty practice areas within nursing experience higher levels of trauma. For example, pediatric nurses were found to experience stress at higher levels than other nurses working within different specialties (Kellogg et al., 2018). Researchers opined that this may be because pediatric nurses care for not only the pediatric patient but also for the family members of the child, which challenges the nurse both intellectually and emotionally (Kellogg et al., 2018; Barrett, Denieffe, Bergin, & Gooney, 2017). In the cross-sectional study by Kellogg et al. (2018), of 338 certified pediatric nurses, over half the sample of nurses suffered from moderate, high, or severe secondary trauma stress. Findings indicated that the sample of pediatric nurses reported higher secondary trauma stress scores than those reported in other specialties of nursing such as: labor and delivery, oncology, and sexual assault nurse examiners (Kellogg et al., 2018). Kellogg et al., (2018) stated some nurses described their work when caring for suffering pediatric patients as an "intimate closeness to anguish" (p. 97).

Emergency nurses and personnel are also often affected emotionally by experiencing a child trauma or death. In 2013, nearly 7,000 of 55,000 infant and children deaths were attributed

to traumatic causes (Lindsay & Heliker, 2018). Approximately 75% of pediatric deaths occurred in hospitals, most often in emergency centers (Lindsay & Heliker, 2018). Lindsay and Heliker (2018), recruited emergency nurse participants for a qualitative study related to traumatic experiences while caring for abused children. Eight individuals participated in the study and were interviewed focusing on traumatic experiences (Lindsay & Heliker, 2018). Interviews determined that emergency staff often witnessed the effects of abuse on children. Emergency personnel are frequently present for the physical and emotional consequences of abuse and suffer from the circumstances surrounding the situation (Lindsay & Heliker, 2018). Suffering includes feelings of injustice and pain from traumatic circumstances that are unable to be undone and from not having the authority to enact justice in traumatic situations (Lindsay & Heliker, 2018).

Child protection services are often involved when nurses are working with children of abuse. The literature exposed the exceedingly high responsibility of nurses working with child protection services. This responsibility can make nurses feel intimidated. Barrett et al. (2017) found that caring for children who require child protection intervention had a personal lasting effect on the nurse after the experience. This effect was particularly noted in nurses with less experience. In a qualitative research study, interviews with 10 pediatric nurses identified the high level of responsibility pediatric nurses have when working with child abuse cases (Barrett et al., 2017). This may have been because the cases required the nurse to recognize risk factors of abuse and distinguish accidental versus nonaccidental injuries while caring for the injured child, but also because of the responsibility for reporting and documentation of injuries (Barrett et al., 2017). In addition, the ability to communicate the situation of abuse to other health professionals and with the abusers was included in the nurse's responsibility (Barrett et al., 2017).

Communication during abuse situations is stressful for nurses. Participants in Barrett et al. (2017) reported maintaining professionalism and objectivity was tough when caring for abused children and their parents, particularly when both the child and parents required care and support. But, communication and interaction with parents or family members who are suspected to have caused the abuse of the child caused even greater difficulty for nurses (Barrett et al., 2017). Nevertheless, pediatric nurses considered the ability to communicate effectively in all circumstances essential to providing nursing care that is family centered (Barrett et al., 2017).

The difficult dilemma for nurses caring for victimized children when communicating with the suspected abuser was also found in other studies. In a qualitative study by Tingberg, Bredlöv, and Ygge (2008), 11 nurses who cared for abused children and their parents were interviewed to identify the nurse's experiences in the clinical care of abused children. The participants were asked to describe how they remained objective and non-judgmental, especially when the suspected perpetrator was a parent. Participants expressed difficulties in maintaining professional roles in clinical encounters with parents. The nurses described feelings of hate for the abuser, while simultaneously feeling empathy for the child and family circumstances (Tingberg et al., 2008). Overall, nurses in this study were unhappy in their conflicting roles of both "policing and nursing" (Tingberg et al., 2008, p. 2721).

Communication about child abuse was not only related to the care provided, but also included mandatory reporting of concerns of child abuse. Mandatory reporting was another reason reported as traumatic to nurses working with abused children. . Nurses reported a concern with reporting a suspicion of abuse for fear of being wrong or of unwanted consequences for the nurse and family (Barrett et al., 2017). Additionally, nurses reported fear for personal safety

because of the possibility of parental anger escalating to violence when working in small numbers or alone (Tingberg et al., 2008).

Nurses' personal reactions to trauma stress are unique. Sigad, Davidov, Lev-Wiesel, and Eisikovits (2016), interviewed 40 participant professionals involved with addressing the problem of child abuse, including educators, physicians, nurses, law enforcement officers, social workers, and mental health providers. The group represented a wide range of years of experience in fields that worked with the problem of child abuse. The purpose of the study was to examine the impact of involvement with child abuse intervention and prevention on the private lives of the professionals. Emotional responses reported included confusion, fear, and anxiety and in extreme cases caused destruction in the professional's sense of self and parental identity (Sigad et al., 2016).

 Descriptions of the personal reactions of professionals after exposure to child abuse cases ranged from rejection of the reality of abuse, to recognition of the abuse but maintaining a strong boundary, thus keeping the reality clear and distant from one's own private life (Sigad et al., 2016). Those who rejected knowledge of abuse, remained distanced when treating the abuse. The professional's failure to acknowledge the reality of the abuse resulted in the further trauma of victims (Sigad et al., 2016). Those who took a more accepting approach toward the exposure of abuse, coped through integration of consequences of the toxic knowledge into their lives and were able to protect their family and children from the reality of abuse. Conversely, some professionals took a more direct approach and taught their children about abuse and how to protect themselves (Sigad et al., 2016).

Not only do nurses react to trauma in unique ways but the ways in which they cope with trauma is personal. Missouridou (2017), described nurses' emotional responses from exposure to

patient trauma that led to negative behaviors like disengagement or overinvolvement

(Missouridou, 2017). Nurses feeling overwhelmed by the care of victims of trauma may distance

themselves from the patient and their family or in opposition some may become overly involved

and cross professional boundaries (Missouridou, 2017). Sometimes nurses overidentify with their

patient's experiences or the patient's coping response, which causes them to feel a similar level

of traumatization to that of the patient (Missouridou, 2017). When a nurse overidentifies with the

victim, he or she may begin to feel protective and that he or she is the only one who can give

proper and appropriate care to the patient (Missouridou, 2017). The overinvolvement in patient

care may lead to not sharing important information with colleagues, thus interfering with the

team approach to caring for the patient and may inevitably affect patient outcomes (Missouridou,

2017).

Sources reviewed, commonly concluded that nurses caring for abused children face

significant mental, physical, and spiritual demands. Furthermore, stress experienced by the nurse

had an impact on patient outcomes (Geoffrion et al., 2016; Maloney, 2012; Sigad et al., 2016;

Missouridou, 2017). The emotional and physical consequences of this stress can impact the

ability to provide effective care, establish therapeutic relationships, and maintain health and

wellbeing (Dunning, 2006; Coles et al., 2013; Kanno, 2010; Geoffrion et al., 2016; Maloney,

2012; Meadors & Lamson, 2008; Pistorius et al., 2008; Kellogg et al., 2018; Barrett et al., 2017;

Lindsay & Heliker, 2018; Sigad et al., 2016; & Missouridou, 2017). Nurses ineffectively

managing their trauma also tend to have less empathy toward victims and thus reduces the

effectiveness of their care (Meadors & Lamson, 2008). Maloney (2012) connected the amplified

nurse stress to increased malpractice. The quality and effectiveness of an organization's care can

be affected by nurses who were unable to manage their trauma (Meadors & Lamson, 2008).

Strategies

      This subsection will present current evidence of effective strategies to help nurses heal

from trauma experienced from caring for abused children. This process can be a complex and

difficult journey that involves coping with complicated and often opposing emotions. For

example, participants in a study reported that deeply feeling one thing and at the same time

having to act as if you do not feel, was one of the greatest challenges faced by the nurses

(Tingberg et al., 2008).

      Affected nurses have identified the need for support to cope with the confusing emotions.

Nurses in the previously described study displayed difficulty coping with their feelings and

expressed the need for psychological support, either informally with colleagues or formal

psychological counseling (Tingberg et al., 2008). Tingberg et al. (2008) concluded that in order

for nurses to heal after experiencing trauma from caring for victims of trauma, the nurses must

first recognize themselves as humans and understand the emotional reactions that result from a

traumatic experience is part of the experience. This acknowledgement is the first step in

developing personal strategies for coping with emotional turmoil that inevitably results from

disturbing experiences when caring for traumatized children.

      The literature supported personal strategies of care as imperative for preventing traumatic

stress symptoms. Meadors and Lamson (2008) analyzed compassion fatigue and coping

strategies nurses used within critical care units caring for children and found participants in the

lower stress group demonstrated more positive coping behaviors when they intentionally

engaged in self-care activities such as, mediation, massage, regular exercise, and healthy eating

habits. But effective self-care to reduce stress was not only implemented in the participants

personal life, but also included taking time away from work, and setting personal limits while at

work (Meadors & Lamson, 2008; Beck, 2011). These self-assertive behaviors as well as rituals

for situations dealing with loss were found to be beneficial (Meadors & Lamson, 2008).

Meadors and Lamson's (2008) findings indicated that nurses who had a plan to manage their

stress at work and home lowered stress and increased overall wellness because participants had

sufficient resources to leverage in coping efforts. Conversely, those with higher stress levels did

not feel they had adequate resources to manage stressors (Meadors & Lamson, 2008).

        The personal acknowledgement of stress is not sufficient to completely combat nurse

stress in stressful environments and acknowledgement of the stress within the workplace is

essential to addressing the stress related symptoms. In contrast, there is a lack of symptom

awareness when stressful events are not discussed within the place of work (Meadors & Lamson,

2008). Furthermore, poor training regarding job stress is tied to higher rates of compassion

fatigue and trauma stress symptoms (Meadors & Lamson, 2008). Thus, Meadors & Lamson

(2008) suggested employers have significant responsibility to facilitate nurse coping within an

inherently stressful and traumatic practice environment. Findings from Meadors & Lamson's

2008 study suggested that educational seminars focused on the topic of compassion fatigue, not

only increased awareness of compassion fatigue and its implications, but also decreased nurses'

clinical stress level (Meadors & Lamson, 2008).

        Pistorius et al. (2008) added strength to the concept of employer responsibility for

supporting employees in stressful care environments. This qualitative research study explored the

personal and professional experiences of licensed female therapists working with sexually

abused children. Therapists were interviewed in an unstructured and open-ended question format

(Pistorius et al., 2008). Topics of self, trauma, trauma impact and coping mechanisms were

incorporated into the interviews (Pistorius et al., 2008). Pistorius et al. (2008), concluded that

weekly staff meetings, employee bonding, and individual or group therapy were effective to improve employee's relationships and bonding within the group. Strong colleague relationships were found to help cope with the effects of working with traumatized children (Pistorius et al., 2008).

Along with group interaction, the literature revealed that debriefing was an effective strategy to help alleviate stress from trauma on the job (Maloney, 2012; Missouridou, 2017; Lindsay & Heliker, 2018; Kellogg et al., 2018). Effective debriefing is ideally conducted on or near the site of a traumatic event as soon as possible, or no more than 72 hours after the traumatic event (Maloney, 2012). Each situation is unique, and debriefing can be completed in large or small groups, or one to one (Maloney, 2012). Debriefing is not a critique of the event but rather a systematic review of the events leading to, during, and after the trauma (Maloney, 2012). Debriefing was described as a means to process an event and to reflect on its personal impact, but also allowing the voicing of emotions and thoughts associated with the trauma (Maloney, 2012; Missouridou, 2017; Lindsay & Heliker, 2018; Kellogg et al., 2018). Moreover, debriefing offered grieving healthcare providers support and an opportunity to make meaning of traumatic events (Maloney, 2012).

It is evident that traumatized nurses experience overwhelming emotions. The literature provided some evidence that support strategies for nurse healing from trauma following caring for a victimized child. The strategies were grouped into categories that encompassed personal strategies, professional education, support, and traumatic event debriefing.

Summary of Evidence

The literature demonstrated a deep effect on the nurses' emotional, physical, and spiritual being when caring for victimized children (Dunning, 2006; Coles et al., 2013; Kanno, 2010;

Geoffrion et al., 2016; Maloney, 2012; Meadors & Lamson, 2008; Pistorius et al., 2008; Kellogg et al., 2018; Barrett et al., 2017; Lindsay & Heliker, 2018; Sigad et al., 2016; & Missouridou, 2017). Certain specialty areas of nursing are more effected than others for reasons stated above (Craig & Sprang, 2010; Kellogg et al., 2018; Lindsay & Heliker, 2018; Barrett et al., 2017). Nurses experience different types of trauma when caring for abused children (Geoffrion et al., 2016; Maloney, 2012; Meadors & Lamson, 2008; Beck, 2011; Kellogg et al., 2018; Coles et al., 2013). However, regardless of the type of trauma, the resulting effect on nurses was the same (Geoffrion et al., 2016; Maloney, 2012; Meadors & Lamson, 2008; Pistorius et al., 2008; Coles et al., 2013; Missouridou, 2017). Moreover, these negative effects adversely impact the care nurses provide to patients (Geoffrion et al., 2016; Maloney, 2012; Sigad et al., 2016; Missouridou, 2017).

The literature not only illustrated the problem, but also provided evidence for strategies to strengthen the nurse's personal, professional, and organizational environments (Tingberg et al., 2008; Meadors & Lamson, 2008; Beck, 2011; Pistorius et al., 2008; Maloney, 2012; Missouridou, 2017; Lindsay & Heliker, 2018; Kellogg et al., 2018). The evidence indicated that effective strategies requires an intentional collaboration among nurses', colleagues and institutions (Tingberg et al., 2008; Meadors & Lamson, 2008; & Pistorius et al., 2008). When this collaboration occurs, the progression to healing from trauma may begin.

The literature was also searched to find evidence of others using the theory of The Nurse as the Wounded Healer. Although the search identified several studies related to lateral violence and one article related to the application of the theory to post traumatic stress disorder, the search did not identify any sources that applied a theory to the wounding of nurses caring for abused children. This project applied the Theory of Nurse as Wounded Healer as a unique and

innovative way to understand experiences of nurses in caring for abused children. The next section will integrate the evidence and theoretic application to propose recommendations for potential strategies for healing these wounded healers.

Discussion

Caring for children of abuse has lasting impacts on the nurse. It is important that nurses and their employers begin to recognize how caring for abused children may impact the personal lives and their professional ability to care for future patients (Meadors & Lamson, 2008; Pistorius et al., 2008; Missouridou, 2017; Maloney, 2012; & Kellogg et al., 2018). Although numerous providers have been exposed and are impacted by prolonged patient suffering, they are not aware of the personal implications associated with the experience or how these encounters negatively affected the care they provided to the patients (Meadors & Lamson, 2008). Poor training regarding job stress is also tied to higher rates of compassion fatigue and stress symptoms (Meadors & Lamson, 2008). This lack of understanding and awareness has led to worsening of symptoms associated with trauma exposure, as well as professional problems, such as leaving the profession, decreased productivity, and medical errors (Meadors & Lamson, 2008).

Walking Wounded

It was evident through the literature that certain groups of nurses are more at risk for traumatization due to the increased exposure of caring for victimized children. This includes those working in the specialties of pediatrics or emergency departments (Kellogg et al., 2018 & Lindsay & Heliker, 2018). Nurses working with victimized children often suffer overwhelming emotional consequences (Missouridou, 2017). They tend to suffer from lowered concentration levels, confusion, and memory lapse which can contribute to negative patient outcomes

(Geoffrion et al., 2016; Maloney, 2012). Often in an attempt to cope, nurses use negative

behaviors, such as disengagement from social contacts or self-medicating with alcohol or

substance abuse and gambling (Kellogg et al., 2018). Even more alarming, nurses working with

victimized children have increased risk for thoughts of harm to themselves or to others

(Geoffrion et al., 2016; Maloney, 2012).

Symptoms of the emotional impact from working with children of abuse can result in

emotional, social and physical consequences. Affected nurses may appear irritated, impatient, or

exhibit aggressive behaviors that separates the nurses from their professional network (Geoffrion

et al., 2016; Maloney, 2012). This disengagement from social interactions with peers and

personal contacts creates a barrier for communication necessary to improve patient care and

nurse coping (Missouridou, 2017). The stress can also create physical effects when some nurses

suffer from sleep disorders or a decreased appetite (Geoffrion et al., 2016; Maloney, 2012),

which in turn compounds the emotional responses, and thus it creates a vicious circle. If one is

unable to understand the effect or transcend the trauma experience, the individual becomes the

"walking wounded" (Dunning, 2006). According to Dunning (2006), healthcare professionals

need a level of self-awareness and self-care in order to transcend their wounds and maintain a

healing state to meet the needs of their clients.

Wounded Healer

Healing from the stress and trauma that nurses experience when caring for victimized

children takes dedicated and intentional actions. The first step is for traumatized nurses to

recognize the etiology of the emotional responses and symptoms that emerge because of the

stress from the trauma. Acknowledgement of the personal trauma is essential before a nurse can

begin to cope with the symptoms of trauma (Meadors & Lamson, 2008). The ways in which

nurses acknowledge and cope with trauma exposure is personal. Sometimes nurses are not aware of the potential for experiencing trauma themselves after caring for a victimized child. Nurses personal reactions to exposure of child abused ranged from rejection of the reality of the abuse to recognition of the abuse but keeping it clear and distant from one's own private affairs (Sigad et al., 2016). It is critical for nurses to reflect about the emotional toll that comes from working with abused children, as well as becoming aware of the potentially serious implications and personal ramifications this can have on personal and family lives (Sigad et al., 2016). Evidence supports that nurses who engage in reflection to recognize, accept and experience grief, secondary to the trauma experienced have an improved chance for personal and professional growth following a traumatic experience (Missouridou, 2017). Personal and professional reflection are important to understand how exposure to traumatic events, or "wounds", can be transcended and used in holistic care of patients (Barrett et al.,2017; Dunning, 2006), but also to plan and engage in effective self-care.

The next part of the plan for nurse healing includes self-care in their personal and professional lives (Tingberg et al., 2008; Meadors & Lamson, 2008; Beck, 2011; Pistorius et al., 2008; Maloney, 2012; Missouridou, 2017; Lindsay & Heliker, 2018; Kellogg et al., 2018). Nurses need a level of self care in order to remain well and to be able to transcend wounds (Dunning, 2006). Self-care routines and personal health care plans should be integrated into one's daily life; this includes self-care practices such as the enhancement of physical, mental, and spiritual balance (Dunning, 2006). In addition to personal self care strategies, professional self care strategies are equally important. Time away from work and setting personal limits while at work are effective strategies to reduce stress (Meadors & Lamson, 2008; Beck, 2011).

But the strategies cannot be just internal to the wounded nurse; instead there are strategies that organizations can take to facilitate the healing process (Beck, 2011). The final step in the healing plan is to engage places of employment as a healing partner to provide adequate resources, space, and promote respectful colleague relationships where individuals feel comfortable to visit with one another about difficult work situations. Employers can facilitate nurse coping with stressful and/or traumatic events during practice by offering educational seminars to nurses, which focus on compassion fatigue and its implications (Meadors & Lamson, 2008). Connecting with others within the nurse's work community is an effective strategy for healing. Evidence from this review supported weekly staff meetings and employee bonding were helpful to improve employee's relationships and created a sense of support for traumatic situations (Pistorius et al., 2008). Discussions among co-workers regarding work related stress and to determine how the environment can be changed to create healing was effective for increasing perceptions of support (Dunning, 2006).

Debriefing is an effective tool to discuss and process a traumatic event as well as reflect on its impact, while allowing nurses to voice emotions and thoughts associated with the trauma (Maloney, 2012; Missouridou, 2017; Lindsay & Heliker, 2018; Kellogg et al., 2018). It is a systematic review of events leading to, during, and after a traumatic event (Maloney, 2012). Debriefing also offers a means of grieving and an opportunity to make meaning of traumatic events (Maloney, 2012). Debriefing should typically occur as close to the time of and site of the event as possible (Maloney, 2012). Debriefing can be completed one-to-one or in large or small group settings (Maloney, 2012).

There are seven phases that serve to guide the debriefing process (Maloney, 2012). First, the introduction phase asks members of the debriefing to introduce themselves and to explain the

purpose of the meeting (Maloney, 2012). The goal is to create a debriefing environment that is

conductive, reassuring, and that gains participant cooperation (Maloney, 2012). The next phase is

the fact phase. During this phase, the participants describe the traumatic event from their

perspective including their role during the incident (Maloney, 2012). From here, participants

move into the thought phase. In this phase participants state their first thought that occurred

during the incident (Maloney, 2012). This helps to transition thoughts to emotional reactions

(Maloney, 2012). The reaction phase occurs after. In the reaction phase, participants identify the

most personally traumatic aspect of his/her emotional reactions (Maloney, 2012). For many, this

tends to be the most emotionally powerful time of debriefing (Maloney, 2012). After the reaction

phase, participants move to the symptom phase in which participants are asked to describe

affective, behavioral, cognitive, or physical reactions they may have occurred during the incident

(Maloney, 2012). Succeeding the symptom phase is the teaching phase. The entire participant

team is active in teaching about stress symptoms encountered and provides a variety of stress

reduction and management strategies (Maloney, 2012). Last is the re-entry phase. The re-entry

phase allows participants to clarify issues, answer questions, and to summarize interventions

(Maloney, 2012). This last phase puts closure on the discussions held throughout the phases

above (Maloney, 2012).

Lastly, psychological support, either informally from colleagues or formally by referral to

outside psychological counseling, has been expressed as important in the healing process for

nurses (Tingberg et al., 2008). Traumatized nurses have reported problems coping with their own

feelings, therefore, professional counseling can be an important intervention in assisting

traumatized nurses to cope (Tingberg et al., 2008). Furthermore, coping strategies provided

through counseling can enable traumatized nurses to remain professional in their encounters with

abused children and their parents (Tingberg, et al., 2008). Support systems and networks can be

established with recognized "violence teams" at work for those that work with violence and

trauma (Coles et al., 2013). Peer to peer support and opportunities to discuss difficult or

distressing cases with co-workers can also be beneficial in provide psychological support (Coles

et al., 2013). Debriefing is another tool that can be used to complement psychological support.

Recommendations for Transformation and Transcendence

Dunning (2006) asserted that health care is associated with healing and a transformation

that includes suffering of the healthcare professional. It is when nurses exposed to traumatic

experiences are able to effectively care for patients as well as engage in the therapeutic use of

self, that transformation and transcendence occur (Mealer & Jones, 2013). Thus, the nurse is able

to therapeutically help others.

Nurses must first heal themselves in order to help heal others (Dunning, 2006). Conte-

O'Hare contended that effective healers are "wounded healers" who have suffered a personal

wound, grown and transcended through the wound, and have transformed their experiences into

healing relationships (Conte-O'Hare cited in Dunning, 2006). One's awareness of brokenness

becomes a powerful tool when caring for those who are victims of trauma (Corso, 2012). Barrett

et al. (2017) made note that being aware of self and the environment and reflecting on

experiences enhances patient care. Conti O'Hare (2018), recommended the use of the Q.U.E.S.T.

Model for self-transcendence to help guide nurses in the recognition and evaluation of

themselves in their ability to deal with and heal from trauma. Transcending or recovering from a

wound requires great insight and reflection to understand the purpose of the experience and to

utilize the experience in a positive way to help others (Dunning, 2006). Wounded healers can

transform experiences to positive uses by recognizing, questioning, and consciously using the experience (Dunning, 2006, Conti-O'Hare, 2002).

To transcend wounds, nurses need to maintain a level of self-care. The integration of self-care routines and enhancement of physical, mental, and spiritual health enables nurses to maintain not only their own personal health but also enhances healing abilities towards their patients (Dunning, 2006). Nurses can apply self-care strategies they use to care for their clients to their own lives (Dunning, 2006). The integration of self-care routines should be integrated into one's daily life and not saved for days off or holidays (Dunning, 2006). In order for nurses to personally care of themselves, it is recommended they get enough sleep, exercise regularly, get good nutrition, relax, enjoy non-work-related activities, manage a good work-family balance, develop coping skills, and concentrate on spiritual needs (Beck, 2011; Coles et al., 2013; Pistorius et al., 2008). To do so, nurses can use the Q.U.E.S.T. Model to help raise questions and self-awareness of their personal situation and potential injury from caring for abused children (Conti-O'Hare, 2002).

The Q.U.E.S.T model begins with a self-assessment is the first step in facing trauma and initiating self-care (Conti-O'Hare, 2002). If one is not self-aware, unhealed trauma within the body and mind may counteract healing (Conti-O'Hare, 2002). If dysfunctional patterns are present in the nurse's life, they must be uncovered (Conti-O'Hare, 2002). Conti-O'Hare (2018) contended that if nurses can recall feelings from a traumatic event and find the meaning of those feelings, they may be able to transform and transcend from the trauma. When past traumatic events can be examined with a renewed focus, nurses are more capable of healing and caring for themselves (Conti-O'Hare, 2002). Nurses who have an awareness of their personal risk of trauma and whom have been informed about traumatic consequences that may occur, can set

limits and priorities, give and accept praise, discuss concerns with others for coping, and develop

a personal plan that includes work, play, rest, physical, psychological, and spiritual care as

additional means of self-care (Dunning, 2006; Coles et al., 2013).

Employers and peers can help educate nurses about potential trauma consequences by

helping them understand and sense the vulnerability, fear, or inadequacy that may need to be

addressed when working with children of abuse (Coles et al., 2013). The understanding of the

various types of trauma implications should be integrated into training for all professionals

working with children of abuse (Coles et al., 2013). Once educated about trauma implications

nurses are better equipped to make self-healing choices throughout the day, such as avoiding

retraumatizing material, like newspapers or movies (Coles et al., 2013). Furthermore, one's day

should be started in balance to begin the day with peace and a positive attitude (Dunning, 2006).

If feasible, doing something creative, gardening, going to church, praying, writing, and traveling

are activities that can further benefit psychological and spiritual health (Coles et al., 2013).

Above all, each nurse has to find his or her own way to manage stress and to use self care

activities to transform and enable growth (Dunning, 2006). Essentially, whatever method works

for the individual to do so, is the "right" way, providing the nurse makes healthy and appropriate

choices (Dunning, 2006, p. 255).

Employment organizations can also contribute to assisting wounded nurses into healing

by educating about potential effects from working with traumatized children. Not only can

organizations educate about recognition and potential effects of trauma but also nursing

vulnerability when working with trauma, risk factors, and coping strategies (Beck, 2011). From

this information nurses may be better able to recognize their own trauma. Providing this

education also helps to facilitate collaboration between colleagues and expression of feelings by

nurses. Encouraging group lunches on a regular basis is another way to help employees to bond and provide comradery needed to cope with the effects of working with abused children (Pistorius et al., 2008). Employers can also offer individual or group therapy for nurses to help them deal with the impact of the job (Pistorius et al., 2008). Weekly meetings can be beneficial to discuss cases and issues of concern as well (Pistorius et al., 2008). Debriefing is an important concept in the process of expressing concerns of trauma. Organizations can utilize debriefing to brainstorm ideas to overcome future traumatic events and to help nurses ventilate feelings. In turn, this helps nurses to transform and transcend to wounded healers.

Implications For Nursing

As noted throughout this review, there are significant impacts on nurses emotional, physical, and spiritual health from working with abused children. It is imperative for the future of nursing that nurses have a better understanding of how to overcome trauma associated from working with abused children and how to become a wounded healer that therapeutically uses oneself to improve patient care. Further research about how nurses can overcome trauma will not only impact nurses directly working with children victimized by abuse but can be generalized to relate to all areas of nursing including nursing education, nursing administration, and nursing practice.

Nurse educators should prepare nurses by educating students on basic competencies in recognizing and responding to violence in positive and helpful ways, as well as in delivery of care to children of child abuse (Coles et al., 2013). Nurses should be educated about trauma symptoms and techniques to manage or minimize symptoms (Meadors & Lamson, 2008). This includes learning about self-care after exposure to trauma to minimize the likelihood of compassion fatigue or other associated trauma consequences (Meadors & Lamson, 2008). This

education can be done through the use of in-services, professional curriculums, simulation

exercises, or role play (Lindsay & Heliker, 2018).

Managers and supervisors in nursing practice, need to be aware of nurses demonstrating

difficulty managing stress and help them develop stress management strategies (Christie &

Jones, 2013). It is imperative that nurse administrators ensure support and supervision from more

experienced nurses trained in responding trauma to help novice nurses in the management of

upsetting cases (Coles et al., 2013). Nurse administrators can also establish workplace

development programs that include trauma and how to identify early warning signs amongst

oneself and others (Coles et al., 2013). Additionally, managers should provide employee

referrals to Employee Assistance Programs or Human Resource Departments asking for

resources for employees who need to resolve professional trauma consequences (Christie &

Jones, 2013). Nurse administrators can be significant in helping nurses initiate the first steps to

becoming a wounded healer.

Summary/Conclusions

This review explored the significance of trauma experienced by nurses caring for abused

or neglected children. Nurses working with children are often faced with witnessing abuse

incidences, working in hostile situations, and conflict with parents/care givers (Coles et al.,

2013). These factors are reasons that make working with children of abuse more challenging and

traumatic.

There are various forms of trauma experienced by nurses. Associated traumas were

defined and differentiated in the review and included compassion fatigue, primary

traumatization, secondary trauma, and vicarious trauma. The exposure to the associated trauma is

more commonly experienced in nurses working with pediatrics and in emergency type settings.

Effects from the exposed trauma have profound effects on the nurses personal and professional life and can have substantial effects on the care provided to patients. Significant mental, physical, and spiritual effects complicate the nurse's ability to provide effective care, establish therapeutic relationships, and remain healthy (Dunning, 2006; Coles et al., 2013; Kanno, 2010; Geoffrion et al., 2016; Maloney, 2012; Meadors & Lamson, 2008; Pistorius et al., 2008; Kellogg et al., 2018; Barrett et al., 2017; Lindsay & Heliker, 2018; Sigad et al., 2016; & Missouridou, 2017). Thus, the nurse becomes a walking wounded.

Current evidence emerged from this review for effective strategies to employ for coping and professional healing. The strategies included acknowledgement of the trauma, self-care, and intentional collaboration among nurses and institutions of employment. The evidence-based strategies were organized through the lens of the theory of The Nurse as the Wounded Healer by Conti-O'Hare.

In conclusion, caring for children of abuse has lasting impacts on the nurse. This project presented evidence-based strategies to offer nurses a theoretic model for transformation and transcendence to overcome the trauma experienced from caring for abused children (see figure 1). With strategies to promote transformation and transcendence to overcome trauma, nurses can become wounded healers that have the ability to therapeutically use oneself to help others. This is imperative for the future of nursing and quality patient care.

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Appendix A

Presentation Poster

Figure 1

Appendix B

Summary of Evidence from Various Levels of the Melnyk's Pyramid

Authors/ Publication Year	Purpose	Design	Sample	Data Collection and Measurement	Findings	Strengths	Limitations	Level of Evidence
Beck, C./2011	To review the literature on secondary traumatic stress in nurses

Defining secondary traumatic stress

Reviewing instruments available to assess secondary traumatic stress symptoms

Clinical implications for nurses at risk of secondary traumatic | Systematic Review | 7 studies reviewed | Data sources: CINAHL, PubMed, PsycINFO databases

Searches included keywords: secondary traumatic stress, compassion fatigue, vicarious traumatization, secondary trauma, PTSD, and nurses

Review of research studies | 7 studies found re: secondary traumatic stress in nurses | Good description of secondary traumatic stress and those at risk

Some recommendation provided for those at risk | Small samples and use of different instruments did not allow for ability to make comparisons across study findings or to draw conclusions | Level V- Systematic Review according to Melnyk Pyramid |

stress are addressed								

Authors/ Publication Year	Purpose	Design	Sample	Data Collection and Measurement	Findings	Strengths	Limitations	Level of Evidence
Maloney, C./2012	To discuss the issue of compassion fatigue and secondary traumatic stress in nursing and the use of debriefing to support traumatized nurses	Conceptual article	N/A-Not listed	N/A-Not listed	Compassion fatigue and secondary traumatic stress are common in nurses There needs to be more focus on the impact or lack of emotional support for those who deal with critical incidence Effects of debriefing discussed	Nice description of the effects of secondary traumatic stress/compassion fatigue Strategy (debriefing) recommended	How data was obtained was not thoroughly discussed, makes reader question value of content	Level V
Authors/ Publication Year	Purpose	Design	Sample	Data Collection and Measurement	Findings	Strengths	Limitations	Level of Evidence
Mealer & Jones/2013	Reporting an analysis of PTSD and its application to nursing	Concept analysis/Literature review	9 articles reviewed in full	Literature review for 1994-2011 with keywords: secondary traumatic stress, compassion fatigue, vicarious traumatization, post-traumatic stress disorder, and nurse	Concept of posttraumatic stress disorder in nursing population well described in Nurse as Wounded Healer Theory Consequences of PTSD in nursing population leads to worldview changes, retention issues,	Link of PTSD/Trauma to Nurse as Wounded Healer Theory	Limited to published and electronically accessible literature which identified the concept of PTSD in nursing or a related term	Level V-Concept Analysis/Literature Review according to Melnyk Pyramid

				Databases searched: CINAHL, PsychINFO, PubMed, and Ovid Inclusion criteria: literature conducted with a nursing sample, studies that measured secondary traumatic stress, compassion fatigue, vicarious traumatization, PTSD, and English language. Articles using non-nursing populations were excluded.	sleep disruption, social network disturbances			
Authors/ Publication Year	Purpose	Design	Sample	Data Collection and Measurement	Findings	Strengths	Limitations	Level of Evidence
Corso/2012	Discussion of compassion fatigue in nurses and benefits of the wounded healer	Conceptual article	N/A-Not listed	N/A-Not listed	Wounded healers powerful and looked up to by other nurses Ones awareness of brokenness and mortality become powerful tools when caring for others	Discussed relevance of trauma and within specialties in nursing Wounded healer benefits discussed	How data was obtained was not thoroughly discussed, makes reader question value of content; Is this opinion?	Level V
Authors/ Publication Year	Purpose	Design	Sample	Data Collection and Measurement	Findings	Strengths	Limitations	Level of Evidence

| Christie & Jones/ 2013 | Description of the nurse of the Nurse as Wounded Healer Theory and how it can be applied in situations of lateral violence. | Conceptual article | N/A-Not listed | N/A-Not listed | Thorough discussion of Nurse as Wounded Healer Theory and application in case of lateral violence in nursing

Lateral violence can be as significant and painful as trauma thus the same pathway through the nurse as wounded healer theory can bring about healing (walking wounded to recognition, to transformation, to transcendence, to wounded healer)

As nurses promote health in their patients, they must also promote health in themselves | Overview and development of Nurse as Wounded Healer Theory discussed | How data was obtained was not thoroughly discussed, makes reader question value of content; Is this opinion? | Level V |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Authors/ Publication Year** | **Purpose** | **Design** | **Sample** | **Data Collection and Measurement** | **Findings** | **Strengths** | **Limitations** | **Level of Evidence** |
| Dunning/2006 | Discuss the impact of stress on healthcare providers | Conceptual article | N/A-Not listed | N/A-Not listed | Healthcare professionals need to preserve their own health in order to help others | Good discussion of health professionals as wounded healers, effects | Article goes in depth into essential oil use as a self-care measure, this | Level V |

					Findings	Strengths	Limitations	
and provide ideas for self-care					Health professionals can recognize healing potential of their own wounds and use them to develop therapeutic relationships with their clients Self-care is an important aspect of being a health professional	of trauma, and self-care ideas	detail not applicable to my project	
Authors/ Publication Year	**Purpose**	**Design**	**Sample**	**Data Collection and Measurement**	**Findings**	**Strengths**	**Limitations**	**Level of Evidence**
Barrett, Denieffe, Bergin, & Gooney/2017	To explore pediatric nurses' views, challenges, and needs of caring for infants who have suffered nonaccidental injuries	Qualitative Research Design	Purposive sampling 10 pediatric nurses from pediatric unit in Ireland	Semi-structured interviews conducted with 10 pediatric nurses (men and women qualified between 2-32 years) and who had cared for infants determined to have suffered a nonaccidental injury Pilot interviews conducted first, then 10 interviews conducted over an 8-month period; length of time for	Pediatric nurses' views of caring for infants who have suffered nonaccidental injuries were stabled under four main themes: personal impact, professional role, nurse-client relationship, and resources Personal emotions are evoked, and experience influenced	Semi structured interviews provided structure to meet aims and objectives of study but also allowed participates to talk openly Strongly ties in support of my independent study project	Small sample size but considered to be diverse due to range of experiences in different pediatric settings and total number of years in practice Participants only recruited from a single acute pediatric ward	Level VI-Single qualitative study according to Melnyk Pyramid

				each interview varied between 24-49 minutes Data analyzed using framework approach	reflection on own lives			
Authors/ Publication Year	**Purpose**	**Design**	**Sample**	**Data Collection and Measurement**	**Findings**	**Strengths**	**Limitations**	**Level of Evidence**
Coles, Dartnall, & Astbury/ 2013	Outline a framework for understanding reactions of primary care providers working in trauma exposed environments; discuss emotional and physical safety issues at work; discuss social, emotional, and physical impacts of child abuse and violence at work; discuss strategies to	Author's Expert Opinion & Conceptual article	N/A	N/A	Discussion of different types of trauma experienced by health care workers exposed to trauma: compassion fatigue, secondary trauma, burnout, and vicarious trauma	Good description of types of traumas	Personal opinion of author	Level V

				reduce and manage potential trauma				
Authors/ Publication Year	**Purpose**	**Design**	**Sample**	**Data Collection and Measurement**	**Findings**	**Strengths**	**Limitations**	**Level of Evidence**
Tingberg, Bredlov, & Ygge/2008	Identify nurse's experiences in the clinical care of children experiencing abuse; access how nurses remain professional especially when the suspected perpetrator is a parent	Qualitative descriptive study	11 (10 female, 1 male) nurses who cared for abused children and their parents in a tertiary care children's hospital Participants were identified via nurse managers at the hospital	Nurses were asked to review the clinical encounter with the child before the interview session Semi-structured interviews gathering information about critical incidents which lasted 30-45 minutes Important areas of discussion in the interviews that came up frequently were identified; the material was coded and categorized, and common themes were identified	Participants expressed difficulties in maintaining professional role in clinical encounters with parents; nurses unhappy with conflicting roles of policing and nursing To remain professional, education, counseling, and experience were essential	Good tie for nurses caring for abused children and their reactions to this Real interview quotes from participants included in article	Generalizations cannot be made Selection process of participants	Level VI-Single qualitative study according to Melnyk Pyramid
Authors/ Publication Year	**Purpose**	**Design**	**Sample**	**Data Collection and Measurement**	**Findings**	**Strengths**	**Limitations**	**Level of Evidence**
Kanno/2010	Discuss importance of	Viewpoint	N/A	N/A-literature	N/A-see strengths	Discussion of prevalence of violence	Personal opinion with little	Level VII

| | | | | | Symptoms of secondary trauma

Discussion of including secondary trauma in the DSM-V | | evidence for support | |
|---|---|---|---|---|---|---|---|---|
| **Authors/ Publication Year** | **Purpose** | **Design** | **Sample** | **Data Collection and Measurement** | **Findings** | **Strengths** | **Limitations** | **Level of Evidence** |
| Missouridou/2017 | To examine and describe nurses' emotional responses in the face of their exposure to patients' trauma. | Conceptual article | N/A | N/A-not listed | Exposure to trauma sometimes causes overwhelming emotions in nurses and this in turn leads to negative behaviors of the nurse (ex. Disengagement, overinvolvement, etc.) | Different perspectives on negative behaviors of nurses exposed to trauma (ex. Overinvolvement) | Limited information within the article that is tied specifically to independent study; conceptual review and does not address the strength of the evidence. | Level V |
| **Authors/ Publication Year** | **Purpose** | **Design** | **Sample** | **Data Collection and Measurement** | **Findings** | **Strengths** | **Limitations** | **Level of Evidence** |
| Lindsay & Heliker/2018 | Explore the lived experiences of emergency service personnel involved in unsuccessful pediatric | Hermeneutic phenomenological approach- goal of understanding the phenomenon from the | Eight emergency service personnel | Semi structured, face to face interview, length of 35-75 minutes

Participants were recruited via flyers at an in-service at a level 1 trauma center and a local | Existential themes included: lived time, lived other, lived space, and lived body | Statistical data of pediatric trauma incidences

Emergency service personnel include nurses caring for | Geographical location of study sample was limited to southeast Texas

Gender diversity-only 2 men participated | Level VI-Single qualitative study according to Melnyk Pyramid |

	resuscitation efforts and how the experience affected them personally and professionally	perspective of each participant rather than generalized feelings Qualitative Study		Emergency Nurse Association meeting Inclusion: emergency service personnel working in emergency centers who experienced the unexpected death of a child after unsuccessful resuscitative effort Use of van Manen's methodology helped analyze the interview data to achieve an understanding of each participant's reflection		abused children- article focuses on this population with ties to independent study project Personal reflections of traumatized nurses included in the article	Researcher's bias of own experience as a pediatric emergency nurse

Authors/ Publication Year	Purpose	Design	Sample	Data Collection and Measurement	Findings	Strengths	Limitations	Level of Evidence
Kellogg, Knight, Dowling, & Crawford/2018	To expand the knowledge of secondary traumatic stress in pediatric nursing by examining statistical relationships between secondary traumatic stress, age of the nurse, years of nursing experience, and coping responses	Cross sectional study with predictive correlational design	N=338 certified pediatric nurses	Convenience sample of certified pediatric nurses were surveyed; hierarchical linear regression and descriptive statistics used to examine secondary traumatic stress with other variables Link to survey material was emailed to a random sample of 6000 certified pediatric nurses for a list of nearly 11700 that was provided by the Pediatric Nursing Certification Board. Collection continued until 350 nurses completed the survey.	Secondary traumatic stress affected more than half the nurses surveyed with age and years of experience not predicting secondary trauma stress	Large sample of nurses from across the US Great description of secondary traumatic stress in nurses	True cause and effect relationship cannot be determined Selection bias potential Truthfulness of self surveys Limitations of online survey use (technology limitations)	Level II-cross sectional study according to Melnyk Pyramid
Authors/ Publication Year	Purpose	Design	Sample	Data Collection and Measurement	Findings	Strengths	Limitations	Level of Evidence
Meadors & Lamson/ 2008	To describe the scope of compassion fatigue in health care	Quantitative Study	185 providers who were employed within a	Participants voluntarily completed a questionnaire	The educational seminar was successful in raising awareness on compassion	Findings supported by previous research and provides	Primarily female sample pool Majority of sample is from	Level II- Quantitative Study (RCT)

	providers working on critical care units with children Evaluate the effectiveness of providing educational seminars on compassion fatigue to health care providers working on critical care units with children		Children's Hospital (PICU, NICU, Peds, Emergency/ other) that attended an educational seminar 179 females, 6 males	before and after the seminar	fatigue and reducing clinical stress Results suggested that providers who experienced higher levels of personal stressors also experienced higher levels of clinical stress and compassion fatigue	avenues for future research	the nursing profession Majority of the pool was employed in the NICU Researchers developed many of their own questions on the questionnaires	
Authors/ Publication Year	**Purpose**	**Design**	**Sample**	**Data Collection and Measurement**	**Findings**	**Strengths**	**Limitations**	**Level of Evidence**
Pistorius, Feinauer, Harper, Stahmann, & Miller/2008	To determine how providing psychotherapy to sexually abused children might impact therapists personally; determine	Qualitative research design	14 Female therapist volunteers, required to have a 2 years post degree clinical, licensed to practice in mental health and worked with sexually	Unstructured interviews with open-ended questions; probing questions for concerning topics of self, trauma, impact, and coping mechanisms	The relationship between the therapist's ability to work effectively with abused children and having strong personal and professional support networks, therapist psychotherapy, colleague group interactions, debriefing/supervisi	Although discussion geared toward reactions from therapists, this ties to other health professionals including nurses	Small sample size from only two different facilities	Level VI-Single qualitative study according to Melnyk Pyramid

	how working with sexually abused children impacted the subject's personal life, thoughts, ideas, beliefs, and behaviors		abused children for a minimum of 6 months Recruited from 2 clinical sites (Texas and Utah)		on sessions, and increased training These explored and recommendations and implications for therapists are provided Personal impacts: experiencing symptoms of vicarious trauma, maintaining appropriate boundaries, greater appreciation for life, increasing own personal growth Coping with the stresses of working with sexually abused children			
Authors/ Publication Year	**Purpose**	**Design**	**Sample**	**Data Collection and Measurement**	**Findings**	**Strengths**	**Limitations**	**Level of Evidence**
Sigad, Davidov, Lev-Wiesel, & Eisikovits/2016	To examine the multiple ways in which the private lives of professional are affected by involvement	Descriptive-phenomenological perspective study Qualitative data study	40 participating professional who had direct exposure to child victims of abuse	In-depth qualitative interviews with semi-structured interview guides were conducted with professionals from various fields (educators, medical professionals like physicians and	Process of internalizing child abuse occurs in two domains: one affirms or denies the existence of the phenomenon; the other concerns the strategies used to contend with the	Participants selected from diverse occupational groups throughout the country Great descriptions of	More detail needed for sample characteristics and gender, etc.	Level VI-Single descriptive, qualitative study

	with child abuse intervention and prevention		Ages 30-70 with 3-46 years' experience in the field of child abuse	nurses, law enforcement officers, and social work and mental health professionals) Open coding was used to identify units of meaning followed by cross-case analysis in which core themes emerged	effects of working in abuse	effects of child abuse exposure on professionals and the different processes they go through		
Authors/ Publication Year	**Purpose**	**Design**	**Sample**	**Data Collection and Measurement**	**Findings**	**Strengths**	**Limitations**	**Level of Evidence**
Geoffrion, Morselli, & Guay/2016	To draw on current literature on compassion fatigue and professional identity to further extend the understanding of compassion fatigue in child protection settings The information	Conceptual article	N/A	Notions of compassion fatigue and identity theory are reviewed These concepts are then articulated around 4 work related stressors specific to child protection work	Integration of notions from identity theory into Figley's compassion fatigue model The way workers negotiate their identities may soothe or exacerbate the impact of compassion fatigue on mental health Cognitive-behavioral therapy may be	Correlation between identity and compassion fatigue Strong summarization of compassion fatigue Although re: child protection workers, data similarly relates to other health professionals such as nurses	Limited to child protection worker data	Level V

	is then expanded upon sociological studies and links psychological states to self-conceptions					beneficiation to help child-protection workers who develop compassion fatigue by reframing means given to work stressors in ways consistent with professional boundaries			
Craig, C., & Sprang, G. (2010).	To investigate the impact of using evidence-based practices on compassion fatigue, burnout, and compassion satisfaction in a random, national sample of self-identified trauma specialists	Correlational design	N=532 Licensed social workers and psychologist from professional membership rosters; 34% male, 65% female; ages 27-83	Random sample of 2000 practitioners representing psychology and social work were selected from a national registry and identified themselves as having some expertise in trauma treatment; surveys distributed and 542 returned with usable data; 10 not used due to having license other than masters or PhD; 30 item professional quality of life scale and 19 item trauma practices questionnaire survey	Age and years of experience proved to be powerful predictors of only two of the three criterion variables, with younger professionals reporting higher levels of burnout and more experienced providers endorsing higher levels of compassion satisfaction. The utilization of evidence-based practices predicted statistically significant decreases in compassion fatigue and burnout and increases in	Findings supporting evidence-based practice to decrease compassion fatigue	Needs expansion to other professional groups	Level VI

					compassion satisfaction.			